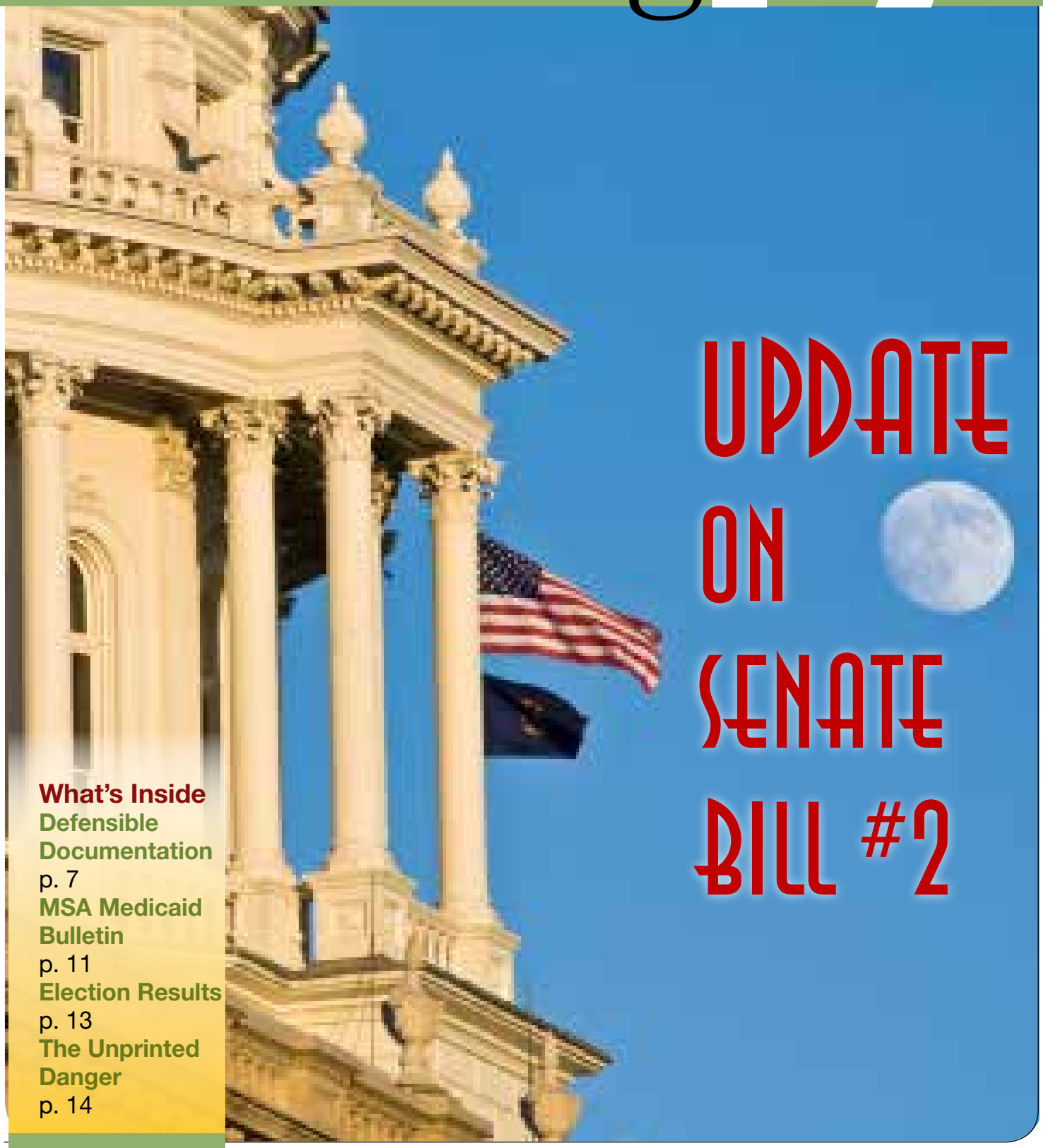
June 2013

The Only Informational Resource for Michigan Physician Assistants

Michigan PA



UPDATE ON SENATE BILL #2

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MichiganPA

MichiganPA Newsletter
Vol. 34, No. 2 • June 2013

Michigan Academy of Physician Assistants
1390 Eisenhower Place
Ann Arbor, MI 48108
Phone: 734-677-2270
Fax: 734-677-2407
E-mail: mapa@michiganpa.org
Website: www.michiganpa.org

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MAPA's Mission

The Michigan Academy of Physician Assistants is the essential resource for the Physician Assistant 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, enhancement of the PA practice environment, and preservation of the PA/physician team concept.

President's MESSAGE

Ron X. Stavale, PA-C

On Memorial Day at the American Academy of Physician Assistants House of Delegates (HOD) meeting there was an announcement for a moment of silence to commemorate the lives of the six physician assistants who have surrendered their lives in the service of our country. The moment of silence was prefaced with the context of how long this moment would last if we, the members of the HOD, were a soldier in harm's way and how precious this moment would be, since it may be last moment of a soldier's life. This was a soul piercing reflective moment that took the over 200 delegates away from their planned speeches and concerns for the policy that drives our American Academy of Physician Assistants. Later on that evening there was a two hour memorial service with songs and speeches and a haunting 'roll call' that replicated what soldiers do in a platoon when one of their comrades dies. They go through a roll call of the group and each soldier, in response to hearing their name called, shouts loudly "present!" When the roll call then shouts out the name of their deceased comrade, the whole platoon shouts three times in unison **"PRESENT!"** and then the roll call continues. That Memorial Day evening we heard the names of fellow PAs: **Army Capt. Michael P. Cassidy; Army CW2 (Ret) Michael G. Cahill; Army Capt. Cory J. Jenkins; Army Capt. Kafele H. Sims; Army Capt. Anthony R. Garcia; Army Capt. Sean Grimes (of Michigan); Navy ENS Jerry "Buck" Pope** and the crowd of over 200 PAs and supporters, all in unison after each name was called, shouted and filled the hall with a resounding **"PRESENT!"**

Reflecting on my year as President of the Michigan Academy of Physician Assistants, I must say that it was an extreme honor to serve in this position. That my fellow colleagues would entrust in me the responsibility of representing the 4,000 physician assistants to the Michigan Legislature, to the American Academy, to other health care organizations and to the public is an immense honor. With that though, comes an immense responsibility.

