YOUR VOICE. YOUR PROFESSION.

MICHIGAN PA

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YOUR VOICE.
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Your Newsletter Editor's Corner

It has been a very busy year for MAPA as we continue to expand and implement our visionary and strategic plan. The excitement & joy of the plan is evident to us as hopefully it will be to you. Since our vision is not only continuing to strive to do better, it is actually to be the best PA state academy in the region and to have an environment that is the best for practicing PAs. This exciting and transformative plan has brought and will be bringing more benefits to your membership. We have already seen the impact at the legislative level and we are advancing this ideal even further. At the internal level, we are redesigning the website and adding new benefits and information that we believe will enhance your professional practice and needs, respectively. We are on the move, never standing still!

Our world is an ever changing place and so are we. As we prepare to welcome our new Board members, we are already setting our sights on our annual Fall CME Conference. I can assure you this new class of your peer leaders are already planning new programs and projects to continue building that unique membership experience, way beyond than what we have traditionally experienced in the past. As a vested member, we seek your input, your feedback and your time. We want to partner with you to help us produce a vibrant and responsive organization, while grooming the next "generation of leaders for life"—you!

As always, we have a great collection of articles that cover a wide range of topics in this edition, so get that cup of your favorite beverage and start enjoying this newsletter at your leisure. As you can see, we at MAPA have not missed a beat; let's continue our march forward, staying the course and keeping your career on track and strong all year around! We thank you for joining us in this journey, it promises to be more exciting each season.

Cordially yours,

Marcos A. Vargas, MSHA, PA-C
'MichiganPA' Newsletter Editor

President's Message

New Beginnings

Fall is my favorite season. I love the cool mornings, warm days and cool nights. I love the changing colors in the trees, football games, and of course attending MAPA's Annual Fall CME Conference in Traverse City. I also love the fall because I have the luxury of seeing my PA students graduate from WMU. I teach part-time there and precept students in my clinic as well. I've grown attached to them and take pride in their accomplishments; much like a father takes pride in his son or daughter as they achieve milestones. This year is extra special to me because I get to watch my wife graduate from WMU's PA program after two years of hard labor and sacrifices. As MAPA's sitting President, I was asked to be the keynote speaker at her graduation this year. As graduation marks the end of a grueling PA student career and ushers in a new beginning as a practicing PA for my wife and all of her classmates, it also ushers in a new wrinkle in my career. Speaking at her graduation will be one of the first visible and tangible duties I will undertake in my role as MAPA President. As she sets forth beginning her new career, I too officially set forth on a new beginning of sorts in my career.

This fall not only serves as a new beginning for PA students, like my wife as they begin their rewarding careers as PAs; it also serves as a new beginning for MAPA and PAs across Michigan. You may have noticed the new logo on the cover of this newsletter. MAPA has been working to revamp our image, fine tune our message, and forge forward with renewed emphasis on being 'Your Voice, Your Profession.' MAPA will go through a "rebirth" of sorts this year. We are rolling out an updated website, a new logo, and will be discovering new ways to engage and serve our PAs on the regional level. MAPA will also be hiring a new Executive Director this year, as we make a transition with the retirement of our current Executive Director, Mike DeGrow. Mr. DeGrow has been an advocate and resource for MAPA of almost 20 years and he will be difficult to replace.

Legislatively, we at MAPA are working to promote legislation in HB 5533, that if passed as written, could revolutionize legislation for PAs in Michigan, but also serve as a template for other states to provide what we feel is the best legislation for PAs in the country. We are currently keeping a close eye on potential changes that can impact PAs in the Mental Health Code as well. With a spotlight on mental health and the opioid epidemic from the public, our legislators in Michigan are looking

to healthcare providers for guidance on how to improve care for these patients and concerns they have on these health issues. MAPA will be there to make sure PAs are part of the solution.

Change is necessary and we must adapt to our changing healthcare environment. We need to be reborn from time to time, and with our changing healthcare and political climate, there is no better time than now. I would like to offer congratulations to all the new graduates from our six wonderful PA Programs in Michigan on their new beginnings, and offer a promise of vigilance and service to all PAs in Michigan as we usher in our own "new beginnings." These are exciting times for new grads and MAPA, because with new beginnings, great opportunities await.

Best Regards,

R. David Doan III, MS, PA-C
MAPA President 2016-2017

Introducing the New

MAPA Logo

As the landscape of healthcare changes and evolves, so too does MAPA. Over the past months, MAPA has been diligent on redefining our identity and working on being more relevant and refreshing. The starting point of MAPA's makeover was with our 'brand' (what we offer MI PAs), key messaging (ideas/products that will resonate with MI PAs) as "Your Voice. Your Profession." and a more defined and uniquely identifying logo; as introduced here…

PROTECTING ADULTS:

Are You Meeting the Standards for Adult Immunization Practice?

Guest Contributor: **Jacklyn Chandler, M.S., Outreach Coordinator, MDHHS Division of Immunization**

Making sure your adult patients are up-to-date on vaccines recommended by the Centers for Disease Control and Prevention (CDC) and the Michigan Department of Health and Human Services (MDHHS) gives them the best protection available from several serious diseases and related complications. The National Vaccine Advisory Committee (NVAC) recently revised and updated the Standards for Adult Immunization Practice to reflect the important role that all healthcare professionals play in ensuring adults are getting the vaccines they need.

