YOUR VOICE. YOUR PROFESSION.

MICHIGAN PA

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MICHIGAN PA

YOUR VOICE.
YOUR PROFESSION.

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Your Newsletter Editor's Corner

Hello MAPA friends,

I hope this letter finds you well and I certainly hope you are enjoying some sunshine in your neck of the woods! We had an overwhelming response to our call for articles email-thank you all so much! As such, our newsletter is chock-full of interesting articles and news that I'm sure you will enjoy. On a personal note, I asked my father-in-law, Dr. Charles Schisler to write a piece sharing his thoughts of how medicine has changed since he began practicing as a family doc in 1971. We practice in a completely different world compared to 47 years ago!

I would like to encourage you to become a MAPA committee volunteer. The time commitment is manageable and I promise you will enjoy the work. Please see our website, michiganpa.org for opportunities.

Finally, please consider sharing your thoughts or opinions, a brief case report, essay or an article for any of our newsletters. If you are interested or have questions about the MichiganPA Newsletter, please feel free to contact me at kate.schisler@michiganpa.org or call 989-415-2200.

Sincerely,

Kate Schisler, MSM, PA-C, MichiganPA Newsletter Editor-In-Chief,
MAPA Treasurer

And the Winners are . . .

2018-2019 MAPA BOARD OF DIRECTORS ELECTION RESULTS

The 2018-2019 MAPA election is complete and the votes have been counted and verified. The following fellows have the honor to serve the PA community in Michigan.

Congratulations to the following candidates:

President-Elect
Jodi Zych, PA-C

Treasurer
Kate Schisler, PA-C

Region 2 Representative
Fred Kaspriak, PA-C

Region 4 Representative
Blake Geschke, PA-C

Region 6 Representative
Julia Burkhardt, PA-C

AAPA Chief Delegate
Molly Paulson, PA-C

AAPA 2019 Delegates
Julia Burkhardt, PA-C
Janet Burns, PhD, PA-C
Mary Huyck, PA-C
Steven Myers, PA-C
Zarna Patel, PA-C
Michelle Petropoulos, PA-C
Ron Stavale, PA-C
Heather Sutton, PA-C
Karl Wagner, PA
Jodi Zych, PA-C

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

Congratulations to our MAPA BOD 2018-2019. These leaders will continue to serve the patients and PAs of the State of Michigan and keep us the constituent organization that the AAPA looks to for guidance to help around the country.

An Unexpected Way TO CAPITALIZE ON A PA DEGREE

Dawn Miller, PA-C

Do you wish you could travel more, need a new car, or perhaps student loans are weighing you down? Have you ever wondered how to capitalize on your physician assistant education?

Last fall was the first time I was faced with all of my kids in school a full day. GASP! I began to look at ways to put more focus on my career without interfering with my kid's schedules or my clinical position. I didn't want to commit to a full-time job, just something to fit in the nooks and crannies of my life that didn't include selling things to my friends on social media.

A former classmate introduced me to a review company. I was on-boarded into a whole new culture of medicine that I was surprised to find existed and was thriving. I currently hold a position in content support for the company. I am charged with answering questions that other physician assistants have about the content. There are other PAs hired to edit content, create content and even do a podcast.

Another unique opportunity is becoming a question author. The compensation is great and the work can be done at your convenience. This opportunity is great for new grads and for seasoned practitioners. It requires no extra qualifications, just a physician assistant license.

So, what are you waiting for? Get out there and try it out! What do you have to lose?

FAQ: CONTROLLED SUBSTANCE PRESCRIBING

(UPDATED 6.25.18)

As you know, Michigan's requirements for controlled substances are evolving. MAPA leaders continue to work with state and healthcare leaders to advocate for PAs and our patients. See a detailed version of the FAQ's describing PAs prescribing or dispensing controlled substances.

CALL FOR ARTICLES

MAPA invites you to share your thoughts or opinions, a brief case report, essay or article for future issues of our MichiganPA newsletter.

We are looking for newsletter contributions, both clinical and non-clinical articles, from all areas of medicine including but not limited to family medicine, internal medicine, ID, cardiovascular, respiratory, neurology, orthopedics, psychiatry, OB/GYN, or any other area of medicine you think would be interesting to your fellow PAs. We are also interested in topics covering legislation, reimbursement and professional and business management. **Submissions should be double spaced, 1-3 pages in length, and include written permission to reprint the article from the author.** Please note that MAPA and its Communications Committee reserves the right to edit articles as needed. Submissions can be submitted to Kate Schisler at kschisler@michiganpa.org or to mapa@michiganpa.org.

HEALTH CARE FRAUD AND PA KICKBACK SCHEMES

A Follow Up to Michigan PA September 2013 Newsletter Article: *Business Arrangements that Could End Your Career*

Natalie J. Dillman, PA

My name is Natalie Dillman (Schutte) and I co-authored an article in the September 2013 MAPA Newsletter called *Business Arrangements That Could End Your Career.* This article was a precursor to the lecture I gave at the Fall 2013 MAPA Conference regarding Healthcare Fraud and Kickback Schemes. To give you a brief history, in 2012, I was arrested and later convicted with a felony for receiving a healthcare kickback. I was connected with some very bad people early on in my PA career and I made some very bad decisions regarding business. The effects on my medical license have been career halting, if not ending. The education and average PA insight into medical business is nearly nonexistent yet the consequences for participation in fraud and kickback schemes is career suicide. It is crucial for PAs to self-educate and be aware of current schemes prominent in Michigan. Additionally, you should understand the terminology, be able to identify current kickback schemes and ways they are disguised, and have access to educational resources and help if issues arise.

