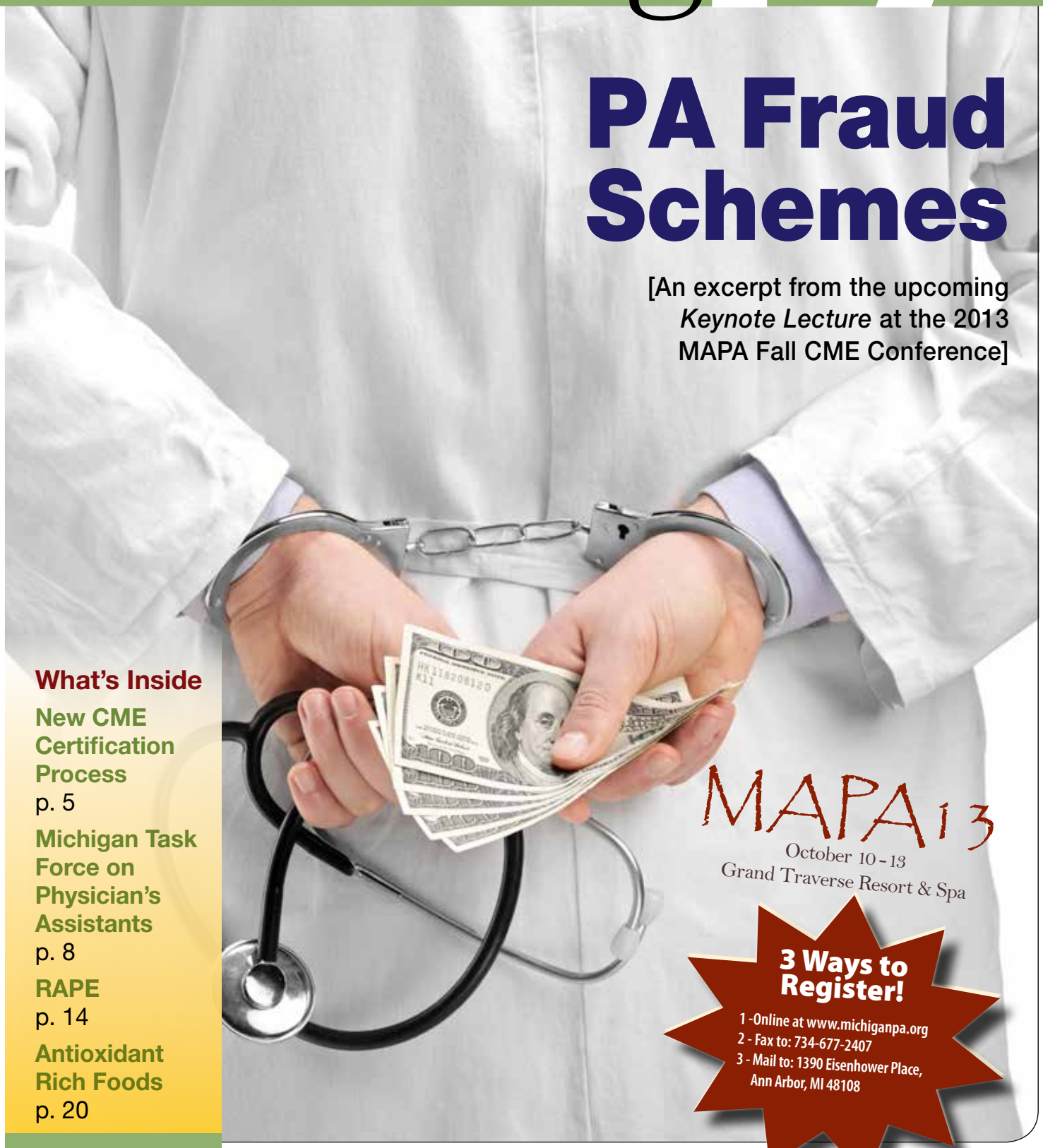
September 2013

*The Only Informational Resource for Michigan Physician Assistants*

# Michigan PA

# PA Fraud Schemes

[An excerpt from the upcoming *Keynote Lecture* at the 2013 MAPA Fall CME Conference]



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MAPA 13
October 10 - 13
Grand Traverse Resort & Spa

**3 Ways to Register!**

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

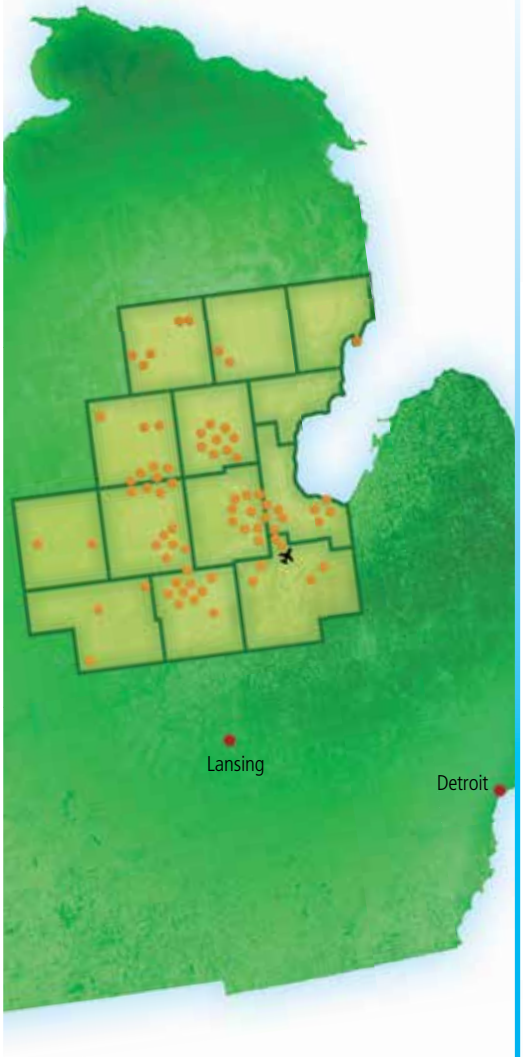
# A Great Place to Live and Work

*"I like that I work near where I live. Everything is so convenient."*

*"It would be hard to match the level of technology available at MidMichigan."*

*"I like working with colleagues I trust and respect."*

*"My whole family loves it here."*




A rewarding career and a fulfilling home life. Physician assistants at MidMichigan Health say they didn't have to choose one over the other. Here are just a few reasons why this is where they want to be:

- Highly competitive compensation plans, including a full benefits package.
- World-class facilities and state of the art technology.
- Family-friendly communities with excellent recreation and short commutes.
- Freedom to practice medicine with the supportive environment to succeed.
- Partnering with the University of Michigan.

A chance to finally achieve that perfect balance between your personal and professional life – you'll find it here at MidMichigan. It's not just what we say. It's what our physician assistants say. And it's what you'll see if you come for a visit.

MidMichigan Health is a non-profit health system affiliated with the University of Michigan Health System. Headquartered in Midland, Mich., it covers a 14-county region with medical centers in Alma, Clare, Gladwin and Midland, as well as urgent care centers, home care, nursing homes, physicians, and other specialty services. MidMichigan has 6,300 employees, physicians, providers and volunteers.

