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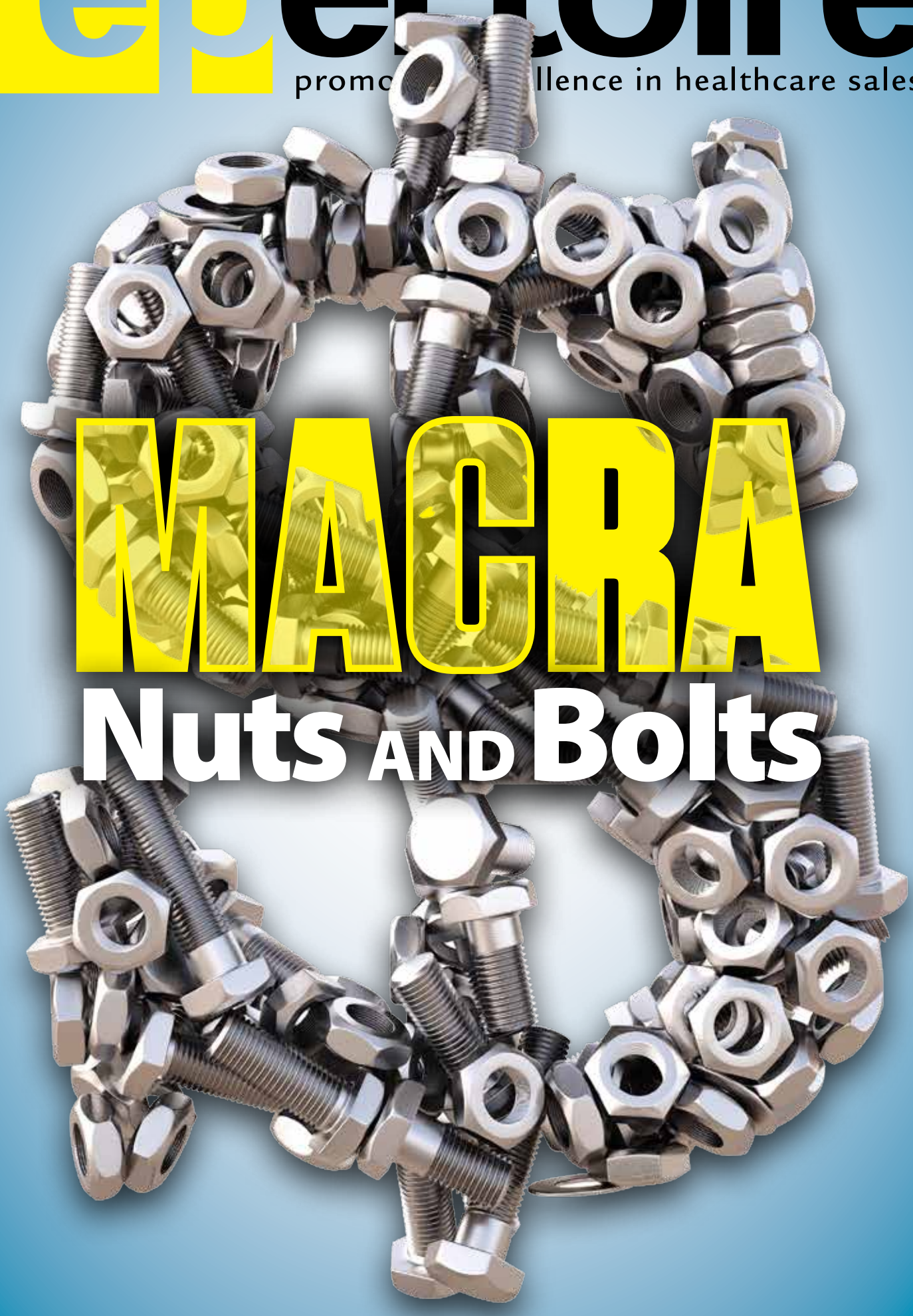

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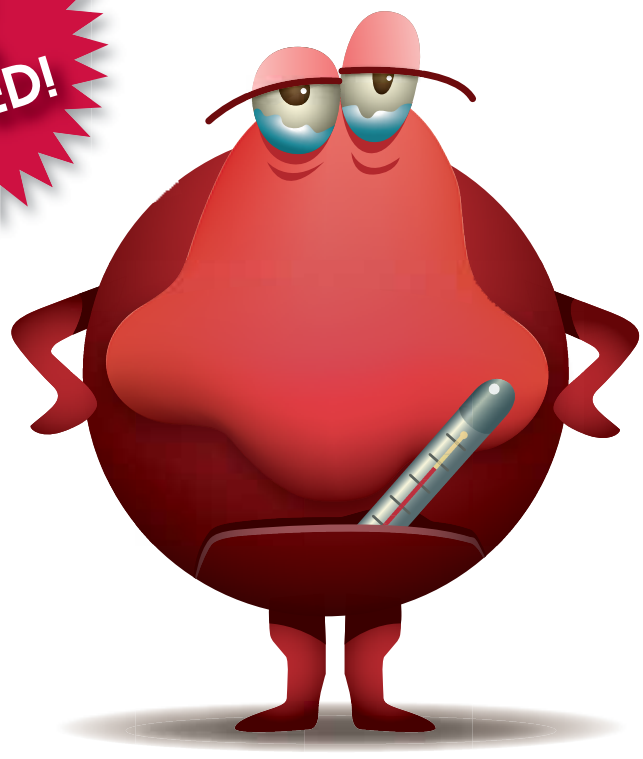

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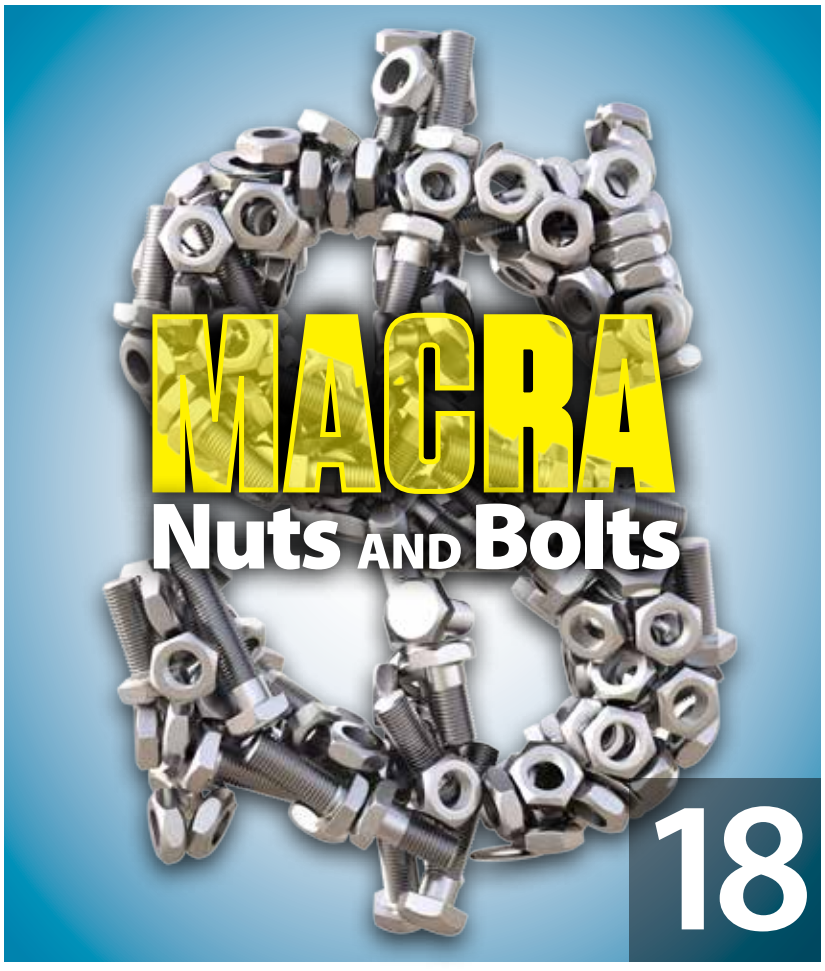

PUBLISHER'S LETTER

BRINGING OUT THE TED IN YOU

IDN OPPORTUNITIES

TRENDS

POST-ACUTE CARE

A Lifeline

PACE allows frail elderly to stay at home, yet under the watchful eyes of an interdisciplinary care team

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Love is in the air, except if you're a caregiver trying to figure out MACRA!


Scott Adams

Every type of physician practice in America should be signed up under the MIPS or APM program. These two tracks are the pathways to reimbursement in the coming years.

Unfortunately, many of your customers don't realize they need to be signed up today! For example, we hosted a meeting in Dallas in early December. One of our speakers, who I'll leave unnamed, runs a huge system in Texas that employees over 600 physicians. His office did a survey with all the doctors in the system and 45 percent of them had never heard the term MACRA.

This is your opportunity!

Last week I was honored to speak at Mortara's national sales meeting. The main message I wanted to deliver to that sales group is the same for the readers of *Repertoire*. For the last 12-18 months, we have been talking to suppliers about "Content Marketing" as a way to draw your customers to you, verses telling them what you want them to hear. Said another way, content marketing is timely, compelling content that a customer wants to consume, rather than a marketing/sales pitch that the supplier wants to tell the customers. Which one has more impact?

MACRA is content your customers need to understand. So my message is simple: be a "Content Sales Representative." Whether you're working for BD, Alere, Quidel, Sekisui, Midmark, Mortara, PDI, McKesson, Schein, Owens or any other supplier, you can use MACRA as a tool to draw your customers closer to you.

Please take the time to read our cover story this month on MACRA. This article may not cover every aspect, but you can use it to educate yourself on this payment reform. From there take the next few months in your territory to ensure those practices who rely on Medicare reimbursement are signed up and measuring against the guidelines in these new tracks.

If you want a deeper dive into MACRA, MIPS, and APM, please go to www.repertoireuniversity.com and buy our library of education modules on each of these topics.

Content Selling is Our Future,

R. Scott Adams

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The Art of Persuasion

Editor's note: *Whether selling a product, training hospital staff, or presenting to the board of directors, the quality of the presentation matters just as much as the content. Chris Anderson, president of TED – the nonprofit organization dedicated to spreading innovative ideas, and sponsor of worldwide TED conferences – recently published the book* Ted Talks: The Official TED Guide to Public Speaking. *Last month, our "Bringing Out the TED in You" segment discussed how you can effectively explain your ideas to your audience. This month (and the last installment of our series), we take it one step further, turning explanation into persuasion – a vital tool for successful selling.*

A reasoned argument convinces a ready audience.

By David Thill

"Persuasion means convinc-ing an audience that the way they currently see the world isn't quite right," writes Chris Anderson, president of TED, in his 2016 book *TED Talks: The Official TED Guide to Public Speaking*. "And that means taking down the parts that aren't working, as well as rebuilding something better."

Priming the customer

When making an argument, Anderson suggests the speaker begin by priming their audience. Priming is not a rigorous argument; "it is simply a way of nudging someone in your direction." To better illustrate his point, he offers the example of a 2005 TED talk presented by psychologist Barry Schwartz, who argued that too much choice can be a bad thing.

"Had [Schwartz] just gone straight to 'Too many choices can make you unhappy,' we might have been skeptical," writes Anderson. Instead, Schwartz began with a story:

> I went to replace my jeans after years of wearing these old ones, and I said, "I want a pair of jeans. Here's my size." And the shopkeeper said, "Do you want slim fit, easy fit, relaxed fit? You want button fly or zipper fly? You want stonewashed or acid-washed? Do you want them distressed? You want boot cut, tapered, blah blah blah."

"Even though his story is a single story of a single man and can't possibly by itself justify the statement that too much choice makes you unhappy, nonetheless we get where he is heading," observes Anderson. "Suddenly, the case he's building seems a lot more plausible."

After the audience has been primed, they are more receptive to the main argument. And the best way to convey that argument, he says, is to use "the most noble tool of them all, a tool that can wield the most impact over the very long term."

That tool is reason.

'The long reach of reason'

"In a reasoned argument, provided the starting assumptions are true, then the validly reasoned conclusions must also be true and can be known to be true," Anderson writes. "If you can walk someone through a reasoned argument convincingly, the idea you have planted in her mind will lodge there and never let go.

