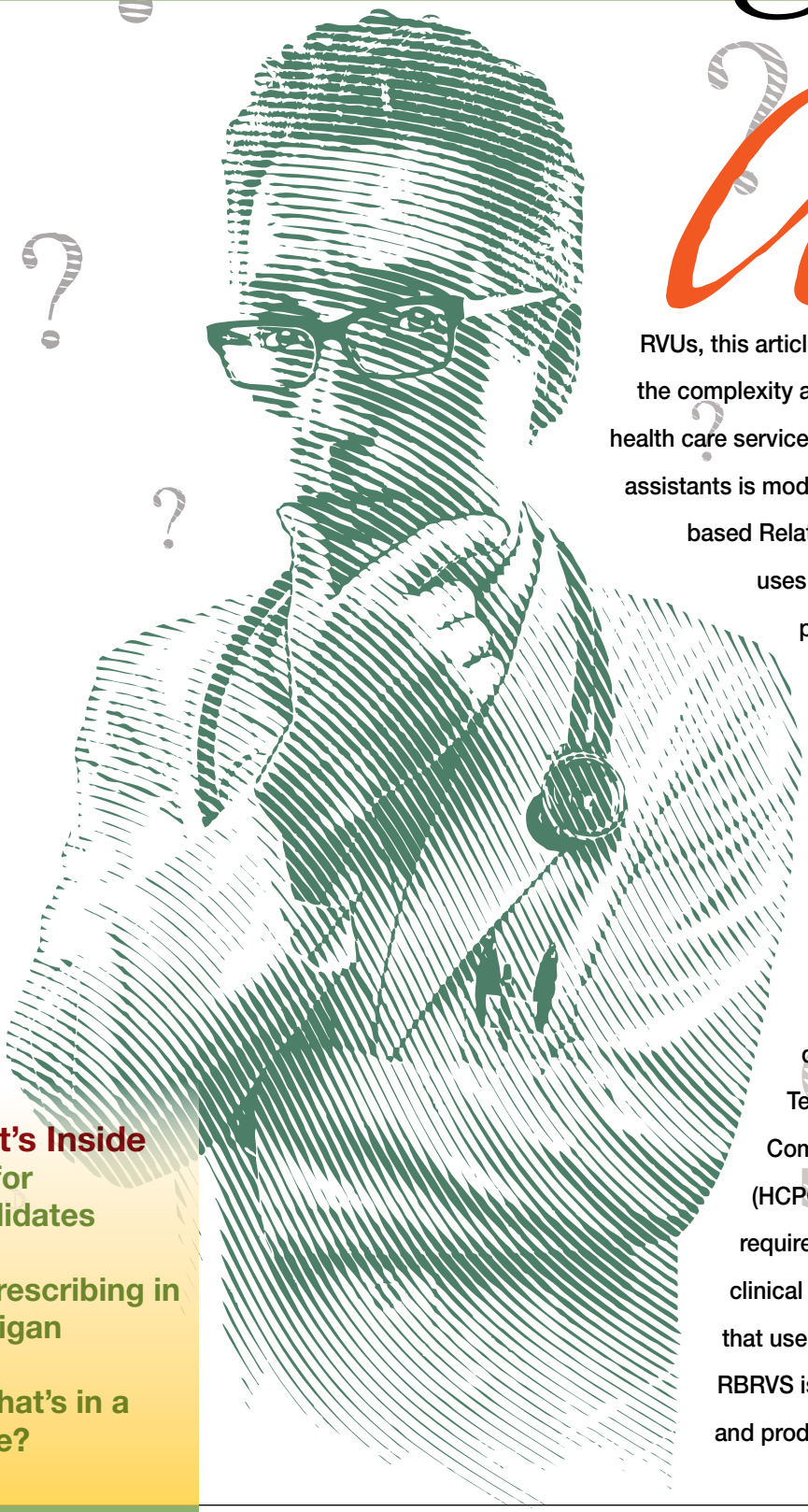
March 2012

The Only Informational Resource for Michigan Physician Assistants

Michigan PA



Acronyms abound in our daily lives and one that physician assistants need to be acutely aware of is RVUs, this article helps to define this term and reveals the complexity and value behind it. Reimbursement for health care services provided by physicians and physician assistants is modeled after a system called Resource-based Relative Value Scale (RBRVS). Medicare uses this fee schedule to determine payments for over 7500 physician services. The fee for a service depends on the relative value and the resources used to provide the service. The resources mentioned include the physician's work, practice expenses and professional liability (malpractice) insurance. The physician services are categorized and described under the Current Procedural Terminology (CPT) codes and Healthcare Common Procedure Coding System (HCPCS). Services range from those that require considerable physician time and effort, clinical staff and equipment to those services that use minimal resources. At the heart of the RBRVS is the RVU, which helps define payment and productivity.

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MichiganPA

MichiganPA Newsletter
Vol. 33, No. 1 • March 2012

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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.

Brian M. Gallagher, MSPA, PA-C

Even the Best-Laid Plans Take Time

A Brief History of Public Act 210 of 2011

In September of 2010, the leaders from MSMS, MOA and MAPA met to identify barriers that inhibit patient access to care and affect workforce and patient safety in Michigan. The three organizations then worked with Sen. James Marleau to craft legislation that would result in increased access to care and improved patient and workforce safety. The legislation directly removed limitations placed on the physician/PA and the physician/NP teams. Though originally included in the bill, during the vetting period, the Michigan Council for Nurse Practitioners asked for the NPs to be removed from the legislation. The resulting bill passed unanimously through the Michigan Senate and Michigan House of Representatives. On November 8, 2011, Governor Rick Snyder signed the bill into law as Public Act 210 of 2011, immediately implementing the changes.

