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Sense of Urgency

Urgent care centers are catching on, but the question remains: Are they a low-cost alternative to the ER, or a high-cost alternative to the doctor’s office?

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Less force makes access easy.¹

¹ Engineering data on file.

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For the past 18 years, I have been blessed to be in the medical distribution industry. Fortunately, along the way there have been mentors and friends to help guide me. Repertoire Publisher Brian Taylor has been one of those mentors, and I am proud to say, a friend. I am thankful for the wisdom Brian has given me over the years, and I’m excited to share my insights about the industry in this column.

When my career started in 1996, Repertoire was barely 3 years old. The good old days – back when there were branches in every city and manufacturer reps could show up and ask for an order and then go out and sell that inventory with his or her distribution reps.

Monthly sales meetings at the branch used to be common place. For $250 in free goods, manufacturers were given 30 minutes in front of the reps to do their dog and pony show. It was how we trained reps to sell our products, and how we stayed a tight community. Repertoire’s goal was simple “be the voice of the industry to the distribution reps.”

Today, reps may get together once or twice a year at the national sales meeting or an occasional regional meeting. There is less time spent together as an organization. We spend so much more time on email and text that we hardly even talk to each other anymore – much less stop to understand all that is going on in our industry. It’s just the reality of change and consolidation. Countless reps have told me over the last seven years how much they appreciate Repertoire each month and how it helps to maintain the community of distribution reps and the industry.

As we move into the next 20 years, Repertoire’s plan is to stay as close to the distribution rep as possible. We want to cover the topics that shape their careers and help grow their business. We will still have a simple goal to “be the voice of the industry to the distribution reps” and help maintain a sense of community.

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Value-Based Purchasing

Providers reimbursed on basis of quality – not quantity – of care

*Supplier success in a post-reform healthcare market depends on a lot of factors, including a thorough understanding of the foundation of healthcare reform. This is part of an ongoing series designed to help Repertoire readers understand the implications of reform.*

The overall goals of the Affordable Care Act are to improve the quality of care in our country while reducing the waste and costs associated with that care. One cost-containment incentive program to come out of the ACA is Value-Based Purchasing.

Value-Based Purchasing, or VBP, is aimed at shifting Medicare’s fee-for-service payment system toward a system based on quality of care and patient outcomes.

Starting Oct. 1, 2012, participating hospitals began to be rewarded for how well they perform based on a set of quality measures as well as how much they improve relative to their performance baseline. The better a hospital does on its quality measures, the greater the reward it receives. Providers are held accountable for the quality and overall cost of the healthcare services provided. Incentives are structured to discourage inappropriate, unnecessary, and costly care.

VBP will have a huge impact on these organizations and is expected to reduce Medicare spending by approximately $214 billion over the next 10 years. It is designed to help providers focus on specific goals for their facilities:

- Improve the clinical quality of care.
- Address problems of underuse, overuse and misuse of services.
- Encourage patient-centered care.
- Reduce hospital adverse events and work to improve patient safety.
- Avoid unnecessary costs related to care.
- Improve care processes.
- Make performance results transparent and useable by consumers.
- Avoid creating additional disparities and reduce existing disparities in care.

Value-Based Purchasing could help the U.S. healthcare system address such problems as these:

- One in seven Medicare patients are expected to experience an adverse event, preventable illness or injury while in the hospital. In 2009, Medicare spent an estimated $4.4 billion to care for patients who were harmed or injured while in the hospital.
- One in three Medicare beneficiaries discharged from the hospital are readmitted within one month. These readmissions cost Medicare another $26 billion per year, including $17 billion for return trips that would not happen if the patient had received the proper care during his or her initial visit.
- Every year, 98,000 Americans die from errors due to hospital care or hospital-acquired conditions.

How the program works

Hospitals continue to receive payments based on the current Medicare Inpatient Prospective Payment System. Starting in 2013, however, these payments were reduced by 1 percent across the board to create funding for Value-Based Purchasing. This reduction created $850 million for incentive payments to be paid out during 2013 based on quality measures linked to improved care processes and patient satisfaction.

To participate in VBP, hospitals are measured on a set of 12 quality measures that have been linked to improved clinical processes of care, and eight measures dealing with patient satisfaction and experience. Hospitals are scored on their performance relative to other hospitals and how their individual performance on each measure improves.
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over time. The incentive payments are determined by using the higher of these scores on each measure. By rewarding the higher achievement or improvement on measures, VBP gives hospitals the financial incentive to continually improve how they deliver care.

An example of one of the 12 quality measures is the following: How often do patients with heart failure get the discharge instructions they need to care for themselves? Heart failure patients leave the hospital with many new medications and treatment regimens. Their follow-up care can be overwhelming, and these patients are more likely than many other patient types to be readmitted to the hospital within 30 days. Understanding how to care for themselves after discharge can keep heart failure patients healthy and out of the hospital. Value-Based Purchasing measures how often hospital staff provide heart failure patients with the information they need to manage their symptoms after they leave the hospital. Teaching these patients to care for themselves is expected to reduce hospital readmissions and help lower healthcare costs.

An example of one of the eight measures targeting patient satisfaction is the following: How satisfied are patients with their experience of care at the hospital? VBP measures patient satisfaction by randomly surveying patients who are discharged from hospitals across the country about their experience while in the hospital. The goal of this survey is to ensure that patients feel comfortable and safe in the hospital and have the correct information they need to continue healing once they are discharged. The hoped-for results are more educated patients and fewer hospital readmissions.

Clinical process-of-care measures
1. Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival.
2. Primary Percutaneous Coronary Intervention (PCI) Received Within 90 Minutes of Hospital Arrival.
3. Discharge Instructions.
4. Blood Cultures Performed in the Emergency Department Prior to Initial Antibiotic Received in Hospital.
5. Initial Antibiotic Selection for Community-Acquired Pneumonia (CAP) in Immunocompetent Patient.
6. Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision.
9. Cardiac Surgery Patients with Controlled 6:00 a.m. Postoperative Serum Glucose.
10. Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered.
11. Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery.
12. Surgery Patients on a Beta Blocker Prior to Arrival That Received a Beta Blocker During the Perioperative Period.

Patient experience-of-care measures
1. Communication with nurses.
2. Communication with doctors.
3. Responsiveness of hospital staff.
4. Pain management.
5. Communication about medicines.
6. Cleanliness and quietness of hospital environment.
7. Discharge information.
8. Overall rating of hospital.

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

Like you, our consultancy works in the trenches of the medical practice market – and we have a different vantage point than the media covering our industry. The regulatory agenda seems to favor consolidation, and the news coverage seems to focus on hospital acquisitions and the dominance of big systems like Kaiser, Mayo and the Cleveland Clinic. But we see an underreported private practice reawakening.

Big organizations just aren’t for everyone. If you’re an independent rep, you know from your own experience that many of us who work for ourselves happily trade off stability and even income for more flexibility and freedom. These same lifestyle qualities appeal to many doctors, too.

That's what we're hearing from the many physicians who’ve called us to get our input on setting up solo or small practices. And we’re not the only ones hearing these physician voices. Key technology vendors that make billing, electronic medical records management, and reporting for government programs easy and affordable have hit their stride. Billing services are undergoing an expansion, too – expanding and offering more value to their practice clients, partly by piggybacking on technology advances. We’ve even noticed banks quietly launching or expanding financing options for private practices. It’s clearly not just us noticing that there is opportunity for physicians who want to remain or become independent.

Have you heard from a physician at a larger group who’s thinking of going solo? Or one who’s having trouble adapting to the bureaucracy
of the hospital that acquired his group, and is contemplating forming a new private practice down the road? If so, how should you respond?

First, know that it is a sign of significant trust when a doctor confides in you. Honor that trust – and the trust of the organization they’re still with. Pledge to help however you can – after they give notice to their current practice. (After all, the larger organization that currently employs them is your client, too!) Remember that cold feet can take hold. Many of the doctors we talk with who are considering going private wind up delaying or waiting for a better time – for example, because of family or financial concerns. Remaining neutral helps you support your physician client to make the choice that’s right for them at the right time.

Once a physician is committed to making a move, you can play an invaluable role by connecting your client to resources that can make their new venture a success. Many aspects of setting up a practice are highly time-sensitive. If they’re not done early, they can cost a young practice thousands of dollars. These include credentialing (which can take months), editing and establishing profiles in payer and physician rating directories (which can be much harder if done after moving), creating hiring plans (especially for key hires that will help get the practice up and running), and reviewing and choosing technology.

Consultants can help with many of these tasks – and you can help, too, by keeping track of resources your other clients have relied on, be they individual advisors, reliable technology and service vendors, or even informative books, websites and other media. By helping a physician get a new practice off to a strong start, you’ll solidify your business relationship – and you might even be helping to launch what will one day be a key client for your own business. 

Many of the doctors we talk with who are considering going private wind up delaying or waiting for a better time – for example, because of family or financial concerns.
Contracting Executive Profile

David Chaudier, Vice president strategic sourcing, Aurora Health Care Inc., Milwaukee, Wisc.

Aurora Health Care Inc., is a fully integrated healthcare provider with 15 hospitals; over 185 clinics and 70 pharmacies, rehabilitation centers and home healthcare. Over 1.2 million patients annually; 3,153 licensed beds.

David Chaudier joined Aurora Health Care in 1999 and has since held positions in operations improvement, finance, cardiac and surgical service lines, and has served as vice president of operations for Aurora Health Care’s quaternary care hospital, Aurora St. Luke’s Medical Center. Currently, he oversees cardiac, surgical and radiology services, as well as various support departments. His responsibilities include strategic sourcing and negotiations, contracting and purchasing supplies, pharmacy, purchased services and capital exceeding $1 billion.

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

David Chaudier: When I assumed my current role in 2012, the first order of business was to assess and implement a new strategy and structure for the entire department. To increase department moral, we focused on three points:

- **People.** We engaged everyone and bought into a new vision of how to do things and teamwork.
- **Purpose.** We created an environment where people can feel good about what they do, and how and why they do it. We rewarded success.
- **Passion.** We focused on lifting up everyone in the department, from the most senior caregiver to newly hired individuals. We began with motivation and the belief that we can – and must – be better.

This was the building block for all future changes, which have enabled supply chain and the sourcing team to exceed their savings goals.

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

We look forward to continuing to improve the quality and quantity of work in our department. We will accomplish this through changed responsibilities, by defining processes and by creating teams capable of exceeding expectations.
Chaudier: We look forward to continuing to improve the quality and quantity of work in our department. We will accomplish this through changed responsibilities, by defining processes and by creating teams capable of exceeding expectations. In addition, we look forward to integrating the supply process within the building of the system service line departments, including:

- Partnering with physicians and key leaders in areas such as cardiac, ortho, neuro, women’s health and cancer.
- Developing physician panels with a strong supply understanding and a willingness to champion change.
- Integrating strategic account managers from supply groups to work with physician leaders and vendors.

