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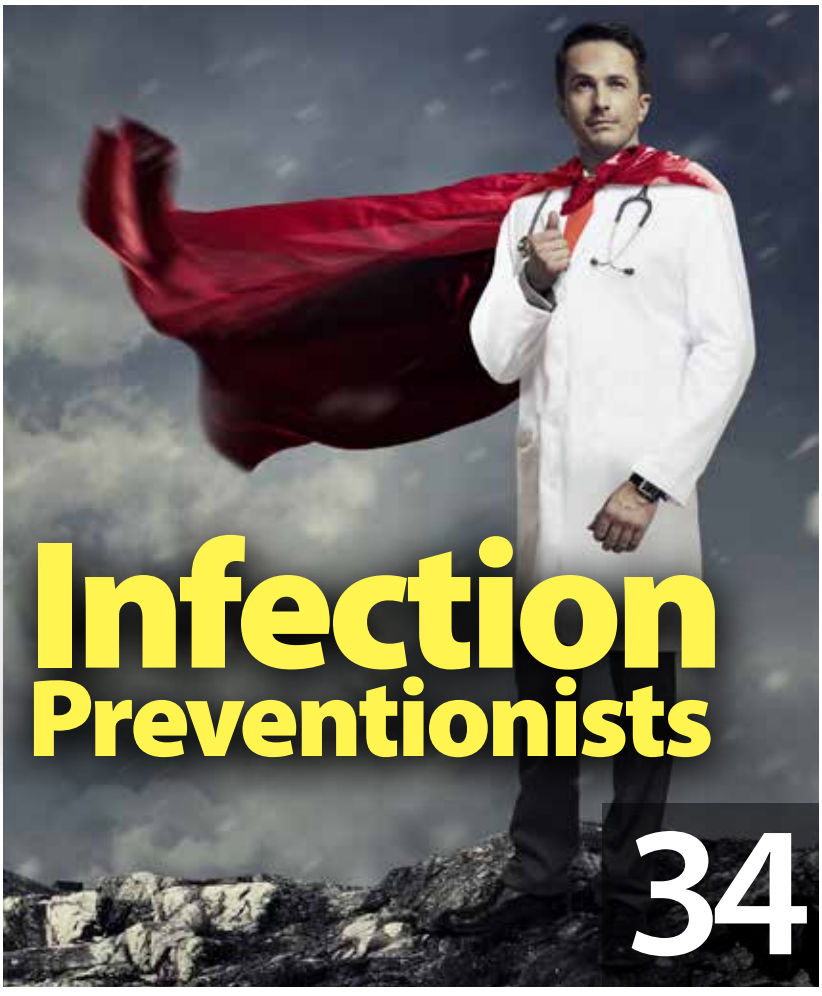

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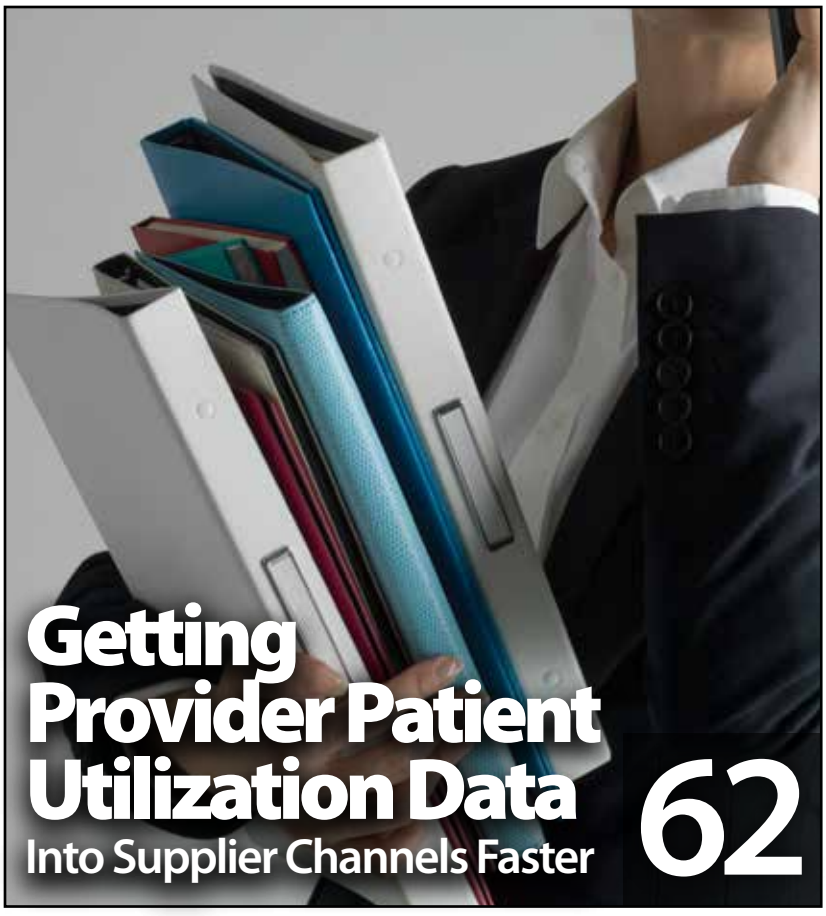

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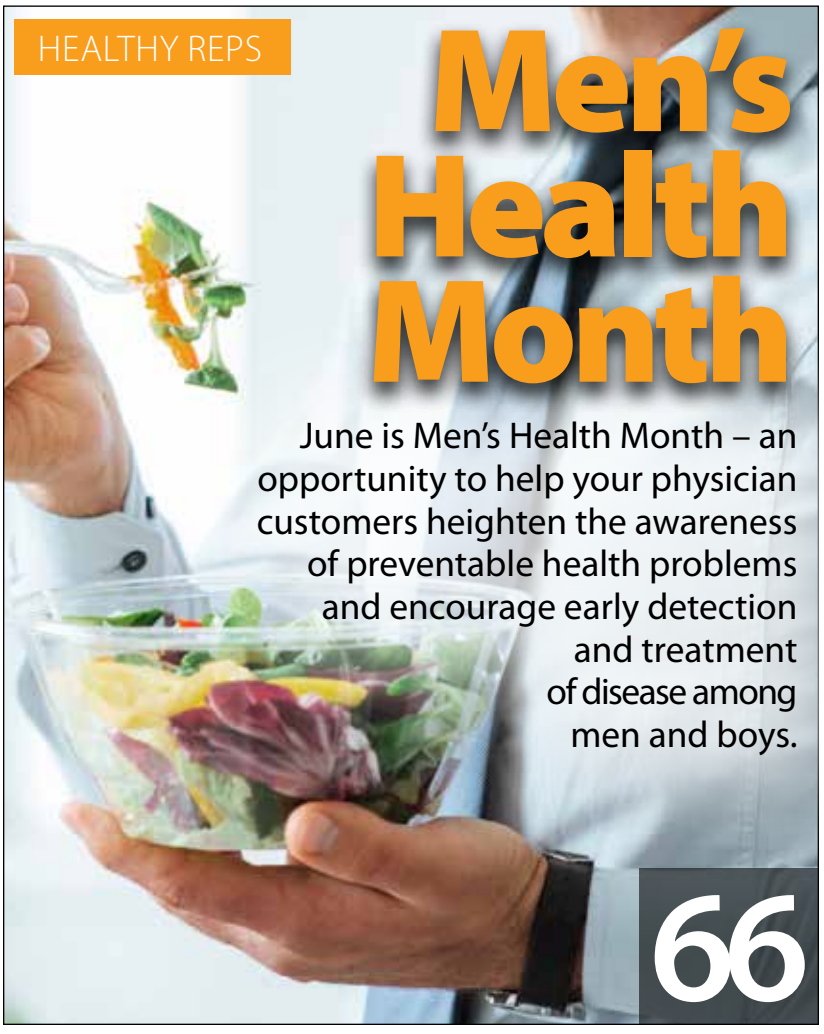

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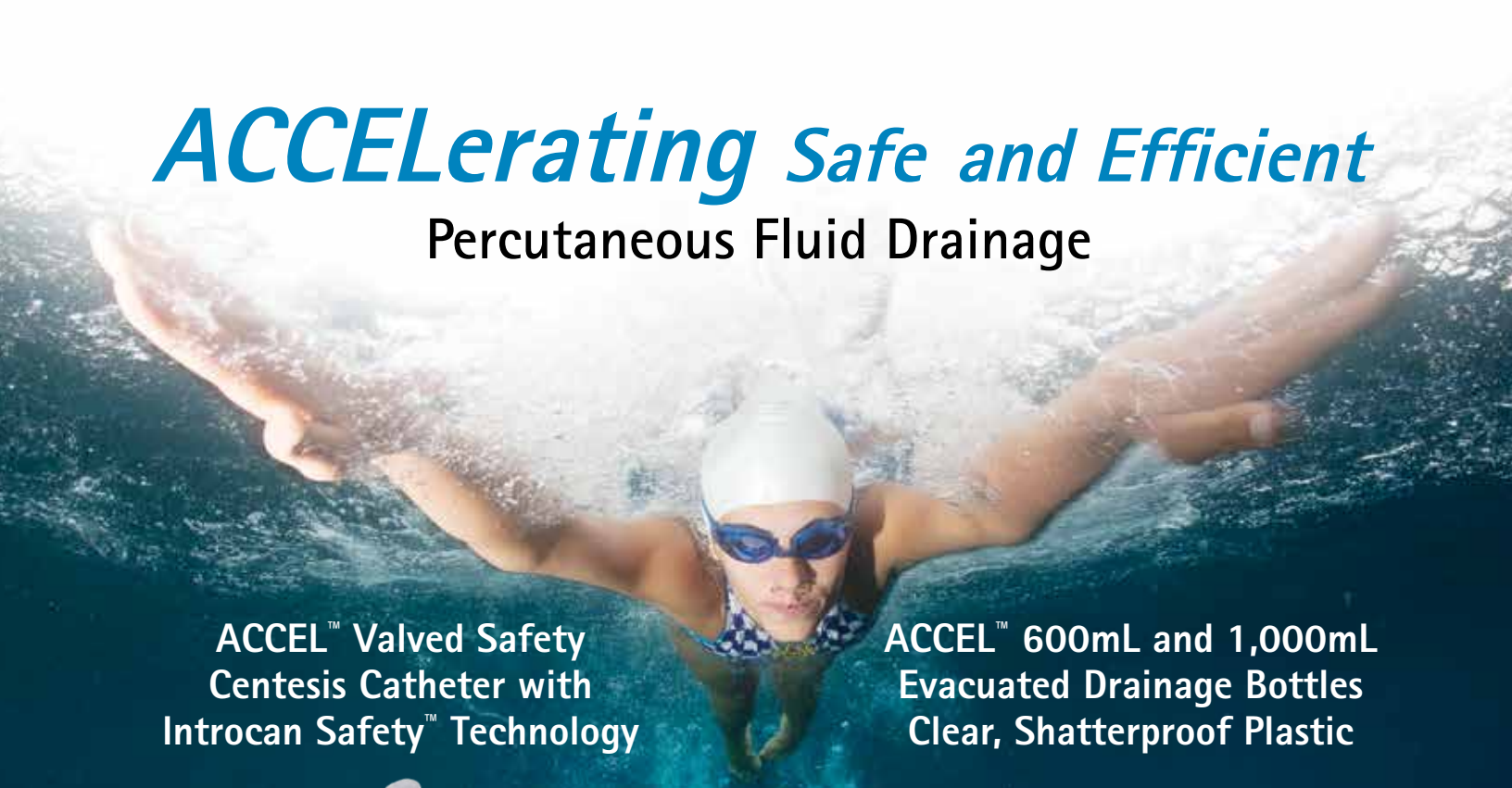

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Summer Blockbusters are Better with Superheroes

Scott Adams

It's June, which means it's *Repertoire*'s annual Infection Prevention issue. Our goal with this issue is to place a spotlight on the importance of this category. Many of us (myself included) often think of Infection Prevention as simply hand washing and surfaces disinfectants. Those are part of the category, but it is also so much more. For most of you reading this issue, Infection Prevention is more than 30 percent of your annual sales.

Stop and let that sink in for a minute.

What other category makes up that much of your volume at the margin it delivers, combined with the fact that most of these products are annuities? So that's what's in it for you!

Now, what's in it for the people you serve, as well as the people they care for in their facilities? Like the people of Gotham, your customers need a superhero when it comes to Infection Prevention. What is the number one task of a superhero? To save!

Weaved within the content of this issue are several ways you can save the care givers of America. By planning for each of these facilities and walking them through the benefits of a healthy practice, you can increase your top line sales and your bottom line GP. A healthy practice means you save them money, by saving them employed days missed and ensuring better patient outcomes.

The key to being the superhero they need is understanding the overall category, and becoming a consultant that helps them make the right decisions for their practice and themselves. By combining the content in this issue, along with the manufacturer reps in this space, you can start becoming that superhero in what is probably the largest category in your bag.

As I have said in the past, protect the Infection Prevention business in your territory. It is great business and a great sense of pride to know you have your accounts' best interests in mind.

Dedicated to Distribution
R. Scott Adams

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A Debt of Gratitude

Industry Hall of Famer honored at NDC Exhibition 2016 – "The Power of Partnership"

NDC bade farewell to longtime board chairman Ted Almon of Claflin Company, and welcomed its new financial partnership with Court Square Capital Partners, at NDC Exhibition 2016 – "The Power of Partnership" – in New Orleans this spring. NDC members also got a close-up look at NuEdge Alliance, the non-acute-care-focused GPO, which is a partnership between NDC and Provista.

In addition to bringing together medical distributors, manufacturers and GPO representatives, NDC also hosted the NDC MOtion1 Sales Meeting. The NDC MOtion1 (rehab) program ran concurrently with the NDC Exhibition, providing rehab-focused dealers with enhanced education, networking opportunities and a tradeshow exhibition.

'Transformational leadership'

In his tribute to Almon, Mark Seitz, NDC president and CEO, said, "If medical distribution were a branch of military service, Ted would be one of the country's most highly decorated veterans.

"During nearly two decades as NDC Chairman, Almon has provided remarkable, transformational leadership," Seitz said. "When Ted was sworn in as Chairman of the Board in July 1998, NDC was operating as ABCO Dealers. ABCO was a buying cooperative serving approximately 30 distributors, focused primarily on the acute care market. Alongside fellow board members, Ted helped design, and then presided over, the decade-long plan to transition ABCO Dealers from a buying cooperative into the healthcare supply company now known to us as NDC.

"Today, as Almon steps down as Chairman of the Board, NDC serves over 300 member distributors and provides sophisticated supply chain services to virtually every independent distributor, to almost every medical supply manufacturer, and to most of the group purchasing organizations serving our industry. All of us that are part of NDC or, for that matter, a part of our industry, owe a tremendous debt of gratitude to Ted Almon for his selfless and effective leadership."

Seitz also announced NDC's new partnership with Court Square Capital Partners. "Court Square is an independent private equity firm that has a long history of successful investments in healthcare and healthcare distribution," he said. "With Court Square's resources and the support of the medical distribution community, NDC will be better equipped to expand our value to independent distribution."

"If medical distribution were a branch of military service, Ted Almon would be one of the country's most highly decorated veterans."

– Mark Seitz

Initiatives

NDC launched several new strategic initiatives in New Orleans.

A new co-branding strategy was announced that is designed to allow member distributors to embrace NDC's recent rebranding efforts and to showcase their affiliation with an extensive network of independent distributors. Among other things, this initiative allows member distributors to win business by leveraging the security of the redundant capabilities of NDC's supply chain.

Also at the Exhibition, representatives from NuEdge and Provista hosted educational sessions and in-booth training on the NuEdge offering. With a new web portal recently launched, showcasing customizable profile pages and features for distributor and manufacturer partners, as well as a quote tool for gaining new customers, NuEdge Alliance is gaining traction among distributors and manufacturers by providing an independent solution to expand share, according to NDC. Enrollment for customers is said to be easy and free of charge.

