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1. General Chapter <800> Hazardous Drugs—Handling of Drugs in Healthcare Settings Published February 1, 2016.
Reflections of 2017

It is hard to believe I am writing the final Publisher’s Letter for 2017. My plan was to write about the stories we are covering in this issue, but here at the last minute I decided to recap the year.

We spent much of this year writing about MACRA and how to use this payment reform as content to pull your customers closer to you by using it to help improve their businesses. I would like to thank the national distributors and the manufacturers who had me come and speak during your national meetings on this topic. Content selling is the way we will all gain market share going forward.

This year certainly didn’t disappoint in the M&A category. Just like the past several years, we saw over 100 mergers and acquisitions across our industry. While the majority were in the provider arena, there were several notable on our side. Early in 2017 Mortara was acquired by Hill-Rom, followed quickly by Concordance acquiring Rockwell Medical Supply. Then in March, Cardinal acquired the patient product portfolio from Medtronic for $6 billion, and BD acquired Bard for $24 billion. By this point the lab companies were feeling a little left out, so Alere sold Triage to Quidel and set them up to be acquired by Abbott in October. Even Share Moving Media jumped into the mix by acquiring DentalFax. And as we close the year, Owens & Minor announced their intent to acquire Halyard Health. My guess is we will see more of the same in 2018.

When we look to next year, PAMA will be launching in the lab community, and MACRA will be starting to take shape. Between the many acquisitions, payment reform, and the continued push for better patient outcomes, we will all have our work cut out for us in helping the care givers navigate these waters.

As we close this 2017 chapter, I would like to personally thank you, our readers, and the advertisers who support us each year. Repertoire Magazine turns 25 years old in September of 2018, and there is no way we could have done it without you.

Merry Christmas and Happy Holidays,

R. Scott Adams

PS: We have a new lab column starting in January written by Mr. Jim Poggi. I am excited for the readership to meet Jim, who is a great guy and has more one liners than each of the drill sergeants in all four branches of the military combined. You’re going to love it, and hopefully sell more lab products than ever next year.

PSS: I am jumping in the deep end of the pool and starting two new content platforms next year, a podcast and a weekly newsletter on events that effect you. Stay tuned.
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The Year in Review

Amazon on My Mind

By Mark Thill

Year-end reviews are supposed to recap events of the year just passed and glean wisdom from them. But the events of the year 2017 are forcing me to look forward at least as much as backward. That says something about the pace of change today.

In September, for example, Boston-based Day Zero Diagnostics was selected as the winner of the 2017 MedTech Innovator competition at The MedTech Conference. The company combines genome sequencing and machine learning to combat antimicrobial-resistant infections, enabling physicians to switch from broad-spectrum antibiotic therapy to a targeted antibiotic in hours rather than days. Talk about the future.

Then in October, the American Medical Association announced an online platform designed to bring physicians and health tech companies together to develop and improve healthcare technology solutions. The Physician Innovation Network is an online community where physicians can connect with companies and entrepreneurs who are seeking physician input in the development of healthcare technology products and services. Sounds like a crowdsourcing variation-on-a-theme.

And by now we all have heard about Amazon’s intent to dive into the healthcare supply chain. This fall, it was reported that the company was obtaining wholesale pharmacy licenses in states across the country.

Bots can do it

Amazon is definitely on the mind of Richard Zane, M.D., professor of

Imagine an automated attendant listening to an asthmatic patient’s complaint of a respiratory ailment, processing his medical history, getting a reading on current atmospheric conditions (such as pollen count, humidity, etc.), and then making a recommendation for how that patient should navigate his or her day. Maybe Alexa can help?
emergency medicine and chief innovation officer for UCHealth in Aurora, Colo. Speaking at the 59th Annual Meeting of the American Society of Radiation Oncology (ASTRO) in San Diego, Zane said he believes that the digital revolution – wearables, the cloud, bots – may save healthcare. It's an industry ripe for disruption by companies such as Amazon, in terms of money spent, money wasted, and old ways of doing things that contribute little to better health, he said. Not to mention that healthcare has about the same safety profile as bungee jumping. “We kill almost 440,000 Americans a year,” he said.

Zane believes that Amazon will bring its “last mile revolution” not just to the delivery of medical devices and pharmaceuticals, but to medical care itself. It will be joined by companies like Google, whose Project Baseline is studying how wearables can redefine what a healthy and unhealthy human looks and acts like.

When you speak about the potential of wearables, you’re talking about a continuous stream of data, providing accurate, reliable information about a person’s physical and emotional state of being, Zane pointed out. That’s great. Problem is, not even the best, smartest doctor or other diagnostician can process all that information and make good on-the-spot medical decisions. But bots can, said Zane.

Imagine an automated attendant listening to an asthmatic patient’s complaint of a respiratory ailment, processing his medical history, getting a reading on current atmospheric conditions (such as pollen count, humidity, etc.), and then making a recommendation for how that patient should navigate his or her day. Maybe Alexa can help?

But if – or when – we come to rely on bots or automated systems to make diagnostic and prescriptive decisions, where does that leave tomorrow’s physician? And closer to home, will bots be making product decisions for providers? If so, what will be the role of the sales rep or the contracting executive? And will we – gulp – need journalists to make sense of it all?

Yes, it’s safe to say that Zane has Amazon on his mind. So should we all. 🤔
Medical Innovations for the Year Ahead

Cleveland Clinic announced its “Top 10 Medical Innovations of 2018” at its 2017 Medical Innovation Summit this fall.

To receive consideration, nominated technologies had to:

• Have significant clinical impact and offer significant patient benefit in comparison to current practices. It must also have high user-related functionality that improves healthcare delivery.
• Have a high probability of commercial success.
• Be in or exiting clinical trials and be available on the market sometime in the coming year.
• Have significant human interest in its application or benefits and must have the ability to visualize human impact.

They are (in order of anticipated importance):

1. **Hybrid closed-loop insulin delivery system**, which enables direct communication between the continuous glucose monitoring device and insulin pump. (No human intervention needed.)

2. **Neuromodulation to treat obstructive sleep apnea**, an implant that delivers stimulation to open key airway muscles during sleep (because some 40 percent of sleep apnea patients refuse to wear continuous positive airway pressure (CPAP) devices).

3. **Gene therapy for inherited retinal diseases**, expected to receive FDA clearance in 2018, which delivers a new gene to targeted cells in the body via viral “vectors” to provide visual function improvements in some patients with genetic mutations.

4. **The unprecedented reduction of LDL cholesterol**, with a new class of cholesterol-lowering drugs (PCSK9 inhibitors), which have the potential of reducing LCL by 75 percent.

5. **The emergence of distance health**, or telehealth. In 2018:

   Hospitals are said to be getting ready for widespread adoption; as many as 7 million patients (a 19-fold increase from 2013) are predicted to use telehealth; and more than 19 million patients are projected to use remote monitoring devices (e.g., attachable devices that record and report medical information to healthcare providers).

6. **Next-generation vaccine platforms**, including new mechanisms to develop and deliver vaccines to vast populations, as well as new ways to deliver the vaccines to patients (e.g., oral, edible and mucosally delivered).

7. **Arsenal of targeted breast cancer therapies to supplement hormone therapy**, chemotherapy and radiation, including PARP inhibitors for patients with specific mutations in BRCA1 or BRCA2, and novel CDK 4/6 inhibitors for ER-Positive/HER-2-negative breast cancer.

8. **Enhanced recovery after surgery, that is**, protocols that permit patients to eat before surgery (which limits opioids by prescribing alternate medications) and encourage regular walking (which reduces complication rates and speeds recovery). These protocols can reduce blood clots, nausea, infection, muscle atrophy, hospital stay and more.

9. **Centralized monitoring of hospital patients**, as part of a “mission control” operation in which offsite personnel use sensors and high-definition cameras to monitor blood pressure, heart rate, respiration, pulse oximetry and more. Complex data are assimilated to trigger onsite intervention when appropriate, while filtering out many unimportant alarms, which can lead to “alarm fatigue” on the part of busy caregivers.

10. **Scalp cooling for reducing chemotherapy hair loss**, cleared for marketing by the FDA in May 2017, which reduces the temperature of the scalp a few degrees immediately before, during and after chemotherapy (and has been shown to be highly effective for preserving hair in women receiving chemotherapy for early-stage breast cancer).
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Supply chain executives, distributors and manufacturers in Texas and Florida recently shared their hurricane stories with Share Moving Media, publisher of Repertoire and the Journal of Healthcare Contracting. Below are several of those stories. To view others, and to hear accounts of the storms from Izzy Paseau of Concordance Healthcare Solutions and Ed Lewis of Texas Childrens Hospital, go to the Repertoire blog at www.repertoiremag.com/storm-stories.html.

High alert
A conversation with Michael Boyd, EMS account manager, Concordance Healthcare Solutions.

*Repertoire*: What preparations did you and your customers make in the days immediately preceding Harvey’s landfall on Aug. 25?

*Michael Boyd*: Preparations on our side included sending numerous quotes to customers for needed supplies, specifically to the shelters and EMS departments. Supplies included over-the-counter medications, clothes, blankets and drinks (Pedialyte, Ensure, etc.). Another delay was getting orders packaged and shipped via overnight by coordinating with FedEx, and other private delivery methods.
**Repertoire:** What were you doing at the height of the storm?