There are many key terms and laws related to healthcare fraud including: *fraud, waste, abuse, False Claims Act, Federal Anti-Kickback Statute, Physician Self-Referral Laws (Stark Laws), Exclusion Authorities, and Civil Monetary Penalties Law*. It's important to understand the basics of what these terms mean and how they apply to your practice. For the purposes of this article, I will refer you to the Offices of Inspector General (OIG) (https://oig.hhs.gov/compliance/compliance-resource-portal/) and Centers For Medicare and Medicaid Services (CMS) (https://www.cms.gov/Outreach-and-Education/Outreach-and-Education.html) for most of the definitions and examples. However, there are a few terms I must define. *Health care fraud*: According to the Western District of Michigan United States Attorney's Office (USAO), "*Health care fraud* occurs when an individual, a group of people, or a company knowingly mis-represents or mis-states something about the type, the scope, or the nature of the medical treatment or service provided, in a manner that could result in unauthorized payments being made." (https://www.justice.gov/usao-wdmi/health-care-fraud). *Health care abuse* is defined as any practice that is not consistent with the goals of providing patients with services that are medically necessary, meet professionally recognized standards, and are fairly priced (www.oig.hhs.gov/fraud). Lastly, the *Federal Antikickback Statute* makes it illegal to "offer, pay, solicit, or receive any remuneration directly or indirectly to induce or reward items or services

reimbursable by a Federal Healthcare program." (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/fraud-and-abuse.pdf) Some states, including Michigan, additionally have similar statutes which protect both the private and public payors. **The take away point is that you cannot receive any sort of payment or gifts based upon volume or value of referrals.**

Now that we have discussed definitions, let's consider some of the common areas currently infiltrated with fraud schemes that you may be exposed to. Unfortunately, due to length limitations there isn't enough space for examples so I've tried to highlight key points for you to keep in mind when you encounter any arrangements or practice in these areas.

Rent: Rent must be fair market value and being paid anything over or under this could be considered a kickback.

Diagnostic Tests/DME: It is critical to make sure that tests and DME orders are medically necessary and there are no hidden incentives or arrangements with them. Be wary if a lab company offers you a "free" phlebotomist or "free" urine drug screen cups in exchange for you using their service (keep in mind, it won't be presented that blatantly to you!). Another red flag is "supervision fees." To be paid a legitimate supervision fee you must 1) make sure you are a qualified supervisor, 2) confirm the supervision fee is acknowledged and payable by the payor, and 3) make sure the amount you are paid matches the fee schedule. Remember, **you cannot be paid in any way based upon the volume or *value* of services.**

Free or Reduced Services: Offering free or discounted services for cash paying patients or waiving copays can be viewed as buying business. If you are going to offer free services, waive copays, or charge cash paying patients a reduced rate you need to document a financial hardship. More information can be found on the CMS website (https://oig.hhs.gov/compliance/physician-education/01laws.asp).

Home Health Care/Visiting Physician Services: To qualify for Home Health Care and Visiting Physician services, patients must be homebound. In many instances services are ordered on patients that are not homebound and costs pile up excessively for unnecessary treatments.

Prescription Fraud Schemes: It is your responsibility to fully understand the most up to date opioid prescribing guidelines and practice diligently with any prescriptions you write, making sure the prescriptions are medically needed. Additionally, while urine tox screening has increased dramatically over the years with the increase in opioid prescriptions and tighter

continued

FRAUD *continued*

prescribing regulations, you should make sure your testing is necessary and your arrangements with your lab company are square.

Now that you have a little more insight on health care fraud and kickback schemes, it's critical that you further educate yourself and assess your business practices. I've listed some very useful websites below which offer free CME, current cases, and what to do if you think you are involved in a compromising situation. Aside from educating yourself, everyone should consult an attorney to review contracts and actual business practices (make sure they understand how you are actually being paid as opposed to just reviewing what is written in your contract). It's a very small investment upfront that could potentially save you the loss of your career. Additionally, don't hesitate to ask questions if something is unclear, always trust your instincts, and make sure to react to red flags (don't be passive about it or assume it's something else). I also recommend doing a background check (licensing boards, google, etc.) on your employer. In the State of Michigan, you do not have to be a licensed provider to own a health care business so consequences for fraudsters are not as severe or career stopping. In my case, my employer had previously been convicted at the State level of health care fraud and was merely slapped on the hands with small fines. He was not stopped and so went on to create an entire empire again prior to my even moving to Michigan which resulted in the 1 million-dollar fraud scheme he was convicted of in 2012. Lookout for yourself and don't assume you are in a secure and fraud free environment. Here are the websites:

US Attorney's Office – Western District of Michigan:
https://www.justice.gov/usao-wdmi

US Attorney's Office – Eastern District of Michigan:
https://www.justice.gov/usao-edmi

Office of Inspector General -A Roadmap for New Physicians: Fraud & Abuse Laws
https://oig.hhs.gov/compliance/physician-education/01laws.asp

