YOUR VOICE. YOUR PROFESSION.

MICHIGAN PA

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MICHIGAN ACADEMY of PHYSICIAN ASSISTANTS

Michigan Academy of Physician Assistants
1390 Eisenhower Place
Ann Arbor, MI 48108
Phone: 734-353-4752 Fax: 734-677-2407
email: mapa@michiganpa.org
web: michiganpa.org / mapaevents.org

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Your Newsletter Editor's Corner

If you are wondering how your peers felt or would describe our recent Fall conference, wonder no more. The excitement of this year's great Fall conference that was held in Traverse City can be best summed up in these few quotes from some of our 663 attendees:

"The team did a wonderful job."

"The conference was excellent."

"Was very impressed with Nisha on the Women's lecture and the female pelvic prolapse/ incontinence speaker."

"The nutrition speaker was also great! As always, it was a wonderful conference and I will be back."

"Very impressed with the presenters of Fall Risk, EKG review, Derm for non-derm PAs and Genetics."

By anyone's standard it was a great educational meeting as well as a superb social event. The energized ambiance and camaraderie was palpable, the hallway conversations were memorable and the speakers were dynamic. Sure this may be behind us now, especially now that the Holiday season is upon us. But much like last year and at the expense of sounding repetitious, again this past year has been a banner year for MAPA, with continued and invigorating growth all around.

Obviously we have some new faces that have taken the helm of key leadership positions, while in partnership with AMR, the team (MAPA's Board of Directors) worked together to expand our services and offerings to you—our members. Along the same vein, I would like to thank and acknowledge all the contributing authors/writers through the year in making my tenure as your Newsletter editor this 2nd year, an enjoyable one. Whether you were a student or a seasoned veteran, your insights and observations enriched all of us. In closing, let's all be thankful for all the good things in our lives and as our president reminded us in his piece. Have a blessed Holiday Season and thank you for your support!

Cordially yours,

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

President's Message

Michigan PAs have lots to be Thankful for. . .

As I sit to write this message, it is early November. The leaves are changing, the air is getting cooler and the wild and crazy election season will FINALLY be over! It will be early December when this message goes to print, and many of you will have raked the yards clear of leaves and donned warmer outdoor wear. In the time between my writing this message and you reading it, Thanksgiving will have passed as well. I don't know about you, but in November, my Facebook feed always seems to be filled with "30 Days of Thankfulness" from friends and family. For those of you who are unaware of this Facebook tradition, "30 Days of Thankfulness" is a Facebook challenge, where the posting individual will post a comment on what he or she is thankful for…for each day of November. In the spirit of Thanksgiving, and the "30 Days of Thankfulness," I would like to share a few things Michigan PAs should be thankful for:

1. Michigan has some of the best practice laws on the books, and MAPA is working to make them even better! MAPA has worked with state legislatures to develop HB 5533, which is currently moving along through the legislature on its way to becoming law. With the proposed bill, the term "supervision and delegation" will be removed from statute when referring to the PA-physician teams, PAs would no longer be "delegate" providers and instead be "prescribers" within a practice agreement. The bill will remove arbitrary PA/physician ratios as well.

2. Michigan PAs are paid well! The median yearly income for Michigan PAs is around $95,000.

3. If you're a PA, Michigan is hiring! PAs are in the top 10 (#5!) of the U.S. News & World Report's "100 Best Jobs" report. The average PA graduate has 2-3 job offers after graduation. MAPA has a job listing site on the MAPA website (www.michiganpa.org), so log on and find that job!

4. Michigan has 6 great PA programs! Many PAs in Michigan hail from one of our 6 great PA programs. With several of the programs ranked high nationally, it is easy to see why so many PAs in Michigan are so well respected and sought after by employers!

5. We have MAPA!!! The Michigan Academy of Physician Assistants continues to be a trend setter for other state chapters when it comes to advancing the PA practice. Made up of hardworking,

passionate volunteers, MAPA pushes the profession forward and continuously battles reimbursement and legislative interpretation issues. MAPA provides excellent conferences for CME and networking, and works tirelessly to improve the lives of all PAs in the state!

