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MICHIGAN PA

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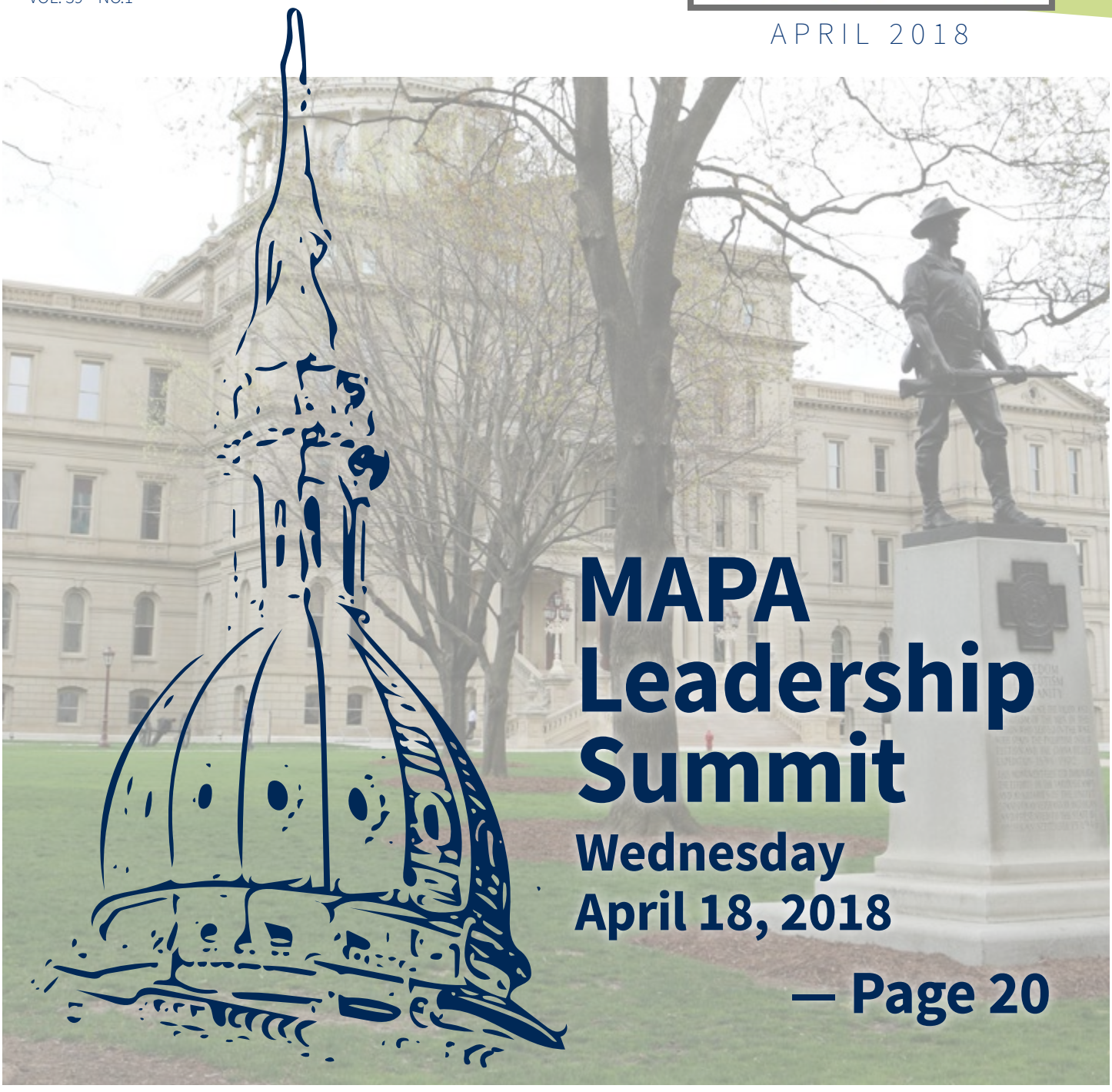

MAPA Leadership Summit

Wednesday April 18, 2018

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MICHIGAN PA

YOUR VOICE.
YOUR PROFESSION.

MICHIGAN ACADEMY of PHYSICIAN ASSISTANTS

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Your Newsletter Editor's Corner

Dear MAPA members,

As I sit to write this message to you, the birds are chirping outside my kitchen window which reminds me that spring is finally right around the corner! As John mentioned in his President's Message, our Spring Conference in Novi is coming up soon and I hope you will consider joining us. Additionally, it is time for board elections, so please see the Call for Candidates message in this newsletter. I promise that becoming involved in MAPA will be worth your time and energy!

This quarter, we are focusing on Influenza, immunizations, peripheral artery disease (PAD) and documentation. Unfortunately, we have had a severe flu season across the country but hopefully it will end very soon and - fingers crossed - no more deaths. Considering this, we wanted to provide you with an influenza update as well as a great article covering influenza in pregnancy.

Other topics in this newsletter:

- A very thorough review of common and very important immunizations for adults and children.
- Everyone loves documenting, RIGHT?? Therefore, we have added some best practice documentation tips.
- A mental health legislative update and
- Some great news from AAPA regarding PAs and hospice care.

I want to thank all those who contributed to this edition of the MichiganPA Newsletter and I hope you enjoy reading it and learn something valuable from it! As always, please consider sharing your thoughts or opinions, a brief case report, essay or article for any of our newsletters. Just email me at kate.schisler@michiganpa.org or contact MAPA to get in touch with me.

Sincerely,

Kate Schisler, MSM, PA-C, MichiganPA Newsletter Editor-In-Chief,
MAPA Region 3 Representative

President's Message

Greetings fellow PAs,

The year 2018 has brought with it a swing in temperatures as well as an abundance of snow to Michigan. We started the year with more great progress for Michigan PAs. MAPA has continued to update our members regarding Blue Cross Blue Shield of Michigan credentialing changes for PAs. On February 1, PAs were credentialed with BCBS - and for the first time - with Blue Care Network, including their Medicare Advantage plans.

Our legislative committee continues to work diligently to pass legislation to include PAs in the Michigan Mental Health Code. At the national level, the president signed a law which allows PAs to be reimbursed when managing and providing hospice care to Medicare patients. I wish to thank our AAPA advocacy team and the representatives for getting this legislation passed!

Progress does not come by accident and we are very fortunate in Michigan to have the best PA practice laws in the nation! This work, like the recently passed PA 379, cannot be done without our political action committee, PAMPAC. Did you know that your MAPA member dues do not fund PAMPAC? It is a separate entity and therefore relies completely on donations. PAMPAC supports Michigan Legislators who support PAs. Without their hard work, we certainly would not be in the same position as we are in today. Please take time and donate to PAMPAC so we can continue to lead the nation in PA practice.

I also want to thank all the dedicated PAs serving on state medical boards, in practice leadership, on our academy boards and more who passionately contribute to advance our profession day after day. MAPA provides a conduit where ideas can be shared and translated into regulatory changes and progress through new laws. I encourage you to talk to your PA colleagues and make sure they are a MAPA member!