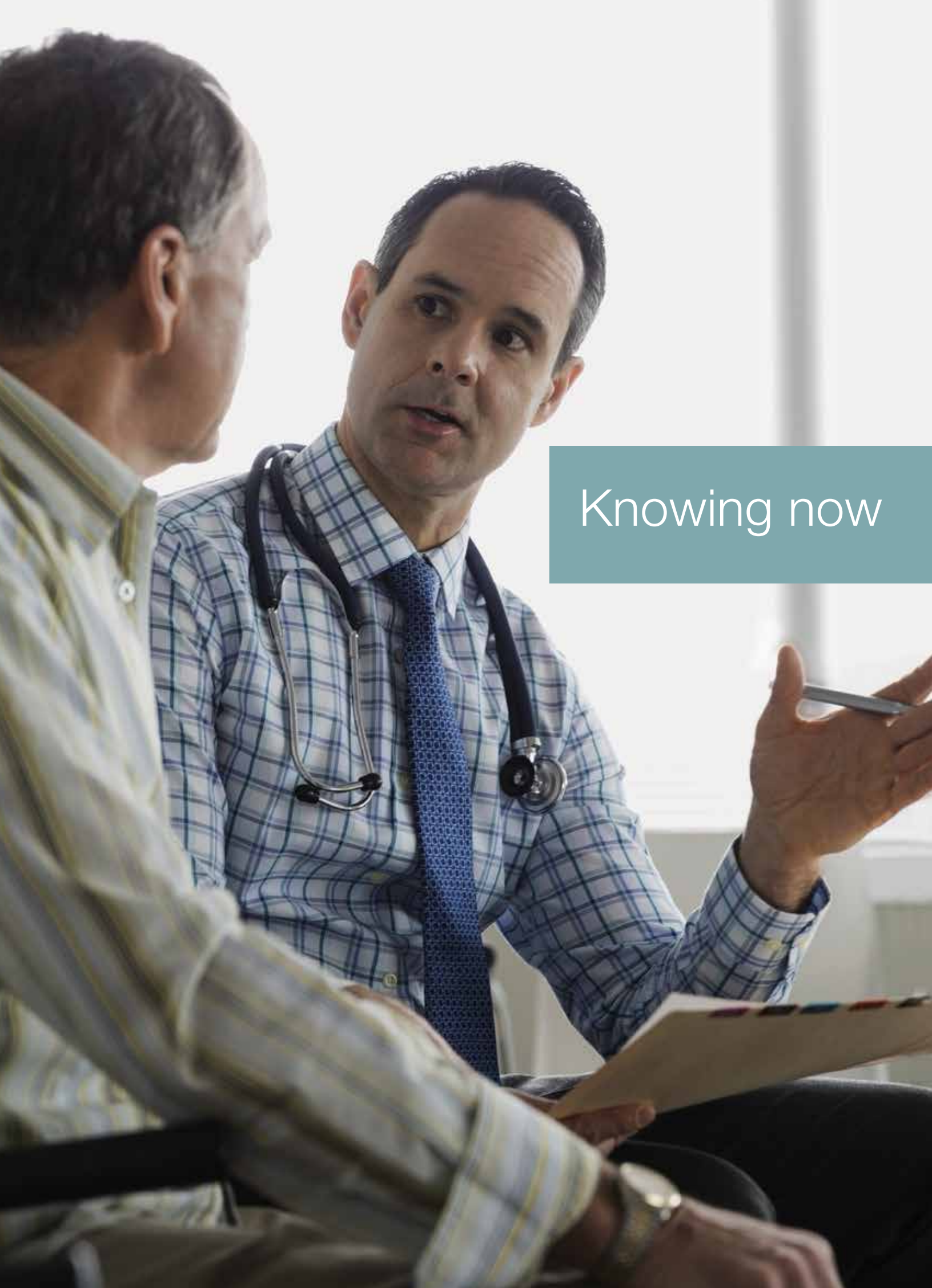
Meanwhile, NDC launched a marketing portal designed to revolutionize members' advertising efforts. The new system – which NDC developed in partnership with Lellyett & Rogers Company, a digital asset and print management firm – will enable distributors to instantly customize and download a variety of marketing collateral supplied by NDC and their manufacturer partners. Products offered include promotional and sales flyers, email marketing, social media campaigns, corporate identity templates, presentation tools and more.

Education

This year's educational sessions offered attendees multiple tracks pertaining to all disciplines within the business. Highlights included operations management, contracts and rebates, and sessions geared toward engaging distributor attendees in membership and technology benefits available through NDC. Sales and executive sessions were highly attended, led by Mike Sperduti, CEO and Founder of Emerge Sales, a leader in business innovation and reinvention, sales acceleration, inside sales and pipeline development.

Midmark Corporation sponsored this year's keynote speaker, graffiti artist, author and entrepreneur Erik Wahl. Wahl's signature keynote, UNthink™, delivered a multimedia experience designed to encourage organizations toward profitability through innovation and superior levels of performance. His on-stage painting challenged attendees to let go of traditional thought patterns and gain a better understanding of how to create disruptive strategies of innovation.

Another highlight of the Exhibition were the owner and manager "Peer-to-Peer" forums. These distributor-only sessions provided a collaborative setting where owners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NDC award winners

Member of the Year:
The Claflin Company

Vendor of the Year:
Smith & Nephew
Wound Management

Member Sales Representative of the Year:
Shane Hutzenbiler, Kreisers, Inc.

Vendor Sales Representative of the Year:
Dan Ingersoll, Mölnlycke Health Care

Trendsetter Award:
ECP Distributors,
Cobalt Medical Supply, Inc.

MedChain Supply Award:
Arkansas Surgical Supply

Customer Service Appreciation Award:
Saginaw Medical Service, Inc.

Marketing Excellence Award:
Claflin Medical Equipment

Phoenix Vendor Awards:
Ansell, Micro-Scientific,
Performance Health

Pro Advantage Awards:
Lynn Medical Inc. (growth);
Kreisers Inc. (sales).

Fast Track Award:
Dove Medical Supply, LLC

Outstanding Performance Vendor Awards:
Midmark Corp. (vendor direct),
Health o meter Professional
Scales (warehouse)

and managers in the acute care, long-term/post-acute and physician markets could share insights on market trends and challenges. This business-to-business networking is one of the most valuable benefits of belonging to NDC.

This year, NDC Premier Vendors hosted distributor attendees at nearby Fulton Alley, for an evening mixing business with fun. The Exhibition culminated with a Mardi Gras Ball/Awards Dinner, sponsored by Roche Diagnostics. Highlights of the evening were Member of the Year, awarded to The Claflin Company, and Vendor of the Year, presented to Smith & Nephew Wound Management. Shane Hutzenbiler of Kreisers, Inc., and Dan Ingersoll of Mölnlycke Health Care, were also recognized as Distributor and Manufacturer Sales Representatives of the Year, respectively. rep


Member of the Year.


Reps of the Year.


Vendor of the Year.

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What Value Analysts Want

Wanda Lane, RN, MAed, CVAHP

Did you ever stop to think how closely your job as a sales rep parallels that of the value analysis professionals upon whom you call? Think about it.

Every salesperson ponders the key to reaching the gatekeeper in targeted accounts. Some product and device reps make it a priority to know and cater to these elusive individuals just long enough to get their wares into the account, and then move on to the next target. Valued distributor reps function a little differently. They deal with both sides of the equation. Every day is one part product rep, one part hospital or IDN account manager, sometimes in direct conflict with one another, sometimes placing you in the middle.

Value analysts, meanwhile, have become the primary point of entry for anyone selling a product or service. Their day consists of one part clinical, one part business, often in direct conflict with one another, placing them in the middle. They act as the bridge between clinical and business, interpreter for both sides, and overseer of all things product.

Recognizing the similarities of the pressures involved with our positions can help the distributor rep and value analyst forge a mutually beneficial relationship. The key lies in knowing what value analysis professionals want.

To explore that question, we gathered together a group of value analysts and asked them to describe their dream distributor account manager. Not surprisingly, some common themes surfaced.

A few too many delays in conversions, or too many well-intentioned but overstated savings promises can destroy a value analyst's credibility in short order.

Trust. Value analysis professionals risk their reputations within the organization daily. A few too many delays in conversions, or too many well-intentioned but overstated savings promises can destroy a value analyst's credibility in short order. Understand if she is wary and overly cautious. Be cognizant of her credibility when discussing savings opportunities and time projections. The best rule of thumb is under-promise and over-deliver – every time. When the inevitable happens – a time frame is extended or savings projection goes awry – own the problem with her. Accept accountability and share the blame. This is even more crucial if your value analyst is new and still learning. Assist her with some wins, and be willing to coach her through the process. Trust-building is time-consuming, but well worth the effort.

Know the reps who support you in the hospital or IDN. A single point of contact was a universal desire. Value analysis professionals know virtually everyone in the hospitals they serve, multiple device and product reps, and you. They navigate the preferences, wishes, wants and requirements of multiple departments, clinicians and physicians, while attending to backorders, recalls, and stockouts. They answer questions regarding contracts, pricing, compliance, quality and outcomes, as they sort through hundreds of emails per day. They rely on you – their distributor account manager – to know the reps providing products to the facility well enough to protect them. Your relationship with product reps is crucial to early notification of problems in the supply chain. That relationship serves as a buffer for the value analyst, providing comfort in having one less thing to worry about.

No surprises. In the supply chain world, surprises are rarely good news. In fact, they are usually crisis-causers. If you are informed of a situation that could affect your customer's supply chain, tell them immediately. Help them understand the intricacies involved with logistics. Remember they are probably clinical; they have limited (if any) knowledge of the number of touches occurring between origination and destination. They may not have considered how weather or natural events, such as earthquakes on the other side of the globe, can affect their product availability. They also don't know what they don't know. But you do. Be their educator and their protector. Make them aware of the steps involved. And keep them apprised of anything that could affect their product supply. Keep the surprises pleasant and keep them informed.

Be proactive. Value analysts are busy people with multiple priorities vying for their attention. Go-to reps will be the ones who are prepared with a possible solution to every challenge. For example, if you must tell your customer that a proprietary product has been discontinued, do some legwork to find a solution before sharing this news.

Second, do your homework. Develop relationships with clinical people in a variety of settings to act as trusted advisers. If you think of a possible solution, confirm feasibility before presenting it to the customer. Saving them the time and hassle of investigating alternatives and determining the feasibility of the proposal will enhance your credibility. The goal is to be the rep the customer trusts to do the right thing and bring the correct information.

Value analysis professionals battle to maintain clinical credibility while providing supply cost containment required from the business side.

Become a part of the team. Work to dissolve the barrier inherent in the term "vendor." Becoming part of the team is essential to overcoming resistance and building trust. Anticipate glitches in the supply chain. When the inevitable backorder occurs, protect your value analysis professional. Align alternative vendors to step in and fill the gap immediately.

Become the buffer. If you know a rep is notorious for going AWOL during a backorder situation, develop a plan of action with that rep for early notification. Be vigilant in protecting your customers and take their challenges personally. They do. They are the face of supply chain. When a product is unavailable, they personally absorb the frustration. Be their partner in this process.

Help them with process challenges. If they don't have a conversion team, suggest that they form one. Ask to be a part of the team and provide insight into the effects of evaluations and conversions on their contracts and product depletion timing.

Make them look great! Value analysis professionals seem to thrive in the spotlight; however, they usually get a bad rap. They battle to maintain clinical credibility while providing supply cost containment required from the business side. This positions you, as the distributor rep, to score some big wins for both sides.

First, suggest projects that will earn them credibility with their peers and enhance the efficiencies of their position. For example, during winter months, supply chain disturbances increase because of road condition delays. Suggest a "winter preparedness" order on crucial supplies. If you know of other potential supply chain challenges, offer creative solutions and assist with presentations.

Second, practicing full disclosure regarding challenges to the supply chain allows time to adjust course. A perfect example of this occurred a few years ago. An entire shipload of containers was retained by United States Customs officers. Anticipating interruptions in the supply chain, a rep chose to alert his customer to the pending crisis. She was empowered by this information to bulk purchase the most problematic supplies caught in the customs snare. The clinical side experienced no interruptions in supply, the extra product was used efficiently, and the materials management staff was commended for the proactive solution-based operation. Without the full disclosure from the rep, the value analyst would not have had time to implement a plan.

When the inevitable backorder occurs, protect your value analysis professional.

Each of these behaviors requires mindfulness and effort. However, the rewards for practicing these principles will be customer loyalty and a flawless reputation. These are just a few suggestions; your value analysis professional will welcome the opportunity to share specific desires from her or his perspective. Ask the question with an open mind and listen. Really listen. Then bring back a plan that addresses their specific needs. These practices will net the elusive key to the gatekeeper. rep

Wanda Lane, RN, MaED, is value analysis manager for Regional One Health, Memphis, Tenn., and Southeast Regional Director for the Association of Healthcare Value Analysis Professionals (AHVAP).

Under the Radar

Interaction between nurses and sales reps studied

The Physician Payment Sunshine Act threw a spotlight on how many payments and items of value vendors give to physicians and teaching hospitals. But a recent article in the *Annals of Internal Medicine*, the journal of the American College of Physicians, may turn a spotlight onto a hitherto unexplored relationship – that between industry reps and nurses.

"Nurse–industry interactions may be common and influential, but they remain invisible in the current policy climate," write the authors of the article – Quinn Grundy, PhD, RN; Lisa A. Bero, PhD; and Ruth E. Malone, PhD, RN.

"Although some aspects of these interactions may be beneficial, others may pose financial risks to hospitals or safety risks to patients. Disclosure strategies alone do not provide health professionals with adequate support to manage day-to-day interactions. Management of industry interactions must include guidance for nurses."

Under the radar

"[A]lmost nothing is known about the ways that RNs interact with industry, though research suggests they may have become an important 'soft target' for industry and a back door to prescribers in light of increasing restrictions on physician-industry interactions," according to the authors. "This has been accompanied by a shift within the medical industry away from traditional marketing channels targeted at physicians, including a reduction in face-to-face marketing and an increase in marketing directed at non-physician clinicians, payers and patients."

Yet administrators appear to be unaware of what's going on.

To find out the true nature of nurse-sales rep interaction, the researchers surveyed and shadowed staff nurses, and asked questions of administrators, supply chain professionals and vendor representatives. "Administrators at eight institutions were initially approached," write the authors. "However, most asserted that nurse-industry interactions 'didn't happen' at their hospitals and that 'nurses didn't have much interface' with industry." None of the hospitals' policies on industry explicitly referenced nurses or nursing practice.

Administrators often characterized reps' in-service education to staff nurses as a "one-time, one-way, contracted event that was therefore outside the scope of industry relations policy," according to the authors. "However, nurses who were responsible for in-service education experienced industry-delivered in-service education as a different phenomenon that was more akin to marketing."

Although marketing to nurses was widely considered innocuous because it is difficult to link to particular decisions, nurses spoke of their ability to influence the distribution of resources and to affect patient care and institutional systems. For example, one infection control nurse served on all of the purchasing committees at her hospital. "She explained that for every product being considered for purchase, 'my concerns have to be addressed before we make a final decision to go with a company or against a company.' This nurse reported that she was heavily courted by sales representatives, who sought to form a relationship with her and to provide product information, gifts, and samples."

Solutions

The researchers concluded that although some aspects of these interactions may be beneficial, others may pose risks "to the financial viability of hospitals, the safety of patient care, and the preservation of the public's trust in the healthcare system." What's needed are policies that include all health care disciplines and aim to manage marketing and conflicts of interest, they say.

The researchers recommend that providers take the following steps.

- Include nurses at all levels in the development of university and hospital-industry relations policy to ensure that the policy is relevant to their practice.
- Allow the nursing profession to take a leadership role by incorporating nurse-industry interactions into professional codes of ethics, adopting conflict-of-interest policies in nursing schools and professional associations, and incorporating preparation for interactions with industry into curricula.
- Use industry representatives to augment clinical expertise, but don't outsource that function to them. Industry-delivered education should be supervised by hospital staff.
- Vendors should compensate support personnel with salary, not commission. Nursing staff should receive regular training to ensure that the boundaries between sales and support are maintained.
- Hospitals should invest in in-house education and support to ensure unbiased, evidence-based continuing education and adherence to hospital policy.
- Hospital administrators need to recognize and support nurses' work with industry. "Such work through purchasing and product evaluation committees should be supported with policies and tools to identify and manage conflicts of interest and to support independent, evidence-based and cost-effective decision-making."

