JUNE 2016

MICHIGAN PA

The Only Informational Resource for Michigan Physician Assistants

MICHIGAN ACADEMY OF PHYSICIAN ASSISTANTS
MAPA

www.michiganpa.org

What You Need to Know about Zika

Zika virus was first discovered by scientists in the Zika Forest of Uganda in 1947, while conducting research on Yellow Fever. The scientists were able to isolate the virus from blood samples from an infected rhesus monkey. One year later from that same site, the researchers isolated the virus from a mosquito.[1] Initial human cases were identified in 1952 from serologic studies in Uganda and Nigeria...

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President's Message

As my year of being MAPA President comes to a close, I can choose to reflect on what has been accomplished by the collective board over the last year or I can choose to remember where we came from and continue on the path of where we need to go; I choose the latter. From where we were as an academy of just a few years ago until present, we have made and are making advances to 'Your Academy', to the PA environment in Michigan and laying the foundation for many positive strides for the future of the PA profession in Michigan.

Over the last year, changes and improvements to 'Your Academy' include:

- A dedicated person to solely focus as Membership Chair
- Increased conversation and involvement of volunteers on the Legislative Committee
- Record-breaking attendance at the Fall Conference
- New design and structure of the MAPA website is on-going
- Multiple levels and new content are being added to the MAPA website
- New and improved member benefits are being added
- We are partnering with sponsors to offer additional services to members
- Contracted with a marketing firm to help reassess MAPA's identity and branding

The most newsworthy addition that MAPA has been working on over the last several months is a house bill that will advance the PA practice in Michigan to its fullest potential. HB 5533 will remove terms of 'supervision' and 'delegation' from the state statute, removes the arbitrary PA/physician ratios in the statute, states that PAs will work within a practice agreement and PAs will be included in the definition of "prescribers." This legislation was introduced into the Michigan House by Rep. Canfield and will be up for consideration at summers end. When this HB 5533 passes, it will make Michigan a leader amongst all states in proactive PA practice environment and legislation.

Over the last couple of years, 'Your Academy' Board of Directors have laid the foundation for significant change, updates and improvement, most of which will become evident over the next several months. The MAPA board is committed to continuing its advocacy, protection and advancement of the PA profession in Michigan; MAPA is the only organization that will perform these tasks.

As your President, I serve at the pleasure of the membership and as your academy leader you need to have a vision for the future and develop strategies or projects to lead you into the future. But, this is not accomplished by just one person, 'it takes a village' statement is very appropriate in this case. It takes a board of vested individuals to make decisions that they determine is in the best interest for the PAs of Michigan.

Best Regards,

Chris Noth, PA-C, FAPACVS
MAPA President 2015-2016

ZIKA VIRUS

Information about the Virus & Current Updates

By John R. Young PA-C

HISTORY OF ZIKA VIRUS

Zika virus was first discovered by scientists in the Zika Forest of Uganda in 1947, while conducting research on Yellow Fever. The scientists were able to isolate the virus from blood samples from an infected rhesus monkey. One year later from that same site, the researchers isolated the virus from a mosquito.1 Initial human cases were identified in 1952 from serologic studies in Uganda and Nigeria. Interestingly, the studies showed antibody production and a high level of immunity to the virus suggesting a longstanding presence in the regional human population.

From the 1950's to the 2000's the virus spread from the African continent to Southeast Asia, the Philippines, and the Pacific Islands. The virus's inevitable course found its way to the Americas in April 2015 during an outbreak in Brazil. It has since spread to South and Central America, Mexico, and the Caribbean.[1]

As seen in Figure 1 , Travel-associated cases have now been reported in many U.S. states and as of May 2016-544 travel related cases have been reported in the U.S.6

As with similar mosquito born virus's, transmission to the U.S. is inevitable. The CDC estimates that states like Florida, Hawaii, and Texas may well have cases or small clusters of Zika that are spread by infected mosquitoes.

ABOUT ZIKA VIRUS

The Zika virus disease is caused primarily through the bite of an infected Aedes africanus and to a lesser degree by the Aedes albopictus type mosquito (See Figure 2). The virus is a single stranded RNA virus of the Flavivirus genus.7 The vector mosquito breeds in standing water and are most active in the daytime. Secondary transmission of the virus has been reported through sexual contact and the virus is reported to persist in semen for >62 days. Perinatal in-utero infections from mother to fetus have been shown to cause microcephaly and the virus has been detected in breast milk as well.

Figure 1

Figure 2

CLINICAL SIGNS AND SYMPTOMS

Most individuals infected by the virus remain asymptomatic and develop normal immune response.

Clinical findings of an infected individual may be difficult to identify by clinicians not experienced in tropical diseases.

Symptoms are similar to common viral- like illnesses, but more accurately mimic Dengue Fever. Symptoms include acute onset fever, maculopapular rash (usually pruritic), arthralgia, conjunctivitis, headache, and myalgias. Symptom duration and viral presence can last up to one week. Although uncommon, severe disease may require hospitalization, but is associated with a low mortality rate.[3]

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ZIKA VIRUS

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Sequela of the disease may include microcephaly in newborn children and Guillan-Barre syndrome have been reported in Brazil and one reported in the U.S.[7]

It is estimated that 1.5 million people have been infected by Zika virus in Brazil[1], with over 3,500 cases of microcephaly reported between October 2015 and January 2016. In the U.S., 48 reported pregnancies have had adverse outcomes due to Zika infection.[6] Other reported neurologic sequelae include: meningoencephalitis and acute myelitis.[3]

DIAGNOSIS AND REPORTING

Since the clinical presentation of the disease can mimic other infections including: influenza, malaria, parvovirus, enterovirus, and adenovirus; the differential diagnosis can be quite inclusive. Clinicians should take note of recent travel history to endemic regions to aid in a suspected diagnosis. Diagnosis is accomplished by testing serum or plasma to detect virus, viral nucleic acid, or virus-specific immunoglobulin-M and neutralizing antibodies.

The Michigan Department of Health and Human Services (MDHHS) considers all cases indicated below as reportable.

Women

Due to the risk of congenital defects in the developing fetus of pregnant women exposed to Zika virus, ALL pregnant women who have traveled to areas with ongoing Zika virus transmission should be tested.[7]

As of February 5, 2016, CDC expanded their recommendation for Zika virus testing to include *asymptomatic* pregnant women who have traveled to areas with ongoing Zika virus transmission. Testing can be offered to asymptomatic pregnant women 2-12 weeks after their return from travel.[7]

Men

The CDC recommends that men who reside in or have traveled to an area of active Zika virus transmission who have a pregnant partner should abstain from sexual activity or consistently and correctly use condoms during sex for the duration of the pregnancy.[7]

At this time, testing of men for the purpose of assessing risk for sexual transmission is not recommended.[2] Instead, proper precautions to prevent possible sexual transmission to their partners must be exercised.