These new standards were drafted by the National Adult Immunization and Influenza Summit (NAIIS) of over 200 partners, including medical associations, state and local health departments, pharmacists associations, federal agencies, and other immunization stakeholders[1]. What makes adult immunization a priority for leaders in medicine and public health?

Every year, tens of thousands of adult Americans suffer serious health problems, are hospitalized, and even die from diseases that could be prevented by vaccines[2]. These diseases include shingles, influenza, pneumococcal disease, hepatitis A, hepatitis B-related chronic liver disease and liver cancer, HPV-related cancers and genital warts, pertussis ("whooping cough"), tetanus and more. Yet, adult vaccination rates remain extremely low. For example, coverage rates for Tdap and zoster vaccination are less than 30% for adults who are recommended to receive them[3]. In Michigan, even high risk groups are not getting the vaccines they need – only 30.6% of adults younger than 65 years old who are high risk for complications from pneumococcal disease are vaccinated[4].

It is imperative to let your patients know that vaccination is important, because it not only protects the person receiving the vaccine, but also helps prevent the spread of certain diseases, especially to those that are most vulnerable to serious complications- such as infants, young children, the elderly, and those with weakened immune systems. Immunizing adults creates healthier communities and protects the places in which we live, work and play.

Adult patients trust their healthcare provider to advise them about important preventive measures. Most health insurance plans provide coverage for recommended adult vaccines. Furthermore, research indicates that most patients are willing to get vaccinated, if it is recommended by their provider[5,6]. However, many patients report their healthcare providers are not talking with them about vaccines, missing critical opportunities to immunize[7].

MDHHS and MAPA are calling on all Michigan PAs to make adult immunizations a standard of routine patient care in their practice by integrating four key steps[8]:

1. **ASSESS immunization status of all your patients at every clinical encounter**. This involves staying informed about the latest CDC recommendations for immunization of adults and implementing protocols to ensure that patients' vaccination needs are routinely reviewed.

2. **Strongly RECOMMEND vaccines that patients need**. Key components of this include tailoring the recommendation for the patient, explaining the benefits of vaccination and potential costs of getting the diseases they protect against, and addressing patient questions and concerns in clear and understandable language.

3. **ADMINISTER needed vaccines or REFER your patients to a provider who can immunize them**. It may not be possible to stock all vaccines in your office, so refer your patients to other known immunization providers in the area to ensure that they get the vaccines they need to protect their health. Coordinating a strong immunization referral network will reduce a substantial burden on your adult patients and your practice. If your adult patients do not have insurance, or if their insurance does not cover any of the cost of an immunization, check with your local health department to see if your patient qualifies for the following public vaccines: Td, Tdap, MMR, Hep A, Hep B or Zoster.

4. **DOCUMENT vaccines received by your patients.** Help your office, your patients, and your patients' other providers know which vaccines they have had by documenting in the Michigan Care Improvement Registry (MCIR). And for the vaccines you do not stock, follow up to confirm that patients received recommended vaccines.

Want to learn more? MAPA is hosting a CME lecture on Adult Immunizations Update at the 2016 MAPA Fall CME Conference in October. For more information, please refer to the MAPA website for a link to the CDC and for Fall Conference registration and conference schedule at: www.michiganpa.org . There will also be an adult immunization vaccine schedule in the registration material for all conference attendees. MAPA is a participant in the Adult Immunization Multi-Stakeholder Initiative with a stipend to support programs and information to increase awareness and implement standards for adult immunization at Michigan health care practices. Other participating organizations include: ACOG, ACP, HCA, MAFP, MAOFP, MCNP, LARA, MHA, MNA, MOA, MSMS, MPA and MPCA.

Additional educational resources are available to provider offices, including free immunization educational sessions through the MDHHS Immunization Nurse Education program and the Physician Peer Education Project on Immunization. The educational sessions through both educational programs are approved for continuing medical education credit. Visit www.aimtoolkit.org – click "Information for Health Care Professionals" and "Education & Training" for more complete information[9].

Informational brochures about immunization topics are available free of charge from MDHHS. A variety of materials is available and can be ordered online at www.healthymichigan.com – click "Enter Site" and "Immunizations" to begin adding resources to your cart. In spring 2016, the "AIM Packet – Adult" was added- the contents focus on adults and include the immunization schedule, brochures, posters, and other educational flyers and resources for your practice.

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2015-2016 MAPA Legislative *'Year in Review'*

Ron X. Stavale, PA-C, Chairperson, Legislative Committee

MAPA is a non-profit (and the only) organization representing the professional interests of PAs in Michigan. As one of your representatives for Michigan PAs to the Michigan legislature and other health care organizations, I would like to update you on what has occurred over the past year regarding legislation in Michigan that could possibly affect our (PAs) ability to practice medicine.