**Boyd:** Finding the most needed items and getting them to the end user as fast as possible. Once we depleted our stock at the closest warehouse, we pulled from another. We staggered the orders to have multiple small deliveries, based on need, spread out over the coast of Texas, specifically, San Antonio, Beaumont, etc. We had an emergency conference between our order department in Florida, warehouse manager in Louisiana, myself in Texas, and the vice president of our department, Rich Hawkins in St. Louis, to see how we could best tackle the supply chain issues.

**Repertoire:** Describe how the storm affected your company and your customers, and its immediate aftermath.

**Boyd:** The storm struck the most crucial areas, which caused delays. The I-10 had multiple shut-downs from Beaumont through Houston, which caused issues when moving supplies from Baton Rouge to Texas. Our warehouse in Baton Rouge was on high alert from the storm. Our whole team worked late and came in early to help process orders in every part of our company. Our Florida office worked overtime completing orders; our warehouse employees picked and packaged orders, hours after they were to head home during the event. I coordinated with the shelters and EMS departments.

**Repertoire:** What were your greatest challenges (and those of your customers) in the 7-10 days following the storm?

**Boyd:** The greatest challenge my customers faced after the storm was finding long-term care for evacuees; the San Antonio shelters accepted over 2,000 people from Houston through the Port Aransas areas. This included keeping supplies, employees, and evacuees moving in a forward direction.

“...The greatest challenge my customers faced after the storm was finding long-term care for evacuees; the San Antonio shelters accepted over 2,000 people from Houston through the Port Aransas areas. This included keeping supplies, employees, and evacuees moving in a forward direction.”

– Michael Boyd, EMS account manager, Concordance Healthcare Solutions.

**Repertoire:** What preparations did you take in the days leading up to Irma’s landfall on Sept. 10?

**Andy Leaders:** Preparation for Hurricane Irma started Monday, Sept. 4, with first landfall in the Florida Keys Sunday, Sept. 10. Preparations were truly a team effort in conjunction with our provider partners. Our focus the beginning of that week was to work with our provider partners in getting incremental supplies picked, packed, and shipped prior to landfall. For the most part, this included providing 48-72 hours of daily use supplies to prepare for the possibility of travel delays due to wind speeds and road closures due to Irma.

In addition, the entire O&M team put a lot of work in preparing themselves and their families for Irma. This was critical to ensure the safety of our teammates, but also so that we would be in a position to service our providers once we were able to resume work post-landfall.

The team put in a tremendous amount of work to expedite products into the state of Florida prior to the storm all the way up till Saturday, Sept. 5. Starting Wednesday evening and going through the weekend, we were still focusing on getting supplies to our provider partners, but other unforeseen events. That is a balancing act that requires constant movement due to the shelf life of each product. (The average expiration date accepted for most items is 24 months.)

I am very proud of my entire division and I know how hard we all worked to band together in this time of need.

**Duck boat**

A conversation with Andy Leaders, vice president, provider services, Owens & Minor

**Repertoire:** Lessons learned, either for other suppliers or providers, should they face a natural catastrophe such as Harvey?

**Boyd:** Increase your most common-used items during the volatile months to counter the possibility of hurricanes and other unforeseen events. That is a balancing act that requires constant movement due to the shelf life of each product. (The average expiration date accepted for most items is 24 months.)

I am very proud of my entire division and I know how hard we all worked to band together in this time of need.
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- RSV assay is CLIA Waived
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work started to shift to our preparedness in the response of Irma. This included working with our manufacturer partners to divert shipments into our Atlanta facility. This allowed us to get replenishment product into our three distribution centers more quickly.

We also compiled pallets of water for teammate and provider use, along with extra batteries and other essentials. And, we facilitated the leasing of an all-purpose military delivery vehicle and an amphibious “duck boat.” We planned ahead to secure help for our DCs, which included lodging arrangements and additional tractor-trailers for the anticipated increase in delivery needs post Irma. At the end of the week, a lot of work was put in by both O&M and providers to cope with the relocation of patients within the state. We obtained a number of last-minute supplies that we needed for critically ill patients who were transferred into larger healthcare entities better equipped to handle these patients during Irma. This led to several unplanned deliveries on Saturday, Sept. 9. “At the end of the week, a lot of work was put in by both O&M and providers to cope with the relocation of patients within the state. We obtained a number of last-minute supplies that we needed for critically ill patients who were transferred into larger healthcare entities better equipped to handle these patients during Irma. This led to several unplanned deliveries on Saturday, Sept. 9.”

– Andy Leaders, vice president, provider services, Owens & Minor

patients within the state. We obtained a number of last-minute supplies that we needed for critically ill patients who were transferred into larger healthcare entities better equipped to handle these patients during Irma. This led to several unplanned deliveries on Saturday, Sept. 9.

My hat goes off to all O&M teammates and our supply chain teams of our providers for making these accommodations in the face of the imminent landfall of the hurricane. The O&M operations, IT and home office support teams did all they could to help us and supported us throughout the storm.

**Repettoire:** How did you/your provider customers fare during the storm itself?

**Leaders:** In total, the majority of our customers fared very well. Hospitals were forced to use backup power, some experienced flooding, and all of them experienced long work days by clinicians and supply chain teams across the state of Florida.

**Repettoire:** What were your greatest challenges (and those of your customers) in the 7-10 days following the storm?

**Leaders:** Inventory recovery was our major challenge. This was partly due to the path of the storm, which put a moratorium on inbound shipping into the state for quite a few days. We were fortunate that — through pre-planning and diverting inbound freight — we were able to mitigate many of these issues for our provider partners.

**Repettoire:** Longer-term problems or challenges?

**Leaders:** Even after the storm, we continued to see power outages in isolated areas, and a few of our teammates suffered major structural damage during the storm. I feel that we are all fortunate that there was much more time to plan and prepare for this storm. Improvement in meteorology forecasting is helping to save lives.

**Repettoire:** Finally, any lessons learned to share with your colleagues?

**Leaders:** Having a plan prior to a storm like Irma puts all parties in a better situation. Open and honest communication leads to improved outcomes. Last, but not least, remain flexible, as even the best laid plans do not capture all scenarios.

**T-minus**

A conversation with Scott Nelson, senior vice president of supply chain, North America, Cardinal Health. (Penske Logistics provides trucks and drivers for Cardinal Health’s medical segment.)

**Repettoire:** What preparations did you take in the days leading up to landfall?

**Scott Nelson:** For these types of situations, we use a “T-minus” planning schedule, which begins roughly a week prior to landfall. The purpose behind that is to integrate
efforts that span a number of areas, including operations, inventory, transportation, facilities, employees, customers and communications.

One of the first steps we took was to prepare and fill emergency orders in advance, so customers were stocked-up prior to the storm in the event there were disruptions. Penske has been Cardinal Health’s partner operating our private transportation fleet for the last nine years, so we worked closely with [Penske Operations Manager] Mike [Wallin] to identify drivers who had deep knowledge of the road systems and personal relationships with our hospital customers, to ensure we had the best expertise available to execute on alternative routing plans, so customers’ needs would be met.

At the Distribution Center, we also stocked-up on key supplies (food, water, generator fuel) to accommodate employees who might get stranded.

Lastly, we identified and made arrangements for a support team from other Cardinal Health locations to travel to the impacted location and stay at a hotel near the Distribution Center, so we could maintain operations and process emergency orders as quickly as possible. We did the same with key local operations staff.

Repertoire: How did you/your provider customers fare during the storm itself?

Nelson: Given the circumstances and severity of the storm, we feel everyone fared surprisingly well. Our major JIT customers enacted their hurricane preparedness plans and pre-ordered prior to the storm hitting. This helped tremendously, as it lessened the pressure for the first two to three days following the storm.

There were obvious challenges with flooding, which cut off access to certain areas for an extended time and caused some facility issues, and a few hospitals had to evacuate patients and shut down. Overall I’d say providers reacted quickly, and we were able to shift supplies as needed.

We did coordinate efforts with the National Guard and Penske to deliver emergency supplies during this time of
need. A few of Mike’s drivers courageously volunteered to navigate the flooding to get the hospitals their supplies.

**Repertoire:** What were your greatest challenges (and those of your customers) in the 7-10 days following the storm?

**Nelson:** The greatest challenge was scaling back up to full operations as the recovery took hold. I mentioned the support we brought in from other Cardinal Health Distribution Centers to ensure continuity while our employees were tending to their families and homes. We also had moved a significant amount of our order fulfillment for non-metro accounts to neighboring distribution centers, so we had to gradually transition back to a normal staffing and fulfillment model.

We experienced delays in inventory replenishment orders, particularly with port closures, and getting deliveries into the Distribution Center. Many carriers were not operational and would not deliver or accept freight coming to the affected area.

I would say our customers experienced much of the same, as their employees had to balance dealing with personal challenges as well as logistical and freight delivery delays while supporting a ramp-up in patients being treated in their hospitals.

**Repertoire:** How about longer-term problems or challenges?

**Nelson:** One of the more significant challenges will be around staffing. Many people lost everything and were displaced from the area. As the city begins its reconstruction, labor required for clean-up and restoration work will place further demands on an already constrained labor market.

**Repertoire:** Finally, any lessons learned to share with supply chain colleagues?

**Nelson:** Plan early and involve your customers and key business partners in that process. Look beyond what could come up as an immediate need during the situation itself.
and plan for multiple contingencies. Without the joint planning I described earlier between Cardinal, Penske and the providers we serve, this story would have had a very different ending.