"Interacting with industry is a reality for practicing nurses in acute care hospitals," conclude the authors. "This should be made visible and explicitly identified in job descriptions, should be part of staff orientation, and should be regularly supported through continuing education that addresses the ethical and practical aspects of industry relations."

Source: "Marketing and the Most Trusted Profession: The Invisible Interactions Between Registered Nurses and Industry," Annals of Internal Medicine, Vol. 164, No. 11, Jun 7, 2016.

Nurses agree: An issue worth studying

The study in the Annals of Internal Medicine "addresses an important issue, but more research is needed given its narrow scope," said Cheryl A. Peterson, MSN, RN, senior director, nursing programs, American Nurses Association, responding to questions about "Marketing and the Most Trusted Profession: The Invisible Interactions Between Registered Nurses and Industry."

"Conflict-of-interest issues arise in every practice setting," she said. "However, the Code of Ethics for Nurses with Interpretive Statements makes it clear that the nurse's primary duty is to the patient. The Code of Ethics also mandates that nurses in all roles must identify and, whenever possible, avoid conflicts of interest. Nurses must ethically address such conflicts in ways that ensure patient safety and promote the patient's best interests.

"For the past 14 years, the public has voted nursing as the most honest and ethical profession in America, and with good reason. The public trusts nurses, and with that trust comes a responsibility to uphold the highest levels of quality and standards in our practice."

Editor's note: the Code of Ethics for Nurses with Interpretive Statements may be viewed at www.nursingworld.org/MainMenuCategories/EthicsStandards/CodeofEthicsforNurses/Code-of-Ethics-2015-Part-1.pdf.

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Pharmacists and Primary Care

Is the pharmacist's place behind the counter? Increasingly, pharmacists don't think so. Rather, they believe that given their expertise in pharmaceuticals, wellness and care for the chronically ill, they belong upfront with the rest of the caregivers. That could mean that pharmacists might be a new call point for med/surg sales reps.

Why pharmacists might be a new call point for med/surg sales reps

"The demand for pharmacists in ambulatory care is the highest we've ever seen," says Kristy Butler, PharmD, BCPS, BCACP, FASHP, manager of clinical pharmacy specialists for Providence Medical Group, part of Providence Health & Services in Oregon. "That is largely due to the changing healthcare landscape in general, with its emphasis on preventive health and ambulatory services.

"In healthcare today, of course, we want to make sure that patients receive the highest care when they are in our hospitals, but ultimately, we want to keep patients from having to be in any hospital as much as possible. So the opportunities for pharmacists across a wide variety of settings are increasing."

"Pharmacists [are] in a position to positively improve patient health outcomes, especially related to the use of medications," adds Douglas Scheckelhoff, MS, FASHP, vice president office of practice advancement, American Society of Health-System Pharmacists (ASHP). "The way they interact with patients, where they interact and how often will vary based on the needs of the patient and their setting."

They're everywhere

Pharmacists are likely to be found in physician office practices, accountable care organizations, patient-centered medical homes, specialty pharmacies, clinics and clinics within health systems, says Scheckelhoff. Pharmacists stationed in clinics within health systems of more than 300 beds are most likely to be found in anticoagulation (69 percent), oncology (68 percent), medication therapy management (45 percent), diabetes (44 percent) and family medicine (39 percent), according to the 2015 ASHP National Survey, he points out.

At its Ambulatory Care Summit in 2014, the Society adopted the definition of ambulatory care used by the Board of Pharmacy Specialties: "Ambulatory care pharmacy practice is the provision of integrated, accessible healthcare services by pharmacists who are accountable for addressing medication needs, developing sustained partnerships with patients, and practicing in the context of family and community. This is accomplished through direct patient care and medication management for ambulatory patients, long-term relationships, coordination of care, patient advocacy, wellness and health promotion, triage and referral, and patient education and self-management. The ambulatory care pharmacists may work in both an institutional and community-based clinic involved in direct care of a diverse patient population."

> "The demand for pharmacists in ambulatory care is the highest we've ever seen."
>
> **– Kristy Butler, PharmD**

Says Scheckelhoff, "In some cases, the care [provided by pharmacists] is associated with a retail pharmacy. In other cases, pharmacists are assigned to manage medication therapy for a disease or patient population regardless of setting – so the same pharmacist may spend

"The same pharmacist may spend part of her time caring for inpatients and part of her time with ambulatory patients."

– Douglas Scheckelhoff, FASHP

part of her time caring for inpatients and part of her time with ambulatory patients."

The medical home

The patient-centered medical home is an ideal place for the pharmacist's services, says Butler, who is a member of the ASHP Ambulatory Care Conference & Summit's Consensus Recommendations Panel. In fact, the U.S. Department of Veterans Affairs, Indian Health Service, pharmacy schools and HMOs figured this out a long time ago. With some exceptions, traditional health systems have been slower to catch on. "Providence Health & Services has had pharmacists in the ambulatory care clinics for almost 19 years in the Oregon region – but that's not the norm.

"At first, patients have a lot of questions, like, 'What do you mean, I'm going to meet with a pharmacist?'" she says. "But once they do, they generally are appreciative of our help and recognize that we are a vital part of the care team, with a unique expertise."

The pharmacist's scope of practice is determined at the state level, says Butler. Nearly all 50 states have some sort of collaborative practice agreement whereby the physician and pharmacist together can define the pharmacist's role in medication and care management. But direct billing for services provided under Medicare's fee-for-service system – with the exception of the annual Medicare wellness benefit – remains elusive.

"As healthcare reimbursement changes, I think this will be a great opportunity for pharmacists to continue to expand their role, as we move away from physicians getting paid based on how many patients they see, and move toward reimbursement for the quality of care they provide," she says. "My health system bought into that a long time ago, and that's why we have a large group of pharmacists in our medical home."

Advanced roles

In the ASHP Research and Education Foundation's recently published "Pharmacy Forecast: 2016-2020," nearly 80 percent of the pharmacist panelists predicted that at least 25 percent of health systems would have a formal plan for including pharmacists, along with nurse practitioners and physicians assistants, in advanced roles that allow primary-care physicians to care for more patients.

"In our health system, pharmacists were in advanced roles before we widely employed nurse practitioners or physician assistants," says Butler. "We pharmacists have positioned ourselves in our medical group as medication experts. We don't make diagnoses, but we see patients with chronic medical conditions who need long-term follow-up. We adjust medication for patients with diabetes, chronic obstructive pulmonary disease, asthma, high blood pressure and other conditions where medications

are frequently used. We meet with those patients between their visits with the doctor, reinforce the messaging they get from their physician, and follow up on different things. By doing so, we allow the primary care physician to focus their time on patients who need other care."

Scheckelhoff points out that the opening paragraph of the recently published ASHP Minimum Standard for Ambulatory Care Pharmacy Practice describes best what has happened to the pharmaceutical profession in the recent past.

"Payers have created incentives to decrease hospitalization rates and length of stay, making way for a new shift toward pay-for-performance, outcomes-based reimbursement, and accountable care," reads the document. "There is also an increasing focus in medicine on preventive health, patient education, and care transitions. Yet, the number of patients with multiple chronic medical conditions that require longitudinal and integrated care management across a continuum of care settings is growing.

"Appropriate medication therapy in the ambulatory care setting is often the most common and most cost-effective form of treatment, yet the consequences of adverse drug events (ADEs) and the inappropriate use of medications in this setting can be catastrophic. Ambulatory care pharmacy services are therefore an essential component of any comprehensive healthcare delivery system."

Colleges of pharmacy are catching on.
"Students see practitioners providing care in ambulatory settings, and many are able to have experiential rotations with preceptors in these roles," says Scheckelhoff. "Many are excited by the patient interaction and opportunity to improve care. A growing number are also pursuing residency training with a focus on ambulatory care, either as a PGY1 [postgraduate year one] or PGY2 resident. In fact, the number of ambulatory care residencies is growing faster than any other PGY2 residency program type."

ASHP has long supported a section for members practicing outside of an acute care setting, he continues. "The ASHP Section of Ambulatory Care Practitioners is well positioned to provide the education, practice resources, advocacy, and networking needs of members practicing in or transitioning into ambulatory care practice environments." rep

Group Power

The 32 medical schools in the AMA's "Accelerating Change in Medical Education" consortium gather to brainstorm how to prepare today's medical students to be tomorrow's caregivers

By David Thill

The American Medical Association's "Accelerating Change in Medical Education" initiative emerged in 2013 from a desire to use the collective efforts of many to change the education of tomorrow's physicians. Those efforts were palpable in March, when representatives of 32 medical schools – each of which received AMA grants to work as a consortium to rethink medical education in today's changing world – convened as a group for the first time since the AMA expanded the consortium by 21 schools last fall. The meeting, which took place at Penn State College of Medicine in Hershey, Pa., highlighted each institution's initiatives to train physician leaders, improve community health, and encourage students to maintain a healthy lifestyle throughout their careers.

From physician health to community health

"The work we're doing together with these 32 medical schools will directly impact the way that healthcare will soon be delivered to patients nationwide," says Susan E. Skochelak, M.D., MPH, who is AMA's group vice president for medical education.

"With the support of the AMA … our medical students see healthcare and its challenges not only from the perspective of doctors, but also through the patients' eyes," says Therese M. Wolpaw, M.D., Penn State College of Medicine vice dean for educational affairs. With its new Systems Navigation Curriculum (see February 2016 Repertoire), Penn State is one of several schools focusing on improving healthcare systems as a whole and strengthening the bond between all members of the patient's care team, from physician to care coordinator to family.

Part of this process also involves improving community health. Skochelak says that with their grants, several schools will concentrate on how community members learn about topics such as chronic disease and diabetes prevention. Brody School of Medicine at East Carolina University (May 2016 Repertoire) is among the schools that seek to raise health awareness and fitness opportunities in communities as a whole. Brody is also among several schools preparing its students to take leadership roles in their future career paths.

Recent developments in medical education have shed light on the importance of student wellness.

Mayo Medical School is one of the consortium's schools "looking for ways to measure [wellness] and teach good habits for lifelong practice," says Skochelak. Student wellness has become a major focus in medical education because of a continually changing world. "For physicians in practices, it can be difficult to stay on top of changes in medical structure and the healthcare system." Through work of its own and by funding the schools in its consortium, the AMA hopes to encourage students to begin focusing on the work-life balance early in their education.

"Medical students are not passive consumers of their education," Skochelak says, referring to the Innovation Award Challenge. "They have great ideas about how [education] can be better."

The medical school of the future

This year, the AMA introduced its Medical Education Innovation Challenge, and invited students from across the country to submit project proposals in answer to the question, "What does the medical school of the future look like to you?" according to the AMA website. At the March consortium meeting, the AMA announced this year's winners.

These four winning proposals cover a range of subjects, from creating national electronic databases so that students are not isolated in their respective institutions, to training physicians to be culturally competent and able to address healthcare disparities within communities. (More information, as well as videos highlighting each of the four winners, can be found at www.ama-assn.org/ama/ama-wire/post/students-selected-top-ideas-turn-med-ed-its-head.)

"Medical students are not passive consumers of their education," Skochelak says, referring to the Innovation Award Challenge. "They have great ideas about how [education] can be better."

Now that the meeting has concluded, she says, the AMA and its consortium schools will continue to collaborate, "to prepare tomorrow's physicians to be equipped to quickly adapt to the changing healthcare landscape and make a significant impact on the way healthcare is delivered." rep

David Thill is a contributing editor for *Repertoire*.


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Who Owns the 'Little Data?'

By Bruce Stanley

Dire news stories appear daily describing how Big Data is overtaking industries, economies and even individual lives. I believe the real dilemma is the ownership of "Little Data," that is, data that belongs to individuals and is one of the essential building blocks of Big Data.

The issue of patient medical data ownership and how, when, and where to protect it has been around for quite some time. In the past, most patients trusted their clinicians to provide sufficient security to ensure that little harm could come to their (paper) files/data. There was a free exchange and acceptability of risk by the patients. They accepted the equation "use my data = my treatment." That was the end of the story.

Only recently, with the advent of accelerated technology and problems associated with it, have greater concerns been raised. Examples include misaligned EHRs, miscoding, ICD-10 delays, insurance mismatches and treatment delays and refusals, federal incentives for quickly moving to electronic media, innovative technologies using personal data, identity theft and vendor credentialing.

Today, simple questions, such as "WHAT is the data?" and "WHO owns it?" aren't so simple anymore, and the risks are higher than ever.

Who's worried?

Has technology created the risky world of patient data corruption, or is patient data technology a victim of bad processes and handling? Many of us remember when lists of college grades were posted with social security numbers instead of students' names in an effort to protect their identity. Some states even resorted to using social security numbers as driver license ID numbers.

In the past, if you were lucky enough to get hold of your hardcopy patient file, you probably couldn't read the clinician's handwriting anyway. Patients believed their records were stored securely in each practitioner's office.

But concerns are mounting, given various personal data compromises like social security numbers and passwords, large data breaches, encryption struggles between the government and technology providers, and for vendors,

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credentialing concerns. Over time, patients have become aware that personal medical data is becoming much more susceptible to potential criminal activity.

What's more, innovators and venture capitalists would love to have free access to patient data. Entrepreneurs see it as a way to innovate and thus help control costs and improve care while building new platforms for innovative science. It's hard to disagree with their posture.

But patient data needs to be guarded, just as we protect our personal investment accounts or as a company protects its intellectual property. It's a valuable asset. As investors and as healthcare recipients, we release certain data under strict regulations against fraud and abuse to better our investment/treatment and to support the larger market.

Our dilemma is that the healthcare system is not yet sophisticated enough so that patients can make good choices on how or when to share their medical data.

Power to the patients

The answer of ownership appears easy. It belongs to the patients to do as they see fit. Our dilemma is that the healthcare system is not yet sophisticated enough so that patients can make good choices on how or when to share their medical data. Often they are thrust into data decision-making mode when they are most vulnerable. In the future, patient data advocates may be needed to assist patients and caretakers in the decision-making process.

Concerns about the security of patient data don't appear to be age-related. Students in my MBA class have told me they aren't worried about their medical data. They like having access to it at their fingertips on a hand-held device. But I also hear many seniors say they appreciate being able to read their lab test results on a patient portal and to see their physician's comments online.

There are many thoughts on who owns what and who is responsible for which data. Recently, I heard of a patient receiving an email from their physician prescribing serious treatment for a disease that the patient did not have. In fact, the email was meant for another patient. How embarrassing and potentially serious is this? That patient may now have this miscommunication in their permanent record unless its technological trail is fully redacted.

It's quite possible that there are many owners of the specific data that comprises a complete patient data file. If the premise is that patients own their records, do they really own the prescribed treatments and the doctor's comments?

Lastly, some argue that we need personal healthcare data to drive more innovation and without that, it slows the entire system and processes down. Others believe that technology and the potential benefits from innovation far outweigh the concern of privacy of patient data records.

Business rules and common sense regulations that can be easily understood by patients, clinicians and entrepreneurs need to be in place before patients feel comfortable in sharing their data for any clinical or commercial purpose. In the end I say, protect my "Little Data." rep

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

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Infection Preventionists

The heroes who fight the villains

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Take Will Sistrunk, M.D., an infectious disease physician at Mercy, the Chesterfield, Mo.-based IDN with more than 40 hospitals and 700 physician practices and outpatient facilities. He's been at Mercy 20 years, and he's been in infection prevention for 18 of them.

"When I was in medical school and doing my fellowship, HIV and AIDS were new," he says. "A lot of attention was being paid to them, but there was a lot of misunderstanding by the public, a lot of fear. What was so interesting was the fact that infectious disease doctors were the folks who people relied on to guide them through the process, whether that meant collaborating with public health, physicians who were not infectious disease specialists, health system leaders and others."

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Infection Preventionists

Or Michael Geissler, RN, CNOR, ONC, director of perioperative services at Rothman Orthopaedic Specialty Hospital, a six-OR, 24-bed specialty hospital in Bensalem, Pa.