STEPS FOR REPORTING

Once a patient has been identified as described above, you can contact the MDHHS at 517-335-8165. For instructions on specimen collection and handling, you can also follow the link below for instructions:

http://www.michigan.gov/documents/mdhhs/Zika_Virus_Specimen_Collection_and_Transport_Guidelines_514580_7.pdf

1 [4] http://www.cdc.gov/zika/transmission/index.html

[5] http://emedicine.medscape.com/article/2500035-treatment#d2

2 6 http://emedicine.medscape.com/article/2500035-treatment#d2

7 http://www.cdc.gov/zika/hc-providers.html

8 http://www.cdc.gov/zika/hc-providers/clinicalevaluation.html

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TREATMENT

There is currently no vaccine for Zika. Most infected individuals have a benign self-limiting clinical course. Treatment is generally supportive and can include rest, fluids, and use of analgesics and antipyretics. Aspirin and other NSAID's should be avoided until Dengue Fever can be ruled out, due to risk of hemorrhage.[5]

Infected individuals should avoid contact with mosquitos for the first few days to avoid transmission to other mosquitoes.

MOSQUITO PREVENTION

- Wear long-sleeved shirts and pants and treat clothing with permethrin.
- Use screens on the exterior of your home to keep mosquitoes outdoors.
- Repair and seal your septic system.
- Use an EPA-registered insect repellent: www.epa.gov/insect-repellents
- Eliminate standing water surrounding your home to reduce mosquito breeding grounds.
- Remember, they are daytime biters![8]

Some design Images obtained for this article were sourced from www.CDC.com

MICHIGAN ACADEMY OF PHYSICIAN ASSISTANTS

MAPA

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

And the Winners are …

2016 MAPA BOARD OF DIRECTORS ELECTION RESULTS

Thanks to all of you who submitted your votes by the May 31st deadline date.

Congratulations to the following candidates:

President-Elect
John Young, PA-C

Treasurer
Kathy Tuinhoff, PA-C

Region 4 Representative
Kevin Vardon, PA-C

Region 6 Representative
Brad Orville, PhD, PA-C

AAPA Chief Delegate
Jodi Zych, PA-C

AAPA 2017 Delegates

Janet Burns, PhD, PA-C

Megan Dietrich, PA-C

Mary Huyck, PA-C

Sandra Keavey, PA-C

AAPA 2017 Delegates (con't.)

Steven Myers, PA-C

Ron Stavale, PA-C

All candidates are MAPA members in good standing. Elected candidates' term start July 1st.

BLS/ Defibrillation Recreational Youth Sport Legislation

By Karen Byers, MS, PA-C

Wes Leonard - Michigan High school basketball student dies after shooting the game winning shot. http://abcnews.go.com/Health/HeartDisease/high-school-basketball-star-dies-court/story?id=13055595

Claire, High school volleyball player collapses mid-play with immediate CPR and successful defibrillation at 4.5 minutes. Subject: Links to Claire's story and video http://www.nbc12.com/story/31130876/high-school-volleyball-player-collapses-during-game-saved-by-staff.

Both of these headlines are concerning to any parent and definitely to any PA involved in the specialty of cardiology. Much like myself, I am a PA in Cardiology-Electrophysiology at Henry Ford Hospital in Detroit, MI for the past several years. My boys, ages 5 & 10 years old, both play on the Michigan/National flag football league along with many other recreational sports for the past few years.

I was shocked to discover that there are currently no easily accessible AED's (defibrillators) nor are staff/ coaches trained in Basic Life Support/ AED usage, should a player or fan suffer cardiac

arrest at any of the nearly 30 Flag football locations (with ~ 700 players at each location) across the metro Detroit area. There is also a lack of Basic Life Support/ AED training mandate in recreational sports leagues; this could prove disastrous. The goal of this initiative is to prevent the unthinkable from occurring—Sudden Cardiac Death (SCD).

According to Michigan Health & Human Services, "between 1999 and 2009 in Michigan, there were 3,134 young individuals between 1 and 39 years of age, who died of sudden cardiac death. Of those, 246 were between 5 and 19 years

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BLS/ Defibrillation Recreational Youth Sport Legislation

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of age." Due to the above facts and disastrous events that transpired during those years, the governor signed into law- Public Act 12 of 2014.

H.B. 4713/ Public Act 12 of 2014 requires Michigan schools to do as follows:

The governing body of a school that operates any of grades kindergarten to 12 shall adopt and implement a cardiac emergency response plan for the school. The cardiac emergency response plan shall address and provide for at least all of the following:

1. "**Use and regular maintenance of automated external defibrillators if available.**"

   - "All necessary steps shall be taken to ensure that each AED owned by the school shall be readily available and accessible for **all activities which take place at the school including those which take place after regular school hours. AEDs shall never be locked in any office or be stored in a location that is not easily and quickly accessible during any activity.**"

   - *Created by the Michigan Alliance for Prevention of Sudden Cardiac Death of the Young (MAP-SCDY), June 2014.* https://www.migrc.org/Library/HEARTSafe.html

The former State Superintendent of the Michigan Department of Education, Mike Flanagan was supportive of these measures as evidenced by the following statement: "MDE is proud to support MI HEARTSafe schools. Ensuring schools are prepared for sudden cardiac emergencies through planning, training, and AEDs is

an important part of safety for students, staff, and the community." http://www.michigan.gov/mdhhs/0,5885,7-339-73970_71692_8347-324366--,00.html

I recently forwarded my concerns for the lack of easily accessible AED's at the local Michigan flag football fields to the High School principal and Board of Education with the subsequent response: "I think it should be the responsibility of Michigan Youth Flag Football to provide an AED and have it on site." I have been working to educate and implement an emergency action plan with Michigan/ National youth flag football league; sadly their position and response has been flawed and basically indifferent with a response of "it's not required by law."

This problem is widespread throughout all of the youth recreational sports leagues. As such, further mandates need to be enacted legislatively in order to protect our youth and fans. We must continue working with and make the interested parties see the relevance of this public health concern and have them take action.

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BLS/ Defibrillation Recreational Youth Sport Legislation

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The following statements are some facts summarizing the importance of Basic Life Support and early AED use (defibrillation).

Early defibrillation dramatically improves survival rates

Survival rates as high as 89 percent have been achieved in student athletes when defibrillation is provided within three minutes of collapse. **Source: Drezner J, Toresdahl B, Rao A, Huszti E, Harmon K. Outcomes from Sudden Cardiac Arrest in U.S. High Schools: A Two-Year Prospective Study from the National Registry for AED Use in Sports. Br J Sports Med. 2013; 47(18):1179-83.