MAPA's BOD and Committees make recommendations and decisions on fiscal issues facing the academy, legislative issues that may affect Michigan PAs practice for their entire professional career and thus their ability to care for their families, is an immense responsibility!

MAPA's BOD is also charged with anticipating any threats to our profession and to lead Michigan PAs into a position to have a voice in all of the health care changes that will be occurring in the future. That's quite a charge for a group of your colleagues who volunteer their personal time on our Board of Directors, Committees, PA Task Force and the editor of this newsletter. Despite these time commitments and difficulties presented by these tasks, it enlivens us to be part of the MAPA team. Just like working with our colleagues in our clinic or hospital settings, who extend themselves to provide the

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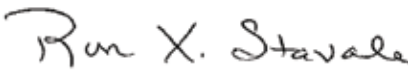
best care and outcomes for our patients; the energy of our volunteer's synergistically rubs off on all of us and allows us to pass through our day easier.

Most of all, it is your membership to this organization that allows us to continue to work towards protecting and maintaining the best practice environment possible in Michigan today.

When our survey shows that 173 out of 174 PAs agree that there should be an organization representing PAs in Michigan, we know that our role is important and validated. When over 80% of the responding PAs acknowledge that if MAPA disbanded, they're aware that AAPA would not come in and do the work in Michigan that MAPA currently does; then we know our roles in MAPA is critical to our professions future. Seventy-five percent of the PAs surveyed did not realize that it takes 1400 members in MAPA to make budget, so that makes communication and membership a necessity. Reaching the 3,300 out of 4,000 Fellow PAs who have not made the commitment to support the organization, which they feel is important to their professional career, **is the challenge that is asked of us as an Academy**.

Challenges are inspiring and obstacles are meant to be overcome. Help the academy remain strong and encourage your fellow colleagues to become members and perhaps even consider at some point, volunteer some episodic time. **The burden is lessened when more hands carry the weight.**



Ron X. Stavale, PA-C
MAPA President, 2012-2013

WHO AM I?

-S/Sx: Headaches, pulsatile tinnitus and lightheadedness
-S/Sx: Hypertension and fluid retention
-ACE-I and ARBs are ineffective treatment medications
-Characteristic "string-of-beads" appearance on angiography
-Treatment: percutaneous balloon angioplasty, B/P control and anti-Plt Rx

(answer in next 'MichiganPA') *(previous Q_3 answer: Von-Hippel-Lindau Disease)*

UPDATE ON SENATE BILL #2

MAPA held its annual Legislative Day in Lansing on May 22nd, it was a very successful event and had a great turnout (but we always want to encourage more MAPA Fellow members to attend as it allows legislators to speak to practicing PAs). A big "Thank You" to the eighteen MAPA Fellow members who attended and to the many students who helped lobby the legislature on key issues that affect our profession.

MAPA has been following the progress of Senate Bill #2, which for our understanding can be termed the 'Nurse Independent Practice Bill'. This bill was originally introduced last fall in the Health Policy Committee by Senator Marleau, who is the Chair of the Health Policy Committee. The bill received an informational hearing and was then awaiting further discussion between the nursing and the physician organizations. Before any additional activity in the Health Policy Committee could take place, the bill ran up against its two-year deadline and died without further action. In the new two-year session that began in January, Senator Mark Jansen re-introduced the bill as Senate Bill #2 and placed it in his Reforms, Restructuring and Reinventing Committee, of which he is the Chair...thereby bypassing the Health Policy Committee and hasten its passage. Senate Bill #2 received a hearing in the "R, R and R" Committee, was voted out of committee and is now currently on the Senate floor.

Senate Bill #2 covers Nurse Practitioners, Clinical Nurse Specialists and Certified Nurse Midwives. The current language for NPs states that: "*A certified nurse practitioner would, within the parameters of his or her education, training, and national certification, focus on the performance of comprehensive assessments; providing physical examinations and other health assessments and screening activities; and diagnosing, treating, and managing patients with acute and chronic illnesses and diseases. Nursing care provided by a C.N.P. would include ordering, performing, supervising, and interpreting laboratory and imaging studies; prescribing pharmacological and nonpharmacological interventions and treatments within the C.N.P.'s specialty role and scope of practice; health promotion; disease prevention; health education; and counseling of patients and families with potential, acute, and chronic health disorders*".

Senate Bill #2 would authorize a licensed A.P.R.N. to possess, prescribe, and administer nonscheduled prescription drugs and controlled substances included in Schedules 2 through 5, within the parameters of his or her education, training, and national certification; if he or she met all of the following:

-- *He or she had completed graduate level pharmacology, pathophysiology, and physical assessment courses and clinical practicum in the role of a C.N.M, C.N.P., or C.N.S.-C., as applicable to his or her A.P.R.N. license.*

-- *He or she had completed the number of contact hours in pharmacology as part of the requisite continuing education for a controlled substances license, and for renewal of his or her license under Part 172.*

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UPDATE ON SENATE BILL #2 *continued from page 5*

-- *He or she held a controlled substances license under the Code.*

-- *He or she possessed, prescribed, or administered the drug or controlled substance only while engaged in the practice of advanced practice registered nursing within the parameters of his or her education, training, and national certification.*

MAPA met with Senator Jansen and expressed our concern that the passage of Senate Bill #2 could place the PA profession in a disadvantageous position with employers. The two most pressing concerns are:

1) If Senate Bill #2 goes into law, then untrained administrators could view NPs as having less regulatory structure and thus 'easier to hire'. PAs would be considered to be administratively 'high maintenance'. MAPA currently receives calls from hospitals and recruiters who confirm these fears.