Initially, Geissler had some hesitation about assuming the double role of director of perioperative services as well as infection preventionist. "There's a lot to take into consideration dealing with the infection process and trying to prevent not only surgical site infection, but communitywide infection as well, whether it be influenza, Ebola, all those things," he says. Challenging, yes, but Geissler is proud of what he and his colleagues have accomplished in safeguarding Rothman's patients and staff.

Or Timothy Bowers, corporate director for infection prevention, Inspira Health Network, Vineland, N.J.

"Infection prevention affects every moment of every day," he says. "It can be difficult to grasp that. Words don't do it justice. But the question for caregivers is, 'How do you go through the day without hurting yourself or your patients?'" Infection preventionists try to provide the answers.

Not for the sedentary

The effective infection preventionist doesn't sit in his or her office for long, says Sistrunk. "You collaborate with people every day." And if H1N1 is this month's issue, next month, it might be Zika or Ebola.

Sistrunk welcomes the fact that colleagues lean on him for his expertise. "They ask, 'How do we take care of our patients?' Infection prevention is a big part of that. As healthcare workers and co-workers, we have to make sure we care for patients in a safe way.

"Our communities expect us to care for patients too," he continues. "If someone comes in with Zika, we have to understand isolation procedures, collaborate with the health department. That's the intriguing part, and that makes it fun – and challenging."

Payers too are increasingly turning their attention to infection prevention, going so far as to review the infection rates of their network providers and would-be providers. "And the government is saying, 'We're not sure we want to pay you [if your infection rates are excessive].'

"There's a lot of education involved," adds Sistrunk. That's because a big part of the infection preventionist's job is to point out all those things that can be done to make patient care as safe as possible, such as practicing good hand hygiene, implementing isolation precautions when necessary, and wearing appropriate personal protective equipment and apparel. "We have to continue teaching these things all the time, otherwise people may stop doing them." Add to that a plethora of new products designed to address infection.

"When I was in medical school, you learned there was an acceptable, unavoidable risk of infection related to healthcare," he says. "But with today's focus on infection prevention, with all the new products available, and with the greater understanding of how infections spread, there no longer is an acceptable rate. Our goal is zero infections. So the pressure is on."

Geissler believes that directing infection prevention activities has actually helped improve his performance as an OR director. "It keeps you focused on your staff, and [empowers] you to give them information quickly. It even affects things like changing supplies. In the director level, you might make changes for reasons of cost containment or someone's personal preference. But [as infection preventionist], I see the potential impact of a supply on infection. So it definitely keeps that person – the OR director – grounded."

"When I was in medical school, you learned there was an acceptable, unavoidable risk of infection related to healthcare. But with today's focus on infection prevention, there no longer is an acceptable rate. Our goal is zero infections. So the pressure is on."

– Will Sistrunk, M.D.

Dual role

At a small specialty facility such as Rothman (with six ORs and 24 beds), Michael Geissler's dual role as director of perioperative services and infection preventionist makes sense.

Though he had years of experience in OR management, Geissler was not formally trained in infection prevention. But he attended courses of the APIC, that is, the Association for Professionals in Infection Control and Epidemiology, which gave him a foundation and structure for his new role. And he reads everything he can get his hands on, as every infection preventionist must do.

Being grounded all the time isn't necessarily easy. "The biggest challenge is being aware of all the minutiae that can lead to infection or increase the potential risk of infection," says Geissler. "As a staff member, these are things you're not necessarily dialed in to."

Then there's the detective work that must be undertaken when a call comes in about a patient with a suspected infection. "You ask, 'What is it?' 'Did we have a breach in protocol?' 'Was the patient sick before surgery?' 'Could it have been caused by an implant from the manufacturer?' 'Did we care for the dressing properly?'

"And I'm thinking, I'm responsible for all of this."

Infection Preventionists

The trick is to raise people's awareness of infection prevention protocol without breathing down their necks, he says. Rather than being perceived as a watchdog or overseer, Geissler has worked to establish a collaborative arrangement with front-line staff so that together, they can ensure the safety of patients and staff. At press time, he was working on a performance improvement project designed to make it "second nature" for OR nurses and techs to practice good hand hygiene prior to opening anything sterile in the field.

"We don't have many surgical site infections," says Geissler. "Over the last 12 months, we've only had two, out of 4,700 cases. Still, I think we can challenge those numbers."

> "The question for caregivers is, 'How do you go through the day without hurting yourself or your patients?'"
>
> **– Timothy Bowers**

Stay informed, stay focused

While working as a medical technologist at Thomas Jefferson University Hospital after graduation, Timothy Bowers developed skills in microbiology and virology, and an interest in patient safety. At the time, infection prevention was a field of rising interest, as some states, including Pennsylvania, were just beginning to mandate that healthcare systems publicly report their incidence of healthcare-acquired infections.

So, at around the same time he received a master's degree in health policy, he accepted a position as infection control practitioner at Penn Presbyterian Medical Center. In 2011, when the corporate director position at Inspira opened up, he gladly pursued the chance to assume a larger role in patient safety.

With so many villains to chase today – including central-line-associated bloodstream infections, catheter-associated urinary tract infections, C difficile, MRSA, surgical site infections and more – where does the infection preventionist focus his or her efforts? That depends on a lot of things, such as where you practice, and when, says Bowers, who is a member of the APIC Communications Committee. So, CAUTI-related issues might take center stage at one point, then C difficile at another, then something else. Bowers dials into the APIC listserv to find out what his colleagues are experiencing, and how they can help each other.

"As a community, we rely on each other," he says, referring to fellow infection preventionists. "And at Inspira, we really engage front line staff," including nursing, transport, environmental services, physicians who see patients on the floor, volunteers, etc.

Infection preventionists rely on another source of support – supply chain management.

"I have a great relationship with our supply chain management group," says Bowers. Front line staffers attend shows and educational conferences throughout the year, and often come back with a suitcase full of product samples and literature. With the help of supply chain, Bowers and his team ask some fundamental questions: "What is this new product addressing?" "Is it something we have already addressed?" "Is this a better way of addressing it?"

A case in point were ultraviolet light "robots" that can disinfect an OR suite or patient room in a few minutes. "A few years ago, there were only a few vendors offering them," says Bowers. "Now there are 12 or 15." The infection prevention team studied the data and, with supply chain's help, secured several of the systems at a reasonable price.

"We really do our due diligence," he says. "We don't want to discount something that could bring additional safety for people, but on the other hand, we don't want to bring everything in."

A good, trusting relationship with vendors helps too. "If I see a vendor in the hall and I'm not too busy, I have no problem sitting down and talking. But I need to know they are being on the level with me. And if you can't tell

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Infection Preventionists

"What is this new product addressing? Is it something we have already addressed? Is this a better way of addressing it?"

–Timothy Bowers

where the relationship ends and the sale starts, you have a problem."

The road ahead

Infection preventionists look to the future with anxiety and optimism.

For example, biofilm makes Geissler nervous. Microorganisms can build up on the surface of a surgical instrument that hasn't been cleaned promptly or thoroughly. But that buildup can be invisible to the human eye; in other words, the instrument looks clean, but isn't. Geissler believes that bleach-based products remain the gold standard for killing spores.

Despite the challenges, Geissler is optimistic about the future. "There's a better focus on infection prevention today," he says. Mass media and social media have helped spread the word throughout the population. The fact that healthcare facilities publish their infection rates has been helpful too. "All these things are definitely helping fuel the fire to keep people's attention on what we can do to prevent infection."

Sistrunk worries about antibiotic resistance. "We see some bacteria that are resistant to almost all antibiotics, and if we use antibiotics more and more, we will have a real problem." The infection prevention team at Mercy collaborates with many people to address the issue. "For example, we work with the microbiology lab to get data to caregivers quickly, so they can make sure our patients are on the correct therapy as soon as possible," he says.

On the bright side, more attention is being paid to infection prevention today than years ago, when Sistrunk was in medical school. Patients, their families, providers and vendors are all more concerned, he says. "As a result, we're having productive discussions that are getting us down the road to patient safety."

What's more, new infection prevention data tools are available to help providers identify patients at risk of infection, so precautionary measures can be put in place quickly. "We have the ability to track infection data in real time, to see what works and what doesn't," says Sistrunk. "That helps us understand how we can more effectively make a difference, and not do something because we think it will work, but because we know it will really help us."

Any time people interact with each other or the environment, the potential for infection exists, says Bowers. That's why infection preventionists need the support of administration to create a culture of safety. Bowers says he has that support at Inspira.

"And our staff is the best," he adds. "Whether they are fresh out of the gate or been here forever, they are all in this for the right reason. When we talk about hand hygiene, they know there won't be any sirens or screaming. We tell them, 'We're trying to keep you safe, so you can provide the best care for your patients.' And they take it in that context." rep

Meet the vendors

Given the product-intensiveness of infection prevention, it's no surprise that infection prevention professionals are inundated with sales pitches from vendors and front-line staff.

Michael Geissler, RN, CNOR, ONC, director of perioperative services at Rothman Orthopaedic Specialty Hospital, a six-OR, 24-bed specialty hospital in Bensalem, Pa., expects sales reps to explain the efficacy of their products and to produce data to back up their claims. He also wants to know that when a vendor walks in the door, he or she knows the population Rothman serves. "If you're not prepared, I'm not entertaining a visit from you," he says.

Meanwhile, Will Sistrunk, M.D., an infectious disease physician at Mercy, the big Catholic IDN based in Chesterfield, Mo., says providers need vendors to think outside the box. (He considers himself lucky to be able to draw on the knowledge of Mercy Research, a subsidiary that performs clinical research and is coming up with new ideas in infection prevention.) "We can no longer consider products that are just OK," he says. "Our goal is zero infections. For us to get there, we have to collaborate with industry. If we do, we will have consistently safer healthcare." rep

Superbugs threaten hospital patients

America is doing a better job of preventing healthcare-associated infections (HAIs), but more work is needed, especially in fighting antibiotic-resistant bacteria, according to the Centers for Disease Control and Prevention in a recent Vital Signs report.

In acute care hospitals, one in seven catheter- and surgery-related HAIs can be caused by any of the six antibiotic-resistant bacteria listed below. That number increases to one in four infections in long-term acute care hospitals, which treat patients who are generally very sick and stay, on average, more than 25 days. The six antibiotic-resistant threats examined are:

- Carbapenem-resistant Enterobacteriaceae (CRE)
- Methicillin-resistant Staphylococcus aureus (MRSA)
- ESBL-producing Enterobacteriaceae (extended-spectrum β-lactamases)
- Vancomycin-resistant Enterococcus (VRE)
- Multidrug-resistant Pseudomonas aeruginosa
- Multidrug-resistant Acinetobacter

Hospitals improving

The national data in the Vital Signs report, along with data from CDC's latest annual progress report on HAI prevention, show that acute care hospitals have achieved:

- A 50 percent decrease in central line-associated bloodstream infections (CLABSIs) between 2008 and 2014. (One in six remaining CLABSIs are caused by urgent or serious antibiotic-resistant bacteria.)
- A 17 percent decrease in surgical site infections (SSIs) between 2008 and 2014 related to 10 procedures tracked in previous HAI progress reports. (One in seven remaining SSIs are caused by urgent or serious antibiotic-resistant bacteria.)
- No change in the overall catheter-associated urinary tract infections (CAUTIs) between 2009 and 2014. During this time, however, there was progress in non-ICU settings, progress in all settings between 2013 and 2014, and most notably, even more progress in all settings towards the end of 2014.

The Vital Signs report also examines the role of Clostridium difficile (C. difficile), the most common type of bacteria responsible for infections in hospitals. C. difficile caused almost half a million infections in the United States in 2011 alone. CDC's annual progress report shows that hospital-onset C. difficile infections fell by 8 percent between 2011 and 2014.

Editor's note: The Vital Signs report can be viewed at www.cdc.gov/vitalsigns/protect-patients/

Infection Preventionists

Leadership a must in big health systems

It's tough enough to instill a culture of safety in one hospital, given the myriad of front-line staff and patient encounters. But how about an IDN of 30 or 40 hospitals, and a bundle of outpatient facilities?

"My typical week is a blend of patient care and leadership and administration," says Will Sistrunk, M.D., an infectious disease physician at Mercy, the 40-plus-hospital IDN based in Chesterfield, Mo.

"The most important thing you can do is make infection prevention a priority of leadership." When leaders meet, when caregivers meet, you want them to be talking about patient safety and infection prevention, he says. "In a big health system, you have to encourage that. You have to have data that supports it. You have to be transparent with that data. And you have to continue to make it a priority. It's not something you can quit talking about.

"There are a lot of priorities out there," he continues. "But with infection prevention, you have to keep at it in order to get everybody to help you. You want to develop a culture of leadership where everybody – physicians, providers, vendors, everybody – is thinking about the patients and about doing the best we can for them."

Timothy Bowers, corporate director for infection prevention, Inspira Health Network, Vineland, N.J., says that although the acute-care hospital may present the greatest risk of an infection-related event occurring, attention must also be paid to outpatient facilities, where hundreds of thousands of patient encounters take place.

The Centers for Disease Control as well as APIC have provided resources regarding infection prevention in the ambulatory care setting, he points out. "But it comes down to having somebody with a fresh set of eyes asking, 'Can somebody get sick from our care?'

"It's a different mindset, but you can usually find at least one person in each setting who realizes that in giving great care, you are preventing infection. It's a great mindset, and if you nurture it, it spreads quickly."

Everything you always wanted to know about infection prevention in the outpatient setting

Are you or an outpatient manager you know looking for information about how to set up and maintain a comprehensive infection prevention program specifically for the outpatient setting? What you're looking for does exist and is available for free download.

The "Guide to Infection Prevention for Outpatient Settings: Minimum Expectations for Safe Care" reflects evidence-based guidelines produced by the Centers for Disease Control and Prevention and the Healthcare Infection Control Practices Advisory Committee.

By highlighting existing CDC and HICPAC recommendations, the guide: 1) provides basic infection prevention recommendations for outpatient (ambulatory care) settings; 2) reaffirms Standard Precautions as the foundation for preventing transmission of infectious agents during patient care in all healthcare settings; and 3) provides links to full guidelines and source documents, which readers can reference for more detailed background and recommendations.

Included are recommendations for:

- Setting up a program, and training staff on it
- Surveillance and reporting of healthcare-associated infections
- Hand hygiene
- Use of personal protective equipment
- Safe injection practices
- Cleaning and disinfection of environmental surfaces
- Cleaning and disinfection or sterilization of medical devices
- Respiratory hygiene/cough etiquette

A link to the Guide and accompanying checklist is available at www.cdc.gov/HAI/settings/outpatient/outpatient-care-guidelines.html

INFECTION PREVENTION: SPONSORED BY GP

Be Their Infection Prevention Hero

With great power comes great profitability

They may not be the diabolical costumed maniacs you see in the movies, but supervillains are real and it is up to you to stop them (cape, tights, and superpowers optional). The villain is disease, and you and your customers are on the frontlines of a literal fight to save the world every single day. With the right approach to your infection prevention offerings, you can improve the health of your practice and become a hero to your accounts.

For many reps, the infection prevention category is an untapped source of power. In most cases the infection prevention category represents more than 30 percent of the total med-surg sales to a practice or a hospital. But for various reasons, many reps don't see the category as a priority.

Reps may tend to shy away from the category because of the lack of regulatory and financial incentives for the markets served by their accounts. Now, possibly more than ever before, infection prevention is a priority in the acute care market. Acute care organizations are under tremendous pressure and highly incentivized to make infection prevention a priority. Like Metropolis has Superman, most of the acute care market is already "taken care of" by various GPOs, RPCs, and so on.

Yet while the acute care market may face the most regulatory pressure to step up its infection-prevention game, disease doesn't limit itself to the emergency department. Physician groups and individual physician offices, dermatology offices, specialty services, long-term care facilities – the rest of the continuum of care is holding out for a hero.

Most tend to think that the category only contains a few, low-dollar products like hand soaps, surface disinfectants, and personal protective equipment such as gloves or surgical masks.

Among reps there is a widespread (and inaccurate) view that infection prevention isn't big enough or lucrative enough to prioritize. Most tend to think that the category only contains a few, low-dollar products like hand soaps, surface disinfectants, and personal protective equipment such as gloves or surgical masks. But those products are only the core of the infection prevention area. A complete infection prevention program includes each and every product that can be used to break the chain of infection.