MLN Booklet - Medicare Fraud & Abuse: Prevention, Detection, & Reporting
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/fraud_and_abuse.pdf

Center for Medicare Advocacy: Combating Fraud, Waste, & Abuse In Health Care
http://www.medicareadvocacy.org/combating-fraud-waste-and-abuse-in-health-care/

Centers for Medicare & Medicaid Services – Training Resources
https://www.cms.gov/Outreach-and-Education/Learn/Get-Training/Get-training-page.html

Looking back all those years ago, it's hard to say where my mind was or how I let myself make so many bad decisions when I should have been smarter about my business practices, however I can honestly say that I never realized the extent of my involvement or the severity of the consequences of my actions and choices. My knowledge on fraud and kickback schemes was nonexistent. Naivety and ignorance of the law are no excuse. Remember, the only person looking out for you and the ultimate value of your medical license is you. Healthcare fraud is rampant everywhere in Michigan and to think it is as simple as "only bad people" getting tied up in it is ignorant. The USAO's office, just in Michigan, has collected more than $32 million in criminal fines and civil damages related to healthcare fraud in the past 5 years (https://www.justice.gov/usao-wdmi/health-care-fraud). That's insane! You are exposed to these people and these schemes. My hope is that you now at least have more insight on the topic and knowledge of how you could be approached or fall into a kickback scheme. Please use the resources I've provided, consult an attorney, and share with your colleagues and coworkers to spread the word that these issues are real and happening right outside of your door.

How do I get Involved?

Engage with MAPA and Your Community

Are you looking for more ways to be involved with the community? Are you interested in the physician assistant (PA) profession and networking opportunities? If you answered "yes," then please consider becoming more involved with the Michigan Academy of Physician Assistants (MAPA) - an organization that fosters professional and personal growth for PAs in the state of Michigan.

On Saturday, June 9th twenty MAPA members joined the Crohn's and Colitis Foundation for its annual Take Steps walk, where volunteers assisted with children activities and refreshments. Members also had the chance to interact with other health care providers and relay information about the PA profession and its key role in the health care team. It was a wonderful event for all to gather, highlighting the positive importance of volunteerism.

Dedicated to finding cures for Crohn's disease and ulcerative colitis, the Crohn's and Colitis Foundation focuses its efforts on research, education, and patient support. As current and future health care providers, it is important that we are educated in disease states, treatment, latest research, prognosis, and even further, understand the social impact of various diseases that could potentially affect our patients.

Community volunteerism enables one to better recognize those social impacts and their effects on patients and families. A meaningful understanding promotes insightfulness, improved patient/provider communication, and the development of more empathetic providers.

MAPA is committed to making a positive impact within the community, enhance social connections within various sectors, and provide mentorship within the PA profession and in collaboration with community members, heath systems and foundations.

continued

VOLUNTEER *continued*

I encourage you to become engaged in your community by volunteering, student precepting, guest lecturing, leading outreach efforts, mentoring, researching, or simply lending a helping hand to those in need. Thank you for making a meaningful difference in the lives of your patients and colleagues.

Please save the date for our second MAPA Mixer in Troy, Michigan on Thursday, November 29th -an evening to mingle with prospective and current PA students, PAs, and community leaders. More information will be posted closer to the event. Please also stay tuned for future events and ways to grow in the PA profession while making a difference within our community.

Felicia Shaya, PA-C
MAPA Volunteer Coordinator

MICHIGAN ACADEMY of PHYSICIAN ASSISTANTS

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

INHERITED
LONG QT SYNDROME

Fred Clifford, PA-S, Central Michigan University Class of 2019

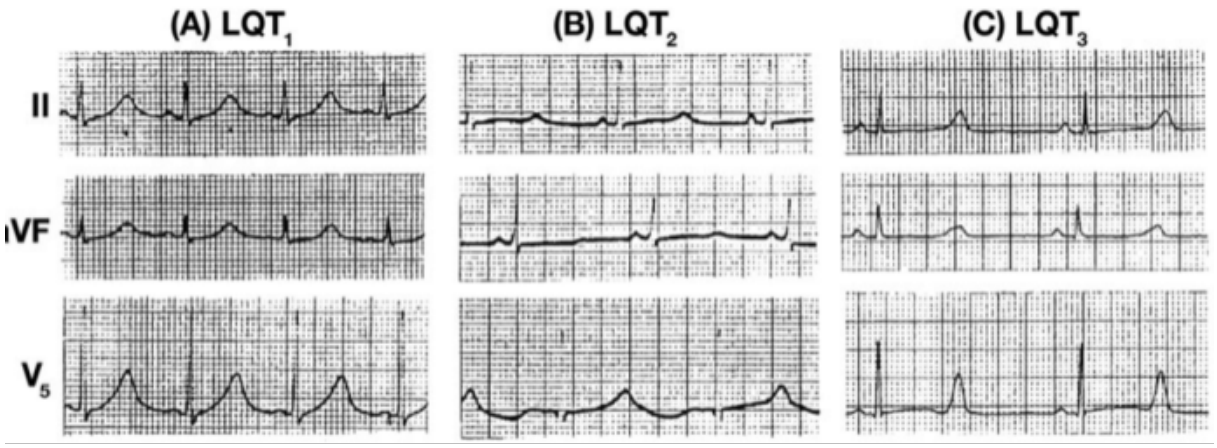


Image 1. EKG waveforms of the common inherited LQTS types. Source: Moss AJ et al. Circulation. 1995;92:2929.