How common is sudden cardiac arrest in children?

It is well documented that *SCA is the leading cause of death of adults* in the United States. However, the numbers for children are not as clear, because the causes of death in children were not tracked until 2013. It is the #1 killer of student athletes and is responsible for up to 15% of all sudden infant deaths. The American Academy of Pediatrics estimates that two thousand children die every year from SCA.

This need can't go unmet, nor should our youth be at risk because of political apathy.

MAPA's 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's 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.

AAPA HOD Discussions and Resolutions from the National Conference

MAPA Representation at the 2016 AAPA House of Delegates was in force with seven members attending:

Chief Delegate -
Donna Hines

Delegates -
Mary Huyck
Molly Paulson
Susan Raaymakers
Janet Burns
Jodi Zych
Megan Dietrich

The House of Delegates covered policy that was up for a 5 year review – addressing relevancy and generalization vs. specific points, allowing policy no longer necessary to be dropped, and rewording policy to fit general themes and ideas. Updates to Health Illiteracy, Domestic Violence, Removal of Barriers to Care and Discrimination were adopted. Rural Health policy was renewed stating that the AAPA encourages PAs to continue to be used as clinical providers as was the original intent with the policy.

The most important topic addressed was the NCCPA proposed guidelines to certification maintenance. The AAPA Board of Directors created a 6-point resolution for this topic. All members of the House

listened to NCCPA President- Dennis Woodmansee, MS, PA-C, address the professional reasons the process is being re-evaluated. Concerns for professional credibility and general patient safety and the rapid doubling of medical knowledge (every 70 days) were reviewed. AAPA Executive Director- Jenna Dorn, set the stage with her report on the goals of AAPA, to make it known that PAs are trained as generalists, and while many work in specialty areas, there remains the FLEXIBILITY to move from specialty to specialty or primary care and back again as each PA moves through their career. She reiterated that AAPA will work with NCCPA to an agreeable out come; however, she stated firmly that she was not afraid to have legal input if no agreement could be reached.

The AAPA Board of Directors 6-point resolution passed the House and includes the following:

- AAPA supports assessing general medical knowledge for initial certification and licensing of PAs.
- AAPA supports the use of evidence-based alternatives to testing for maintenance of certification.
- AAPA opposes any requirement that PAs take a closed-book, proctored exam in a specialty area for maintenance of certification.
- AAPA opposes any requirement that PAs take multiple examinations during a 10-year recertification cycle.
- AAPA supports uncoupling maintenance of certification requirements from maintenance of license and prescribing privileges in state laws.
- AAPA urges NCCPA and the NCCPA Foundation to undertake rigorous and replicable research to determine the relationship, if any, between taking the NCCPA recertification test and patient outcomes, safety and satisfaction.

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AAPA HOD Discussions and Resolutions from the National Conference

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A letter by AAPA President Jeffrey Katz, PA-C was sent to the NCPPA reiterating these resolutions.

The AAPA endorses the Federation of State Medical Board's (FSMB) Maintenance of Licensure (MOL) Guiding Principles:

- Maintenance of licensure should support PA's commitment to lifelong learning and facilitate improvement in PA practice.
- Maintenance of licensure systems should be administratively feasible and should be developed in collaboration with other stakeholders.
- Maintenance of licensure should not compromise patient care or create barriers to PA practice.
- The infrastructure to support PA compliance with MOL requirements must be flexible and offer a choice of options for meeting requirements.
- Maintenance of licensure processes should balance transparency with privacy protections.

And Further Resolved,

The AAPA believes:

The authority for establishing MOL requirements is strictly within the purview of state legislative or PA regulatory authorities.

AAPA strongly encourages all state constituent organizations to advocate for legislation to adopt MOL processes consistent with the FSMB guiding principles and academy policy.

Other Resolutions addressed:

The Proper address of a PA will be "PA Surname" forgoing Mr/Ms. Surname or the First Name, PA, etc.

The PANCE and PANRE have been incorrectly referred to as "the Boards" in relationship to our ***certification exams***.

Rejection of having a Doctor of Podiatry (DPM) as a supervising/collaborating physician. Con arguments included– difficulty of CMS reimbursement, difficulty with orthopedic physicians, an increased risk of PA being asked to practice outside the scope of practice of the supervising physician. Pro arguments included- Podiatry would be as narrow a practice as a subspecialty, would allow practice opportunities, and there was also fear that allowing DPM supervision would open up for DPT, PharmD, DNP or other "doctorate" degree providers to supervise PAs.

License portability was also discussed, with AAPA calling for uniform application of licensure that would include portability from state to state – this concept has been discussed previously and the road to fruition is still unclear; this has been added to the list of AAPA goals.

Social Security/CMS are urged to reimburse Medical/Psychiatric/Surgical services provided by PAs and reimburse as all Medicare Providers are. Public and Third party payers are urged to enroll PAs to help with the impact on health care system – allowing for the tracking of volume and quality of care. CMS, third party payers, third party administrators and employers should be educated by the AAPA that PAs are providers.

Marijuana was discussed at length with final adoption of policy to continue researching and to consider its Schedule I status -

- The AAPA believes that additional clinical research should be conducted on the therapeutic value, efficacy and safety of cannabinoids. Safety and packaging warnings were encouraged as follows:
  - AAPA supports continued education programs and public health based strategies relating to the abuse of marijuana, and addressing and reducing the use of marijuana.
  - AAPA supports public health based strategies, instead of incarceration, when dealing with persons in possession of marijuana.
  - AAPA discourages the use of marijuana by women who are planning to become pregnant, are pregnant, or breastfeeding

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AAPA HOD Discussions and Resolutions from the National Conference

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and shall treat and counsel women on cessation of marijuana use.

- AAPA discourages the use of marijuana by those persons under the age of 21 and discourages the use of marijuana by adults who are in the presence of persons under the age of 21.
- AAPA supports legislation that requires labeling and child-proof packaging of marijuana and marijuana related products and that limit advertising to adolescents.

The pain/opioid abuse crisis – The AAPA encourages student and graduate PAs to recognize the crises of pain management and opioid abuse. The AAPA encourages student and graduate PAs to work toward a solution to these crises at the local, state, and national level through advocacy, collaboration and by educating student and practicing PAs about pain and opioids abuse. These include a team approach using different modalities of pain control and referral to pain specialists where appropriate. AAPA supports increased access to opioid treatment programs for patients with opioid use disorder, and therefore recommends identification and removal of obstacles to full PA utilization in such programs.

Head Trauma – existing helmet safety policy was amended to include all contact sports or activities that Traumatic Brain Injury is a risk.

Discussion of **post graduate programs** with a position paper offered for review: Adoption of AAPA to accredit and optimize the training of post graduate PAs. It is felt the model is one that maintains PA flexibility along the career path.