The Benefits

Public Act 210 has five key benefits for the physician/PA team. First, it clarifies the physician's ability to delegate to a PA, rounds on patients in hospitals, nursing homes, ambulatory care clinics, extended care facilities, and other public institutions. Second, it extends the physician's ability to delegate to a PA, prescribing of schedule II medications. Third, it allows physicians to delegate authority to a PA to sign forms that request a physician's signature, with the exception to death certificates. Fourth, it clarifies the PA's role in ordering restraints for patients. Fifth, it requires a PA's name, along with the supervising physician's name, to appear on individual prescription labels.

MAPA NEEDS YOU…to bring the PA voice and message to Michigan's state capitol on May 16, 2012.

A Problem Develops

In January, the Michigan Pharmacists Association obtained a legal opinion from their counsel and contacted MAPA's Executive Director with the results. In their lawyer's opinion, the initial rules that gave PA's the ability to prescribe scheduled medications from 1997 were still in place and the new law did not supersede them. Also, the language from the DO section of the law does not match the language in the MD section, no matter what the intent was, PAs writing under DOs are still limited to the seven day prescription written at the time of discharge from a hospital or inpatient institution. In late January, the Michigan Pharmacists Association sent out an alert to their members recommending not filling schedule II scripts signed only by a PA that writes under a DO. The fear is that insurance companies will not reimburse the pharmacies for these prescriptions.

MAPA Moves to Resolve the Problem

We are continuing to work with the Michigan Department of Community Health and the Boards of Medicine to change the rules from 1997. As of February 2nd, the rules change has passed both the MD and DO licensing boards. However, as with any hospital, there are multiple committees that need to approve the change. The

Even the Best-Laid Plans *continued from page 3*

rules change was sent to the department of Licensing and Regulatory Affairs (LARA) for approval and then on to the Office of Regulatory Reinvention for their approval. A public hearing will be held to obtain public input, and finally the Joint Committee on Administrative Rules will complete the process and the rules could change. This process should be completed by Fall 2012. Additionally, we have requested the Attorney General's office to provide an official opinion on the law; which may take an additional six months. Finally, Sen. Marleau has agreed to introduce legislation to modify the DO section of the law making it the same as the MD section. This legislation has been drafted and we are waiting for it to be introduced.

What's Next?

The rules change process is underway and at this time there is no opposition for the change. By the time all of the departments and committees meet, it will be early fall and the rules change should be completed. The Attorney General's office is in the process of forming an initial evaluation of the law with an official opinion requiring more time. As for the legislative revision, MAPA NEEDS YOU to attend Legislative Day in Lansing on Wednesday May 16, 2012; bring the PA voice and message to Michigan's state capitol. We are requesting 5 hours of Category I CME for the day and it is free of charge to all MAPA members.

In summary, despite bringing legislative, physician and PA leaders together to create and pass Public Act 210, a legal opinion has caused a temporary delay for PA's writing of schedule II medications under a DO. This opinion was based on the risk that insurance companies may not reimburse pharmacies for schedule II prescriptions signed by a PA without a physician co-signature. As a result, MAPA is recommending that Michigan PAs that have a DO supervising physician not write schedule II prescriptions without a physician co-signature. We hope to have this issue resolved by the fall and apologize for any inconvenience this may cause. At this time PAs writing under an MD are not affected by the legal opinion.

Sincerely,

Brian M. Gallagher, MSPA, PA-C
MAPA President 2011 - 2012

Introducing…

Association Management Resources (AMR) is a multi-client association management company. We provide comprehensive management services to state, national, and international groups. Our firm specializes in two areas: association management and event management.

By partnering with AMR, our clients get the advantage of shared resources and collective knowledge which saves money and improves outcomes. We are the professionals who provide solutions to achieve client objectives.

AMR is excited to be the new management company for the Michigan Academy of Physician Assistants. AMR and MAPA look forward to a wonderful partnership in the coming years.

If you have any questions, please feel free to contact me directly at (877) YES-MAPA or apowell@michiganpa.org.

Alecia Powell, CMP
MAPA Academy Administrator

MAPA
Calls For Candidates

Did you ever wonder how the organization that represents and supports physician assistants in Michigan does what it does or that you could have a positive impact on the future of the PA profession? If so, maybe now is the time to consider running for one of the positions on MAPA's Board of Directors because the **Michigan Academy of Physician Assistants Wants You!** There is no better way to develop both personal and professional leadership skills than by serving on the MAPA Board of Directors. This volunteer leadership commitment challenges you to go beyond the required ideals for your profession and allows you to hear and understand different perspectives about the many issues that confront the PA profession today. You, along with your board colleagues and the committee members will shape the future of MAPA; a responsibility that is both a challenge and an honor. MAPA needs new ideas and thoughts on the direction that our academy will take in the years to come. Volunteer participation on MAPA's board will allow you to meet and work with other leaders, peers and health care professionals who have similar interests in advancing our academy into the future.