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

Chaudier: We look for a vendor willing to partner for the long-term; be proactive in the relationship; and one that understands our situation, as well as big-picture healthcare and its future.

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

Chaudier: We will need to partner with vendors to reduce costs, including finding a balance to offer the highest quality products at the best value, while maintaining choices for physicians. In addition, we will have to partner with physician leaders to maintain a competitive advantage. Sourcing and contracting will have to transform itself with data and technology by analyzing reimbursements, standardization, utilization and quality indicators. The challenge will be to find the best strategy for each product while continuing to provide the best care at the best value and highest quality.
Teresa Dail’s healthcare career began in clinical nursing, followed by a role in clinical practice administration for a private practice group. Her exposure to vendor/physician relationships led to various supply chain positions, including director of supply chain at Vanderbilt University Medical Center upon joining the health system in 2007. Today, as chief supply chain officer, she oversees all areas of operations related to supply chain, including a strong self-contracting model, procurement, GPO oversight, capital acquisition and data base development, and more. She is also responsible for supply chain activities at a 50,000-square-foot off-site case cart operation center, which handles case picks for Vanderbilt’s adult hospital.

Repertoire: What has been the most challenging and rewarding project you have been involved in recently? Teresa Dail: Our most recent project is the Vanderbilt Supply Chain Services (VSCS) program, which will enable us to work with other non-owned hospitals or systems. We currently have nine hospitals in the program and a focused growth plan to add participants. Our goal is multi-faceted. We know that we can bring value to these entities through the self-contracting model that we have in place and our ability to drive compliance. By working on behalf of these organizations, it is our goal to help them improve their margins so that they can continue to provide services within their communities. With the changes occurring today in healthcare, we must find a way to allow these small-to-medium size community hospitals to keep their doors open. We will also work to share best practice and innovative approaches to management of complex supply chain issues. Our goal is to position the supply chain to be a strong, integrated member of the healthcare team in the effort to drive quality and reduce cost.

Repertoire: Please describe a project you look forward to implementing in the next year or two.
Being able to step out of the box that has previously defined the way they traditionally sell or contract with an organization, thinking broader about how we can work together to drive value for each other and being willing to be a risk taker.

Dail: We have a new product and technology program that embraces physician and clinician leadership and engagement that has been in place for six years. While the committees have been very successful in supporting standardization, centralized contracting, cost reductions and new technology assessment/acquisition, we realize that we need to evolve beyond that. Internally, we are working closely with our senior leadership team to understand how the committees, and supply chain in general, can help support the patient care centers as they become more engaged in Episode of Care (bundles) initiatives, focused growth and centers of excellence.

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

Dail: A combination of flexibility and innovation. Being able to step out of the box that has previously defined the way they traditionally sell or contract with an organization, thinking broader about how we can work together to drive value for each other and being willing to be a risk taker.

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

Dail: Outcomes are going to be the center of a health system’s focus, and the level of scrutiny around what drives differences will, I believe, ultimately flush out and negate the need to have two, three or nine suppliers in a given category.
Sense of Urgency

Urgent care centers are catching on, but the question remains: Are they a low-cost alternative to the ER, or a high-cost alternative to the doctor’s office?

Situated somewhere among physicians’ offices, retail clinics, and emergency rooms – in terms of the severity of illnesses treated as well as cost to the patient – urgent care centers are becoming part of the medical neighborhood. Even if, as one Repertoire reader recently reported, some newly opened centers are still quiet, hospital systems, private equity firms, insurers, doctors and private companies are betting that walk-in traffic will grow in the months ahead.
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“Urgent care bridges the gap between the hospital emergency room and the traditional doctor’s office,” says Ian Slinkman, director of marketing and public relations for Patient First, a privately held owner and operator of urgent care clinics, headquartered in Glen Allen, Va. Founded in 1981, the company opened its 54th in Chantilly, Va., in July.

“Many of the conditions routinely treated at hospital emergency rooms can be treated at Patient First for a fraction of the cost and much more quickly,” he says. “If necessary, we will refer patients requiring additional care to specialists or to hospital emergency rooms, as appropriate.

“On the other side of things, we are open extended evening, weekend, and holiday hours—times when a traditional doctor’s office is typically closed …. If a patient wishes us to do so, we will forward a copy of the visit record to his or her primary care physician. We are each important components of the healthcare landscape, working together to provide the best possible care to patients.”

‘Urgent care’ defined
Urgent care centers provide walk-in, extended-hour access to adults and children for non-acute illness and injury care, according to the Urgent Care Association of America. They may also provide other healthcare services, such as sports and school physicals, travel medicine, and occupational medicine. Ideally, patients should visit an urgent care center when their condition is beyond the scope or availability of a primary care provider, but not severe enough to warrant a trip to the emergency room, according to the association. They are typically staffed with physicians, but may also have physician assistants, nurses, nurse practitioners, medical assistants and radiology technicians.

Some of the most common conditions treated are fevers, upper respiratory infections, sprains and strains, lacerations, contusions, and back pain, reports the association. But most centers also treat fractures, can provide IV fluids, and have X-ray and lab capabilities.

“We also see conditions like allergic reactions; cough; ear or sinus pain; eye swelling, irritation, redness or pain; frequent and painful urination; mild to moderate asthma attacks; nausea; vomiting; diarrhea; rashes; and sore throats,” says Slinkman, speaking of Patient First. The company’s centers also treat fractures, provide IV fluids, have on-site labs and X-ray, provide EKGs and dispense prescription drugs as part of a patient’s treatment.

As of 2013, of the 9,000 centers in the United States, roughly 31 percent were corporate-owned; 35 percent were physician-owned; 25 percent were hospital-owned; and 6 percent were either owned by non-physician individuals or part of a franchise, according to the Urgent Care Association of America.

“As a segment of the healthcare landscape, I think urgent care has become more recognized in recent years as a good option as a convenient, cost-effective alternative to overcrowded emergency rooms for non-life-threatening conditions.”

– Ian Slinkman, Patient First
“There is increased interest in urgent care today,” says Tom Charland, CEO, Merchant Medicine, Shoreview, Minn., a strategic planning consulting service focusing on non-acute-care. “But there has been consistent interest and growth since we started covering it in 2007.” The growth has been steadier than that of retail clinics, which has tended to advance in fits and starts, he adds.

Historically, urgent care centers often were independently owned, stand-alone facilities, according to the Center for Studying Health System Change. But that has changed.

Three of the big players today are private equity firms, payers/insurers, and hospital systems, each with its own set of reasons for participating in the market, says Charland.

Private equity
Private equity firms have always had an interest in urgent care, but that interest has heated up in the last couple of years, Charland says. There are a few reasons for this, most notably the changing healthcare scene. “More people are insured, fewer family physicians are taking on new patients, and health systems are at risk now, so it’s no longer in their interest to have people go to their emergency rooms. Now, people are being encouraged to seek healthcare elsewhere by the hospital systems themselves.”

Private equity firms see this as a platform for growth. “They see a market in which, unlike retail clinics, there has been very little consolidation,” says Charland. Whereas five companies dominate the retail clinic market, the top 20 urgent care companies still comprise only a quarter or less of the market. That spells roll-up opportunities for private equity firms, he says.

Insurers
Payers are also interested in the urgent care market for many reasons, says Charland. “First and foremost, going forward, the commercial insurance market is not going to be as profitable as it has been in the past, and insurers are looking for other lines of business,” he says. Secondly, for those clients for whom they assume full risk, insurers would much rather see patients go to an urgent care center than a more expensive hospital emergency department. Some payers, such as UnitedHealth Group, with its Optum division, have begun opening urgent care

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centers of their own. Others have invested in urgent care companies, including WellPoint, which invested in Physicians Immediate Care.

When Blue Cross and Blue Shield of North Carolina announced in September 2012 that it was making an investment in Clayton, N.C.-based FastMed Urgent Care, it noted that ER use had consistently increased over the previous decade, significantly increasing the overall cost of care. Statistics cited included:

- More than 20 percent of ER visits are for non-emergencies.
- A 5-percent shift from ER use to urgent care centers could reduce medical spending by $8 million annually.

Hospital systems

Hospital systems have a growing interest in urgent care as they slowly move away from fee-for-service to population health management, says Charland. “They are approaching large groups – either employers or government groups – and agreeing to keep a given population healthy on a per-member-per-month basis.” Seeing someone in the ER for an ear infection isn’t as attractive as it was in the fee-for-service world.

Hospitals are interested in urgent care centers for a second, closely related reason, he says. “In
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taking on risk, you want as many healthy people in the funnel as you can. What better way to widen the funnel than to have a network of branded urgent care centers in the community?” Episodic illnesses – the kind that tend to draw patients to urgent care centers – occur all the time, and they affect healthy individuals as much as chronically ill ones. “If the center does a good job with people coming in, and it’s convenient, the hospital has a great way to get people into the funnel.”

**Physician’s perspective**

Physician-owned urgent care centers can bring more to patients than others, says Matt Bruckel, M.D., owner, president and CEO of Total Access Urgent Care, which operates five urgent care centers in the St. Louis, Mo., area, and, at press time, was preparing to open a sixth.

Teams at Total Access Urgent Care centers provide multiple medications directly onsite, start IVs for both fluids and medications, perform EKGs, run more than 30 lab tests onsite, suture lacerations, reduce dislocations, splint fractures, drain abscesses and more, the company says. Its Web Check-In service allows patients to enter demographic and insurance information from his or her home, office, or cell phone prior to arriving at the urgent care center.

Being small, independent and physician-owned offers many advantages to Total Access and its patients, says Bruckel. “The most effective eye for improvement of a process is that of the person who does it on a daily basis,” he says. “When you separate the operator from the owner, organizations often find the board room making decisions without a helpful understanding of operational realities. Furthermore, working clinically keeps leadership directly connected to the employees’ needs, challenges and motivations.”

Unlike many hospital-owned urgent care centers, Total Access Urgent Care doesn’t charge a large “facility fee,” that is, a fee for simply visiting the center, on top of which is added the doctor’s fee and other costs.

“We are more aggressive and more advanced and sophisticated than your typical urgent care center,” says Bruckel, a board-certified ER doctor who founded the company in 2008. “The traditional urgent care provides a few more services than a doctor’s office, but typically, a lot less than the ER. We push toward the services the ER provides. We recognize we’re not an ER, but, unless you have to be admitted to the hospital or you need to have surgery today, we can provide the healthcare you need.”