"But for the process to work, it must be broken down into small steps, each of which must be totally convincing." Each step begins at a point that is clearly true to the audience, or that has already been proven true in a previous step. This idea can be illustrated by an "if-then" statement: If X is true, then Y follows.

The example Anderson provides is from a 2013 TED talk presented by charity reformer Dan Pallotta, in which Pallotta argued that the nonprofit sector is handicapped by societal expectations of businesses.

"A robust argument, even if it isn't immediately accepted by everyone, will gradually gather new adherents until it becomes unstoppable."

After pointing out that we encourage companies to take risks but frown on nonprofits for doing so, he said this: "Well, you and I know when you prohibit failure, you kill innovation. If you kill innovation in fundraising, you can't raise more revenue. If you can't raise more revenue, you can't grow. And if you can't grow, you can't possibly solve large social problems."

"Case proven," Anderson responds.

Another "devastatingly powerful" form of reasoned argument is reductio ad absurdum: basically, proving that the opposing argument is wrong. "If that counter position is false, your position is strengthened (or even proven, if there are no other possible positions that could be taken)," says Anderson.

Once again, he uses Pallotta's talk as an example. When illustrating the dichotomy between high-salaried nonprofit leaders and high-salaried leaders in other areas, Pallotta made this case: "You want to make fifty million dollars selling violent video games to kids, go for it. We'll put you on the cover of Wired magazine. But you want to make half a million dollars trying to cure kids of malaria, you're considered a parasite yourself."

As Anderson notes, "Rhetorically, that's a home run."

However, it is also important to heed Anderson's caveat: Reductio ad absurdum is better used on issues than directly on opponents. "I'm fine with: 'It's not hard to understand why we've been given a different impression by the media on this for years. You sell newspapers with drama, not boring scientific evidence.' But uncomfortable with: 'Of course he says that. He's paid to say that.'"

Arguments based in reason may not be the most popular ones right out of the gate, because they are harder to process than some other arguments. But TED talks based in reason are some of the most important, he says, "because reason is the best way of building wisdom for the long term. A robust argument, even if it isn't immediately accepted by everyone, will gradually gather new adherents until it becomes unstoppable." rep


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Intalere Eastern Alliance

By seeking input from all of its members, Intalere Eastern Alliance continues to add new contracts and increase savings for its participants.

Don Smalley-Rader

Amerinet Eastern Alliance was formed in 2013 with the intent "to bring the purchasing power of all of the facilities Amerinet represented together to standardize and lower cost," David Hanline, then vice chair of AEA and director of ancillary services at OSS Health (York, Pa.), said in a 2015 interview with *Repertoire*'s sister publication, the *Journal of Healthcare Contracting*.

Three years after it was first formed, we checked in on the alliance – now known as Intalere Eastern Alliance (IEA) – to see how it has developed since we first spoke. Following is an interview with Don Smalley-Rader, senior director of strategic alliance solutions for Intalere.

***Repertoire*: Almost two years ago, David Hanline, vice chair of what was then called the Amerinet Eastern Alliance, told the *Journal of Healthcare Contracting* that AEA had 14 organizations, ranging from ambulatory surgery centers, clinics, profit and not-for-profit hospitals. Can you give us an update? How many organizations? What types of facilities are they? Over what geographic area are they spread?**

Don Smalley-Rader: [Intalere Eastern Alliance] is comprised of six regional subgroups representing 212 parent organizations. They are comprised of all classes of trade such as physician office groups, surgery center groups, critical access and small regional hospitals. They are mainly in the eastern half of the country, but the Alliance's committed contract program is available to Intalere members throughout the country.

***Repertoire*: Many regional purchasing coalitions seem to be comprised primarily of acute-care**

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facilities and systems. Is Intalere Eastern Alliance different in this regard? Please elaborate.

Smalley-Rader: Our program is designed so that all healthcare facility types are able to participate. Compliance is based on the categories you actually purchase and you are not penalized if you do not purchase product within the category. The leadership council members (comprised of participating members in all [classes of trade]) specifically wanted to build a program that enabled this. Their goals were to design a program that was inclusive and enables all of our regional sub group members (212 total) to be able to opt into the program if it made sense to them financially and they were able to convert to the vendors within the program.

"If decisions are made without the data and the full support of your program members, you will be doomed to failure."

***Repertoire*: Can you please talk about your "management structure?" In other words, do you have full-time staff devoted to running IEA?**

Smalley-Rader: Intalere's Alliance program is staffed full time with four team members that are 100% dedicated to the growth and maintenance of the Alliances at Intalere. In addition to this we have a custom contracting team that is dedicated to our alliance contracts and enhanced tier program. Our account management teams and program specialists are in partnership with us to provide our Alliance members the best support available to GPO members anywhere. The true difference is that we employ member-driven boards to assist in driving the direction of each regional sub group as well as having an eight-member leadership council work on program oversight and development.

***Repertoire*: Can you explain the process whereby your supply chain executives meet and make their decisions?**

Smalley-Rader: Our regional subgroups meet quarterly to review the needs within their region and to collect input from membership on future program advancements. We base all decisions on group spend and seek members' input into all decisions before enhancing or creating new contracts for the group. Vendors provide contract enhancement presentations at these regional meetings, and additionally, we seek industry-specific education for our members based on their requests.

***Repertoire*: When we last spoke with IEA, we learned that initiatives pursued in the prior 12 months included distribution, negative pressure and wound care/bandages. How are those agreements progressing?**

Smalley-Rader: We have progressed positively in regards to the creation and expansion of our programs. We typically add 16 to 20 contracts/enhancements annually to our IEA base portfolio offering to our alliance members. And [we] are putting the finishing touches on our committed program portfolio, which is averaging 17 percent additional savings to our members off contracted pricing.

***Repertoire*: Any lessons learned since you signed them, in terms of how contracting on behalf of an RPC differs from contracting for a single hospital or hospital system?**

Smalley-Rader: It is critical for the success of any regional collaborative to be driven from the members' perspective. If decisions are made without the data and the full support of your program members, you will be doomed to failure. These two elements are the very essence of a successful program. One other element that is critical is to work with vendors who truly want to partner with your organization's goals. If there isn't a sense of team from the member, vendor and GPO, this program doesn't work.

***Repertoire*: Since signing the agreements, what have been your primary contracting initiatives?**

Smalley-Rader: We continue to evolve the Alliance programs based on our members' input. No collaborative

should ever be a static program. What worked two years ago may be fine or, based on the evolving healthcare landscape, may need only minor tweaks or a major overhaul. The idea is to embrace change and stay ahead of the curve. Our past initiatives mainly focused on the med/surg product categories. We plan to look into all areas of spend and assist in the development of programs that benefit our members in every avenue of cost to the membership.

***Repertoire*: Two years ago, David Hanline told *JHC* that participating IEA members gained a lot more than good contracts, namely, "The ability to sit and discuss issues that your facility may be facing and figure out solutions together," many of which are not even related to purchasing. How would you describe the non-contracting-related benefits to healthcare organizations who commit to an RPC?**

Smalley-Rader: The networking that occurs within a successful collaborative should be the driving force of why a member attends quarterly meetings and participates in these programs. The sharing of ideas, successes and, frankly, the failures they experience is invaluable to them as a whole. History is the great educator and if we can avoid mistakes by learning from our respected peers it is a great time- and expense-savings. The greatest quotes I get usually come from prospective members who attend our meetings as guests. They can't believe the culture and environment we foster as a group. Even though they are not members, our staff and membership seek out their input based on their outside perspective and they are made to feel like what they share with us matters. It is a culture that many are amazed at and undeniably why, once we get them to attend, it is a far easier path to get them to join and participate.

> "First and foremost, find the right partner. Make sure it is one that will allow the membership to drive the program. Without a member driven process it doesn't succeed."

***Repertoire*: How do you and Intalere interact? For example, do you use Intalere contracts or not? Do you rely on Intalere people to be actively engaged in IEA? Why or why not?**

Smalley-Rader: IEA and Intalere are a joined program. Intalere is the engine and IEA is the driver. Our members utilize the Intalere contract program and through IEA are able to gain tier enhancements or options contracts to benefit the membership.

***Repertoire*: Your IEA Committed Savings Program promises higher savings for those who commit to a select group of contracts. Can you explain the program? Can you offer an example or two of how it has worked?**

Smalley-Rader: We are putting the finishing touches on our committed program portfolio, which is averaging 17 percent additional savings to our members on contracted pricing. The program has been so successful we have made it a national program that is still being driven by the IEA leadership council. Basically, members need to participate in 70 percent of the applicable contract categories to qualify. They have to reward that contract category vendor 80 percent of their spend to qualify for that contract.

***Repertoire*: Do you have any suggestions or advice for supply chain executives wishing to start an RPC? Is there anything you believe they need to be aware of that will make them more successful?**

Smalley-Rader: First and foremost, find the right partner. Make sure it is one that will allow the membership to drive the program. Without a member driven process it doesn't succeed. Make sure the members make the participation rules and are a part of the oversight and maintenance of the program. And remember that decisions are for the groups' best interest, not any one individual's needs. rep

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MACRA Nuts and Bolts

Editor's note: *The Medicare Access and CHIP Reauthorization Act of 2015 – known as MACRA – will change the way physician practices work, as well as the way distributor reps sell products and services.* Repertoire *readers should be familiar with the law. But it's long – almost 2,400 pages. Watch* Repertoire *for brief explanations of the law throughout the year. This month: A brief overview of the law. (Source: the Centers for Medicare and Medicaid Services)*

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) repeals the Medicare Sustainable Growth Rate (SGR) methodology for updates to the Physician Fee Schedule (PFS). It replaces SGR – which was the cause for never-ending headaches in the physician community – with a new approach to payment called the Quality Payment Program. Simply put, the program is intended to encourage physicians to focus on care quality, rather than quantity of services provided.

The Quality Payment Program rewards the delivery of high-quality patient care through two avenues:

- **MIPS.** The Merit-based Incentive Payment System consolidates components of three existing programs: the Physician Quality Reporting System (PQRS), the Physician Value-based Payment Modifier (VM), and the Medicare Electronic Health Record (EHR) Incentive Program for Eligible Professionals. But it will continue the focus on quality, cost, and use of certified EHR technology; and it will allow providers to earn a performance-based payment adjustment.
- **Advanced APMs.** Alternative Payment Models are payment approaches, developed in partnership with the clinician community, that provide added incentives to deliver high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population; and they allow the provider to earn an incentive payment for participating in an innovative payment model.

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Understanding MACRA

a physician, physician assistant, nurse practitioner, clinical nurse specialist or certified registered nurse anesthetist.

The first performance period was to open Jan. 1, 2017, and close Dec. 31, 2017. During 2017, physician practices are instructed to record quality data and how they used technology to support their practice. If the practice decides to adopt Advanced APMs, it can provide care during the year through that model.

Practices may earn a positive MIPS payment adjustment beginning Jan. 1, 2019, if they submit 2017 data by March 31, 2018. If they participate in an Advanced APM in 2017, they may earn a 5 percent incentive payment in 2019.

Practices may pick their pace for the Quality Payment Program. They can start collecting performance data on Jan. 1, 2017. But if they aren't prepared to do so, they may start anytime between Jan. 1 and Oct. 2, 2017. Regardless of the start data, practices will need to send in performance data by March 31, 2018. The first payment adjustments based on performance go into effect on Jan. 1, 2019.

MIPS

Physicians electing to participate in traditional Medicare Part B, rather than an Advanced APM, will participate in the Merit-based Incentive Payment System, or MIPS, earning a performance-based payment adjustment to their Medicare payment.

Physicians earn a payment adjustment based on evidence-based and practice-specific quality data. To show evidence that they provided high-quality, efficient care supported by technology, they must send in information in the following categories:

- **Quality.** (60 percent). Replaces PQRS. Most participants will report up to six quality measures, including an outcome measure, for a minimum of 90 days. Groups using the web interface will report 15 quality measures for a full year.
- **Advancing care information.** (25 percent) Replaces the Medicare EHR incentive program, also called Meaningful Use. Some components: security risk analysis, e-prescribing, request/accept summary of care, etc.
- **Improvement activities.** (15 percent) Most participants must attest that they completed up to four improvement activities (e.g., expanded practice access, care coordination, patient safety and practice assessment, etc.) for a minimum of 90 days. Participants in certified patient-centered medical homes, comparable specialty practices, or an APM designated as a Medical Home Model will automatically earn full credit.
- **A fourth category – cost** – will be calculated from claims in 2017, but will not be used to determine the physician's payment adjustment. In 2018, CMS will start using the cost category to determine payment adjustments.