MAPA is seeking nominations for the offices of **President-Elect** and **Treasurer.** Additionally, nominations are being sought for elected **Regional Representatives** to the BOD from **Regions 2, 4 and 6.**

Candidates seeking to be placed on the election ballot must submit a statement of interest to the MAPA office that includes biographical data, eligibility for office, credentials and answering the election interview questionnaire - **by April 28, 2012.** This information can be submitted in the form of a cover letter with resume' and will be distributed electronically to the voting MAPA members along with the ballot.

Also starting this year there will be a short questionnaire that we will ask you to complete in order to give MAPA members an opportunity to compare your backgrounds and thoughts on the various issues that are facing physician assistants today.

A candidate for the office of President-Elect must have been a fellow member of MAPA for at least three of the last five years. The proposed nominee must have accumulated during the past five years, two distinct years of experience as a member of the board of directors, or either as a MAPA delegate to the HOD, on any of MAPA's standing committees or accumulated the necessary experience deemed appropriate by the Nominations Committee.

A candidate for the office of Treasurer must have been a fellow member of MAPA for at least two of the last five years and/or accumulated the necessary experience deemed appropriate by the Nominations Committee.

Candidates for Regional Representative must be a fellow member of MAPA in good standing and live in the region they seek to represent. You can refer to the MAPA website to see the region you live in.

MAPA is also seeking nominations for Chief Delegate, delegates and alternates to the 2013 AAPA House of Delegates (HOD). All candidates for MAPA Chief Delegate, delegate and alternate to AAPA HOD must be current members of AAPA and fellow MAPA members for the year preceding candidacy. All candidates for MAPA Chief Delegate shall have served at least one term as a delegate with the Michigan delegation. All candidates for MAPA delegate to the AAPA HOD shall have served one term as an alternate delegate with the Michigan delegation. The term for delegates/alternates from Michigan to the AAPA House of Delegates shall be one year and begins on July 15th of the year of election. Delegates and alternates will serve as representatives of the MAPA membership at the AAPA HOD.

If you have any questions on any of these positions please contact one of the current members of the MAPA BOD listed on the MAPA website.

To continue the progressive direction that MAPA's BOD has embarked on we need creative and energetic individuals who will help promote and protect the professional environment for PAs in order to deliver quality health care in the state of Michigan. Nominations are due to the MAPA office no later than April 28, 2012. E-mail to: apowell@managedbyamr.com or mail paperwork to-

MAPA
C/o Academy Administrator
1390 Eisenhower Place
Ann Arbor, MI 48108

MAPA's 2012 Legislative Day

You will soon be able to sign up for the 2012 MAPA Legislative Day that will convene on **Wednesday, May 16, 2012** at "a site to be determined", on MAPA's website. Great strides have been achieved over the last few months for PAs in the state of Michigan as it relates to ability to practice. Governor Snyder signed SB 384 into law as Public Act 210 of 2011 which will help increase access to care for Michigan residents. Lectures will surround this new law and other topics relevant to PAs.

The **cost is free** to MAPA members and we will be requesting 5 hours of Category I CME credit. Visit MAPA's website for further details at www.michiganpa.org

MichiganPA Note:

Governor Rick Snyder appoints five members to the Michigan Task Force on Physician's Assistants; four PAs and one public member. Gov. Snyder also appointed two PAs to the Michigan Board of Osteopathic Medicine and Surgery. A full description of these appointments can be found on MAPA's website at www.michiganpa.org and congratulations to all!

RVUs

by Chris Noth, PA-C

BACKGROUND

The concept of establishing a payment system based on relative values for medical services began in the 1950's. The term "relative value" was coined and used to describe how each service unit value could be measured in relationship to other service values. This unit value for a service was then multiplied by a dollar amount called a conversion factor (CF), to yield a fee for that service. As the healthcare industry became more complex and HMOs emerged as the models for hospital systems, DRGs came into vogue. Diagnostic Related Groups (DRGs) were developed to classify 'products' that the patient received, from which assigned DRGs were grouped by a program called ICD (International Classification of Diseases); current version is ICD-10. This system of DRGs provided a basis for prospective payment for hospital services and is still used today.

During the 1980's, Medicare spending escalated and a disparity emerged between procedural services and cognitive clinical services; leading to income-based choices for medical graduates. This disparity led to a re-investigation of the physician fee-for-service reimbursement scale. In 1986, the Physician Payment Review Commission mandated the creation of a new resource-based physician fee schedule, which would belay the disparity and control health care costs. In 1988, the Health Care Financing Administration (HCFA), predecessor to the Centers for Medicare and Medicaid Services (CMS), funded a study to evaluate the costs and resources associated with delivery of physician services. This change in financial thinking was to help move from payments based on "usual and customary fees" to a standardized payment schedule and the introduction in 1992 of the RBRVS physician fee schedule. The RBRVS system helps describe, quantify and reimburse physician services "relative" to one another; in effect- allowing comparison of apples to oranges (surgical procedures to primary care visits) with a goal of correcting disparities across disciplines. The idea behind this new system was to create equity among different services, using time analysis and geographic adjustors to reflect the difference in cost of labor, facility expenses or malpractice premiums across the country.

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THE BASICS

The RBRVS model for physician services reimbursement has at its core, the 'Relative Value Unit' (**RVU**), which ranks on a common scale, the resources used to provide each service. The total RVU is based on the sum of three components: physician work (52% - 54%), practice expense (44%) and malpractice expense (4%). Physician work RVUs (wRVU) account for time, technical skill and effort, mental effort and judgment and stress to provide a service. Practice expense RVUs (peRVU) account for the non-physician clinical and non-clinical labor of the practice, along with expenses of building space, equipment and office supplies. Malpractice expense RVUs (mpRVU) account for the cost of malpractice premiums. The table below gives an example of varied services and the RVUs associated with each.