6. The MAPA Fall & Spring Conferences! With stunning locations like the Grand Traverse Resort and Spa in Traverse City and the Amway Grand Hotel in Grand Rapids (during ArtPrize!), PAs in Michigan get the chance to partake in a CME conference in stunning and vibrant locales each fall. With rotating sites in smaller, quaint locales like Frankenmuth and Midland (and more to come), PAs in Michigan can enjoy a quick, local getaway each spring while earring CME on professional and clinical topics alike!

7. Michigan is a beautiful state with lots to offer! With four very distinctive seasons, lakes, rivers, and the Great Lakes; PAs in Michigan can kick back and enjoy some ridiculously amazing nature! If you like to swim, hike, kayak, boat, ski, skate, bike, run, etc; Michigan is the perfect spot. I challenge you to find a better state than Michigan when it comes to natural beauty. And don't even get me started on the U.P. and what breathtaking views await you north of the bridge!

8. Michigan PAs are simply awesome! PAs in Michigan are found on hospital floors, private practices, clinics, surgical suites, and in board rooms. Nearly every PA I have met in Michigan has been intelligent, motivated, humble and caring.

9. The state is full of great PAs. Just ask the patients who see them! Numerous articles and studies report that patients are very satisfied with seeing a PA.

So, with so much to be thankful for, it's no wonder I love my job as a PA while working in Michigan! It is a privilege to be a PA, and working as a PA is wonderful. Working here in Michigan, I get to work alongside my physician colleagues as a team and do what I was trained to do. I am most thankful for the ability to practice medicine to the fullest of my training and work as a team member of a great physician-led team. MAPA has worked tirelessly for decades to get PAs in Michigan to where we are today (and to enter new horizons yet to come). The work has been done by many, but will need more to carry the torch into the future. If you are grateful for all that Michigan provides for PAs, I challenge you to take the torch as well. Grab a fellow PA at the office or on the hospital floor and have a conversation about joining MAPA and supporting those who are working to keep Michigan a great place to be a PA.

Happy Holidays,

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

"Just Say No." Really?

By Michael J. White, P.A.-C

Over the last year, a couple of deaths have caused me to step back from the hurried pace of my life and to reflect on what I have chosen to do with my life and how I do it. I will admit that middle aged males are prone to this kind of contemplation, but I think my ruminations may have something to say for other Physician Assistants. I have been a PA for 25 years now and I have worked in an emergency department over the last 9 years. It was through my duties in the ED that I met a 32 year old woman, Nicky (not her real name) who passed away this last year. She was a young woman with two children. I had cared for her and her children on and off over the last 9 years. She was the kind of patient that I usually dread seeing and was an opiate addict with history of IVDA. She suffered from chronic hepatitis C and was also afflicted with Diabetes Mellitus type 1. When I first started in my current position, she often came into the ED with complaints of back pain and dental problems. Over time though she stopped her frequent visits and I would only see her when she brought in her children to be seen; as it was obvious that she cared deeply for her children. At times she would reassure me that she was "doing good" and was no longer using drugs.

It surprised me then that one day she was brought to our ED by her neighbor. She was complaining of severe left sided chest pain. Her neighbor was very concerned about her and told me that she had never seen Nicky in this state before. Nicky was tachycardic and very agitated. I was suspicious that she may be in drug withdrawal. On physical exam, she was exquisitely tender to even light palpation over the left chest wall. She denied any history of trauma. I told her that I would avoid any opiate analgesics and reassured her that I would evaluate her chest pain thoroughly. I ordered Toradol 30mg IV, basic blood work, and a left sided rib series. The rib series showed no rib fractures but did show a few nodules in the left lung. Chest CT demonstrated these nodules to be consistent with septic pulmonary emboli probably due to endocarditis. I ordered Nicki a dose of Dilaudid 1mg IV for her pain and called for admission. A PICC line was placed and she was started on IV antibiotic therapy for the endocarditis. Blood cultures were

positive for Staph aureus. She would need a 6-week course of IV antibiotics, so she was discharged home with daily home health visits. This visit would be the last time that I saw Nicki. About 2 weeks later, she was found dead in her home. She had injected a lethal dose of morphine into her PICC line. Unfortunately, Nicki's demise is not an uncommon occurrence in our community or anywhere else in the United States.