APMs

An Alternative Payment Model, or APM, is a payment approach that gives added incentive payments to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population.

Advanced APMs are a subset of APMs, and let practices earn more for taking on some risk related to their patients' outcomes. Physicians may earn a 5 percent incentive payment by going further in improving patient care and taking on risk through an Advanced APM.

Anticipated models of Advanced APMs in 2017 are:

- **Comprehensive ESRD Care (CEC).** A two-sided risk, the Comprehensive ESRD Care (CEC) Model is designed to identify, test, and evaluate new ways to improve care for Medicare beneficiaries with end-stage renal disease (ESRD). Through the CEC Model, CMS will partner with healthcare providers and suppliers to test the effectiveness of a new payment and service delivery model in providing beneficiaries with person-centered, high-quality care.
- **Comprehensive Primary Care Plus.** CPC+ is a national advanced primary care medical home model that aims to strengthen primary care through a regionally based multipayer payment reform and care delivery transformation. The multipayer payment redesign will give practices greater financial resources and flexibility to make appropriate investments to improve the quality and efficiency of care, and reduce unnecessary health care utilization. CPC+ will provide practices with a robust learning system, as well as actionable patient-level cost and utilization data feedback, to

guide their decision-making. CPC+ is a five-year model that was scheduled to begin in January 2017.

- **Next Generation ACO Model.** Building upon experience from the Pioneer ACO Model and the Medicare Shared Savings Program, the Next Generation ACO Model offers a new opportunity in accountable care – one that sets predictable financial targets, enables providers and beneficiaries greater opportunities to coordinate care, and aims to attain the highest quality standards of care.
- **The Medicare Shared Savings Program.** Congress created the Shared Savings Program to facilitate coordination and cooperation among providers to improve the quality of care for Medicare fee-for-service beneficiaries and reduce unnecessary costs. Eligible providers, hospitals, and suppliers may participate in the Shared Savings Program by creating or participating in an Accountable Care Organization (ACO).
- **Oncology Care Model.** Under the Oncology Care Model (OCM), physician practices have entered into payment arrangements that include financial and performance accountability for episodes of care surrounding chemotherapy administration to cancer patients. The Centers for Medicare and Medicaid Services (CMS) is also partnering with commercial payers in the model. The practices participating in OCM have committed to providing enhanced services to Medicare beneficiaries such as care coordination, navigation, and national treatment guidelines for care. rep

To review an Executive Summary of the Quality Payment Program, published by the Centers for Medicare & Medicaid Services on Oct. 14, 2016, go to https://qpp.cms.gov/docs/QPP_Executive_Summary_of_Final_Rule.pdf

MACRA good for primary care doctors: American College of Physicians

The American College of Physicians (ACP) applauded the Centers for Medicare and Medicaid Services for including several initiatives to support high-value primary care in its 2017 Medicare Physician Fee Schedule final rule. "The policies in the rule more accurately recognize the work of primary care physicians and other cognitive specialties to accommodate the changing needs of Medicare beneficiaries," said Nitin S. Damle, MD, MS, MACP, president of the ACP, in a statement. ACP members include 148,000 internists, related subspecialists, and medical students.

ACP noted steps taken by CMS to support primary care, reduce barriers to chronic care management, improve access to behavioral health services, and prevention, including:

- Payment for care coordination by primary care physicians. The final rule will help reduce barriers to effective care of patients with chronic illnesses by allowing payment for more complex, time-intensive chronic care management (CCM) services, according to ACP. The College supports CMS' removal of the health information technology requirements necessary to bill CCM codes.
- Addressing undervaluation of primary care services. The new rule adopts current procedural terminology (CPT) guidelines for separate payments for non-face-to-face prolonged services.
- Cognitive impairment care assessment and planning. The final rule lays down a new code and policies to pay for cognitive and functional assessment and care planning for patients with cognitive impairment (e.g., for patients with Alzheimer's).
- Integrating mental and behavioral health into team-based primary care. CMS is implementing a new evidence-based approach to caring for patients with behavioral health conditions through the Psychiatric Collaborative Care Model (CoCM) as well as the expansion of the Medicare Diabetes Prevention Program – allowing Medicare beneficiaries to access preventive diabetes services without being subject to co-payments while providing participating physicians and other clinicians additional payments for furnishing preventive services to eligible beneficiaries.

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A Lifeline

PACE allows frail elderly to stay at home, yet under the watchful eyes of an interdisciplinary care team

Andrea Logan believes she has seen a viable option for healthcare for the elderly right in southeastern Michigan. It's a program called PACE. "It offers truly coordinated care for the senior population," says Logan, vice president of sales, TwinMed, LLC.

PACE – the Programs of All-Inclusive Care for the Elderly – provides comprehensive medical and social services to certain frail, community-dwelling elderly individuals, most of whom are dually eligible for Medicare and Medicaid benefits, according to the Centers for Medicare & Medicaid Services. For most participants, the comprehensive service package enables them to remain in the community rather than receive care in a nursing home. (Participants frequent the local PACE day center to see physicians, therapists and nutritionists, and simply to socialize.)

Currently, there are 121 PACE programs in 31 states serving 38,072 participants, according to the National PACE Association. The state of Michigan has 10.

PACE uses interdisciplinary care teams – including physicians, nurse practitioners, nurses, social workers, therapists, van drivers, and aides – to exchange information and solve problems as the conditions and needs of each participant change, according to organizers at On Lok, a San Francisco, Calif.-based nonprofit organization credited with starting (and continuing to operate) the first PACE program in the country in 1979. Providers deliver all medically necessary services participants need rather than only those reimbursable under Medicare and Medicaid fee-for-service plans.

"I'm enthusiastic about PACE because everything is coordinated, from doctors' visits, to lab, to medical equipment, to disposable products," she says. A team of professionals provides individualized care plans, rather than leaving that burden to the family. "It's truly the only coordination of Medicare and Medicaid benefits. It's cost-effective. But the best thing is, seniors get to be in their own homes, and who wouldn't want that?

"I see this as a solution to the problem we're going to be facing in the next 10 years, as Baby Boomers with limited funds face some big financial challenges."

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'Think preventive'

Huron Valley PACE in Ypsilanti, Mich., is approved for 225 participants, and right now, provides services for 140, says Rick Bluhm, executive director of the program, which serves Washtenaw and parts of Monroe Oakland, Wayne and Livingston counties. The state of Michigan caps the organization's enrollment each month. Huron Valley PACE will be at capacity in 14 to 16 months.

"We provide all Medicare and Medicaid covered services, including Part D drugs," says Bluhm, who was director of the University of Michigan Health System's geriatric division prior to helping launch Huron Valley PACE in March 2014. "We were the sixth PACE program in Michigan; and the 100th in the United States when we opened," he says.

> "PACE allows us to promote independence, improve quality of life and provide necessary services where they are needed, when they are needed, regardless of income."
>
> **– John Thorhauer**

United Methodist Retirement Communities Inc. in Chelsea, Mich. – a provider of residential and long-term care facilities and other health and human services for seniors in southeastern Michigan – has an 80 percent interest in Huron Valley PACE in Ypsilanti, as well as an 80 percent interest in Thome PACE in Jackson, Mich., and a 20 percent interest in Senior CommUnity Care of Michigan in Lansing, explains John Thorhauer, president and CEO of United Methodist Retirement Communities.

"UMRC has 110 years of experience helping older adults not just live, but to live well," he says. "PACE allows us to promote independence, improve quality of life and provide necessary services where they are needed, when they are needed, regardless of income."

Huron Valley PACE is a managed care company that has a contract with CMS, he explains. "The thing that's unique about PACE is, there's no middleman between the insurance piece and the provider." Huron Valley PACE operates as a staff model, meaning its doctors and clinical staff are often salaried employees.

"In the fee-for-service world, doctors see patients when those patients are sick or there is some medical necessity," he says. "Our physicians are on staff to care only for our participants. They provide preventive care, working to reduce hospitalizations, ER visits, nursing home stays. There are no mixed incentives in our model.

"We need to be proactive and 'think preventive' in order to help our participants avoid exacerbation of the chronic illnesses they have, along with [ramifications] of aging. Our goal is to increase quality of life and independence, and help them live safely in the community until the end of their lives."

PACE participants can see physicians and other team members without an appointment. "We are responsible for them 24/7," says Bluhm. The day center offers physical therapy and occupational therapy; a recreational common area where people congregate for meals, activities, socializing; personal care rooms, where participants who need help with bathing can receive it; and a laundry facility, so participants always have clean clothes. The organization provides transportation to and from the day center for those who need it.

"We don't have specialists onsite, but we make referrals, schedule appointments and provide transportation to other providers when necessary," says Bluhm.

By virtue of its participation in Medicaid, Huron Valley provides home meals, some care-related services in the home, and even modest modifications to the home (e.g., ramps or even bedbug remediation). The day center has a pharmacist, and Huron Valley PACE delivers medications directly to participants' homes.

Coordinated care

"The No. 1 thing about PACE is the coordinated care," says Thorhauer. "We've been in the healthcare industry 110 years, and we see firsthand what happens when people have to use different parts of the health system. It's very uncoordinated. There are a lot of handoffs, and everybody assumes everybody else has all the information on the patient. But we truly do have access to that information, and we follow through."

The PACE staffing model allows the organization to follow participants wherever they are in the

healthcare system, he continues. "If a participant goes into the hospital, a physician who works with our contracted hospital communicates directly with that patient's PACE physician. We provide a lot of services, and for those we don't provide, we provide a high level of coordination."

Hospitals can find it challenging to deal with frail older adults who lack a support network, he says. For example, if the hospitalist arranges a post-discharge visit, there's no assurance the patient will make it, or that they will take their medication as instructed. "We serve as family support for those who lack it. We accompany [participants] to the follow-up visit; we get the results from that visit and share it with the interdisciplinary team; we monitor the participant's medications. We spend more money upfront on preventive measures instead of letting things fall where they may."

Healthcare professionals who work within PACE either come to the program with a well-developed sense of teamwork and collaboration, or are open to learning about it, says Thorhauer.

"The physician has no more authority than the bus driver or the home worker, who often know as much about what's going on with the client," he says. "The bus driver might observe something as the person is getting onto the bus; or a certified nursing assistant may observe something at home that is valuable to that person's care."

Team members meet daily to review changes in their participants' circumstances and strategize on solutions. It differs from the traditional approach, in which caregivers may exchange notes or medical records, but never speak to each other, says Thorhauer. "In PACE, the nurse is speaking with the doctor, the bus driver, the dietician, the social worker, the pharmacist. They interact, so they can come up with the best solutions."

Where is PACE headed?

"We've been here almost three years, and we are becoming more well known in the community," says Bluhm. "It has been rewarding to see how quickly PACE has been accepted in the community, and the strong number of referrals we receive each month." Many of those referrals come from home health agencies. Hospitals have proven to be strong referral sources too, as well as primary care doctors, specialists, meals programs, churches and others.

"Will PACE serve millions of people in Michigan?" asks Thorhauer. "No. But it could serve hundreds of thousands of people in a given state." For that to occur, organizers would have to open up more day centers around the state, and that presents its own set of challenges.

Starting a program calls for a significant capital investment, and payback can't be expected for two to three years, he says. There's the cost of securing a building for the day center, either through lease or purchase, plus improvements. Then the organization has to hire a staff and train them.

Even so, because of the benefits of the program, Huron Valley PACE is exploring ways to provide services to a broader population than it currently does, says Bluhm. Some examples:

- Participants who are eligible for Medicare but not Medicaid. "We could create some pricing tiers for what Medicaid would have covered, so they would only pay for what they use or need," he says.
- Participants who are not quite nursing-home-eligible.
- Participants who are eligible for Medicare but who earn just enough money to make them ineligible for Medicaid.

"Given the continued focus on managed care and the Triple Aim of healthcare – better health, better care, and lower cost – we believe PACE is well positioned to continue to serve very frail older adults," says Thorhauer. "Data suggests that PACE offers very high participant satisfaction for a lower cost and keeps participants at home and out of institutions. In fact, we are able to keep approximately 98 percent of our participants at home.