Service (CPT code)	Time (minutes)	wRVU	peRVU	mpRVU	Total RVU
Office Visit- Intermediate (99214)	40	1.42	1.06	0.05	2.53
In-patient Consult- Moderate (99253)	55	2.27	0.84	0.11	3.22
Diagnostic Colonoscopy (45378)	75	3.69	1.65	0.30	5.64
Total Hip Replacement (27130)	N/A	21.61	12.54	3.51	37.66
ED Visit- Level 4 (99284)	N/A	2.56	0.62	0.22	3.44

Once the RVUs are known for a specific service rendered, each of the three RVU components are multiplied by a geographical variant. Medicare adjusts payment by designating a geographic price cost index (GPCI) to account for the geographic differences in the costs of practice across the country. CMS calculates separate GPCIs for each of the three individual RVU components. To complete the Medicare payment equation for services rendered, a conversion factor (CF) converts the RVUs into actual dollar amounts. The dollar multiplier (CF) is updated on an annual basis according to a formula specified by statute. On inception in 1992, the CF was set at $31.0010; the highest valued CF was in 2008 at $38.0870 and the **current 2011 CF value is $33.9764**. Therefore, the Medicare payment formula is as follows:

[(wRVU x wGPCI) + (peRVU x peGPCI) + (mpRVU x mpGPCI)] x current CF = Medicare payment ($) for that CPT code

Referring back to the above example table, Medicare payments yield:

CPT code	Total RVUs	Reimbursement ($)
99214	2.53	85.96
99253	3.22	109.40
45378	5.64	191.63
27130*	37.66	1,279.55
99284	3.44	116.88

As previously stated, the CF is reviewed/updated annually; while the RVUs are reviewed no less often than every five years, required by the Social Security Act (Section 1848). (*Note- The fee for major surgeries, like 27130 and others, encompasses the estimated physician input during the global period. The global period is a timeframe from the day of surgery through post-surgical follow-up, typically 90 days.)

RVUs and PRACTICE IMPACT

To reiterate, a physician service (from simple office visits to complex surgeries) is reported using a CPT code. The code's total RVU is multiplied by the GPCI and CF to obtain the Medicare reimbursement for that specific code.

The RVU captures the three components of patient care as it relates to level of time, skill, training and intensity of services along with associated costs of the practice.

The component of total RVUs that is weighed the heaviest is work RVU (wRVU) and accounts for about 52% - 54% of the total RVU. The wRVU is composed of two separate elements: time (~70%) and effort (~30%). Time is based on time spent prior to a service, performing the service and time following the service/procedure - charting or dictating. Effort or intensity consists of the physical effort, skill and stress involved. Therefore, increased complex medical problems equates to a higher wRVU; a crude example: a service provided with a wRVU of "2" is considered twice as much work as a wRVU of "1". The RBRVS and RVU system has become the standard measurement for cost benchmarking and is used by most third-party payers besides Medicare.

Benefits-

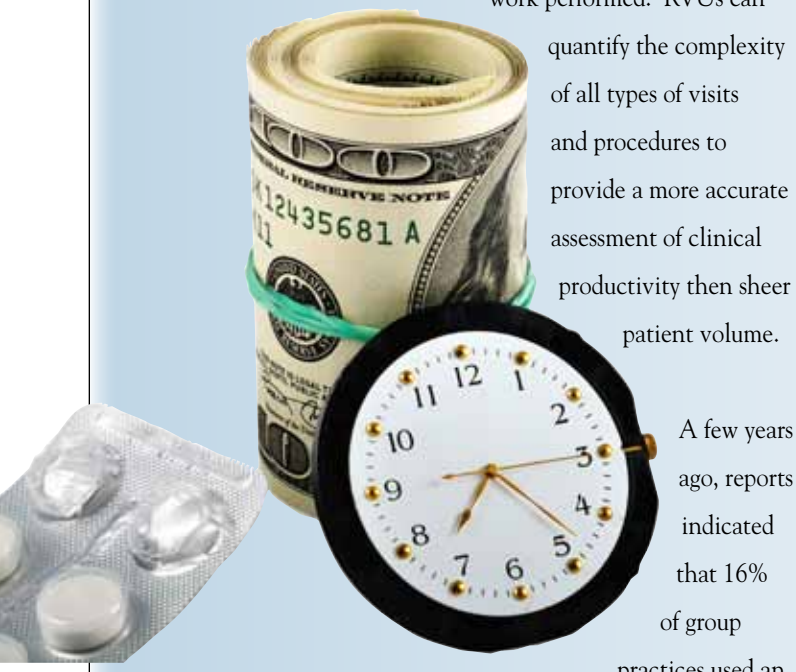
PRACTICE EFFICIENCY

A medical practice can utilize RVUs to track revenues and derive resources consumed by the practice for a procedure or service; leading to practice efficiency. RVUs can also be used to formulate benefits, work force numbers and expectations for future practice growth and identify opportunities for improving documentation and billing practices. RVU patterns can help identify team opportunities and use interdisciplinary roles more efficiently and lend consistency to the practice as the team expands. The knowledgeable use of RVUs is a powerful management skill that strengthens leaders' ability to negotiate resources and manage expectations.