2) There are many mixed PA and NP practices in the state of Michigan. If Senate Bill #2 passes as written, then the NP in the practice would fall under the nursing regulatory body while the PA would fall under the medical boards and PA Task Force; potentially creating two distinct practice profiles for practitioners performing the same care for patients in the same practice setting.

As of this writing, Senator Marleau is preparing to introduce a more comprehensive bill to streamline the practice of medicine by placing all practitioners-PAs, NPs, DOs, and MDs under one regulatory board, instead of the current distinct MD, DO and PA regulatory bodies. This bill also seeks to use corresponding language with NPs and PAs so that patients will have equal access to an integrated, coordinated medical home with comparable medical care; whether they see a PA or an NP. As a result, there will no longer be any administrative advantages or disadvantages for either profession. MAPA will keep members apprised of any progress and we may ask you to take time to visit Lansing again to lobby the legislature.

Respectfully submitted,
Ron X. Stavale, PA-C
MAPA President, 2012-2013

SOURCES/LINKS/CONTACTS:

Michigan Academy of Physician Assistants: MAPA at 1-734-353-4752 or www.michiganpa.org
American Academy of Physician Assistants: AAPA at 1-703-836-2272 or www.aapa.org
National Commission on Certification of Physician Assistants: NCCPA at www.nccpa.net
Accreditation Review Commission on Education for the Physician Assistant: ARC-PA at www.arc-pa.org
Michigan Department of Community Health for PA license at www.michigan.gov
Drug Enforcement Administration (DEA) license at www.deadiversion.usdoj.gov
Michigan Physician Assistant Foundation (MI PAF) at www.mipaf.com

Defensible Documentation: What You Need to Know

In any medical malpractice case there are strengths, weaknesses and potential egregious breaches; plaintiff attorneys look for other soft potential *'red flags'* in the medical record. These *'red flags'* can include: ineffective charting, communication lapses between staff or providers, care-giving mishaps and missing or incomplete charting/documentation. Others like to zero in on brief notes & finger pointing or illegible documentation among many others.

From the medical chart *'red flags'* plaintiff or defense attorneys also examine for specific triggers in medical chart. Plain and simple, they look for a ***solid defensible or a glaring indefensible*** medical record as the common denominator. In most cases, these denominators are not even remotely close in the minds of many unsuspecting PAs, yet these are the *'red flags'* that we often times fall prey to in our hurried day-to-day clinical practices. While poor documentation is equated mostly with non-defensibility, rightfully so—it can mean many things to different people.

The liability controversy always seems to hover around the perennial question of what's "poor documentation". One where in most instances, it has nothing to do with how much is too much or how brief is too brief. It has more to do with what most clinicians feel constitutes poor documentation. Regardless of whether you're a heavy or brief documenter, the issue transcends beyond that. In fact, for all practical purposes, the question should be rephrased to: Is your documentation defensible or poor?

Poor documentation is where one doesn't document their Clinical Decision making process succinctly or clearly in the medical chart. While some Risk Management Professionals argue that you can never document too much; conversely, others are just as quick to point out that "*too much documentation*" can be counterproductive. They would argue that documenting "everything" needlessly would provide the plaintiff's attorney the evidence or "ammunition" that can be used against you in an allegation of medical malpractice.

So were does the happy medium reside? Despite the controversy, most agree that regardless of which camp you may subscribe too, the clinician ultimately should see this as an opportunity. Not only to document contemporaneously of how or what was the medical care provided, but more importantly, an opportunity to educate others of the what, how, why and when- the provider arrived to a particular set of views or conclusions regarding the diagnosis and plan of care,

etc.; given the data available or obtained from the work-up. In essence, there is no right or wrong amount of documentation that needs to be on a patient's chart, as long as you make your case and your plan supports your conclusion; that's the proper amount of documentation.

Definitely avoidance of sketchy or brief documentation surely boosts your case. In other words, the defensibility of your provided care becomes that much more robust when scrutinized. But more importantly, it raises your professional credibility when stating clearly and briefly what features of the history and/or physical findings steered you in the direction undertaken and the conclusions documented.

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

This brief description sheds light on how to avoid poor documentation practices with commonly associated allegations raised in lawsuits against PAs, when an adverse outcome occurs. In summary, brief or sketchy medical records documentation (*'red flags'*) can be considered nothing less than medical malpractice cases waiting to happen, particularly if the patient suffered an injury or poor outcome.

***Marcos A. Vargas, MSHA, PA-C**, is a physician assistant in Orthopedic Services at Hurley Medical Center in Flint. He is also MAPA's Region V Representative, has an extensive work experience and has been retained by legal firms for an expert opinion and counseling reviews.*

2013 MAPA Fall CME Conference

October 10 - 13
Grand Traverse Resort & Spa

JOIN US!

LEARN –

Earn up to 25 hours of Category I CME Credit from the high quality lectures you have come to expect. The variety of topics is expansive and will include hands-on workshops and pharmaceutical-sponsored meal lectures.

CONNECT –

There are endless opportunities during the Fall CME Conference for attendees to meet colleagues, friends and classmates. You will be able to attend the MAPA Board of Directors meeting, interact with Board members and vendors throughout the conference. Follow us on Twitter or Facebook. You can also network for potential job openings.

ENJOY –

We have planned multiple activities that will appeal to a variety of tastes. We will have the Peninsular Wine Tour, Oktoberfest Beer Tasting, 5K Fun Run, University receptions, Welcome Reception, Members Banquet, GTR Spa amenities and more. Besides obtaining quality CME, we want you to enjoy yourselves at this classic Fall destination.

3 Ways to Register!

1 -Online at www.michiganpa.org
2 - Fax to: 734-677-2407
3 - Mail to: 1390 Eisenhower Place, Ann Arbor, MI 48108

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2013 MAPA Fall CME Conference CHARITY!