"Regardless of whether the Affordable Care Act is repealed, modified or replaced, PACE is a viable, responsible model for delivering high quality care in a cost-effective manner."

Individuals can join PACE if they meet certain conditions:

- Medicare- and Medicaid-eligible
- Age 55 or older
- Live in the service area of a PACE organization
- Eligible for nursing home care
- Able to live safely in the community

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[1] Donahue SP, Arthur B, Neely DE, Arnold RW, Silbert D, Rubin JR. Guidelines for automated preschool vision screening: A 10-year, evidence-based update. J AAPOS. 2013;17(1):4-8.

[2] http://www.cdc.gov/visionhealth/basic_information/eye_disorders.htm:CDC - About Vision Health – Common Eye Disorders - Vision Health Initiative (VHI)

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PACE services include:

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- Nutritional counseling
- Social services
- Laboratory/X-ray services
- Social work counseling
- Medical transportation
- Medical specialty services
- Primary care (including doctor and nursing services)
- Medications
- Hospital care and long-term care
- Prescription drugs
- Emergency services
- Home health and personal care
- Physical, occupational and speech therapy
- Caregiver respite
- Medical equipment

PACE also includes all other services that are available in its service area and determined necessary by the participant's team of healthcare professionals to improve and maintain overall health.

PACE expansion to be tested

The Centers for Medicare & Medicaid Services released a Request for Information (RFI) seeking public input on potential adaptations of the Programs of All-Inclusive Care for the Elderly (PACE) for new populations, including individuals with physical disabilities, under the authority provided by the PACE Innovation Act.

The PACE Innovation Act of 2015 (PIA) provides authority to test application of PACE-like models for additional populations, including populations under the age of 55 and those who do not qualify for a nursing home level of care.

The RFI includes two parts:

- In the first part, CMS seeks comment on potential elements of a five-year PACE-like model test for individuals dually eligible for Medicare and Medicaid, age 21 and older, with disabilities that impair their mobility and who are assessed as requiring a nursing home level of care, among other eligibility criteria. CMS has provisionally named this model "Person Centered Community Care" or P3C.

- In the second part of the RFI, CMS seeks information on additional specific populations whose health outcomes could benefit from enrollment in PACE-like models, and how the PACE model of care could be adapted to better serve the needs of these populations and the currently eligible population.

The RFI is available at: www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/PACEInnovationAct.html

Millennials Will Shake Up Healthcare

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

Did you know that Millennials are now the largest generation in America? This generation has grown up in an era of ever-increasing technological sophistication that has improved speed, efficiency, and convenience of services. And this experience has shaped how they make healthcare decisions.

Millennials have fundamentally different expectations for healthcare providers. HIDA has recently released new research on how this generation approaches healthcare, based on an in-depth survey of over 1,000 patients. Here are some key insights from this research:

Younger consumers prefer a transactional approach to healthcare

Compared to older consumers, Millennials are less interested in personal, long-term relationships with their healthcare providers and more interested in convenience. They are less likely to have a primary care physician, and are not impressed solely by the amount of time a provider spends with them. Additionally, they are much more likely than earlier generations to switch providers if they are unsatisfied.

They scrutinize medical visits closely

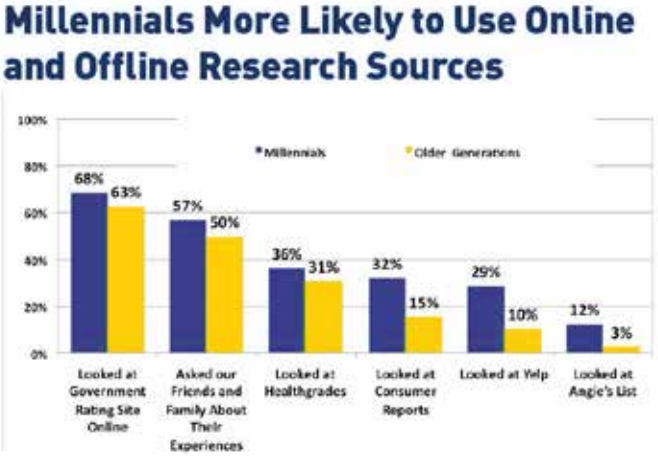
Millennials pay attention during healthcare visits, and they are more likely than their elders to rate a provider as excellent or poor. They are better than earlier generations at explaining why a provider either met, failed to meet, or exceeded their expectations. Millennial patients are also more likely to research providers, either through online rating sites like Yelp or by asking friends.

They expect providers to value their time and money

Millennials grew up in the Internet age in which almost any question can be answered instantaneously – so they are not happy about waiting for lab results. In fact, the leading cause of provider dissatisfaction among Millennials is being unable to get laboratory results during the same visit. These patients want to limit the number of times they go to the doctor and lower their out-of-pocket expenses.

They have high expectations for their providers

Millennials have strong opinions about their providers and care about every aspect of their visit. In addition to seeking quick and efficient care, they want facilities that are comfortable and easy to navigate. They prefer providers who have offices with open spaces, comfortable chairs, and who provide snacks and beverages while they wait. They also expect their providers to have modern offices with up-to-date equipment and technology.



While this generation may prove challenging for providers, learning more about their preferences can make you a valuable partner to your customers. By helping your customers improve their facility layout and amenities, helping them improve speed and efficiency, and apprising them of new equipment and technology, you can help them stand out with this important demographic.

To access the Horizon Report Millennials As Healthcare Consumers and other HIDA Research & Analytics reports, visit www.HIDA.org/HorizonReport.

Warming up Cold Calls

Homework, networking mean the cold call doesn't have to be so cold anymore.

Editor's note: Repertoire *asked a couple of med/surg sales veterans about the current state of the cold call, following the release of a position from the American College of Physicians opposing "unsolicited communications." It turns out ACP was not targeting med/surg or pharmaceutical reps. (See sidebar.) But "the status of the cold call" seemed like a fitting topic to pursue anyway.*

Information resources available to distributor reps today differ from what was available when Ty Ford first began selling medical supplies in 2002. "So much information is available at your fingertips," says Ford, vice president of sales for the Western U.S. region at Henry Schein. If reps use the many resources available, "it should never be a cold call at this point."

Ford believes that cold calling – or "warm calling," that is, cold calling with the right preparation – is extremely important for sales reps to develop their business. Account turnover is the normal course of business, he says. If reps aren't continually looking for opportunities to grow their account base – in other words, if they are not prospecting – "they're doing themselves and their organization a disservice." Establishing strong networks – through local associations, manufacturing partners, and others – will help.

Victor Amat, owner and president of American Medical Supplies and Equipment in Miami, Fla., advises his sales reps to warm up their cold calls by leveraging their relationships with current customers. "We don't buy from a stranger," he observes. "We buy from who we like." Getting a referral from a current customer can help bridge the gap between the rep and a prospective customer.

Do your homework

Reps who find ways to demonstrate their value will make it hard for prospective customers to keep their door closed, says Ford. New potential customers may have a myriad of objections, making the cold call a source of apprehension for reps. However, distribution companies such as Henry Schein offer ongoing training and support to help reps overcome these challenges and advise them on when may be the best time for calls to produce the most effective results.

Ford also notes that information technology can make it easier to avoid mistakes. For example, electronic data resources, such as Definitive Healthcare (a partner of Share Moving Media, *Repertoire*'s publisher), provide reps with information on key decision-makers at hospitals, physician practices, and integrated delivery networks.

"When you do your homework and you understand all aspects of the office – from the best timing, to what their needs are, to what they're focused on as an organization," the cold call will be more worthwhile for prospective customers, says Ford. "Aligning your goals with their goals is the key step."

"Don't just show up and say, 'Hey, I sell medical supplies cheaper and I can get them to you faster,'" says Amat. It's not always about saving money; it's about being prepared and offering a solution. rep

American College of Physicians and 'unsolicited communications'

At the end of 2016, the American College of Physicians (ACP) adopted a policy statement addressing unsolicited communications, aka "cold calling." The statement reads, in part, "ACP opposes unsolicited communications ('cold calling') of pharmaceuticals, durable medical equipment, supplies, and healthcare services that target patients and/or physicians and/or other prescribing clinicians including via direct mail, telecommunications, or facsimile."

When *Repertoire* contacted ACP for clarification, Hilary Daniel, senior analyst of health policy and regulatory affairs, said the statement is not in reference to pharmaceutical or medical device sales reps. "In this context, the 'cold calls' or unsolicited communications are primarily actions that target patients and are often done without physician knowledge.

"For example, if a Medicare patient is reordering diabetes test supplies over the phone and the person taking the order tells them they can also get a leg brace for free if they have diabetes-related leg pain…. The patient agrees and the physician [receives] forms to sign off on something they have not recommended to the patient."

According to the policy statement, "ACP believes this practice [unsolicited communications] can lead to inappropriate treatment, interferes with the patient-clinician relationship, adds unnecessary costs to the health care system, and raises legal issues."

Daniel expands on that sentence: "Physicians are responsible for providing evidence-based, effective, and efficient care in the patient's best interest…. If a physician were to appropriately deny a request for a drug or medical device as the result of patient-targeted 'cold calling,' it may gradually lead to distrust between the patient and physician."

To view the full statement on the ACP website, visit www.acponline.org/acp-newsroom/american-college-of-physicians-recently-adopted-position-statement-on-unsolicited-communications.

Screening for Colorectal Cancer

Colorectal cancer is one of the most commonly diagnosed diseases, but also one of the easiest to prevent.

Editor's note: This is a reprint of an article *Repertoire* published in March 2014, updated with the most current statistics.

Colorectal cancer is the second leading cause of cancer-related deaths in the United States and the third most common cancer in men and in women, according to the Centers for Disease Control and Prevention.

In 2013 (the most recent year numbers are available):

- 136,119 people in the United States were diagnosed with colorectal cancer, including 71,099 men and 65,020 women.
- 51,813 people in the United States died from colorectal cancer, including 27,230 men and 24,583 women

One of the early warning signs of the disease is hidden (or occult) blood in the stool, which can be detected by a fecal occult blood test. For over 40 years, guaiac fecal occult blood tests (gFOBTs) have been available, which are based on the oxidation of guaiac by hydrogen peroxide to a blue-colored compound. A positive gFOBT may be due to bleeding in the upper and/or lower gastrointestinal tract and does not necessarily indicate colon cancer. In addition, gFOBT is not specific for human hemoglobin. Certain foods and medications can interfere with the accuracy of the test results.

Immunochemical fecal occult tests (IFOBT) – also called fecal immunochemical tests (FIT) – have been available for the last 14 years. They are said to be more sensitive and specific to human hemoglobin and do not involve the dietary or medicine restrictions indicated by guaiac tests. Although FITs do not detect upper gastrointestinal bleeding, they can be used to determine lower gastrointestinal bleeding indicative of colorectal cancer. FITs can also be used to screen for polyps, diverticulitis and colitis.

In spite of the benefits of FITs, some physicians continue to rely on digital rectal exams (DRE) to screen for colorectal cancer. However, medical guidelines warn against using DREs, as they tend to generate negative results, and some studies suggest these patients have nearly the same likelihood of having advanced neoplasia as patients who do not undergo any stool testing.

How the test works

Fecal immunochemical tests are antibody-based tests designed to screen for blood in the stool. They may be used to determine gastrointestinal bleeding found in several gastrointestinal disorders, including colorectal cancer, polyps, diverticulitis and colitis. Primary care physicians (e.g., internists, general practitioners and family physicians), gastroenterologists and ob/gyns usually perform FITs as an annual screening in their offices, however the test also is used in laboratories and hospitals. Most medical societies recommend that patients be screened beginning at age 50, unless they are at high risk for colorectal cancer. (See related article.) The American Cancer Society Guidelines for the Early Detection of Colorectal Cancer recommends that patients also use the multiple-day stool take-home test, as one test performed in the physician's office is not adequate.

The fecal immunochemical test is a one-step lateral flow chromatographic immunoassay test. Depending on the test, the patient generally takes a collection device home to collect his or her stool, and then returns the device to the physician's office. The fecal sample is applied to a dry sample collection card, or it is suspended in a liquid and placed into a cassette for testing and results.

How to sell

A good number of physicians today continue to rely on traditional guaiac tests, and convincing them to switch to fecal immunochemical tests can sometimes present a challenge. True, FITs cost the physician more money upfront, but they offer greater clinical sensitivity and specificity and, as such, a valuable service to patients. In order for physicians to be reimbursed for either test, the patient must return the collection device with his or her stool sample. However, guaiac tests are associated with low reimbursement rates, and some doctors do not bother to file.