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Unlike many hospital-owned urgent care centers, Total Access Urgent Care doesn’t charge a large “facility fee,” that is, a fee for simply visiting the center, on top of which is added the doctor’s fee and other costs, says Bruckel. Nor is the center motivated to immediately send patients to the ER, as is often the case with hospital-owned urgent-care centers.

**Urgent care stats**

- Approximately 9,000 centers in the United States provide urgent care services.
- An average 357 weekly patient visits per center.
- 85 percent of urgent care centers are open seven days a week.
- 70 percent of centers open at 8 a.m. or earlier; 95 percent close after 7 p.m.

“We provide most of the services of the ER at the cost of a doctor’s office, whereas hospital-owned centers provide the services of a doctor’s office at the cost of the ER,” he says.

Being physician-owned also means taking a longer-term view of the patient’s health than most urgent care centers, Bruckel adds. For example, whereas other centers might refer a particular patient to the hospital, “we may elect to treat them aggressively in urgent care, then bring them back the next day for evaluation. We monitor these patients much more closely than traditional urgent care centers, which tend to be one-offs.”

**Future**

Patient First has been growing steadily since 1981 and expects to continue that gradual expansion, says Slinkman. “As a segment of the healthcare landscape, I think urgent care has become more recognized in recent years as a good option as a convenient, cost-effective alternative to overcrowded emergency rooms for non-life-threatening conditions,” he says. “I suspect that this general increased awareness of the value of urgent care is spurring some of the segment’s recent growth.”

Rather than view other emerging venues of care – particularly, retail clinics and freestanding ERs – as competitors, Patient First is trying to adopt a collaborative approach. “We make it a point to work closely with the existing healthcare delivery sites, including emergency rooms, primary care physicians, specialists, and retail clinics,” says Slinkman. “We keep an open line of communication with primary care providers, hospitals and specialists as part of the same healthcare delivery landscape.

“There are some other facilities that do things similar to what we offer, but you will typically find distinctions. A major distinction is that we offer urgent care as well as primary care to patients without a regular physician. We provide physician-directed medical care on a walk-in basis, while working closely and in a collaborative fashion with the area’s medical community.”

Bruckel believes urgent care centers will continue to fill a valuable niche for the foreseeable future. “The hard truth is, primary care physicians are busy. They’re busy all the time, every day.” As much as they would like to see every patient immediately who calls with a sore arm, they can’t. “So doctors have traditionally told people, ‘Go to the E.R.’ That has always...
For consumers, urgent care centers can be a convenient and affordable alternative to the ER, if the centers hold the line on price.

been the backup, the safety net. But with ER costs ranging from four to six times as much as a visit to the doctor or urgent care center, patients can’t afford to take that advice.” Cost isn’t the only issue, he says. Convenience and efficiency are important too. Add up those factors, and a great urgent care center is often the best option.

One question remains: Are urgent care centers diverting patients away from expensive – and perhaps unnecessary – ER visits, or are they driving patients away from less expensive visits to their primary care physician?

The question must be answered from two perspectives: health policy and consumer experience, says Charland.

From a health policy perspective, the jury is still out, he says. The incentives associated with healthcare reform, and all the market maneuvers to steer people to the right place for their condition, are still being worked out. For consumers, urgent care centers can be a convenient and affordable alternative to the ER, if the centers hold the line on price. “The consumer with a high-deductible health plan will start figuring all this out,” says Charland, referring to such things as urgent care facility fees. “It doesn’t matter if the center is in-network or not, if it’s coming out of your pocket, you will go where the service is good and the price is right.”

The urgent care market has been active for some time. Here are just a few highlights from the past four years.

- **May 2014:** Tenet Healthcare Corp. launched a national brand of urgent care centers called MedPost Urgent Care. At press time, the hospital system had 23 such centers in Arizona, California, Florida, Georgia, Mississippi, Missouri, Tennessee and Texas; and planned to double the number of centers by the end of 2014.

- **November 2013:** After identifying markets nationwide with high emergency room utilization and shortages of primary care physicians, UnitedHealth Group announced plans to open Optum Clinic Urgent Care facilities. The first locations were to open in December 2013, starting with one in Overland Park, Kan., and followed by centers in the Tanglewood and Copperfield communities in Houston, Texas.

- **March 2013:** American Family Care agreed to terms to acquire Doctors Express, said to be the largest franchisor of urgent care clinics in the United States. At the time, American Family Care had 37 clinics in Alabama, Georgia and Tennessee; while Doctors Express had 63 centers in 25 states. In July 2014, American Family Care reported that it operated 126 clinics.

- **September 2012:** Blue Cross Blue Shield of North Carolina made an investment in FastMed Urgent Care to expand its network of physician-owned urgent care clinics across the state. In July 2014, FastMed listed 41 urgent care locations in North Carolina and 35 in Arizona on its website.

- **July 2012:** California-based IDN Dignity Health announced plans to acquire U.S. HealthWorks, said to be the largest independent operator of occupational health and urgent care centers in the United States. Dignity Health said the
acquisition would transform the parent company from local Mercy hospitals into a national healthcare system with 172 centers in 16 states. Dignity added that it planned to expand U.S. HealthWorks operations nationally – and boost surgical and imaging services via partnerships with United Surgical Partners International and SimonMed Imaging. As of July 2014, U.S. HealthWorks operated 218 locations in 19 states. Of those, 37 were work sites, that is, clinics located inside major employers (hence, not available for urgent care). Urgent care services were available at the remaining 181 locations.

- **July 2012:** LLR Partners, a middle market private equity firm with more than $1.4 billion under management, and WellPoint announced a growth capital investment in Physicians Immediate Care LLC, which provided management services to 20 independently owned medical clinics in Illinois, Nebraska, and Oklahoma operated under the trade name “Physicians Immediate Care.” These clinics offered urgent care, occupational medicine, physical therapy and employer services such as physicals and drug screening. As of July 2014, Physicians Immediate Care operated 31 urgent care centers in three states – Illinois, Indiana and Nebraska.

- **November 2010:** Humana Inc. announced it signed a definitive agreement to purchase Addison, Texas-based Concentra Inc., for approximately $790 million in cash. At the time, Concentra delivered occupational medicine, urgent care, physical therapy and wellness services to workers and the general public from more than 300 medical centers in 42 states.

- **September 2010:** Sequoia Capital acquired a stake in MedExpress Urgent Care, which operated 47 clinics in four states. As of July 2014, MedExpress listed 135 clinics on its website.
What role can urgent care and other ambulatory care facilities play in the patient-centered medical home movement?

The National Committee for Quality Assurance (NCQA) – an independent healthcare quality oversight organization, which has developed standards and criteria for patient-centered medical homes – was at press time soliciting the public’s input on proposed standards for a program that would evaluate ambulatory care providers on their ability to provide patient-centered care and to become part of “virtual patient-centered neighborhoods” with medical homes. Eligible entities would include telemedicine providers, worksite clinics, urgent care clinics and retail clinics.

A medical home is a model of primary care that combines teamwork, care coordination and information technology to improve care, improve patients’ experience of care and reduce costs, according to NCQA.

The new NCQA recognition program, tentatively named “Patient-Centered Connected Care,” would evaluate and encourage the application of patient-centered principles, such as engaging patients and families in decision-making, promoting self-care, providing culturally and linguistically appropriate care and committing to continuous quality improvement.

“As the use of telemedicine and ambulatory care clinics providing convenient, episodic care grows, so does the need to assimilate them into the ‘medical home neighborhood’ and to ensure that information about care they deliver is shared with the medical home,” Patricia Barrett, NCQA vice president of product development, was quoted as saying.

Connecting with primary care. Connecting patients to primary care providers and sharing information about the care they receive at ambulatory care clinics is critical to reducing fragmented care and improving outcomes and overall patient experience, says NCQA. Care patients receive in an ambulatory care setting presents an opportunity to connect patients to medical homes and to communicate the importance of follow-up with primary care practitioners (for patients who have them). It is imperative to share pertinent information with patients’ primary care practitioners following a visit to form a complete picture of the care their patients receive and empower practitioners to make effective decisions based on a whole-person perspective.

Triage and referral. Ensuring patients receive care in the appropriate setting is important to effective care delivery, says NCQA. An established triage and referral process in the ambulatory care setting can optimize continuity of care across the healthcare delivery system. For conditions falling outside an ambulatory care provider’s defined scope of services or expertise, patients are...
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integrated qualitative and quantitative performance data paint a comprehensive picture of an ambulatory care provider’s performance.

to develop treatment and follow-up plans that reflect patient preferences and educational needs.

**Test tracking.** Monitoring the status of laboratory and imaging tests facilitates the appropriate follow-up process for the ambulatory care provider, says NCQA. Tracking test results minimizes the chance for duplicate testing, and providing timely test results to patients and primary care practitioners is essential to initiating proper treatment.

**System capabilities.** Integrating technological system capabilities into clinical processes can improve the quality and standardization of care delivery, says NCQA. Clinical data can be used to understand a patient’s condition and guide follow-up care. Documenting patient information and clinical data in a structured electronic health record (EHR) provides timely and relevant data in a form usable for quality improvement. Electronic prescribing connects care providers and guides the decision-making process for appropriate care management.

**Measure and improve performance.** Measuring performance is the first step to identifying quality improvement opportunities, according to NCQA. Integrated qualitative and quantitative performance data paint a comprehensive picture of an ambulatory care provider’s performance. The ambulatory care provider uses the collected data to set realistic goals for quality improvement and implements operational and clinical processes to achieve the goals.

NCQA is a private, non-profit organization that accredits and certifies a wide range of healthcare organizations. It also recognizes clinicians and practices in key areas of performance. NCQA’s Healthcare Effectiveness Data and Information Set (HEDIS®) is the most widely used performance measurement tool in healthcare, according to the organization.

To learn more about NCQA’s Patient-Centered Connected Care program, go to www.ncqa.org/HomePage/NCQPUBLICCOMMENTS/PatientCenteredConnectedCarePublicComment.aspx
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The Urgent Care Association of America (UCAOA) launched an accreditation and certification program for the urgent care industry this spring. The UCAOA represents urgent care centers and the multi-disciplinary individuals working with and for the urgent care industry.

“The urgent care industry is experiencing explosive growth and strong demand from consumers who want convenient, affordable and quality healthcare,” Dr. Nate Newman, president of the UCAOA board of directors, was quoted as saying. “There is tremendous merit in evaluating the industry and striving for higher quality and standards of care.”

Under the new accreditation program, centers will be required to meet or exceed UCAOA standards around key operational and clinical care matters including:

- Governance
- Human resources
- Patient care processes
- Quality improvement
- Physical environment
- Health record management
- Patient privacy/rights and responsibilities
- Scope of care

These areas will be measured through onsite tours administered by an independent third party with experience working in urgent care; interviews with patients and staff; and other qualitative and quantitative assessments, according to UCAOA.