To find out how you, too, can have the Best of Both Worlds, view our short video clips at **www.midmichigan.org/opportunities** or e-mail us at **recruitment@midmichigan.org**.

**MidMichigan Health**
UNIVERSITY OF MICHIGAN HEALTH SYSTEM

MichiganPA

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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.*

Michigan Academy of Physician Assistants

@MAPA_tweets

# President's MESSAGE

Jay Kaszyca, PA-C

As an organization, MAPA is entering its second full year of a relationship with the management company Association Management Resources (AMR). In the PA profession, the ability of PAs to be flexible and employed in so many different subsets or specialties of medicine; makes us a perfect solution to the shortage of available medical professionals that serve the public. MAPA has continued in its efforts to mimic the profession in being flexible in order to better our state Academy and the work environment for PAs in Michigan. Over the last few years, MAPA's Board of Directors (BOD) has shifted its attention to become more involved in the states' political atmosphere as it pertains to the PA environment and making membership in MAPA a priority.

Without members, there ceases to be a MAPA and subsequently, no advocacy or vigilant voice to represent or protect the PAs in Michigan. Our BOD has asked AMR to join us in being flexible and help improve our membership numbers and value to the physician assistant in Michigan; making MAPA membership a priority for them also. By having AMR work with MAPA's BOD on increasing membership and member retention, we will have the power in numbers and a stronger voice on our side. Why is this so important? Now, as much as ever before, we need our Academy voice and message to resonate; "to protect and improve the PA profession in Michigan." This is accomplished by increasing membership, along with the help of our Executive Director/Lobbyist and the hard work of AMR.

*"Membership is at the heart of MAPA."*

To protect and improve the PA practice environment in Michigan, participating in the legislative process in Lansing, is key. We need the power of EVERY PA in Michigan to assist us of informing and educating our legislators on what and how PAs deliver quality and affordable health care. Some of this power and enthusiasm was evident at MAPA's recent Legislative Day in Lansing. A record number of PAs and PA students heard lectures and visited our law makers at the state capitol. There is also a renewed interest and spirit in PAMPAC, with donations and as our agent in Lansing.

In the state of Michigan, we have before us, an **impending review of the public health code**. 'The medical section of the public health code is the portion of Michigan law which defines physicians, PAs, our practice of medicine, and how laws provide and protect our scope of practice.' As MAPA joins the conversation on the review of the public health code, the effect is better heard with more voices from all PAs in Michigan that are focused and unified. We need to concentrate our energy on the best interests of PAs and to the patients we care for. Rarely, a day goes by when MAPA isn't contacted by a PA with a question or concern about their practice. The upcoming review and potential changes in the public health code will provoke more questions than ever. You should be on the lookout for more information, with more specific expectations of what we anticipate in the public health code debate and review. We will exert all possible efforts to assure the PA profession is protected and enhanced in Michigan; **MAPA is standing by to assist all of you**. We ask that you assist us in adding your voice to all of your colleagues that we represent and that you support MAPA with your involvement, membership and PAMPAC in all of their efforts.

Respectfully submitted,

Jay Kaszyca, PA-C
MAPA President, 2013-2014

*P.S. Attending the MAPA Fall CME Conference is a great way to take advantage of quality CME as well as networking and renewing seasoned relationships with fellow PAs. It is also a great way to get involved in your Academy and support our Political Action Committee.*

# New PA CME Certification Requirements

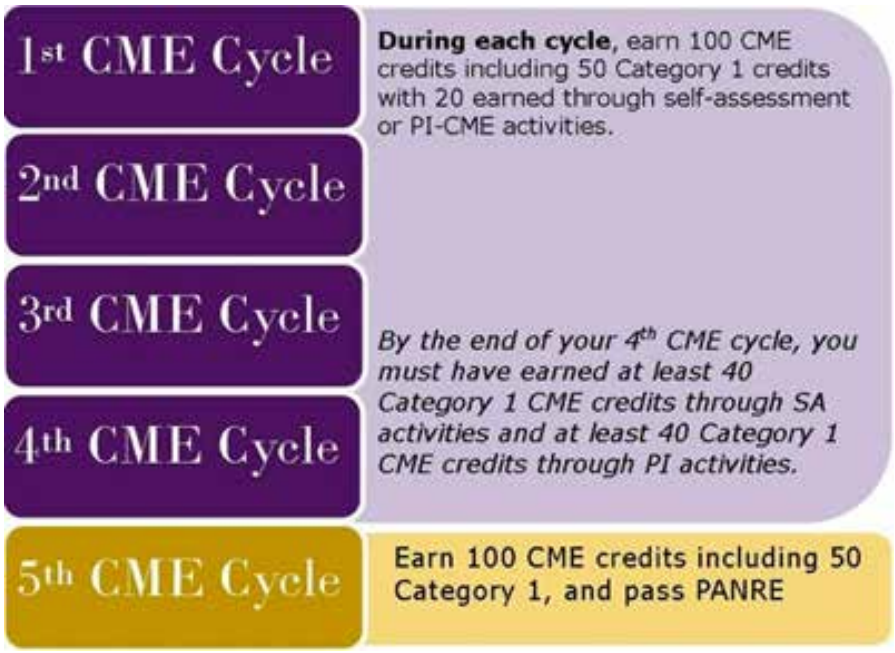
For Physician Assistants (PAs) working in the United States, the recertification process has been unchanged since 1981. For more than three decades, the recertification process has included a recertification exam every 6 years. During that cycle, a minimum of 100 Continuing Medical Education (CME) credits were required to be accrued every two years and logged with the National Commission on Certification of Physician Assistants (NCCPA); in the last several years this has been done online. Over the past several years, the NCCPA has been informing PAs that things will be changing and beginning in 2014, there will be a transition from a 6-year to a 10-year certification maintenance cycle. Along with this significant change, there will be new, more specific CME requirements. PAs will still need to obtain 100 CME credits every two years, with at least 50 of the credits being Category I credits. For the first four 2-year CME cycles, 20 of the 50 Category I credits need to be earned through self-assessment (SA) or performance improvement (PI) CME activities. By the end of the fourth 2-year CME cycle, each PA should have earned at least 40 Category I CME credits through SA activities and 40 Category I CME credits through PI activities. The fifth and final 2-year CME cycle will require 100 CME credits with at least 50 Category I credits, but they don't have to be from SA or PI activities, much like current requirements (see table).

### So what are these SA and PI CME credits?

SA or "self-assessment" CME credits are simply the process of systematically reviewing your own knowledge; this can be used to assess your own performance or skills as well. Per the NCCPA and AAPA websites, self-assessment activities are most commonly a simple, in-depth medical knowledge test. These self-assessment tests have been used for several years by our physician counterparts for CME credits. There are some examples already available and the AAPA is working with the NCCPA to develop more. A well-known example is the American College of Physicians Medical Knowledge Self-Assessment Program (MKSAP). Unlike our PANCE or PANRE, the SA CME tests don't require a passing score; it is simply there to help you self-assess your knowledge, skills and performance. Often, you can take the test over and over to improve where you are lacking.

PI or "performance improvement" CME activities are defined as "a PA centric data driven activity, focusing on the needs of the individual PA." The NCCPA has mapped these activities out as having three stages:

- In the first stage, the PA will perform a practice assessment by comparing a current practice in a clinical area with a national benchmark/performance guideline and data submitted by other PAs.