Communicate realistic expectations with your customers. We were committed to being fully operational as quickly as possible; however we set a clear foundation that it would not be “business as usual” and there would be challenges with inbound freight and outbound volume surges from the backlog. That candor and opportunity to jointly prioritize actions to achieve stabilization built a stronger relationship with our partners.

Lastly, take care of your employees first, and they will make sure that the customer is taken care of. The Penske drivers were rock stars throughout this ordeal. They were so willing to put their personal challenges aside and safety in question so our customers would get what they need.

**Team effort**

A conversation with Enrique Sanabria, regional sales manager for lab distribution at Cardinal Health.

**Repertoire:** What preparations did you take in the days leading up to landfall of Hurricane Harvey on Aug. 25?

**Enrique Sanabria:** At the start of hurricane season, we always increase stocking levels of critical supplies, like PPE items. Then we:

- Set a plan for ensuring employees were accounted for during the storm.
- Worked on emergency orders, so customers were prepared prior to the storm in case of inability to service. We stocked up supplies (food, water, etc.) at the DC for emergency if employees were stranded there.
- Tested our onsite generator and topped off the tank.
- Arranged for an out-of-town support team to stay at a hotel near the DC, along with an operations manager, so we could process as quickly as possible. Although a small group, we were functioning and processing emergency orders right away.
- Began making daily calls with key customers three days before estimated landfall. We discussed and encouraged them to order extra supplies to prepare for the possibility of interrupted deliveries.
- Conducted twice-daily conference calls with Cardinal Health corporate and local teams to include our DC Houston and DC Grand Prairie director of operations, customer service, inventory teams, global security and Penske Logistics to ensure all needs internally and with our customers were met before, during and after the storm.

**Repertoire:** How did you/your provider customers fare during the storm itself?

**Sanabria:** Both Cardinal Health and our customers were successful during the storm. Despite obvious challenges – such as flooding and a few hospitals having to move patients and shut down – we reacted quickly and we were able to shift supplies as needed.

“We brought in 40 people from out of town to support the DC while our employees were getting back into operations. Our teams did everything they could to mitigate programs and ensure success.”

– Enrique Sanabria, regional sales manager for lab distribution at Cardinal Health

To mitigate any crisis, during our internal, twice daily calls, we discussed our daily delivery schedule and uploaded emergency orders as needed to ensure stock was delivered to the facilities with the most need at that time. For example, we made deliveries to at least five of the 12 hospitals in one major health system every single day throughout the duration of the storm. As the waters began to recede, we increased the number of deliveries each day until we returned to business as usual.

**Repertoire:** What were your greatest challenges (and those of your customers) in the 7-10 days following the storm?

**Sanabria:** Many of our customers were affected personally at home and at work by this tragedy. They understood many of
the challenges we were facing because they were facing the same challenges.

The greatest challenge for us and our customers was with logistics, inventory of products, returning to “normal” schedules and tempering expectations post-storm.

Scaling back up to full operations at the Houston DC, which services the Houston metro area and southeast Texas, was a challenge. This was where the brunt of the storm hit. Many of our carriers were not operational and would not deliver or accept freight coming to the Houston area. In fact, many carriers stopped delivering two days before Harvey made landfall, and did not begin delivering again until almost 10-12 days after the storm.

We brought in 40 people from out of town to support the DC while our employees were getting back into operations. Our teams did everything they could to mitigate programs and ensure success.

Repertoire: Longer-term problems or challenges?
Sanabria: Many people lost everything and were displaced from the area. Now, there are many reconstruction job openings in the market, so although we are a permanent job with benefits, the availability of the clean-up and restoration work may compete with our ability to secure local job applicants.

Repertoire: Finally, any lessons learned to share with your colleagues?
Sanabria: Yes:

• Take care of your employees first, and they will ensure the customer is taken care of.
• Plan early and be prepared: focus on the needs beyond what could come up as an immediate need during the situation itself and plan for multiple contingencies.
• Communicate realistic expectations with your customers. For example, at the Houston Medical DC, we were committed to being up as quickly as possible, but we set a clear foundation that we would not be able to open our doors for business as usual from day one. I think that built a stronger relationship with our partners. Communication and planning are critical before, during, and after the storm. Our teams were constantly on the phone working to ensure each hospital had the supplies needed to treat their patients.
• Ensure you are preparing for these types of events during the “off” season to be as prepared as possible when it does happen. For example, ask key customers to compile a list of the most critical items to have available during a crisis like this, so we can add additional stock at the beginning of each hurricane season moving forward.

Enrique Sanabria wanted to make clear the story isn’t his alone, but that of an entire team, including: Donnie Jackson, territory account manager for lab distribution, Cardinal Health, Houston and Southeast Texas; Kimberly Barrett, director of operations, Cardinal Health, Houston Medical Distribution Center; Michelle Fort, core account manager, Cardinal Health, Houston; Freddie Bloomfield, strategic account executive, Cardinal Health, Houston; Janet Russell, field service consultant, Cardinal Health; Kelly Virmash, field service senior specialist, Cardinal Health; and many more folks.

“One of the first steps we took was to prepare and fill emergency orders in advance, so customers were stocked-up prior to the storm in the event there were disruptions.”

— Scott Nelson, senior vice president of supply chain, North America, Cardinal Health
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Texas Health Resources is one of the largest faith-based, nonprofit health systems in the United States, and the largest in North Texas in terms of patients served. The health system includes Texas Health Physicians Group and hospitals under the banners of Texas Health Presbyterian, Texas Health Arlington Memorial, Texas Health Harris Methodist and Texas Health Huguley. Texas Health has partnered and affiliated with numerous organizations – from all aspects of the healthcare industry – to better serve the more than 7 million residents of North Texas. These relationships, along with other major initiatives and quality programs, are supported by Texas Health’s more than 350 points of access, 23,000 employees and 5,500 physicians with active staff privileges.

Shaun Clinton began his career in healthcare in 1994 as an intern writing training manuals at Baxter’s financial shared services organization in Albuquerque, New Mexico. “The funny thing is, I had never heard of Baxter or considered a job in healthcare until I took that role,” he says. “I had been in retail management roles for my short professional life to that point.” But he and his wife moved to New Mexico with his wife’s job, and Clinton decided to take some business classes at the local community college. An instructor suggested he talk to the instructor’s wife – a manager at Baxter – about the role at Baxter. “I became fascinated with the myriad of moving parts in the healthcare supply chain and decided in short order I would make a career of it.” Since then, he has spent time on the distribution, GPO, and provider sides, “and every day I think I learn something new.”

Q: What has been the most challenging and/or rewarding supply-chain-related project in which you have been involved in the past 12-18 months?

A: A project that has been both challenging and rewarding in the past year is the category management team’s efforts to “codify” the work they do,
so we can be very transparent to the entire enterprise about where we are in any given cycle, the stakeholders involved in the decision-making process, and the economic value generated by each project they are working on. This effort began almost three years ago, when we decided to explore building an algorithm describing how we do everything that comes across supply chain’s desk. It starts by asking simple questions – Is it a product? A pharmaceutical? What steps do we take to evaluate it? How do we communicate and operationalize our decision? By building a tool that spells all this out, we can help our customers respect the decision-making process, lend consistency to strategic sourcing, and help bring new people up to speed quickly on our processes. We intend to roll out this tool this summer.

Q: Please describe a project on which you look forward to working in the next year.

A: We are just beginning a business transformation project that coincides with our migration to Oracle PeopleSoft over the next few years. The team and I are extremely excited to begin to build what a future-state, cutting-edge supply chain organization will look like over the next few years. For me, it comes down to, “How are we going to service our customers, and what products will we produce for them so they can do their jobs well and see value?” I expect we’ll be working on this for three years, at least.

Q: In what way(s) have you improved the way you approach your job or profession in the last five to 10 years?

A: This one’s easy: I have learned not to take everything personally! I consider supply chain a calling and not just a career, so it’s sometimes hard to hear negative feedback. But thanks to folks like John Gaida (my former leader at Texas Health) and others like him in the industry, I’ve come to realize that not everything will go perfectly, and if I trust the team around me, I’m doing just fine.

Q: What do you need/want to do to become a better supply chain executive in the coming year(s)?

A: I’m in the habit of writing down phrases that resonate with me, no matter the context. In the past couple of years two that I’ve written down are “Defer to expertise” and “Make it easy to do the right thing.” The healthcare supply chain is complex, exhilarating, and sometimes maddening. My hope is that in the next few years I can continue to apply these two phrases, and both learn new things and teach others to share the same passion I feel for this part of healthcare.

The team and I are extremely excited to begin to build what a future-state, cutting-edge supply chain organization will look like over the next few years. For me, it comes down to, “How are we going to service our customers, and what products will we produce for them so they can do their jobs well and see value?”
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Challenges with Government sales coverage? We can help navigate you through.
Not long ago, the position Jack Stephens holds at McKesson Medical-Surgical was referred to as supplier management. Stephens’ title today is senior vice president product strategy and supplier partnerships. It’s more than just a word change.

In fact, it marks the latest stage of an evolutionary process begun when Joan Eliasek – currently president, extended care sales – was responsible for supplier relations. “Joan built an excellent foundation,” says Stephens. “We have a strong team with deep experience. Our goal is to be more strategic with our customers and our suppliers. It’s not just a matter of telling our customers, ‘We can...”

Suppliers’ Partner

With a background in consulting and process improvement, Jack Stephens is molding McKesson Medical-Surgical’s relationships with customers and suppliers.
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offer you this product at the best price,’ or to our suppliers, ‘We want this product at the best cost.’