Last year, MAPA worked with the Michigan State Medical Society (MSMS) and the Michigan Osteopathic Association (MOA) to monitor the NP Independent Practice Bill. MAPA testified at the Michigan Senate's Health Policy Committee Hearing regarding the NP bill on behalf of all of Michigan's PAs. Our testimony focused on informing the committee that the State of Michigan and Federal Authorities have traditionally treated NPs and PAs equally. Plus, the other emphasis of our testimony was that there are hundreds of mixed NP/PA practice settings in Michigan where PAs and NPs care for patients alongside each other. If the NP bill would have passed, without making similar changes in PAs practice laws, it would have created different levels of practice abilities; creating significant office and practice inefficiencies and confusion. In 2015, Senate Bill 68 was voted out of committee and while on the Senate floor there were amendments added that made it difficult for the NPs to support their own bill and it was never voted on. The NPs then introduced another bill into the House of Representatives early in 2016. Information on this bill can be found by logging onto www.legislature.mi.gov and typing in the number 5400.

With the support of Representative Ned Canfield DO, MAPA was been able to introduce our own bill into the House of Representatives earlier this year, labeled **HB 5533**. This bill is currently in a position to where it could have a hearing this coming fall. You may find the language of the bill by going to the same site listed above and placing the number 5533 in the search area. **House Bill 5533** will modernize and update the PA practice law in Michigan. Information about the bill was previously sent out to all Michigan PAs in our email database in May by then MAPA President Chris Noth, PA-C; in the email was stated:

"To advance the PA practice to its fullest potential in Michigan, as it is called, **HB 5533** delineates points and clarifies items of a practice agreement between PAs and physicians. The 'good news' from this bill is that the terms 'supervision' and 'delegation' would be removed from the statute when referring to PA-physician teams and PAs would no longer be delegated prescribers, but 'prescribers within a practice agreement'. Here are the summary points of the proposed PA legislation of **HB 5533**:

- ***PAs will*** *continue to practice medicine and remain a sub-field of Medicine, Osteopathic Medicine and Podiatry boards and continue to be subject to the rules promulgated by these boards.*

- ***PAs will*** *continue to practice with a physician as a member of a practice team.*

- ***PAs will*** *work within a practice agreement with a physician that defines an inter-professional process for communication, availability and decision making which enables the shared knowledge and skills of health care providers to deliver medical treatment to patients based upon each provider's education, training and experience and specifies the following:*

- *includes the signature of each party to the agreement*

- includes a termination provision

- defines the methods of communication between, and periods of availability of, each of the parties in the agreement

- stipulates that a party to the agreement cannot practice outside their scope and training

*- **Continue to** be held to the standards of competency and training: "A physician's assistant shall not undertake or represent that he or she is qualified to undertake provision of a medical care service that he or she knows or reasonably should know to be outside of his or her competence or is prohibited by law."*

*- **The practice** agreement would remove supervision and delegation provisions in the statute, in favor of physician oversight within the practice agreement.*

*- **Mandate that** the "Boards" consider rules to be developed that may further define a practice agreement.*

*- **Removes arbitrary** PA/physician ratios in statute and allows the "Boards" to deliberate on a more comprehensive approach through the rules process.*

*- **PAs will** be included in the definition of "prescribers," but prescribe only as a party to a practice agreement with a physician.*

PAs have always promoted the benefit of practicing with physicians and these same physicians have embraced this team concept with PAs. In summary, **HB 5533** would modernize the language in the Public Health Code of Michigan and mirror how PAs practice, while adhering to our team practice concept with physicians."

I would like to take a moment to thank my fellow committee members and your colleagues (you should thank them too!): Andrea Frey, John Young, Marc Moote, Cristina Munn, James Kilmark, Greg Bennett, Chris Noth, Heather Klopp, Meghan Dietrich, Jodi Zych, Karen Byers, David Doan and Lauren Gasso. A special thanks to our Executive Director and Lobbyist- Mike DeGrow, who has guided us through a difficult political and legislative obstacle course.

You can be assured that your MAPA representatives will continue to work hard to get this bill passed, but

like all bills, it will require your assistance! MAPA will notify you when the time is right to write, email or call your representatives and more importantly MAPA will be asking you to actually visit with your representatives for a greater impact. We will provide information and talking points, but keep this in mind, MAPA cannot do this alone.

MAPA 2016 Fall CME Conference

The 2016 MAPA Continuing Medical Education Conference is less than two months away. This is the premier, annual event for Michigan PAs and those from nearby states to gather for high quality CME, catching up with friends and classmates and a time to relax in a beautiful northern Michigan setting. The conference is October 13 – 16, 2016 at the spectacular Grand Traverse Resort and Spa.

We are offering basic and advanced workshops in ultrasound and suturing. There is also an opportunity to participate in the joint injection workshop introduced in 2015. The speakers and topics will provide quality CME in all areas of PA practice and attendees will gain valuable information and CME credits. The NCCPA will be presenting on Saturday morning and this is a great opportunity to update and ask questions.

Our charity partner this year will be Child and Family Services of Northwestern Michigan. We will be assisting them in their goal of "ensuring the safety and well-being of children, youth, adults and families in times of crisis, challenge and life transition". Our donations will allow them to continue their fine work. If you would like to donate, please visit www.mapaevents.org and click on "Conference Charity" link for the list of requested items.