AAPA **will accept as Category I CME** – credits earned through the European Union Medical Specialists/European Accreditation Council for Continuing Medical Education (UMES/EUACCME).

The **Student Delegation** brought forth a resolution discussing the multiple barriers to **student clinical rotations**. Many factors to these barriers were discussed both pro and con the barriers. One mentioned ARC-PA accrediting programs without discussing how, where the students would rotate; some schools in the same area have competition to get the students into practices, hospitals and other rotations. The decision of the Reference Committee stood – A Joint Task Force will be created and meet with PAEA (the educational organization) to investigate barriers to rotations and barriers of practicing PAs to serve as preceptors. Reporting will occur at 2017 HOD.

The House of Delegates said "goodbye" to new AAPA president L. Gail Curtis as she stepped down as Speaker of the House. The House will reconvene in Las Vegas May 15, 2017.

Speaker L Gail Curtis at the podium

Michigan has received another delegate seat, bringing our total to 8 seats (votes). As MAPA elections will be completed by May 31, 2017 there may be one or more seats available. If interested in becoming a MAPA delegate to the AAPA HOD, please send a letter of intent to serve and your CV to: www.michiganpa.org. A desire to statesmanship, follow Parliamentary Procedure, and read bylaws and policies are welcome. Time commitment besides reading on your own is a meeting in October, a conference call or two and physical and mental presence at the AAPA national conference, in the House of Delegates area for 2.5 days. Category II credit is earned for your time.

For a detailed review of all actions please visit https://www.aapa.org/WorkArea/DownloadAsset.aspx?id=6442451313

MAPA hosted its annual chapter reception during AAPA's Annual Conference in San Antonio. Michigan PAs mixed, mingled, and enjoyed a great time!

Lessons Learned in the ICU Waiting Room:

White Coat to White Knuckled. How I Renewed My Patience for Patients

R. David Doan III, MS, PA-C

It's easy to get comfortable functioning in a routine. I work practically the same schedule at work, and with the same MA and types of patients. With time, I have become comfortable with getting to work around the same time, seeing the same types of office visits, and treating the same types of medical conditions. I would even venture to say that I excel when I stick to a routine; it is comforting to me. However, sometimes getting a little uncomfortable can be good as well. Getting too comfortable can cause you to become complacent and unwilling to strive for improvement. Getting too comfortable can give you the false sense that you "have this in the bag." When you get too comfortable, you can miss out on the big picture.

Recently, I was taken out of my comfort zone. I am comfortable as the PA in the office that makes the diagnosis, decides on treatment plans, and gives advice to the patient on how to move forward. Earlier this year I received a panicked call from my father, my mother was headed to a large hospital from their small town ER, and it was serious. It was late in the evening, and it was a "no-brainer" that I should meet him at the ER. He was distraught and I was worried. The minimal information my father was able to provide sounded grim. My mother was ultimately diagnosed with Bacterial Meningitis, a dire diagnosis for many. She was intubated and sent to the ICU for treatment and stayed in the ICU for about a week before embarking on a recovery journey that involved a 3 week stay in the hospital and likely will involve a long recovery at home. I am grateful for the care she received as she is miraculously, recovering nicely at home without any significant sequelae. The uncomfortableness came when I had to take my PA hat off and be the family member of a seriously ill patient. Remember, I feel comfortable with routine and this was not routine. I feel comfortable with making the diagnosis, formulating a plan, giving advice; basically I am more comfortable when in control of a situation. As the "patient's family," I wasn't in control. Certainly, knowing the diagnosis and potential outcomes was not helping my comfort level.

What I learned in my new found uncomfortable state was that I could be a better medical provider. I was reminded of the importance of being empathetic, caring, and patient with the patient and their family. The staff at this large hospital provided excellent medical care; but also, they provided my family with lots of answers to many questions. They were empathetic to our pain, and they went out of their way to be sure we were as comfortable as we could be in such a precarious situation. You see, I was reminded that to receive the best care and outcome, we as patients expect our providers to not only treat us based on their expertise in medicine, but also to listen to our concerns and comfort us when we come to them in our most vulnerable moments. My mother's care was wonderful, and we felt we were heard and not forgotten. We could feel the concern they had for her and our needs, and they shared our joy when she showed signs of significant progress and recovery. We, as the patient's family, felt that the hospital staff (Docs, PAs, NPs, Nurses and staff) were sharing the experience with us. They appeared to have the same emotion invested in my mother's care, which was very comforting to my family.

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When I returned to work, it had been 8 days from the day my mother was admitted to the hospital and she still had a long road ahead of her. From my recent experience, my view of patient care had changed. I have been told that I have a good "bed-side manner" by many patients, but I have to admit that there are times when I could be better. When my day becomes crazy, when the paperwork and charting backs up, and when those "problem patients" come in, I will be the first to admit that my caring, empathetic and patient qualities often take a back seat and I become more withdrawn from the patient. My mother's stay in the hospital was a reminder that I need to treat all my patients with the utmost respect and to care for them as I wanted my mother cared for. When the schedule gets hectic or the charting backs up, I need to block it out and leave it outside the patient's room and give the patient all my attention. When the "problem patient" comes in, I need to step up and be more caring and empathetic. I need to treat the patient's concerns and questions with all seriousness and attention; no matter how trivial I feel the concern or symptoms are. Our patients come to us when they are most vulnerable and in the most need. We have been given the opportunity to impact their lives in profound ways and to show and share kindness.

We have studied and spent countless hours learning and honing skills to be great clinicians, but when it really comes down to it, the best providers are those who can communicate and connect with his or her patients. My experience as a patient's family member was uncomfortable, but only in the sense of concern for my mother's health and the feeling of not being in control of her care. I certainly felt comforted by the care she received and the empathy and caring nature of the Doctors, PAs, Nurses, Therapists and hospital staff where she was hospitalized. We all have heard stories from patients, family or friends who have unfortunately experienced less than stellar care in a hospital. The common thread is not how the illness turned out (usually), but rather how the patient and/or family were treated as people while there. After all, many times, we may not have a real say in how an illness will turn out; we can only do our best to fight it with what we have been taught, and keep the patient as comfortable as possible. It is often out of our hands. What we can control, is how we treat the patient and family on a personal level. I will take this experience with my mother's illness and carry what I have experienced into each office visit encounter. I may not always be able to make a profound health effect for a patient (but will give 110% in effort!) in each encounter. I can treat the patient with dignity, give all my attention, be empathetic, offer everything I can, and show I care… EVERY TIME! As a patient, I would expect this from my provider; as a family member of a sick patient, I would expect the same.