*continued on page 6*

## New PA CME Certification Requirements *continued from page 5*

- For stage two, the PA will need to develop a plan to improve the aforementioned "current practice" and implement said plan. This will require engaging in educational activities and collecting resources to use in your daily practice, etc.
- The third stage would require the PA to reassess the practice to measure the effect of the improvement plan.

It is important to note that you don't have to demonstrate actual practice improvement to receive CME credit; the primary intent is to help you reflect on your own practice.

It may be easier to understand these new recertification requirements with an example. Let's look at a sample 10-year certification maintenance cycle. If we break the 10 years down into five 2-year CME cycles, we can see that it is not as complicated as it seems. Each PA will need 100 CME credits each 2-year cycle; of these credits, at least 50 must come from Category I credits. The remaining can be Category II credits. For the first four 2-year cycles, we must break the minimum 50 Category I credits down further with 20 of these credits from one of the new special CME credits (either SA or PI CME).

So, for our example- the first 2-year cycle could look like this:

- 30 Category I credits (perhaps 20+ from MAPA's Fall CME Conference and the remaining from JAAPA articles)
- 20 Self Assessment credits (from the MKSAP or other AAPA approved programs)
- 50 Category II credits from precepting students or other activities

We could have done a PI CME credit in place of the SA credits if we wanted. The next three 2-year cycles would be very similar to this first cycle. The only thing to remember is that during the first 4 cycles of 100 credits obtained (totaling 400 credits earned), 40 credits must be SA and 40 must be PI. I would suggest alternating years of SA credits with PI credits, to provide the required number of credits and offer a little variety. Another way would be to simply do the first two cycles the same and the 3rd and 4th cycles the same. For your fifth and final 2-year cycle of CME credit requirements, you do not need to include any SA or PI CME credit requirements. You just need 100 CME credits consisting of a minimum of 50 Category I credits and then pass the PANRE. **You will still need to log any and all CME credits earned towards the 100 credits every two years, as you have in the past.**

I hope this article has cleared up this new certification maintenance process. If you find yourself confused, don't feel alone, many others are as well. There is a video tutorial on the process available for viewing on the NCCPA website; check it out at www.nccpa.net today!

**R. David Doan III, MS, PA-C** *is currently practicing at ProMed Family Practice in Portage & Richland, MI and teaches part-time at WMU's PA Program. He also serves as MAPA's Secretary and Communications Committee Chair. He can be reached at davedoanpac@gmail.com*

# PAMPAC Gears Up For Fall Conference

*by Brian Gallagher, PA-C. PAMPAC Chair*

On Thursday October 10, 2013 at the MAPA Fall CME Conference 'Welcome Reception', PAMPAC will hold a fundraising event. At last years' Fall Conference, donations topped nearly $6,000 for the Physician Assistants of Michigan Political Action Committee. These donations have been utilized to carry the PA message to Lansing by supporting those legislators who support and believe in the PA profession. For a full list of donations, please see the PAMPAC Annual Report located at the PAMPAC table at the Fall CME Conference.

**This fall, the Michigan legislature is scheduled to revamp the entire Michigan Public Health Code, putting our PA profession at risk.** As a result, this year's PAMPAC donations will be more critical than ever. We need your donations again to protect our ability to practice medicine in Michigan. In an effort to provide our donors with visible recognition and appreciation of their donations, every PAMPAC donor will receive recognition for their level of donation. The levels are:

| | |
|---|---|
| **PA**rtner: | Up to $99 |
| **PA**triot: | $100 to $499 |
| **PA**ladin: | $500 and above |

Those **PA**ladin Club donors are invited to an exclusive reception, to be held at the Fall CME Conference. Current **PA**ladin Club members are: Kevin Duffy, PA-C; Brian Gallagher, PA-C; Rose Marie Higgins, PA-C and Chris Noth, PA-C. We look forward to expanding this list at this years' MAPA Fall CME Conference. Please stop by the PAMPAC table to receive a copy of the Annual Report and make your 2013 donation at the Fall CME Conference in Traverse City!

## MAPA Timeline Additions

It has been several years since an update to the MAPA Timeline was published (August 2010). Although, the number of recent additions appear to be few, they are significant none the less. It is also a testament to MAPA's BOD, MAPA's Legislative Committee and Executive Director/Lobbyist- Mike DeGrow and PAMPAC, that we remain vigilant to the never-ending assaults to the PA practice in Michigan. A review of the Public Health Code is our next topic that we will scrutinize and be involved in.

Recent Additions-

**PA 210 of 2011** (November 9, 2011)

1. Removed the restriction of a physician being able to delegate to a PA, prescribing of Schedule II medications in all settings.
2. A physician may delegate to a PA the ability to round on patients in public institutions, nursing homes, hospitals, extended care facilities, ambulatory care clinics, etc.
3. A physician may delegate to a PA the ability to sign a form requesting physician's signature, with the exception of a death certificate.
4. A physician may delegate to a PA the ability to order restraints.
5. The PA's name and the supervising physician's name will be included on the prescription label for prescriptions written by the physician assistant.

**PA 618 of 2012** (December 31, 2012)

1. Added Osteopathic Physicians to PA 210; to correct a technical oversight.

From the tireless efforts of the above mentioned people, it is possible for you to have a healthy physician assistant practice environment in Michigan. These efforts are supported by your membership and involvement in MAPA and donations to PAMPAC.

# Michigan Task Force on Physician's Assistants

With the passage of the initial enabling legislation authorizing the practice of medicine by Physician's Assistants in 1976, an advisory committee to the Department of Community Health was established to provide advice to the Department regarding matters pertaining to Physician's Assistants (PA). Public Act 420 described the duties and responsibilities of the committee. In addition, the committee, it was also authorized to determine sanctions when persons licensed under the PA practice act were found to have violated the public health code or other applicable laws. In 1978, Public Act 368 transferred the committee's authority to the Public Health Code and changed the name to the Task Force on Physician's Assistants (here forward, referred to as: Task Force).

The Task Force provides advice to the Bureau of Health Care Services (Bureau) of the Department of Licensing and Regulatory Affairs (LARA). The Task Force is composed of 13 members: 7 PAs, 3 public members, and one each from the Board of Medicine, Board of Osteopathic Medicine and Surgery, and Board of Podiatric Medicine and Surgery. Members are volunteers and appointed by the Governor, serve four year terms and may not serve more than two consecutive terms on the Task Force.

**The Task Force is charged with a number of duties regarding the regulation of PA practice in Michigan, with its primary goal- 'the protection of the public's health and safety'**. The Task Force is responsible for the development of rules and requirements for the education, training, and experience for PA licensure, as well as developing guidelines for the delegation of duties and supervision of PAs. While the guidelines are not binding, they serve to provide the Bureau with Task Force's expectations regarding delegation and supervision. The Task Force also promulgates rules regarding criteria used to evaluate PA training programs and the qualifications and ability of their graduates to safely practice medicine. The Task Force is required to apply nationally recognized standards for education and training when developing rules regarding education and training programs. In addition, the Task Force also reviews rules associated with the Practice Act and provides input to the Bureau during rule development. Examples include the rules associated with recent changes to prescribing and hospital rounds enacted two years ago. The Task Force meets quarterly and is in compliance with the Open Meetings Act and the 1990 Americans With Disabilities Act.