PHYSICIAN PRODUCTIVITY AND COMPENSATION

Traditionally, volume-based metrics attached to the number of patients seen yielded the revenue billed or collected. Conceptually, productivity is a result of labor and is a measure of efficiency, but is distinct from quality and service. The RVU system can and is used to track practice productivity and hence, the compensation afforded physicians. RVUs are an

obvious choice for productivity measures because they are consistent and reliable between individual physicians and across specialties and reflect the time and intensity of the work performed. RVUs can quantify the complexity of all types of visits and procedures to provide a more accurate assessment of clinical productivity then sheer patient volume.



A few years ago, reports indicated that 16% of group practices used an RVU formula to calculate productivity and compensation and that 34% of physicians had their compensation tied to RVUs. In 2010, 35% of practices used RVUs for productivity/compensation metrics and 61% used RVUs for compensation. This can easily be translated to physician assistant practices, compensation and expectations for employment.

An inclusion of quality incentives needs to be incorporated as part of the overall compensation structure. If RVUs are used solely for compensation, then this is still a fee-for-service model. Complementing an RVU incentive model with qualitative measures like patient satisfaction and outcome measures will help transition to a more evidence-based medicine and to the "value-based modifier" for Medicare patients coming in 2015.

The advantage of the RVU system is that it dilutes the disparity of compensation across medical specialties vs. primary care. It also moves reimbursement from a volume-based metric to a procedural/quality-based measurement. The RBRVS allows for variances based on intensity of service delivered and geographical differences for services; all the while, reducing health care costs. RVUs can also improve documentation; better documentation can yield higher total RVUs and lead to better compensation for a service.

CRITICISMS

Reimbursement based on effort rather than effect skews incentives, leading to more complicated procedures without consideration for outcomes; contrasting with evidence-based medicine that has an endpoint of outcomes. The medical value to the patient is not included in reimbursement amount and payment is based on difficulty of service, not effectiveness. RVUs are geared towards a fee-for-service model of health care, which is not beneficial in a capitated environment.

Another criticism is because specialist services require more effort and training, specialists are paid more, this incentivizes physicians to specialize and hence, decrease primary care providers. Another risk associated with the casual use of RVU data is with performance targets. If as part of a contract for a health care provider, specific RVU totals are listed and not achieved, the person is thought not to be efficient or productive. Maximizing RVUs is at odds with time-consuming work that is not billable, as with patients requiring teaching, counseling or coordinating patient care.

Finally, RVUs do not measure the quality of care received, reflect outcomes or patient satisfaction. It merely reflects the work performed and prevents the accurate reflection of the work performed in primary care and the overall value to society.

Conclusion

Relative Value Units empower practice administrators to objectively measure and quantify a medical practice productivity and performance data vs. traditional productivity measures- such as office visits, net charges and collections, etc. The RBRVS RVU work component is specifically designed to measure physician and mid-level provider efforts and the degree of independent decision-making skill required for performing a procedure, therefore, productivity is directly linked to coding. As physician assistants, we have to carefully examine the overall balance of capacity for patient care, the cost of that capacity (the team) and the reliability of team services to achieve strategic goals and generate revenue. Increasingly, many practices measure salary guidelines and compensation against RVUs. Do these measurements accurately tell the story of the practitioners skill set, patient rapport and their true value of delivering quality health care?

Future models for reimbursement should include quality and outcome measures, patient satisfaction and physician accessibility. Distant productivity measures need to account for all that practitioners perform in practice and for participation in activities that are not easily valued in an objective way. PA

Chris Noth, PA-C, FAPACVS *is a physician assistant at Genesys Regional Medical Center in Grand Blanc, in cardiothoracic surgery and CME Chairperson for MAPA. He is also editor of the newsletter 'MichiganPA' and on the Michigan PA Task Force.*

Physician Assistant Prescribing in Michigan – Follow the Culture or the Law?

When Public Act 210 of 2011 was passed, many of Michigan's PAs had to review their delegated prescriptive privileges and determine whether they needed to modify their current DEA Schedule registrations. As we recall, the new law allowed for expanded physician delegation of scheduled II medications, notably in the outpatient setting, and removed restrictions at discharge from a hospital. If the PAs DEA schedule registration was more limited than the new law (e.g. schedules III-V only), these PAs were required to update both their Federal DEA registration and their delegation authorization form and fax it to the DEA office in Detroit (info on MAPA's website). The passing of PA 210 resulted in many questions about general PA prescribing from both new PAs as well as seasoned PAs, prompting this article to review PA prescribing within Michigan.

In short, Michigan PAs do not have controlled substance licenses and have no inherent right to prescribe medications since our prescriptive authority is derived from our supervising physician(s) under delegation. The state of Michigan allows physicians to delegate this privilege to us; by law the delegating physician's name must be identified on every prescription (i.e. both controlled and non controlled medications). Section 333.17076 of the Public Health Code states:

"When delegated prescription occurs, both the physician's assistant's name and the supervising physician's name shall be used, recorded, or otherwise indicated in connection with each individual prescription so that the individual who dispenses or administers the prescription knows under whose delegated authority the physician's assistant is prescribing. When delegated prescription of drugs that are included in schedules II to V occurs, both the physician's assistant's and the supervising physician's DEA registration number shall be used, recorded, or otherwise indicated in connection with each individual prescription."