The Wayne County Sexual Assault Forensic Examiner's Program (WC SAFE) is a non-profit 501 (c)3 specialty organization that provides compassionate and comprehensive care to victims of Sexual Assault throughout Wayne County. Opened in 2006 and staffed 24/7 by specially trained medical personnel, the organization provides medical examinations, forensic collections and crisis interventions for rape victims. In 2010, additions of community-based confidential advocacy services with social workers/counselors who are specially trained in sexual assault, provide crisis intervention, short and long-term counseling, advocacy and other supportive services. In addition to the medical-forensic exam and crisis intervention, they provide medication prophylaxis, emotional advocacy, counseling, expert witness testimony and community education on sexual assault and available services. There are four clinic locations for victims and the services are FREE of charge to the survivors.

There are approximately 5000 rapes occurring in Michigan every year and in America- someone is sexually assaulted every two minutes. One out of six women have been victims of attempted or completed rape in their lifetime and 66% know their assailant. One in thirty-three men will be a victim of sexual assault. From these statistics, the WC SAFE Program has two statements that are at the heart of their treatment:

You are NOT alone!

Remember, it wasn't your Fault!

Multiple government and private grants, along with private donations from the community, support WC SAFE; but the need is still great. **WC SAFE has been chosen as the 2013 MAPA Fall CME Conference charity**. Below is a list of medical and personal items which are needed to sustain these clinics. The five Michigan PA schools will compete for the most well-rounded donation of necessary items to WC SAFE at the Fall Conference. Conference attendees are encouraged to bring donations (either items on the list or monetary donations) to the conference and drop them off at the donation table.

Medical Supplies

Pregnancy Tests, medicine cups, BP cuffs
Ear speculums, Sharps containers
Plastic speculums, syringes (10cc, 3cc)
Band-Aids, alcohol pads, latex-free gloves
Swabs, sterile water, lubricant, chux pads
Cotton balls, needles, tourniquets
Bacitracin, Tylenol, Motrin, 1% Lidocaine
Benadryl, Doxy, Rocephin, Z-packs

Personal Care Items

Underwear (adult sizes), toothbrushes
toothpaste, soap, deodorant, tampons
feminine pads, panty liners, socks, etc.

Office/Household Supplies

paper, pens, file folders, manila folders, etc.
cleaning supplies

WC SAFE has the purpose of providing a comprehensive, compassionate and victim-centered continuum of care for rape victims in the community. For more information on WC SAFE or to volunteer, check out their website at: www.wcsafe.org .

MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Bulletin Number: MSA 12-42

Distribution: All Providers

Issued: August 31, 2012

Subject: Medicaid Enrollment of Physician Assistants and Nurse Practitioners

Effective: October 1, 2012

Programs Affected: Medicaid

Purpose

This bulletin provides information describing the mandatory enrollment of licensed Physician Assistants (PAs) and Nurse Practitioners (NPs) who render, order, or bill for covered services to Medicaid beneficiaries. Starting October 1, 2012, these providers are to begin enrolling in the Community Health Automated Medicaid Processing System (CHAMPS). As of January 1, 2013, PAs and NPs will no longer bill for rendered services under their delegating/supervising physician's National Provider Identifier (NPI) and must be uniquely identified on all claims.

Provider Enrollment of Physician Assistants

PAs must enroll with an Individual (Type 1) NPI number as a Rendering/Servicing-Only provider. As a Rendering/Service-Only provider, services are strictly provided under the delegation and supervision of a physician licensed under part 170, part 175 or part 180 of Michigan Public Act 368 of 1978, as amended.

Upon enrollment, PAs are also required to affiliate themselves with the billing NPI of their respective delegating/supervising physicians. Individual PAs are not eligible for direct Medicaid reimbursement. Direct payment for services rendered by a PA will be issued to the PA's affiliated delegating/supervising physician, group or billing provider NPI. The NPI of the PA's delegating/supervising physician will also be required on claim submissions for reimbursement.

Provider Enrollment of Nurse Practitioners

NPs who render services under the delegation and supervision of a physician are required to enroll with an Individual Provider (Type 1) NPI number as a Rendering/Servicing-Only provider. Under this type of enrollment, NPs are required to affiliate themselves with the billing NPI of their respective delegating/supervising physicians. Payment for NP services will be issued to the affiliated, delegating/supervising physician, group or billing provider NPI. The NPI of the NP's delegating/supervising physician will also be required on claim submissions for reimbursement.

The enrollment requirements and procedures for NPs who render services pursuant to formal, written provisions of a current collaborative practice agreement with a physician are unchanged from current policy as outlined in the Michigan Department of Community Health (MDCH) Medicaid Provider Manual, Practitioner Chapter, Section 26.1. Direct payment for NP services may be made to these enrolled NP providers.

Additional Comments

Provider enrollment procedures and regulations are outlined in the MDCH Medicaid Provider Manual. Additional information regarding provider enrollment is available at www.michigan.gov/medicaidproviders or by contacting Provider Support at 1-(800) 292-2550.

MSA *continued from page 11*

PAs and NPs, as eligible providers, must comply with all licensing laws, certification requirements, and regulations applicable to the provider's practice in Michigan. Additionally, enrolled PA and NP providers are subject to all the limitations that apply to physician services and to all applicable provisions set forth in the MDCH Medicaid Provider Manual.

Community Health Automated Medicaid Processing System (CHAMPS) claim editing will be applied to the billing, rendering, supervising, attending, and referring providers as applicable. Payment for PA and NP rendered services will be made according to current physician practitioner reimbursement methodology.

Manual Maintenance

Retain this bulletin until the information has been incorporated into the Michigan Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mailed to ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved

Stephen Fitton, Director
Medical Services Administration

Michigan Medicaid... are you enrolled?!

As of October 1st, 2012 the Michigan Department of Community Health (MDCH) announced the requirement that all Physician Assistants who render, order or bill for covered services to Michigan Medicaid beneficiaries, enroll in the Community Health Automated Medicaid Processing System (CHAMPS). In addition, as of January 1, 2013 PAs will no longer bill for rendered services under their supervising physicians NPI and must be uniquely identified on any submitted claims. This mandate allows Physician Assistants to continue to provide services to Medicaid patients and bill for services rendered under the PAs NPI and the practice in which they work will be reimbursed at 100% of the Medicaid physician fee schedule.