In February, I was honored to be the first PA to attend the Healthcare Leadership Academy sponsored by MSU, the Michigan Health & Hospital Association (MHA) and the Michigan Osteopathic Association (MOA). I will use this experience and apply this invaluable insight and training to better serve our profession and promote PA leadership in the state. I encourage anyone interested in healthcare leadership to attend this event next year.

Join Michigan's PA Leaders for the MAPA Leadership Summit in Lansing on Wednesday, April 18.

This event is open to all PAs, includes two CME credits and is provided **FREE** for all MAPA members. This Summit will be held **IN** the Capitol Building! We will hear from PA practice owners sharing their strategies. A representative from LARA will talk about the new opioid laws. We will also hear from several key legislators. Wrapping up the day will be a PAMPAC reception and finally a MAPA social-reception. Register here.

The MAPA Spring Conference is on **Saturday, May 5** at the Suburban Collection Showplace in Novi. Thank you to our CME Chair Karen Byers for planning a great day packed with eight CME credits. Registration is now open on the MAPA website.

Are you going to AAPA in New Orleans? Join MAPA and Michigan PA's for a reception at the conference center Saturday, May 19 from 5:30-7pm.

Save the date for the MAPA Fall Conference, October 4-7 in Traverse City.

Thank you for your support!

John R. Young, PA-C
MAPA President

MAPA Mission

The Michigan Academy of Physician Assistants is the essential resource for the PA profession in Michigan and the primary advocate for PAs in the state.

MAPA Vision

The Michigan Academy of Physician Assistants is committed to providing quality, cost-effective and accessible health care through the promotion of professional growth and enhancement of the PA practice environment.

MAPA Values

- PAs are advocates of accessible and compassionate health care
- PAs promote improved health in our communities through a team-based approach
- PAs have a commitment to lifelong personal and professional learning
- PAs adhere to the AAPA Code of Ethical Conduct
- Promote the acceptance and utilization of PAs
- Instill the values of accountability and transparency in the work environment
- Promote excellence and equity in the delivery of cost effective quality health care
- Foster mutual support and inclusion of all PAs

THERE'S A VACCINE FOR THAT...

Understanding the Adult Immunization Schedule for Primary Care Medicine

R. David Doan III, MS, PA-C, CPAAPA; Kaely Schlosser, BS, PA-Student

Dave is seeing Monty, a 32-year-old man, for a physical today. Monty describes his health as "pretty good" and he only deals with intermittent asthma. Monty further explains that he usually has one or two asthma flares per year, and they are usually associated with an upper respiratory infection. He doesn't smoke, and he has received a flu shot every year for as long as he can remember; including this year. He had a flare up of his asthma last month with an associated cold and has since recovered. He inquires about a pneumonia shot. Can he have one? If so, which one?

Kaely, a PA student rotating with Dave this month, is in the next room seeing Hazel, a 66-year-old patient, for medication refills. Hazel takes Lisinopril for hypertension and Atorvastatin for her mixed hyperlipidemia and is doing well with no complaints today; however, she does have some concern about contracting shingles. A friend of hers who lives in Arizona recently suffered a great deal of pain from shingles. She doesn't want to have a similar experience and inquires about getting a shingles vaccine.

Knowing what shot to give for adults can seem easy with some vaccines, while others can be confusing. Inquiries on some vaccinations (influenza, pneumonia, shingles) occur frequently in the primary care setting, while others are often forgotten. Unlike in pediatric settings, adult patient visits often overlook immunizations designed for adults. Tens of thousands of adult Americans suffer serious health problems, are hospitalized, or die from preventable diseases every year1. Vaccines are available for many of these such as pneumococcal disease, influenza, shingles, hepatitis A, hepatitis B-related chronic liver disease & liver cancer, HPV-related cancers, pertussis, tetanus and more. Despite the available vaccines for these devastating diseases, vaccination rates among adults are low. As an example here in Michigan, only 30.6% of adults younger than 65 years old who are at high risk for complications from pneumococcal disease are vaccinated.

MAPA has been working with the Michigan Department of Health and Human Services (MDHHS) to help spread the word on adult vaccinations to assist Physician Assistants in Michigan in implementing strategies to make adult immunizations a standard of routine patient care in their practice. In an article titled "Protecting Adults: Are You meeting the Standards for Adult Immunization Practice?" in the September 2016 issue of MichiganPA, the author suggested implementing the following:

1. Assess immunization status of all your patients at every clinic encounter;
2. Strongly recommend vaccines that patients need;
3. Administer needed vaccines or refer your patients to a provider who can immunize them;
4. Document vaccines received by your patients.

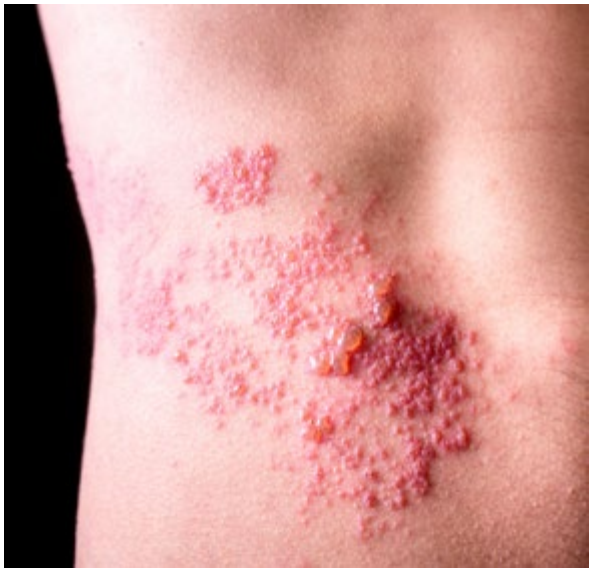
These steps are a great approach to vaccinating adults who could be overlooked in most situations. What remains unclear for some providers may be knowing what vaccine to give to whom.

The Centers for Disease Control and Prevention (CDC) has provided us with a guideline on adult immunizations with numerous recommendations. The guidelines are reviewed regularly. In February 2018, *the Recommended Immunization Schedule for Adults Aged 19 Years or Older, United States, 2018* became effective, as recommended by the Advisory Committee on Immunization Practices (ACIP) and approved by the CDC. The CDC also has a webpage for providers listing the guideline and other tools that may be useful! Check it out at: https://www.cdc.gov/vaccines/schedules/hcp/adult.html.

There are several vaccinations recommended for adults, some more commonly encountered than others. Below are some recommendations on some commonly inquired about vaccines for adults in a primary care setting.