The second death in the last year that has affected me was the passing of Nancy Reagan. I am a lifelong liberal democrat, so I do not look back on the Reagan Administration with fondness. But I do remember Ronnie's "War on Drugs" and Nancy's public health campaign to "Just Say No." And so these events have left me sitting at my desk wondering if I need to start saying 'no more', more often in the ED when people are asking me for "something stronger" for pain control. Saying no is just not problematic for me, it is a problem that we all share in healthcare. We chose our profession because we want to help people, fight disease, and alleviate pain. If you were trained in the 1990s, you were taught about the concept of "oligoanesthesia." We were all told that we were undertreating pain and that our patients were needlessly suffering. We were all schooled on the results of a study done by Porter and Jick, titled "Addiction Rare in Patients Treated with Narcotics," that was published in the New England Journal of Medicine in 1980. The study looked at 12,000 patients who were enrolled in the Boston Collaborative Drug Surveillance Program. The studied indicated that addiction was rare after patients were given opiates for pain control. Add to that information, the adoption of pain as the fifth vital sign by JCAHO and the VA in 1998. And finally we were pushed even harder to treat pain by the evolution of customer satisfaction scores in the Affordable Care Act. We now have Press Ganey polling our patients to be sure that we have adequately treated their pain. We also have metrics in the ED that demand that we provide analgesia for long bone fractures within 30 minutes of presentation. The result of all these factors is that we all prescribed a lot of opiates.

To say that we have prescribed "a lot of opiates" is really an understatement. According to the World Health Organization, the United States (5.5% of world population) in 2009 consumed 55.9% of all the opiates produced in the world. [1] Since 1999, the amount of prescription opiates being prescribed has quadrupled in our country yet there has not been any significant change in the amount of pain that our patients report. [2,3,4] In the state of Michigan in 2012, we wrote 107 prescriptions for opiates for every 100 people living in our state. [5] Yes, you got that right. In one year we wrote more than one prescription for opiates for every man, woman, and child in the state.

So what has been the result of all this emphasis on pain control and patient satisfaction? You have been reading about the tidal wave of opiate addiction and overdose deaths in the media just like I have. More people died of drug overdoses in 2014 than in any year on record. [6] From 2000 to 2014 nearly half a million people died of drug overdoses. To put that in perspective, that is 78 deaths per day from an opioid overdose. [7] The death rates from the heroin plague in the 1970s or the crack cocaine scourge of the 1990s were only about 1/15th of today's overdose mortality. [8] The Centers for Disease Control believes that almost 2 million Americans abused or were dependent on prescription opiates in 2014.[9] They estimate that as many as 1 in 4 people who receive prescription opioids for chronic non-cancer pain in the primary care setting are struggling with addiction. [10]

Oh, about Porter and Jick, the paper that I referenced earlier that eased us into this mess, it turns out that those 12,000 patients were all inpatient encounters. They were receiving opiates mainly for postoperative pain and pain from trauma. The study's results would not have any bearing on the management of chronic pain in an outpatient setting. These patients were also seen in the era before the mass marketing of long acting opiates like OxyContin and MS Contin.

So where do we go from here? The Center for Disease Control has now come out with 12 recommendations

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"Just Say No."

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for determining when to initiate opioid therapy for chronic pain. You can check out these guidelines online at: https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm. On one hand, I think this document is a must read for any PA who is writing for opiate analgesics. On the other hand, I do not find the guideline helpful in dealing with the chronic pain of a 25 year old patient who is taking Cymbalta 60mg daily along with Neurontin 600mg TID, has a Lidocaine 5% patch stuck on his back, and also has an allergy to Toradol. He tells me that he has been on physical therapy for months and that Ibuprofen and Tylenol "do not touch" his pain. His current pain level is "10/10" even though he is sitting in front of you in no acute distress with normal vital signs. I dread this encounter, but there are some recent papers that seem to indicate that "just saying no" is easier to do than we may have thought.