“It’s about understanding what will have the biggest impact on healthcare in the United States, and how to best deliver those services and solutions to our customers. It’s about looking back to our suppliers and asking, ‘How can we form tighter partnerships,’ so those suppliers decide, ‘McKesson is our best partner for growth.’”

Consulting background
Following a career that included consulting for Arthur Andersen, Booz Allen and his own firm, Performax, Stephens joined McKesson in September 2007 as director of process improvement. He held leadership positions in revenue management solutions, business processes and generic pharmaceuticals before assuming his current role in June 2016.

His experience in consulting and process improvement left him well-prepared for his work in product strategy and supplier partnerships, he says.

“What’s great about consulting is this: You come into a situation where, even if you know the industry, you don’t know the business, the players and the people. What that does is sharpen your skills at cutting through the non-essential information and getting right to, ‘What is the problem we are trying to solve? What is the true opportunity here?’ That calls for going deep quickly and understanding the customer, the suppliers and the business economics.

“I’ve tried to bring that approach to my current role, starting with understanding the customer — understanding their needs, preferences, the jobs they perform and how they perform them,” he says. “That informs the products we need to bring to market, the suppliers we need to partner with, the kind of deals we make. We understand how our customers value each characteristic of a product, including clinical preference as well as economics. Then we turn to our suppliers and take the same approach: We ask, ‘What are your needs? What are you trying to accomplish?’ Then we bring those two pieces together to form a solution. That’s what consulting is.”

A message to suppliers
Having a great team, a strong foundation and productive relationships with sales reps and suppliers has afforded Stephens the opportunity to learn the complex business of med/surg distribution. “That has been my No. 1 goal in my first year — to understand the customers and the suppliers,” he says.

He has a three-tiered message to suppliers.

“No. 1 is growth,” he says. “We are investing in growth, and that means growth for our suppliers too. No. 2 is a message of efficiency. We want to be an efficient partner, from the supply chain to the back office, including contract administration. And No. 3 is innovation.

“We value innovation and believe it can occur anywhere. We especially value innovation from our suppliers in the form of new products, solutions or programs,” he says. “It drives growth, and our customers love it.” So do sales reps, as innovation leads to more engaging conversations with customers.

But customers and suppliers aren’t the only sources of innovation, says Stephens, recalling a quote attributed to automaker Henry Ford, who reportedly said: “If I had asked people what they wanted, they would have told me ‘faster horses.’” McKesson can be a stimulus for innovation too.

“One of our roles is helping suppliers not just enhance current products or processes, but to think about things differently,” he says. “We want to get involved in the design stage; we want to help launch innovative products and services; and we want to help all the way into post-launch.”
What’s next?

After a year and a half of learning, Stephens and the McKesson Medical-Surgical team look forward to the year ahead. “Our focus areas are lab, pharmacy, health systems, HME and e-commerce, and we want our preferred suppliers to share in that growth,” he says. “We will invest in specialist sales forces and category product managers, add new products and solutions, and create new support resources on the back end.”

The company is preparing to launch a new manufacturer services program at the spring 2018 national sales meeting. An important contributor to that program will be newly appointed Senior Director of Supplier Marketing Jennifer Conner, who brings experience in lab, home care and med/surg marketing.

McKesson Medical-Surgical, its customers and suppliers face challenges ahead, says Stephens. But each offers opportunity for innovation. For example, this year’s hurricanes in Florida, Texas and Puerto Rico prompted the company to partner with a supplier to help physicians set up replacement offices.

Consolidation is another challenge – and, it turns out, opportunity.

“A textbook MBA-type analysis would tell you that supplier consolidation would harm distributors, because the manufacturers could exert more power,” he says. “But we’re seeing the opposite.” That’s true for three reasons.

“First, because more procedures are moving to the non-acute setting, when these companies combine, that opportunity becomes that much larger for them, so they are engaging us more than they have been before.

“Second, as these companies become larger, efficiency becomes more important to them. That forces us to be more efficient and to reduce our cost to serve.

“And third, as these companies grow, they invest more in R&D for non-acute innovation. I think that will end up being good for our customers, our reps and McKesson.”

“One of our roles is helping suppliers not just enhance current products or processes, but to think about things differently.”
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Here’s an acronym you’ll want to remember: CCTM. It stands for “Care Coordination and Transition Management.” In a world of post-acute care, population health and care continuum, chances are you’ll be calling on more people — often, registered nurses — whose name is followed by CCTM.

Care coordination and transition management (CCTM) is a way for the healthcare team to involve patients and their families in organizing the patient’s care activities among several healthcare team members, healthcare services, and settings of care, says the American Academy of Ambulatory Care Nurses. CCTM helps patients navigate the maze of specialists, hospital departments, outpatient appointments, tests, procedures, medications, and follow-up appointments.

AAACN – in conjunction with Medical-Surgical Nursing Certification Board – created the CCTM™ credential in 2015. As of Nov. 15, 2017, 499 people were CCTMs. But care coordination goes back a lot further than 2015.

“We have come full circle, with nurses once again taking the appropriate role of patient advocate and team leader, who coordinates care of populations of individuals, resulting in a reduction of healthcare dollars spent,” says Harmon, who serves as chair of two AAACN committees in the Care Coordination and Transition Management program: test development and item writers.

A day in the life

An RN is particularly well-suited to coordinate care for patients who are at high risk for hospital readmission or in deteriorating health, adds Harmon. “He or she typically works as part of a team, with the physician, the pharmacist, informatics, etc. But the care coordinator is the quarterback, pulling it all together.”

The care coordinator may be found in a variety of environments — “anywhere there is an opportunity to leverage...
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resources available through a health system, the community, the patients themselves,” says Harmon. The care coordinator may be employed by a hospital, health system, payer, outpatient clinics, etc.

“A typical day for the RN-CCTM might include the use of informatics – data extrapolated from electronic healthcare records to identify individuals in high-risk populations who would benefit from early intervention. This intervention most likely would begin with a phone call to interact with the patient and family and perform a baseline assessment. Following that, personal encounters – either home visits or office visits – allow the RN-CCTM to coach, educate, and evaluate continuing needs.

“The RN-CCTM would communicate with other members of the health team as appropriate – pharmacist, physician, etc. The RN-CCTM might also assist patients in identifying community resources for help with needs such as nutrition, mental support or transportation. Documentation and communication can be the most challenging aspect when working within an EHR that is not highly interoperable.”

Training

It takes a high level of education to give good care to high-risk, high-cost patients, says Harmon. “Sometimes a nurse can develop those competencies through experience, but I feel very strongly that we need a structured training and certification program in place, to cultivate individuals who are going to pursue care coordination/transition management.” Some health systems already have such programs.

The Medical-Surgical Nursing Certification Board makes the following distinction between care coordination and case management:

“CCTM, in its broadest sense, deals with populations of patients over time, especially those with chronic illnesses/diseases such as diabetes, heart disease, asthma, etc. Case management, on the other hand, deals more with the utilization of resources. For example, helping the patient with insurance and payment issues and health resources needed when they return home (e.g., home health nurse, supplies).”

Care coordination or case management?

The AAACN Care Coordination and Transition Management course offers 13 online modules covering a variety of competencies and activities, including:

- Advocacy
- Education and engagement of patients and families
- Coaching and counseling of patients and families
- Patient-centered care planning
- Support for self-management
- Teamwork and collaboration
- Population health management
- Care coordination between acute care and ambulatory care

“Right now the domain of care coordination is fluid and rapidly evolving,” says Harmon. “In the future, I believe that the role will become more clearly defined as one that belongs to nursing, with delineated and quantifiable competencies. The development of competencies will be achieved through structured education programs for RN-CCTM nurses, available either through health systems or as continuing nursing education activities, with the ultimate confirmation of expertise demonstrated through certification in CCTM.”
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There is a saying in healthcare: “If you have seen one health system, you have only ever seen one health system.” No two health systems are alike, nor are the patient-care needs of your clients. Cepheid understands this. Therefore, 20 years ago, Cepheid embarked on an ambitious mission. The vision was to enable as many people as possible to have access to molecular diagnostic tests that provide critical information quickly, to guide treatment and patient management. Cepheid found that access to best-in-class molecular diagnostics had been limited by the complexity of specimens, tests, and the systems that run them.

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Cepheid’s innovation of accuracy, speed, and ease-of-use will continue with the addition of the Xpert® Xpress product line. Xpert® Xpress features next-generation test design and cartridge innovations for best-in-class workflow and dramatically faster results (as soon as 20 minutes). In other words, it’s rapid testing with NO compromise in ease-of-use, quality, and accuracy. Xpert® Xpress Flu, Flu/RSV, and Strep A for non-waived laboratories are all available now, with Xpert® Xpress CT/NG, and Xpert® Xpress Vaginitis/Vaginosis soon following. The GeneXpert® will go through the CLIA waiver process with the new Xpert® Xpress product line in 2018, making tests available for physician office use.

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“Cepheid has taken the manual hands-on steps involved in current molecular procedures and simplified it to just adding a sample and letting the GeneXpert do the work! Accurate and actionable molecular testing made simple.” – Denise Furtado, Marketing Manager, Non-Acute


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References

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Protein Energy Malnutrition will result in a marked increase in the incidence of pressure injuries. According to the National Pressure Advisory Panel (NPUAP), the prevalence of wounds or any chronic, non-healing wound, such as a PI, surgical site wound, trauma, or burn injury is a serious healthcare problem. Therefore, employees that work in the supply and distribution industry need to understand how they can provide solutions for customers to help prevent and treat wounds.