Urgent care centers provide walk-in, extended-hour access for non-acute illness and injury care that is either beyond the scope or the availability of the typical primary care practice or clinic, says UCAOA. On average, an urgent care center receives 357 patient visits per week, which translates to more than 3 million patients per week or 160 million patients annually nationwide.

Among the most common conditions treated in urgent care centers are fevers, upper respiratory infections, sprains and strains, lacerations, contusions and back pain. Most centers also treat fractures and provide intravenous fluids, as well as offer onsite X-ray and lab services. Urgent care centers do not care for life (or limb) threatening situations, but will stabilize patients in need of emergency transport.

The majority of urgent care centers employ family practice and emergency physicians, as well as non-physician practitioners, including registered nurses, X-ray technicians, physician assistants and nurse practitioners.

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Needlestick Safety in the Physician Office

Many physicians’ offices lag behind hospitals, but therein lies the sales opportunity

Sales reps know that change is in store – some of it good, some maybe not so good – when the local hospital system acquires one of their physician practice customers. Increased sales of safety-engineered sharps – that is, safety needles and syringes, phlebotomy devices, sutures, etc. – may very well be one of those changes.

The law clearly states that physicians offices – even solo practitioners – should have evaluated and switched to safety sharps a long time ago. But sometimes it takes the watchful – and cautious – eye of hospital administrators and infection prevention professionals to jolt freestanding offices into action.

U.S. healthcare workers sustain an estimated 600,000 percutaneous injuries involving contaminated sharps per year, says Gina Pugliese, RN, MS, FSHEA, vice president of Premier Safety Institute, citing statistics from the Centers for Disease Control and Prevention. Of them, 400,000 are among hospital workers, meaning 200,000 occur outside the hospital, including physician offices, clinics, home care settings, etc. “And this number is probably low, since under-reporting is a continuing problem,” she says.

Blood Pathogens Standard

Physician offices are required to use safety devices whenever possible. OSHA’s Bloodborne Pathogens Standard, including its 2001 revisions, applies to all employers who have employees with occupational exposure, i.e., reasonably anticipated skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials. Even solo practitioners are required to have in place an Exposure Control Plan, that is, a written program outlining the protective measures the employer will take to eliminate or minimize employee exposure to blood and other potentially infectious material.

What’s more, the law states that employees must be involved in decisions about which safety products to use. Front-line, clinical workers are specifically named in the OSHA regulations, points out Pugliese. These regulations read, “An employer…shall solicit input from non-managerial employees responsible for direct patient care … in the identification, evaluation, and selection of effective engineering and work practice controls.” [1910.1030, paragraph (C)(1)(ii)]

But in fact, the Occupational Safety and Health Administration has focused its attention on larger healthcare facilities, says Pugliese. “This enforcement strategy has encouraged hospitals to switch to safety-engineered devices.” Now OSHA is beginning to look more closely at office practices and outpatient clinics. And with good reason.

“The key question is not, ‘Who is using what?’ but rather, ‘Is the risk different enough to warrant not using safety-engineered devices in physician offices?’” she says. The risk is
the same with any given procedure, regardless of where it is performed. “For example, the risk from a needlestick incurred during phlebotomy is the same, regardless of whether it is performed in a hospital or in an office.”

**Impact of hospital acquisition**

Though it is difficult to quantify the impact that hospital acquisition of physician practices has had – or will have – on the implementation of safety-engineered devices, “certainly large healthcare organizations would be looking at affiliated practices to assess whether they meet the requirements of OSHA, The Joint Commission and local health departments,” says Pugliese.

“The issue is, nobody has ever regulated the physician’s office,” says Kim Strelczyk, RN, MSN, ACNS-BC, CIC, consultant, Specialists in Infection Prevention & Control LLC. “But good practices know that the OSHA Bloodborne Pathogens Standard applies to any employer who has employees who use sharps and may be exposed to blood and other potentially infectious fluid,” says Strelczyk, who gave a presentation at this summer’s APIC 2014 Annual Conference in Anaheim, Calif, titled “The Changing Infection Prevention Program – It’s Not Just for Hospitals: Expanding your Program to Include Hospital-Owned Clinics.”

“The really good ones assign someone in their office to make sure they comply with the Standard, and they have an annual education event,” she says. “But in other practices, it’s a situation where nobody ever told them [about the Standard], or it went right over their head. It’s not until the hospital buys the practice that they find out.” At that point, it becomes the responsibility of the hospitals’ infection prevention team to bring the practices up to speed.

Strelczyk recalls consulting one hospital system some time after it had acquired 36 clinics. It was clear that it had been years – if ever – since an infection prevention professional had set foot inside the offices, she says. At that time, there wasn’t a blueprint to show hospital systems how to bring newly acquired practices into compliance with the Bloodborne Pathogens Standard. Strelczyk found such a blueprint in the CDC document “Guide to Infection Prevention in Outpatient Settings: Minimum Expectations for Safe Care” (http://www.cdc.gov/hai/pdfs/guidelines/ambulatory-care-04-2011.pdf).

**Converting the practice**

Step 1 is getting into the clinic(s) and “doing a quick and dirty assessment” to determine how bad – or good – the practice is from an infection control perspective, says Strelczyk. “From there, you figure out what resources you’ll need to make changes.”

There are procedures for which the caregiver team cannot use a safety-engineered device. “But by and large, 99 percent of what we do can be done with safety devices,” she says. “There are dozens and dozens of brands, and they all work a little differently; they have a little bit different mechanism to deploy the safety device. So we have to trial them and see what works best for the staff.”

However, for some physicians, old habits die hard. “As hard as we try, we still find people who have a stash of their favorite needles and syringes in a locker,” she says. Some IDNs have addressed the situation by insisting that a department or outpatient center purchase non-safety-engineered devices only with approval from the infection prevention department.

“But we continue to have outbreaks of hepatitis B and C as a result of poor infection control and safety practices,” she says. “It’s unbelievable.”

In the case of the hospital system that had acquired 36 clinics, Strelczyk and her team assembled the office managers from each of the clinics and went through the basics of infection prevention. “We had pictures I had taken in some of the clinics, and offered tips of what to do and what not to do,” she says. The office managers then shared that information with their staffs.

“It’s not rocket science,” she says, referring to the topics covered with the managers. “We were talking about basic safety, cleanliness and simple things, such as, ‘What do you do when you have a coughing patient in the waiting room?’” (Answer: Give them a mask and get them into an exam room, away from other patients.) Many practices fail to monitor their sterilizers properly, she adds. “Practices almost always have a tabletop sterilizer, and they almost never do the monitoring correctly.”

It’s not uncommon for the hospital system’s infection prevention team to meet some resistance from the staff of newly acquired physician practices, continues Strelczyk.

“Often, the people [in the practices] have been there a long time, they’ve done things a certain way, and now, some new person comes in and asks, ‘Why are you doing that?’”

**Selling safety devices**

Some practices believe their patients are “low risk” for diseases such as HIV, HBV and HCV, says Pugliese. “This is simply not true. Since no one can tell by appearance who is infected, all blood must be treated as potentially infectious. Recent reports of dramatic increases in HCV among the ‘Boomer’ generation, the increased treatment of HIV in community settings, and the proliferation of body tattoos make universal precautions more important than ever in the office practice.”
Sample survey to measure healthcare personnel’s perceptions of a culture of safety

The following suggested survey is designed to assess how well the provider is doing in promoting safety.

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<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree or Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
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<tr>
<td>1. The safety of workers is a priority in this healthcare organization.</td>
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<td>2. Safety issues are an ongoing agenda item for discussion during staff meetings.</td>
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<td>3. The organization encourages and rewards the recognition and reporting of errors and hazardous conditions.</td>
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<td>4. Personal accountability for safety is assessed during annual performance evaluations.</td>
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<td>5. Hazardous problems are quickly corrected once they are brought to management’s attention.</td>
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<td>6. Sharps containers are available where and when I need them to dispose of needles and other sharp devices.</td>
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<td>7. Employees and management work together to ensure the safest possible healthcare environment for patients and personnel.</td>
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<td>8. Safety training is part of staff development orientations and programs.</td>
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<td>9. The organization provides devices to prevent needlestick injuries.</td>
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<td>10. I would not fear being criticized or reprimanded for reporting a sharps injury that I sustained.</td>
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Resources for your customers

There’s no shortage of resources for your customers to consult when implementing a sharps-prevention program. Here are just a few.


- “Model Plans and Programs for the OSHA Bloodborne Pathogens and Hazard Communications Standards,” Occupational Health and Safety Administration (www.osha.gov/Publications/osh3186.html). These model documents can be used as templates for a provider’s workplace exposure control plan and hazard communication program.


Some practices may object to the marginally higher cost of safety-engineered devices. That said, “OSHA does not accept cost as a solitary criteria for device selection,” says Pugliese. The law states, “Selecting a safer device based solely on the lowest cost is not appropriate. Selection must be based on employee feedback and device effectiveness.”

Sharps containers

Safety devices include sharps containers. Data from 2000-2006 shows that 36 percent of injuries occurred during the use of the sharp, and 16 percent occurred after use prior to disposal, says Pugliese, citing data from the US EPINet Sharps Injury and Blood and Body Fluid Exposure Surveillance Research Group of the International Healthcare Worker Safety Center of the University of Virginia. That means that as many as 48 percent of injuries occurred during or after disposal.

“It is essential that disposal boxes be located at the point of use,” says Pugliese. “[The National Institute for Occupational Safety and Health (NIOSH) of the CDC] has developed specific descriptions for disposal boxes that can be used in the selection and placement of these tools.”

Sales reps who meet resistance to safety-engineered devices based on purchase price should point out that in a recent study, the baseline cost of a needlestick was estimated between $400 and $6,000, not including follow-up testing, visits by the infectious disease physician, medications, etc. “This cost, in addition to time lost and emotional trauma, should be considered in the overall economic analysis of the cost for safer devices,” says Pugliese.

“Using – not just buying and storing – safety-engineered devices and having an established plan to involve front-line employees in the selection process will surely be an asset for any practice. These steps may also affect worker compensation rates for the practice and will, in the long run, make economic sense.”
Key steps in the product evaluation process

The Centers for Disease Control and Prevention suggests that healthcare providers adopt an 11-step approach to the evaluation of safety-engineered devices:

Step 1: Organize a product selection and evaluation team.
Step 2: Set priorities for product consideration.
Step 3: Gather information on use of the conventional device.
Step 4: Determine selection criteria.
Step 5: Obtain information on available products.
Step 6: Obtain samples of devices under consideration.
Step 7: Develop a product evaluation form.
Step 8: Develop and implement a product evaluation plan.
Step 9: Tabulate and analyze the evaluation results.
Step 10: Select and implement the preferred product.
Step 11: Perform post-implementation monitoring.