Our fear of poor Press Ganey scores may be overblown. There was one study done in two emergency departments in academic medical centers in New England. The Press Ganey surveys of 4,749 patients were analyzed to determine if the administration of opiate analgesics had any effect on patient satisfaction scores. After controlling for several confounding factors, there was found to be no relationship between patient satisfaction scores and the receipt of an opiate analgesic. The authors concluded, "This suggests that ED clinicians can administer analgesic medications in the ED according to clinical and patient factors without being concerned about Press Ganey scores." [11]

Another interesting paper seems to indicate that there are certain groups of patients that we should definitely be denying opiate analgesics. In this paper, the authors looked at a meta-analysis of 10 studies that looked at the prevalence of opiate addiction in pain clinic settings. Factors associated with increased misuse of opiates included: substance abuse disorder, younger age, major depression, and use of psychotropic medications. Looking back to the 25 year old patient that I mentioned earlier, there are multiple red flags that should indicate that the denial of opiate analgesia is medically appropriate. [12]

There have also been a couple of interesting papers that have changed how I talk to patients about narcotics. I now mention to any patient that asks for "something stronger" for their backache, that opiates cause addiction. In Anand, et al., 2010, it was shown that tolerance to opiates develops in as little as 5-7 days and these patients do suffer withdrawal symptoms when the opiate is stopped.

I also tell patients about the concept of opioid-induced hyperalgesia. This phenomenon occurs when the body develops increased sensitivity to pain secondary to opiate use. In as little as a few days of opiate therapy, the pain fibers become more sensitive to pain stimuli. As a result when opiate therapy is stopped, the patient has a heightened perception of pain stimuli. The end game is that the patient may feel worse even though they are healing. [13]

Another item that I counsel patients about is that while an opioid may provide better pain relief in the short term, it may also slow down their recovery. In a study of 8443 workmans' compensation claims for back injuries that controlled for type of injury and level of pain at presentation, the patients who received opioids for pain early were disabled for 69 days longer

than those patients who did not receive opioids. The opiate treatment group was also 3 times more likely than the no opioid group to have surgery. [14] Another study of workmans' compensation claims for back pain in Washington state looked at 1883 patients. After adjustment for baseline pain, function, and injury severity, the strongest predictor of long term opioid therapy was the dose of opiates taken in the first quarter of the injury. Patients taking 40 morphine equivalents per day (think Norco 10mg/325mg QID) had a 6 fold greater risk of receiving long term opioids. [15]

So I hope that this information gives you a couple of tools to justify "just saying no" to the appropriate patients requesting opiate analgesics. If we can get better at controlling pain without opiates, we will be able to save many lives and spare our patients from the horrors of addiction. Really!

(Endnotes)

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"Invest in Your Future"

As a shareholder in your profession, invest in the academy that advocates for your ability to practice medicine. You don't need to go it alone, MAPA has your back.

Physician Assistants of Michigan Political Action Committee (PAMPAC)

PAMPAC had a booth at the recent 2016 MAPA Fall Conference in Traverse City. We spoke to students and graduates about staying connected with their state and federal legislators. The reason for staying in touch with your legislator is that MAPA may need you to contact them for support on PA legislation. At the state level, House Bill 5533 has passed the House Health Policy Committee and we are awaiting a vote of the full House. After that, it moves on to the Senate Health Policy Committee and then to the full Senate. You will be notified if we need your support and for you to have you contact your legislator about this bill.

The money that is collected by PAMPAC, and we did receive donations of $3200 this year by PAs at the Fall Conference, is used to meet with key legislators at political fundraisers that they hold. We usually concentrate on legislators who are on the Health Policy Committees in the House and Senate. This gives MAPA face to face time with these key people.

If you were not at the Fall Conference or were but did not have the opportunity to donate to PAMPAC, you can do so by **visiting MAPA's website and clicking on the PAMPAC logo** or you can do so by sending your donation to:

PAMPAC
327 Seymour Street
Lansing, MI 48933

Your support is crucial at this time as we work on groundbreaking legislation for PA's in Michigan, and if passed, our legislation will be a template for all states to use.

Vaughn Begick PA-C
PAMPAC Committee Chair

Introducing MAPA's Next Executive Director and Lobbyist

I am pleased to announce Thadd Gormas will take over as MAPA's Executive Director and Lobbyist when I retire next year. Thadd was the MAPA Board's unanimous choice among many able candidates for this position. He has a strong record of creating collaborative, inclusive work environments, and has served on non-profit boards himself.

Thadd Gormas

A 16-year veteran in public affairs, Thadd is experienced with non-profit administration, advocacy and fundraising. His tenure includes the State Executive Office, a non-profit organization, a multi-client lobbying firm and various administrative staff positions in the Michigan Legislature. Most recently, Thadd comes from the Michigan Senate where his team is responsible for the $25B Health and Human Services agency budget.