High-risk individuals
Clinicians require evidence-based tools that help identify residents who are at risk, so that prompt attention is directed on the nutritional status of patients. High-risk individuals can be identified by screening for nutritional risk factors, along with understanding pressure injury triggers.

Examples of some PI triggers include the following: unintended weight loss >10 percent in 180 days, BMI (Body Mass Index <18.5 or >30), poor oral intake, dehydration, diagnoses impacting cognition (such as dementia and Alzheimer’s Disease), and/or urinary or fecal incontinence, etc. Advanced wound care programs are now available through various distributors, suppliers and/or

Nutrition: The ‘forgotten element’ of wound healing

By Lisa Logan, R.D., CNSC

The role of nutrition in pressure injury (PI) prevention and treatment is a well-recognized factor and an essential component of wound management. Unfortunately, proper nutritional support is often the “forgotten element” that is necessary in maintaining all phases of wound healing. Wounds will not heal without proper nutrition, and malnutrition is a key risk factor in the development of wounds.

Protein Energy Malnutrition will result in a marked increase in the incidence of pressure injuries. According to the National Pressure Advisory Panel (NPUAP), the prevalence of wounds or any chronic, non-healing wound, such as a PI, surgical site wound, trauma, or burn injury is a serious healthcare problem. Therefore, employees that work in the supply and distribution industry need to understand how they can provide solutions for customers to help prevent and treat wounds.
manufacturers. These programs provide comprehensive tools and guidelines to help customers develop strategies in areas relating to wound care prevention and treatment.

Medical Nutrition Therapy (MNT) treatment plans are an essential component to wound management. The nursing staff and registered dietitian (RD) are primarily responsible for developing a treatment and prevention plan, as well as documenting nutrition and nursing assessment plans. Routine monitoring and validated assessment tools need to be integrated into a patient’s care plan and an organization’s clinical protocols. The goal is to provide adequate calories, protein, fluid, vitamins and minerals, as well as to understand their role in wound healing. Some important components are as follows:

- **Protein** is important to help repair damaged tissue and promote healing. (Protein requirements are markedly increased, as collagen – the most abundant protein – is a critical component of collagen synthesis needed for wound healing).
- **Fat** is an essential component of all cell membranes.
- Other semi-essential amino acids like arginine, the building blocks of protein, are required for tissue repair and to help transport oxygen delivery to the wounds.
- Vitamins and minerals are necessary for all phases of wound healing. A supplement is needed when dietary intake is poor or deficiencies are suspected. (E.g., vitamin C supports formation of new blood vessels and wound strength, and zinc is required for protein synthesis and immunity.)

**Oral and tube feeding**

Patients benefit from fortified and/or high-calorie foods, as well as high protein oral supplements between meals when nutritional requirements can’t be achieved by dietary intake. This strategy can help combat unintended weight loss, anorexia and malnutrition. These supplements may be delivered orally or through a feeding tube. It is important to consider alternatives like enteral (tube) feeding or parenteral (IV) feeding, when oral consumption remains suboptimal.

Tube feeding is the preferred route, if the gastrointestinal tract is functioning. Depending on the clinical condition, tube feeding necessity will vary in terms of length of need. The formulas mimic what is in a typical diet and contain a variety of nutrients consumed by healthy individuals to meet the recommended dietary needs. It is the clinicians’ responsibility to evaluate enteral products for clinical efficacy and to develop formularies to meet the needs of their health care setting.

The primary food ingredients in both oral and tube feeding products include these:

- Carbohydrates, usually in the form of corn syrup solids and maltodextrin.
- Protein, usually in the form of soy protein and casein.
- Fat, typically canola, soybean or safflower oil.
- Fiber – soluble or insoluble.

**Quality standards**

Considerable evidence exists regarding the seriousness of pressure ulcers and the relationship between pressure ulcers and pain, decreased quality of life, and increased mortality in aging populations. Therefore, state and regulatory agencies like CMS have funded quality measure projects like National Quality Forum (NQF), established

Clinicians require evidence-based tools that help identify residents who are at risk, so that prompt attention is directed on the nutritional status of patients.
Until recently, nursing home care has been a key component of long-term care, especially for older adults. However, although the U.S. population aged 65 and over increased from 10.6 percent to 14.9 percent in 2015, use of nursing home care began to decline as early as 2000. A variety of factors likely contributed to this ongoing decline, including changes in consumer care preferences and the availability of additional long-term care options with the growth of residential care communities, such as assisted living.

Lisa Logan, Registered Dietitian (R.D.) and Certified Nutrition Support Clinician (CNSC), is enteral program manager/nutrition support clinician for the extended care-clinical resource team, McKesson Medical-Surgical.
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The Frail Elderly

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Conventional wisdom has it that a very small percentage of Medicare patients account for a very large part of the Medicare budget. With funding from The Commonwealth Fund, a group of researchers tried to put a finer point on that wisdom by defining who these high-cost, high-usage subpopulations are, and how much “preventable spending” they account for.

Perhaps not surprisingly, they are primarily what the researchers categorize as the “frail elderly.”

Beneficiaries in the highest 10 percent of total standardized individual spending were defined as “high-cost” patients, using a 20 percent sample of Medicare fee-for-service claims from 2012.

Researchers calculated potentially preventable spending by summing costs for avoidable emergency department visits plus inpatient and associated 30-day post-acute costs for ambulatory-care-sensitive conditions (ACSCs). They compared the amount and proportion of potentially preventable spending across the high-cost subpopulations and by individual ACSCs.

The researchers found that in 2012:

- 4.8 percent of Medicare spending was potentially preventable, of which 73.8 percent was incurred by high-cost patients.
- Despite making up only 4 percent of the Medicare population, high-cost, frail elderly persons accounted for 43.9 percent of total potentially preventable spending ($6,593 per person).
- High-cost nonelderly disabled persons accounted for 14.8 percent of potentially preventable spending ($3,421 per person).
- The major complex chronic group accounted for 11.2 percent ($3,327 per person) of potentially preventable spending.
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Frail elderly persons accounted for most spending related to admissions for urinary tract infections, dehydration, heart failure, and bacterial pneumonia.

Which site of care?
The researchers examined potentially preventable hospitalizations and emergency-department visits, and associated costs. Using federal government data, they examined potentially preventable hospitalizations related to specific conditions, such as heart failure, diabetes, hypertension and asthma, “for which good outpatient care can likely prevent the need for hospitalization.”

On average, frail elderly persons accounted for the most potentially preventable inpatient spending for nearly all individual ambulatory-care-sensitive conditions. Much of the preventable inpatient spending in this group was related to acute care visits for:

- Heart failure ($451 per person).
- Bacterial pneumonia ($355 per person).
- Urinary tract infections ($289 per person).
- Diabetes long-term complications ($152 per person).
- Dehydration ($121 per person).

The nonelderly disabled group accounted for the most potentially preventable spending for admissions related to diabetes short-term complications.

“These findings highlight the need to understand and mitigate the health consequences of frailty, especially as the U.S. population ages and frailty becomes more prevalent,” the researchers write. “Given the high concentration of potentially modifiable spending among frail elderly persons, interventions that target this population may lead to disproportionate reductions in healthcare costs.

“Our work suggests that simple interventions in the outpatient setting, such as close management of heart failure and prevention of urinary tract infections, may substantially reduce unnecessary spending.”

Aging U.S. Population to Drive Home Healthcare Market Growth

The home healthcare market is expected to grow from $100 billion in 2016 to $225 billion by 2024. Key factors driving this expansion include an aging U.S. population and the lower cost of home care when compared to other post-acute settings. As the market continues to expand, the number of providers offering home care services is expected to reach 46,000 in 2021, up from 37,000 in 2016.

HIDA’s 2017 Home Care Market Report offers an in-depth look at home healthcare market conditions, as well as the factors affecting utilization and demand. Below is a look at some of the key trends and data points gathered for this new HIDA report:

Due to the aging population, experts believe there will be a shortage in senior housing (which includes assisted living, independent living, memory care, and skilled nursing facilities) beginning in 2025 and reaching 1 million units by 2049 if not addressed.

- Disabilities that inhibit an individual’s ability to perform household chores will grow from 15 million to 27 million.

The increasing prevalence of both utilization of home care services and chronic disorders requiring long-term patient care are expected to contribute to higher spending on durable medical equipment (DME). Because of this shift, the DME market is expected to reach $70.7 billion by 2025, up from $50.6 billion in 2017.

Historical and Projected U.S. DME Spend

While there are several factors driving demand for DME, the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Competitive Bidding Program (CBP) will continue to limit DME suppliers’ Medicare reimbursement. Under the current process, reimbursements cover, on average, 88 percent of the cost of providing a piece of DME.

DME suppliers affected by the CBP are taking several steps to control costs, including cutting staff, limiting product offerings, and consolidating.

While these are some of the key trends affecting providers in the home healthcare market, providers in this space will face several industry challenges, including a shortage of skilled workers and key payer changes. For an in-depth look at these trends, visit www.HIDA.org/MarketReports to purchase your copy of HIDA’s 2017 Home Care Market Report.
In February 2017, the U.S. Food and Drug Administration issued a final order reclassifying antigen-based RIDTs (rapid influenza virus antigen detection test systems) from Class I into Class II devices. The reclassification to Class II – a higher-risk designation – is intended to improve the quality of testing for influenza.