**Bloodborne Pathogens Standard: A primer**

**Q: What is the Bloodborne Pathogens Standard?**  
**A:** OSHA’s Bloodborne Pathogens Standard (29 CFR 1910.1030) as amended pursuant to the Needlestick Safety and Prevention Act of 2000, prescribes safeguards to protect workers against the health hazards caused by bloodborne pathogens. Its requirements address items such as exposure control plans, universal precautions, engineering and work practice controls, personal protective equipment, housekeeping, laboratories, hepatitis B vaccination, post-exposure follow-up, hazard communication and training, and recordkeeping. The Standard places requirements on employers whose workers can be reasonably anticipated to contact blood or other potentially infectious materials (OPIM), such as unfixed human tissues and certain body fluids.

**Q: What is the Needlestick Safety and Prevention Act?**  
**A:** The Needlestick Safety and Prevention Act (Pub. L. 106-430) was signed into law on Nov. 6, 2000. Because occupational exposure to bloodborne pathogens from accidental sharps injuries in healthcare and other occupational settings continues to be a serious problem, Congress required modification of OSHA’s Bloodborne Pathogens Standard to set forth in greater detail OSHA’s requirement for employers to identify, evaluate and implement safer medical devices such as needleless systems and sharps with engineered sharps protections. The Act also mandated additional requirements for maintaining a sharps injury log and for the involvement of non-managerial healthcare workers in identifying, evaluating and choosing effective engineering and work practice controls. These are workers who are responsible for direct patient care and be potentially exposed to injuries from contaminated sharps.

**Q: How does the standard affect states that operate their own federally approved occupational safety and health programs?**  
**A:** States and territories that operate their own OSHA-approved state programs are required to adopt a Bloodborne Pathogens Standard that is at least as effective as the federal OSHA Standard.

**Q: To whom does the Bloodborne Pathogens Standard and the Needlestick Safety and Prevention Act apply?**  
**A:** OSHA’s Bloodborne Pathogens Standard, including its 2001 revisions, applies to all employers who have an employee(s) with occupational exposure (i.e., reasonably anticipated skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials that may result from the performance of the employee’s duties). These employers must implement the requirements set forth in the standard.

**Q: What does the standard say about the use of safer medical devices?**  
**A:** The standard states that “engineering and work practice controls shall be used to eliminate or minimize employee exposure.” The 2001 revision defines engineering controls as “controls (e.g., sharps disposal containers, self-sheathing needles, safer medical devices, such as sharps with engineered sharps injury protections and needleless systems) that isolate or remove the bloodborne pathogens hazard from the workplace.” Employers who have employees exposed to contaminated sharps must consider and implement appropriate commercially available and effective safer medical devices designed to eliminate or minimize occupational exposure. Also, employees with occupational exposure must be trained in the use and limitations of methods that will prevent or reduce...
exposure, including appropriate engineering controls, work practices and personal protective equipment. Therefore, training must include instruction on any new techniques and practices associated with new engineering controls.

**Q: How many non-managerial employees must be included in the process of choosing safer medical devices?**

**A:** Small medical offices may want to seek input from all occupationally exposed employees when making their decisions. Larger facilities are not required to request input from all exposed employees; however, the employees selected should represent the range of exposure situations encountered in the workplace (e.g., pediatrics, emergency department, etc.). Regardless of the number chosen, in order to be included in the process, the workers must be responsible for direct patient care and be potentially exposed to injuries from contaminated sharps. The solicitation of employees who have been involved in the input and evaluation process must be documented in the Exposure Control Plan.

**Q: Does OSHA have a list of available safer medical devices?**

**A:** No. OSHA does not approve or endorse any product. It is the employer’s responsibility to identify and implement appropriate, commercially available and effective safer medical devices for the specific medical procedures being conducted.

**Q: Does the revised Bloodborne Pathogens Standard apply to medical or dental offices that have fewer than 10 employees?**

**A:** OSHA’s Bloodborne Pathogens Standard applies to all employers with employees who have occupational exposure to blood or other potentially infectious materials, regardless of how many workers are employed. However, the offices and clinics of medical doctors and dentists are exempt from the requirement to keep a log of occupational injuries and illnesses and thus exempt from maintaining a sharps injury log. (See Appendix A to Subpart B of 29 CFR Part 1904.) All other applicable provisions of the Bloodborne Pathogens Standard still apply.

**Q: Are employers responsible for providing sharps containers for employees who are diabetic and need insulin shots in a non-healthcare related facility?**

**A:** The employer would not be required to provide a sharps container to an employee using insulin syringes for personal therapeutic reasons. To eliminate potential exposures to other workers, however, the employer could require that the employee provide his or her own workplace sharps container.

**Q: What does OSHA currently accept as appropriate disinfectants to prevent the spread of HIV and HBV?**

**A:** EPA-registered tuberculocidal disinfectants, diluted bleach solutions and EPA-registered disinfectants that are labeled as effective against both HIV and HBV, as well as Sterilants/High-Level Disinfectants cleared by the FDA, meet the requirement in the standard and are “appropriate” disinfectants to clean contaminated surfaces, provided that such surfaces have not become contaminated with agent(s) or volumes of or concentrations of agent(s) for which higher level disinfection is recommended. It is important to emphasize the EPA-approved label section titled “SPECIAL INSTRUCTIONS FOR CLEANING AND DECONTAMINATION AGAINST HIV-1 AND HBV OF SURFACES\OBJECTS SOILED WITH BLOOD\BODY FLUIDS.”

**Source:** https://www.osha.gov/SLTC/bloodbornepathogens/bloodborne_quickref.html

For more information, visit OSHA’s “Bloodborne Pathogens and Needlestick Prevention” web page, https://www.osha.gov/SLTC/bloodbornepathogens/index.html
On Dec. 6, 1991, the Occupational Safety and Health Administration (OSHA) promulgated the Bloodborne Pathogens Standard, designed to protect workers from the risk of exposure to bloodborne pathogens, such as the Human Immunodeficiency Virus (HIV) and the Hepatitis B Virus (HBV). The Standard, which was revised by the Needlestick Safety and Prevention Act of 2000, calls for employers to have an exposure control plan in place outlining the protective measures the employer will take to eliminate or minimize employee exposure to blood and other potentially infectious material. Following are portions of a Q&A regarding exposure control plans from the OSHA website.

Q: What is an exposure control plan?
A: The exposure control plan is the employer’s written program that outlines the protective measures an employer will take to eliminate or minimize employee exposure to blood and OPIM [other potentially infectious material]. The plan must contain, at a minimum:

• The exposure determination, which identifies job classifications with occupational exposure and tasks and procedures where there is occupational exposure and that are performed by employees in job classifications in which some employees have occupational exposure.
• The procedures for evaluating the circumstances surrounding exposure incidents.
• A schedule of how other provisions of the standard are implemented, including: methods of compliance, hepatitis B vaccination and post-exposure evaluation and follow-up, communication of hazards to employees, and recordkeeping. Methods of compliance include: Universal Precautions; engineering and work practice controls, e.g., safer medical devices, sharps disposal containers, hand hygiene; personal protective equipment; and housekeeping, including decontamination procedures and removal of regulated waste.
• Documentation that on an annual basis, the provider considered and implemented commercially available and effective safer medical devices, and solicited input from non-managerial healthcare workers (who are responsible for direct patient care and are potentially exposed to injuries from contaminated sharps) about the identification, evaluation, and selection of effective engineering and work practice controls.

Q: In the exposure control plan, are employers required to list specific tasks that place the employee at risk for all job classifications?
A: No. If all the employees within a specific job classification perform duties where occupational exposure occurs, then a list of specific tasks and procedures is not required for that job classification. However, the job classification (e.g., “nurse”) must be listed in the plan’s exposure determination, and all employees within the job classification must be included under the requirements of the standard.

Q: Can tasks and procedures be grouped for certain job classifications?
A: Yes. Tasks and procedures that are closely related may be grouped. In other words, they must share a common activity, such as “vascular access procedure” or “handling of contaminated sharps.”

Q: Does the exposure control plan need to be a separate document?
A: No. The exposure control plan may be part of another document, such as the facility’s health and safety manual, as long as all components are included.

Q: How often must the exposure control plan be reviewed?
A: The Standard requires an annual review. In addition, whenever changes in tasks, procedures, or employee positions affect or create new occupational exposure, the existing plan must be reviewed and updated.
Q: Must the exposure control plan be accessible to employees?
A: Yes, the exposure control plan must be accessible to employees, as well as to OSHA and NIOSH representatives. The location of the plan may be adapted to the circumstances of a particular workplace, provided that employees can access a copy at the workplace during the workshift. If the plan is maintained solely on computer, employees must be trained to operate the computer. A hard copy of the exposure control plan must be provided within 15 working days of the employee’s request.

Q: What should be included in the evaluation of an exposure incident?
A: Following an exposure incident, employers are required to document, at a minimum, the route(s) of exposure, and the circumstances under which the exposure incident occurred. To be useful, the documentation must contain sufficient detail about the incident. There should be information about the following:

- The engineering controls in use at the time, and work practices followed.
- Description of the device in use.
- The protective equipment or clothing used at the time of the exposure incident.
- Location of the incident and procedures being performed when the incident occurred.
- Employee’s training.
- The source individual, unless the employer can establish that identification is infeasible or prohibited by state or local law.

The employer should evaluate the policies and “failures of controls” at the time of the exposure incident to determine actions that could prevent future incidents.

For other OSHA-provided questions and answers regarding the Bloodborne Pathogens Standard, go to www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=INTERPRETATIONS&p_id=21010&p_text_version=FALSE
Long-term care

The share of older people residing in skilled nursing facilities declined from 4.5 percent in 2000 to 3.1 percent in 2010, while the share of those in other long-term care facilities, such as assisted living, has been growing. These are among the facts presented by the U.S. Census Bureau in its recently released report, “65+ in the United States: 2010.”

The facts from the report bear out conventional wisdom: America is getting older. In 2011, the Baby Boom generation – people born from 1946 to 1964 – began to turn age 65. As this cohort ages, the United States will experience rapid growth in both the number aged 65 and older and their share of the total population. The social and economic implications of the aging of the U.S. population will be of significant interest to policy makers, the private sector, and individuals, and will have an impact on long-term care.

Following are some of the report’s key findings related to long-term care.