Shingles

The Varicella-Zoster Virus (VZV) is an alpha herpesvirus which results in several clinical manifestations including both the chickenpox and shingles. Varicella (chickenpox) is the primary infection, typically occurring in childhood. Others will be exposed via vaccination as the CDC recommends that children are vaccinated for this starting at 12 months of age. Once exposed to the VZV, by infection or vaccination, it remains dormant until reactivated as Herpes Zoster (shingles). The elderly and immunosuppressed are at most risk for developing shingles and are therefore recommended to get vaccinated. Current vaccinations available for Herpes Zoster include Zostavax (live vaccine) and Shingrix (recombinant vaccine).



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VACCINES *continued*

Zostavax has been licensed by the FDA since 2006 and is available to patients age 60 and older. This is a live attenuated virus vaccine which reduces the risk of developing shingles by 51% and post herpetic neuralgia (PHN) by 67%. This is administered as one single shot. The CDC recommends Zostavax once for patients age 60 and older, but it is contraindicated for use with pregnant or severely immunocompromised patients.

Shingrix, the recombinant vaccine, is the newest and preferred vaccine against shingles. It is available for patients age 50 and older. Two doses of this vaccine reduces the risk of developing shingles and PHN by over 90%. This vaccine is a two shot series, separated by two to six months. Shingrix protects above 85% for at least the first four years after being vaccinated. Recommendations are that the vaccine be given in two doses 2-6 months apart (regardless of past episode of Herpes Zoster or Zostavax administration; should be at least two months after Zostavax was given if patient had Zostavax previously).

Pneumococcal

There are two available vaccines: the 13-valent pneumococcal conjugate vaccine (PCV13) and the 23-valent pneumococcal polysaccharide vaccine (PPSV23). All immunocompetent adults over the age of 65 are recommended to get a pneumococcal vaccine. If the patient hadn't had one previously, the first shot should be the PCV13 followed by the PPSV23 at least one year after the PCV13 shot. What if the patient already had the PPSV23 and not the PCV13? In this case, give a PCV13 at least one year after the previously received PPSV23. When both shots are indicated, you should try to give the PCV13 first, then at least one year later, give the PPSV23. Don't give at the same visit.

What about adults age 19-64? There are some populations where a pneumococcal vaccine is recommended and include patients with the following chronic conditions: chronic heart disease (not hypertension), chronic lung disease (asthma included), chronic liver disease, alcoholism, diabetes mellitus, cigarette smoking. These patients should get one dose of PPSV23; then, when over the age of 65, give one dose of PCV13 (be sure there is at least one year between shots) and another PPSV23 a year after the PCV13 (and at least 5 years after the initial PPSV23). There are other recommendations for special populations (i.e. immunodeficiency disorders, HIV infections, anatomical or functional asplenia and chronic renal failure & nephrotic syndrome). See recommendations here: https://www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule-bw.pdf)

Tetanus

The CDC recommends that all adults be vaccinated against tetanus. There are two types of vaccines available to adults; Tdap (tetanus, diphtheria, and pertussis) and Td (tetanus and diphtheria toxoids). The CDC recommends adults have at least one dose of Tdap followed by a Td booster every ten years.

The CDC recommends that all pregnant women should get at least one dose of Tdap, preferably in the early part of gestational weeks 27-36.

Influenza

Yearly influenza vaccinations are recommended for all ages. The CDC recommends a single dose of an age-appropriate inactivated influenza vaccine (IIV) or a recombinant influenza vaccine (RIV) yearly. For the 2017-2018 influenza season, the live attenuated influenza vaccine (LAIV) is NOT RECOMMENDED. The shot is for EVERYONE! That includes pregnant women

and adults with hive-only egg allergy. For patients with an egg allergy other than hives, the vaccine is STILL RECOMMENDED; only under supervision of a health care provider in a medical setting.

Meningitis

The CDC recommends that all children age 16-23 (preferred 16-18) get the Meningitis serogroup B vaccine. They could have had Bexsero or Trumenba. Patients who are at increased risk for meningitis include those who are asplenic, microbiologists, military recruits, college residents, travelers, or who are among an area with an outbreak. These patients should also receive either Menactra or Menveo. If there is still a high risk with patients who received the Menveo or Menactra, revaccination is needed every 5 years. These vaccines are only available until age 55. For those older than age 55, they should receive the vaccine MPSV4, a quadrivalent meningococcal polysaccharide vaccine. For more information on special populations, see the recommendations here: https://www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule-bw.pdf

Hepatitis B

The CDC recommends vaccination against Hepatitis B for those at risk and those who simply want protection. Populations who are at risk include those who are sexually active, work in a healthcare setting, who use injectable drugs, are on dialysis, have HIV, or chronic liver disease.

The vaccination is a three dose series; with at least four weeks between dose one and two, at least eight weeks between dose two and three. There should be at least 16 weeks between dose one and three. If there is an extended interval between doses, the series does not have to be started again. It is also not harmful if an extra dose of the vaccine is given if documentation of the vaccine series is unavailable. Booster vaccinations are only recommended in certain populations including hemodialysis and immunocompromised patients.

The latest approved Hepatitis B vaccine was approved in 2017 and is called Heplisav-B. This is the first two-dose series for Hepatitis B and injections should be given at least one month apart.

continued

VACCINES *continued*

Human papillomavirus

The human papillomavirus (HPV) vaccine is recommended in females through age 26 and in

males through age 21; although, a male can receive the vaccine through 26 based on individual clinic decision. How many doses are needed? This depends on the patient's age at the initial HPV vaccination.

If no previous dose was given, give the three-dose series. The second shot should be given one-two months after the first and the last shot six months after the first shot. If you give a shot too soon, you must repeat the shot. See the recommendations (https://www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule-bw.pdf) for the accelerated/minimal interval time frame.

If the patient was age 9-14 when the series initiated, and the patient received one or two doses less than five months apart, give one dose.

If the patient was age 9-14 when the series initiated, and the patient received two doses at least five months apart, no additional dose is needed.

Immunocompromised (including HIV) patients should get the HPV vaccine through age 26 as a three shot series as noted above. Men who have sex with men through age 26 should receive the HPV vaccine as above based on age of initial administration. They need the three-shot series if not previously given. What about pregnant women? It is NOT RECOMMENDED, but there is no evidence that it is harmful. What is recommended is that you delay the remaining doses until after pregnancy through age 26. You do not need to test for pregnancy before giving the shot.

Others:

The CDC also recommends adults be vaccinated against measles, mumps & rubella (MMR), varicella, hepatitis A, and haemophilus influenzae type b (Hib). We recommend assessing the status of patients at all visits to be sure the patient is up-to-date on the vaccinations detailed above as well as those that were not detailed. Please refer to the recommendations found here https://www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule-bw.pdf for details on special populations.

In the hallway outside each patient's room, Dave and Kaely discuss each case and the topic of immunizations comes up. With Monty, his immunization status was assessed and he is up-to-date on immunizations, but due to his asthmatic status, he is eligible for a pneumonia shot today. After consulting the latest recommendations, they decide to administer the PPSV23 vaccine today. When he turns 65, he will then get the PCV13. With Hazel, her immunizations were up-to-date as well, but she would qualify for both a pneumonia shot and a shingles vaccine being over the age of 65. Because she hasn't had a pneumonia shot previously, she should get a PCV13 today and next year she should get the PPSV23. As for the shingles vaccine, we recommend Shingrix (recombinant vaccine) with her first shot today, and she will need another Shingrix shot between 2 and 6 months later.