Inherited long QT syndrome (LQTS) is an abnormality in the genes that code for cardiomyocyte ion channels resulting in channelopathies that prolong the QT segment. Excessive prolongation of the QT segment increases the risk of life-threatening ventricular arrhythmias, specifically torsades de pointes (TDP) and ventricular fibrillation (VF). If left untreated, patients with LQTS carry a 5% risk of death per year. LQTS is categorized as either inherited or acquired. This article will focus on inherited LQTS and a future article will address acquired LQTS.

There are three major subgroups of LQTS, known as LQT1, LQT2, and LQT3. Each of these forms has a distinct EKG presentation, shown in image 1. LQT1 and LQT2 are the most common forms of LQTS. LQT1 and LQT2 are due to K+ channel mutations on chromosome 11 and 7 respectively. LQT1 has an autosomal dominant form (Romano-Ward syndrome) and an autosomal recessive form (Jervall-Lange-Nielsen syndrome). Jervall-Lange-Nielsen is distinct due to the presence of congenital bilateral deafness in addition to cardiac abnormalities. LQT3 is much less common and distinct from LQT1 and LQT2 in that it is a disorder of myocardial Na+ channels due to mutations on chromosome 3. Patients with LQT3 are less likely to experience cardiac events, however those events are more likely to be lethal. Other subgroups of LQTS exist however they are quite rare and beyond the scope of this article.

CRITERION		POINTS
ELECTROCARDIOGRAM FINDINGS		
QTc (ms) calculated by Bazett's formula	>480	3
	460-469	2
	450-459 in male	1
TDP		2
T-wave alternans		1
Notched T wave in 3 leads		1
Low heart rate for age (<2nd percentile for age)		0.5
CLINICAL HISTORY		
Syncope	With stress	2
	Without stress	1
Congenital deafness		0.5
FAMILY HISTORY		
Family member with definite LQTS*		1
Unexplained sudden cardiac death <30 y/o in an immediate family member*		0.5
POINT TOTAL	RISK OF LQTS	
<1	Low	
1 to <4	Intermediate	
>4	High	
*The same family member cannot be counted for both criteria.		

continued

LONG QT SYNDROME *continued*

CLINICAL PRESENTATION

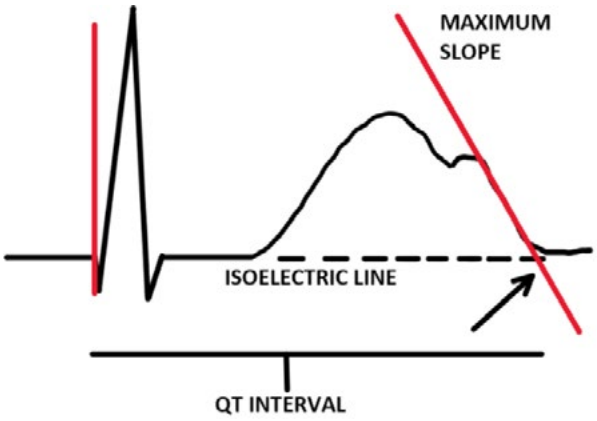
Inherited LQTS is subtle and can be easily missed. These patients present with a history of syncope or seizure activity due to TDP following physical exertion, emotional excitement or a loud noise. These episodes usually first present between the ages of 9 and 12 years. Between episodes the patient will be asymptomatic with an unremarkable physical exam. They often have a normal EKG between episodes and while at rest. There is some variation in presentations between the different subgroups of inherited LQTS. LQT1 cardiac events can be preceded by exercise, especially swimming. LQT2 cardiac events often follow an emotional event, exercise or exposure to a loud sound (e.g. ringing of a phone or doorbell). LQT3 cardiac events typically occur while sleeping. Schwartz et al developed diagnostic criteria in 1993 that is still considered the best clinical approach to identifying inherited LQTS. Definitive diagnosis of inherited LQTS is made by genetic testing and identification of an LQT genotype. Testing should be considered in an asymptomatic patient with idiopathic QTc prolongation >480 ms on serial EKGs. If a patient is identified as having inherited LQTS their immediate family members should undergo mutation-specific genetic testing.

INVESTIGATION

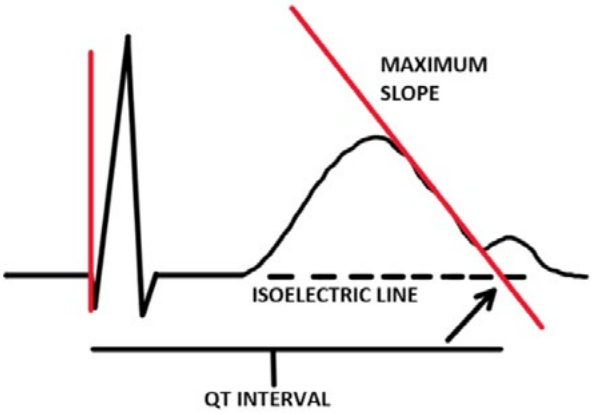
Because the QT interval changes with the heart rate, the QTc or "QT corrected for rate" is utilized to give a standardized value. Generally a QTc <440 ms is considered normal, a QTc of >460 ms is abnormal and a QTc >500 ms significantly increases the risk for TDP. The difference in values in men and women is only seen in patients over the age of 13 years.