The MAPA Board of Directors meeting is Thursday morning and open to all attendees. Come and witness your academy at work.

The Exhibit Hall opens at 1:00pm on Thursday and will remain open until 6:45pm for the Wines and Steins Tasting.

Friday evening starts with the University Receptions followed by the Michigan PA Foundation Student Quiz Bowl. Come cheer your school or alma mater, test your knowledge against the students or just enjoy the contest.

Saturday evening we have the MI PA Foundation Silent Auction followed by a new reception sponsored by MAPA.

Please join us for this CME opportunity in this scenic setting.

Registration is open. Please see the MAPA website for registration information or visit our new events website at mapaevents.org. See you in Traverse City in October.

Donna Hines and Jeff Collinson
CME co-chairs

Community Volunteers — PAs in action

On May 7th MAPA Community Volunteers in coordination with Habitat for Humanity hosted the inaugural MAPA Community Volunteers event.

On a cool and sunny Saturday morning in Hazel Park, 10 eager participants put on their painting shirts, work pants, and tool belts to start the day long task of finish work on a single story ranch. The volunteer group; made up of Pre-PA students, PA-Students, and practicing PA's alike, divided up into teams. The team's were tasked with painting interior walls, landscaping, clean up, and installing flashing around the perimeter of the roofs edge. As the day progressed the participants managed to complete all tasks appointed by the site supervisor, which exceeded his expectations. The supervisor then thanked and commended the group for its dedicated effort, work ethic, and professionalism.

This event was part of a months long renovation build of a one story bungalow. The recipient of this renovation is a veteran of the Armed Services who is in need of a low cost home. Once settled into her new home this veteran will dedicate her office space to meet with and advise fellow veterans which are in need of assistance and guidance to help them apply for and receive benefits or needed treatment.

This inaugural MAPA Community Volunteer event will be one of many to come. Currently, Region 6 (Metro Detroit area) is the flagship region to garner support for this volunteer effort. If you are interested in volunteer events please contact your MAPA Regional Representative!

From top left: John Young, Paul Neamonitakis, Stephanie Hargraves, Mona Sater, Michelle De Varenes, Sarah Gorial, Savanah Hadle, Jessica Firman and Carmen Ayar.

UNDERSTANDING THE VARIOUS TYPES OF DEPOSITIONS

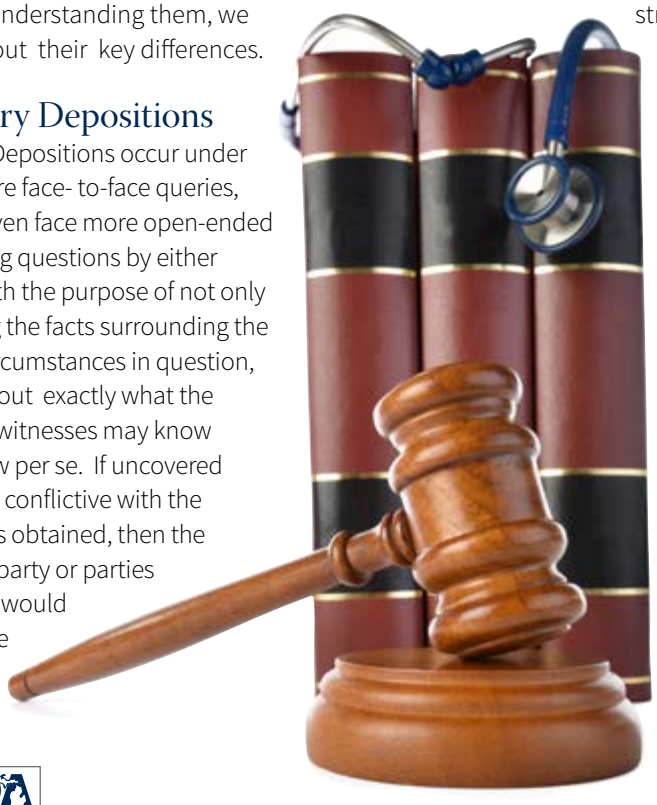
Marcos A. Vargas, MSHA, PA-C

So you receive a subpoena to appear for a deposition. Your heart is in your throat and you begin experiencing abdominal pain. You are required to give testimony on a lawsuit at an attorney's office and this is your first time for this experience. A deposition is an out-of-court oral testimony of a witness that is used for discovery purposes to gather information in preparation for trial. The deposition has two purposes: to find out what the witness knows and to preserve the witnesses testimony. It is commonly used in civil litigation or suits for financial damages or for equitable relief.

In the most basic sense, there are two kinds of depositions: "***discovery***" and "***trial***" depositions. They both are tools that trial attorneys employ in their quest to uncover all related facts to an alleged negligent claim. This discovery process is basically almost routine during the pre-trial motions of most if not all medical malpractice allegations; but before we can proceed any further in understanding them, we must sort out their key differences.

Discovery Depositions

Discovery Depositions occur under oath and are face- to-face queries, you may even face more open-ended and probing questions by either counsel with the purpose of not only uncovering the facts surrounding the event or circumstances in question, but to find out exactly what the witness or witnesses may know or not know per se. If uncovered evidence is conflictive with the testimonies obtained, then the respective party or parties most likely would have to face additional questions, most likely in front of the judge. Yet, still privileged communication that remains protected throughout the trial process as delineated by the rules of evidence in your state.