A subcommittee of the Task Force, the Disciplinary Subcommittee (DSC), is charged with imposing sanctions against Michigan licensed PAs. If an allegation of a violation of the Public Health Code is made, or a PA is convicted of certain crimes, an investigation is conducted by the State Attorney General's (AG) office. If the allegation is substantiated, the DSC is charged with determining what the penalty against the PA should be. In many instances, this occurs after a compliance conference is conducted between the licensee, a member of the DSC, and representative of the AG. In most cases, the conference results in a settlement offer to the licensee, which, if accepted, is then reviewed by the DSC as a whole. At this point, the DSC may accept, modify, or reject the settlement offer. If the revised settlement is not accepted by the licensee, the case then proceeds to a hearing before an administrative law judge for LARA. The following table outlines the sanctions that may be imposed on a license.

***John E. Lopes Jr.,*** *DHSc, PA-C, DFAAPA is an Associate Professor in the Physician Assistant program at Central Michigan University and a member of the Task Force on Physician's Assistants.*

| SANCTIONS THAT CAN BE IMPOSED ON A LICENSE | |
|---|---|
| **Community Service** | Requires that the individual offer assistance to a community based agency at no cost. |
| **Fine** | A dollar amount up to $250,000 is allowed under the Public Health Code for certain violations. |
| **Limitation** | An imposition of restrictions or conditions, or both, on a license. |
| **Reprimand** | A formal rebuke which indicates that the licensee violated the Public Health Code, but which does not restrict the licensee's practice in any way. |
| **Restitution** | A requirement that the licensee reimburse an individual or agency for loss of damage. |
| **Revocation** | Removal of the license to practice for a period of 3 years (or 5 years for certain types of convictions). The licensee must formally ask the Task Force to reinstate the license. |
| **Suspension** | A prohibition against the licensee practicing for a specified period of time:<br>-For suspensions of 1 day to 6 months, the licensee can resume practice at the end of the suspension period without additional review by the Task Force unless otherwise specified in the final order of suspension.<br>-For suspensions of 6 months and a day, or more, the licensee must formally ask the Task Force for reinstatement. |
| **Direct, On-site Supervision** | The oversight or participation in the licensee's work by a supervisor, with continuous availability of in-person communication between the licensee and the supervisor. |
| **General Supervision** | The licensee must have another licensee oversee their practice with the supervisor available at all times by phone, radio or telecommunication; the supervisor should regularly review the records of the sanctioned licensee. |
| **Restrict ability to prescribe, or have access to, controlled substances** | A requirement to work in a setting where the licensee does not have access to controlled substances or their ability to prescribe controlled substances can be removed. |
| **Restrict hours of practice** | A requirement to work only specified hours, such as when a supervisor is readily available. |
| **Restrict ownership or financial interest** | A prohibition from owning, on whole or in part, a business regulated by the Task Force, or owned by the licensee. |
| **Restrict performance of certain procedures** | The licensee can be ordered not to perform certain procedures; be required to have a supervisor present during a certain procedure; have a chaperone present in procedures involving females, etc. |
| **Restrict place of practice** | The licensee can be required to work in specified facilities or locations, or not work alone in independent practice. |
| **Probation** | A sanction which permits the Task Force to evaluate over a period of time a licensee's fitness to continue to practice their profession. Certain terms and conditions such as completion of continuing education, attendance at a training course, or passage of an examination may be required of the probationer. |

# Business Arrangements That Could End Your Career

*By Natalie Schutte, PA and Ray Beckering III, AUSA*

*Do you think that your work arrangements are legitimate? Are you confident that your employer is doing business in a way that would never have a negative impact on your career?* ***Are you willing to bet your ability to practice medicine on it?***

Many practitioners have the utmost confidence in their employers and how company business is conducted. Many of us do not feel that we should understand business operations because they have no direct impact on our clinical duties. However, instead of making assumptions that our employer is operating under legal and ethical business practices, we should be taking a closer look into these business arrangements, which could have a very large impact on us. Did you know for example, that in the State of Michigan, the owner of a medical business does not have to be a licensed medical provider, as is required in some other states? This fact greatly reduces the risk and impact of negative and improper business tactics, because they don't have a medical license; whereas the impact on us as PAs can be significant. In addition, it is common practice for physicians to regularly consult with an attorney regarding their business arrangements and contracts. However, most physician assistants and nurse practitioners do not adopt this practice upon entering the workforce, but instead, blindly "trust" that their employers and supervising physicians have their best interest in mind. Unfortunately, this is not always the case and there are many people operating healthcare businesses today that are willing to sacrifice the careers of healthcare professionals, like physician assistants, all for personal gain.

My story begins after I graduated from PA school in 2008. I immediately began working for a well known businessman in the Central Michigan area; I thought life was amazing! I had the perfect job, was well compensated and loved the company I worked for. I considered many of my co-workers as family and thought I would work with the company forever. My supervising physicians were respected members of the community, with careers in medicine older than me. I followed their leads and contributed to a very successful practice. I was worried about making sure I did not harm any patients, like we are taught in PA school…I did not need any malpractice issues early in my career! There was also the business aspect of being a good PA. I had to maintain patient counts and be productive to keep the boss happy. Easy, no issues there as I had all the resources and tools I needed to stay busy and bring money into the practice, all the while keeping patients healthy and happy. Unfortunately, while I was busy abiding by the terms of my contract and enjoying finally getting to practice medicine after eight long years in school, my employer was operating on his own agenda, to secure his future at all costs. In January 2012, my employer and many of the administrators in his company were indicted for healthcare fraud. I had "profit sharing" bonuses in my contract, so I did not think that I had participated in any illegal activity. I never had an attorney review my contract or look at my employment or business arrangements; ***I just assumed it was all ok.*** Bad decision!!! Today, I sit with a felony conviction for receiving a healthcare kickback, was on house arrest, have $120,000 in restitution and I am excluded from Medicare and Medicaid for a minimum of five years. The medical director and eight other individuals involved in this case (including two fellow PAs) have also been sentenced with either: incarceration, fines,

exclusions or deportation. Michigan's Attorney General Bill Schuette said of this case: ***"It is essential to maintain integrity in our healthcare system. Patients deserve to know that when a doctor refers them for additional treatment, the decision to do so is based upon quality health advice- not what is best for the doctor's bottom line. Kickbacks with the Medicaid program do not just hurt patients, they affect the taxpayers whose hard-earned dollars subsidize healthcare for those in need."*** It has been almost two years since I was indicted and I am not even close to resuming a resemblance of a normal life. Why? ***I was naive and did not take the time to protect myself and I was eager to prove myself.*** There are many fraud schemes currently active in the State of Michigan. The people behind these schemes know how to successfully deceive highly educated and ethical people, into participating in business arrangements that can end very badly! Do not let this happen to you! ***Please come join me*** and, ironically, the Federal Prosecutor in my case, Mr. Raymond Beckering III, Assistant U.S. Attorney, Western District of Michigan, ***at the 2013 MAPA Fall CME Conference in Traverse City.*** Learn first-hand about the ever growing healthcare fraud trends active in Michigan and how PAs are deceived into participating in these career ending schemes. We will also review ways that you can protect yourself and your career, or handle questionable situations that you are sure to see during your career. Our goal is not just to educate healthcare professionals about the laws, but to describe the deceptive ways in which you could be approached to become involved in an illegal arrangement. I only wish that someone would have educated people earlier about the fraud that is so prevalent; I would have been wiser as to my employer's deception. If you think that this type of situation could never happen to you and that healthcare fraud is black and white, 'you are extremely wrong'. I guarantee that you will be shocked by the amount of fraud you can be exposed too and hopefully be driven to do something about it! See you there!