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NEW LAW PERMITS PAs TO PROVIDE HOSPICE CARE TO MEDICARE PATIENTS

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Contact: *Berit Mansour, 571-319-4394, bmansour@aapa.org*

ALEXANDRIA, Va. (Feb. 9, 2018) – This morning, Congress passed and President Trump signed into law two improvements to Medicare that represent significant victories for PAs and the patients they serve.

The first improvement will allow PAs to manage and provide hospice care to terminally-ill Medicare patients; another will allow PAs to supervise cardiac and pulmonary rehabilitation programs under the Medicare program.

Specifically, the new law modernizes outdated Medicare law with language specific to PAs in the Medicare Patient Access to Hospice Act.

"Literally hundreds of PAs have made the case to members of Congress about the necessity to eliminate the unwarranted restrictions which have prevented PAs from providing hospice care to their Medicare patients. Too many PAs have patients that have been under their care for years who have been forced to choose between continued care and hospice," said L. Gail Curtis, PA-C, MPAS, DFAAPA, president and chair of AAPA's Board of Directors. "This new law will empower PAs to offer continuity of care at a time when patients and their families are most vulnerable."

Medicare beneficiaries throughout the nation, especially those living in rural and other medically underserved communities where PAs may be the sole healthcare professional, will benefit from this important legislation. This change will take effect Jan. 1, 2019.

AAPA is thankful to the Congressional champions who supported this legislative change, including Senators Mike Enzi (R-WY) and Tom Carper (D-DE), and Representatives Lynn Jenkins (R-KS) and Mike Thompson (D-CA).

The new law also includes language from the Improving Access to Cardiac and Pulmonary Rehabilitation Act, which goes into effect Jan. 1, 2024, to allow PAs and other advanced practice providers to supervise cardiac and pulmonary rehabilitation programs for Medicare patients.

The Congressional champions for this legislative change include Senators Mike Crapo (R-ID), Amy Klobuchar (D-MN), Debbie Stabenow (D-MI), Senate Minority Leader Chuck Schumer (D-NY), and Representatives Lynn Jenkins (R-KS) and John Lewis (D-GA).

These healthcare provisions were part of a two-year budget agreement that includes stopgap government funding that runs through March 23, 2018. AAPA will continue to push for additional changes to improve PA practice for the more than 123,000 PAs and the patients they serve.

About the American Academy of PAs

AAPA is the national organization that advocates for all PAs and provides tools to improve PA practice and patient care. Founded in 1968, AAPA represents a profession of more than 123,000 PAs across all medical and surgical specialties in all fifty states, the District of Columbia, the U.S. territories and the uniformed services. Visit www.aapa.org to learn more.

MAPA Legislative Update

Mental Health Task Force

Approximately two years ago, Psychiatrist Dr. Michele Reid contacted MAPA regarding the inability of one of her PA colleagues to perform the initial certification for involuntary admission of the PA's patient to a psychiatric facility. The involuntary admission occurs when a patient is considered to be in danger of harm to themselves or the community and they are resisting admission to a hospital. This circumstance caused a psychiatrist from another facility to have to leave the patients they were seeing to drive across the county to another Community Mental Health facility to assess the patient and sign the certification. Sounds like an inefficient use of providers, eh?

Apparently, it is not general knowledge among health care stakeholders that psychiatric medicine is part of every PA's education and training. Despite a ruling from an attorney at the State of Michigan's Office of Recipient Rights, stating that a PA practices medicine and that a physician may delegate this aspect of care to a PA (delegation and supervision occurred prior to the passage of Public Act 379), a judge in Oakland County refused to accept that opinion and this inefficient approach to patient care continued. We have since learned that judges and state facility auditors have encouraged a patchwork of policies regarding psychiatric PAs. Examples of facility policies limiting PA practice include involuntary certifications, chemical and physical restraints, and even H&Ps in mental health facilities.

MAPA has long been aware that PAs are not listed as Mental Health Providers in the Mental Health Code (separate from the Public Health Code). While working on Public Act 379, we mentioned to legislators and to the medical organizations that including PAs in the Mental Health Code would be next. PAs were never included in the Mental Health Code because PAs were not a profession when the code was established. The ambiguities in the Public Health Code caused MAPA to clarify the ability of PAs caring for patients by introducing at least 15 patient-centered legislative initiatives over the last 20 years and we didn't want to go through that again with the Mental Health Code.

MAPA's Legislative Committee, along with Mike DeGrow, Dr. Reid and a Nurse Practitioner Doctoral Student at Wayne State, Andrea Esu, created a Mental Health Task Force and met over a period of months to review the current statue and create language in order to draft legislation. We invited other providers in on the process and contacted Thadd Gormas, then Chief of Staff to Senator Jim Marleau, to discuss the possibility of amending Michigan Law to address these concerns. The Task Force spent months of talking to additional Psychiatrist, PA and APRN providers, contacting other States, and meetings to draft language.

Several months later the task force started meeting with other medical organizations to share the draft bill to them and address any potential concerns prior to introduction of the bill. We had fairly good success until we met with the Michigan Psychiatric Society (MPS) who had stated a strong opposition to the bill. MAPA representatives, including Ron Stavale PA-C, Thadd Gormas (now our new MAPA Executive Director) and Ken Gorney PA-C, met with MPS. After this meeting and 3 subsequent meetings we were not able to receive specific concerns from MPS which could be addressed in the draft bill.

Two weeks ago the Task Force, including Alison Badger, PA-C from Michigan Medicine, met with three other organizations including National Alliance of Mental Illness Michigan, Michigan Association of Community Mental Health Boards and Mental Health Association of Michigan. After listening to each others' concerns, we agreed the Michigan Mental Health Code should be amended to better care for patients with psychiatric illness. We adjusted the language on the bill to allow for broader support from these organizations but not enough to change the intent of the bill to provider safer mental health care.

MAPA hopes the bill will be introduced soon. When the bill is introduced, we will call upon Michigan PAs currently practicing in psychiatry and the psychiatrists they work with to testify at hearings and/or write letters to their elected representatives to support this bill. Thanks to Ken Gorney, PA-C, Sarah Ann Scantamburlo, PA-C, and Alison Badger, PA-C, as well as the other PAs working in mental health for their support in this process. This is an example of your organization working to improve the practice environment in Michigan for all PAs by supporting safer patient care.

Stay tuned and stay members of MAPA!