The duration of this process can take 15 minutes or much longer. Theoretically, it can last days or weeks depending on how confident the plaintiff or defense attorney feels about their uncovered facts or other related issues and if there is a lot of information and facts that need to be uncovered or discovered.

Trial Depositions

Conversely, in Trial Depositions, the counsel questioning becomes more leading, suggestive and ultimately intensely razor-sharp focused than what occurs in a ***discovery*** deposition. Herein, either counsel sets the line of reasoning so the potential case theme doesn't stray into ambiguity, thus jeopardizing their overall case strategy. In fact, the witness could be easily impeached on a minor "key point" more readily since responses sought must be to the point. In nearly all cases, there's less re-wording or re-questioning by the attorneys, given the need of the deponent's accurate testimony and response brevity during the latter. Sometimes a ***video*** deposition is taken because the deponent/witness is unable to testify in person.

So when subpoenaed for any deposition, you should be familiar with the following points:

1. Figure out which kind of deposition you will be facing, chances are you will be faced with a ***discovery*** deposition first before a ***trial*** deposition.

2. Know that some states have a different process for ***discovery*** depositions and ***trial*** depositions.
3. Depositions are always aimed to uncover what the deponent knows and doesn't know regarding the alleged events or circumstances of the case.
4. Both type of depositions can be videotaped for review and used in court to impeach the witness.
5. Anything can be asked if it's likely to lead to discoverable evidence to either party.
6. Be prepared and familiarize yourself with your counsel case strategy for either type of deposition- career fate and case outcome could hinge on this.
7. Be well rested both physically and mentally so you can perform at your very best.
8. Do not anticipate the questions that might or should be asked.
9. Always only answer the actual questions- do not volunteer opinions or add any additional information.
10. Request and insist on having two pre-depositions conferences with your attorney so you can be prepared and feel confident about the anticipated process.
11. Confirmation of your receipt of the subpoena within 72 hrs is a must. While there are overlapping procedural similarities between the two types of depositions, not every deposition focus is the same. Luckily, just a handful of states recognizes *trial depositions* in addition to *discovery depositions* as discussed. There are differences between depositions and if you are required to be a part of a deposition, the above information will hopefully give you some direction and information to make them seem not so gut-wrenching.

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.

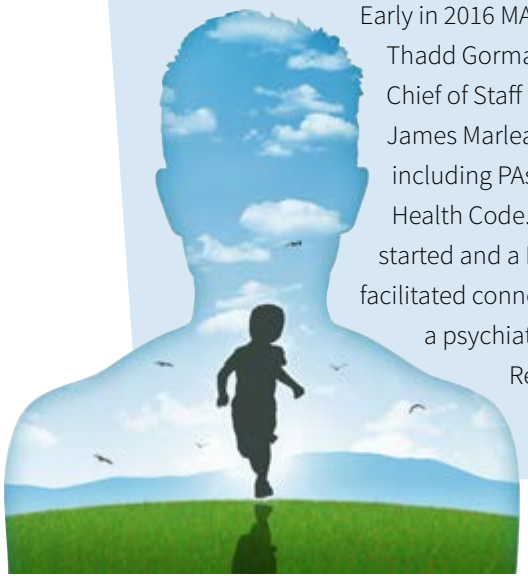
MAPA Values

- 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

Michigan's Mental Health Code – Time for an Update!

By Ron X. Stavale, PA-C, Chairperson, Legislative Committee

Over the years, MAPA has fielded many requests from employed PAs in mental health, regarding the various barriers they face in practice. These issues ranged from prescribing to reimbursement, but also other problems limiting PAs in providing care for patients with mental health issues. Some of these limitations have been based on the fact that the PA profession was just emerging in the early 70's, and despite being well defined in the Public Health Code, unfortunately PAs were not included in the Mental Health Code when it was written in 1974. While our Michigan State Law allows for physicians and psychiatrists to delegate the practice of medicine to PAs, this is not the case in the mental health arena; since PAs were not listed as providers in the Mental Health Code back then (ironically, Registered Nurses are!). Therefore, PAs have become limited to practice in the mental health arena because of this glitch and that some office or hospital administrators interpret this glitch as a reason for not allowing PAs to perform a specific aspect of a practice.



Early in 2016 MAPA approached Thadd Gormas, who is the Chief of Staff for Senator James Marleau, about including PAs in the Mental Health Code. Initial work was started and a Psychiatric PA facilitated connecting MAPA with a psychiatrist, Michelle Reid, MD who has already been actively working to include PAs in the Mental Health Code and in the Medicaid Manual. So for the past two months, a group of providers have been meeting weekly to address this issue. The group consists of myself, Dr. Reid, and another psychiatrist colleague from their department, along with a doctoral NP student, Thadd Gormas and MAPA's Executive Director- Mike DeGrow. We have been going through the Mental Health Code- adding the title PA to the list of providers in each section, so that PAs will be specifically mentioned throughout the code instead of leaving the possibility that some administrator or provider would interpret the lack of mentioning 'PAs' as reason to deny a PA the ability to care for patients with mental health issues.