Microbiologist/Biochemist Sally Hojvat, Ph.D., addressed some of the key points and concerns surrounding the reclassification in a recent webinar “Meeting the Standards: The Impact of Flu Tests Reclassified,” sponsored by Sekisui Diagnostics. Dr. Hojvat spent 12 years with the U.S. Food and Drug Administration as the Director of the Division of Microbiology Devices. Among the items Dr. Hojvat discussed:

**Reasons behind the reclassification.** Class I influenza diagnostics don’t always meet the needs of patients, physicians or public health officials, Dr. Hojvat says. “This was seen in particular during 2009-2010 H1N1 influenza outbreak, where only 61 percent of infected patients with that virus strain were actually diagnosed correctly. There was a need to know how to mitigate or reduce the known risks associated with the poor performance of the Class I RIDTs.” This is due to the viral antigenic changes that occur in circulating strains as the influenza virus evolves. The FDA believes that general controls are not sufficient to reasonably assure what’s known as the safety and effectiveness of the RIDT. By reclassifying them to Class II, that allowed the FDA to institute Special Controls to be applied to the RIDTs, says Dr. Hojvat. One of the added benefits was to try establish and maintain the minimum performance criteria for RIDTs throughout their product life cycle.

**Special Controls.** The first thing the Special Controls say is that (Class II RIDTs) must have a minimum clinical performance requirement, says Dr. Hojvat. They have to demonstrate that by using currently appropriate and FDA acceptable comparison methods. Second, there is a requirement for annual reactivity testing and results reporting. The third Special Control deals with provision for testing in a declared emergency or potential emergency once viral samples are available. For example, if a new strain comes in like H1N1 and viral samples will be made available.

**Implementation date.** The final order effective date was February 13, 2017. Special Controls compliance date for devices legally marketed prior to February 13, 2017 is January 12, 2018. “The FDA gave manufacturers a year to come into compliance with those Special Controls,” says Dr. Hojvat.

**The implications of the reclassification for manufacturers, distributors, physicians and lab facilities.** After January 12, the FDA could take actions, such as pursuing seizure of Influenza RIDTs held by a distributor that do not meet the Special Controls held by a distributor that do not meet the Special Controls. Although a low FDA priority, distributors should manage their inventory so that they only possess and distribute devices that meet the Special Controls as of the compliance date.

**Although a low FDA priority, distributors should manage their inventory so that they only possess and distribute devices that meet the Special Controls as of the compliance date.**

Repertoire readers wishing to view the recording of the webinar, can do so here: www.repertoiremag.com/meeting-the-standards-the-impact-of-rapid-flu-test-reclassification-webinar.html. To learn more about the OSOM Ultra Flu test from Sekisui Diagnostics, which meets the new FDA Guidelines, visit http://go.sekisui-dx.com/flureclass-osom

www.repertoiremag.com • December 2017 45
Sepsis: Deadly without rapid intervention

Every year more than 1.5 million people develop sepsis in the United States, and at least 250,000 die as a result, according to the Centers for Disease Control and Prevention. While deadly, sepsis is treatable – but only if caregivers’ response is rapid.

Sepsis is the body’s extreme response to an infection – in the skin, lungs, urinary tract or somewhere else – which triggers a chain reaction throughout the body. It begins outside of the hospital for nearly 80 percent of patients. Without timely treatment, sepsis can rapidly lead to tissue damage, organ failure, and death.

The signs and symptoms of sepsis can include:
- Confusion or disorientation
- Shortness of breath
- High heart rate
- Fever, or shivering, or feeling very cold.
- Extreme pain or discomfort
- Clammy or sweaty skin.

The most frequently identified germs that cause infections that develop into sepsis are *Staphylococcus aureus* (staph), *Escherichia coli* (E. coli) and some types of *Streptococcus*.

Although sepsis typically develops in the community, people with sepsis are treated in the hospital, says CDC. Research shows that rapid, effective sepsis treatment, which includes giving antibiotics, maintaining blood flow to organs, and treating the source of infection, can save lives. Doctors treat sepsis with antibiotics as soon as possible. Many patients receive oxygen and intravenous fluids to maintain blood flow and oxygen to organs.

Doctors treat sepsis with antibiotics as soon as possible. Many patients receive oxygen and intravenous fluids to maintain blood flow and oxygen to organs.

Post-sepsis syndrome

Half of sepsis survivors suffer physical and/or psychological long-term effects, according to the Sepsis Alliance, an advocacy organization founded in 2007. Those effects include:
- Insomnia, difficulty getting to sleep or staying asleep.
- Nightmares, vivid hallucinations and panic attacks.
- Disabling muscle and joint pains.
- Extreme fatigue.
- Poor concentration.
- Decreased mental (cognitive) functioning.

PSS can affect people of any age, but a study from the University of Michigan Health System, published in 2010 in the medical journal *JAMA*, found that older severe sepsis survivors were at higher risk for long-term cognitive impairment and physical problems than others their age who were treated for other illnesses. Their problems ranged from not being able to walk, even though they could before they became ill, to not being able to do everyday activities, such as bathing, toileting, or preparing meals. Changes in mental status can range from no longer being able to perform complicated tasks to not being able to remember everyday things.

The study’s authors wrote, “Sixty percent of hospitalizations for severe sepsis were associated with worsened cognitive and physical function among surviving older adults. The odds of acquiring moderate to severe cognitive impairment were 3.3 times higher following an episode of sepsis than for other hospitalizations.”

For information on sepsis and on the CDC’s “Get Ahead of Sepsis” initiative, go to www.cdc.gov/sepsis/get-ahead-of-sepsis/
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Early recognition, early intervention

Ohio hospitals achieved a 13.4 percent statewide reduction in sepsis mortality, representing an estimated 1,486 lives saved over the first 18 months of an Ohio Hospital Association initiative, which began in June 2015.

The initiative rests on two key strategies: 1) early recognition, and 2) early, appropriate intervention with the incorporation of the Surviving Sepsis Campaign’s three-hour sepsis bundle (i.e., blood cultures, broad-spectrum antibiotic agents, and lactate measurement).

Participating hospitals reported the following activities:

- Coordinating with EMS/ambulance services to provide sepsis education and early appropriate intervention protocols.
- Incorporating national Sepsis Alliance templates for discharge instructions of sepsis patients.
- Reviewing rapid response team protocols and activation process to treat sepsis patients.
- Improving recognition and treatment before rapid response team is needed.
- Implementing Focused Assessments to determine condition of septic patient.
- Creating and distributing education materials (signs of sepsis) for the community and partners.
- Assigning a dedicated “sepsis coordinator” to work with clinical team on policies and protocols.
- Expanding education for staff orientation.
- Distributing a sepsis alert page throughout the hospital when a patient arrives or is identified as septic, creating a mandatory consult for a critical care physician and ensuring information is passed, including the time for the six-hour focused exam and the location of the patient.
- Developing marketing materials such as radio ads and billboards to educate the community on the signs of sepsis.


Treatment delays costly

The real opportunity for sepsis survival lies in identifying and treating sepsis before it becomes severe, according to the University of Kansas Health System. “In some cases, we identify the potential for sepsis early and prescribe antibiotics, but we don’t get them into the patient quickly enough,” reports the health system on its “Management of the Sepsis Patient” web page. “The answer can be as simple as issuing a STAT order or following up with the hospital’s inpatient pharmacy and the patient to ensure rapid delivery. When we see a patient with a severe injury – say a bleeding artery – we don’t delay. We take immediate action to stop the bleeding.

“Similarly, if a patient enters the emergency room with an infection, he is probably sick enough to warrant STAT antibiotics.”

Some key statistics from the University of Kansas:

- Every hour we delay treatment, we add 7 percent to the mortality rate.
- Elevated creatinine levels increase mortality dramatically.
- Mortality for severe sepsis without rapid response is 30-50 percent.
- If the patient develops shock, the mortality rate rises to 60-80 percent.
- Sepsis is not just a community hospital problem. Even in major academic medical centers, the mortality rate for sepsis is 50 percent if treatment for septic shock is delayed more than four hours.

Source: University of Kansas Health System: www.kansashealthsystem.com/for-professionals/publications-resources/newsletters/read-innovations-review/sepsis-may
Explore Go-To-Market Strategies Across the Care Continuum at HIDA’s Channel Strategies Conferences

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Have you ever fallen in love with a song, only to cringe when you heard it performed live? Professional musicians use editing technology to make their recordings clear – but when they overdo it, it’s hard to know if they’re really that good, or if it’s all editing.

It helps to think of ECGs the same way. Except we’re talking about heart health, not a missed note.

**What is filtering?**
To make ECGs easier to read and interpret, ECG filtering exists to remove noise from ECG recordings so physicians can see waveform data more clearly. An overly filtered ECG may look nice and clean – but too much filtering can distort or remove authentic waveform data physicians may need in order to diagnose correctly.

When it comes to overly filtered ECGs, the problem is this – physicians may not know what they’re missing.

**Is filtering good or bad?**
Filtering is generally good if the filters are set to an appropriate threshold, and if the interpretive algorithm still looks at the original vs. the processed waveform. Governing bodies like the ACC, AHA and HRS publish adult and pediatric guidelines providing guidance to:

- Limit filtering so not to sacrifice potentially lifesaving waveform data
- Clearly disclose filtering so physicians can more easily identify original vs. processed waveform data

You know what your favorite song should sound like, but your customers may not know what every ECG reading should look like. ECG technology should be carefully chosen to provide the best clinical decision support possible. It’s worth asking your customers about their ECG technology: What could they be missing?