We as PAs can touch the lives of each patient we see. Don't let distractions steer you away from being the best PA you can be. Leave your baggage and distractions out of the patient's room and give your patient your full attention. Look the patient in the eye and really listen. A patient who feels heard and validated will be more compliant with care and be more satisfied by their care. We can be the providers that make the difference in quality of care; we just need to step out of our comfort zone, and step into renewed efforts to be more empathetic.

Educating Employers of our Intangible Benefits: How to get the most value from the services you provide.

By Ginger Biesbrock, PA-C, MPH, MPAS, AACC, Vice President- MedAxiom Consulting

Recently, two large integrated delivery systems quoted $10 million to $30 million dollar losses on their organizational Advanced Practice Provider (APP) program/services. To a lesser extreme, but in a dichotomous way, administrators informed me that their APP program is "a valuable investment" because it provides a better work/life balance for their physicians, yet sadly enough, they do not feel the APP program brings monetary value to the organization. These scenarios are very unfortunate, unhelpful and unnecessary to all stakeholders; especially when there is plenty of evidence to support APPs being an integral and valuable commodity to a system's provider team. In fact, we have examples where APPs represent a very sound investment, with charges 2.5 - 4x their salary and collection rates of up to 57% (1). In addition, a recent MGMA APP survey suggests that groups that employ APPs have higher physician compensation (2). So, where do the above reported losses come from? Are they truly losses or the result of systemic administrative operational inefficiencies? Are APPs not working to the top of their licensure, billing appropriately for their work, or accounting for their productivity correctly? It is likely a combination of all three of these questions. To create a profitable APP model, an organization has to evaluate and address areas of: scope of practice and utilization, billing practices, and valuation.

Scope of Practice and Utilization - poorly understood by administrators, coders & billers

First and foremost, APPs should be practicing at the top of their licensure. They are providers and the majority of their work—evaluation and management that contributes to an episode of care as part of a global period—should be reimbursable. An APP's scope of practice is dictated by their state license and the scope of practice of their supervising or collaborating physician.

A full evaluation of current roles and responsibilities should be performed to ensure that all are based on licensure, not convenience or lack of understanding of true scope of practice. This means defining roles and describing how the APP supports a particular team, patient panel, or chronic disease management program or special population. It is through these transparent definitions that appropriate time allotment can be assigned to each encounter, whether it involves routine follow-up visits, post-hospital visits or even hospital-based rounding services.

A full evaluation of current roles and responsibilities should be done to ensure that all are based on licensure, not convenience or lack of understanding of true scope of practice.

It is important to take into account the real support required vs. the perceived support a PA needs to continue performing at the top of their license. This is very similar to how you would manage physician utilization. If you are expecting the PA to see a patient in 15 or 20 minutes and they spend 10 minutes 'fishing' for records, this is not an appropriate expectation. Time studies can be helpful to better understand the scope of work being performed. I have seen examples where a request was placed for an additional APP to a team, and in review, what they really needed was a Medical

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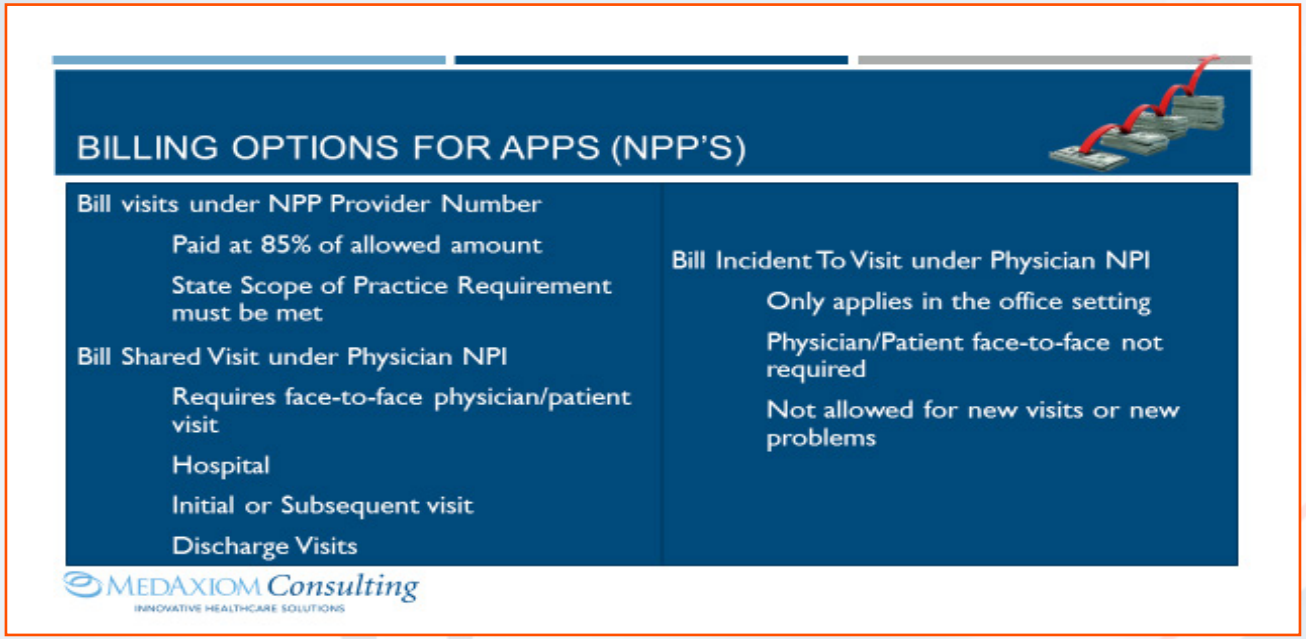
Records technician. A full organizational systemic evaluation of roles and responsibilities should be done any time an additional provider is requested.



Billing Practices - Informed and correct practices are a must

A colleague recently told me that her administrator came to her six months after her hire date and revealed that no billing had been done for the work that she has already performed. Other stories I have heard include APPs were seeing patients on a limited basis, because the organization did not want to lose the 15% reduction that would occur by billing under the APP NPI number. This means that the APP was not being fully utilized and working inefficiently—probably at a big loss to both the practice and to the APP.

An organization or clinic should never be afraid to bill under the APPs NPI number or avoid independent work; the 15% billing reimbursement difference may not equate to more than $10-$20 per encounter, but there may very well be an opportunity to bill as "incident to" or "shared visits". In other cases, some private payers do not recognize APPs and will allow for the work performed to be billed under the supervising physician; the dollar difference ends up being minimal. In fact, a fantastic way to use an APP is to assist in managing a patient panel in which most of the visits are routine follow-up, since a plan of care is already in place, many of these can be billed "incident to". A "shared visit" in the hospital-based setting can cut the physician rounding time by more than half, allowing their utilization to be shifted to procedures, surgery or testing interpretations.