Modern 12 lead monitors report a QTc , however these computer generated values must be verified by the clinician, especially if LQTS is suspected on clinical presentation or visual inspection of EKG. As a general rule, the QT interval should be less than ½ the RR interval and the following steps can be used to manually calculate the QTc.

First, determine if the QRS duration is normal (<120 ms). Inherited LQTS is a primary repolarization abnormality characterized by a normal QRS duration with an abnormal QT interval, opposed to secondary repolarization abnormalities where the QT is prolonged secondary to QRS abnormalities. Second, identify the lead with the longest QT interval. Third, identify the beginning of the QRS and the end of the T wave. This can be made difficult with exceptionally wide T waves or when U waves (or P waves of the next cycle) are superimposed on T waves. The following method is useful and known as the "maximum slope intercept method".



1. QT measurements should be taken from several consecutive complexes and the largest interval should be used.
2. A vertical line is drawn at the beginning of the QRS complex.
3. The slope of the T wave's relative refractory period should be extended down to the isoelectric line.
4. If the T wave complex has a large U wave (>1mm) that fuses with the T wave, it should be included.
5. If the T wave complex has a small U wave (<1mm) that does not fuse with the T wave, it should be excluded.
6. The distance between the two lines from steps 2 and 3 is the QT interval.



The QT interval measured across 3-5 complexes and the heart rate or RR interval is used to calculate the QTc. Bazett's formula is the most commonly used formula for QTc calculation and though it is problematic with slow, fast and irregular rhythms, its use here is indicated since Schwartz's diagnostic criteria utilizes a QTc calculated from Bazett's. Bazett's formula is QTc = QT ÷RR and can be easily calculated at www.mdcalc.com/corrected-qt-interval-qtc by simply inputting the measured QT and the heart rate.

TREATMENT

Treatment of LQTS focuses on preventing TDP or VF and includes avoidance of QT-prolonging drugs, correction of electrolyte abnormalities, and avoidance of genotype-specific triggers (strenuous swimming in LQT1, loud noises in LQT2). Beta adrenergic antagonists, specifically propranolol, nadolol, metoprolol or atenolol are the cornerstone of long-term LQTS treatment. The dosing and selection of these agents should involve a specialist familiar with LQTS as specific genotype therapy may be required. For example, beta blockers are contraindicated in LQT3 and K+ supplements and spironolactone are useful in LQT2. An implanted cardioverter-defibrillator should be considered in any LQTS patient with a history of cardiac arrest. Asymptomatic patients known to have a LQTS gene mutation with a normal QT interval may benefit from use of a β-blocker.

Care of any young athlete with known or suspected LQTS should involve a cardiologist experienced in the management of these conditions. Asymptomatic genotype-positive/phenotype-negative athletes can participate in sports if they avoid QT-prolonging drugs. Symptomatic athletes may be eligible for sports participation if precautionary measures are taken, treatment is being administered, and the athlete has been asymptomatic while receiving medication therapy for at least three months.

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MAKING THE DIAGNOSIS, A HISTORICAL PROSPECTIVE

Charles Schisler, D.O.

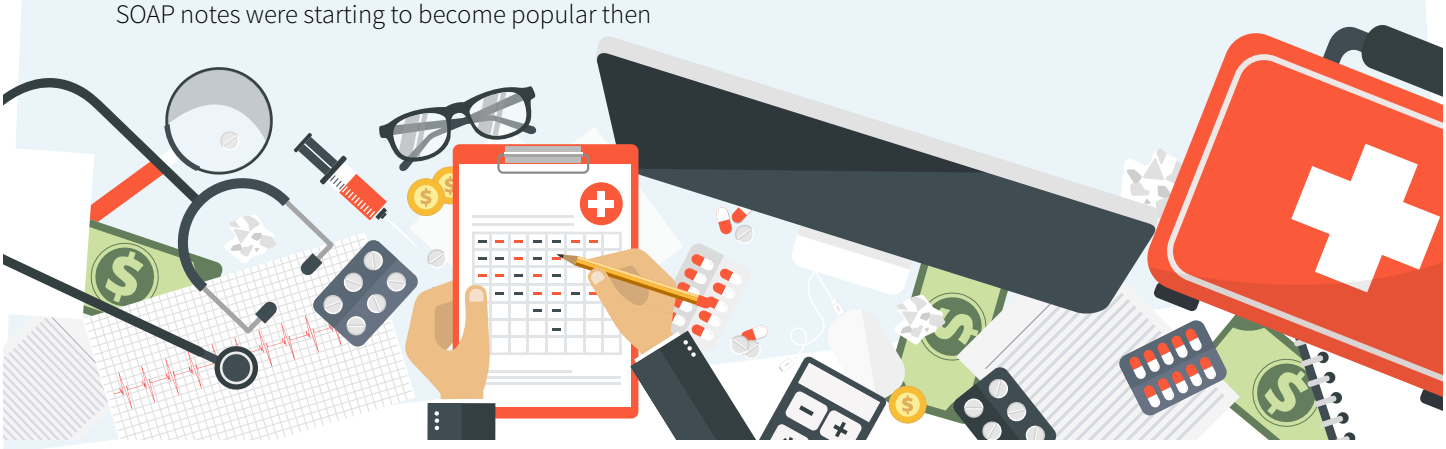
Imagine that you have a patient with acute right lower quadrant pain but someone in his family has a gastrointestinal virus. Temp is 99.2° F, white blood count is slightly elevated and an abdominal x-ray is non-diagnostic. Does this patient have acute appendicitis? This scenario was all too common in 1970. Today, things have changed. More information can be obtained to make this diagnosis much easier.