Be the street-wise Hercules – fight the rising odds

So what would a complete infection prevention program look like? A robust infection prevention offering includes everything from the obvious products like gloves and surface disinfectant down to the everyday necessities. Every single practice and hospital has an essential need for many other related products like paper towels, toilet paper, facial tissue, and soap and/or sanitizer.

For example, nurses wash their hands countless times every

day. It goes without saying that your infection prevention offering will need to include hand soap and sanitizers to stop any potential disease transmission during handwashing. But that soap isn't doing your account any good if the first thing they touch after handwashing, paper towels, are exposed to cross contamination. To help your account truly break the chain of transmission in the hand-hygiene area, they are going to need more than just hand soap. A logical and ideal solution to such a dastardly threat is enclosed dispensers with touchless dispensing.

Such a dynamic duo is a winning situation for both your customer and you. Not only will your account benefit from reducing the likelihood of cross-contamination, but such dispensers also reduce waste and associated costs by cutting down on the over usage that can occur with pump soap and multifold towels.

There are opportunities like that all over the infection prevention category. Your accounts need these products every single day for their employees, patients, and visitors. The savvy rep will seize this opportunity and include all of those often-overlooked but essential products to their infection prevention program

Knowledge is power

Infection prevention can make you the most valuable rep to your practices. Knowledge is power. Talk to your practices about infection prevention. They no doubt understand the importance of infection prevention but they may not realize just how much they can actually do about it. Talk to them about how you and they can work together to assemble a complete infection prevention strategy. Alerting them to the need for and then providing them with a robust offering of infection prevention products and solutions will boost your repertoire and make you their hero.

You win as well. The infection prevention category is a great source of annual revenue. Whether it's the threat is just the common cold or this year's superplague, infection prevention is a never ending fight. Since the category is not seasonal like many other products, it is a steady revenue stream, month in, month out. For instance, the covered dispenser solutions can create sticky and lasting business for you. Once that dispenser goes up on the wall it becomes an indispensable aspect of the account's infection prevention practices. A quality dispenser may last for years, which means it is going to need years and years of refills. Think about it this way, when there is trouble in Gotham, they turn on the bat-signal. If you've established your hero credibility, when a practice needs a refill, they are going to come to you first to place those orders.

Infection prevention can make you the most valuable rep to your practices. Knowledge is power. Talk to your practices about infection prevention. They no doubt understand the importance of infection prevention but they may not realize just how much they can actually do about it.

Excelsior!

With the right plan, you will directly improve the health of your customers' practices. Implementing a complete infection prevention program will lead to both a healthier patient population as well as a healthier staff. Once you win their business, your accounts stay with you for years to come. That business doesn't stop at the infection prevention category. By keeping their practice (literally) healthy and helping them deliver better patient care/outcomes, you will become the hero your accounts need. Going forward, whether it's one of those top-dollar items, advice on various products, or anything in between, when that practice is in need, the first person they will look to is you, their friendly neighborhood sales rep! rep

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Help Their Patients

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PERFORMANCE AT WORK™

INFECTION PREVENTION: SPONSORED BY BD

BD Vacutainer® UltraTouch™ Blood Collection Sets

New device helps improve infection prevention and enhance the patient experience.

The new BD Vacutainer® UltraTouch™ Push Button Blood Collection Set aims to improve phlebotomy procedures for both clinicians and their patients. It not only offers clinically proven protection for clinicians against costly needlestick injuries that potentially expose them to bloodborne pathogens, but also features proprietary needle technology to help enhance the patient experience.

"Phlebotomy is often one of the first procedures hospital patients undergo and one of the first interactions they have with an institution's clinical staff, which can set the tone for the entire hospital stay," says Dr. Ana K. Stankovic, worldwide vice president of medical affairs for BD Life Sciences – Preanalytical Systems and Global Health. "With U.S. reimbursement levels tied to patient satisfaction and the rise of online patient reviews, clinicians are seeking ways to improve these high-touch procedures."

The BD Vacutainer UltraTouch Push Button Blood Collection Set employs patented PentaPoint™ Comfort 5-bevel needle technology. Studies have shown that this design helps reduce the chance of a painful injection by creating a flatter, thinner surface to help penetrate the skin with significantly greater ease.[1] When combined with BD RightGauge™ technology, which increases the needle's inner diameter and enables clinicians to select a smaller gauge needle, this new device can reduce penetration forces by up to 32 percent when compared to another leading blood collection set.[2]

"The ability to use smaller gauge needles should also help clinicians access veins more successfully," says Dr. Stankovic. "This could prove especially valuable in certain patient populations, which have difficult or fragile veins."

According to Dr. Stankovic, clinicians are traditionally reluctant to use smaller gauge needles (i.e., a 25-gauge needle versus a 23-gauge) for fear of increasing hemolysis – the rupture or destruction of red blood cells – as the blood passes slowly through the narrow cannula.

"With BD Vacutainer UltraTouch Push Button Blood Collection Sets, clinicians can select the gauge that is most appropriate for their patients, without compromising sample quality, testing accuracy and their own efficiency," says Dr. Stankovic.

This new product also features clinically demonstrated safety technology – a split-second retracting needle that offers in-vein activation – which has been shown to reduce needlestick injuries by up to 88 percent over forward-shielding safety blood collection sets.[3]

To determine whether this next-generation safety blood collection set is right for their clinical customers, sales reps should ask:

- "What kind of feedback do you receive from your patients about their blood collection procedures?"
- "How often are your clinicians challenged with accessing difficult or fragile veins during phlebotomy procedures?"
- "Do your clinicians currently use a forward-shielding safety blood collection set?"
- "Are phlebotomy-related needlestick injuries a concern to your clinicians?"

[1] Hirsch L.J. et al. *Journal of Diabetes Science and Technology*. 2012, 6(2):328-35.

[2] 2015 BD bench testing versus BD Vacutainer® Push Button Blood Collection Sets

[3] Hotaling M. A retractable safety winged steel (butterfly) needle performance improvement project. *Joint Commission Journal on Quality and Patient Safety* 2009, 35(2):100-105.

Draw a new experience.

BD Vacutainer® *UltraTouch*™
Push Button Blood Collection Set

Reduces accidental needlesticks up to 88%
Single-handed, in-vein safety activation instantly retracts needle after use.

Minimizes patient discomfort
PentaPoint™ bevel requires 32% less penetration force.

Improved venipuncture
Ultra-thin RightGauge™ cannula allows the use of a smaller gauge suitable for more veins, without compromising filling times or sample quality.

It's unparalleled—for patients and clinicians

Now you can offer the BD Vacutainer® *UltraTouch*™ Push Button Blood Collection Set.

BD item #	Item description
367363	25G x 0.75" needle with 12" tubing and luer adapter
367364	23G x 0.75" needle with 12" tubing and luer adapter
367365	21G x 0.75" needle with 12" tubing and luer adapter
367391	25G x 0.75" needle with 7" tubing and luer adapter
367392	23G x 0.75" needle with 7" tubing and luer adapter
367393	21G x 0.75" needle with 7" tubing and luer adapter

BD

INFECTION PREVENTION: SPONSORED BY PDI

PDI Addresses Surgical Site Infections

Expensive to treat and hazardous to patients, surgical site infections must be prevented.

Surgical site infections (SSIs) are among the most common healthcare-associated infections (HAIs). The average SSI costs a hospital approximately $21,000 and accounts for over 30 percent of all HAIs[1].

Prevantics® Maxi Swabstick – featuring PDI's proprietary 3.15 percent chlorhexidine gluconate (CHG) and 70 percent isopropyl alcohol (IPA) formulation – is a single-step, broad-spectrum antiseptic that significantly reduces the number of microorganisms on intact skin, including the skin bacteria that potentially cause SSIs. It is indicated for patient preoperative skin preparation, and it complies with evidence-based practices and guidelines from the Centers for Disease Control and Prevention (CDC) and Association for Perioperative Registered Nurses (AORN).

Prevantics Maxi Swabstick provides continuous antimicrobial activity for up to seven days for rapid microbial reduction. It is ideal for body contours, such as joints and between toes and fingers. Additionally, its foam head is pre-saturated for easy application, and the intuitive swabstick format keeps clinicians' gloved hands away from prep sites. Prevantics Maxi Swabstick contains 5.1 mL of the CHG/IPA solution and can cover a 7x7 square inch area for preoperative preparation. Clinicians should scrub a patient's skin with one side of the Prevantics Maxi Swabstick for 60 seconds, flip the swabstick and scrub for an additional 60 seconds with the unused side before allowing the patient's skin to dry for 90 seconds.

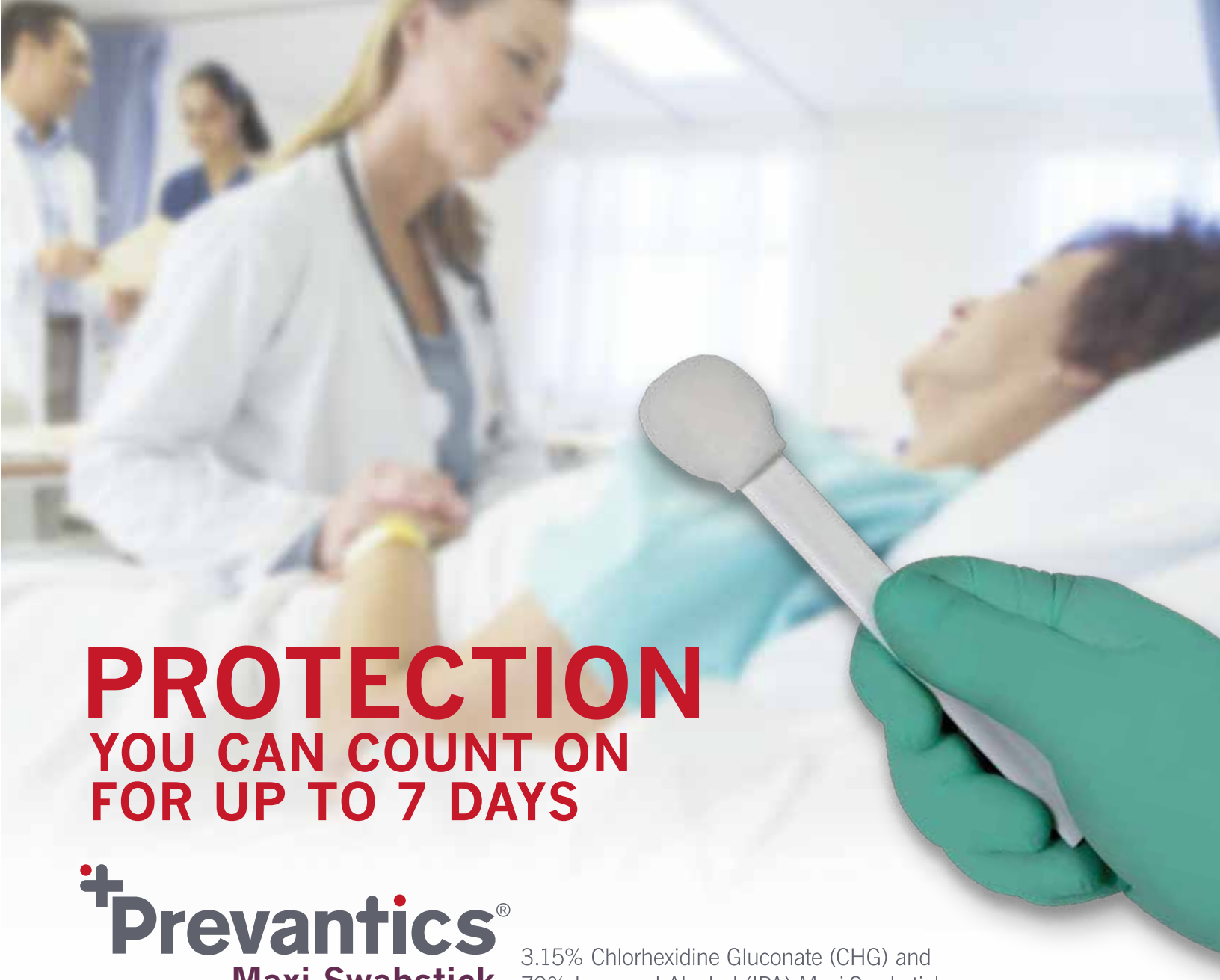
Prevantics Maxi Swabstick provides continuous antimicrobial activity for up to seven days for rapid microbial reduction. It is ideal for body contours, such as joints and between toes and fingers.

Sales reps should ask their primary care and ambulatory surgery center customers how they prepare patients' skin prior to a small surgery and clarify how they protect their patients from surgical site infections. In addition, sales reps should highlight the above benefits of Prevantics Maxi Swabstick.

Prevantics Maxi Swabstick does not contain a tinted solution, and some healthcare providers may object to using a non-tinted preoperative skin preparation product. Sales reps should ask physicians how they use tint and why it is important to them. For example, some healthcare providers like to see the outline of the prepped area of skin. While Prevantics Maxi Swabstick does not contain a tint, CHG solution does leave a slight sheen indicating that the area has been prepped. If clinicians are prepping the skin themselves, they will know the outline and may not require tint. Sales reps should also let primary care/ambulatory surgery center customers know that Prevantics Maxi Swabstick may be more cost effective than other preoperative skin preparation products, which may improve their department budget.

PDI strives to Be the Difference® every day by partnering with customers to prevent healthcare associated infections. To learn more about how to prevent SSIs – and how PDI can help your physician customers do so – please contact pdihc.com or contact your PDI territory sales manager. rep

[1] **Source:** US Centers for Disease Control and Prevention, www.cdc.gov/hai, electronically accessed April 25, 2016.



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70% Isopropyl Alcohol (IPA) Maxi Swabstick

Add Prevantics® Maxi Swabstick to your pre-op skin preparation regimen.

- Helps reduce bacteria that can potentially cause skin infection[1,2]
- Up to 7 days of continued antimicrobial activity[3]
- Single step, broad spectrum, persistent antiseptic that significantly reduces the number of microorganisms on intact skin
- Ideal for body contours, such as joints and between toes and fingers

Reorder #S41950

Complies with evidence-based practices and guidelines from the CDC[4] and AORN[5].

Learn how to help prevent SSI†s and more at pdihc.com or contact your PDI Territory Sales Manager.

†SSI = surgical site infection
[1]Prevantics® Maxi Swabstick product label. Orangeburg, NY: PDI; 2014.
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INFECTION PREVENTION: SPONSORED BY SKLAR

Infection Prevention:

The Shift to Sterile Single-Use Solutions

Over the last few decades, the rate of health-care-as-sociated infections (HAIs) has caused great concern and placed infection prevention at the forefront of healthcare initiatives to improve safety and quality of care. But, despite changes in infection prevention protocols and the introduction of new equipment and products to prevent infection, problems with HAIs continue to plague the healthcare industry. Healthcare organizations also face increasing pressure to reduce costs. Healthcare providers – especially those in hospital owned practices – are making a rapid switch to sterile, single-use instrumentation to reduce HAIs and cross-contamination, as well as the costs associated with cleaning and sterilizing – or reprocessing – reusable instruments, which have been directly linked to HAIs.

Surgical Site Infections (SSIs) are the most common HAIs. In a 2015 Report, the Centers for Disease Control and Prevention (CDC) reported that SSIs account for 31 percent of all HAIs, or approximately 157,000 patients. Three percent of these patients (approximately 4,700) die, and 75 percent (approximately 3,700) of these deaths are directly attributed to the SSI. The cost of SSIs ranges between $10,433 and $25,546 for each event – a total cost of more than $4 billion annually.[1] According to the Center for Public Integrity (CPI), it is difficult to accurately assess how often dirty instruments cause infections, since bacteria can hide anywhere, but experts say it happens far more often than is generally understood. "The cases we hear about," says Dr. Melissa Schaefer, a CDC medical officer, "are only the tip of the iceberg."[2]

Surgical Site Infections (SSIs) are the most common HAIs. In a 2015 Report, the Centers for Disease Control and Prevention (CDC) reported that SSIs account for 31 percent of all HAIs, or approximately 157,000 patients.