Known as a trusted source by health industry stakeholders throughout Michigan, Thadd's major contributions are health care system reforms. He has been instrumental in PA scope of practice enhancements, the Healthy Michigan Plan design, and Michigan's I'm Sorry Law to name a few. He also serves as an advisory board member at the University of Michigan's School of Public Health for their nationally recognized Center for Value-Based Insurance Design (VBID).

Thadd is a familiar face at MAPA events as a health policy speaker and husband to a physician assistant. He and his wife, Michelle Gormas, PA-C have been married for almost 10 years and are the parents of two children. They live in the Lansing area where Michelle practices internal medicine. Michelle has recently been appointed by the Governor to serve as the PA on Michigan's Board of Medicine. I have known Thadd and Michelle to enjoy music performances, boating from Lake Charlevoix and any excuse to play with their kids.

MAPA is well prepared for our leadership transition with renewed focus, energy and an updated strategic plan. Thadd joins MAPA officially in January when we'll work together until I retire at the end of June. He will lead the executive aspects of MAPA, including managing board activities and other volunteer groups. Thadd will serve as the main public contact and spokesperson for the organization, and as our liaison to state agencies, the Michigan Legislature and the Governor's office.

Welcome, Thadd. You're a great addition to the MAPA family!

Mike DeGrow
MAPA Executive Director/Lobbyist

TEN VERBAL BLUNDERS: CREDIBILITY THIEVES IN OUR PRACTICES

Marcos A. Vargas, MSHA, PA-C

Through the years I have seen some of the best clinicians instantly loose all credibility when letting a verbal blunder slip into the verbal interaction. At a glance, what appears to be an honest assertion or an insignificant remark to us might not be so to a patient. Moreover, these tongue slip-ups can rob you of your credibility and trusting rapport that you have enjoyed for years.

The following statements or phrases are those culprits referred to:

1. ***"It's not a big deal"***: While the single closure of a wound might have not been your very best that day after countless other ones through the years, for the patient this statement would be received as you didn't take the time or cared for the cosmetic outcome. Your careless statement basically discounted their trust and expectation.

2. ***"It's a slam dunk"***: Sure, easy for you to say since you're not the recipient of an unfamiliar procedure or intervention for an anxious or distrusting individual of the medical industry. Patients like to be informed of all attendant risks…not some or partially.

3. ***"You're making this more difficult than it really is"***: Your empathy just went out the window with that negative reassuring comment –if you thought it was one. Best practice would be to say, "I will do my very best to minimize any pain or discomfort or possible complications". 'I/we will get you through this together".

4. ***"Bee sting"***: The sight of a needle is anxiety provoking even in the "toughest folks" or "weekend warriors". Downplaying the discomfort even with the best of techniques doesn't help anyone under these circumstances. Pain or discomfort should never be "embellished"—just be truthful from the outset. It is best if you tell them you will be as gentle as you can be. Again, never say "this won't hurt you".

5. ***"There's nothing wrong with..."*** This dismissive statement simply translates into the patient's mind that you doubt his/her concern or complaint being legitimate. Before closing the door diagnostically speaking it might behoove you to do some preliminary testing or investigation. Avoid early diagnostic closure, (aka Anchoring—a medical heuristic) especially if there's an unexpected or bad medical outcome.

6. ***"Guaranteed, this will..."*** get better and/or resolve in 2 days…2 weeks… 2 months. Assurances are best to leave out of discussions, rephrase outcomes or your expectations in terms of probabilities instead. For instance:.."my best guess is…" by using this statement, the patient will be less disappointed if the course of the illness or ailment takes longer to resolve or improve.. Early resolution, and you are a hero—simple as that.

7. ***"Sorry for the delay, we're busy today."*** Patient's view their time just as important as yours. If there's a delay notify them at once and explain that you will be late. They will be appreciative if you can re-schedule or give an approximate time of seeing them. Saying you're busy is not as good as saying an impromptu situation caused the delay thus requiring your immediate attention before seeing the patient. Always close or state that you appreciate their patience & understanding.

8. ***"Oopsie"***: Not something you want to say when a mishap or an error happens. This word does not mitigate the bad outcome or the unintended consequence even though you might think so. Be honest and use a direct approach when explaining what went wrong or possibly caused the departure. Stick to honesty.