# MAPA 13

## Fall CME Conference

October 10 - 13 • Grand Traverse Resort & Spa

# Join Us!


WC SAFE has been chosen as the MAPA Fall CME Conference Charity. For list of needed items, see MAPA's website at www.michiganpa.org.

## Thursday Oct. 10

'Opening Session' on:
*Rape and Neurobiology behind this sexual assault*

CME Sessions

**MAPA BOD meeting -** open to all

'Welcome Reception' with PAMPAC donation drive

Family Fun Night

## Friday Oct. 11

Issues & Answers

**Keynote Lecture:** PA Fraud Schemes by Ray Beckering III, AUSA

Exhibit Hall Opens

5K Fun Run

Oktoberfest Beer Tasting

University Receptions

Family Movie night

MI PA Foundation Student Quiz Bowl

**Registration online at www.michiganpa.org.**

**LEARN** — You will have the ability to earn over 26 hours of Cat I CME credit from lectures provided by experts in their field.

**CONNECT** — Meet colleagues, friends and fellow students and interact with MAPA Board members.

**Hotel information is also found online.**

**ENJOY** — Take time to enjoy the many activities available to you at the conference. Whether at the conference, the GTR Spa or in and around Traverse City, fall is the time to appreciate this destination.

## Saturday Oct. 12

AAPA President-Elect lecture

CME Sessions

Peninsular Wine Tour

MI PA Foundation 'Silent Auction'

**Members' Banquet** with entertainment by Judson Laippley

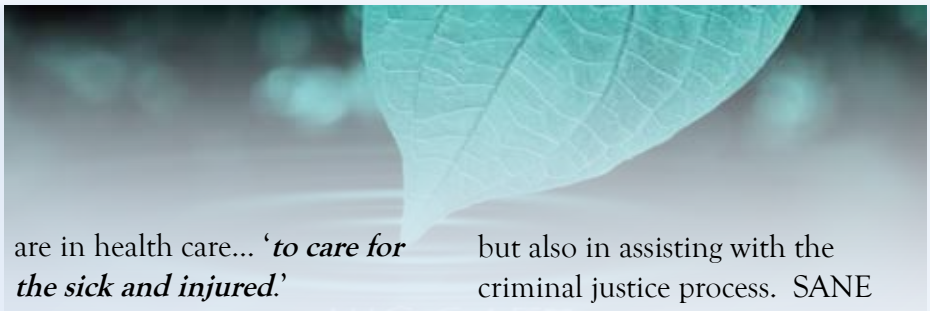
## Sunday Oct. 13

CME Sessions

**3 Ways to Register!**

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

GRAND TRAVERSE RESORT AND SPA



**Rape**... is rarely ever discussed or how to care for a patient who has just been sexually assaulted. Not during our initial schooling or in our ongoing continuing education as physician assistants. No information about the actual neurobiology behind what happens during such a traumatic event or an explanation as to why patients respond the different ways that they do. No direction on how to perform a sexual assault evidence collection kit, otherwise known as a *rape kit*. Nothing about how to provide prophylactic treatment for sexually transmitted diseases (HIV) or for pregnancy. No insight on how to interact compassionately and support your patient as he or she goes through this process, and ultimately, minimize any further trauma. Nothing on the different resources that are available for this underserved and vulnerable patient population.

A majority of PAs work in specialties that bring us into contact with these patients, at some point and time. The importance of compassionate and comprehensive care, at the most critical time in some of our patient's lives, is imperative and at the heart of why many of us are in health care... '***to care for the sick and injured***.'

Throughout the state of Michigan, there are Sexual Assault Nurse Examiner or Sexual Assault Forensic Examiner (SANE or SAFE) programs. These programs consist of specially trained nurses, nurse practitioners, physician assistants and physicians who provide this specialty care. They have unique training in providing medical-forensic examinations and state of the art equipment to assist in injury identification and documentation. It is important to note that these programs are medical first and forensics second. They are not 'cops in white coats', but are providing timely and sensitive medical care within the first hours post-assault. We collect evidence as a courtesy to law enforcement as the patient is evaluated, in an effort to minimize the patient having to go through multiple exams and re-telling their history of the assault, over and over again. These programs are typically 24/7 and housed either within a hospital, advocacy centers that deal with domestic violence & sexual assault or are independent clinics. These clinics have proven invaluable, not only in standardizing the care for this patient population, but also in assisting with the criminal justice process. SANE or SAFE certified practitioners are trained in providing expert witness testimony in court. These types of programs/clinics have revolutionized the overall response to sexual assault in our communities. Evidence-based research shows these types of programs are one of the most important ways to decrease overall effects of PTSD in this patient population.

But what happens if you live in a community where there is no SANE or SAFE program? The responsibility lies on you, as the health care provider, to care for these patients. It is your obligation to complete the evidence collection kit to the best of your ability, in a way that is supportive and not traumatizing to the patient. Please join me at the 2013 MAPA Fall CME Conference for a special look at how to understand this patient population and tips on how to perform a competent medical-forensic examination. **WC SAFE is the chosen MAPA Fall CME Conference charity; please visit their table with your needed donations** (list of needed items can be found on the MAPA website at www.michiganpa.org).

**Kim Hurst, PA-C** *is Executive Director of WC SAFE in Wayne County*

# MAPA's Legislative Day '13 Success!

On Wednesday May 22, 2013 the Michigan Academy of Physician Assistants held its annual Legislative Day in downtown Lansing. One hundred sixty eight PA and PA students stormed the capitol and carried the physician assistant message to their Senators and Representatives.

The morning session began with Anne Rosewarne, Chair of the Michigan Health Council, giving a presentation on "Michigan's Provider Shortage: Are there enough PAs?" Following this lecture and realizing the critical provider shortage Michigan is facing, Senator Jim Marleau's (Chair of Senate Health Policy Committee) Chief Of Staff, Thadd Gormas discussed "Michigan's Barriers and Solutions to the Patient Protection and Affordable Care Act." He was able to identify the challenges of implementing the mandatory requirements of the legislation in Michigan and how the Senate Health Policy Committee is working to resolve those challenges. Next, Michigan Osteopathic Association' s Lobbyist, Kevin McKinney, spoke on the "Landscape of Health Care Legislation in Michigan." It is amazing the number of groups and organizations that impact health care legislation; from providers, insurers, special interest groups and many others, all weigh in and lobby legislation in hopes their opinions aide legislators in voting on a specific piece of legislation.