Until the early 1990s, surgical instruments were simpler, much larger, easy to clean and required minimal time and effort to sterilize effectively in order to prevent infection. With the healthcare industry moving toward better technologies, the use of micro-instrumentation to perform less invasive procedures on patients is growing rapidly. These instruments are harder to clean and reuse, and, as a result, instrument reprocessing has become a very complex process.

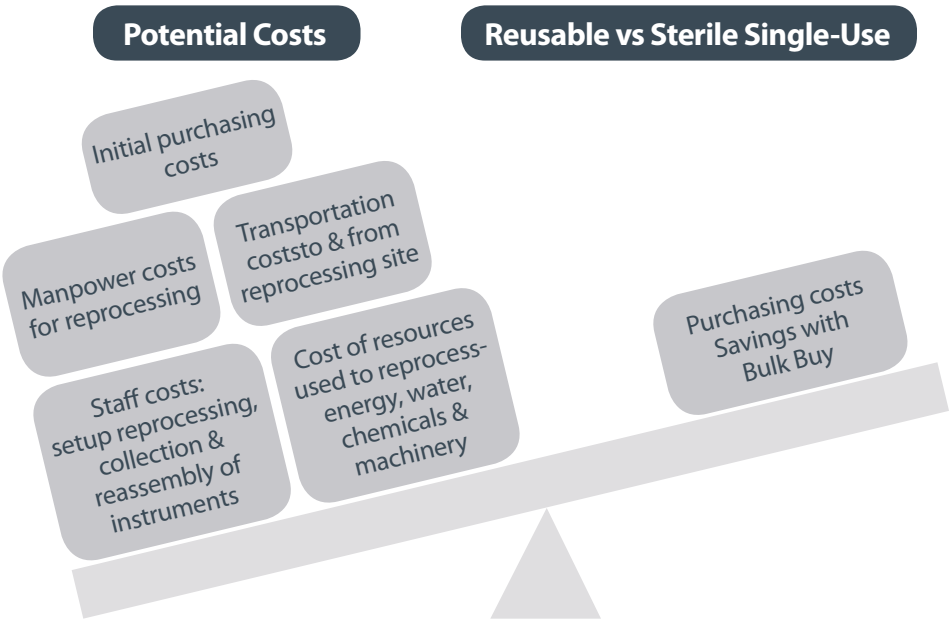
Healthcare providers know how critical it is to clean, disinfect and sterilize reusable surgical instruments, yet the thoroughness of cleaning and sterilizing surgical instruments is not standardized. The U.S. Food and Drug Administration (FDA), CDC and The Joint Commission have issued warnings, guidance and new reprocessing requirements. The Association for the Advancement of Medical Instrumentation (AAMI) and other standards-developing organizations have established or updated industry-recognized standards for reprocessing. Manufacturers and service providers have created new products and tools, and professional organizations have published guidance and recommended practices for healthcare staff on the various aspects of reprocessing. Yet, reprocessing remains a significant and persistent problem.[3]

Sterile, single-use instruments are the only way to guarantee 100 percent sterility for each patient

Many surgeons are moving to single-use solutions, indicating that safety and convenience are their primary motivations. U.S demand for single-use medical supplies will expand 4.1 percent annually to $49.3 billion in 2018.[4] This widespread change and market growth is the result of vast improvements in the quality of single-use instruments – quality that is now comparable to that of many reusable instruments. Sterile, single-use instruments are the only way to guarantee 100 percent sterility for each patient. The benefits of sterile, single-use instruments are driving demand and increased use in hospitals and outpatient procedures.

The broad benefits of sterile single-use instrumentation are evaluated in the following areas:

- **Risk management.** Managing the risk of infection and cross-contamination is a top priority for every healthcare professional. Using sterile, single-use instruments reduces the risk of HAIs and cross-contamination, providing peace of mind for both surgeons and healthcare managers.
- **Decontamination and sterilization.** Using sterile, single-use instruments removes all of the costs and headaches associated with reusable instruments and operating an autoclave, including adherence to compliance regulations and expenditures, such as the dead time spent running decontamination cycles.
- **Instrument traceability.** Single-use instruments are all individually traceable. The lot number that appears on the packaging is all the information that is required to trace the instrument back to its production batch and date.
- **Logistics and supplies.** Minor surgical procedures in the non-acute space are growing at a rapid rate. Retaining stocks of expensive, reusable, surgical instruments is not cost effective. Reprocessing reusable instruments is also a very significant cost in terms of both finances and manpower. It is essential that healthcare providers have sufficient quantities of sterile, single-use instruments. Purchasing sterile, single-use surgical instruments allows providers to manage their own supplies in line with their demand, at low cost and with order fulfillment in 48 hours or less.
- **Cost allocation.** Hospitals and healthcare reimbursement agencies are under increasing financial constraints, which has made it even more important that the true cost of each procedure is accurately assessed. True cost of sterilization and instrument tracking is difficult to record, with many costs hidden in resources such as utility bills and staffing costs. Single-use surgical instrument costs are simple and easy to calculate.
- **Insurance reimbursement.** Reimbursement for reusable and single-use supplies varies greatly. Reusable items are categorized as routine supplies in healthcare reimbursement policy. According to Moda Health, "In most cases payment for these supplies is included in the administration charge, which is reportable with a CPT or HCPCS code. In the inpatient setting, the administration service is included in the room charge or facility fee, and reimbursement for these supplies is included in the reimbursement for the eligible services. These items, if identified on a claim or itemized bill,



are not eligible for separate reimbursement or for inclusion in outlier calculations for additional reimbursement."[5] Single-use items, on the other hand, are considered ancillary – or non-routine supplies – because they are non-reusable. Non-routine supplies are directly identifiable to a specific patient and therefore are separately billable, either with or without a HCPCS code, with the appropriate revenue code.[6] Before submitting billing, please consult your billing manager for policy details.

- **Cost savings.** Disposing of an instrument after only one use may seem like a waste, but when you consider the amount of time and resources associated with reprocessing a reusable instrument and the documentation required to validate that it has been done properly, the cost savings greatly outweigh the negatives.

These solutions include the expansion of our sterilization facilities to provide an extended line of sterile kits, which are customizable, multiple grades and breadth-of-line for sterile single-use instruments, as well as consulting services to help customers transition seamlessly from reusable to single-use solutions.

Ron Templeton, executive vice president of Sklar Instruments, states, "Single-use solutions are the way of the future for healthcare. They are the safest, most convenient and reliable choice. Not only do they provide cost savings, they can serve as an additional revenue stream for providers, because when a single-use instrument is utilized in a procedure, in some cases, it can be billed by the provider and reimbursed."

Sklar has been following these healthcare trends and offers a wide range of sterile, single-use solutions to fit our customers' needs. These solutions include the expansion of our sterilization facilities to provide an extended line of sterile kits, which are customizable, multiple grades and breadth-of-line for sterile single-use instruments, as well as consulting services to help customers transition seamlessly from reusable to single-use solutions. Sklar has the largest number of SKUs and patterns of high quality sterile, single-use instrumentation. To find out more about how you can take advantage of Sklar's sterile single-use products and services, visit www.sklarcorp.com or contact us today at 1-800-221-2166 to request a sample. rep

About Sklar

For over 125 years, Sklar has built a legacy of offering surgical instruments that are unparalleled in quality and value to meet the ever-changing needs and standards of the healthcare industry. Since 1892, Sklar has been a leading supplier to the U.S. hospital network and a leader in both sterile, single-use and reusable solutions. Sklar has a comprehensive product line that is extremely competitive, offers over 19,000 SKUs and covers the following specialties: bariatric, cardiovascular/thoracic, colon/rectal, dental, dermatology, electrosurgery, ENT, laparoscopic/endoscopic, laser surgery, micro-surgery, neurology, OB/GYN, ophthalmic, orthopedic, pediatric, plastic surgery, podiatry and veterinary.

Notes:

[1] Centers for Disease Control and Prevention (CDC). Surgical Site Infection (SSI) Event. January 2015. http://www.cdc.gov/nhsn/PDFs/pscManual/9pscSSIcurrent.pdf

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[5] Moda Health. Reimbursement Policy: hospital routine supplies and services, October 2009: November 2015. https://www.modahealth.com/pdfs/reimburse/RPM043.pdf.

[6] Nave, Shelley, RHIA CPC-H. "Hospital Supplies—To Bill or Not To Bill?" Coding & Compliance Focus News, December 2011. http://medassets.com/_assets/pdf/ccfn_2011-10of10.pdf.

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96-2972	Iris Scissor - Curved	25/Box
96-2976	Kelly Forcep - Straight	25/Box
96-2977	Kelly Forcep - Curved	25/Box
96-2968	Webster Needle Holder	25/Box
96-2979	Adson Dressing Forcep	25/Box
96-2980	Adson Tissue Forcep	25/Box
96-2967	Splinter Forcep	25/Box
96-2966	Tube Occluding Forcep	25/Box
96-2965	Sponge Forcep	25/Box
96-2974	Halsted Forcep - Straight	25/Box
96-2975	Halsted Forcep - Curved	25/Box
96-2937	Dressing Forcep	25/Box
96-2970	Lister Bandage Scissor	25/Box
96-2933	Crile Forcep	25/Box
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Reducing Readmissions

Growing awareness on the part of post-acute-care facilities, together with financial penalties, are expected to continue to reduce hospital readmissions.

By Laura Thill

Organizations – from hospitals to post-acute-care organizations to medical products distributors – are doing their part to facilitate changes that reduce hospital readmissions. However, the approach to change varies from one organization to the next, making it more important than ever for distributor sales reps to understand the issues and provide their accounts with the best possible solutions to address them.

"We use this conference as an opportunity to advance our strategic initiatives with current suppliers, and a chance to identify prospective business partners."

David Myers
EVP & Chief Customer Officer
Concordance Healthcare

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"There are several issues that post-acute care facilities face now – and certainly will face in the future – regarding hospital readmissions," says Susan LaGrange, RN, BSN, NHA, CDONA, CIMT, director of education, Pathway Health. "For several years now, hospitals have been choosing their post-acute care partners and providers wisely, due to the financial consequences of readmissions within 30 days with certain diagnoses. Effective April, 2016, the Centers for Medicare and Medicaid Services (CMS) began posting data for six new Quality Measures, including the Percentage of short-stay residents who were re-hospitalized after a nursing home admission." With Value Based Purchasing (VBP), organizations that have a high 30-day re-hospitalization rate (including observation stays) will face financial penalties, she adds.

Long-term-care facilities – long before they morphed into post-acute-care organizations – recognized the need for protocols designed to reduce hospital readmissions, but until now, their approach has varied. "Up to this point, there have been vast differences in how organizations have embraced the need for change," says LaGrange. "Some organizations have been proactive by putting into place evidence-based standards of practice [designed to] keep the resident safely in the facility." For instance, some programs provide front-line staff with resources and training to identify acute changes in a patient's condition early on, she explains, allowing them to communicate more closely with the practitioner and better manage the patient's treatment. That said, "there are some organizations that have yet to put into place an organized process," she adds.

"I do believe that the readmission penalties have led to some improved discharge practices, including better communication of resident needs and stability of resident condition when discharged into the post–acute care settings."

– Susan LaGrange

Moving forward

Readmission penalties – together with the changing mindset that providers must take steps to improve the quality and coordination of care from hospitalization through recovery – have led hospitals to change their discharge practices, according to experts. "I do believe that the readmission penalties have led to some improved discharge practices, including better communication of resident needs and stability of resident condition when discharged into the post–acute care settings," says LaGrange. "In talking to providers across the country, [I see] there continues to be a good number of hospital discharges that occur on a Friday or Saturday, when the facility staff must talk to on-call physicians to clarify orders, or discuss unstable conditions, and these physicians are not always familiar with the resident. There may continue to be opportunities in this area on both sides – that of the hospital to ensure stability of the resident's condition for discharge with good communication, and that of the post-acute care facility to prepare with a good pre-admission

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assessment process for a successful care transition."

LaGrange predicts that post-acute-care facilities that closely consider "the culture of the readmission process, from admission through discharge, and collaborate with all entities the facility works with, as well as in-house systems" will be most likely to succeed at limiting hospital readmissions. This will entail the following, she notes:

- **Communicate.** Communication with the acute-care provider is crucial to ensure that the resident is appropriate for discharge to the post-acute care setting and that the proper care and resources are ready for the admission.
- **Organize.** The organizational process and systems management in the organization are essential to be able to identify early changes of condition and a streamlined approach to the evaluation/assessment, communication and care management in the facility.
- **Educate and train.** Nurses require training on the assessment process, disease management and system processes for quality of care.
- **Plan.** Successful discharge planning should start on the day of admission.
- **Follow up.** It's important to follow up on discharged patients to ensure the successful transition of care and assistance with management in a new setting.

"The biggest obstacles today revolve around time. Nurses (both acute care and post-acute care) face such challenges as time and inadequate staffing resources."

Indeed, it's essential that post-acute-care facilities collaborate and communicate well with acute-care providers, she continues. "The post-acute care provider could have a key clinical contact meet with the hospital discharge planning team to discuss opportunities for successful care transition and to include good assessment, preparation and communication of the patient's needs and condition," she says. "The biggest obstacles today revolve around time. Nurses (both acute care and post-acute care) face such challenges as time and inadequate staffing

resources. Unfortunately, with Value Based Purchasing, the nursing home could face an even greater struggle with resources if quality systems are not in place and the readmission numbers are high."

Providing value to your accounts

What post-acute care facilities need today are distributor rep partners, notes LaGrange. Sales reps should focus less on sales and more on providing value-added consultation, she explains. For instance, sales reps should conduct onsite rounds and audits with central supply and/or clinical leadership once a month to identify any equipment that needs to be replaced, she points out. "Group discussions with clinical staff to discuss resident equipment and supply needs during these rounds could also be a win-win collaboration effort."

In addition, reps should provide their accounts with services that lead to better care, such as value-added system and process programs; education on organizational culture change; preventative device management; and training for the post-acute-care staff on identification, assessment and disease management, she continues. "Products that could assist organizations include adequate assessment equipment for employees to do their jobs effectively, such as high quality stethoscopes, sphygmomanometers (all size ranges), thermometers, pulse oximeters, vital signs monitors, etc. for the assessment process. In addition, reps should offer resident care devices; and new equipment to replace old, worn or non-functioning items in the facility."

> "When good systems are in place for all sides of the care transition process, changes of condition are identified early and managed."