To successfully convert accounts from guaiac to FITs, sales reps should be prepared to discuss technology and performance, as well as reimbursement and costs. They should separate the patient take-home collection cost from the total cost of the test. In spite of the higher cost of FITs, reimbursement is significantly higher, making this option economically feasible. (Again, physicians are reimbursed only when the patient returns his or her sample and the development portion of the test is completed.)

Sales reps should approach their physician customers with the following questions:

- "How many patients at risk for colorectal cancer do you see each year?"
- "How do you currently address colorectal cancer with these patients?"
- "Are you interested in expanding your use of rapid tests?"
- "Do you currently use guaiac tests or fecal immunochemical tests for colorectal cancer screening?"
- "Are you aware of the benefits of fecal immunochemical tests?"
- In addition, they should educate their customers on variations in manufacturer recommendations, as well as recommendations from key medical societies and the U.S. Preventive Services Task Force.

In some cases physicians are under contract to refer their patients to a lab for fecal immunochemical testing. In general, however, many doctors can test in-house.

FITs have been reimbursable by Medicare since 2003. Reimbursement rates may vary by region or insurer. rep

Selling iFOBT

Susan Ward, global product manager, point of care, Sekisui Diagnostics – maker of OSOM® iFOBT – offers this advice on selling iFOBT.

***Repertoire*: Name three ways in which iFOBT tests represent advancement over guaiac-based fecal-occult-blood testing?**

Susan Ward: The gFOBT often returns false positives based on the presence of non-specific hemoglobin in a patient's stool. FIT/iFOB is both sensitive and specific in that it only returns a positive for the presence of human hemoglobin.

The gFOBT tests require a patient to follow a seven-day dietary and drug-restriction regimen. Patients who are non-compliant with this pre-test regimen are at risk for returning an erroneous result, which could lead to further and more expensive diagnostic procedures.

The gFOBT tests required multiple stool samples following the above seven-day drug and dietary restriction due to chemicals or diet affecting the gFOBT test. Patient compliance with an FIT/iFOB will be much higher due to collection of one stool sample and no dietary or drug restrictions prior to collection for the test.

***Repertoire*: Which physician specialty(ies) are most likely to have an interest in iFOBT?**

Ward: Family practice, internal medicine, OB/GYN, urgent care, multispecialty clinics.

***Repertoire*: What probing questions should sales reps ask to initiate a discussion about iFOBT?**

Ward: Here are some simple questions to ask your customers to get a conversation started:

- Do you currently screen for colorectal cancer?
- Do you send the collection kit home with the patient, or do you do a digital exam in the office? What type of patient compliance are you getting?
- Are you currently using an iFOB test? If so, which one?

***Repertoire*: What objections might sales reps encounter, and how should they respond?**

Ward: The main objection is that still physicians are utilizing gFOBT during patient visits, which can increase the risk of returning an erroneous result – which could lead to further and more expensive diagnostic procedures.

Sales reps can provide physicians with the correct information and the benefits of utilizing a highly accurate iFOB test, which will reduce the unnecessary need for more invasive patient procedures, such as a colonoscopies, reducing cancer treatment expenses, hospital stays, and long-term-care costs that are critical to improving our healthcare system.

What the experts say

Colorectal cancer is among the leading causes of cancer-related deaths for men and women in the United States. Early detection – better yet, prevention – is critical. But what's the best way to screen for colorectal cancer? A number of medical societies have weighed in with their own recommendations. Which to follow?

The American College of Physicians has an answer. In 2012, ACP published a guidance statement on screening for colorectal cancer after assessing current guidelines developed by other organizations. "When multiple guidelines are available on a topic or when existing guidelines conflict, ACP believes that it is more valuable to provide clinicians with a rigorous review of the available guidelines rather than develop a new guideline on the same topic."

Screen for colorectal cancer starting at age 50 years and continuing until age 75 years.

American Cancer Society

The American Cancer Society believes that preventing colorectal cancer – and not just finding it early – should be a major reason for getting tested. Having polyps found and removed keeps some people from getting colorectal cancer, according to the Society. Tests that have the best chance of finding both polyps and cancer are preferred.

Starting at age 50, men and women at average risk for developing colorectal cancer should use one of the screening tests below:

Tests that find polyps and cancer

- Flexible sigmoidoscopy every five years. (Colonoscopy should be done if test results are positive.)
- Colonoscopy every 10 years.
- Double-contrast barium enema every five years. (Colonoscopy should be done if test results are positive.)
- CT colonography (virtual colonoscopy) every five years. (Colonoscopy should be done if test results are positive.)

Tests that mainly find cancer

- Guaiac-based fecal occult blood test (gFOBT) every year. (Colonoscopy should be done if test results are positive. Highly sensitive versions of these tests should be used with the take-home multiple sample method.)
- Fecal immunochemical test (FIT) every year. (Colonoscopy should be done if test results are positive. Highly sensitive versions of these tests should be used with the take-home multiple sample method.)
- Stool DNA test every three years. (Colonoscopy should be done if test results are positive.)

People who are at an increased or high risk of colorectal cancer might need to start colorectal cancer screening before age 50 and/or be screened more often, according to the Society. The following conditions make one's risk higher than average:

- A personal history of colorectal cancer or adenomatous polyps.
- A personal history of inflammatory bowel disease (ulcerative colitis or Crohn's disease).
- A strong family history of colorectal cancer or polyps.
- A known family history of a hereditary colorectal cancer syndrome such as familial adenomatous polyposis (FAP) or Lynch syndrome (hereditary non-polyposis colon cancer or HNPCC).

Source: American Cancer Society, www.cancer.org/cancer/colonandrectumcancer/moreinformation/colonandrectumcancerearlydetection/colorectal-cancer-early-detection-acs-recommendations

American Gastroenterological Association

As part of Choosing Wisely® (www.choosingwisely.org) – a seven-year-old campaign in which more than 70 medical specialty societies have identified wasteful or unnecessary medical tests, treatments and

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procedures – the American Gastroenterological Association made this recommendation:

- Do not repeat colorectal cancer screening (by any method) for 10 years after a high-quality colonoscopy that does not detect neoplasia.

- A screening colonoscopy every 10 years is the recommended interval for adults without increased risk for colorectal cancer, beginning at age 50 years, according to AGA. Published studies indicate the risk of cancer is low for 10 years after a high-quality colonoscopy fails to detect neoplasia in this population. Therefore, following a high-quality colonoscopy that does not detect neoplasia, the next interval for any colorectal screening should be 10 years following that normal colonoscopy.

Source: Choosing Wisely®, www.choosingwisely.org/societies/american-gastroenterological-association/

U.S. Preventive Services Task Force

In June 2016, the U.S. Preventive Services Task Force posted these recommendations on colorectal cancer screening on its website:

- For adults aged 50 to 75 years: Screen for colorectal cancer starting at age 50 years and continuing until age 75 years.

- Adults aged 76 to 85 years: The decision to screen for colorectal cancer in adults aged 76 to 85 years should be an individual one, taking into account the patient's overall health and prior screening history. Adults in this age group who have never been screened for colorectal cancer are more likely to benefit.

- Screening would be most appropriate among adults who 1) are healthy enough to undergo treatment if colorectal cancer is detected and 2) do not have comorbid conditions that would significantly limit their life expectancy.

Source: U.S. Preventive Services Task Force, www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/colorectal-cancer-screening2?ds=1&s=colorectal

American College of Physicians

To develop its 2012 Guidance Statement, the American College of Physicians searched the National Guideline Clearinghouse to identify guidelines developed in the United States. Four guidelines met the inclusion criteria: a joint guideline developed by the American Cancer Society, the U.S. Multi-Society Task Force on Colorectal Cancer, and the American College of Radiology and individual guidelines developed by the Institute for Clinical Systems Improvement, the U.S. Preventive Services Task Force, and the American College of Radiology.

Guidance Statement 1: ACP recommends that clinicians perform individualized assessment of risk for colorectal cancer in all adults.

Guidance Statement 2: ACP recommends that clinicians screen for colorectal cancer in average-risk adults starting at the age of 50 years and in high-risk adults starting at the age of 40 years or 10 years younger than the age at which the youngest affected relative was diagnosed with colorectal cancer.

Guidance Statement 3: ACP recommends using a stool-based test, flexible sigmoidoscopy, or optical colonoscopy as a screening test in patients who are at average risk. ACP recommends using optical colonoscopy as a screening test in patients who are at high risk. Clinicians should select the test based on the benefits and harms of the screening test, availability of the screening test, and patient preferences.

Guidance Statement 4: ACP recommends that clinicians stop screening for colorectal cancer in adults over the age of 75 years or in adults with a life expectancy of less than 10 years.

Source: "Screening for Colorectal Cancer: A Guidance Statement From the American College of Physicians," March 6, 2012 Annals of Internal Medicine, http://annals.org/aim/article/1090701/screening-colorectal-cancer-guidance-statement-from-american-college-physicians

Next Steps

Efforts continue to streamline the vendor credentialing process, ensure the accuracy of the data that providers demand, and reduce costs for all.

The Consortium for Universal Healthcare Credentialing (C4UHC) – formerly the Coalition for Best Practices in Healthcare Industry Representatives – issued an RFI in November seeking a service provider to work with the Consortium to create a standardized, open, and interoperable individual and company credentialing system.

Currently, the nation's hospitals use a number of vendor credentialing organizations (and, in some cases, their own staffs) to collect and certify information about the vendor reps who call on them. Not only do their standards (e.g., TB tests, vaccinations, training on bloodborne pathogens standards, timing of background checks and drug screens, etc.) vary, but so does the documentation required to verify that the standards have been met. That means that reps and their companies must submit different information in different formats to multiple vendor credentialing organizations and hospitals.

The Consortium – through its RFI – is seeking a solution that could aggregate, store and allow access to a rep's credentialing information, says Rhett Suhre, Consortium chairperson. The data would be accurately loaded once by the accountable party and be available interoperatively. As much as a billion dollars annually might be saved across the supply chain, if earlier estimates are accurate, says Suhre.

> "Over time, we think that the efficiencies gained from standard data elements and a streamlined process will help to drive costs down for all stakeholders."

"For years, either the Consortium or its predecessors have been actively engaging all stakeholders – including providers, suppliers and regulators – in the process of determining precisely what [the] standards [for credentialing] should be," says Suhre. "Proposed standards have existed for 10 years, and all essentially recommend the same requirements for representatives based on their level of access and potential risk to patients." Furthermore, "most responsible supplier companies have had policies in place for years prior to the advent of credentialing that ensured that their employees did not pose a risk to their customers or patients.

"The challenge today lies in the fact that, in absence of any top-down standard required by regulators or accrediting bodies, healthcare facilities have implemented varying requirements and multiple processes and systems to document compliance to these requirements," says Suhre. "Often, the requirements differ in seemingly small ways, such as by requiring a background check within a certain time-period before the supplier's employee is allowed to visit the site. But those small varying requirements result in duplicative efforts that do not materially improve patient safety, but instead, increase costs and actually increase the risk to patients by creating a system that is prone to error. Only with consistency can there be valuable transparency and accountability.

"The Consortium is not asking for significant changes to most

health care systems' requirements, but rather, is asking them to accept our standardized documentation – data elements – to reduce delays, avoid duplicative requirements, and eliminate waste in the system."

The key question for the industry has been, How can credentialing be systemized so that the accountable party – in most cases, the employer – can ensure their representatives have met providers' requirements and then communicate that one time so that everybody is aware of that, says Suhre. "Right now, even if we have the same requirement – e.g., a background check – everybody still requires it on their own form of documentation, whether it's blue, green, in a PDF, or a copy of the background check summary," he says. "So even when the requirement is quote-unquote the same, the documentation process is extremely labor-intensive and repetitive. What we're trying to do is boil down each requirement to the most basic element – e.g., 'compliant' or 'not compliant.'"

"What we're trying to do is boil down each requirement to the most basic element – e.g., 'compliant' or 'not compliant.'"

The suppliers and providers participating in the Consortium agree that if such a system were set up, "it wouldn't matter what background check company you used, or what vendor credentialing organization you used, or what process you used to verify the information. We all feel we could boil it down to that data element. Ultimately we're giving everybody what they need – documentation that the standard has been met."