This synergy of forces has allowed us to project the ability and send a draft of a bill to our Legislative Service Bureau by the end of August; hopefully, having a draft of a bill that can be fine tuned and submitted for consideration in the fall's legislative session. We are limiting the focus of this bill to including PAs as providers, knowing that the more issues that are addressed in a specific bill the better chance other professions will comment or amend the bill. We don't expect this to be a slam dunk; so therefore, MAPA would like to make a list of all of the Michigan PAs working in psychiatry so that we can contact PAs and physicians who would be supportive of this effort. We will need the support of physicians, administrators and PAs working in the mental health community to allow this process to become successful. Hence, we are asking all Michigan PAs working in psychiatry to contact the MAPA office or myself to be included in this process.

The MAPA office phone is: 877-YES- MAPA (877-937-6272) or email our Academy Administrator Sara at: ssurprenant@managedbyamr.com

MAPA Annual Report: 2016-2017

This MAPA Annual Report is to call your attention to the activities that MAPA has addressed over the previous year, and what MAPA is working on or is planning over the coming year. Your membership dollars are being used to support these activities and to help us continue to advocate for you as a Michigan PA and as a member of MAPA. Thank you for your membership!

ACTIVITIES ADDRESSED:

- Successful Fall and Spring CME Conferences
- **House Bill 5533**- PA Legislation Bill that will remove 'supervision' and 'delegation' terms, remove physician/PA ratios, PAs will have a 'practice agreement' with physicians and PAs will be defined as 'prescribers.'

ACTIVITIES PLANNED OR WORKING ON:

- Fall and Spring CME Conferences
- Adding value to offered MAPA membership benefits
- Updating and revitalizing the MAPA website to make it more functional, relevant and an essential resource for members: www.michiganpa.org
- Contracted with BCP Marketing firm to help MAPA realign its priorities and develop a 'brand' for ourselves
- Continue the working relationship between MSMS/MOA and MAPA leadership
- Continue working with legislators to support HB 5533 and work towards approval

If there are issues that you deem important or want MAPA to address, feel free to forward them to us at: mapa@michiganpa.org .

If you want to become involved in the MAPA Board in some capacity, send us your contact information.

Best Regards,
MAPA BOD

The Heroin Epidemic

By: Chris Noth, PA-C and R. Dave Doan III, PA-C

Heroin- So why has there been an explosion of heroin use over the last decade or so? It is due in large part to the abuse and over prescribing of prescriptive opioid pain medication- such as Oxycontin and Vicodin (these are currently among the most commonly abused drugs in the US). Research suggests that abuse of these drugs may open the door to heroin abuse. About half of the young people who inject heroin reported abusing prescription opioids before starting to use heroin. Individuals stated that **heroin is cheaper and easier to obtain and a 'better high' is achieved than with prescriptive opioids.** Linda Davis, a district judge in Clinton Township and president of Families Against Narcotics is advocating for more public education, changes in insurance practices, a change in prescription culture and legislation to increase the availability of Naloxone. Davis states- **"The reason for heroin abuse growth in the state is the change in culture of medical practice which has turned from pain management to pain elimination, resulting in over prescription."** There are many patients out there who suffer from various types and forms of pain. Whether it is post-surgical or post-procedural pain, pain from an acute event or pain from a chronic condition, all of these typically are treated with some types of oral pain medication. Granted, when a patient is in pain, we naturally want to remove the pain through appropriate pain medication. There is a fine line between totally removing the pain and making the pain manageable and use other forms of pain management options.

Heroin is a derivative of morphine alkaloid which comes from the seedpod of the opium poppy plant. Heroin was first made in 1874 in London. Later, the German drug company- Bayer, marketed diacetylmorphine as an OTC remedy for coughs and was also used to treat pain from TB. It was marketed under the trademark name Heroin (derived from the Greek word "*heros*", for its perceived 'heroic' and strong effects on the user). Heroin is classified as a Schedule I controlled substance and as such, has no acceptable medical use in the US. In 2012, an estimated 95% of the world's opium was produced in Afghanistan; most of the heroin that is available in the US today comes from Mexico and Columbia. It is the most widely used and fastest acting opiate available and is 2-3X more potent then morphine. The pain-killing properties stem from the fact that it mimics endorphins, the natural pain-killing substances produced by the body. As heroin binds rapidly with opioid receptors [in the brain], the pain-killing effect is extended and magnified, producing a pleasurable sensation called a 'rush.' Pure heroin is a bitter white powder; most of the illicit heroin is 'cut' with non-harmful substances (sugar, starch, powdered milk, quinine), but sometimes it is 'cut' with strychnine or other poisons that could increase the risk of overdose or death.