Ron X. Stavale, PA-C
MAPA Past President
Member, MAPA Legislative Committee

2017-2018 INFLUENZA UPDATE

The Year is 2018; there is an air of apprehension among the population during the winter months and for good reason. Reports indicate that nearly every state in the continental U.S. is experiencing widespread disease activity. Hospitals in some major cities have erected military style tents to accommodate the influx of sick patients seeking help. Many hospitals have also put in place strict restrictions on hospital visitors. And the CDC has issued multiple advisories cautioning the population to avoid contact with sick persons as the mortality rate has averaged 100 people a week so far during this outbreak. While this may seem like the preface to an apocalypse style novel, it is in fact the current reality of this year's influenza season.

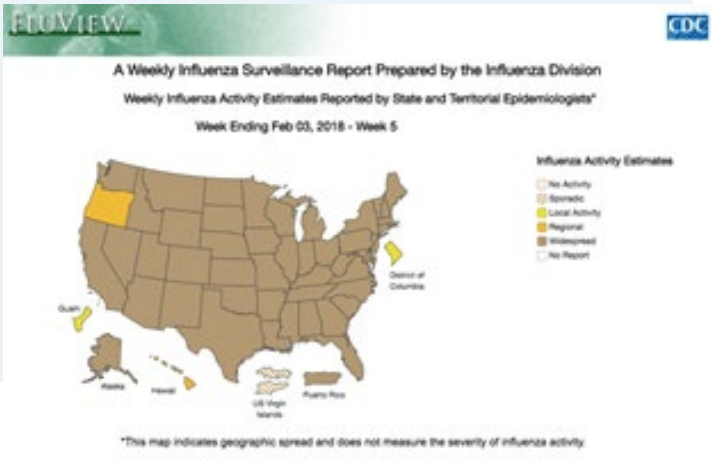
This flu season's conditions provided the perfect storm for an above average widespread flu epidemic now reaching the levels of a pandemic. A dangerous flu variant combined with a less effective vaccine has led to widespread dissemination and millions of people afflicted. Granted, while each year the number of individuals who succumb to the flu in the U.S. meets the CDC criteria for an epidemic, this year is certainly more severe than average and is reaching levels similar to the H1N1 pandemic of 2009.

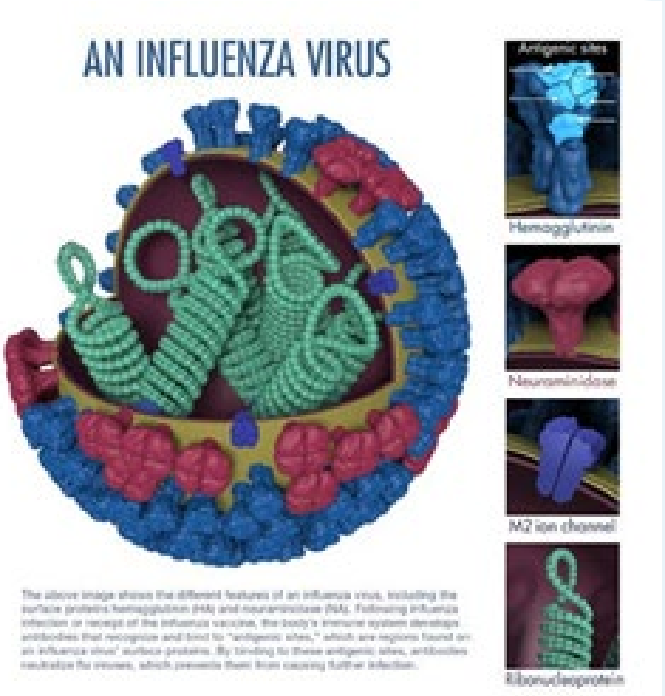
Why is the influenza virus more virulent this year?

The influenza-A variant H3N2 is the predominant virus this season in the U.S., and according to CDC Director Brenda Fitzgerald, MD, "When H3 viruses are predominant, we tend to have a worse flu season, with more hospitalizations and more deaths." Flu virus vaccines are most commonly made by egg-based incubation which can produce live attenuated or inactivated virus. Before any vaccine production begins, the CDC uses analytic data to forecast the upcoming flu season. They use this data to select target influenza variants called "candidate vaccine viruses" (CVVs) which they anticipate will be most effective for the coming influenza season. The problem this year was that during production, the Influenza-A virus mutated and the result is a vaccination which is 10-20% effective.

Why are influenza vaccines changed every year?

Each year the influenza vaccine is manufactured to prevent 3 or 4 of the most likely strains for the upcoming flu season. As part of the World Health Organization (WHO) collaboration, over 100 designated laboratories in 100 different countries conduct surveillance and perform laboratory and clinical studies year round. Biannually, the WHO holds meetings with directors from the 100 influenza centers to review the surveillance data. It is from this meeting that the WHO will provide recommendations to countries regarding specific influenza strains in vaccines based on regional data. It is up to the individual countries to accept and implement the WHO recommendations. In the United States, the FDA's Vaccines and Related Biological Products Advisory Committee is responsible for choosing the strains of influenza to target in vaccines each year. Once the FDA approves the selected strains, and





sometimes even before, private sector manufactures begin vaccine production. The predominant method for growing viruses for vaccines utilizes chicken eggs as growth medium. It takes at least 6 months to produce substantial quantities of vaccine and manufactures need to have vaccines available before fall flu season to be effective. This year's highly virulent H3N2 does not grow well in chicken eggs and although this year's vaccine included the "A/ Hong Kong/4801/2014 (H3N2)-like virus," this strain of H3N2 mutated and has led to a vaccine that is only 10-20% effective. Interestingly on a side note, this year's trivalent vaccine included a variant from the 2015 Michigan H1N1 strain.

Treatment recommendations for patients with the flu

The goal for treating patients with the flu is to identify and treat those at high risk.

Antiviral drug recommendation

The CDC has made the following recommendations regarding the use of antiviral drugs in influenza:

- Antiviral treatment is recommended as soon as possible for patients with confirmed or suspected influenza who have severe, complicated, or progressive illness or who require hospitalization
- Antiviral treatment is recommended as soon as possible for outpatients with confirmed or suspected influenza who are at higher risk for influenza complications on the basis of their age or underlying medical conditions; clinical judgment should be an important component of outpatient treatment decisions
- Currently recommended antiviral medications include oseltamivir and zanamivir
- Oseltamivir may be used for treatment or chemoprophylaxis of influenza among infants younger than 1 year, when indicated
- Antiviral treatment also may be considered on the basis of clinical judgment for any outpatient with confirmed or suspected influenza who does not have known risk factors for severe illness, if treatment can be initiated within 48 hours of illness onset

The flu season is likely to continue at its high rates for several more weeks. During this time when the activity of the H3N2 virus is beginning to abate, it is likely that a strain of influenza B will emerge as the predominant strain; as this scenario is common in the waning weeks of the flu season.

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Be sure to check out this link to the Michigan Department of Health and Human Services (MDHHS) ***Michigan Flu Focus***, a Weekly Influenza Surveillance Report.