While reviewing responses to the RFI, Suhre said that the Consortium has no preconceived idea for the ideal solution or who will provide it. "The goal of the RFI was to cast a wide net in the hopes that interested parties would respond. There are likely many companies with technology solutions that could help with the entire project or various pieces of the overall solution. With the RFI, the Consortium seeks to better understand the technology solutions that are available and refine the specifications in order to issue an RFP for a pilot program in 2017."

Regardless of who ultimately signs a contract, third-party companies – including vendor credentialing organizations, background screening companies, medical testing organizations, and those that offer training to healthcare industry representatives – "will still be an important part of the credentialing process," says Suhre.

"The Consortium does not intend to force any stakeholder to switch current relationships or contracts. With standard data elements and a streamlined process, the responsible and accountable party can still work with their current supplier on that piece of credentialing. Over time, we think that the efficiencies gained from standard data elements and a streamlined process will help to drive costs down for all stakeholders by eliminating duplicative requirements." rep

For more information on the Consortium for Universal Healthcare Credentialing, visit www.universalhealthcarecredentialing.org.

Consortium members, supporters

Members of the Consortium for Universal Healthcare Credentialing are:

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- Siemens Medical Solutions USA, Inc./Siemens Healthcare Diagnostics, Inc.
- STERIS Corporation
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What's Ahead for Healthcare Reform

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

President Donald Trump campaigned on a promise to repeal the Affordable Care Act (ACA), and Congress has begun the complicated legislative process to deliver on that promise. In addition to repealing the ACA, President Trump and many Republicans in Congress are interested in additional changes to the U.S. healthcare system. These proposals include giving states a greater role in Medicaid and giving consumers more responsibility in saving for healthcare. While both the president and congressional GOP leaders have offered broad outlines about their plans, many questions remain about what legislative action will actually follow, how the transition will go, and the impact on the industry.

Here are some of the key healthcare issues to watch under the next presidential administration.

ACA in transition

While many in Congress are already focused on ensuring there are no major disruptions to the health insurance marketplace, some policymakers have suggested an effective date for full repeal of the ACA may not come for several more years. Even if the ACA is repealed, several recently implemented policies are expected to remain in place. These include value-based purchasing, reimbursements based on readmissions and hospital-acquired conditions, and authority for accountable care organizations.

Health Savings Accounts

Both President Trump and Republican legislators support expanding the use of Health Savings Accounts (HSAs). We expect several initiatives to boost the eligibility and incentivize HSA use, including allowing anyone to open and contribute to an HSA regardless of their type of insurance coverage, enabling spouses to make catch-up contributions to the same HSA account, and allowing individuals eligible for TRICARE coverage to contribute to HSAs.

Medicaid reform

One of President Trump's campaign promises was to reform Medicaid into a block-grant program, where states would receive a certain amount of money (based on poverty levels) to manage their program with a degree of freedom. Republican governors have supported this idea, maintaining it will control costs. Republican majorities in Congress create a new opportunity to pursue this reform.

Price transparency

President Trump will likely seek improved price transparency across all providers, including clinics and hospitals. This measure has the potential to generate conflict between the White House and Congress, as insurers, pharmaceutical companies, physicians, and provider organizations may lobby against transparency efforts.

Nominees provide insights for potential Trump policies

President Trump's selection of former Rep. Tom Price (R-GA) to head the Department of Health and Human Services and Seema Verma to head the Centers for Medicare and Medicaid Services offers some insights into the policies the administration will pursue. Both are believed to favor free market and consumer-directed solutions to healthcare challenges.

While Rep. Price has been a longstanding opponent of the ACA, he has also been a key ally for the healthcare distribution industry. Notably, he has advocated on behalf of industry stakeholders for replacing Medicare's Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program.

Verma is formerly President and CEO of a national health policy consulting company. She is considered the architect of Indiana's Medicaid program, the Healthy Indiana Plan, and has also developed Medicaid reform programs, including waivers for Iowa, Kentucky, and Ohio. She has also helped implement HSA policies and healthy lifestyle requirements for Medicaid beneficiaries.

With these proposals and nominees, Congress and the White House will likely pursue a more market-oriented healthcare agenda. Though Republicans hold a majority in both houses of Congress, some of their proposals will be vulnerable to Democratic filibusters in the Senate. Republicans may be able to advance some initiatives through budget reconciliation and by collaborating with Democrats who face competitive races in 2018.

HIDA will continue to monitor the Trump administration's health reform efforts throughout the year. Contact us at HIDAGovAffairs@HIDA.org if you have any questions, or want more information. rep

rep corner

A Calling

It's no wonder Jamie Manning finds herself in healthcare

Jamie Manning grew up in healthcare. Her dad, Doug Sewell, went to nursing school after finishing a tour of duty in Vietnam with the U.S. Marine Corps. He worked in nursing administration for many years, and finished his career as a hospital administrator. Her mom, Jeanne Sewell, is an RN who worked for many years in public health and as a nursing instructor.

"Our daily dinnertime conversations were about healthcare," says Manning, a territory rep for Gericare Medical Supply in Monroeville, Ala.

Twenty-three years ago, she married Mark Manning, a nursing home administrator. Today he serves as a regional administrator working with several nursing homes and assisted living facilities throughout south Alabama.

Small wonder that Manning finds herself in healthcare.

Step by step

Manning was born in Mobile, Ala., and raised in Monroeville. She graduated from Troy University in Troy, Ala., with a degree in psychology with minors in biology and communication with the hearing impaired. "I was part of the pre-allied-health program, designed to prepare you for graduate school in any number of health-related fields," she says. She did indeed get a master's degree – in sports science, with an emphasis on sports medicine and cardiac rehabilitation. While working in a cardiac rehab program in Mobile, she decided to pursue her RN, which she received in 1995 from Jefferson Davis Community College.

Jamie Manning

While working in home health, she found herself working closely with Hill-Rom, manufacturer of therapy beds. Eventually, she joined the company's home care division, calling primarily on home health agencies.

"I like working with products I really believe are beneficial to the patient," she says. "That's my bridge between nursing and sales."

In 2001, she took a position with the state of Alabama to help develop a regional plan for ALL Kids, Alabama's Child Health Insurance Program. Working through private insurance, the program uses federal and state dollars to provide insurance coverage to children under 19 who fail to qualify for Medicaid or private insurance. "We put together a team to work with providers, community partners, families and others to reach these children," she recalls. "We got it institutionalized, all systems flowing. And the program is alive and well today."

During her time with ALL Kids, she completed the South Central Public Health Leadership Institute through Tulane University, and was inducted into the Alabama Public Health Association Hall of Fame.

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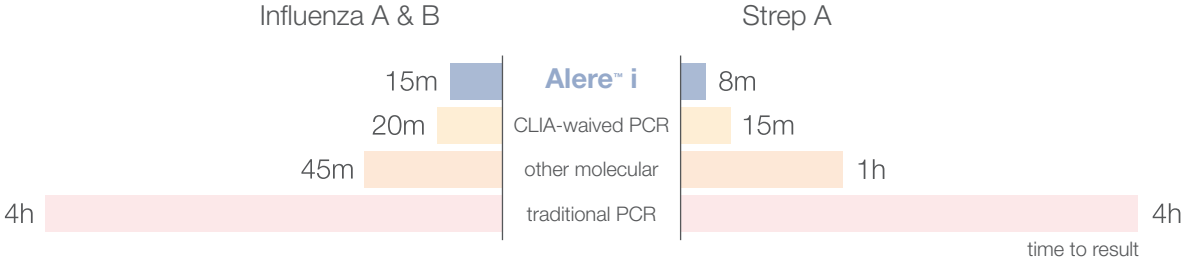

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Manning family.

Medical sales

In 2013, as Manning's project with the state was nearing an end, Gericare owner Billy Jones and Vice President Bob Miller offered her the opportunity to take over the territory of Glenda Prewett, who was retiring after 26 years. "It was a wonderful opportunity," she says. "I was able to work with Glenda over her last several months with the company; I credit my successful transition largely to this. I still work off many of the notes she left."

In fact, the most daunting part of her new job was stepping into the big shoes left by Prewett. "She worked so well with all the customers," says Manning. "So [my job] was making sure I nurtured those relationships, and made the customers feel secure with a brand new rep coming in."

"I like working with products I really believe are beneficial to the patient. That's my bridge between nursing and sales."

The clinical skills she had exercised on prior healthcare jobs certainly helped, she adds. Given distributor reps' big bag of products, "any time you can get a jump start on products helps. It also helped that I was very comfortable with the healthcare setting." She has found that one of the best parts of her job is the fact that there is no "typical" day. "I may look at new drapes for a facility in the morning, work with wound care products in the afternoon, and finish up addressing enteral needs," she says.

"Long-term care, as anything else, is constantly changing," she adds. "There are unique differences in each facility and even in each community. The resident or patient mixes are different. You see 'traditional' long-term units, but you also see dementia and rehab units. You see facilities having numerous admissions and discharges each day, which is very different than what we saw several years ago.

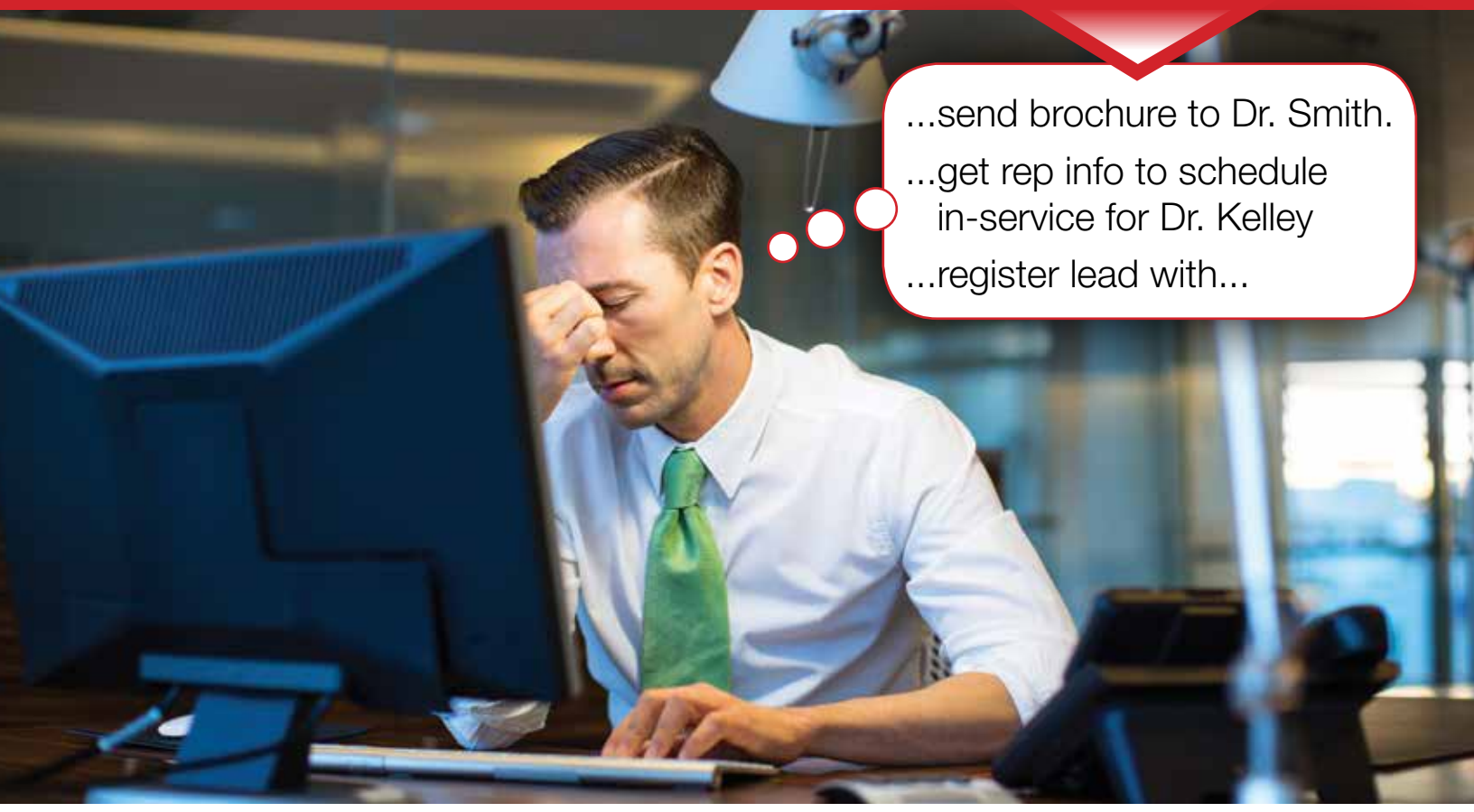
"All of these changes strengthen the importance of the distributor rep. Our facilities have numerous challenges meeting the needs of their residents. As distributor reps, our job should be to make their life a little easier by assisting in finding solutions. I feel I have been most successful when I have listened to my customer and matched their need with a solution offered by one of my trusted vendors. It is all about solutions – meeting our customers where they are at the time and helping make things a little easier. My daily prayer is to be a blessing to my customers and in turn a blessing to the people they serve."