9. ***"I'm the best at this"***: Based on whose opinion—Consumer's report? They think not. Perhaps stating how many X-Y-Z procedures you have done with safe outcomes might be more prudent and

less arrogant-sounding to their ears. Moreover, it would be best if your supervising attending physician or colleague would endorse you by saying or praising your accolades even though there's nothing wrong feeling you're the right person for the job or task at hand.

10. ***"I have nothing ' else' for you…I wish"***: Short of a terminal illness which you can always consider palliative or hospice care, you must consider exhausting all medical resources and/or venues before uttering this "I/we're giving up" on you. We must keep a balanced perspective (naturally) and accept that we are not to engage in practicing futile medicine, but we must not abandon the ship to soon if there's some significant statistical chance of medical recovery.

Sometimes another medical perspective is reasonable and needed. Remember, each of these statements, words or phrases could easily undermine your *patient's trust in you as a medical provider. Place yourself in your patient's shoes if you're to be the recipient of these verbal faux pas. You would feel resentful or upset at the very least. Don't you think?*

So, before you engage your tongue …you must engage your brain to avoid these verbal blunders so that they are not a part of your day-to-day communication.

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 High School Sports Concussion-Upgraded Protocol for "Return to Play"

By: John Young, PA-C

In recent years, the growing awareness of sports related concussions has led to the implementation of concussion protocols and legislative acts, all designed to help protect the wellbeing of student athletes. We can all agree that it is important for student athletes to learn important values of teamwork, perseverance, commitment, and self discipline-while building lifelong friendships. It's also imperative that there are procedures in place to identify concussions at the time of the incident and provide an evaluation and monitoring timeline to facilitate a safe time to "return to play" a sport again. The Michigan High School Athletic Association (MHSAA) concussion protocol is initiated in real time, when any referee or coach notices any athlete who demonstrates any symptoms of concussion. In 2013, the Michigan Legislature passed the Michigan Sports Concussion Law. This sports concussion legislation requires all coaches, employees, volunteers, and other adults involved with a youth athletic activity to complete a concussion awareness on-line training program. [1] This ensures early concussion symptom recognition, and removing the athlete from play. The player is then required to be evaluated by a healthcare professional and have written clearance to resume play.

Until 2016, the concussion "return to play" release form was only authorized by a MD or DO. However, the MHSAA has now revised its protocol to include and authorize PAs to make that assessment. The return to play waiver can be found on www.MHSAA.com. This positive step forward is another example of how Michigan PAs can help increase access to care and provide quality and effective care for our patients.

Diagnosing concussions and mild traumatic brain injuries (MTBI's) can be challenging as symptoms of

MTBI are common to those of other medical conditions and the onset and/or recognition of symptoms may occur days or weeks after the initial injury[2]. For clinicians who may encounter patients with concussions, it is recommended by the CDC that providers complete a concussion training module and also have protocols in place to determine the best management of the patient. The CDC website (http://www.cdc.gov/headsup/providers/return_to_activities.html) provides training modules and practice resources for providers to accurately diagnose, treat, and if necessary, refer patients for more advanced care. It is paramount that our student athletes participate in safe and competitive sports activities and Michigan PAs will continue to play an active role to promote the health and well being of all of our patients.

Sources

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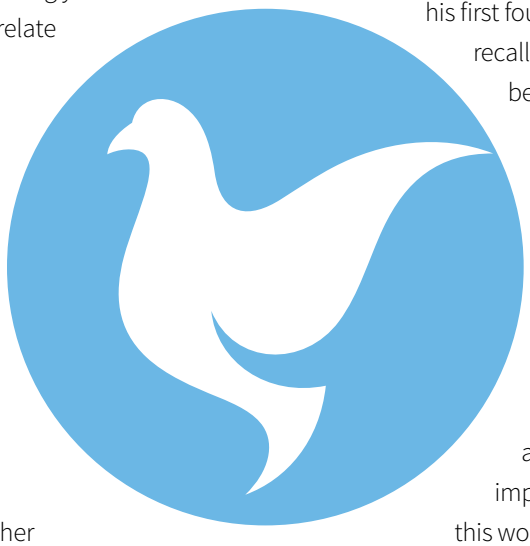
HOSPICE: A Call for Consideration & Implementation in Your Treatment Plans

By: Bradley W. Orville, PA-C, PhD

What image, meaning or emotion(s) does the word hospice bring to mind? As clinicians and providers, it may bring a myriad of experiences, some which were pleasant, unpleasant or possibly an ambivalent feeling. In this personal piece, I will try to raise your consideration of implementing this adjunctive treatment modality when faced with personal and professional dilemmas in your daily practices regarding end-of-life care. More importantly, I would like you to re-evaluate your mindset regarding your current referral patterns as they relate to hospice; a lesser used form of palliative care.