I was asked to write about how things have changed in medicine over the years that I have been in practice. I am 74, and started my career in 1971 as a general practice physician and am still going strong. Back then, we had no choice but to handle many serious clinical conditions - like the one above - because we had very few specialists and even fewer subspecialty physicians to help. Many of the cases I handled back then would be managed by a specialist today. Many patients were transferred to Ann Arbor or other large institutions whereas today, many of our local healthcare organizations can keep the patient in-house and provide the proper care.

Office practice was also very different when I started practicing. Obviously, we weren't documenting charts electronically. In fact, office visit notes were just beginning to be kept in charts. Prior to that, they were kept on a 5x7 card and stored in a small box. SOAP notes were starting to become popular then too. Notes were brief and commonly just notated the chief complaint, vitals, and one line documenting the physical exam, diagnosis and treatment plan, such as "lungs clear, URI, Penicillin."

Fees were paid in cash and office calls were $4-$6 and there were no limits on the number of chief complaints. The diagnosis was made based on the history and physical exam findings. Labs and x-rays were available, if needed, but there was no endoscopy for example, like we have today. Sigmoidoscopies were done using a 12" tube and a gastroscopy was done using a straight tube. There were no CTs, MRIs, or invasive cardiac procedures. Because we could not "look inside" our patients, the surgery schedule was flooded with exploratory laparotomy cases. Technology has drastically changed how we practice. Diagnosis has become more accurate and faster (when insurance companies allow us to use those technologies) but at a cost.

We have lost some of our skills in physical diagnosis and our patient-provider relationships have been negatively affected. However, I am pleased with the speed and accuracy that technology has provided, but it is good to remember that we still treat and counsel people. Sometimes a compassionate, kind word or a hug can be as comforting as a fast, accurate diagnosis.



APPROACH TO Preventing Pressure Ulcers

Elizabeth Erickson, PA-C, Trauma/General Surgery Mid-Michigan Medical Center

In any hospital or long-term care setting, pressure ulcer development is a major concern. It is not only devastating to a patient, but also presents a setback to recovery. A pressure ulcer is a localized injury to the skin and/or underlying tissue. Pressure slows the blood flow to an area, leading to tissue death. Several risk factors such as: poor nutrition, unintentional weight loss or obesity, inability to move or reposition oneself, incontinence, inability to feel pain, and altered mental awareness; can increase the likelihood of an ulcer developing.

The Braden scale1 is used to measure ulcer risk and based on six indicators: sensory perception, moisture, activity, mobility, nutrition, and friction or shear. The lower the Braden scale score, the higher the risk.1 After a pressure ulcer has been discovered, they are graded or staged, to indicate the amount of tissue damage:

- Stage 1 pressure ulcers include non-blanchable erythema to intact skin. The area may be painful, firm or soft, or warm or cool compared with the surrounding tissue.2
- Stage 2 pressure ulcers include partial-thickness injuries (loss of dermis). They may present as a shallow open ulcer with a red or pink wound bed. They may also present as an intact or open blister. 2
- Stage 3 pressure ulcers include full-thickness tissue loss. Subcutaneous fat may be visible, but not bone, tendon or muscle. Sloughing will occur with or without undermining or tunneling.2
- Stage 4 pressure ulcers may have bone, muscle, and tendons within the wound bed (Figure 1) .2
- Ulcers with full thickness loss, where the actual depth of the ulcer is obscured by slough or eschar within the wound bed, are sometimes considered "unstageable." Until the slough or eschar is removed to expose the base of the wound, the depth of the ulcer cannot be determined or staged.2

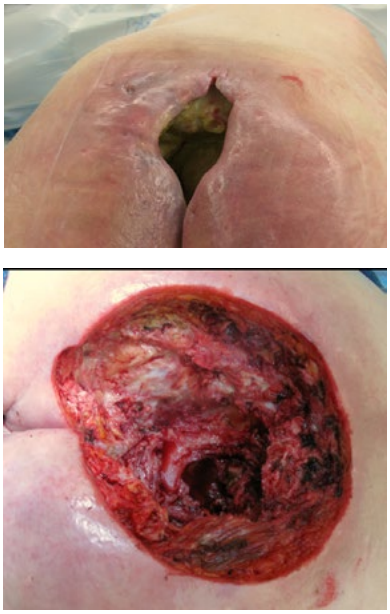


Figure 1. Stage 4 pressure ulcer after surgical debridement

Pressure ulcers not only cause physical pain, they can also lead to secondary complications, including depression, sepsis, gangrene, osteomyelitis, anemia, and death. More than 60,000 patients die each year as a direct result of a pressure ulcer.3 In addition to causing the patient harm, pressure ulcers can be quite costly to the patient and hospital.