## MAPA's Legislative Day *continued*

The afternoon session consisted of visiting individual legislators. The attendees met with 33 of 37 Senators and multiple Representatives. The conversations mainly focused on: the health care provider shortage in Michigan, the proven, cost-effective and efficient team approach to medicine and the role of the PA in this health care team approach. The message was well received by all and set the stage for the fall legislative session, where the Public Health Code will likely be revamped. Thank you to those who attended and educated our legislators on the PA profession!

## SOURCES/LINKS/CONTACTS:

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

# Say "Store Brand"

When patients ask about over-the-counter medications, sometimes it's just easier to recommend – *and say!* – the brand name.

But, just because you know that **store brand OTCs contain the same active ingredients and offer the same relief as thier national brand counterparts,** it doesn't mean your patients do.

**36%**
**SAVINGS**

When they buy store brands, **patients can save an average of 36%, which can even help with their medication compliance.**


So, instead of worrying about how to direct your patients to buy Omeprazole or Cetirizine, **just say "store brand."** It will be next to the name brand drug at their favorite retailer, with the same active ingredient(s) listed on the back.

Saying "store brand" probably won't be all that different to you, but in terms of savings and relief for your patients, **that little change in communication may mean a lot.**

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*E-mail medical-relations@perrigo.com to order tear pads with high-value coupons on OTC medications for your office.*

*Perrigo is the world's largest manufacturer of OTC pharmaceutical products for the store brand market.*

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## Disability Income

# Do You Have A Contingency Plan?

An individual was recently diagnosed with testicular cancer. He was told he needs immediate surgery with extensive follow-up treatment. Both the cancer and affected lymph nodes were scheduled for resection and he was expected to be out of work recovering for many months. In a panic, he called our office to purchase disability insurance. Like so many others, he learned he was too late; making a bad situation even worse. And now with a preexisting condition, he will have to wait 7 – 10 years (while treatment is on-going and for symptom-free time period) before becoming eligible for future consideration. We suggested he consider employer group coverage and he responded that his company discontinued that plan three years ago to lower employee benefit costs. He now realizes he should never have relied on employer benefits for family income protection... And neither should you.

Consider the following scenario...

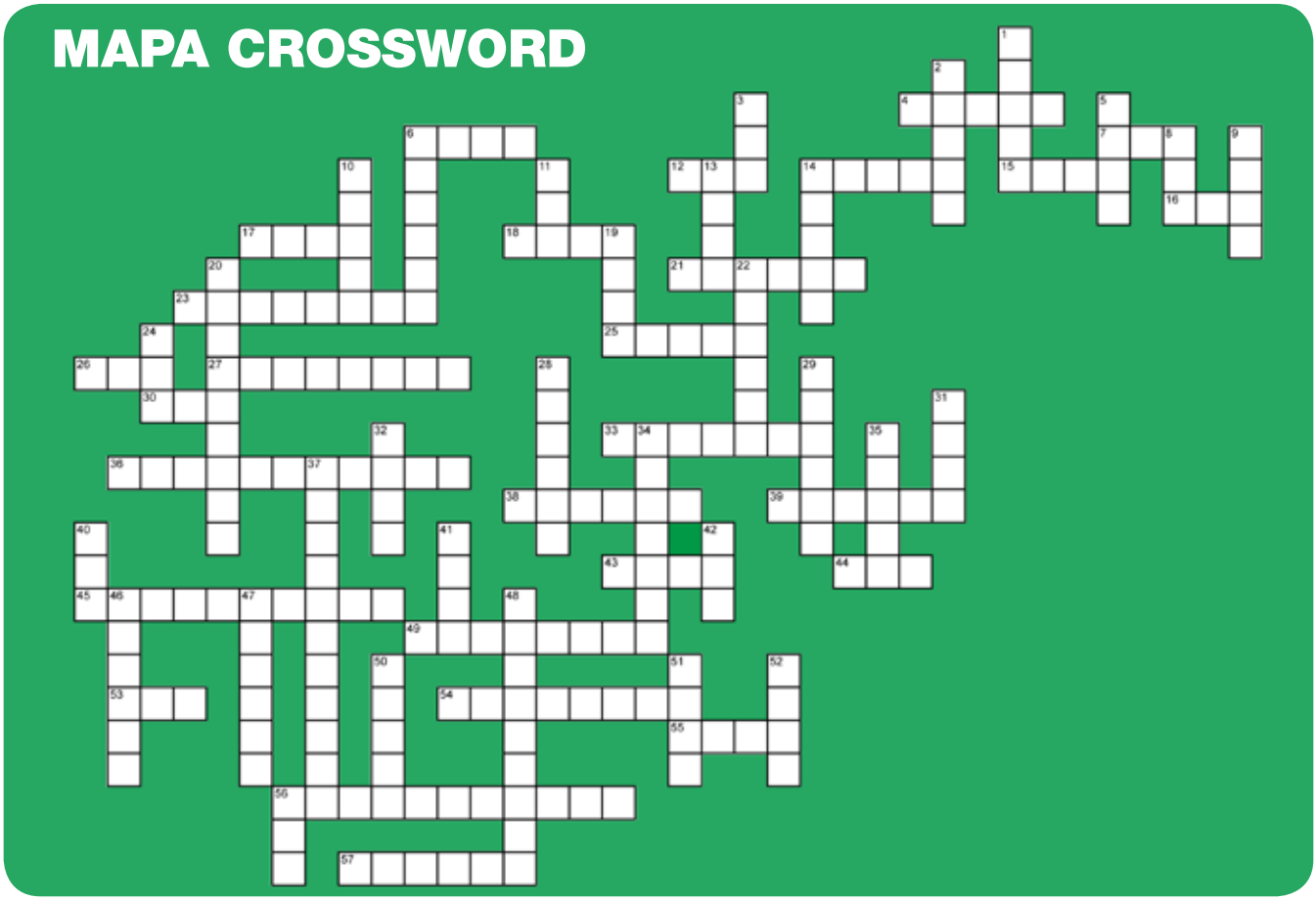
Chances are, you have insured your home and car, started adding to retirement savings, and likely purchased health insurance. You have thoroughly reduced the chance that **others will not get paid** if something bad happens to you or yours. Isn't it time you do the same for yourself?

If you have individual disability income policies, review them. Maybe even call a professional to accelerate your learning curve and better understand what is covered or excluded. If you don't already have coverage or enough of it, **disability income provides cash** to you and your family, if you are unable to work because of any injury or sickness, job related or not. To be eligible for purchase, you need to be actively working in your profession.

Policies include both individual and employer group plans. Once purchased, individual rates and benefits are typically frozen for the rest of your career. Similar to health insurance, new policies typically cost more and cover less; often much less than their predecessors, which is why existing policies are seldom replaced. New plans are purchased for additional layers of coverage.