Off duty

Jamie Manning and her husband, Mark, have two children, Jones and Morgan, both of whom attend her alma mater, Troy University. "We have always been very involved in supporting their numerous activities and loved every minute," she says. "We are now empty-nesters, and enjoying that as well."

She is a paddle-boarder and avid bridge player. "I am one of nine very special friends that meet weekly to play cards, discuss children and anything else that may arise," she says. "We have done everything from traveling, running half marathons, supporting local charities and supporting all of our children and families through various adventures. Our children often say they are blessed with nine mothers." rep

What does your “after hours” look like?



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Surprising Discoveries

Life expectancy dropped in 2015 for the first time in over 20 years. The reasons for that drop are numerous and complex.

American life expectancy in 2015 dropped for the first time in over two decades, according to a December 2016 *Washington Post* article documenting the National Center for Health Statistics (NCHS) "Mortality in the United States, 2015" data brief.

"In all, death rates rose for eight of the top 10 leading causes of death," the article stated, citing rising fatalities from heart disease and stroke, diabetes, drug overdoses, accidents, and other conditions.

Overall life expectancy fell from 78.9 years in 2014 to 78.8 years in 2015 – one-tenth of a year – the first time a decline has occurred since 1993. Additionally, the overall national death rate rose 1.2 percent in 2015, the first time since 1999.

"Experts cautioned against interpreting too much from a single year of data; the numbers could reverse themselves next year," the article notes. It also notes that despite a rise in death rates for the above-mentioned conditions, the mortality rate for cancer dropped from 2014 to 2015 – most likely because fewer people are smoking, the disease is being detected earlier, and new treatments have been developed recently, experts said.

A problem with no easy solution

Among the findings in the NCHS mortality data brief was an increase in deaths from heart disease, which could be linked to American obesity rates.

On the subject of obesity, Frank Sacks, M.D., professor of cardiovascular disease prevention at Harvard School of Public Health, asks this question: Why do some people lose 50 pounds on a diet while others on the same diet gain a few pounds?

Sacks's research was the subject of a *New York Times* article examining recent findings that compare obesity to cancer: not one disease, but many. "You can look at two people with the same amount of excess body weight and they put on the weight for very different reasons," said Arya Sharma, M.D., professor of medicine at the University of Alberta.

Overall life expectancy fell from 78.9 years in 2014 to 78.8 years in 2015 – one-tenth of a year – the first time a decline has occurred since 1993. Additionally, the overall national death rate rose 1.2 percent in 2015, the first time since 1999.

It makes as much sense to insist there is one way to prevent all types of obesity – get rid of sugary sodas, clear the stores of junk foods, shun carbohydrates, eat breakfast, get more sleep – as it does to say you can avoid lung cancer by staying out of the sun, according to Lee Kaplan, M.D., Ph.D., director of the Massachusetts General Hospital Weight Center. He has counted 59 types of obesity, with a range of causes.

Research indicates that these causes range from genetic factors, to medication, to diseases. To help patients find an effective way to lose weight, specialists begin by determining if there is an obvious cause for a person's excess weight, such as a medication, that can be switched for something else.

"If not, they suggest patients try one thing after another starting with the least invasive options, and hope something works," said the article.

Sacks, the Harvard professor, examined 811 overweight and obese adults, randomly assigning them to follow one of four diets and undergo behavioral counseling to help them stick to those diets. Based on current trends, the diets varied as follows: Two were low in fat, but one was high in protein and the other had average amounts of protein. The other two diets were high in fat; one of them had high amounts of protein and the other had average amounts.

"The research was designed to answer the question of whether one diet was any better than another and it provided an answer: None of the diets elicited much weight loss on average, and no diet stood out from the others."

A less deadly peanut

Most people seem to have some experience with peanut allergies, whether having to stay alert for the sake of their own safety or that of their children, or simply experiencing daily life and the "peanut-free zones" it brings.

Allergic reactions to peanuts cause around 500 hospitalizations and even some deaths in the United States each year, according to a December 2016 article in the *New York Times* Magazine. "Food that contains trace amounts, because it was produced with factory equipment or kitchen tools that came into contact with peanuts, can prove fatal for allergic individuals who consume it unsuspectingly."

Some scientists are trying to alter peanuts to make them less dangerous for people who are allergic. Among these researchers is Alrgn Bio, a Greensboro, N.C.-based food technology start-up. Alrgn Bio uses an enzyme called Alcalase, mixed with water, to soak peanuts and destroy biologically reactive parts of certain proteins in the legume that cause allergic reactions.

"The hope is that the proteins are so changed that they won't be recognized by the immune system – and will be less likely to elicit an allergic reaction, or at least a deadly one – in someone with the allergy," said the article. rep

Editor's note: Technology is playing an increasing role in the day-to-day business of sales reps. In this department, *Repertoire* will profile the latest developments in software and gadgets that reps can use for work and play.

Technology news

Drone-based security

Long work days? The Sunflower Home Awareness System by Alex Pachikov is available for pre-ordering. Designed to offer peace of mind while homeowners are away, the system is said to be the world's first smart sensor and drone-based home security system. It is designed to unite intelligent outdoor sensors with an aerial drone-based camera to provide a complete view of what's happening around one's home. If a disturbance turns out to be a raccoon, the sensors can chase it away with flashing lights and a warning noise. When family arrives home, they are greeted with an increase in the light level. However, when someone unknown approaches the house, the system deploys the drone to investigate. Users don't need to possess pilot skills, since the drone will fly itself to any suspicious activity. At nighttime, the drone employs its high-res camera with infrared light. For more information visit www.digitaltrends.com/cool-tech/sunflower-home-awareness-system/.

Lego of my coffee

Looking for a fresh way to begin a busy workday? Creative team Astonishing Studios has taken Lego building a step beyond conventionality by constructing a coffeemaker almost entirely out of Legos. The Lego Coffee Maker's exterior – as well as many of its moving parts – are comprised of Lego blocks, and powered by various motors. However, the coffee isn't free. The machine requires coins to produce a fresh cup of coffee. After a coin is inserted, the coffee maker drops an instant coffee – in this case, Starbucks – into a cup underneath the device's dispenser. Water is funneled from an interior water bottle into the cup, and a heat coil is lowered into the concocted beverage to zap the liquid. Voila! A fresh cup of instant coffee is ready for consumption. For more information, visit www.digitaltrends.com/home/astonishing-studios-builds-lego-coffee-machine/#ixzz4PMTDB81P or www.digitaltrends.com/home/astonishing-studios-builds-lego-coffee-machine/.

Useful tech products

- The Twelve South HiRise is an iPhone dock with a metal body, whose design allows users to also use it with an iPad. Its deluxe retail package includes a lightning and a microUSB cable. The latter is convenient for those who use their iPhone with a battery case. (From $33)

- Microsoft's Universal Foldable Keyboard is only 5 millimeters thin, and can connect to Windows, Android and iOS devices. It can handle accidental spills and will fit in one's jacket pocket when folded. It comes with a three-year warranty and a reportedly long battery life. ($50)

- The Ring video doorbell allows users to see and talk to visitors, even when they are away from home. The device is available in several colors, and setup is said to be easy. The doorbell's weather-resistant design helps ensure that water and humidity won't damage the ring. (From $169)

- Canary, an all-in-one home security gadget, is designed to stream 1080p video, while monitoring the temperature, humidity and air quality of one's home. The device features motion-activated recording, night vision and intelligent notifications. (From $132)

- The Canon Selphy CP1200 is a compact and user-friendly wireless photo printer. Its Wi-Fi connectivity enables it to connect to mobile devices via a free app by Canon, as well as via AirPrint and Wireless PictBridge standards. The device can also print from SD and microSD cards, and USB flash drives. The Selphy CP1200 has a 2.7-inch color display, and can deliver photos in multiple sizes, including 4 by 6 inches. Its rechargeable battery allows it deliver up to 54 images per day. ($100)

For more information visit www.bestproducts.com/tech/g864/cool-tech-products-you-need/.

Privacy? What's that?

Google Glass may have banned facial recognition apps amid privacy concerns, but that hasn't stopped British augmented-reality startup Blippar from creating a similar technology, according to a recent article in *The Telegraph* by James Titcomb. The technology reportedly can identify a person by scanning his or her face. Blippar has added the feature to its app, allowing users to point their phone's camera at a person and see if the image matches a face on its database. The company said it was the most highly requested addition to the app, which is used to scan and identify real-world objects, such as food and buildings. The feature has launched with a list of 70,000 public figures, including politicians, musicians and sports personalities. Members of the public will soon be able to add their own face to the app by scanning it from different angles. Users simply can point their phone at people – or even at unlabeled photos in the newspaper – to identify others. When the software recognizes someone, it provides such information as the individual's name and various other biographical details. The user, in turn, can edit this information on his or her personal media profile. Blippar has stated that faces will be added on a strictly opt-in basis; people can't be added to the app against their will, and the 70,000 public figures will be able to remove themselves should they wish. The accuracy of the app is said to be above 99 percent. For more information visit www.telegraph.co.uk/technology/2016/12/06/blippar-app-can-reveal-someones-identity-scanning-face/.

More useful gadgets

- Tile Slim Bluetooth Tracker. This credit-card-sized gadget by Tile is designed to help users locate their lost cell phone, as long as the phone is within its Bluetooth range. Its non-removable battery reportedly lasts for a year. $30

- Nomad Key for iPhone. The Nomad Key for iPhone is designed to eliminate the stress of leaving one's Lightning cable behind. Designed to attach to a keychain, the accessory is compatible with all Apple devices with a Lightning port. $20

- Casio WSD-F10 Smart Outdoor Watch. Casio's first Android Wear smartwatch is water-resistant to 50 meters of depth, as well as compliant with military standards for shock and dust resistance. The gadget features two LCD displays (one color and one monochrome), which allow it to deliver a blend of smart features and battery life. $500

- The UE ROLL 2. The waterproof speaker is controlled via a smartphone app, and is said to offer quality sound for its small size. $80

For more information visit www.bestproducts.com/tech/g864/cool-tech-products-you-need/.

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

Automotive-related news

Driving can be a pain

Four out of five people suffer from lower back pain, according to an article in *The Telegraph* by James Foxall. While driving is not necessarily the primary cause, it's known to aggravate the problem. In part, the issue is due to the design of the car. More often than not, however, it's associated with the way drivers are seated. Indeed, many osteopaths and chiropractors agree that people tend not to take time to set up the driving position properly. The human body isn't designed to spend long periods in a sitting position, note experts. Setting the car seat in a higher position can provide relief, as can taking frequent breaks when driving for longer periods. For more information visit www.telegraph.co.uk/cars/advice/avoid-back-pain-driving/.

Stay connected…safely

Navdy has introduced its Augmented Driving device, which is designed to leverage augmented reality (AR) technology to project information directly in the driver's line of sight. The user interface projects a transparent image on the road ahead, as well as incorporates Hand Gestures to accept calls with the wave of one's hand. A specially engineered Dial and advanced software permits the driver to control his or her phone hands-free. Maps, calls, messages, notifications, music and car information are projected directly in front of the driver. For the first time, drivers can Look Forward© while Staying Connected©. Features include:

Look Forward© Display: By projecting information into the distance, the road stays in focus.

Intuitive Interface: Navdy Hand Gestures enable the driver to accept a call or message with the simple wave of the hand.

Never Miss a Turn: Navdy's Projected Navigation© system is powered by Google Maps®. The feature offers full dynamic maps as a transparent image, without obstructing the driver's view of the road.