Based upon some of the calls and emails that MAPA has received, it appears that some PAs have been writing for medications and using only their own name on the prescription. Some pharmacies have been filling these prescriptions and thus, once out in practice, some newly hired or newly practicing PAs have picked up this prescribing style and it then becomes a culture or a presumed standard of practice based on dubious anecdotal experience. While attempting to inform a fellow PA about this, I was met with a shrug of their shoulders stating "…well the pharmacy fills them?" **The problem with this culture of prescribing is that, in fact, these prescriptions are technically illegal. Physician assistants who are writing prescriptions as described here are putting themselves at unnecessary risk.** Identifying your supervising physician on a prescription may seem unnecessary, yet it remains a requirement

under the current state law and administrative rules. By contrast, the risk of failing to abide by this requirement could result in a potential audit, fines and/or limitations on a PAs practice. Of note, the states' requirement that the supervising physician's name appears on each script for both controlled medications and non-controlled medications should not be misinterpreted as requiring a physician's co-signature. There is no requirement for co-signature on medication prescriptions. If the physician's name is pre-printed on the prescription pad (and DEA # included on controlled medications) then circling his or her name is sufficient to identify the delegated relationship.

Unfortunately, the age of electronic prescribing makes meeting this requirement more onerous for PAs and much less intuitive. To our knowledge, no electronic prescribing vendor software was designed with PA prescribing under delegation in mind- consequently, in order to meet the states' requirement, you must place supervising physicians' name (for non controlled medications) or supervising physician's name PLUS DEA number (for controlled medications) in the "comments to pharmacist" text window, or alternatively print out the electronic prescription and hand-write the appropriate information on the prescription.

In closing, it is our responsibility as PAs to know the law that we practice under. By following our clinical 'risk vs. benefit' strategy it seems clearer to take the time and ensure we take the proper steps in prescribing medications. There are ongoing discussions into the dilemma of e-prescribing and we appreciate your comments or experience with any solutions or suggestions you may have. PA

Respectfully submitted by:
Ron X. Stavale, PA-C President-Elect, MAPA
Mike DeGrow Executive Director, MAPA
Marc Moote, PA-C Legislative Committee, MAPA

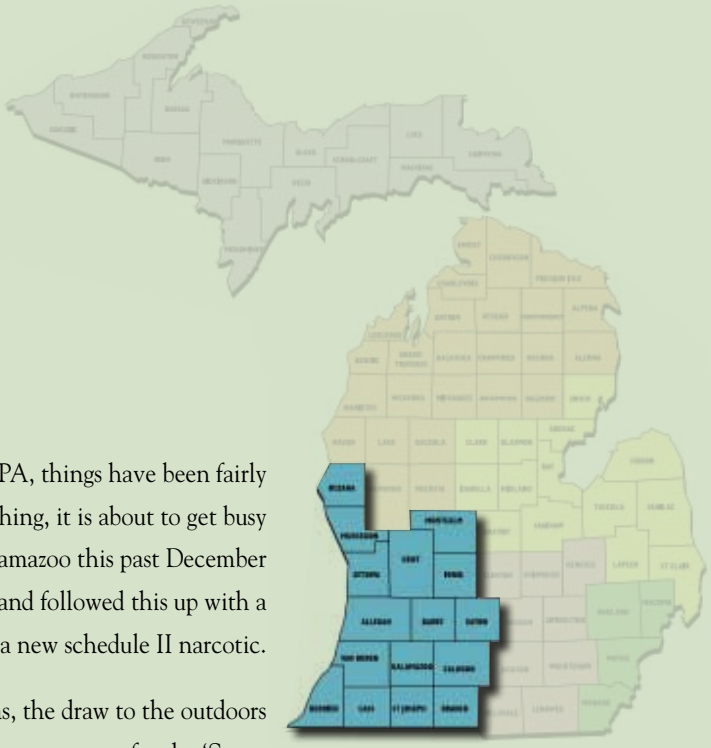
Quote:

"Be a yardstick of quality. Some people aren't use to an environment where excellence is expected"

Steve Jobs 1955-2011
Businessman, Inventor, Co-founder of Apple, Inc.

MAPA Region 4 Update

by: R. David Doan III, MS, PA-C



With the busy holidays and changes at MAPA, things have been fairly quiet in region 4, but with spring fast approaching, it is about to get busy again! We had a nice dinner meeting in Kalamazoo this past December and talked about Public Act 210 of 2011 and followed this up with a pharmaceutical sponsored talk on a new schedule II narcotic.

As snow begins to melt and the weather warms, the draw to the outdoors is undeniable. Again this spring, I will be setting up a team for the 'Susan G. Koman Race for a Cure' in Kalamazoo. The race is in May and runners and walkers alike are needed to make our group of PAs (with PA friends and family) a large supporting group for finding cures for breast cancer! Last year's turnout was low, but I have high hopes this year for a large group. Contact me via email if you want more information and would like to participate, either by walking or running the 5K.

Also coming up in Region 4, Western Michigan University's PA program is holding a job fair on Thursday March 29, 2012. It will be held at the College of Health & Human Services Rm. 4010 from 3-6 pm. Email me for directions if you need them.

I hope you have had a wonderful start to the New Year and look forward to seeing many of you at the Spring Symposium and in dinners to come in Grand Rapids and Kalamazoo! Keep a look out for updates via email for upcoming dinner meetings.

WHO AM I?

I cause myalgias, gum disease, lethargy and bone pain.
Humans, bats and guinea pigs cannot synthesize my key component.
Boiling the needles of the Eastern White Cedar to make tea can prevent me.
My key component can be destroyed by exposure to air and copper.
A daily ration of this gave rise to the term 'Limey' for British soldiers and saved many a sailor and pirate from my fate.