continued

PRESSURE ULCERS *continued*

Steps Toward Prevention

There are several things that can be done on a daily basis to reduce a patient's risk for developing pressure ulcers:

- Proper positioning or turning patients every couple of hours to redistribute pressure is crucial. Establishing a repositioning schedule and avoiding positioning patients on a pre-existing ulcer. Patients should avoid prolonged sitting positions for more than 1 hour, as less pressure is exerted when patients are lying down.4
- After a stage 3-4 ulcer has been identified, surgical removal of all necrotic or devitalized tissue by debridement should be done as early as possible to clean the wound bed for healing (Figure 1).
- Manage moisture by correcting diarrhea, providing bladder training, and providing and changing diapers often. Consider Foley catheters, barrier creams or, in extreme cases, a diverting colostomy.
- Manage nutrition and hydration. Achieving a weight as close as possible to the patient's ideal body weight is important. Consider assessing pre-albumin and serum albumin levels. The goal should be to provide 30 to 35 cal/kg/day.5
- Reduce friction and shear as much as possible. Consider using a trapeze or pull sheet for lifting and moving patients in bed.
- Protect bony prominences by using heel protectors, float heels, or pressure redistribution beds. Inman and colleagues conducted a randomized, parallel group and controlled clinical trial in a 30-bed intensive care unit (ICU). One hundred patients at risk were assigned to receive treatment with either a pressure-redistribution bed or a standard ICU bed.8 Pressure-redistribution beds were associated with fewer developments of pressure ulcers and were more cost effective.
- Identify at-risk patients early and assess the skin on admission.4 Use the Braden Scale on admission to help distinguish patients at greatest risk for pressure ulcers.1
- Make at-risk patients well known to staff when they are admitted. Place a sign on the door or above the bed to heighten staff awareness of the patient's risk.
- Share monthly reports of incidence among units to help units that may not be doing as well.
- Involve wound care staff from admission, as most hospitals have a wound care service. Also consider assigning a wound care "champion" to each unit to assist with monitoring and documentation.
- Use overhead chimes to act as a reminder to the staff that patients should be turned.5
- Educate staff, including nursing aids and nurses, about assessing pressure ulcers using the Braden Scale, identifying at-risk patients, and initial treatment modalities.

Summary

Implementation of a pressure ulcer prevention plan requires a multidisciplinary approach. Prevention programs have decreased prevalence by 90% in nursing homes and 25% among critically ill patients.4 Every hospital and long-term care unit should have a plan to lower a patient's risk for these debilitating and costly events.

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TAX CUTS AND JOBS ACT

The Tax Cuts and Jobs Act legislation was signed into law on December 22, 2017. The Act makes extensive changes that affect both individuals and businesses. Some key provisions of the Act are discussed below. Most provisions are effective for 2018. Many individual tax provisions sunset and revert to pre-existing law after 2025; the corporate tax rates provision is made permanent. Comparisons below are generally for 2018.

Individual income tax rates

Pre-existing law. There were seven regular income tax brackets: 10%, 15%, 25%, 28%, 33%, 35%, and 39.6%.

New law. There are seven tax brackets: 10%, 12%, 22%, 24%, 32%, 35%, and 37%. These provisions sunset and revert to pre-existing law after 2025.

Standard deduction, itemized deductions, and personal exemptions

Pre-existing law. In general, personal (and dependency) exemptions were available for you, your spouse, and your dependents. Personal exemptions were phased out for those with higher adjusted gross incomes. You could generally choose to take the standard deduction or to itemize deductions. Additional standard deduction amounts were available if you were blind or age 65 or older. Itemized deductions included deductions for: medical expenses, state and local taxes, home mortgage interest, investment interest, charitable gifts, casualty and theft losses, job expenses and certain miscellaneous deductions, and other miscellaneous deductions. There was an overall limitation on itemized deductions based on the amount of your adjusted gross income.

New law. The standard deduction is significantly increased, and the additional standard deduction amounts for those over age 65 or blind are still available. The personal and dependency exemptions are no longer available. Many itemized deductions are eliminated or restricted. The overall limitation on itemized deductions based on the amount of your adjusted gross income is eliminated.

- The 10% of AGI floor for the deduction of medical expenses is reduced to 7.5% in 2017 and 2018 (for regular tax and alternative minimum tax).
- The deduction for state and local taxes is limited to $10,000. An individual cannot prepay 2018 income taxes in 2017 in order to avoid the dollar limitation in 2018.
- The deduction for mortgage interest is still available, but the benefit is reduced for some individuals, and interest on home equity loans is no longer deductible.
- The charitable deduction is still available, but modified.
- The deduction for personal casualty losses is eliminated unless the loss is incurred in a federally declared disaster.

Income Bracket Thresholds					
Tax Rate	**Single**	**Married Filing Jointly/ Surviving Spouse**	**Married Filing Separately**	**Head of Household**	**Trust/Estate**
10%	$0	$0	$0	$0	$0
12%	$9,525	$19,050	$9,525	$13,600	N/A
22%	$38,700	$77,400	$38,700	$51,800	N/A
24%	$82,500	$165,000	$82,500	$82,500	$2,550
32%	$157,500	$315,000	$157,500	$157,500	N/A
35%	$200,000	$400,000	$200,000	$200,000	$9,150
37%	$500,000	$600,000	$300,000	$500,000	$12,500

TAX CUTS *continued*

These provisions sunset and revert to pre-existing law after 2025.