- According to the 2010 Census, 3.1 percent of the older population resided in skilled nursing facilities, down from 4.5 percent in 2000.
- The share of the older population residing in nursing facilities rises progressively among older age groups, from 0.9 percent for the population aged 65 to 74, to 3.2 percent for those aged 75 to 84, and to 11.2 percent for those aged 85 and over. In addition to those residing in skilled nursing facilities, another 2.4 percent of older people resided in senior housing facilities that offered one or more special support services.
- While the share living in nursing homes is down, the share in other care settings, such as assisted living facilities, has been growing. Among Medicare enrollees residing in a long-term care facility, the proportion living in an assisted living facility increased from 15 percent in 1992 to nearly 25 percent in 1998, as based on the Medicare Current Beneficiary Survey.
- There were 31,100 residential care facilities, such as assisted living facilities and personal care homes, with 971,900 beds nationwide, according to data from the 2010 National Survey of Residential Care Facilities. The vast majority (91 percent) of residents in these residential care facilities were non-Hispanic white, and 70 percent were female. More than half (54 percent) of the residents were aged 85 and over, and more than a quarter (27 percent) were 75 to 84 years old, while 9 percent were aged 65 to 74, and 11 percent were under age 65.

The cost and funding of long-term care

- Medicaid funds for long-term care have been shifting away from nursing homes, with funding for home- and community-based services increasing from 13 percent of total funding in 1990 to 43 percent in 2007.
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¹ First quarter 2014 data, total dollar volume and share of producted distributor unit sales of Coagulation Reagents/Kits, POC (91994) by GHX Market Intelligence Data. Data on file at Roche Diagnostics.
² CoaguChek XS PT Test package insert, 2013.
⁴ GHX Market Intelligence. Data on file at Roche Diagnostics.
In 2010, Alzheimer’s disease was the fifth leading cause of death among the older population, up from seventh position in 2000. In contrast to declining mortality from most other causes of death, the death rate for Alzheimer’s rose more than 50 percent from 1999 to 2007.

- The cost of long-term care varies by care setting. The average cost of a private room in a nursing home was $229 per day, or $83,585 annually, in 2010. Average assisted living rates were $3,293 per month or $39,516 annually. For in-home care, rates averaged $21 per hour for home health aides and $19 per hour for homemakers. Adult day care centers cost on average $67 a day. However, the average cost varies widely across states. Increases in the costs of these options have also varied. For instance, from 2005 to 2011, the cost of nursing home care and assisted living facilities rose by 4.4 percent annually, compared with just 1.4 percent annually for home health aides.
- Less than one-fifth of older people have enough personal resources to live in a nursing home for more than three years, and almost two-thirds cannot afford even one year. Out-of-pocket expenses accounted for only 28 percent of total long-term-care spending in 2006.
- The largest share (43 percent) of long-term-care expenditures was covered by Medicaid. This is more than Medicare (18 percent) and private long-term-care insurance and Medigap combined (7 percent). Medicare provides skilled nursing home coverage to aged and disabled patients for only short time periods after hospitalization.
- Residential care facilities, in general, provide care to a more affluent population. Assisted living facilities largely have residents who self-pay. In 2010, Medicaid, which is available to low-income individuals, paid for at least some services for 19 percent of residents in residential care facilities, with Medicaid services more common for younger residents than for older residents. Other researchers found that assisted living facilities are more often located in areas where there is higher educational attainment, higher income, and greater housing wealth.

Home and community-based care

The distribution of Medicaid funds has been shifting towards home- and community-based services. Such options for long-term care are increasingly popular, in part because of people’s desire to remain in their own homes. It has been reported that almost 90 percent of adults aged 50 and over want to stay in their own home as long as possible. In addition, health insurance providers are increasingly funding non-institutional care options, which are cheaper than institutional care. Medicaid can provide home- and community-based services to three people for the same cost as one patient in a nursing home. Funding for home- and community-based services increased from 13 percent of total funding in 1990 to 43 percent in 2007. The growth of such options may help to explain the decline in the proportion of older people who reside in nursing homes.
In 2010, 40.3 million people were aged 65 and older, 12 times the number in 1900.

The percentage of the population aged 65 and over among the total population increased from 4.1 percent in 1900 to 13 percent in 2010, and is projected to reach 20.9 percent by 2050.

From 2010 onwards, the older dependency ratio is expected to rise sharply as the Baby Boomers enter the older ages. In 2030, when all Baby Boomers will have already passed age 65, the older dependency ratio is expected to be 37, which translates into fewer than three people of working age (20 to 64) to support every older person.

In 2010, Alzheimer's disease was the fifth leading cause of death among the older population, up from seventh position in 2000. In contrast to declining mortality from most other causes of death, the death rate for Alzheimer's rose more than 50 percent from 1999 to 2007.

More than 38 percent of those aged 65 and over had one or more disabilities in 2010, with the most common difficulties being walking, climbing stairs, and doing errands alone.

States with the highest proportions of older people in their populations in 2010 were Florida, West Virginia, Maine, and Pennsylvania (all above 15 percent).

The West and South regions experienced the fastest growth in their 65-plus and 85-plus populations between 2000 and 2010.

Changing marital trends, such as the rise of divorces, as well as the increase in living alone among the 65-and-over population, will likely alter the social support needs of aging Baby Boomers.

Only 27 percent of respondents indicated that they have or plan to formally integrate by merging with another physician-owned practice or by selling practice ownership to a hospital or health system.

The Medical Group Management Association conducted its seventh annual “Medical Practice Today: What Members Have to Say” survey between Jan. 2 and Jan. 24. The association invited members via email to participate in a web-based questionnaire in which they rated 28 issues and identified which challenges were most applicable to and intense in their daily work.

“It’s not surprising that medical practices are exploring ways to accommodate patients and combat mounting administrative pressures – and are looking beyond the walls of their organization to do so,” Susan L. Turney, MD, MS, FACP, FACMPE, president and chief executive officer of MGMA, was quoted as saying.

According to 542 respondents, the most applicable and intense challenges of running a group practice include preparing for the transition to ICD-10 diagnosis coding, dealing with rising operating costs, and preparing for reimbursement models that place a greater share of financial risk on the practice. Respondents also cited “engaging patients to improve outcomes” and “leveraging new technologies to enhance patient communications through patient portals, emails, websites and video conferencing” as highly applicable in running a medical practice.

“Medical practice executives and clinicians are teaming to design mechanisms to engage with patients to improve outcomes,” said Turney. “It’s encouraging to see that medical practices are being proactive in this changing environment and leveraging new technologies to respond to patient needs and expectations.”

**Physician compensation**

Meanwhile, another MGMA survey shows that quality measures continue to be a small yet increasing percentage of total compensation for physicians. According to the MGMA “Physician Compensation and Production Survey: 2014 Report Based on 2013 Data,” primary care physicians (who indicated that they were not part of an accountable care organization or a patient-centered medical home) reported that an average of 5.96 percent of their total compensation was based upon measures of quality. Specialists reported that an average of 5.7 percent of their total compensation was based upon quality metrics. Some specialists, including anesthesiologists, internists and hospitalists, reported that a higher percentage of their total compensation was tied to quality metrics.

Practices also reported that patient satisfaction played a small role in physician compensation. Primary care physicians reported a slight increase in the percentage of compensation tied to patient satisfaction, and specialists reported that an average of 2.31 percent of their compensation was tied to patient satisfaction, compared to 1.61 percent reported in 2012.
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One cardiologist has demonstrated that taking an average of six readings during a patient visit can lead to more accurate results and appropriate treatment.

Early this summer, Robert Smith, MD, a practicing cardiologist at Saint Francis Hospital and Medical Center in Hartford, Conn., and an associate professor of medicine at the University of Connecticut School of Medicine in Farmington, released the results of his study designed to compare single in-office automated blood pressure readings to the average of multiple automated blood pressure readings.

Readings were collected on 187 adult patients using a Welch Allyn Connex® Vital Signs Monitor (Model 6300) with Office Profile and automatic base-lining technology enabled. Smith’s analysis showed that blood pressure diagnosis varies over a range of consecutive readings, suggesting that it can be important to calculate an average blood pressure in order to obtain the most accurate representation of the true blood pressure in the doctor’s office.

“The purpose of this study was to compare single in-office blood pressure readings to average in-office blood pressure readings and observe the differences in accuracy and potential variation in diagnoses between the two methodologies,” he said. “An inaccurate diagnosis of high blood pressure could lead to the overprescribing of blood pressure-lowering medications, which may result in adverse events associated with hypotension, which is the last thing we want
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Reclassified patients

To mimic the true office experience, Smith and his staff started the first blood pressure measurements at varied times after patients entered the exam room one to three minutes into the test. Five subsequent measurements were taken at intervals of one minute, and the monitor automatically calculated a recommended average that included up to six of these measurements.

Results showed that with averaged readings, half of the patients previously classified as hypertensive using the single reading methodology were reclassified into pre- and normotensive categories. More than half of the patients that would have required the physician to provide hypertensive care did not display the medical need with an averaged reading.

Smith described another interesting finding of his study: In general, it is recommended that the first blood pressure reading in the office visit be eliminated, the assumption being that that will be the highest, he said. “When we evaluated these 187 people, we found that 41 percent of the time, their first reading was the highest; but with many, their second, third, fourth or even last reading was higher. This emphasized, in my practice, that using averaging as a means of evaluating people has a lot of merit.”

Patients were pleased with the procedure, Smith said in response to a question from Repertoire. “They are engaged and interested in the results. And when I see them, a lot of uncertainty is eliminated. You can either reassure someone that they are normal, or that they are not normal and should take medication. If they already are on medication, you get an indication whether it’s working effectively or not.

“Time is a concern for everyone in a busy office,” he said. “But in our practice, [taking six readings] didn’t slow me down at all. If anything, it gave me useful information, so that when I walked into the exam room, we were pointed in the right direction, because we were dealing with accurate numbers.”

Based on the findings of the study, Smith’s practice has adopted the averaging technique as standard routine. “It has improved the overall quality of care. At this point, if we tried to go back, we would be unhappy, and our patients would be unhappy.”

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<th>Reading #</th>
<th>Frequency of Reading Being the Highest in a Set of 6</th>
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<td>1</td>
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*Source: Welch Allyn*
As the market continues to shift from hospital settings (traditionally, hospitals have claimed 70 percent of the market) to ambulatory care – including urgent care centers, clinics and other off-site offices – today, as much as half of one’s customer base may include stand-alone facilities. Particularly as more health systems seek a consistent look across multiple sites – and often across multiple states – distributors working with reputable manufacturer partners can guarantee the high level of quality assurance their customers require, including regulatory consistency and cabinet construction designed to ensure the facility meets LEED certification and sustainability requirements.