(answer in next 'MichiganPA') *(previous Q_3 answer: Central Pontine Myelinolysis)*

Q3 QUARTERLY QUIZ QUESTION

Question: What's in a Name?

by: Donna Hines, PA-C

What is a PA? What does the clinician wish to be known as? What should 'PA' stand for?

Currently, the American Academy of Physician Assistants (AAPA) has a four page color glossy advertisement that defines our profession:

> *"Physician Assistants (PAs) are health care professionals authorized to practice medicine as part of the health care team managed by a physician. PAs perform a comprehensive range of medical duties from basic primary care to assisting in major surgery. They can prescribe medication in all states, the District of Columbia and many U.S. territories. PAs individual responsibilities depend on state laws, the type of practice, their experience and their working relationship with their physician and other health care providers."*

Historically, starting with the medics from the Vietnam War and the vision of Eugene Stead, Jr. M.D. who began a PA program with three students at Duke, there have been varied names taken on by these pioneering providers. At one time or another, titles included physician associate, doctor's associate, health associate and Medex. The advocates, educators and regulators came up with physician assistant and was translated into the health code as physician's assistant. A lengthy struggle and strong grass roots groundwork help settle the title as ***Physician Assistant***.

Fast forward 46 years, that is 46 years of political maneuvering, educating the physicians and the patient/public about our clinical skills, education, stamina and loyalty to the physician-PA team concept. PAs educate each other, medical students, military personnel and the public and treat patients in urban, military and rural areas. PAs have expanded their roles and lead departments, serve on medical review boards, educational departments and lead brigades of soldiers. We also run companies of home care, temporary staffing, mobile centers and medical clinics; we participate in leadership at hospitals, clinics, county and state health departments and at the federal level. A 2009 AAPA poll demonstrated that 66% of the American public had heard of a PA and 33% received health care from a PA.

Question: What's in a Name? *continued from page 15*

In the past few years, a movement has begun to rename the PA profession as '*physician associate*.' The image in dispute is that 'assistant' implies a technician level position, yet most PAs graduated from a Master's level curriculum. The current use of mid-level provider could be construed to imply that a higher level of care is available, but not offered; and that nurses, technologists, etc. are providing "low level of care." The term 'associate' would imply a partnership, congeniality and a collaborative teamwork in health care delivery; and does more accurately represent the relationship with our physician team mates. The scope of practice would not change with either name.

What needs to be realized is that to simply say 'let's change our professions name' is no simple task. To change the name of our profession would incur statutory and regulatory language changes at the state and national levels. PA constituent organizations would need to change all documentation and agreements; advocacy efforts and legal counsel for AAPA and constituent organizations would be long term and have the potential to be financially burdensome. After the 46 years of saturating organizations, hospitals and regulatory boards with PAs, to reinvent the wheel by renaming this profession would be a huge investment in time and money.

AAPA fears that once the rule books are opened, there would be those who would scrutinize and use this opportunity to restrict scope of practice for PAs, all the while, opening the floor for discussions. The AAPA driven PR campaign over the last few years would have been for naught and the public and other health care providers may become confused with a name change . The energy spent on name changing and all the ramifications that would ensue will deplete the resources and time for future AAPA and state PA organization endeavors.

What can you do? Or What should you know? The House of Delegates (HOD) is the determining body that will tell AAPA what decision has been made. Michigan has seven delegates and therefore, seven votes; which will be cast at the annual AAPA conference (ImPAct 2012, in Toronto) in May. Last year at AAPA's conference, a verbal vote was taken without debate- 'nay' to the name change was the majority. This year there will be an open debate on this topic, so please consider this debate and discuss it with your colleagues and mentors. Let your Michigan delegate know how you would like them to vote on this subject, contact your HOD delegate at www.michiganpa.org .

Donna Hines, PA-C *is a physician assistant in Cardiology at St. Joseph Mercy Oakland and is a delegate to the Michigan HOD for AAPA.*

Developing the Future Leaders of our Profession

by: Christine Oldenburg-McGee, PA-C

There's more to PA school than just classes...

Many of us remember our PA school days as reading pages upon pages of clinical medicine, anatomy and pharmacology followed by endless tests and grueling rotations. Now out in the real world and working as a PA, we realize there is a lot more to being a PA than just practicing clinically. For example, how do we get to prescribe schedule II narcotics without restrictions? How are we able to write for restraints or durable equipment? What direction is our profession going to take with health care reform looming? Who are going to be the future leaders of our profession?

We all make contributions to our profession every day by providing the best care possible for our patients. Some of us will go on to make great contributions to the profession by volunteering our time to MAPA, AAPA and other volunteer organizations. Developing our future leaders is an important challenge to MAPA and that is why MAPA promotes student participation in many aspects of our programs.

Students who attend MAPA and AAPA conferences are able to interact and establish contacts with practicing PAs. Students may become involved as moderators at conferences, as representatives on MAPA and AAPA governing boards and by attending lectures specifically designed with student interests in mind.