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New Best Practices Aimed at UDI Compliance in LUM, JIT Programs

Low-unit-of-measure (LUM) and just-in-time (JIT) programs are popular with providers, but they can create a headache for compliance with the Food and Drug Administration’s (FDA) unique device identifier (UDI) rule. For example, a manufacturer may sell a product by the case, whereas distributors break the cases into boxes or even eaches based on customer needs. While the manufacturer’s original packaging will possess UDI-compliant labeling, smaller batches or eaches of the product may not have the necessary labels, and distributing these smaller units through a LUM or JIT program to providers would risk non-compliance with the UDI rules.

To help distributors and their trading partners meet this challenge, HIDA has prepared a list of best practices for ensuring their products meet the FDA’s requirements as they move through the supply chain in LUM and JIT programs.

**Best practices**

Communications between trading partners is key for maintaining UDI compliance. Manufacturers need a clear understanding of the services distributors offer so they can appropriately package and label their products. To facilitate this communication, distributors and manufacturers should follow these steps:

1. **Initiate trading partner discussions.** The distributor needs to make sure the manufacturer fully understands the JIT or LUM program they offer. Due to anti-trust concerns, these conversations must be conducted one-on-one between individual trading partners.

2. **Share key data.** The distributor must then share a list of products distributed in their LUM or JIT programs.

3. **Analyze.** The manufacturer reviews the distributor’s data and gathers up-to-date UDI implementation plans from their product teams. The manufacturer then determines if there are any gaps in UDI compliance because of the distributor’s programs.

4. **Dialogue.** The manufacturer presents the distributor with a plan for how products can remain UDI-compliant when they are sold via a LUM or JIT program. During this step, the manufacturer may require additional information, and the distributor may need to gather input from their provider customers.

5. **Develop a plan.** In this step, manufacturers and distributors decide on how to implement the necessary changes to comply with UDI requirements, and how to communicate necessary information to customers.

6. **Continued dialogue.** Distributors and manufacturers should maintain an open dialogue to ensure that UDI requirements are met as customer needs change.

**Background**

On September 24, 2013, the FDA issued the UDI rule. The rule applies to most medical devices, and requires that they have a label on the packaging or the product itself that can be used to identify key product information. Due to the complexity of this rule, the FDA has created several exceptions and extended certain deadlines.

These exceptions and extensions have been vital for HIDA members as they work to comply with these regulations, and have given HIDA the time needed to develop the above best practices.

These best practices are one of several resources on UDI compliance that HIDA can offer. To learn more about these guidelines, or for more information about UDI requirements, feel free to contact us at HIDAGovAffairs@HIDA.org.
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One in a million
The probability that a random person in the population could look at your iPhone X and unlock it using Face ID is approximately 1 in 1,000,000 (versus 1 in 50,000 for Touch ID), says Apple in its Face ID Security white paper. Face ID allows only five unsuccessful match attempts before a passcode is required to obtain access to your iPhone. The probability of a false match is different for twins and siblings that look like you as well as among children under the age of 13, because their distinct facial features may not have fully developed. If you’re concerned about this, we recommend using a passcode to authenticate.

Smiling faces
Are you surprised? Younger millennials (ages 18-24) take more photos than any other age group in the United States – averaging 439 photos every six months, according to new research from the Consumer Technology Association. The study, “Focus on Digital Imaging Industry Drivers: Apps, Outputs and Storage,” also shows that among the 81 percent of Americans who take photos and use apps, more than half (53 percent) have used a dedicated digital imaging (DI) tool or service app, such photo editing, management, output or kiosk services.

The smart home
The smart home is likely to become a major generator of connected and IoT (Internet of Things) device deployment growth during the 2020s, according to research by Strategy Analytics. Smart home devices will overtake smartphones by 2021 as a share of deployed connect IoT devices.

One word for you: Graphite
Electric vehicle manufacturers and battery makers have long been searching for the “Holy Grail” technology that could lower the cost of batteries while also extending their range, according to SafeHaven.com. One material that could actually lead to cheap, long-range and fast-charging electric vehicles is graphite. Within graphite is graphene, the world’s thinnest material. Graphene is durable and tough – 200 times stronger than steel – yet ultra-light weight. It is also transparent, and conducts electricity substantially better than copper, says SafeHaven.com. Electrons can travel using graphene with virtually zero resistance and no heat loss, nearly qualifying it as a superconductor. These virtues have singled it out as one of candidates most likely to take lithium-ion batteries to the next level, potentially leading to a breakthrough for electric vehicles. The only problem is that production of graphene is still low. Graphite itself is still cheap, but the trick is rendering out the graphene. Scientists were only able to separate out graphene in 2004, and researchers and entrepreneurs are still looking for ways to mass-produce the material at low cost.

The Facebook of its time
AOL Instant Messenger was scheduled to end its two-decade run on Dec. 15. From a Wall Street Journal “eulogy”: “The late 1990s was a period of technological growing pains. Cellphones weren’t smart. People dialed up the Internet through beige boxes with squawking 56K modems. The only glimmer of an always-on future came from shiny ‘America Online’ discs that arrived in the mail. It wasn’t cool, but it was the Facebook of its time. Family and friends signed up, mostly because loved ones were there. One AOL feature did induce envy: a window where you could type anything you wanted, and your ‘buddy’ could reply immediately. This was instant messaging.”

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.
Wolf X-Ray has solved where to store your cross table device problem - Anywhere you want to.

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Riding her horse with a group of girlfriends to Terwilliger Pond for swimming, horse shows, University of Florida homecoming parades and lunches at Sonny’s barbecue formed the basis for friendships that would last a lifetime for Becky Munden … and would become the subject matter for a recently published book for young adults, “The Idylwild Cowgirls.”

“We didn’t call ourselves ‘cowgirls’ back then,” says Munden, who is president of Sun Surgical Supply in Gainesville, Fla. “The ‘cowgirls’ comes from some narrative at the end of Chapter 1 in the book.” But if they weren’t called by that name, in the early 1970s, they looked and acted like a group of cowgirls. Their story was written and recently published by one of them, Debra Segal.

Idylwild is a neighborhood in Gainesville, Fla., located near Idylwild Elementary School, explains Munden. “I would describe it as a country setting. The roads in the neighborhood were paved, but the roads around it, like Crown Road, were all dirt.

“The area has remained much the same, despite some new construction,” she continues. “The biggest change is that much of the land has been purchased, and the owners have put up fences, making some of the back trails no longer accessible for riding. Today, where Oaks Mall sits – that was open field.”

But in 1973, the year in which the story takes place, the six girls had plenty of places to ride, and they spent many of their summer days doing just that.

“We had all this freedom,” says Munden. “We didn't have beepers or cellphones, just 10 cents in case we needed to make a phone call. But the horses were so in tune with where we
lived, I could let go of the reins on Speedy and let him take me home.” Speedy also knew to move out of the way at the distant sound of an oncoming car.

“As children, Debra was fascinated by nature, animals and her environment in general,” says Munden. “I can’t remember a time she specifically mentioned she was interested in writing. [But] I wasn’t surprised by her writing this book.”

Segal had initially intended her story to be about growing up on a farm, but she turned her attention to her days riding with her friends. “She reached out to me and the other ‘cowgirls,’” recalls Munden. “We all had dinner and some wine, and spent an evening laughing and crying as we recounted our horse stories.”

The book has been a hit in Gainesville, where Segal, Munden and some of the other cowgirls have participated in book signings. But the biggest payoff has been in renewing old friendships and recalling good times.

“It’s great – incredible – for Debbie to bring back some of those memories and the history of Gainesville, along with the serenity of our riding days,” says Munden. “I’m proud of her for doing that.”

From the book jacket of “The Idylwild Cowgirls:”

The Idylwild Cowgirls gallop through a memorable summer of adventure, independence, and courage only to find themselves struggling to survive the perils of nature and the predicaments from their foolhardy decisions. When a neighbor threatens to pave the historic, oak-lined dirt road, the cowgirls rally together to protect their beloved Idylwild neighborhood. Filled with gutsy explorations and heart-warming friendships, this story captures the remarkable bond between girls and their horses.
Social Health

Relationships: A public health priority
Elevating social connection should be a public health priority, according to an article in a special issue of American Psychologist, the journal of the American Psychological Association. A robust body of scientific evidence suggests that being in high-quality close relationships and feeling socially connected are associated with decreased risk of mortality, according to researchers. Social isolation, loneliness and relationship discord are well-established risk factors for poor health. Despite the importance of social connection for good health, government agencies, healthcare providers and healthcare funders have been slow to recognize social connection as a public health priority, according to the authors. They give an overview of the extent of the problem (as many as 43 percent of U.S. adults older than 60 experience frequent or intense loneliness) and provide suggestions on how to integrate social relationships into public health priorities by researching and developing interventions to improve social connection.