Stay Connected: Navdy lets drivers make and receive calls, listen to messages, control music, receive calendar reminders and stay connected to the apps on your phone. Navdy also connects to your car with Navdy Dash, showing the speed and RPM and automatically recommending nearby gas stations when the fuel level is low.

The system is compatible with iOS 9 and 10, and Android Jelly Bean (4.1) or newer, and reportedly works in any car with Navdy's magnetic mounting system. It can be stored in the glove box when not in use. It is available for as low as $71 per month with 12-month financing, or $799 as a one-time purchase with no monthly fees. For more information visit www.marketwired.com/press-release/navdy-reinvents-the-driving-experience-ships-first-augmented-driving-device-2169382.htm.

Making driving safer for everyone

Sales reps aren't the only ones who must drive safely. So must their teenage or college age children. Indeed, the dangers of distracted driving have been well quantified, according to an article on distracteddriveraccidents.com by Rob Tindula. Texting while driving takes one's eyes off the road for an average of five seconds, while also increasing his or her risk of crashing by 23 times. Over the past few years, a number of different apps – some free, some available at cost – have been developed to prevent distracted driving by disabling certain features of one's phone while driving. In fact, a number not only place one's phone on airplane mode, they also offer incentives for driving distraction free. Here are a few apps to consider:

- **Down for the Count.** Ideal for teens, this app allows drivers to have sponsors who can reward them for logging time while the app is open. If the app is closed at any point during the ride, the time or mileage for that entire ride is negated. Sponsors set up certain thresholds for the driver to reach before the reward is given, such as five hours of drive time or a certain number of miles.

- **SafeDrive.** The app uses a point-based system to give out rewards. Whenever the driver's speed is above 6mph or 10 km/h, they automatically start earning points to their account. However, any time the release button is pressed on the app, all points for that trip are lost. Points can be used to get discounts from participating stores in the SafeDrive Marketplace. This app also offers other features, such as a challenge between drivers, with the winner getting a percentage of the point total.

- **Drive Beehive.** With Drive Beehive, Safe Miles are accrued, as long as the phone is not in use. This app allows the driver to pair with one sponsor, who will enter a reward and total number of miles needed to reach that award. Safe Miles can be converted into coupons, discounts and free merchandise.

- **LifeSaver** is a multidimensional app that automatically locks the driver's phone while the car is in motion. It also includes such features as arrival notifications and in-drive status, letting those who are trying to contact the driver know they are behind the wheel. Parents can set up monthly awards for good driving behavior. One drawback of this application is that it uses GPS, which can drain battery life and use up data.

For more information visit http://distracteddriveraccidents.com/4-free-apps-incentivize-driving-safely/.

Smartphone apps for drivers

iGasUp. The app, which reportedly includes 110,000 fuel stations in its database, displays the 10 nearest fuel stations and their prices. It soon will add fuel-station amenities, such as carwashes. ($0.99)

My Max Speed 2.0. Using the accelerometer in an Android phone, My Max Speed 2.0 logs speed and location every 5 seconds and makes the data available for exporting to a spreadsheet. The app is intended to be used two ways: to monitor a teen's driving habits and to provide an accurate record with which to argue against speeding tickets. It can also provide a location history or send a message if the phone carrying the app travels outside a preset location perimeter. ($4.99)

Trapster. The app lets users pinpoint the location of speed cameras, red-light cameras and live speed traps, as well as delivers voice alerts when the driver approaches a trap or exceeds a speed limit. (Free)

For more information visit http://coolpile.com/gadgets-magazine/47-coolest-car-gadgets-bring-wheels-future. rep

Industry News/Products

Owens & Minor's Erika Davis named to *Savoy Magazine*'s 2016 Top Influential Women in Corporate America list

Owens & Minor Inc (Richmond, VA) announced that Erika T. Davis, SVP and chief administrative officer of Owens & Minor, was named to *Savoy Magazine*'s list of the 2016 Top Influential Women in Corporate America. According to *Savoy*, these women "embody talent, leadership and grace while executing critical roles" in their companies. *Savoy*'s list is considered to be the definitive accounting of African American Women who hold leadership positions in U.S. corporations across a wide range of industries. At Owens & Minor, Davis is responsible for global customer engagement and shared services. She has responsibility for assessing, designing, and implementing best-in-class customer service capabilities on a global platform. She also leads the company's Program Management Office. Davis works closely with the company's board of directors and assists the president and CEO in developing strategy and ensuring collaboration among the senior leaders in pursuit of the company's strategic initiatives.

Henry Schein's 18th annual Holiday Cheer For Children spreads joy to children and their families

Henry Schein Inc (Melville, NY) spread holiday cheer to children and their families around the world through its 18th annual "Holiday Cheer for Children" program, a flagship initiative of Henry Schein Cares. Team Schein members from 20 company locations in the U.S., Canada, the U.K., Spain, and Germany participated in the program. At many company locations, participating children and their families were given toys, clothing, games, and other gifts purchased by the company's Team Schein members, who spend their own time and money to sponsor individual children. Families also received gift certificates to major supermarket chains through the program. To help identify children and families who would benefit from participating in the Holiday Cheer for Children program, Henry Schein partnered with local social service organizations at a number of company locations. At other company locations, Team Schein members raised funds for local charities and people in need.

Long-time DETECTO clinical rep Jim Kaye retires


Jim Kaye

DETECTO's longest-tenured clinical manufacturer rep, Jim Kaye (President) of Sheffield Medical Corp., retired Jan. 1, 2017. Kaye's sales territory covered all New England States for DETECTO. Sheffield Medical (Wayland, MA) primarily worked with hospitals, surgery centers, and physician practices. Kaye joined the Robert Desaritz Manufacturing Rep company covering New York City and Long Island in 1979. Kaye was transferred to New England in 1982, which is the same year DETECTO was sold to Cardinal Scale Manufacturing Company, located in Webb City, MO. In 1988, Sheffield Medical was founded by Kaye and DETECTO was the first line the new company represented. Sheffield Medical's territory has always covered the New England States for all of those years until Kay's pending retirement. "DETECTO wishes Jim the best in his retirement and greatly appreciates the 28 years of high-quality salesmanship he has brought to the clinical scale industry," the company said in a release.

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Why Being Helpful Isn't Just for Nice Guys (and Gals)

By Lisa Earle McLeod

If I tell you someone is helpful, what image crosses your mind? Most people associate the word helpful with jobs like a crossing guard, or a traveler's aide at the airport. Helpful people are nice to be around, but they're rarely in charge, or so the thinking goes.

When my husband and I were naming our first child, we got a book that gave the psychological response to names. We were shocked to find that our chosen name, Betsy, rated high on cheerfulness and helpfulness. Our second choice, Elizabeth, rated high on intelligence and power. So dismissive was I of helpfulness, we changed our daughter's name at the last minute. Elizabeth would never be a Betsy because I wanted the world to regard her as a smart powerful woman.

Turns out, I had created a dichotomy that was absolutely inaccurate. Recent research reveals helpfulness is actually a key underpinning of success.

In a recent paper, noted author and Wharton School professor Adam Grant outlined a Harvard study of U.S. intelligence system. Grant writes, "The team, led by Richard Hackman, wanted to determine what makes intelligence units effective. By surveying, interviewing, and observing hundreds of analysts across 64 different intelligence groups, the researchers ranked those units from best to worst.

Then they identified what they thought was a comprehensive list of factors that drive a unit's effectiveness – only to discover, after parsing the data, that the most important factor wasn't on their list. The critical factor wasn't having a stable team membership and the right number of people. It wasn't having a vision that is clear, challenging, and meaningful. Nor was it well-defined roles and responsibilities; appropriate rewards, recognition, and resources; or strong leadership.

Rather, the single strongest predictor of group effectiveness was the amount of help that analysts gave to each other."

Helpfulness isn't just nice to have, it's a must have. Sadly, most organizations undervalue helpfulness. In fact, leaders often create systems that promote the opposite of helpfulness. Imagine a helpful Betsy being ranked against an intelligent Elizabeth. A typical manager is more likely to give points, and thus raises and promotions to the person who displays individual smarts versus the person who is actually contributing more to group results.

In his article titled "*Givers take all: The hidden dimension of corporate culture*," Grant cites evidence from

studies led by Indiana University's Philip Podsakoff demonstrating, "the frequency with which employees help one another predicts sales revenues in pharmaceutical units and retail stores; profits, costs, and customer service in banks; creativity in consulting and engineering firms; productivity in paper mills; and revenues, operating efficiency, customer satisfaction, and performance quality in restaurants."

When employees are force ranked against each other, and must compete for resources, they're rarely inclined to be helpful to each other. My father used to say, "Why do any of my people have to be a 2? If I'm doing my job right, all my people are 9 and 10s."

Leaders who want to create a giver culture must create an environment where employees feel their needs will be met, where people view each other as essential players in solving problems and helping customers.

Leaders who want to create a giver culture must create an environment where employees feel their needs will be met, where people view each other as essential players in solving problems and helping customers.

Thankfully our own Elizabeth is both helpful and intelligent. She never succumbed to the false dichotomy her well-intended parents once believed.

If you want to create success, and happiness, spread the word. Helpful doesn't mean subservient, it's actually the fastest route to success. rep

Lisa is a sales leadership consultant, and author of Selling with Noble Purpose. *Companies like Apple, Kimberly-Clark and Pfizer hire her to help them create passionate, purpose-driven sales forces. She has appeared on The Today Show, and has been featured in* Forbes, Fortune *and* The Wall Street Journal. *She provides executive coaching sessions, strategy workshops, and keynote speeches. Visit www.LisaEarleMcLeod.com*

Focus on Your Strengths

By Dan Nielsen

In scores of interviews I have conducted for America's Healthcare Leaders over the years, I have had the opportunity to ask leaders what they consider to be their top leadership strengths. One particular response has stuck out to me, that of Bruce Brandes, founder and CEO of Lucro.

When asked what his top three leadership strengths were, Brandes' listed his strengths as:

1. Having a self-awareness of what he is good at and what he is not.
2. Being very good at simplifying complex things.
3. Recognizing if there is not a third thing, don't make one up!

Brandes has led a remarkable career, and while I feel his strength list no doubt extends past these three he mentioned, I was impressed by the humility and self-awareness he showed in his interview. He understands who he is and where his strengths lie, and he embraces these strengths.

As a leader, it is critically important to have this self-awareness about both your strengths and weaknesses. In my upcoming book, *Be An Inspirational Leader: Engage, Inspire, Empower*, Jim Wetrich puts it this way:

"The most important thing is that authentic leaders know what they don't know and aren't afraid to admit it."

It takes a humble confidence to admit your weaknesses, and the leaders who have openly admitted these have impressed me. However, while awareness of weakness is necessary, I would encourage each and every one of you to focus far more on your strengths.

In an episode of the EntreLeadership Podcast, author Marcus Buckingham discussed the importance of focusing on strengths more than weaknesses. He put it this way:

> *"The best leaders are not well rounded, they're sharp. Their teams are well rounded. Precisely because they've figured out where they're sharp, and then surrounded themselves with people who are sharp where they are blunt."*

True leadership calls for being aware of yourself while bringing out the best in your team. Know what you are good at and where you struggle, and surround yourself with a team that fills in the gaps. Then focus on and improve your strengths!

Dan Nielsen is the author of the books Presidential Leadership *(2013) and* Be An Inspirational Leader *(2016). He regularly writes and speaks on the topics of Leadership Excellence and Achieving Greater Success, and is available to deliver keynote presentations or facilitate discussions for your organization. For more info, please visit www.americashealthcareleaders.com/speaking*

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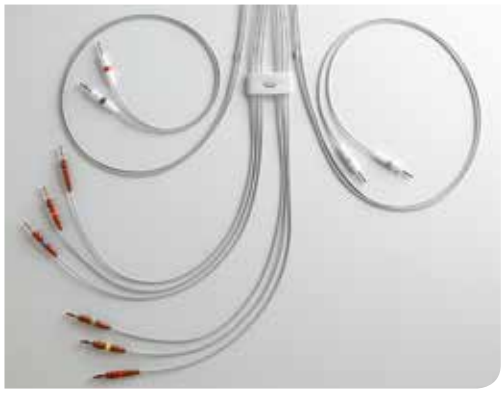

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