Previously, Physician Assistants were able to see and treat Medicaid patients, but the bill for rendered services was submitted under the supervising physicians NPI and the practice was reimbursed. The change will allow more transparency to practices on which provider is rendering services to Medicaid patients within a practice.

Please see Michigan Medicaid transmittal: MSA 12-42 for details on how to enroll! http://www.michigan.gov/documents/mdch/MSA_12-42_396734_7.pdf

Feel free to contact the Michigan Academy of Physician Assistants- Reimbursement Committee Chairperson: James Kilmark, PA-C with any questions regarding this issue at jkilmark@yahoo.com

And the Winners are …

2013 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
Heather Klopp, PA-C

Secretary
R. David Doan III, PA-C

Region 1 Representative
Amber Gustafson, PA-C

Region 3 Representative
Ryan Murtha, PA-C

Region 5 Representative
Jay Peterson, PA-C

Chief Delegate
Karl Wagner, PA-C

AAPA 2013 Delegates
Jay Kaszyca, PA-C
Marc Moote, PA-C
Molly Paulson, PA-C
Susan Raaymakers, PA-C

AAPA 2013 Alternate Delegates
Steve Heckel, PA-C
Heather Klopp, PA-C

A Special Congratulation goes out to John McGinnity, PA-C for his election win as AAPA's President-Elect; a Michigan native and MAPA Past-President!

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

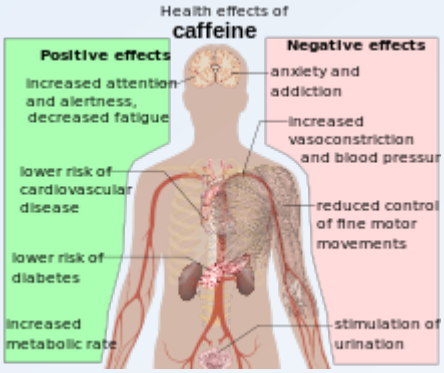
Follow us: @MAPA_TWEETS MICHIGAN ACADEMY OF PHYSICIAN ASSISTANTS

The Unprinted Danger

Caffeine is the elixir of many peoples' morning ritual, a cup of coffee to start the day. Global consumption of caffeine is estimated at 120,000 tonnes per year (1 tonne = 1000kg) or one caffeinated beverage for every person every day. Caffeine is found at various concentrations in seeds, leaves and fruit of some plants, and is commonly consumed from infusions extracted from the seeds of the coffee plant and the leaves of the tea bush, as well as foods with kola nut derivatives. The first documented description of caffeine effect was approximately 3000BC in China, where tea leaves were steamed in water that produced a fragrant and restorative effect. Early evidence of cocoa bean use was by the Mayans around 600BC; consuming the beans helped fight fatigue. Coffee made its debut in the ninth century in their origin of Ethiopia; by eating the berries, a sense of vitality was experienced.

In humans, caffeine acts as a central nervous system stimulant and is the worlds most widely consumed psychoactive drug. As well as a CNS stimulant, caffeine also stimulates the metabolic system and is used to both recreationally and medically reduce physical fatigue and to restore alertness when drowsy. At moderate doses, caffeine can improve sports performance, but at higher doses, athletic performance can be impaired- interfering with coordination. Negative effects of caffeine include nervousness, irritability, restlessness, insomnia, headaches and heart palpitations. Positive attributes include lowering overall risk of cancer, decreases the risk of Parkinson's Disease and developing type 2 diabetes, increase effects of certain medications to treat headaches, primary treatment for breathing disorders in premature infants, mild diuretic effect and increased muscle performance. The median lethal dose (LD_{50}) in humans is estimated at 150-200mg/kg (roughly 10gms) or about 80-100 cups of coffee. The FDA classifies caffeine as GRAS (Generally Recognized As Safe) because toxic doses (10gms) are much higher than typical daily ingested doses (<500mg). Fluroxamine or Levofloxacin block the liver enzyme responsible for caffeine metabolism and can increase effects and blood concentration of caffeine five-fold. The cause of death from caffeine is not exactly clear, but may result from cardiac arrhythmia, leading to cardiac arrest.

Caffeine is a common ingredient in soft drinks and energy drinks and is also found in some dietary supplements and supplements aimed at weight loss. The theories about how caffeine may affect weight include appetite suppression, calorie burning through thermogenesis or its mild diuretic action. As a side note, energy drinks may also have another ingredient called '*guarana*', which weight for weight, has double the amount of caffeine as caffeine does itself. Routes of caffeine administration are oral- liquid (coffee, etc.) or tablets, IV,



aerosol, dissolving strips, enema and lip balm (SpazzStick). Caffeine's mechanism of action is that it antagonizes adenosine (an inhibitor of neurotransmission) and increases activity in the neurotransmission of acetylcholine, epinephrine, dopamine, serotonin, glutamate, norepinephrine and cortisol. This increased neurotransmission yields the effect of anxiety, insomnia, rapid heart and respiration rates. Caffeine is water soluble and is absorbed by the small intestine within 45 minutes of ingestion; reaches peak blood concentration in one hour and has a half-life ($T_{½}$) of about five hours. Cigarette smoking decreases the half-life, while oral contraception and pregnancy prolongs the half-life. Certain medications can increase the concentration of caffeine in the blood, like Ciprofloxacin and Echinacea or caffeine may increase the medication concentration itself, as is the case with Theophylline.

[*Decaffeination is the extraction of caffeine from coffee; this can be accomplished by using solvents, CO_2, or the more environmentally friendly method is by using water. Coffee beans are soaked in water, the water is then passed through activated charcoal which removes the caffeine. The recovered caffeine is then re-sold for use in soft drinks and caffeine tablets.*]

CAFFEINE CONSUMPTION BY POPULATION

Group	Safe Daily Consumption	FDA Daily Recommendation
Adults	< 500mg	200-400mg
Pregnant Women	< 200mg	N/A
Adolescents	< 100mg	45-85mg, based on weight

An abrupt decrease or cessation in caffeine consumption may cause withdrawal symptoms- such as headaches, fatigue, irritability and nervousness. Read product labels for content (not all products list caffeine content), cutback gradually, go decaf and shorten tea brewing time.