Personally, I wish to share with you how this came to my attention with the passing of my older brother- Doug and his battle with metastatic Renal Cell Carcinoma. Mine was a favorable one, as they provided services which brought comfort, peace and assistance to my brother during his fight. After he failed to respond to standard of care treatment, I contacted the Cleveland Clinic, where the national renowned guru practiced, specializing in the disease which would all too soon take my brother of 42 years. Once in the clinic, the renal cancer specialist systematically performed an examination, reviewed the most recent diagnostic studies, the treatment modalities that failed their intended purpose, (yet were cruelly successful in their side effects) causing misery and distress. He also noted his progressive hypercalcemic state despite aggressive recent intravenous interventions.

The stately oncologic specialist shared with me his ominous and devastating opinion, one based on years of treating this cancer, but never having mastered it. Following his comprehensive consultation, his words, albeit unintended, did pierce my very being. He stated in a straightforward and sterile manner: "Brad, take your brother home and make him comfortable, as I have nothing to offer him." As one who spent his first four years in oncology, my mind recalled the countless times I had been on the giving end of that very same information, which was now given to me. The same prognosis, which I so professionally gave to others, I was now receiving. Nevertheless, it achieved the same outcome of fear, pain, sorrow, angst and an overwhelming feeling of impending loss. I suspected that this would be the probable outcome, prior to the trip from Detroit where I live, picking my brother up in Youngstown and then driving the hour and a half to the specialist at the prestigious Cleveland Clinic. This time, however, I was the recipient of the confirmation of this dismal prognosis on behalf of my older brother. Now it was me, like many of you reading this piece, as the family member with medical and/or oncology training, expected to step up to the plate and help guide my brother's wife and our family as to what would be the next step.

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We packed up the litany of data, scans, slides and reports... this intricate collection of technical words that gave the sad tale of defining my brother's incurable cancer. This collection, now having completed its intended purpose, confirmed that his disease was worse than a parasite that intends to keep its host alive, would continue its despicable and unrelenting quest, until my brother's demise. We drove my brother back to his home, having an eerily quiet ride, based on the gravity of what we had just experienced. My brother, a pragmatist, asked the formidable question: "So, Brad, what is going to happen to me?" "I know what the doctor said," his tearful blue eyes peered into mine, as I sensed his painful understanding of the meaning behind the specialist opinion and grave prognosis. So much to ponder, as my mind instantly reflected on so many of the family meetings which have long passed, discussing code status, end of life negotiations and being asked to polish my crystal ball, querying for a prediction of the time remaining for the loved one in question. Now it was my older brother, 7 years my senior, who this time, was the flesh and blood asking the question; the same question each of us has been asked who has ever practiced medicine.

I mentally donned my pressed, bleached white clinical cloak, telling him that "it was hard to predict and that we would be there every step of the way." He continued to press me for an expected outcome after we got him situated back home in his favorite beige easy chair. At this time, I felt that no one would present the future from both a clinical and personal perspective any better. So with his wife present, I shared with them the facts and the realities for renal cell carcinoma status-post failed nephrectomy, failed interferon and interleukin therapy, the lack of experimental protocols available from a world renowned medical center and the meaning of a catastrophic weight loss from 360# to 150# in a period of five months.

Following this sharing of the medical information, he then looked at me and smiled, saying "I wish you hadn't told me the gory details." I looked at him and said "the fight was not over, but the perspective of the battle had to change," hence the discussion regarding home hospice. He understood and accepted the concept readily and the support services of a RN, Chaplain and Social Worker, as well as all of the equipment necessary to meet his needs. Then the intensive on-the-job education he, his wife and their kids were to undergo was initiated; he was now on the last journey of his life in home hospice.