Influenza IN PREGNANCY

By Julia Burkhardt PA-C

Influenza season is upon us and with reports of increased incidence of influenza and influenza-like illnesses, it is imperative for PAs to understand how to diagnose and treat these illnesses.1 This can be even more crucial for high risk populations, such as pregnant women, who are at increased risk of morbidity and mortality when infected by seasonal and pandemic influenza.[2] Although only a small percentage of clinically practicing PAs work in Obstetrics and Gynecology, management of pregnant women with influenza or influenza-like illnesses is crucial for PAs working in a myriad of areas including primary care, emergency medicine, and urgent care. Prior to reviewing how to manage influenza in pregnant women, below is an overview of the epidemiology, signs and symptoms, and diagnosis of influenza.

Influenza Pathophysiology

Influenza is a highly infectious viral illness with the first documented pandemic in 1580. The last pandemic (H1N1) was during the 2009-2010 season.[3] The influenza virus was first isolated in 1933. It is a single-stranded RNA virus from the orthomyxoviridae family and has been isolated in three types (A, B, and C). Type A generally causes moderate to severe illness, is generally seen in all age groups, and can affect humans and other animals.[3] Type B generally results in milder epidemics, primarily affects children, and affects humans only. Type C influenza is rarely reported in humans.[3]

Pathogenesis

Influenza spreads via respiratory transmission.[3] After the virus has been inhaled replication occurs in the respiratory epithelium with subsequent destruction of cells.3 Viremia is rarely documented.[3] Incubation period is generally two days (ranging from one to four days) and viral shed is in respiratory secretions occurs for five to ten days.[3]

Influenza Season

The CDC notes that influenza season varies from year to year, and that seasonal influenza infections

can occur at any time.[1] However, influenza season in the United States generally lasts from October to as late as May with a peak between December and February.[1]

During the 2017-2018 the most common influenza virus subtype reported by public health laboratories has been Influenza A(H3) with elevated positive reports of respiratory specimens.[1]

Signs and Symptoms

Signs and symptoms of influenza in pregnancy are very similar to those in the general population which include fever, nonproductive cough, rhinorrhea, sore throat, headache, shortness of breath, and myalgia.[4] These symptoms generally begin abruptly after a one to four day incubation period.[4]

Although, the above symptoms are the “classic” presentation, there are many different presentations for influenza. For instance, although fevers are common, influenza can also present as an afebrile upper respiratory infection or gastrointestinal illness involving vomiting and diarrhea.

Diagnosis

Influenza is often a clinical diagnosis and the prompt recognition and treatment is imperative in the

treatment of at risk populations, such as during pregnancy. There are also a number of diagnostic testing imploring the isolation of influenza viruses in specimens (i.e., throat, nasopharynx, sputum) along with a significant rise in influenza IgG by serologic assay.[4]

Complications in Pregnancy

Pregnant women appear to be at higher risk of serious complications from influenza such as intensive care admissions and preterm birth. Influenza or influenza-like illnesses in the first trimester shows increased risk of congenital abnormalities such as cleft lip, neural tube defects, hydrocephalus, and congenital heart defects.[5] Similarly, there are increased risk of spontaneous abortion, preterm delivery, low birth weight, birth of small for gestational age infant, and fetal death.[6] This is most likely due to the hyperthermia experienced by those whose are infected with seasonal influenza since hyperthermic maternal states are associated with neural tube defects along with other congenital abnormalities.[6] However, research on this is limited.

Maternal effects of seasonal influenza infection seem to have increased complications when contracted during the third trimester (28 weeks gestation to birth) and the first four weeks postpartum resulting in increased severity of cases and increased hospital admissions from complications such as severe respiratory disease.[7] Furthermore, these complications are more likely if the patient has comorbidities (i.e., HIV or asthma), obstetric issues (i.e., history of or current preterm labor) or inability to care for self or arrange follow-up.[8] Additionally, pregnant women who receive delayed or no treatment with neuraminidase inhibitors, such as oseltamivir or zanamivir, were more likely to develop severe disease.[9]

Treatment

Symptomatic treatment is indicated in any pregnant woman with seasonal influenza or influenza-like illness. Pregnant women should use tylenol as the antipyretic and analgesic of choice, staying away from NSAIDs. The use of antipyretics is especially important during the first trimester due to the increased risk for congenital anomalies.[6]

PREGNANCY *continued*

Additionally, prophylactic treatment is advised with antivirals even without confirmatory testing if the patient is at high risk for developing influenza.[8] For prophylaxis, oseltamivir should be dosed 75 mg qd for ten days. It should begin within 48 hours of potential exposure. If the patient is at low risk, treatment with antivirals such as oseltamivir or zanamivir and close clinical follow-up within 24 to 48 hours is advised.[8] If the patient is at moderate risk, pregnant patients should be evaluated in an ambulatory setting that is able to combine physical exam and diagnostic testing to confirm diagnosis and then antiviral treatment should begin. Finally, if the patient is at elevated risk (i.e., showing warning signs such as shortness of breath, chest pain with coughing, intolerance to po intake, etc.) she should be referred immediately to an emergency department for treatment.[8]

Antivirals should be dosed per CDC guidelines. Oseltamivir is the preferred treatment and should be prescribed 75-mg PO twice a day for 5 days.[8] Alternatively, Zanamivir may be prescribed in two 5-mg puff inhalations [10 mg total] twice daily for five days.8 Furthermore, the decision to start antiviral treatment should not wait for laboratory confirmation of influenza since clinical benefit is greatest when used closest to onset as possible.[10]

Prevention

As with all other populations the best way to combat influenza is prevention. Influenza vaccination is recommended during pregnancy and is considered a part of preconception, prenatal, and postpartum care since pregnant women and those in the immediate postpartum period are at increased risk of serious illness.[2] Pregnant women can receive either the quadrivalent or trivalent inactivated vaccine; pregnant women should not receive the live attenuated influenza vaccine.[11]

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CALL FOR CANDIDATES

to the 2018-2019 MAPA Board of Directors

Are you interested in becoming involved in PA leadership? If so, **MAPA Wants You!** Do you want to give back to your state academy for all the work it has done to protect your PA work environment in Michigan? If so, **MAPA Wants You!** With the passage of PA 379 (the new PA law in Michigan), our state is now the model from which all other states will emulate. There is no better way to develop both personal and professional leadership skills than by serving on the Michigan Academy of Physician Assistants- Board of Directors. This volunteer leadership commitment challenges you to go beyond the required ideals for your profession and provide ideas and solutions that make an impact to the academy that represents Michigan PAs. Board service allows you to hear different perspectives on issues and helps you form contacts for your professional growth. Volunteer participation on MAPA's board will allow you to meet and work with professionals who have similar interests and help advance our state academy.

MAPA is seeking nominations for the offices of President-Elect and Treasurer. Additionally, nominations are being sought for elected Regional Representatives to the BOD from Regions 2, 4 and 6. Candidates seeking to be placed on the election ballot must submit a statement of interest to the MAPA office that includes biographical data, eligibility for office, credentials and election platform- by **April 15, 2018**. This information can be submitted in the form of a cover letter with resume' and will be made available for review on the MAPA website to the voting MAPA members.