Efficient use of space
Distributor sales reps can help their customers make better use of their space when they fully understand office workflow and how that space will be used, note experts. This includes planning for growth (e.g., installing modular cabinet configurations, which help accommodate expansion) or changing needs, such as new lighting solutions. Sometimes only 15 to 20 patients come through a particular space, and the facility might not require full cabinets so much as cabinets that are easily stocked and accessible to caregivers. Many organizations are utilizing lean methodologies, which means casework is stocked with only the items needed for the day. The items in the casework are easily stocked and accessible, and the facility avoids having to dispose of expired items.

In many cases, carts offer a value-added means of transporting products to patients, thereby eliminating wasted steps from the casework to the patient, and back. Even the smallest detail, such as the placement of drawer and cabinet locks, can impact office efficiency. For instance, when locks are placed higher up (just under the countertop), it means less bending and better ergonomics for physicians, nurses and other caregivers. In addition,
When helping their accounts select the best cabinet solutions, sales reps should keep in mind that the cabinets themselves are not LEED certified. Furthermore, many customers today are looking at LEED alternatives. Either way, cabinets can have a positive—or negative—influence on a facility’s LEED (or LEED alternative) certification.

Some important points to consider with regard to LEED and LEED alternative certification are:

- **Product sustainability.** Cabinets constructed of recycled materials and organic materials carry a higher rating for certification.
- **Modular vs. permanent construction.** Whereas modular cabinets can be expanded, permanent cabinets can only be removed by ripping them from the wall. In the process, they become damaged and parts often must be thrown out, contributing to environmental waste. (As a plus, modular cabinets may depreciate similarly to capital equipment, whereas cabinets affixed to the wall are considered part of the building structure.)

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Less expensive—and lower-end—cabinets (or components of the cabinets), which might be designed for general office use rather than healthcare settings, may need to be replaced soon after they are installed.

Some cabinet drawers include single-piece units that can be popped out for cleaning.) Wooden drawers and shelves must be designed to withstand cleaning and disinfection between patients, or else the wood might peel (also known as delamination).

Countertops present similar considerations: Laminate may be inexpensive, but it has seams, which can be a source of infection control issues. For this reason, seamless, solid surface counters are becoming increasingly attractive.

**Working with customers**

Cabinets are but one piece of the office setup process. Sales reps should talk to their accounts about how their new cabinets will fit in with the overall office design—including exam tables, lighting, chairs and other equipment. And while customers may be trying to achieve a certain look, at the end of the day, it’s important to balance function with aesthetics. If cabinets detract from workflow or storage needs, or if they lead to infection control issues, they are not providing a value for customers. When sales reps fully understand their accounts’ needs and goals, they can provide the right solutions.

**Editor’s note:** Repertoire would like to thank Midmark Corp. for its assistance with this piece.
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Mononucleosis (mono) most commonly affects adolescents and young adults. Young children generally have few symptoms, and older adults often are immune to the disease. Although mono isn’t as contagious as some infections, including the common cold, it can be transmitted through saliva (hence, one of its nicknames, the kissing disease), as well as through a cough or sneeze, or by sharing a glass, utensils or a toothbrush with an infected person, according to Mayo Clinic.

Mono is caused by the Epstein-Barr virus (EBV) and may lead to the following symptoms:
- Fatigue
- General feeling of being unwell
- Sore throat, or a strep throat that doesn’t respond to antibiotic treatment
- Fever
- Swollen lymph nodes in one’s neck or armpits
- Swollen tonsils
- Headache
- Skin rash
- Soft, swollen spleen

Usually, mono isn’t serious and can be addressed with rest and a healthy diet. However, sometimes complications of the disease can become quite serious. Mono can cause enlargement of the spleen, according to Mayo, and in severe cases the spleen may rupture. It can also lead to hepatitis (mild liver inflammation) and jaundice (yellowing of the skin and whites of the eyes). Complications that are less common include:
- Anemia
- Thrombocytopenia. (Low count of platelets, which aid in clotting)
- Heart problems

Traditionally, physicians have relied on a couple of testing methods to diagnose mononucleosis, according to WebMD.com:
- **Monospot test** (heterophil test). A quick screening blood test detects the heterophil antibody, which forms during certain infections. The presence of heterophil – and blood clumping on the test slide – often indicates mono infection. The test generally detects antibodies between two and nine weeks after a person is infected. Other infectious diseases, such as cytomegalovirus, leukemia or lymphoma, rubella, hepatitis or lupus, which have symptoms similar to those of mono, can result in a negative monospot test.
- **EBV antibody test.** If the monospot test result is negative, but mono symptoms are present, an EBV blood test can be done to check for antibodies to EBV. Testing within the first few weeks of becoming infected with EBV can lead to a false-negative result.

If the monospot test result is negative, but mono symptoms are present, an EBV blood test can be done to check for antibodies to EBV.
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September is National Childhood Obesity Awareness Month – an opportunity for reps to ensure their accounts are equipped with the best solutions for tracking patients’ weight and BMI.

Obesity among low-income preschoolers has decreased in many states. Still, childhood obesity continues to be a health problem, according to the Centers for Disease Control and Prevention. Approximately 17 percent (or 12.5 million) of U.S. children and adolescents between two and 19 years of age fall into this category, and overweight or obese preschoolers are more likely than normal weight children to be overweight or obese adults. Good nutrition and a healthy amount of exercise is key to addressing childhood obesity. So are regular preventive health checkups.
Distributor sales reps can provide value to their physician customers this month by reminding them of this opportunity to discuss healthy lifestyles with their younger patients and their parents, as well as ensuring their accounts are aware of the most up-to-date solutions for monitoring weight and body mass index (BMI). For starters, they should help their customers select scales that will continue to meet their needs in years to come.

When selling scales, there is much more to consider than patient weight. The technology physicians acquire today could impact the decisions they make tomorrow. Particularly as the country moves closer to “meaningful use” of electronic medical record systems, physicians should think about adding scale solutions that enable them to connect the scale to the office electronic medical record.

Digital vs. mechanical
As more physicians automate their practices, digital scales are becoming increasingly important for a couple of reasons. First, some doctors feel digital scales can do more than their mechanical predecessors, and do it more accurately, with the capacity to enhance office efficiency and workflow. Additionally, scales that are connected to EMR systems can transmit such information.

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Distributor reps should ask their physician customers some pointed questions to gauge their need for new scales, including the following:

- “What are the primary types of patients you see? Do you see many wheelchair-bound patients?”
- “Has your patient base changed within the last few years? Do you work with different age and weight requirements and therefore require different scales?”
- “How often do you use your office scales? How long do you expect them to last before replacing them?”
- “In addition to basic weigh-ins, do you need to analyze your patients’ body composition?”
- “Do you plan to implement EMR in the next six to 18 months? If so, perhaps you should consider purchasing a digital scale rather than a mechanical unit.”
- “How old are your current scales? Are they accurate?”

Scale sales

healthy reps

as time, date, patient ID, height, weight and body mass index (BMI). Digital height rods, which enable the scale to automatically calculate BMI, also are becoming popular. All of this information is then stored in the patient’s electronic chart. Eliminating any manual input reduces the possibility of transcription errors. This is especially important when recording weight, as doctors use weight to formulate the proper dosage of medications. Incorrectly inputting a patient’s weight can lead to over- or under-dosing of medication, as well as incorrectly diagnosing someone as obese or underweight.

Second, federal regulations are pushing physicians to digital scales. Physicians caring for Medicare patients can collect as much as $44,000 over five years provided they are meaningful users of an electronic health record, per the Health Information Technology for Economic and Clinical Health Act (nicknamed the HITECH Act) of 2009, which was part of the American Recovery and Reinvestment Act, otherwise known as the “stimulus act.” Those who fail to do so will start to experience cuts to their Medicare reimbursement beginning in 2015. (Medicaid providers stand to collect as much as $63,750 over six years if they are meaningful users of EHRs.) As such, physicians and hospitals will be required to incorporate information on their patients’ body mass index (BMI) in their EMR/EHR systems, making it essential to have a digital scale with these capabilities.

That said, some physicians still prefer traditional mechanical scales, because they are not affected by power surges or faulty batteries, and they rarely require service. In fact, many mechanical scales sold in the 1960s continue to be used in practices today. Nevertheless, compared to mechanical scales, digital scales have no moving parts to troubleshoot or mechanically re-calibrate. Repairs usually are done at a modular level, and calibration is accomplished through the scale software. And, digital scales are becoming more affordable. Typically, they retail for $499 to $850, compared with $250 to $450 for mechanical scales. And while it’s true that digital scales need to be replaced every seven to 10 years, given how rapidly the technology changes, some physicians prefer to replace them even sooner.

The more information physicians have, the better the decision they can make. Scales are no exception. Sales reps help their customers navigate the various options at their disposal and make the selection that best serves their practice.

As such, physicians and hospitals will be required to incorporate information on their patients’ body mass index (BMI) in their EMR/EHR systems, making it essential to have a digital scale with these capabilities.

Lifelong health risks

About one in eight preschoolers in the United States is obese, according to the Centers for Disease Control and Prevention (CDC), and overweight preschoolers are five times as likely to be overweight or obese in adulthood, leading to lifelong physical and mental health problems. Even at a young age, obesity can take a harmful toll on one’s body, notes the CDC. Obese children are more likely to have:

- High blood pressure and high cholesterol, which are risk factors for cardiovascular disease.
- Increased risk of impaired glucose tolerance, insulin resistance and type 2 diabetes.
- Breathing problems, such as sleep apnea and asthma.
- Joint problems and musculoskeletal discomfort.
- Fatty liver disease, gallstones and gastroesophageal reflux.
- Increased risk of social and psychological problems, such as discrimination and poor self-esteem, which can continue into adulthood.

For more information visit www.cdc.gov/obesity/childhood/basics.html.

Editor’s note: Repertoire would like to acknowledge the assistance of Health o meter Professional Scales.
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Windshield time

Chances are you spend a lot of time in your car. Here’s some automotive-related news that might help you appreciate your home-away-from-home a little more.

Hit the road, Jack
Planning a late summer vacation? Farmers Insurance offers the following travel tips:

- **Check belts, brakes and fluids.** Before leaving your garage or driveway, be sure to check all the belts and brakes for wear and tear, as well as the fluids. Belts control the air conditioning compressor, power steering pump, alternator and water pump. The brakes are one of the most essential safety mechanisms on the vehicle. Grinding, pulling, brake dust and squeaking are just a few signs that the brakes and brake pads may need to be checked or replaced. It is also important to check a vehicle’s fluids, including coolant, oil and washer fluid.

- **Share the driving.** One person shouldn’t assume this responsibility.