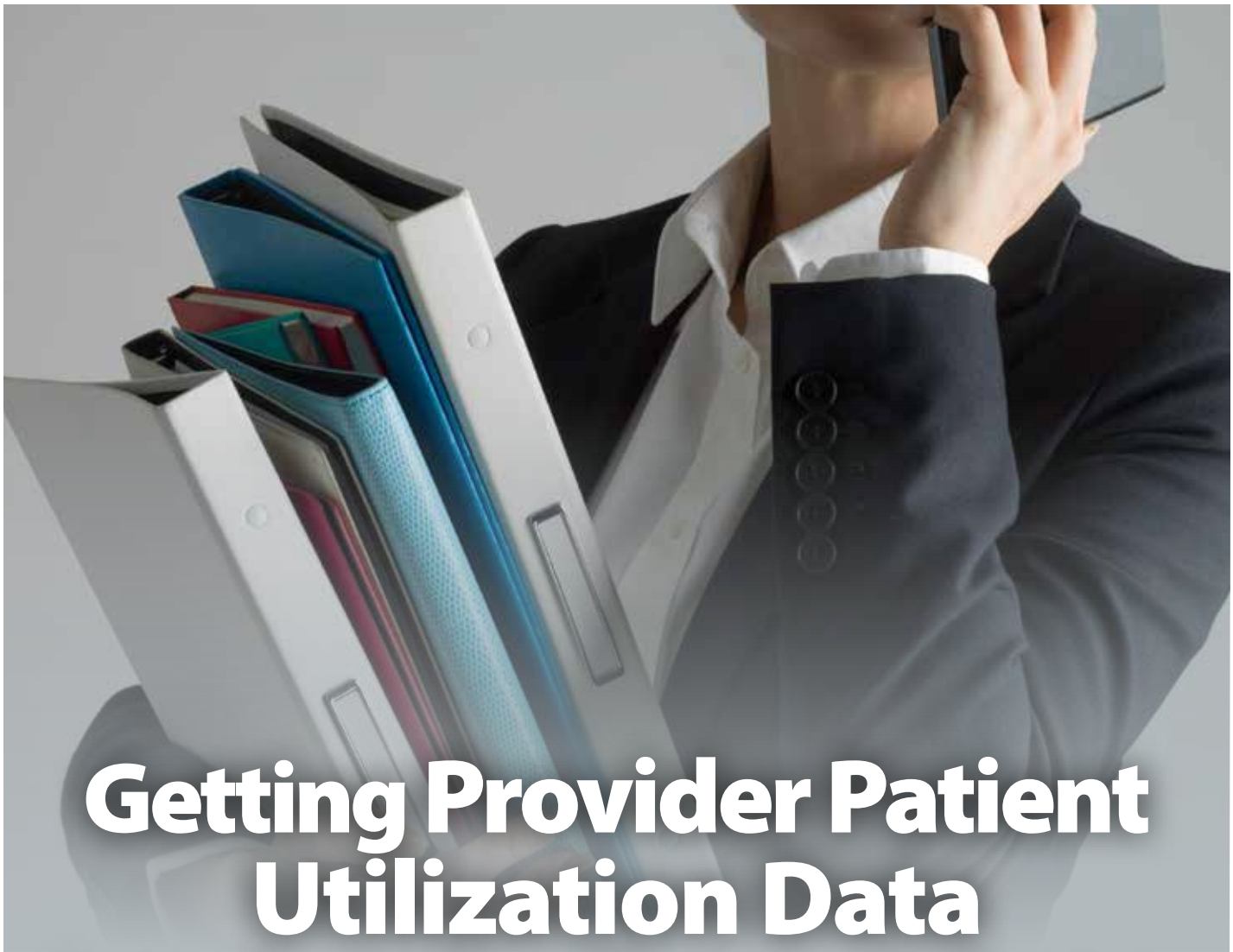
New post-acute-care protocols designed to reduce hospital readmissions are long overdue, notes LaGrange. "Studies have clearly indicated that a good number of hospital readmissions within 30 days of discharge could have been avoided," she points out. "When good systems are in place for all sides of the care transition process, changes of condition are identified early and managed. This provides for quality of care for the [patient], while saving tax payer dollars at the same time." rep

Key Issues and Strategies Impacting Readmissions for Diverse Populations

Topic	Issues and Strategies
Discharge and care transitions	Racial and ethnic minorities are less likely than white patients to follow up with a primary care provider or an appropriate specialist after discharge. • Provide early discharge planning and follow-up for patients at high risk for readmission. • Communicate with patients about the importance of early follow-up. Support may be needed to schedule appointments and address potential barriers to follow-up among racial and ethnic minority patients. (e.g., lack of usual source of care, transportation issues, language barriers).
Usual source of care/ linkage to primary care	Racial and ethnic minorities are less likely to be linked to a primary care provider or have a usual source of care. Lack of this linkage leads to lower quality care. • Determine whether the patient is linked to a primary care provider or has a usual source of care. • If no linkage exists, attempt to provide a referral and assure the patient can be navigated to a new primary care provider.
Language barriers and access to interpreter services	Limited English proficiency is associated with several factors that contribute to avoidable readmissions, including lower rates of outpatient follow-up and use of preventive services, medication adherence, and understanding discharge diagnosis and instructions. • Ensure that patients with limited English proficiency are aware of and have access to professional medical interpreter services during inpatient stays, discharge, and when accessing post-hospital care. • Ensure that discharge instructions are communicated in the patient's preferred language. Written materials should take into account both literacy level and the preferred language of the patient and/or caregiver. Simply translating instructions may be insufficient to ensure patient understanding. • Include family members and/or caregivers in care as appropriate, work with members of the extended care team (such as community health workers), and coordinate with traditional healers to help facilitate culturally competent care for patients with limited English proficiency.
Health literacy	Many factors that contribute to readmissions for racial and ethnic minority populations are associated with health literacy (e.g., limited knowledge of medical condition, poor ability to manage medications and self-care, non-adherence to treatment plans). • Conduct early screening and documentation of literacy and health literacy to ensure providers are aware of the patient's level of health literacy at all stages of care. • Provide low literacy discharge instructions and educational materials that incorporate adult learning principles to facilitate patient understanding of diagnosis and treatment regimen. • Reduce the complexity of self-care instructions provided to patients. • Use terminology the patient understands, and avoid the use of medical jargon. Using relatable language is especially important when working with patients with limited English proficiency who may experience additional barriers to communication.

Culturally competent patient education	Cultural beliefs and customs influence patients' health behaviors, perceptions of care, and interpretation of medical information or advice. • Facilitate trust with patients by demonstrating respect for cultural practices and beliefs that may impact understanding of the disease, treatment, possible outcomes, and risks, as well as patient self-management, and tailor patient education accordingly. • Engage families in care transitions, as appropriate, and leverage cultural beliefs or practices that promote self-care and family or social support. • Link patients to community-based educational programs offered by institutions that engender trust (e.g., faith organizations, community-based cultural organizations). • Address cultural factors predictive of medication non-adherence, such as patient perceptions regarding the benefits of Western vs. Eastern medicine and perceptions of susceptibility to disease/harm.
Social Determinants	Factors linked to socioeconomic resources are associated with higher readmission rates for patients at minority-serving hospitals. • Connect patients with community resources such as medication assistance programs, assistance with daily living, and services that address the social determinants of health (e.g., housing and food security, transportation, employment) in order to address financial barriers that disproportionately affect racial and ethnic minorities. • Facilitate supplemental health insurance for underinsured patients. • Improve social support through family-centered care, use of health information technology, and community-based interventions that reduce social isolation.
Mental health	Anxiety and depression disproportionately impact certain minority groups (e.g., black patients with heart failure), and poor mental health has been shown to impact access to services and self-care after discharge. • Assess patients for depression, assist them in accessing culturally competent mental health services, and support culturally-relevant coping mechanisms (e.g., spirituality). Stigma about diagnosis and variation in the cultural meaning of depression for minority populations may pose challenges to diagnosis and treatment.
Co-morbidities	Racial and ethnic minorities commonly have multiple co-morbidities, resulting in higher readmission risk. • Focus on the full spectrum of the patient's health, not just the admitting diagnosis, especially for patients with multiple chronic conditions. • Ensure appropriate referral to specialty care for co-morbidities. • Implement policies that foster the use of multi-disciplinary disease management teams and provide payment for care coordination.

Source: Guide to Preventing Readmissions Among Racially and Ethnically Diverse Medicare Beneficiaries (Centers for Medicare and Medicaid Services/CMS)



Getting Provider Patient Utilization Data Into Supplier Channels Faster

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

Planning for and understanding demand in the marketplace has always been a challenge. Federal government data can be as much as two years old or more by the time it is readily available for the healthcare supply chain. Distributor-reported sales data typically comes out 45 days after quarter end. And even some providers have a hard time turning around their own data.

In order to more quickly identify crucial factors that affect demand for medical* products, HIDA has created MarketPULSE to gather patient utilization data directly from providers. This information is delivered in a quarterly subscription report on national and regional patient activity for four major markets: acute care, extended care (primarily SNFs), primary care, and laboratory.

HIDA's first Extended Care MarketPULSE will be available next month and other markets will follow throughout 2016. In fact, *Repertoire*'s sister publication *The Journal of Healthcare Contracting* is the sponsor for our upcoming Acute Care MarketPULSE.

These report chartbooks provide a detailed examination of demand metrics to allow you to track patient activity in your customers' markets. In Extended Care, for example, HIDA collects data from a panel of more than 200 skilled nursing facility (SNF) administrators, CEOs, presidents, or owners who report to us on admissions, occupancy, and other key factors that impact purchasing.

HIDA's unique algorithms will weight the top five demand metrics according to market and assign a point value. In Extended Care, this will provide an exclusive Acuity-Weighted Index for skilled nursing facilities. The quarterly report will depict the index's changes over five rolling quarters within a contraction/expansion index to give an easy-to-understand visual on patient demand.

Subscribers will receive this information within 15-21 days of quarter-end, making this one of the fastest views available on utilization. With the report, subscribers will be able to compare the most recent quarter to the prior quarter, as well as quarter-over-quarter detail. Five rolling quarters allow for a full-year view in every report.

Additionally, participation data will be sorted into six geographical regions (NE, SE, NC, SC, NW, SW) as well as by bed size, to allow examination of geographic and facility trends – particularly helpful for distributors who may be limited in size or service area.

Another easy-to-use component in the report will be a visual scorecard on the top five demand metrics, indicating whether they are up, down, or flat compared to the prior quarter. Subscribing manufacturers, distributors, and other industry stakeholders can use both the index and scorecard to compare their own sales to market performance. Each of the four markets covered will have its own specially-designed market-appropriate scorecard. All reports will include both national and regional indices and scorecards, as well as detail by region on each demand marker.

MarketPULSE is an exclusive product created, reported, and analyzed by HIDA's Research and Analytics department. Annual subscriptions will be accepted beginning July 1, at www.HIDA.org/MarketPulse. For more information, call me at 703-838-6116 or email at gsmith@hida.org. rep

*For purposes of this article, medical products include medical, surgical, and laboratory products and equipment.

Use Questions to Diagnose Your Customer's Needs

By Elizabeth Hilla

A good doctor wouldn't prescribe treatment for a patient without asking questions first: What's the issue? How long have you been hurting? Does it bother you when you sleep? and so on.

That's why it makes sense to diagnose first and treat second – but too many of us forget this when we're selling. We want to jump into our "prescription" for the customer before we've asked questions about "where it hurts." Sure, we may ask a couple of cursory questions like "what do you currently use for X?" But really, we're chomping at the bit to start talking. The result can be wasting your customer's time describing a solution that isn't matched to their problem.

So how can you better diagnose a customer's problems while simultaneously providing solutions that meet a real need? Make probing the most important part of your sales call, not just a warm-up to your presentation. Here are some suggestions:

Don't just ask questions to keep the conversation going.

Never start presenting without probing first. The other day I was at a trade show and someone came by and asked, "Why should I join HIDA?" I launched into a really great list of reasons, only to find out that the "prospect" wasn't in the healthcare distribution business. Get more information by asking a question or two of your own, and you can more appropriately tailor your responses for the person to whom you're selling.

Start broad, then focus. "Open probes" are great for finding needs. These questions are non-threatening because they don't try to steer your customer in a particular direction. For example, you might start with "What's your biggest clinical challenge?" rather than "How does your staff manage obese patients?"

Be sincere. Always be genuine when probing. Show your customer that you are invested in their success. Don't just ask questions to keep the conversation going.

Be tactful. You already know never to imply that a customer is using an inferior product or supplier. (Not, "You're still using Acme sutures – don't you know that they cause skin irritation?" but rather, "Acme sutures have been the standard for decades. But have your patients expressed any discomfort?") Phrasing probes tactfully can be tricky when you're trying to identify specific problems. If you want to determine if a facility's readmission rate is high, for example, try appealing to a customer's business strategy: "Many providers are looking intensely at readmissions. Is that a concern here?"

Don't press too hard. Let's say you ask about those readmissions, and the customer says it's not a big issue. It's tempting to try asking your question a different way, especially if you have a product that addresses this issue. However, backing off is usually your best strategy – it shows the customer that you are listening and that you want to address their distinct needs, not that you are pushing a one-size-fits-all solution.

This brings us to probing's all-important partner – **listening.** It's easy to miss your customer's answer if you're thinking about your next question or big pitch. To improve your listening:

Stay present. Ask the question, and focus on the response. Don't worry about what comes next – you'll know what to do once you hear what the customer has to say.

Reduce distractions. This might include trying to move your conversation out of a noisy hallway and into an office, turning off your phone, and forcing your brain to focus on a prospect's words and body language.

Engage yourself both mentally and physically in the conversation. Lean in, take notes, and feed back what you're hearing. Ask follow-up questions like, "So your facility's readmissions rate is actually way better than the norm, is that right?"

Most patients trust their doctors because when doctors ask questions, it is seen as a sign of professionalism and interest, not a waste of time. Use probing and listening to build similar trust and better relationships with your customers. rep

For more on probing and listening, check out HIDA's AMS Sales Training Program.
For more information, contact Elizabeth Hilla, 703-838-6130, hilla@hida.org.

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Men's Health Month

June is Men's Health Month – an opportunity to help your physician customers heighten the awareness of preventable health problems and encourage early detection and treatment of disease among men and boys.

Men die at higher rates than women from the top 10 causes of death, according to the Bureau of Labor Statistics (BLS). According to the Centers for Disease Control and Prevention (CDC), on average, they die almost five years earlier than women.

It gets worse, guys. Men's Health Network (www.menshealthnetwork.org) points out that for every 100,000 people, 863.5 men die compared to 623.5 women. When broken down by disease, the numbers look as follows:

- **Heart disease:** 214.5 men vs. 134.3 women
- **Cerebrovascular disease:** 36.7 men vs. 35.2 women
- **Chronic lower respiratory disease:** 47.5 men vs. 38.5 women
- **Influenza and pneumonia:** 18.6 men vs. 14.0 women
- **Chronic liver disease and cirrhosis:** 13.8 men vs. 6.8 women
- **Diabetes mellitus:** 25.6 men vs. 17.6 women
- **HIV disease:** 3.1 men vs. 1.1 women
- **Unintentional injuries, motor vehicle-related injuries and poisoning:** 53.1 men vs. 26.6 women
- **Kidney disease:** 16.1 men vs. 11.3 women
- **Cancer:** 211.6 men vs. 146.8 women
- **Stroke:** 39.7 men vs. 37.8 women
- **Suicide:** 20.3 men vs. 5.5 women
- **Homicide:** 8.2 men vs. 2.1 women

In fact, one of the only diseases cited that takes a heavier toll on women is Alzheimer's disease. (For every 100,000 people, 25.9 women die of Alzheimer's disease vs. 19.3 men.) That said, one in six men are diagnosed with prostate cancer, according to *Men's Health*.

Staying healthy

It's never too late to take steps to protect one's health. Men's Health recommends the following:

- **Shield your heart:** Arteries become stiff with age, inhibiting bloodflow and increasing the risk of a heart attack or stroke. Irish researchers have found that supplementing with 500 milligrams (mg) of vitamin C daily significantly improves arterial flex.
- **Protect your skin:** While you sleep, your body produces collagen and elastin – two proteins that help the skin stay smooth.
- **Preserve your vision:** Refined carbohydrates can raise your risk of age-related macular degeneration by 49 percent, according to a Tufts University study.
- **Protect your hearing:** Egg yokes are a big source of phosphatidylhcoline, a key component of cell membranes in your ears.

Source: www.menhealth.com/health/5-ways-keep-your-body-strong-and-healthy.

Fun in the sun? Not so fast!

June is also a good time to focus on skin protection, particularly as warm, sunny days lure us outdoors. You can reduce your risk of skin damage and skin cancer by seeking shade under an umbrella, tree or other shelter before you need relief from the sun, advises The Centers for Disease Control (CDC) and Prevention. Even better, when outdoors (whether in the sun or shade), protect your skin by using sunscreen and wearing protective clothing.

Long-sleeved shirts, long pants and skirts can provide protection from UV rays, and clothes made from tightly woven fabric offer the best protection, notes CDC. A wet T-shirt offers much less UV protection than a dry one, and darker colors may offer more protection than lighter colors. Hats – particularly hats with wide, protective brims – offer additional protection from the sun, while sunglasses protect the eyes from UV rays and reduce the risk of cataracts.

Sunscreen

CDC recommends applying a broad-spectrum sunscreen with at least SPF 15 before going outdoors, even on slightly cloudy or cool days. Sunscreen contains chemicals designed to interact with the skin and protect it from UV rays. Most sun protection products work by absorbing, reflecting or scattering sunlight. However, not all products contain the same ingredients, warns the CDC. If one product causes skin sensitivity, it's important to switch to another.