Standard deduction, itemized deductions, and personal exemptions

Personal and Dependency Exemptions (you, your spouse, and dependents)		
	Pre-existing law	**New law**
Exemption	$4,150	No personal exemption

Standard Deduction		
	Pre-existing law	**New law**
Married filing jointly	$13,000	$24,000
Head of household	$9,550	$18,000
Single/married filing separately	$6,500	$12,000
Additional aged/blind		
Single/head of household	$1,600	$1,600
All other filing statuses	$1,300	$1,300

Itemized Deductions		
	Pre-existing law	**New law**
Medical expenses	Yes, to extent expenses exceed 10% of AGI floor	Yes, 10% AGI floor reduced to 7.5% for 2017 and 2018
State and local taxes	Yes, income (or sales) tax, real property tax, personal property tax	Yes, limited to $10,000 ($5,000 for married filing separately)
Home mortgage interest	Yes, limited to $1,000,000 ($100,000 for home equity loan), one-half those amounts for married filing separately	Yes, limited to $750,000 ($375,000 for married filing separately), no home equity loan; the $1,000,000/$500,000 limit still applies to debt incurred before December 16, 2017
Charitable gifts	Yes	Yes, 50% AGI limit raised to 60% for certain cash gifts
Casualty and theft losses	Yes	Federally declared disasters only
Job expenses and certain miscellaneous deductions	Yes	No

Child tax credit

Pre-existing law. The maximum child tax credit was $1,000. The child tax credit was phased out if modified adjusted gross income exceeded certain amounts. If the credit exceeded the tax liability, the child tax credit was refundable up to 15% of the amount of earned income in excess of $3,000 (the earned income threshold).

New law. The maximum child tax credit is increased to $2,000. A nonrefundable credit of $500 is available

Child Tax Credit		
	Pre-existing law	**New law**
Maximum credit	$1,000	$2,000
Non-child dependents	N/A	$500
Maximum refundable	$1,000	$1,400 indexed
Refundable earned income threshold	$3,000	$2,500
Credit phaseout threshold		
Single/head of household	$75,000	$200,000
Married filing jointly	$110,000	$400,000
Married filing separately	$55,000	$200,000

for qualifying dependents other than qualifying children. The maximum refundable amount of the credit is $1,400, indexed for inflation. The amount at which the credit begins to phase out is increased, and the earned income threshold is lowered to $2,500. The changes to the credit sunset and revert to pre-existing law after 2025.

Alternative minimum tax (AMT)

Under the Act, the alternative minimum tax exemptions and exemption phaseout thresholds are increased. The AMT changes sunset and revert to pre-existing law after 2025.

Alternative Minimum Tax (AMT)		
	Pre-existing law	**New law**
Maximum AMT exemption amount	$86,200 (MFJ), $55,400 (Single/HOH), $43,100 (MFS)	$109,400 (MFJ), $70,300 (Single/HOH), $54,700 (MFS)
Exemption phaseout threshold	$164,100 (MFJ), $123,100 (Single/HOH), $82,050 (MFS)	$1,000,000 (MFJ), $500,000 (Single, HOH, MFS)
26% rate applies to AMT income (AMTI) at or below this amount (28% rate applies to AMTI above this amount)	$191,500 (MFJ, Single, HOH), $95,750 (MFS)	$191,500 (MFJ, Single, HOH), $95,750 (MFS)

Kiddie tax

Instead of taxing most unearned income of children at their parents' tax rates (as under pre-existing law), the Act taxes children's unearned income using the trust and estate income tax brackets. This provision sunsets and reverts to pre-existing law after 2025.

Corporate tax rates

Under the Act, corporate income is taxed at a 21% rate. The corporate alternative minimum tax is repealed.

TAX CUTS *continued*

Special provisions for business income of individuals

Under the Act, an individual taxpayer can deduct 20% of domestic qualified business income (excludes compensation) from a partnership, S corporation, or sole proprietorship. The benefit of the deduction is phased out for specified service businesses with taxable income exceeding $157,500 ($315,000 for married filing jointly). The deduction is limited to the greater of (1) 50% of the W-2 wages of the taxpayer, or (2) the sum of (a) 25% of the W-2 wages of the taxpayer, plus (b) 2.5% of the unadjusted basis immediately after acquisition of all qualified property (certain depreciable property). This limit does not apply if taxable income does not exceed $157,500 ($315,000 for married filing jointly), and the limit is phased in for taxable income above those thresholds. This provision sunsets and reverts to pre-existing law after 2025.

Retirement plans

Under the Act, the contribution levels for retirement plans remain the same. However, the Act repeals the special rule permitting a recharacterization to unwind a Roth conversion.

Estate, gift, and generation-skipping transfer tax

The Act doubles the gift and estate tax basic exclusion amount and the generation-skipping transfer tax exemption to about $11,200,000 in 2018. This provision sunsets and reverts to pre-existing law after 2025.

Health insurance individual mandate

The Act eliminates the requirement that individuals must be covered by a health care plan that provides at least minimum essential coverage or pay a penalty tax (the individual shared responsibility payment) for failure to maintain the coverage. The provision is effective for months beginning after December 31, 2018.

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