I call it a 'God-thing', having no better descriptor, when someone who is in a persistent comatose state, awake for a time of lucidity, shortly preceding their passing from this life into the next. Doug had that a few hours before his death, where he attempted to stand, having not stood in weeks. My older brother Greg and I leaped to grab him prior to an impending fall. He looked at us, having just awoken from a deep slumber to attempt to stand, like Lazarus rising, saying with clear steel blue eyes, "its okay boys, I'm okay." We spoke with him for a few minutes with small talk, not wanting this time to pass, on that beautifully, blue skied and lovely warm, sunny day in July. It was a mere few hours later that Doug left us to meet his Maker. His body ravaged and his mind left encephalopathic, from this abominable disease. What was left was a shell of a man I knew all of my life, who only a year prior had accomplished one of his many holes in one while golfing, as well as another 300 game in bowling.

My brother passed peacefully in his favorite easy chair, the hospital bed in the living room never having been used even once, as it made him "feel like a sick person." He made good use of all of the resources of hospice (except the hospital bed), deriving great symptom relief and comfort from the care given. To the caregivers and support staff, I owe a debt of gratitude, which may be the impetus of this article. We knew that things would be okay as he told us hours before he passed, as I was able to be a part of sharing with him during his cancer treatment, God's love and plan of salvation, which he willingly accepted. An abundance of peace was a part of his countenance until he succumbed to the advancing and relentless marching of his cancer.

My reminding plea for all of you, who have read this far about my brother's story, is to go a little farther with me. I challenge you to consider patients in your practice who have remained unresponsive to the standard of care treatment or despite your best ability to intervene, continue to decline. Some patients may find the suggested treatment, albeit appropriate, too aggressive or burdensome at the end stage of life and wish to get the most out of the time they have left, rather than undergo further painful debilitating treatment modalities. Picture those patients who would benefit being transitioned from their current pain and misery, into one focused on comfort, when cure is not possible. Consider suggesting to them, a style and type of treatment which stresses the alleviation of their current symptoms and the associated grief and fear the disease process has wrought. Hospice care exists with the sole purpose and mission: to prepare the patient and family as to what lies ahead on the path of their specific disease process while providing symptom relief. It also continues to minister to the survivors experiencing such a great loss and/or providing bereavement support and counselling for the passing of their loved one.

Each hospice affiliate has a "Hospice Eligibility Guideline" which is provided in the CMS hospice policy. These guidelines are limited in certain diagnoses, however the hospice benefit coverage policy is applicable to all hospice patients. These guidelines help the clinician and practitioner understand both the cancer and non-cancer diagnoses that would qualify. Keep in mind that both you and the hospice medical director have to certify that the patient is terminally ill with a life expectancy of six months or less if the disease follows its natural course.

I implore all of those reading my brother's tragic but true and often repeated ending, to realize that there is more that we can do. Many of you, having similar experiences as I, have had personal experience with patients or family members in the same condition as my brother Doug. By virtue of your education, knowledge and understanding of disease processes and their eventual outcome, you are on the front lines to intervene and educate those in your sphere of influence. I hope that I have brought the point home that an unsuccessful or undesired treatment, when cure is not possible, is not the only option. Hospice care allows you to have input into the quality of life your patient or loved one receives and deserves, with their time remaining.

As for us, we never stopped praying for a miracle for Doug, and each patient needs to know that miracles do happen, some coming in ways unexpected that have nothing to do with curing the disease. As hard as it is for a person of faith to swallow, God not choosing to heal our patients or my brother, does not speak of His inability to heal, only His ability to know with certainty, that which we could never comprehend...that only our Maker could possibly know, that which is the best for our patients and loved ones.

Sometimes the healing desired comes on the other side of this life. I believe that Meister Eckhart in Work and Being said it best; "One must not always think so much about what one should do, but rather what one should be. Our works do not ennoble us, but we must ennoble our works."

Bradley W. Orville, PA-C, Ph.D. *(Psychology) is a practicing PA, a PA faculty member, author, MAPA Region VI Representative and Chaplain.* *As a hospice provider, he believes that the hospice philosophy is misunderstood frequently and it is incumbent upon the provider to educate and inform the patient on the exceptional benefits of hospice services. This paper hopes to outline, through personal experiences, the importance of considering hospice services for appropriate patients, early on in the dying process to benefit from the myriad of services available.*

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SITE: Amway Grand Plaza Hotel
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