Most professionals prefer to maximize individual policy limits at the earliest age, when they are in the best of health. Employer benefits only should be considered as supplemental to personal coverage's' within your control. Employer benefits are typically left behind when changing jobs. Disability insurance is the only investment that expands in value exactly when the unexpected happens and insulates your future earnings from shrinkage. **Can you really live without it?**

# MAPA CROSSWORD



## ACROSS

4. Keeps the beat
6. Pepper's mate
7. Newest school
12. MI PA school
14. PAC exam
15. Dialysis reason
16. Radiology test
17. Chart note
18. Air exchanger
21. Before Leo
23. BPH tissue
25. Bladder fluid
26. BLS core
27. Patient reservoir
30. Techno chart
33. Hospital patron
36. Listening tool
38. Political fundraiser
39. Prevalent cancer
43. Skin abbrev.
44. Allergy specialist
45. Yearly event
49. Protagonism
53. Abbrv. Heart attack
54. Identify problem
55. Now!
56. Necessary PA paperwork
57. Chemical #23

## DOWN

1. You've got some _____
2. _____ pitch
3. MI PA school
5. Childrens' service
6. Surgical thread
8. MI PA school
9. Deoxy blood conduit
10. Don't talk rules
11. MI PA school
13. State
14. On-call device
19. MI PA school
20. Joint Inflammation
22. Beveled poker
24. Test for #23 Across
28. Radiology test
29. Blood conduit
31. Heart ____
32. Morse _____
34. M _____PA
35. _____ teaser
37. Year MAPA started
40. Certified credentials
41. PPI Treatment
42. Cat I Credits
46. 1:4 availability
47. Daily hospital event
48. Heart arresting ion
50. Lab test sample
51. Physician-PA ____
52. National
56. Recurrent admission Dx

Quote:

*"The most powerful weapon on earth is the human soul on fire."*

Ferdinand Foch , 1851 - 1929

French soldier and military theorist

# Antioxident Rich Foods

Many studies have demonstrated that including foods rich in antioxidants help protect our cells from free radicals. But what are free radicals and why is this important? To answer this, we need to review basic chemistry. Our body's cells are made up of different types of molecules. These molecules are made up of one or more atoms that are then joined by chemical bonds. These bonds want to be strong; however, in molecules that are weak, the bond splits, leaving the molecule with unpaired electrons. It is when these weak bonds split, that free radicals are produced. Free radicals are unstable and make every attempt to develop strong bonds. Because of this, they react quickly to seek out bonds with other electrons to regain stability. You can think of it as "stealing" the closest stable molecules electron. By "stealing" the electron, another free radical is formed; that too, will seek out another electron to steal, creating a cascade of free radicals. This spiral can cause damage to the DNA of the cell and ultimately cause cell death. The cells are equipped to handle this insult; however, when coupled with external factors (i.e. environmental toxins like cigarette smoke or pollution); the body's natural production of antioxidants is quickly overwhelmed. Studies have shown that this cell damage leads to aging, cancer, chronic diseases (Parkinson, Alzheimer's) and cardiovascular disease, to name a few. One way to help combat this domino effect is to consume foods that are high in antioxidants.

There are a variety of fruits, vegetables and nuts that are good sources of antioxidants; they also include vitamin A, E and C, nutrients like beta-carotene, flavonoids, polyphenols and selenium. The best way to enrich your diet with antioxidants is to recognize antioxidant-rich foods and make a habit of incorporating them into meals. Good sources of antioxidants include:

1. ***Berries*** – these little antioxidant powerhouses can be added to your cereal or yogurt in the morning, make a tasty snack any time of the day or can be added to salads for a pop of flavor. Examples of antioxidant berries include: blueberries, cranberries, strawberries, raspberries and blackberries.

2. ***Beans*** – a great source of protein and fiber, but also a good source of antioxidants. Types of antioxidant beans include pinto, kidney, black and red. Beans are excellent additions to salads, soups, stews or as a side dish.

3. ***Apples*** – not only a healthy snack, but antioxidant-rich. Examples include: Granny Smith, Gala and Red Delicious.

4. ***Spices*** – cinnamon, cloves and oregano can be added to food preparation for an antioxidant boost.

5. ***Artichokes and Russet potatoes*** – both have antioxidant properties.

6. ***Nuts*** – hazelnuts, pecans and walnuts are rich in antioxidants.

An important note is that preparation does affect the antioxidant value of the food. As one might imagine, unprocessed foods have the most antioxidant bang. Since cooking diminishes antioxidant content, make sure to include raw sources of antioxidants whenever possible for the biggest benefit.

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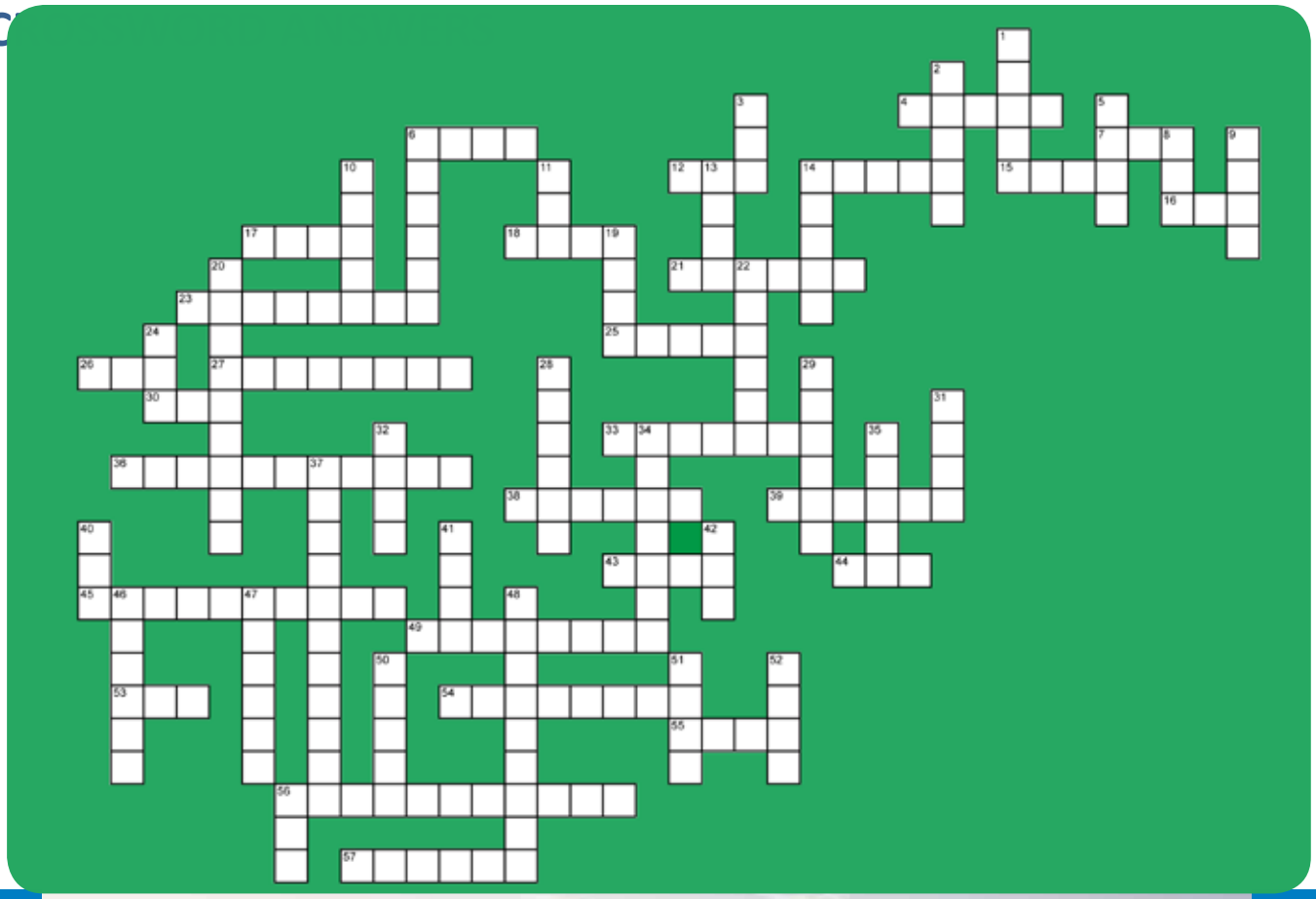