A candidate for the office of **MAPA President-Elect** must have been a fellow member of MAPA for at least three of the last five years. The proposed nominee must have accumulated during the past five years, two distinct years of experience as a member of the board of directors, or either as a MAPA delegate to the HOD, on any of MAPA's standing committees or accumulated the necessary experience deemed appropriate by the Nominations Committee.

A candidate for the office of **MAPA Treasurer** must have been a fellow member of MAPA for at least two of the last five years and/or accumulated the necessary experience deemed appropriate by the Nominations Committee.

Candidates for **MAPA Regional Representative** must be a fellow member of MAPA in good standing and live in the region they seek to represent. You can refer to the MAPA website to see the region you live in.

MAPA is also seeking nominations for Chief Delegate and delegates to the 2018 AAPA House of Delegates (HOD). All candidates for MAPA Chief Delegate and delegates to AAPA HOD must be current members of AAPA and fellow MAPA members for the year preceding candidacy. All candidates for MAPA Chief Delegate shall have served at least one term as a delegate with the Michigan delegation; the term for Chief Delegate is one year. The term for delegates from Michigan to the AAPA House of Delegates shall be one year and begins on July 15th of the year of election. Delegates will serve as representatives of the MAPA membership at the AAPA House of Delegates.

To sustain the atmosphere of MAPA's BOD, we need creative and energetic individuals that will help promote quality health care delivery and the PA profession in the state of Michigan. **Nominations are due to the MAPA office no later than April 15, 2018.** New nominations criteria are available on MAPA's website home page for review.

MAPA
C/o Academy Administrator
1390 Eisenhower Place
Ann Arbor, MI 48108

MAPA Leadership Summit

★ SAVE THE DATE ★

We would like to cordially invite you to attend the MAPA Leadership Summit in Lansing on April 18th. This event is FREE for MAPA members! The Summit will offer CME and be packed with great speakers including state agency directors, LARA representatives, legislators, and PA practice owners. The Summit will conclude with a PAMPAC fundraising event and a grand evening reception for health care leaders from across the state to connect.

The **Leadership Summit** will be held in the **State Capitol Building from 1-4pm (room 405) where we will hear CME presentations** promoting PA practice leadership. A representative from LARA will lead a discussion regarding the new Opioid Laws and will be available for Q&A. Appearances by key legislators will inform the group regarding issues that may impact PAs.

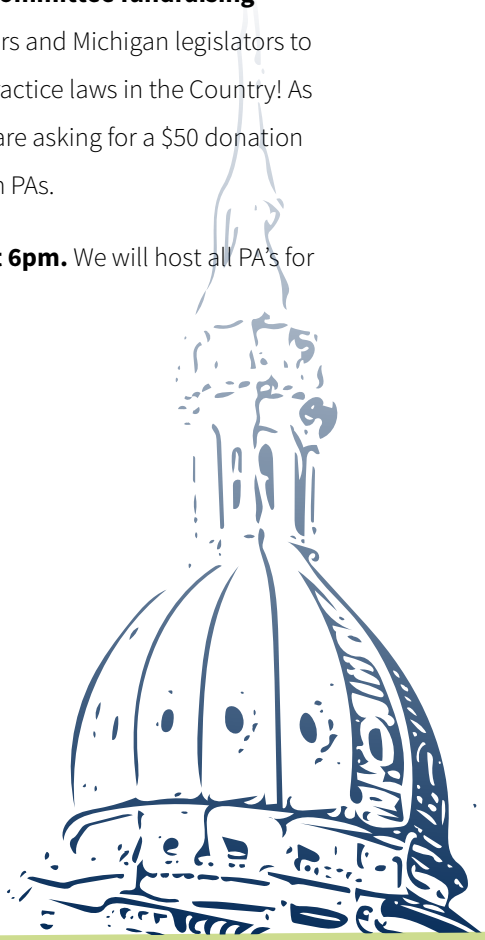
Following the presentations from **5-6pm will be a Michigan PA Political Action Committee fundraising** reception at Troppo restaurant in downtown Lansing. Please join Michigan PA leaders and Michigan legislators to support the legislative efforts which have secured Michigan as having the best PA practice laws in the Country! As a separate organization, your MAPA dues **cannot** and **do not** support PAMPAC! We are asking for a $50 donation to show your support of PA progress, and to support continued success for Michigan PAs.

Finally, the MI PAMPAC reception will become a **MAPA grand reception starting at 6pm.** We will host all PA's for this final event featuring hors d'oeuvres and cocktails.

Thank you for your support,

John R. Young, PA-C, MAPA President
Jodi Zych, PA-C, MAPA Leadership Committee Chair

REGISTER HERE



MICHIGAN PA STUDENTS

Attended AAPA's Leadership and Advocacy Summit

On March 8, four Michigan PA students, along with MAPA leadership, attended AAPA's Leadership and Advocacy Summit in Arlington, Virginia. This yearly summit brings together PA leaders and students from across the country to learn about national issues affecting PAs.

Since all of PA State laws vary, we rely on networking to learn from and also to be inspired by some of the success in other States. Constituent chapters support and assist other States where political roadblocks can often delay or derail PA goals. MAPA realizes the importance of this type of an event because future leaders will be needed to interact with Michigan health care organizations and legislators in order to maintain and protect our professional practice environment. Each year, MAPA sends three or four practicing PAs from our leadership team as well as three or four students who have a passion to learn about our profession.

Sometime around the middle of November each year, MAPA's Student Liaisons contact each State PA program and their respective student representatives. Students are asked to write an essay of 500 words or less on "What is advocacy and why is it important?" Once the essays are received, our Academy Administrator, Sara Surprenant, eliminates any information regarding the student's identity or what program they are from. The essays are then sent to a team of practicing PAs to read and rank in order based on the flow of the essay and how they responded to the question of advocacy in relation to the PA profession.

This year there were 11 students from five of the six Michigan PA programs that responded. As always, the judging is so difficult as the student's essays are all very well written and they equally express the students passion for the PA profession and how important advocacy is to the being a PA.

The top essayists are then notified and arrangements are made for them to attend the AAPA Leadership Summit in Virginia. There they will network with students from other programs and leaders across the country and understand better the challenges PAs face now and will face in the future. We expect to hear about their experience in our next MAPA Newsletter.

This year's finalists were:

Colin Knue, PA-S - Western Michigan University
Ainslee Rubino, PA-S – Wayne State University
Ashley Meerschaert, PA-S – University of Detroit Mercy
Kristina Jennings, PA-S – University of Detroit Mercy

MAPA would also like to thank the following students for their interest and passion for the PA profession.