An epidemic of loneliness?
Writing for Harvard Business Review, former U.S. Surgeon General Vivek Murthy spotlighted the growing “loneliness epidemic,” its risks to a person’s health and happiness – and five ways to fight back, beginning in the workplace, reports The Advisory Board Company. According to Murthy, “Companies in particular have the power to drive change … not only by strengthening connections among employees, partners, and clients, but also by serving as an innovation hub that can inspire other organizations to address loneliness.” Five steps to foster social connection at work are:

• Evaluate how socially connected your workplace is. Do people feel valued by colleagues? Does the culture support giving and receiving kindness?
• Foster understanding for what a “high-quality” relationship looks like. Positive emotions, such as kindness, compassion and generosity, enhance performance and resilience.
• Prioritize the development of social connections. “Designing and modeling a culture that supports connection is more important than any single program,” says Murthy.
• Urge workers to help others and accept themselves. “Although it may seem counterintuitive to assist others when you are feeling lonely, extending help to others and allowing yourself to receive help builds a connection that is mutually affirming,” Murthy writes.
• Create opportunities to learn about colleagues’ personal lives. According to Murthy, “The likelihood that authentic social connections will develop is greater when people feel understood and appreciated as individuals with full lives.”
It's not your imagination: Food allergies are increasing

Food allergies are commonly thought of as a childhood condition, but for some children, food allergies continue into adulthood, and adult-onset food allergy does occur, according to Robin Gelburd, president of FAIR Health. Healthcare claims data suggest that food allergies are predominantly, but not exclusively, found in young people. Almost a third (27 percent) of all claim lines with diagnoses of history of food allergy were attributable to patients between the ages of 0 and 3. Pre-school age children (4-to-5-year-olds) accounted for 8 percent of the total, with individuals between the ages of 6 and 18 making up an additional third (31 percent). Altogether, patients 18 years old and younger accounted for 66 percent of the claim lines, those over 18 years old the remaining 34 percent. Private insurance claim lines (the individual procedures or services listed on an insurance claim) with diagnoses of anaphylactic food reactions climbed 377 percent nationwide from 2007 to 2016, according to FAIR Health. Among specifically identified foods causing anaphylaxis, the most common was peanuts (26 percent), followed closely by tree nuts and seeds (18 percent).

Colon cancer growing concern for white Americans under 55

Colorectal cancer (CRC) incidence has been increasing in the United States among adults younger than 55 years since at least the mid-1990s, with the increase confined to white men and women and most rapid for metastatic disease, reported researchers in the Journal of the American Medical Association (JAMA. 2017;318(6):572-574. doi:10.1001/jama.2017.7630) Although CRC mortality is declining overall, for all ages combined mask patterns in young adults, which have not been comprehensively examined.

Improving bone mineral density in prostate cancer patients

One in two men with prostate cancer receives androgen deprivation therapy (ADT). Unfortunately, ADT is associated with many potential adverse effects, including significant bone loss and increased risk of fractures. But researchers from McMaster University report in Annals of Internal Medicine that evidence shows improvements in bone mineral density with biophosphonates, but whether this is associated with reduced fractures remains unclear. Evidence from available trials show fracture reduction was restricted to one drug: denosumab.

Progress stalls in preventing stroke deaths

Progress in preventing stroke deaths has slowed, following years of progress, according to the Centers for Disease Control and Prevention. While the CDC does not specifically address the reasons behind the slowdown, other studies point to increased numbers of Americans with risk factors such as high blood pressure, obesity, and diabetes. Almost 800,000 people have a stroke each year and more than 140,000 die, even though about 80 percent of strokes are preventable. Blacks continue to have the highest stroke death rates among all races/ethnicities, and stroke death rates increased among Hispanics by 6 percent each year from 2013-15.

Take a movement break

Excessive sedentary time, whether accumulated throughout the day or accrued in prolonged, uninterrupted bouts, is a significant risk factor for all-cause mortality, regardless of exercise habits, according to researchers. Taking movement breaks every 30 minutes throughout the day could help to mitigate the negative health effects of too much sitting. A study published in Annals of Internal Medicine suggests that physical activity guidelines should target reducing and interrupting sedentary time in addition to setting daily goals for moderate- to vigorous-intensity physical activity. Researchers at Columbia University Medical Center, New York-Presbyterian/Weill Cornell Medical Center and other institutions studied a national cohort of 7,985 black and white adults aged 45 years or older to examine the association between sedentary behavior (its total volume and accrual in prolonged, uninterrupted bouts) and all-cause mortality. Sedentary time was objectively measured using a hip-mounted accelerometer. According to the authors, taking a break from sitting every half hour could help to mitigate the negative effects of sedentary time.

A robust body of scientific evidence suggests that being in high-quality close relationships and feeling socially connected are associated with decreased risk of mortality.
LEADERSHIP

Four Ways to Build Resilience

“Success is not final, failure is not fatal, it’s the courage to continue that counts.”

It was inspirational when Winston Churchill said it. But for most of us, mustering the courage to go on in the face of failure is not easy. My ancestors braved war and famine, but if my email goes down, I feel like I can’t cope. Intellectually you recognize, on the scale of human suffering, greater tragedies have been endured. But in the moment, it still feels hopeless.

Challenging situations – be they large or small – require resilience. If you really want to improve your resilience, you need to train your brain. Resilience is a muscle, and like any muscle you must train it if you want it to get stronger.

Here are four techniques to improve your resilience muscle:

1. **Preemptive mindfulness**
   Studies have shown mindfulness, gratitude, and other meditative practices increase your resiliency. Even 10 minutes a day listing your gratitudes will improve your brain’s ability to deal with stress and failure before it happens. If keeping a gratitude journal isn’t your speed, you can increase your resiliency by sleeping, seeing the sun every day, or spending 15 minutes without your phone while you’re eating. These small things add up to a more mindful person, and mindful people can handle stress.

2. **Breathe five times**
   There’s a reason you always hear the words, “take a deep breath.” Breathing gives your brain oxygen. This helps your mind remember things, make measured responses, and be strategic. In a stressful situation, your temptation is to hold your breath. Instead, do the opposite. Take five deep breaths before you even try to think. You can train yourself to use this as your default response to challenges. The 30 seconds won’t matter to the problem, but it will matter very much to your brain.
3. Go to the good
Before you tackle your big challenge, reset your brain by focusing on something positive. When I’m feeling frazzled, I send a gratitude email or a wow you message to a client or colleague. Telling a client what a great job they did on a project builds your resilience muscle because it reminds your brain, things are good. When I do this, I usually get a second round of dopamine when the client sends back a thank you.

4. Look for 10%
Tackling big problems is daunting. Your brain shuts down because it can’t process the full situation. Instead, focus on a marginal gain. Ask yourself, how can I improve this situation by 10%? If you lost a customer, improving the relationship by 10% may mean one sincere phone call. If you got a bad performance review? A 10% improvement may be writing a plan for you to improve. Focus on 10% a few times, and you’ll quickly make a sizeable dent in a setback.

Lisa Earle McLeod is a leading authority on sales leadership and the author of four provocative books including the bestseller, Selling with Noble Purpose. Companies like Apple, Kimberly-Clark and Pfizer hire her to help them create passionate, purpose-driven sales organizations. Her NSP is to help leaders drive revenue and do work that makes them proud.
Cardinal Health announces leadership changes
Cardinal Health (Dublin, OH) named Mike Kaufmann as the company’s next CEO and as a member of the board of directors, effective January 1, 2018. Kaufmann currently is the company’s CFO. He will succeed George Barrett, Cardinal Health’s chairman and CEO since 2009, who will continue to serve as executive chairman of the board of directors through the annual meeting of shareholders in November 2018. At that time, Gregory Kenny, Cardinal Health’s lead independent director, will assume the role of non-executive chairman. As part of the succession plan, Jorge Gomez will succeed Mike Kaufmann as Cardinal Health’s CFO. Gomez currently is SVP and CFO of Cardinal Health’s Medical segment and previously served as CFO of Cardinal Health’s Pharmaceutical segment, as well as in roles as both the company’s treasurer and controller.

Owens & Minor to acquire Halyard Health’s surgical & infection prevention unit for $710M
Owens & Minor (Richmond, VA) signed a definitive agreement to acquire the surgical and infection prevention business of Halyard Health Inc (Alpharetta, GA) for approximately $710 million in cash. Halyard’s S&IP portfolio includes sterilization wraps, surgical drapes and gowns, facial protection, protective apparel, and medical exam gloves. The transaction is expected to close in the first quarter of 2018, subject to customary closing conditions and regulatory approvals.

McKesson announces retirement of Paul Julian
McKesson Corporation announced that Paul Julian, EVP and group president, Distribution Solutions, will retire at the end of 2017. He has been with the company for 21 years. On Julian’s retirement, the presidents of the businesses within Distribution Solutions will report to John H. Hammergren, chairman and CEO.

Amazon acquires wholesale pharmacy licenses in 12 states
Amazon.com Inc has gained approval to become a wholesale distributor from more than 10 state pharmaceutical boards within the last year, according to a review of public records by the St. Louis Post-Dispatch. Amazon holds licenses in at least 12 states: Alabama, Arizona, Connecticut, Idaho, Louisiana, Michigan, Nevada, New Hampshire, New Jersey, North Dakota, Oregon and Tennessee. The company also has an application pending in Maine. This does not mean Amazon can begin shipping prescription drugs or devices directly to consumers; the company would still need to obtain a pharmacy license. The North Dakota license suggests that Amazon could also distribute medical devices or medical gas, according to the license issued February 24. Under license type, it says, “durable medical equipment distributor, medical gas distributor, or both.” In the application in Nevada, which was issued January 25, the Nevada State Board of Pharmacy approved an out-of-state wholesale licenses to Amazon. On the applications where it describes the types of products that will be handled by the wholesale firm, it lists “legend pharmaceuticals, supplies, or devices and hypodermic devices. The license in Nevada allows Amazon to ship into the state from the three facilities in Indiana.
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