- **Avoid potholes.** Leaving a bit more space between one’s car and the one ahead will help avoid uncomfortable hops and bounces, while keeping oneself and one’s passengers safe. When drivers hit a significantly large pothole, they should check their vehicle’s alignment, as it can negatively affect steering and suspension.

- **In case of a roadside emergency,** pull over safely. Drivers should use their hazard lights, flares and other roadside indicators to alert other drivers they may need assistance. Lifting the hood of your car, whether there’s trouble with your engine or not, helps gain attention from fellow motorists or roadside assistance technicians. Important items to have in the car include a first aid kit, fire extinguisher, extra water and food, and a properly inflated spare tire.

Market price
Did you overpay for your car? TruCar Inc., a negotiation-free car buying platform, estimates that the average transaction price for light vehicles in the United States was $30,575 in June 2014, down $245 (-0.8 percent) from June 2013 and down $689 (-2.2 percent) from May 2014. The company provides the following comparisons:

### Average Transaction Price

<table>
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<tr>
<td>Nissan (Nissan, Infiniti)</td>
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<td>$25,475</td>
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<tr>
<td>Toyota (Lexus, Scion, Toyota)</td>
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<td>$29,491</td>
<td>$29,632</td>
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<tr>
<td>Volkswagen (Audi, Porsche, Volkswagen)</td>
<td>$34,754</td>
<td>$36,020</td>
<td>$39,828</td>
<td>-3.5%</td>
<td>-12.7%</td>
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<tr>
<td>Industry</td>
<td>$30,575</td>
<td>$30,820</td>
<td>$31,264</td>
<td>-0.8%</td>
<td>-2.2%</td>
</tr>
</tbody>
</table>
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Quick Bytes

**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.

**Who’s (really) calling?**
The moral is, be nice to your customers and colleagues — or don’t bother calling them. CIAmedia has upgraded the Android version of its Caller Identification App with a range of new features. The app, which detects incoming calls and searches 1.3 billion personal and business listings as the phone rings to display the caller identity, now includes Reputation Check. Bundled as part of the premium feature set, Reputation Check allows users to see how friends, family, peers and others saved them within their contact lists. For privacy protection, the source of the contact list is never disclosed. The labeling of the same phone number in different contact lists can vary greatly, from the real name to flattering nicknames to entries with a negative connotation. Once the self-serve Reputation Check is complete, users can then manage their reputation, remove negative or inaccurate entries and present themselves and their contact details as they wish. Editing ‘My Profile’ in the app makes it easy for users to directly control their digital identity and the CallerID name that appears when they make a call. Users also have the option to set their number to private.

**Leave a message**
Cooliris recently launched BeamIt, a mobile app and service that combines private messaging with a photo experience. The app is designed to help users seeking greater privacy and control for their communication and media, without sacrificing quality. Today, photos are a mainstream communication tool, with 1.8 billion photos being shared daily, according to the 2014 KPCB Internet Trends. Yet, today’s sharing functionality in messaging apps has not necessarily kept pace. Photos are treated as isolated attachments rather than being part of a coherent story. BeamIt is designed to seamlessly integrate photos and text, enabling users to share hundreds at once, all in full resolution, without interrupting the flow of the conversation. The app also enables users to simultaneously and privately share separate groups or people at the same time, saving the sender the pain of having to separately compose the same message multiple times. Finally, an “unsend” feature permits the sender to delete his or her content from the entire group. BeamIt features offline support for composing and curating, so users can interact with their groups, as well as share the media without incurring data usage costs or roaming charges.

**Smartwatch**
AT&T has added the LG G Watch to its portfolio of accessories. The smartwatch reportedly works on any smartphone with Android 4.3 or higher, allowing users to receive notifications and other information at a glance. Other features include:

- Answers to spoken questions.
- 1.65-inch Always-on display.

**The eyes have it**
LusoVU has introduced EyeSpeak, designed to let users talk with their eyes. The system is based on Epson’s BT200 smart glasses, on which a micro-camera, microphone and speaker are integrated. These, in turn, are controlled by a microprocessor unit, which will monitor the user’s eyes position. To reduce latency, the eye tracking algorithms are embedded on the systems’ firmware. With the augmented keyboard shown in the user’s field of view, and the eye tracking routines, users can write words or sentences and have them spoken by a synthetic voice through the systems speaker. This device was designed specifically for people who have disabilities affecting their communication and motor abilities, such as amyotrophic lateral sclerosis, muscular dystrophy, locked-in syndrome, spinal cord injuries, tetraplegia and some cases of traumatic brain injuries.

**Pocket PC**
The Tango PC fits in one’s pocket. Not only that, it is said to be a formidable office as well as entertainment machine with mid-core gaming performance on traditional Windows. The device is reportedly slim and weighs under 7 ounces. The operating system, Windows 7/8, is certified to run on Tango, but any OS compatible with a laptop PC reportedly will work, including Linux, Unix and Chromium OS. The device costs $99, features multiple functions, including IPTV boxes and older gaming consoles. That means once device to carry — and afford.
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Finding his Range

He always loved music. But it took Labsco sales rep Brian Rojik a while to discover his talents.

By Laura Thill

Music has been a staple for Brian Rojik for as long as he can recall. “Growing up, there was always music in the house,” he says. “My mom was a music major and my dad was a huge music fan.” Yet, he himself never took any music lessons, admits the LABSCO sales rep. But, it so happened his roommate in college did take music lessons when he was young and was “a phenomenal guitar player.” When the two hung out, Rojik often found himself singing along to the alternative rock songs his roommate played and was surprised to discover he had a pretty good voice.
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repcorner: Brian Rojik

Still, his studies kept him busy – he was a bio, pre-med major – and after graduating he became interested in laboratory product development. Chemical equations – not musical notes – filled his mind. Rojik settled into a Boston, Mass., apartment and assumed his direction was set.

In part, it was. But, as luck would have it, his complex was swarming with young musicians. “One evening, I brought them my friend’s guitar, hoping it could be tuned.” His musician neighbors saw more than just a guy with a guitar. Before the evening was through, they convinced him to audition as a singer with local bands. “I landed a job singing with a band and played with them for a year, until I moved to the South Shore,” he says. On the side, he taught himself the basics of guitar, which he grew to enjoy.

Unique voices
It wasn’t until Rojik turned 28 that he was approached by a group of friends looking to start Elbow Room, a Boston-area cover band often seen at weddings and other functions. In fact, they looked to him not only as the lead singer, but a guitarist as well. Was he ready to play guitar on stage? “I thought I was,” he laughs. “The band has had a lot of changes since the beginning.”

Today, the five-member group plays material from the 1970s and 1980s, and covers “anything from the Beatles to Justin Timberlake,” he says. “We play at about 10 regular venues.

A few years after Elbow Room took off, Rojik was at a club performing solo on the acoustic guitar, when he caught the attention of another guitarist. The guitarist approached him about helping launch a local band called Harbor Buoys. “I had wanted to play more acoustic material,” he says. “But, having five performers in Elbow Room always called for a lot of compromise.”

Harbor Buoys would only have three members, and fewer personalities in the mix meant a bit more opportunity to try new things. The band performs at only half as many venues as Elbow Room, but it features a more contemporary lineup, which can provide a nice change of pace, Rojik says. Rojik plays no favorites when it comes to his bands. Two bands, two experiences, he says. “On Facebook, Elbow Room has about 2,700 fans and Harbor Buoys has about 600,” he says. “It’s very rare we are not asked to return to a venue.” That’s in spite of not having time during the week to rehearse, he adds. “During the week, it’s about family and work,” he says. “On weekends, we have soccer games and basketball.”

Then, around 8 p.m. on Saturday night, he typically heads to a club for a 9 p.m. performance.

The show must go on
For the most part, the gigs run pretty smoothly. But, there are the occasional challenges. At a performance this summer, 30 seconds into Harbor Buoys’ opening song, the band’s expensive P.A. system failed. “We were playing at the British Beer Company,” Rojik recalls. “We had about 200 people staring at us, waiting!” Fortunately, the previous evening, he had played a gig with Elbow Room and had some backup equipment still sitting in his car. And, while the manufacturer, Bose, replaced its broken equipment, “that didn’t help that evening,” he says. And, as the lead singer, he had to maintain a calm, confident and positive disposition, he adds. “All eyes are on the lead singer. I can’t look unhappy.”

Then there are the personality conflicts, which are bound to arise from time to time in any tight-knit group. “Balancing different personalities can be challenging,” says Rojik. People have “bad nights,” he points out, and the worst thing a band can do is to leave things hanging. Whether someone is playing off key, too loud or is off tune, when the band’s sound is off, it’s important to pick an appropriate time to address it, he explains. “We need to over-communicate with one another” – a skill he finds he is particularly in touch with given his sales background and his experience building relationships with his customers.

Both Elbow Room and The Harbor Buoys are more like family than colleagues. “It’s a nice network and we support each other,” says Rojik. The Boston area as a whole has a tight music community, he says. “Last week, another local band lost a band member [to cancer], and the other musicians in the area have come out to show their support. This is more than simply about playing together in a band on weekends.”
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RPS appoints Peter Grady as new CFO

Rapid Pathogen Screening, Inc. (RPS) announced that Peter Grady has joined the company as Chief Financial Officer. Grady has more than 20 years of financial management experience across a variety of manufacturing companies with worldwide operations. Prior to joining RPS, he was the finance leader of Becton Dickinson’s Biosciences business unit.

Cardinal Health announces board leadership changes

John F. Finn, a Cardinal Health director since 1994, informed the company that he will not stand for re-election when his term expires at the 2014 annual meeting of shareholders. The board appointed Gregory B. Kenny as lead director and chair of the nominating and governance committee, effective November 1, 2014. Kenny has served as a director since 2007 and will succeed Finn, lead director since 2009 and chair of the nominating and governance committee since 2012. Additionally, Clayton M. Jones has assumed the role of chair of the audit committee and David P. King will become chair of the human resources and compensation committee, effective November 1, 2014.

MDSI announces fall 2014 Market Insights Supply Chain Forum

MDSI announced that it will host the Market Insights Supply Chain Forum (formerly called the Healthcare Supplier/Provider Institute Meeting) on October 6-7, 2014. The meeting will take place at the Renaissance SouthPark in Charlotte, North Carolina and focus on trends within the healthcare contracting arena. Attendees will hear from a diverse group of IDN executives about the challenges and issues they experience in today’s environment and how suppliers can work with each of the organizations more effectively. The meeting will also include a look into value analysis from a provider’s perspective, and the impact regional purchasing coalitions have on healthcare contracting. Following the Forum, an optional Purchased Services Summit will be held on October 8, 2014. For more information and to register, visit www.jhconline.com/market-insights-fall-2014.html.

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