Street names for heroin include: smack, H, skag, junk, horse, brown sugar and black tar. Routes of heroin use are vaporized (smoked) or sniffed (snorted)- both take 10-15 minutes for full effect, suppository or oral, but the most common route is injection- with 7-8 seconds for full effect. Injected (IV) heroin is immediately metabolized to morphine which binds to opioid receptors in the brain and the effect disappears within a few hours. A first time user may only require between 5mg and 20mg, while an addict may need 200mg to 300mg per day to achieve

the desired effect. The first feeling is the euphoric 'rush' and is accompanied by a warm flushing of the skin (like a warm hugging sensation), along with a dry mouth and heavy extremities. These initial feelings are followed by alternating states of wakefulness and drowsiness ("on the nod") and mental cloudiness. Other effects include respiratory depression, 'pinpoint' pupils and nausea/ vomiting. IV heroin use can be complicated by sharing and /or of contaminated needles, HIV/AIDS, Hepatitis C and reactions to the impurities from 'cut' substances. Skin popping (superficial injection of heroin- is used once available veins are sclerosed) can lead to abscesses and IV use can cause spontaneous abortions and endocarditis.

With regular heroin use, tolerance develops where the abuser must use more heroin or more often to achieve the same intensity or effect. As higher doses are used, over time physical dependence and addiction develops.

Tolerance - more of the drug is needed to achieve to same 'high'

Dependence - the need to continue use of the drug to avoid withdrawal symptoms

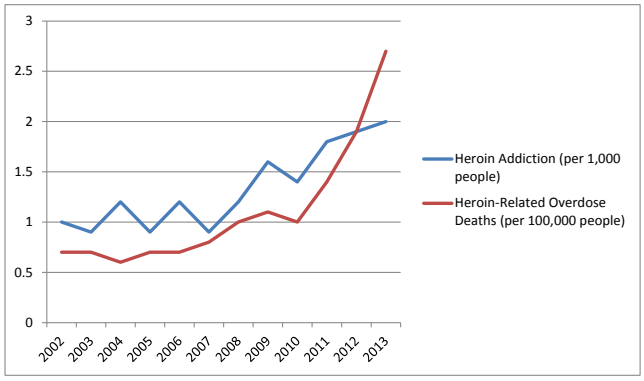
Addiction - a devastating brain disease where without proper treatment, people can't stop using the drug

Continued heroin use causes the brain to reduce or even stop producing its own endorphins, at this point the addicts' body becomes barely capable of managing small amounts of pain or discomfort. Withdrawal symptoms- drug craving, restlessness, pain, insomnia, cold flashes with goose bumps- 'cold-turkey'- typically peak at 48-72 hours.

In 2011, 4.2 million Americans aged 12 or older had used heroin at least once in their lifetime; it is estimated that about 23% of these individuals became dependent on it. By the time students graduate high school, nearly 40% have tried marijuana. Once a person can no longer get the initial 'rush' they seek from a drug, they either increase the drug consumption or look for something stronger or better. A 2007 National Survey on Drug Use and Health (NSDUH) found that 9.5% of youths aged 12 to 17 in the US were current, illegal drug users. In 2011, more than 250,000 visits to hospital emergency departments involved heroin.

	2002-2004*	2011-2013*	Percent Change
Sex			
Male	2.4	3.6	+50%
Female	0.8	1.6	+100%
Age, Years			
12-17	1.8	1.6	-11%
18-25	3.5	7.3	+109%
26 or older	1.2	1.9	+58%
Race/Ethnicity			
Non-Hispanic (White)	1.4	3.0	+114%
Other	2.0	1.7	-15%
Annual Household Income			
Less than $20,000	3.4	5.5	+62%
$20,000-$49,999	1.3	2.3	+77%
$50,000 or more	1.0	1.6	+60%
Health Insurance Coverage			
None	4.2	6.7	+60%
Medicaid	4.3	4.7	+9%
Private or other	0.8	1.3	+63%

*Annual average rate of heroin use (per 1000 people in each group)



Source: National Survey on Drug Use and Health (NSDUH), 2002-2013.

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Heroin use is part of a larger substance abuse problem. Nearly all people who used heroin also used at least one other drug, most used at least three other drugs. People who are addicted to…

Alcohol are **2X** more likely to become addicted to heroin

Marijuana are **3X** more likely to become addicted to heroin

Cocaine are **15X** more likely to become addicted to heroin

Prescription Opioid Painkillers are **40X** more likely to become addicted to heroin

The New Face of Heroin

The image of a listless young heroin addict collapsed in a dark alley is quickly becoming less common. Today's addict could be an early teenager, playing video games and enjoying their music or a middle-aged housewife, appearing smart, stylish and bear none of the common traces of heroin use. Because it is available in various forms, is easier to consume and more affordable, heroin is more tempting than ever. There are many reasons why individuals can become addicted to heroin. For teenagers, it may help to cope with self-image issues or fit into a peer group; adults struggling with depression use heroin to decrease the pain from their mental health issues or they don't receive a benefit anymore from prescription pain medications and are seeking an alternative.

Heroin is the second most commonly cited drug among primary drug treatment admissions in Michigan. Heroin overdose deaths in Michigan increased from 271 (1999-2002) to 728 (2010-2012) and admissions to funded heroin treatment programs doubled in the same time periods. A spike in overdose deaths in 2014 was believed to be linked to heroin laced with Fentanyl.