A thorough review of billing practices and APP utilization should also be performed as there may be an opportunity to increase billing and collections.

Valuation

Finally, it is important to understand your ability to capture the value of the services you provide; since traditional RVU capture is not always accurate. Many commercial payers do not recognize APPs as service providers and the services provided are billed under the supervising physician's NPI. My experience indicates that in most cases, those RVUs are remitted to the physician because appropriate tracking for allocation was not performed, leading to disproportionate value of services provided by the APP. Also, many APPs perform required and supportive care during global periods and these are not typically billable services, but they are necessary and contribute to the care of the patient. If the APP was not performing the visit, the physician would need to perform these visits.

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When the RVU value that is calculated from a service provided by an APP, it is important to take into account correct billing practices and make sure that all the services that an APP is performing are captured and coded properly. In addition to traditional reimbursement, there are many other value-added, non-reimbursable components that only APPs can do and these components need to be translated into non-financial benefits to group's practice administrators or healthcare organizations administrators. Value added examples include: early discharge facilitation, potential improved patient throughput in acute care settings, assurance of core measure fulfillment, appropriate documentation to capture acuity, and more. Again, if the APPs were not performing these responsibilities, the physician would have to and this would lead to lower physician utilization. Thus, by adding an APP to an interventional rounding service, you can take a physician from a full-day rounding role to a half-day rounding role with an additional half day in the cath lab, surgery or office; the value can be seen in either more procedures or an increase in new patients seen. Clearly, these are many additional areas of value that need to be accounted for to really understand, if not have a higher appreciation for, all that the APP can provide to the practice or hospital system.

It is important to understand your ability to capture the value of the APP; traditional RVU capture is not always accurate.

The emerging value-based landscape and payment reform will dramatically change the way we interact with our total patient population and how we get reimbursed for their continued well care. The appropriate and well-planned deployment & utilization of APPs is a requirement to optimally manage patient populations. There is no reason that an APP program should be a loss or a drain on the healthcare system. With a deliberate model of care and role in the healthcare team, APPs can provide a good return on investment. But even more important, the value added should include physician satisfaction, APP satisfaction, team satisfaction and most importantly-patient satisfaction—which are all priceless!

1 Wagonfield, James B. October 2006, "The Non-physician provider in the Gastroenterology Practice" Gastrointestinal Endoscopy Clinics of North America.

2 NPP Utilization in the Future of Healthcare, MGMA, 2014.

Questions You Should Be Asking:

What current services/work are APPs providing in your practice? Are they all at the top of our licensure or scope of practice?

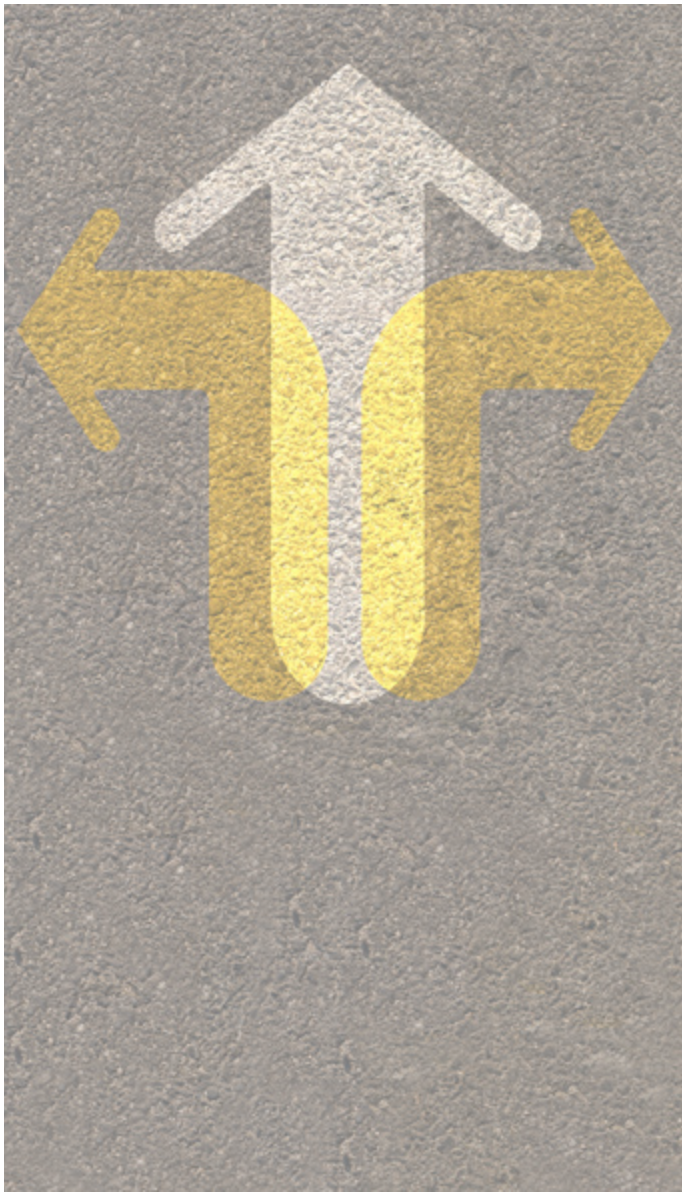
Is all reimbursable work captured and billed for? When is the last time you did an audit of your billing for the services you provided?

Does your current financial report take into account all the services provided by you that end up billed under the physician NPI? Are you able to include the non-reimbursable value that you provide?

Metacognition: Moving Towards a Better Clinical Decision-Making Mindset (Part II)

An Unforgettable Case of Medical Heuristics: One of Premature Closures and Anchoring Biases

Marcos A. Vargas, MSHA, PA-C



Halfway through my 3rd year cardiology run, I became involved as a consultant for my employer in one of the most "atypical" cases of chest pain I have ever came across. Little did I know at the time, this "chest pain consult" case would introduce me to another realm of medicine; one never heard much of or taught anything about until that day—namely medical heuristics.

That day upon entering the room of this "chest pain consult", I noted a pleasant, COPD body habitus & non-conversationally dyspneic middle-aged man sitting in a hospital recliner in NAD. He had an IV pole/line, bilateral ted hoses and a nasal cannula for oxygen supplementation. Oddly enough he had no lip pursing, no central signs of cyanosis, but was wearing his hospital gown backwards, for which it's not rare. At a glance through the paper chart (before EMRs), the presentation and medical history seemed pretty straight forward. Basically, out service was being consulted for ***episodic atypical chest pains*** in a 57 y/o wm, 4 years s/p 3-vessel CABG with all the traditional pre-op CAD risk factors, including a strong smoking history(COPD /Home O2 dependency) and a strong family history; luckily, this patient experienced no prior AMIs.