Audrey Droge, PA-S - Grand Valley State University
Amanda Higgins, PA-S - Western Michigan University
Kristin Ianotti, PA-S - Western Michigan University
Abram Jensen, PA-S - Grand Valley State University
Olivia Presnell, PA-S - Grand Valley State University
Kaely Schlosser, PA-S - Western Michigan University
Amy Verduzco, PA-S - Western Michigan University

We expect to see all of the above named students leading our profession in the years to come. A special thanks goes out to Academy Administrator Sara Surprenant and MAPA Student Liaisons Angela Braun and Stephanie Garnett.

Michigan Physician Assistant Foundation (MIPAF)

CELEBRATING OUR 27TH ANNIVERSARY

The Michigan Physician Assistant Foundation is a nonprofit 501(c)3 charitable organization recognized in 1991 as an IRS qualified organization. We could be considered the charitable arm of MAPA, a professional organization representing the interests of Physician Assistants practicing in Michigan. We are a public foundation, which provides scholarships to second year MICHIGAN physician assistant students. Our motto is "MIPAF provides the scholarship…you provide the future". Our web page is www.mipaf.com.

The annual Michigan Academy of Physician Assistants Fall CME Conference will be held October 4-7, 2018 at the Grand Traverse Resort in Acme, MI. At that conference on Friday evening October 5, the Michigan PA Foundation will again hold the "Student Quiz Bowl." All PA programs from the State of Michigan are invited to participate. It is a fun event with a lot of enthusiasm from the students.

The other event that the PA Foundation holds at the conference is a silent auction. That will be held Saturday evening October 6 prior to and during the dinner. This is a fundraiser for the foundation to enable us to continue to provide scholarships to students. We are looking for donations of items that can be placed in the auction. Tickets to events, hotel stays, golf packages, gift baskets, etc. are welcome. Please contact Vaughn Begick, PA-C at 989-686-0578 or e-mail VaughnPAC@aol.com to donate. You can bring the items to the conference and notify the registration desk that you have them. If you were a past recipient of a scholarship and are now working, you might want to consider a donation for the silent auction. The Foundation also accepts cash donations and it is a charitable contribution as is the donation of an item for the silent auction.

Please consider participating in our "$27 for 27 Years Donation Club". Give $27.00 to represent our 27th year anniversary. Or participate in our $1.00 per year Graduation Club…if you have just recently graduated and have been a PA for 1 year give $1.00…if you have been a PA for 20 years give $20.

So we hope to see you at the Conference and if not, check out our web page and consider a donation to the Foundation. If you are a student, consider applying for a scholarship.

MIPAF is looking for volunteers to help with the future of this organization.

Areas of need:

Student Quiz Bowl
Donations/Silent Auction
President
Secretary
Treasurer
General ideas to improve the organization

If you have an interest in helping with this organization, please join us at our annual open board meeting during the Fall CME Conference on Saturday, October 6, 2018 from 10:00am-12:00pm (room TBA). Maybe you are a past scholarship recipient who wants to give something back, maybe you are a past MAPA board member or volunteer who has expertise in organization, maybe you are a new grad who wants to help future PA students, maybe you're a PA who cares about the scholarship future of the profession and would like to get involved…please join us and bring a friend!

Vaughn Begick PA-C
MPAF Board Member
e-mail: VaughnPAC@aol.com

Robert Ross, PA-C
MPAF President
e-mail: bobross45@gmail.com

Best Documentation Practices:

The Art of Documentation Defensibility

Marcos A. Vargas, MSHA, PA-C

Plaintiff's attorneys look for potential red flags in all medical malpractice cases. Red flags include ineffective charting, communication lapses, and incomplete or illegible documentation.

Aside from those medical chart "red flags," what else do plaintiff and/or defense attorneys look for specifically when sifting through the EMR?

Plain and simple, attorneys look for a **solid *defensible or a glaring indefensible*** medical record. In most cases, these are the common denominators. These are the *"red flags" that* we often fall prey to in our hurried day-to-day clinical practices. And while *poor documentation* is equated mostly with non-defensibility --and rightfully so—it can mean many things to different people.

The liability controversy always seems to hover around the perennial question of what is "poor documentation?" In most instances it has nothing to do with how much is too much or how scant is too scant, even though many clinicians feel this is what constitutes poor documentation.

Regardless of whether you're a crammer or a scanty documenter, the issue transcends that. In fact, for all practical purposes, the question should be rephrased and reframed to: Are you a defensible documenter or not?

The poor documenter is the one who doesn't document their clinical decision process succinctly and/or clearly in the medical chart. While risk management professionals may argue that you can never document too much; conversely, others are just as quick to point out that *"too much documentation*" is counterproductive. They would argue that documenting "everything" needlessly would provide the plaintiff's attorney with evidence or "ammunition" ready to be used against you in an allegation of medical malpractice.

So where does the happy medium reside (many ask)? Most agree that regardless of which camp you may subscribe to, the clinician ultimately should see this as an opportunity not only to document how or what type of care was provided but, more importantly, to educate others of how the provider arrived at a particular set of views or conclusions regarding the diagnosis, plan of care, etc.

Avoidance of sketchy or scant documentation surely boosts your case. The defensibility of your provided care becomes that much more robust when scrutinized. But, more importantly, it raises your professional credibility when stating clearly and briefly which features of the history and/or physical findings steered you in which direction and/or conclusions.

For example, detailing your reasoning as to why you chose to forego antibiotics, or why you withheld a diagnostic study will not only show that you considered the benefit-risk ratio of a specific intervention, but that you also didn't close a diagnostic loop or process too prematurely.

And therein lies the nugget of how to avoid poor documentation practices commonly associated with allegations raised in lawsuits against PAs after an adverse outcome occurs. In sum, scant or sketchy medical records can be considered nothing less than medical malpractice cases waiting to happen, particularly if your patient suffered.

And please remember, the best way to prevent an erroneous malpractice lawsuit is to communicate effectively with your patients!

MAPA SPRING CONFERENCE

Please join us for MAPA's Spring CME Conference - May 5, 2018 at the Suburban Showplace Collection in Novi, MI.

Spring CME Conference Register NOW at mapaevents.org

A Full day of exciting CME

MAPA & AAPA 2017 updates by the current presidents, along with goals looking forward.

Variety of sessions including:

- Vector borne illnesses
- Benefits of acupuncture
- Acute MI/ Cardiovascular update
- Life sustaining treatment initiative- goals of care discussion in the outpatient setting
- And more!

CME in progress

MICHIGAN ACADEMY of PHYSICIAN ASSISTANTS

1390 Eisenhower Place
Ann Arbor, MI 48108

MAPA PLANNER

EVENTS/ CONFERENCES

MAPA Leadership Summit

DATE: April 18, 2018

SITE: Lansing, Michigan

michiganpa.org

MAPA Spring CME Conference

DATE: May 5, 2018

SITE: Suburban Collection Showplace
Novi, Michigan

mapaevents.org

MAPA Fall CME Conference

DATE: October 4-7, 2018

SITE: Grand Traverse Resort and Spa
Acme, Michigan

mapafallevents.org