Treatment

Treatment consists of moving a patient towards substitution therapy- minimizing withdrawal symptoms through less-potent drugs. Substitution treatment takes two forms, Methadone and Suboxone. Suboxone is primarily for those with lesser addictions and mild withdrawal symptoms. Currently, physicians in the state who are certified to administer Suboxone are capped at 100 participants by state law. Methadone (Dolophine) is considered the only option for serious long-term users. Methadone blocks the 'high' caused by using opiates (like heroin); it also reduces the drug craving and withdrawal symptoms caused by opiate use. Naloxone is a drug that blocks or reverses the effects of opioid substances and is used to treat an opioid overdose in an emergency situation. For a heroin overdose- characterized by slowed breathing and heart rate and a loss of consciousness, a single dose of injected Naloxone (Narcan) can counter overdose effects within minutes; the patient should still be seen by a medical professional.

The most effective course of treatment is through a drug treatment program to help cleanse their system of harmful opiate toxins- through detox. A combination of detox, substitution therapy and behavioral counseling will help a client make better decisions concerning their life and the 'triggers' that caused heroin use in the first place. Counseling and support group therapy also help to provide for a successful recovery. To contact a Heroin Detox & Methadone Treatment Center in Michigan, call (586) 439-0608.

MICHIGAN PHYSICIAN ASSISTANT FOUNDATION (MIPAF)

"We Want You to Help Us Celebrate our 25th Anniversary"

The MIPAF is a nonprofit 501(c)3 charitable organization that represents the interests of PAs practicing in Michigan. We are a public foundation that provides scholarships to second year Michigan PA Students. Our motto is- "MIPAF provides the scholarship…you provide the future."

During the annual MAPA Fall CME Conference, which will be held October 13-16, 2016 at the Grand Traverse Resort, the MIPAF will again be hosting several events to raise money for PA Student scholarships and we will be celebrating our 25th Anniversary. On Friday evening during the conference, the MIPAF will again hold the ever popular and competitive 'Student Quiz Bowl.' All six Michigan PA programs are invited to participate. It is a fun event with a lot of enthusiasm from the students and audience. All conference attendees are encouraged to join the event and cheer on your future PA colleagues. We will have a donation table within the hall for attendees to donate money during the 'bowl.'

Another event that the MIPAF holds at the conference is a 'Silent Auction.' This event will be held Saturday evening of the conference during the Evening Reception. This is a fundraiser for the foundation to enable us to continue to provide scholarships to PA 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. - all donations are welcome. Please contact Vaughn Begick at (989) 686-0578 or e-mail VaughnPAC@aol.com to donate. You can bring the items to the conference and notify the registration desk that you have them. If you were a past recipient of a MIPAF scholarship and are now working, you might want to consider a donation for the silent auction. The Foundation also accepts cash donations and it is a charitable contribution as is the donation of an item for the silent auction. We will have a donation table at the conference to accept these donations.

On behalf of myself and all the MIPAF Board Members, I hope to see you at the 2016 MAPA Fall CME Conference and if not, check out our web page and consider a donation to the Foundation. To find out more information, please visit our web page at: www.mipaf.com. Your donations are spent on PA Student scholarships and your donations are tax deductible. YOUR FUTURE COLLEAGUES NEED YOUR SUPPORT. If you are a student, consider applying for a scholarship.

Robert Ross PA-C
MIPAF President

Vaughn Begick PA-C
MIPAF Board Member

A Primer on 'Tail' and 'Nose' Professional Liability Coverages

By Chris Noth, PA-C, FAPACVS

'Tail' Coverage

Every state has a statute of limitations on malpractice claims. With a few exceptions, most states have either a 2 or 3 year term limit to bring these forth, but medical malpractice claims can take several years to work their way through the legal system. Therefore, those same considerations make the issue of 'tail' coverage- 'an insurance policy rider' that protects PAs against claims that arise even after the policy is cancelled- critically important.

In recent years, many insurers scrapped 'occurrence' policies and now mostly only offer 'claims-made' policies, which covers the insured only for claims filed when the policy was still in effect. When the policy is cancelled or expires, so does the coverage; that is where 'tail' coverage is effective. The 'tail' coverage provides coverage for any claim from services rendered while the policy was in effect. In other words, it's the price you pay to convert a 'claims-made' policy to an 'occurrence' policy. The price for 'tail' coverage can be steep, but can be incorporated into an employment package.

Extended Reporting Period (ERP) may be interchanged with the term Extended Reporting Coverage (ERC- another name for 'tail' coverage) and is the period of time during which a claim arising from an act or omission occurring prior to the inception date of the ERP, can (in most cases) be reported and covered.

Most 'Tail' coverage issues can arise whenever a PA leaves a practice, whether due to a change of job or location, retirement, separation or buyout of a practice. So the main reason to buy 'tail' coverage would be to have adequate insurance coverage in place for the defense and potential payment of a medical malpractice claim against you.

'Nose' Coverage

Another supplement to a 'claims-made' policy that may be purchased from an insurance carrier that covers incidents that occurred before the beginning of a new insurance policy has started is called 'nose' coverage or 'prior acts' policy. 'Nose' provides coverage for claims that arise from medical procedures performed while covered under a previous terminated policy, but was first reported under your current policy. If you purchase 'nose' coverage, you do not need 'tail' coverage, and vice versa.

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