Per patient's recall of his own PMHx, he seemed frustrated with these hospitalizations, time after time, his COPD/Angina Pectoris was found to be unchanged from his usual chronic bronchitic baseline. In fact, all his radiographic studies and metabolic labs would return within normal limits and surprisingly, essentially unchanged. Also, as part of the work-ups, he underwent several negative cardiac interventions; among them were a few Dobutamine stress echo studies along with 5 cardiac catherizations, during that 3 year period. Plus, no dysrhythmias or neurocardiogenic issues that could have accounted for the chest pains he complained about. Moreover, he had a preserved LVEF throughout these inpatient encounters. Angiographically, all his coronary saphenous vein bypass grafts were reportedly patent, plus his chamber perfusion pressures remained unchanged.

Nearing the end of the queries, I felt I had not uncovered anything new or groundbreaking in order to

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customize and/or justify my work-up at the very least. While continuing to answer my queries, tears began strolling down his cheeks. Unapologetically, he continued to express his disappointment with the doctors inability to "to figure out" his "***rocking***" chest pain when he would cough and/or push himself up from a sitting position, to stand-up, open a door or even twist open a lid from a jar at other times. Then I realized I was probably focusing too much into uncovering a cardiac etiology and was momentarily stuck in that mindset like many others probably did before me.

I immediately began entertaining other diagnoses mimicking chest pain, such as depression/somatization, etc. As I reframed my mindset and querying, it dawned on me the possibility that I was dealing with a ***non-union*** presentation of his surgical sternotomy, which admittedly, I had not seen more than a handful of cases, early in my days of CVT surgery. When I opened his gown and he attempted to lift himself from the recliner, he grimaced in pain, but more importantly, I was stunned by the sight of his unstable and uneven chest "***rocking***" back and forth as he had mentioned earlier. As I expected, the remaining physical exam was unremarkable.

Our service referred him to the Cardiothoracic service for surgical repair/fixation of his non-union of his sternotomy, after ruling out an ACS event. At the time, he did not require any further "pre-op diagnostic" testing since his last "clean" cardiac cath had been performed a few months back prior to this admission, with no new interval risk were encountered. We felt he had non-cardiac chest pain as corroborated by my physician. He surmounted a prompt post-op response after his sternum was re-wired satisfactorily and released several days later in stable condition.

The Final Analysis: the contributing elements of missed diagnoses

After that encounter, driving home all I could think of was: "How could this diagnosis have been missed"? Was there any miscommunication between all parties involved? Could there be some element of contributory negligence from the patient himself? In essence and after reflection, this case clearly illustrates a myriad of clinical management problematic issues.

The worst of my fears where confirmed when I further asked the patient the above questions in a non-judgmental rephrased manner. He corroborated some of my worst fears: medical errors or misses are compounded when healthcare is fragmented. For example, when medical providers inadvertently miss communicate with patients and/or amongst themselves, regarding medical care and/or cursory work-ups, resulting in cursory H & Ps being performed. These disasters or suboptimal medical encounters, such as this one and are the end-result and are bound to happen when clinicians either "***anchor***" or "***prematurely close***" their diagnostic assessments and reasoning's, due to subconscious biases or prejudices.

Admittedly, this patient also played a role in this medical misadventure by being noncompliant, he continued smoking and stopped his smoking cessation program; he also "fired his PCP" and failed to be proactive in his own cause. As if that wasn't enough, allegedly many providers (per the patient's claim) performed cursory H&Ps—some never "touching him" (meaning not auscultating, palpating or visualizing his chest during the physical exam).

Unfortunately, there's a high correlation of delayed and/or missed diagnoses due to medical heuristics; an underlying force that we must all be cognizant at all times.

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Metacognition

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However, don't be fooled by either the chief complaint or reason for consult; as a former Emergency Medicine PA, one valuable pearl I learned early on was there's oftentimes, more to the story besides "X & Y" listed as complaints. In fact, in many instances the complaints may not be related to the real issue at hand. So investigate, probe and be thorough as much as you can.

Sadly, many physicians', residents and even PAs, disregard prior notations or entries by triage nurses, etc., because they feel these would lead them astray in their clinical decision-making process. From a Risk Management perspective, nothing could be more disastrous, especially when one recalls the 1st fatal Ebola case report in Dallas, TX at the height of the pandemic. So the take home message should be this: 1) avoid cursory H & Ps, 2) avoid "key-hole physical evaluations" (best when patients are undressed), 3) don't be fooled by a "CC", and 4) don't be derailed by medical heuristics or patient's own framing biases. In medicine, sometimes patient encounters hardly appear what they really are—don't be afraid to search and uncover the facts, first from the patient's perspective and then yours, while avoiding someone else's biases.

MICHIGAN PHYSICIAN ASSISTANT FOUNDATION

Celebrating Our 25th Anniversary

The Michigan Physician Assistant Foundation (MIPAF) is a nonprofit 501 (c) 3 charitable organization founded in 1991; considered the charitable arm of MAPA. Our public foundation provides scholarships to second year Michigan PA students. Our motto is: "MIPAF provides the scholarship…you provide the future."

The annual MAPA Fall CME Conference will be held October 13-16, 2016 at the Grand Traverse Resort in Acme, MI. On Friday evening of the conference, the Michigan PA Foundation will again host the "Student Quiz Bowl." All Michigan PA programs are invited to participate; it is a fun event with a lot of enthusiasm from the students and audience. Another event that the MI PA Foundation holds at the Fall Conference is a 'silent auction'. This will be held Saturday evening prior to and during the reception. 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; examples include: tickets to events, hotel stays, golf packages, gift baskets, etc. Please contact Vaughn Begick at 989-686-0578 or by e-mail at 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 as a donation, as a charitable contribution, that is tax deductible. Please consider participating in our "$25 for 25 Years Donation Club". Give $25.00 to represent our 'Silver 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. We will have a donation table to receive cash donations during the MAPA Fall Conference.

So we hope to see you at the MAPA Fall CME Conference and if not, check out our web page at: www.mipaf.com 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 our Foundation. Areas of need include:

- Student Quiz Bowl
- Donations/Silent Auction
- Board positions for Secretary and Treasurer
- General ideas to improve the Foundation

If you have an interest in helping with our foundation, please join us at our annual open board meeting during the MAPA Fall CME Conference on Saturday from 10:00am-12:00pm. Maybe you are- a past scholarship recipient who wants to give something back, a past MAPA board member or volunteer who has expertise in an organization, a new grad who wants to help future PA students or 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.