MAPA's Legislative Day, coming up on May 16, 2012 in Lansing, is another example of developing our future leaders by introducing practicing PAs and students to the legislative process. Legislative Day is a free one day conference that looks at the broad spectrum of health care reform, current Michigan specific legislative issues and the process it takes to get a bill advanced through the legislature, as well as visits to our legislator's offices. Many practicing PAs, let alone our new students, do not realize the endeavors of those before us who dedicated many hours to getting rules and laws changed so that we may continue to provide quality care for our patients and continue to improve our practice abilities. For example, SB 384 now Public Act 210 of 2011, took two years of collaboration prior to being presented in the House as a bill and another 6 months to get approved in both the Senate and House before going in front of the Governor for approval. This is a very important awareness program for all future leaders, PAs and students alike.

In March, MAPA will be sending a group of PAs and three students (selected after an essay submission) to attend Capitol Connection sponsored by AAPA in Alexandria, VA. This conference will further expand upon the legislative process at the national level on Capitol Hill. Capitol Connections is an opportunity to join hundreds of PAs and PA students from across the country, speaking as one unified voice in the halls of Congress, on legislative priority issues such as hospice, electronic health incentives and funding for PA programs. With all the changes going on in health reform, this will be an excellent opportunity for these students to learn first hand how the changes will affect the profession they will one day be joining as certified PAs!

As the need for more PAs in the workforce continues to build, we owe it to our current PA students to mentor them both in and out of the classroom, on the growing demands on our profession. MAPA is dedicated to promoting our profession and promoting leadership within the profession. Are you a future leader? Come join us and continue the tradition of involvement!

Christine Oldenburg-McGee, MS, PA-C *is a physician assistant at the University of Michigan - Trauma Burn Emergency Services. Christine is also the MAPA student advisor and chair of the MAPA's Public Education and Relations Committee.*

MAPA FALL 2012

Saturday Evening
Member's Banquet

THURSDAY EVENING 'WELCOME RECEPTION'
WITH PAMPAC

Expanded Exhibit Hall

Workshops with hands-on learning

Friday morning
'Issues & Answers' Session

Reminder: Don't miss this opportunity to obtain valuable CME, network with colleagues and friends and be a part of the Midwest's Premier PA Conference that is **MAPA- Fall 2012**

On-line registration coming soon at www.michiganpa.org

UDM PA Students Generosity and Activities

The University of Detroit Mercy PA class has been extremely active this past fall. In celebration of PA week, we generously donated items we collected to the local St. Peter and Paul Warming Center, which were desperately needed. For Halloween, we donated bags of candy for Safety Street, a campus wide activity that invites local Detroit children to safely trick-or-treat on campus.

Our class has also been actively fundraising throughout the past semester to help support a family in need. We sold UDM PA t-shirts, Scentsy Warmers and had a jeans day to raise money. Money raised and generous donations were used to adopt a local family for Christmas; together over $700 was used for presents. We were able to supply the family with a $100 gift card to a grocery store, all the items on their wish list and a DVD player. Below is a picture of all of the gifts wrapped just before being delivered to the family. In our upcoming events, we plan to collaborate with Wayne State University PA students to support the Dream Project. We also plan to participate in the 'Polar Plunge' and 'Race for the Cure' in the upcoming semesters. Our class is excited to have wrapped up our first semester and look forward to the upcoming activities in 2012.

Submitted by: Chelsea E. Maruldo, PA-S
UDM MAPA Student Rep.

PLANNER

EVENTS / SEMINARS / CLASSES / CONFERENCES

AAPA's CORE/Capitol Connection

DATE: March 25-27, 2012
SITE: Alexandria, VA
INFO: www.aapa.org

MAPA's Legislative Day

DATE: May 16, 2012 (Wednesday)
TIME: 8am – 2pm
SITE: TBD
INFO: www.michiganpa.org

AAPA's 40th IMPACT Conference

DATE: May 26-31, 2012
SITE: Toronto, Ontario
INFO: www.aapa.org

MAPA's 2012 Fall CME Conference

DATE: October 11-14, 2012
SITE: Soaring Eagle Conference Center
Mt. Pleasant, MI
FEE: On-line registration coming soon
INFO: www.michiganpa.org or call
1-877-YES-MAPA

MAPA's Future Fall CME Conferences

2013 Grand Traverse Resort & Spa (Oct. 10-13)
2014 Grand Traverse Resort & Spa (Oct. 9-12)
2015 Grand Traverse Resort & Spa (Oct. 8-11)
2016 Grand Traverse Resort & Spa (Oct. 13-16)

'The Last Word...'

Transparency is a term that can mean being clear with your intentions, no hidden agenda or being able to see without distortion. It is also a buzz word that can be applied to business culture and corporate board thinking of today. Transparency is used in business and social context and implies an openness, communicating and accountability. These attributes are easily applied to the medical field.

With available technology and social media outlets, patients are scavengers for information regarding their health. The information that is out there for patients to read makes them more invested in their medical health. This translates to us as medical providers, to be clear about the medical plan of our patients, communicate effectively with them and be accountable for treatment therapies and outcomes.

Transparency is also a part of the MAPA Board; the decisions made are influenced by outside opinion and thought processes. We invite outside ideas that will help improve our advocacy to our members and to all PAs in Michigan. There are no hidden agendas or conditions on the MAPA Board, there is the availability of information necessary for collaboration, cooperation and collective decision making. All PAs are welcome at our board meetings and it is this transparency of the MAPA Board that allows participation by non-board members to voice their ideas. Through this process, ideas are transformed into reality and can be implemented to the strategic plan. Transparency exhibited by the MAPA Board helps to serve the PAs of Michigan while removing the secrecy of management.

Chris Noth, PA-C
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