CAFFEINE CONTENT IN PRODUCTS

Category	Product	Size	Caffeine (mg)
Coffee	Espresso, restaurant-style	1 oz.	40-75
	Generic brewed	8 oz.	95-200
	McDonald's brewed	16 oz.	100
	Starbuck's Pike Place brewed	16 oz.	330
	Coffee, decaffeinated	8 oz.	5
Tea	Black	8 oz.	14-61
	Green	8 oz.	24-40
Soft Drinks	Coca-Cola Classic	12 oz.	34
	Diet Coke	12 oz.	46
	Mountain Dew	12 oz.	54
	7-Up or Sprite	12 oz.	0
Energy Drinks	5-Hour Energy	2 oz.	207
	AMP	8 oz.	73
	Monster Energy	8 oz.	80
	Red Bull	8.4 oz.	80
Other Products	Dark Chocolate-coated coffee beans	28 pieces	336
	Hershey's Kisses	9 pieces	9
	Excedrin, ES	2 tablets	130
	No Doz, Maximum Strength	1 tablet	200
	Midol	2 tablets	120
	Dannon Coffee Yogurt	8 oz.	45
	Haagen Dazs coffee ice cream	1 cup	58
	Jolt gum	1 piece	45
Diet Pills	Dexatrim Daytime	1 tablet	200
	Hydroxycut	1 tablet	250
	Xenadrine	1 tablet	200
	Estrin D	1 tablet	300
	Natrol	1 tablet	100
	Stacker 2	1 tablet	200
	Zantrex-3	2 tablets	300

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The Unprinted Danger *continued from page 15*

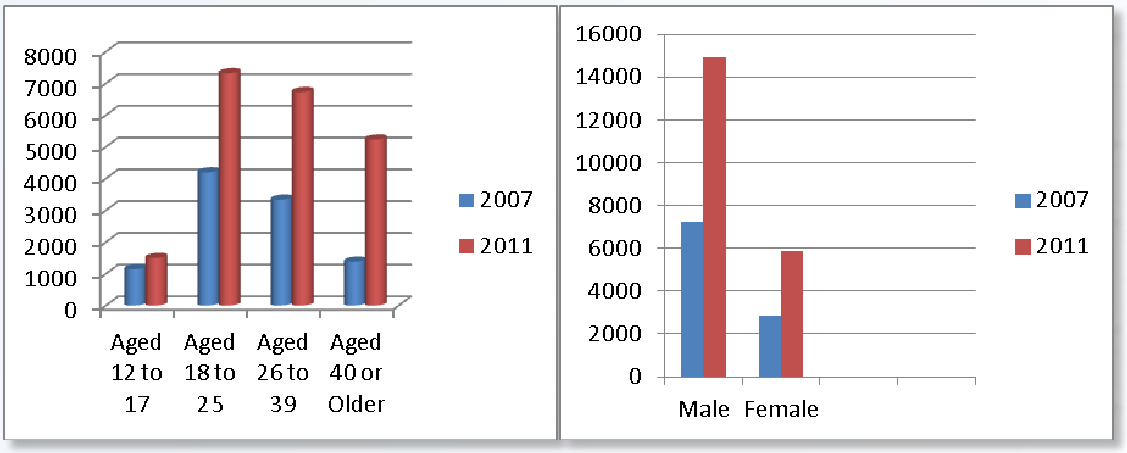
The explosion of availability and consumption of energy drinks has led to problems that end up in hospital emergency departments. In 2005, less than 2000 trips to hospital emergency departments involved energy drinks and their associated problems. By 2011, the number of visits escalated to over 20,000, 58% involved energy drinks alone and the remaining also included other drugs; this rise suggests an increasing propensity for abuse. The energy drink consumers are more commonly men, mostly 18-25 year-olds, though the over 40 demographic grew most rapidly (up 379% between 2007 and 2011).

Overdoses of caffeine typically occur only after ingestion of large amounts, more than 400-500mg at a time. The symptoms of caffeine intoxication may include restlessness, fidgeting, anxiety, excitement, insomnia, flushing of the face, increased urination, gastrointestinal disturbance, muscle twitching, rambling flow of thoughts and speech, irritability, irregular or rapid heartbeat and psychomotor agitation. In cases of much larger overdoses- mania, depression, lapses in judgment, disorientation, disinhibition, delusions, hallucinations, psychosis and rhabdomyolysis can occur. Treatment of severe caffeine intoxication is generally supportive, treating the immediate symptoms; but very high levels of caffeine may require some form of dialysis.

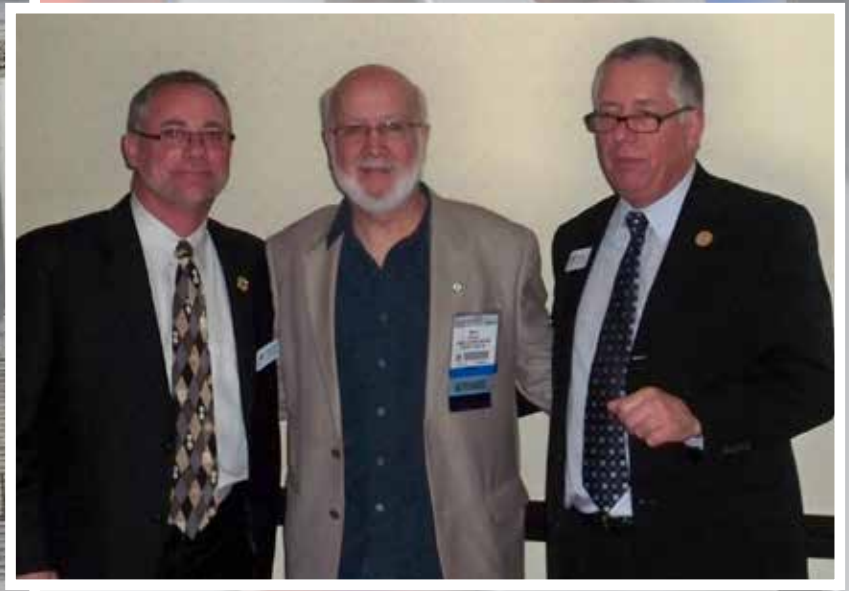
The awareness of products that contain elevated amounts of caffeine is slowly being realized by consumers and watchdog groups. The Council for Responsible Nutrition recently issued voluntary guidelines that instruct companies to label products with the amount of caffeine included, along with suggested daily limits. The FDA is being pushed to address caffeine regulation; supported by a report from the Substance Abuse and Mental Health Services Administration (SAMHSA), which found a rise in deaths and ER visits due to consumption of highly caffeinated products (*Monster Energy has been linked to five deaths*). The FDA has limited caffeine content of sodas to 65mg per 12 ounces, but has yet to address other products with elevated levels. As with anything, moderation is key and an understanding of product content will help to educate ourselves and the public. PA