Sunscreens are assigned a sun protection factor (SPF) number that rates their effectiveness in blocking UV rays. Higher numbers indicate more protection. Sunscreen wears off and must be reapplied, particularly if you stay out in the sun for more than two hours, as well as after swimming, sweating or toweling off. In addition, it's important to keep an eye on the sunscreen's expiration date. Sunscreen without an expiration date has a shelf life of no more than three years, but its shelf life is shorter if it has been exposed to high temperatures. Finally, some makeup and lip balms contain some of the same chemicals used in sunscreens. However, if they do not have at least SPF 15, they don't offer sufficient protection when used alone.

Source: www.cdc.gov/cancer/skin/basic_info/sun-safety.htm.

HIDA Government Affairs Update

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

Reimbursement rules place new requirements on hospice industry

Your hospice customers may be facing some notable changes in the near future based on current 2016 and proposed 2017 Centers for Medicare & Medicaid Services (CMS) reimbursement rules. Hospices have expanded well beyond their traditional scope of caring for cancer patients due to increased patient interest in receiving end-of-life care in non-acute settings. As a result, rising use of these services has prompted regulators and lawmakers to take a closer look at reimbursement for these providers.

CMS has proposed a new rule for FY 2017 that will update hospice payment rates and includes important reporting changes, such as new quality measures. Some of these measures are already shaping how the market will operate over the next few years, while others have yet to be determined.

FY 2016 rule recap

The current rules from CMS for hospice payment took effect last October and included:

- A 1.3 percent hospice payment increase
- Varying payments for routine home care based on a beneficiary's length of stay

Additionally, the post-acute market as a whole is still reacting to the passage of the 2014 IMPACT Act, which seeks to apply common metrics across multiple post-acute settings. The act, which is still in the process of implementation, specifically requires Medicare-certified hospice providers to submit patient assessment data every three years for the next decade. This information will be based on surveys analyzing quality measure performance, resource use, and other measures.

Specifically, providers in the rural Pacific region are expected to see a payment increase of 2.7 percent, while rural areas of the West North Central region would only receive a 1.0 percent increase.

FY 2017 proposed rule highlights

Overall, hospices will see a 2.0 percent aggregate payment increase (approximately $330 million) for FY2017, though this increase could vary substantially by region. Specifically, providers in the rural Pacific region are expected to see a payment increase of 2.7 percent, while rural areas of the West North Central region would only receive a 1.0 percent increase. The rule would also increase the hospice cap – which calculates the value of services rendered per newly admitted beneficiary during a given accounting year – for the 2017 cap year to $28,377.17 from the FY 2016 cap of $27,820.75.

Along with the payment increase, the proposed rule includes a new set of quality measures for the Hospice Quality Reporting Program. These include:

- A measure for hospice visits when death is imminent, which assesses hospice staff visits to both patients and caregivers in the final week of life.
- A Hospice and Palliative Care Composite Process Measure, which measures "the percentage of hospice patients who received care processes consistent with existing guidelines," according to the rule.

Notably, hospices failing to report on these measures will see their payments reduced by two percentage points, so it's important your customers are aware of these proposed metric additions.

This rule is still under consideration and the comment period closes at the end of this month on June 20. As always, if you would like more information, please contact HIDA Government Affairs at HIDAGovAffairs@HIDA.org.

The Problem with our Plans

By Randy Chittum

I talk with a lot of leaders these days about the increas-ing complexity that characterizes our industry, organizations, and even teams. It has been years since anyone has disputed the notion that our environments are becoming more complex. One of the key characteristics of complexity is that the relationship between cause and effect starts to breakdown. In other words, prediction gets more and more difficult.

Paradoxically, this may be even more true for experts. Witness the tech quote, often linked to Bill Gates from 1981 – "640kB (of RAM) ought to be enough for anybody." Or better yet, Charles H. Duell, the Commissioner of the U.S. Office of Patents in 1899 – "Everything that can be invented has been invented."

We do not have a great track record of outstanding prediction!

We are poorly calibrated in this area because we tend to remember those instances when we were right and forget those when we were not. Research from behavioral economics suggests that our predictions are about in line with chance.

Most plans are predicated on some level of prediction. The belief that we have some idea of how things will turn out is the foundation of most plans. While that belief may be primarily unconscious, it is still present. Dwight Eisenhower said "Plans are worthless, but planning is everything." I have always assumed he meant that the process of planning was more valuable than what it produced. In the context of complexity, he may also have meant that we should beware our attachment to our plans.

The opportunity may lie in how certain we are about our plans. Lord Kelvin was certain when he said that "Heavier than air flying machines are impossible." At the time he was the President of the Royal Society of England. He made this statement just eight years before the Wright brothers proved him wrong. This level of certainty narrows our range of what is possible. The military has long been aware of what is referred to as "target fixation" in which a pilot may literally steer into the target because of how focused they were on that one thing. What is your form of target fixation that keeps you from seeing?

Dwight Eisenhower said "plans are worthless, but planning is everything." I have always assumed he meant that the process of planning was more valuable than what it produced.

And just how do we function in organizations where planning, and plans, guide our thinking and actions? I don't think the goal is less planning. I think the goal is less attachment to our plans. Practically, this means more frequent conversations that start not with how are we doing relative to our plan, but with whether are we pursuing the right plan at all. It means bringing new and broader perspective to our plans. It means asking different questions such as "What is trying to emerge here?," "What keeps popping into our frame that we continue to ignore?"

Finally, it means having more humility about our plans and our certainty. rep

rep corner

Mind over Matter

As one rep has discovered, when you set your mind to something, the possibilities are limitless.

By Laura Thill

Whether she is running a marathon, competing in a triathlon or proving her loyalty to a new account, Tashaunna Nola is clear: You can always accomplish more than you think. Indeed, the McKesson Medical-Surgical account manager welcomes a good challenge, knowing that each of her accomplishments motivates her to work toward the next.

A psychology major in college, Nola began her career in cognitive psychology. From there, she moved into real estate development – a field she quickly came to enjoy. However, in 2008, the economy in her home state of California was flailing – perhaps even more than in other parts of the country – and at 23, she sensed it was time for a career change. "I had always liked healthcare and decided to research the industry," she recalls. McKesson caught her eye, and she reached out to a friend there who put her in touch with an account manager. In time, she was hired as a sales associate.

Tashaunna Nola

From there, Nola moved to Denver, Colo., to fill an account management position at McKesson, during which time she was responsible for a territory that included Wyoming, Montana, and half of Colorado. In a brief 4 ½ years, she managed to grow her territory from 2 million to 5 million.

As much as she enjoyed living in the Plains states, Nola missed her native California. When an account manager position became available in Orange County/San Diego in 2015, she accepted the opportunity. "My family lives in Southern California as well, so this was also an opportunity to be closer to them," she points out. The move has been a success: She has grown her new territory from 8 million to more than 10 million. In addition, a longtime animal lover, she finds time to volunteer at pet shelters and foster dogs waiting to be adopted.

Respect and loyalty

In spite of the fact that Nola's sales career has progressed quickly, as for many newcomers, her first year was a time of transition. "The dynamics were new," she recalls, noting that "the greatest challenge was to earn the respect and loyalty of my customers. I found the best way to address this was to simply get out and get to know them. New sales reps need to let their customers know who they are and show them they can be trusted and have their best interests at heart."

> Marathons offer Nola a great way to stay in shape, "plus they teach you to keep pushing through and meet your next goal."

Sure, new positions come with new responsibilities and a learning curve, she admits. But, "it always comes down to working with your customers and becoming their true partner," she says. The goal should be to find the best solutions that permit our customers to provide the best patient care, she points out. In fact, "the worst

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Tashaunna Nola with her boyfriend, Nick Dipaola.

mistake sales reps can make is to not follow up with their customers. We get busy, and it's easy to forget to do this. But, neglecting to do so will make your job that much harder. It's best to get a system in place early on."

Full speed ahead

When it comes to servicing her customers, Nola is all about quality. Once she leaves the office, however, she's all about speed and endurance. Having run five marathons in recent years, at press time, she was training for her first triathlon. A longtime athlete, she "grew up playing soccer and took up running in college. I have run the San Diego Marathon and the L.A. Marathon, [among others]. The year I ran the L.A. Marathon, it was hot – 85 degrees! People had hoses on their front lawn [to cool down the runners]." She's also had her share of marathon mishaps, she admits. "During marathons, they often hand out gel packets to the runners," she says. "In my first race, I thought I was handed a gel pack with a tongue depressor, and I began to eat it. Then, I noticed the woman running next to me apply it under her arms to help prevent chafing!" In all fairness, most medical sales reps will tell you that a tongue depressor belongs in the mouth. But, Nola chose to view it as a learning experience. And, the good news: "I didn't get sick and was able to finish the race."

Marathons offer Nola a great way to stay in shape, "plus they teach you to keep pushing through and meet your next goal," she explains. That said, it was actually her boyfriend who convinced her to register for her first triathlon – the Olympic, scheduled for late June in San Diego. "I was the one who got him to sign up for his first marathon, and ironically he convinced me to do a triathlon," she says.

It's important to start training three months out and follow a sound nutrition plan, she notes. "We take fish oils and glucosamine for our joints, multi-vitamins, and eat plenty of vegetables, protein, sprouted and whole grains, and oatmeal." White bread and alcohol are taboo, she adds.

"Competing in the Olympic won't be as difficult as an Iron Man," she says. Still, it involves a 0.93-mile swim, followed by a 24.8-mile bike ride, and a 6.2-mile run. And, she admits to being an unenthusiastic swimmer, as well as terrified of ocean sharks. "Swimming definitely will be my greatest challenge. [During training], we've been biking on a trail that runs along the ocean, but we have done our swimming in a lake." On the plus side, swimmers are more buoyant in a saltwater ocean. (Wetsuits also are designed to help keep swimmers afloat.)

Her running time has improved since her first event, when she "just wanted to be able to finish it." And while she hopes to beat her best time of 3:56 in future marathons, as far as the upcoming triathlon is concerned, "I just want to see how it goes," she says. "If I'm much better at it than I expect, maybe I'll do a half Iron Man at some point.

"We can learn and accomplish anything if we put our mind to it," says Nola. "Just as we have good days and bad days at work, the same is true in our personal life. But, we can always push back." rep

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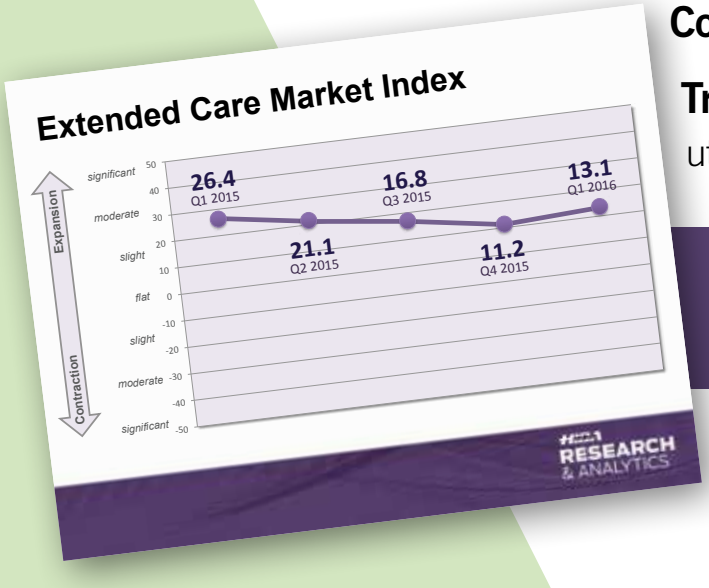

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Industry News

Henry Schein announces new executive appointments

Henry Schein Inc (Melville, NY) established two new senior executive roles. Dave McKinley, currently president of the Henry Schein Medical Group, was promoted to the newly created position of chief commercial officer. Karen Prange, SVP at Boston Scientific Corporation (Boston, MA), will join Henry Schein as EVP and CEO, global animal health & medical group. McKinley is a member of the company's executive management committee, which Prange will join. McKinley will also serve as president of the company's newly formed corporate commercial development group, which will better coordinate and leverage the company's global brand and customer solutions across all of Henry Schein's businesses. In his new role, McKinley will be responsible for global corporate marketing, working across the business to leverage Henry Schein's brand; global product category management; technology initiatives, including customer solutions, e-commerce and business intelligence; and certain specialty businesses. In her new role, Prange will be responsible for Henry Schein's global animal health and medical groups, as well as the global dental surgical group.

Midmark completes acquisition of Versus Technology

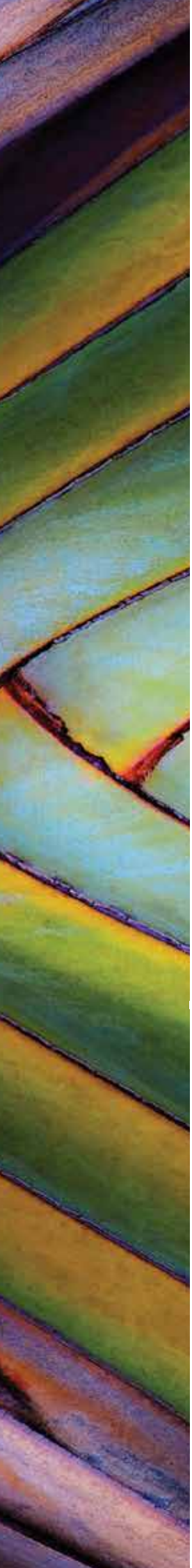
Midmark Corporation (Dayton, OH) completed its previously announced acquisition of Versus Technology Inc (Traverse City, MI). According to the company, Versus Technology is the most-deployed real-time locating systems (RTLS) provider in healthcare, using location technology and rules-based automation tools to make health systems safer and more efficient. The combination of Midmark and Versus will create an offering of clinical workflow solutions that will encompass clinical workflow services, RTLS technology, medical equipment, diagnostic devices, and design assistance, resulting in improved efficiency within health systems. Versus' core operations will remain in Traverse City, Michigan. Details of the merger were not disclosed.

PDI names Matthew Gattuso as president of Infection Prevention division

PDI Inc (Orangeburg, NY) appointed Matthew Gattuso as EVP of the company and president of PDI Infection Prevention. In this role, Gattuso will oversee PDI's Healthcare and Sani-Professional organizations and drive enterprise-wide commercial strategy and have overall responsibility for its financial performance. Gattuso most recently worked as VP and general manager for the Strategic Channel Solutions Division of Medtronic Inc (Mundelein, IL).

Sysmex America announces executive appointments

Sysmex America (Lincolnshire, IL) announced that RalphTaylor, EVP of Sysmex America Inc, will have an expanded role in growing the Latin America region for Sysmex. Taylor will also be responsible for building Sysmex America's clinical flow cytometry business into the North American and Latin American territories. Taylor's new focus is the result of recent expansion of the company's user base and anticipation of future growth. Additionally, Sysmex promoted Andy Hay to EVP and added him to the company's board of directors. In his newly created role, Hay will focus on product marketing, scientific affairs, and enterprise training.



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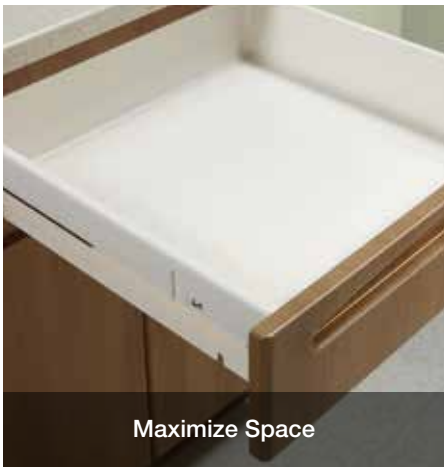

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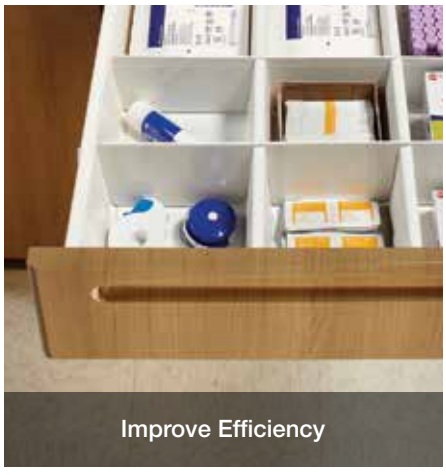

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