MIPAF,

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MIPAF Board Member

Ceruminal Impaction Management 101

Eric T. Kreckman, PA-C

Auricular Ceruminal Disimpaction is not a glamorous task. In fact, sometimes it's a messy, yet common primary care malady seen across the spectrum of life. At times, a few cases need an otolaryngology referral, but the vast majority can be addressed easily in most primary care offices. Admittedly, this isn't rocket science, but it is something you can do and do well without the high end tools of the otolaryngologist; if you are prepared and aware of a few things beforehand. Essentially the process is a straightforward one with 4 basic steps outlined in this article for anyone performing this clinical procedure in the office or clinic.

Assessment

The history, diagnosis and physical findings should be straightforward: no forceful head trauma or ear canal mechanical trauma (i.e. Q-tip) causing tympanic membrane ruptured nor any neurological symptoms or deficits for that matter. On physical exam, no auricular (helix) edema or redness (DX- Acute Perichondritis or Auricular hematoma) should be seen. Most patients often time present with a CC of aural fullness and/or decreased hearing.

Also, you must rule out TMJ, Acute Otitis Externa, and Mastoiditis in your differential dx. The color of the cerumen is often indicative of the hardness of the impaction. Darker nearly black plugs are typically harder and have been present for several months and even years. These darker plugs, especially in the older patients, should be softened prior to extraction. Hard wax has the additional challenge of being firmly secured by ear canal hair. A curette is very helpful in assessing the hardness of the wax. If the curette doesn't easily penetrate the wax then you must stop and soften the wax before attempting to remove the impacted ceruminal plug. Remember to verify that there are no tympanostomy tubes in younger patients with their parents or any barotrauma (i.e., diving injuries); if uncertain of history you may consider a referral to ENT.

If the wax is hard from your inspection, the patient can be sent home with instructions to place 4-5 drops of olive oil in each ear canal and tip the head for 10 minutes or so to ensure good contact once daily for a week. There are lots of other choices /products to use to soften the wax, these include: olive oil, Colace (docusate sodium), sodium bicarbonate, hydrogen peroxide, mineral oil, canola oil, or Debrox (carbamide peroxide). Which one is best? A 2009 Cochrane review concluded "Trials have been heterogeneous and generally of low or moderate quality, making it difficult to offer any defini-

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tive recommendations on the effectiveness of cerumenolytics for the removal of symptomatic ear wax. Using drops of any sort appears to be better than no treatment, but it is uncertain if one type of drop is any better than another."1 One advantage of the oils is that in the event of a tympanic membrane perforation the oils will not cause pain. Hydrogen peroxide in the middle ear will cause exquisite pain and a chemical reaction.

Lavage & Equipment

Solutions for lavage range from distilled water, saline or 1-3% hydrogen peroxide, some with sodium bicarb. There is no definitive ideal solution, however, a 2015 study published in the International Journal of Pediatric Otolaryngology identified the best cerumenolytic solution as a combination of glycerine 10cc + 3% hydrogen peroxide 10cc + 10% sodium bicarbonate 10cc + distilled water 10cc.2 The temperature of the solution affects its efficacy. Try to use the solution at approximately body temp or a few degrees warmer; room temp solutions are less effective and are prone to cause patient discomfort.3

The large syringes and spray bottles are the principal tools for lavage. The advantage of the syringe is that they are widely available and can deliver a lot of fluid quickly. The advantage of the spray bottles is the increased capacity, less mess created, and generally increased patient comfort. Dr Easy Elephant Ear Washer Bottle System is a popular system. It's a common spray bottle with a flexible hose and a tip which can be maneuvered to target different locations in the canal and it delivers a strong stream. Keep in mind that it is a 2 hand system and that the tip can deliver an uncomfortable amount of pressure to the tympanic membrane. The Dr Easy Rhino Ear Washer is very similar to the Elephant except that it utilizes a short rigid nozzle instead of the long flexible one of the Elephant. The advantage being that it can be used one handed and it uses the same Dr Easy tips.

A more recent device is the Bionix OtoClear System. It is similar to the Rhino in basic design. The bottle has an improved grip and trigger with a temperature gauge on the bottle. The Otoclear tip is very different from the Dr Easy tips in that it is wide at the proximal end of the tip and will not enter the ear canal. The tip projects 3 equidistant streams forward to the canal walls, rather than at the tympanic membrane. The tip has 3 large ports so that the lavage solution and smaller bits of cerumen flow through.

PROCEDURAL PEARLS

1. Otitis Media, Perforated TM, and Tympanostomy Tubes are contraindications to cerumen lavage and removal.
2. This is a painless procedure, but if your patient is complaining of pain, stop and refer to ENT.
3. Trim the Dr Easy tip for pediatric use.
4. Code for nurse/MA lavage: 69209
5. Code for provider using tool (curette): 69210
6. When using the Elephant tip, make sure you are using the included shield.
7. Elephant and OtoClear tips are interchangeable, keep both on hand.

Curetting

Often, lavaging is enough to dislodge retained impacted cerumen, however, there are a few occasions when a curette will be required. There are a variety of curettes, most are disposable plastic; curette variations are in angle, loop size, rigidity and color. It's a good idea to have a few different ones on hand. Typically, this is a 3 hand procedure, one for the otoscope, one for the curette and one to gently pull the pinna back and up; the patient can assist in holding the pinna. Be gentle- use the curette to loosen the mass rather than

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attempting to dig it out. Alligator forceps are very helpful in grasping a piece of cerumen. Avoid scraping the canal walls clean with the curette, use the liquid lavage for this step. Sometimes with substantial masses you will need to lavage, loosen and repeat.

Visualizing

Visualize the full tympanic membrane and particularly note the integrity of the tympanic membrane and the canal in your dictation or notes. Occasionally, cotton swab usage within a few days of cleaning will trigger slight bleeding (less than 1 drop), so advise patients to avoid cotton swab usage for several days following cleaning. No follow up is necessary unless the patient is symptomatic. Some patients need cleaning every 6 months by lavage, while others can go years before it is necessary to address.

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2. Int J Pediatr Otorhinolaryngol. 2015 Jul; 79 (7):1096-100. doi: 10.1016/j.ijporl.2015.04.039. Epub 2015 May 6.
3. Am Fam Physician. 2000 Jan 1;61(1):197-198.

MAPA PLANNER

EVENTS/CONFERENCES

MAOFP SUMMER FAMILY MEDICINE UPDATE

DATE: August 4-7, 2016
SITE: Grand Traverse Resort & Spa
Traverse City, Michigan
INFO: www.maofp.org

FOOD ALLERGY& ANAPHYLAXIS MICHIGAN CONFERENCE

DATE: August 6, 2016
SITE: The Kensington Hotel
Ann Arbor, Michigan
INFO: www.foodallergymiassociation.com/conference.html

MAPA Fall CME Conference

DATE: October 13-16, 2016
SITE: Grand Traverse Resort & Spa
Traverse City, Michigan