Chris Noth, PA-C, FAPACVS *is a physician assistant in Vascular Surgery at Integrated Vascular Vein Center of Michigan in Grand Blanc. He is also the MAPA CME Chairperson, the 'MichiganPA' newsletter Editor and Chairman of the Michigan PA Task Force.*

NUMBER OF EMERGENCY DEPARTMENT VISITS



MAPA at AAPA in DC



A Message from MAPA's President-Elect

As we move forward into the summer of 2013, MAPA approaches its next "changing of the guard" for our organization. My path to the Presidency of MAPA started with participation in the Reimbursement Committee with then Past-President, Dan Ladd. When a MAPA Board position opened up in 2008, I ran for and was elected Treasurer and after 4 years in that position, I ran for and won the President-Elect position. I have been very fortunate as a member of MAPA. Maybe the most fortunate thing has been the timing of my progression through the ranks of MAPA. I have been able to participate in the leadership of MAPA with a group of dedicated PAs who have proven themselves as strong leaders and altruistic souls. Their list of accomplishments on behalf of MAPA, its membership and for all Michigan PAs is truly impressive. MAPA's advocacy in our state has made Michigan a great place to practice and a great place for our patients to have confidence in our continued ability to practice.

As I assume the role of President of MAPA for the fiscal year 2013-2014, I will be involved in several important initiatives. Ron Stavale (current MAPA President, who will be transitioning to his Immediate Past-President position) has undertaken a review of the mental health code as it pertains to PAs in Michigan, and I will be assisting him in his efforts to assure that our patients have access to PAs who help provide their care. MAPA will also continue its efforts to promote upcoming legislation that protects our profession and reinforces our team centered approach to patient care.

While these efforts are important and will require time and attention, I don't intend them to be the only efforts I engage in on behalf of our organization. I would encourage all MAPA members to make suggestions regarding issues you think need our attention. We are eager and willing to help solve problems for our members and our patients, but we need your input and feedback if we are to be successful. MAPA is the essential resource for the Physician Assistant profession in Michigan and the primary advocate for Physician Assistants in the state. As such, we take our responsibility to represent our membership very seriously and look forward to working with all of you to keep Michigan a great place to be a PA.

Respectfully,

Jay Kaszyca, PA-C
MAPA President-Elect, 2012-2013

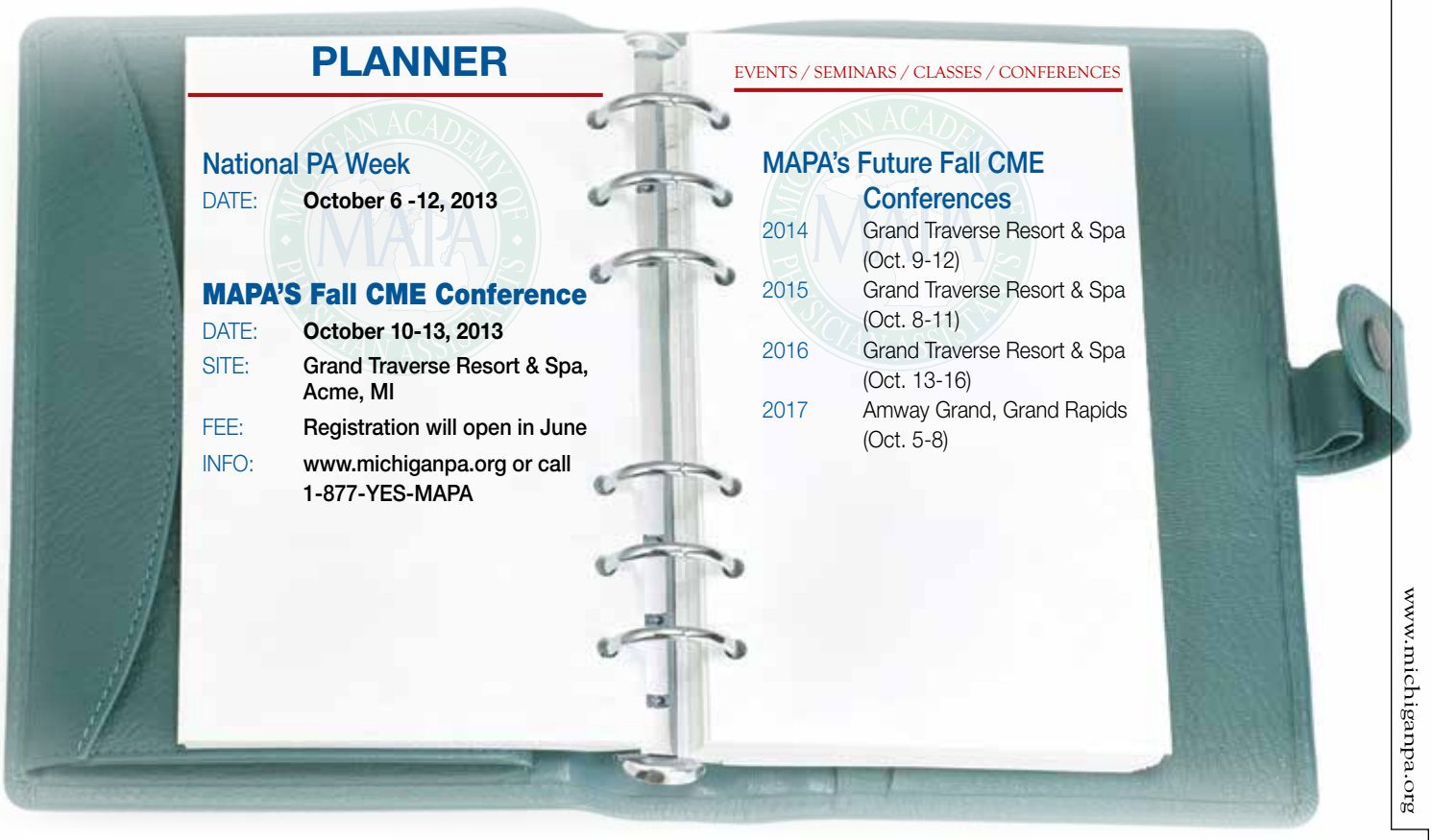
Quote:

"Tell me and I'll forget;

show me and I may remember;

involve me and I'll understand."

Chinese Proverb



PLANNER

EVENTS / SEMINARS / CLASSES / CONFERENCES

National PA Week

DATE: **October 6 -12, 2013**

MAPA'S Fall CME Conference

DATE: **October 10-13, 2013**

SITE: **Grand Traverse Resort & Spa, Acme, MI**

FEE: **Registration will open in June**

INFO: **www.michiganpa.org or call 1-877-YES-MAPA**

MAPA's Future Fall CME Conferences

2014 Grand Traverse Resort & Spa (Oct. 9-12)

2015 Grand Traverse Resort & Spa (Oct. 8-11)

2016 Grand Traverse Resort & Spa (Oct. 13-16)

2017 Amway Grand, Grand Rapids (Oct. 5-8)

'A Tale of Long Ago…'

What Might Have Been?

It was 1979 – the new Michigan PA law was in its infancy. The legislation gave basic parameters and required "Administrative Rules" to interpret the laws. Rep. William Ryan, the father of PA legislation in Michigan, worked incredibly hard to get the legislation approved by both the House and Senate. ***We had finally arrived*** – we were set to practice and all would be wonderful; we could provide quality patient care and save the world. ***We were so naive***.

The House and Senate had approved our existence, the Governor signed the legislation and the Rules Promulgation process began – just as I assumed my position as President of MAPA. Once the law actually was in place, the process of developing these 'Rules' began. The legislation had provided basics, a PA Task Force was formed to oversee PAs, the Medical Board would license physicians (MDs) to supervise PAs and the Osteopathic Board was to license DOs to supervise their PAs. Each PA would be licensed to a specific physician, with an alternate supervisor licensed to supervise when the primary physician was not PHYSICALLY present at the practice site. A problem arose if one physician was an MD and one was a DO; this was just the mere tip of the iceberg. Physical presence at the practice site was another issue in the beginning. As we met many times, MAPA officers, members of the Boards of Medicine and Osteopathy and several less than supportive bureaucrats from the Department of Licensing and Regulation, became increasingly at odds over proposed ideas that were to form the Rules. We were upsetting organized medicine and the Boards that protected the citizenry in the state of Michigan.

Some of the 'Rules' proposed were so restrictive that we would need the physician physically present – IN THE ROOM – to perform even simple tasks. Multiple meetings were held to discuss and supposedly seek compromises to move the 'Rules' along. At one such meeting, we reached something close to acceptable and moved forward; however, the written minutes of the meeting and the resultant presented 'Rules' were not even remotely related to our discussions or the 'Rules' agreed upon. ***We were back at square one***, except for the reported "Consensus" reached at the meeting. The MD & DO board members and state employees scheduled public hearings, which were held by the Joint Committee on Administrative Rules. Several hearings took place with MAPA representatives testifying that the 'Rules' being moved forward were not what were agreed upon and were much too restrictive.

At one hearing, a DO hinted about multiple malpractice suits against PAs. At another hearing, a member of the Medical Board who had proposed a particularly restrictive clause about PA procedures was unable to define his own terms. MAPA Board members and interested parties personally visited with each member of the Joint Committee on Administrative Rules to seek insight and advice. Ultimately, the 'Rules' were struck down, with the comment from then Senator Doug Ross, that the legislature had approved the PA professions existence and these 'Rules' were an attempt to legislate it back out of existence, by being so restrictive. It took untold hours of work just to maintain the status quo. All of us involved at the time were newly practicing PAs with young families, we thought the profession deserved our support; ***service is part of being a Physician Assistant***.

There are many stories like this one, ask any MAPA Past-President and you will hear what it takes to keep the profession safe, vibrant and growing. There have been many assaults on our practice, not all as dramatic as the history I related here, but in many ways, medicine and the PA profession are under assault. If you enjoy the privilege of practicing as a Physician Assistant in Michigan, ***you owe your profession service***. Many professions have been significantly damaged from lack of service from it's' members, as we almost were.

I know you all have incredible stories of patients you have assisted compassionately. I also know many of you have provided many volunteer activities and donated your time for those less fortunate, which is also incredibly commendable. What can you say that you have done for the profession? What have you done for your colleagues? Without significant activity by PAs – looking out for PAs, our livelihoods can be determined by non-PAs, - ask any MAPA Past-President, they all have a story. Most of the stories never make the 6:00 o'clock news, but the assaults are there. It's exciting in the trenches.

James Frick, MS, PA-C, DFAAPA *is Past-President of MAPA 1979-1980 and a Fulbright Scholar 2003-04. Jim currently works in Traverse City, MI at the Neuromuscular & Rehabilitation Association of Northern Michigan.*