# What Is Obesity?

Obesity was once associated with affluence, fertility and royalty, but today it has become a global problem. According to the World Health Organization (WHO), in 2005 approximately 1.6 billion adults ≥16y/o were overweight and at least 400 million adults were obese; at least 20 million children under the age of 5 years were overweight. Experts believe if current trends continue that by 2015, approximately 2.3 billion adults will be overweight and more than 700 million will be obese. Obesity is a leading preventable cause of death worldwide and one of the most serious public health problems of the 21st century.

## Consequences and Health Risks

Obesity is a concern because of its implications for the health of an individual, as it increases the risk of many diseases and health conditions, including:

- Coronary Artery Disease (CAD)
- Type II Diabetes
- Cancers (endometrial, breast, and colon)
- Hypertension
- Dyslipidemia
- Stroke
- Liver and Gall Bladder Diseases
- Sleep Apnea and respiratory problems
- Osteoarthritis
- Gynecological problems

From these conditions listed above, life expectancy of an obese individual will be reduced. On average, obesity reduces life expectancy by six to seven years; a BMI of 30-35 reduces life expectancy by two to four years and a BMI >40 reduces life expectancy by ten years. In the U.S., roughly 300,000 deaths per year are directly related to obesity. For male patients with a BMI >40, life expectancy reduces as much as 20 years and for women with a BMI >40, five years.

To define overweight and obesity in the adult and adolescent populations, there are differing methods. For the adult population, overweight and obesity can be defined most notably by using BMI (Body Mass Index) equation:

$$\text{BMI} = \frac{\text{Mass (kg)}}{(\text{height (m)})^2} \quad \text{or} \quad \frac{\text{Mass (lb.)} \times 703}{(\text{height (in)})^2}$$

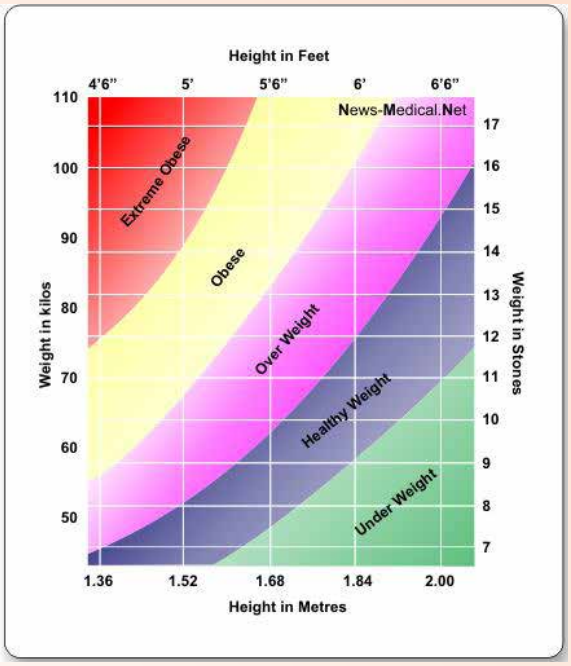
The WHO provided this table to define varying levels of BMI-

| BMI | Classification |
|---|---|
| <18.5 | Underweight |
| 18.5 – 24.9 | Normal weight |
| 25.0 – 29.9 | Overweight |
| 30.0 – 34.9 | Class I Obese |
| 35.0 – 39.9 | Class II Obese |
| 40.0 – 44.9 | Class III Obese |
| >45.0 | Super Obese |

Another method of weight evaluation is related to the fat distribution via the waist-to-hip ratio. Measure the waist at the narrowest point and divide this number by the hip measurement at the widest point. Women with a waist-to-hip ratio > 0.8 and men > 1.0 are *apples*. Does fat distribution matter? *Apples vs. Pears*- having excess fat is a concern, but where the fat is distributed has some implications. The body fat distribution patterns tend to differ in men and women. In general, women collect fat in their hips and buttocks, yielding a '*pear*' shaped figure. Men collect their fat around the belly, giving them more

of an '*apple*' shape. Apple shaped people are more likely to develop many of the health problems associated with obesity.

A third method of weight evaluation is the weight-for-height table, seen below:




The weight-for-height method does not distinguish between excess fat and muscle; as a result, a very muscular person may be classified as obese.

In children, a healthy weight will vary with age and sex. Obesity in children and adolescents is defined by a historical normal group; such that obesity is a BMI greater than the 95th percentile. The problem with this estimate of childhood obesity is that the percentiles are based on data from 1963 – 1994. These percentiles need to be updated to more truthfully reflect the population of today and reveal the serious nature of this problem.


## Causes?

Individually speaking, a combination of excessive food energy intake (poor diet) and a lack of physical activity is at the root of most causes of obesity. Other causes include- genetics, medical reasons, psychiatric illness, easily accessible and palatable diet, increased reliance on cars, mechanical manufacturing and sedentary lifestyle. Currently, 30% of the world's population gets insufficient exercise, primarily due to increase use of mechanized transportation and an increase in labor-saving technology in the home. In both children and adults, there is an association (86%) between television viewing time and the risk of obesity.

**Genetics -** As with other medical conditions, obesity is the result of genetics and environmental factors. As of 2006, greater than 41 sites on the human genome have been linked to the development of obesity, when a favorable environment is present. Some studies have looked at inheritance patterns rather than specific genes and have found that 80% of the offspring of two obese parents were also obese; in contrast to less than 10% of offspring of two parents who were of normal weight.

# What Is Obesity? *continued*

**Medical conditions** that can increase the risk of obesity include: hypothyroidism, Cushing's Syndrome, growth hormone deficiency, rare genetic conditions, eating and some psychiatric disorders. Some medications can also induce weight gain or changes in body composition: insulin, sulfonylureas, thiazolidinidiones, atypical antipsychotics, antidepressants, steroids, certain anticonvulsants and hormonal contraceptives. Stress and perceived low social status appears to increase the risk of obesity. Smoking cessation can cause individuals to gain on average for both sexes, approximately 10lbs, but has little impact to the overall rate of obesity.

Other research has looked at adipose tissue (fat) mediators (adipokines) and their role in obesity. Two such complementary adipokines, leptin and ghrelin, influence appetite. Ghrelin is a short-acting appetite controlling modulator (when stomach is empty you eat, and when the stomach is full and stretched you stop eating). Leptin is produced by adipose tissue and is secreted in response to fat stores, which mediates long-term appetite control (eat more when fat stores are low and eat less when fat stores are high). These two adipokines are peripherally produced but control appetite through actions on the CNS. Most obese individuals are thought to be leptin-resistant, even though having high levels of leptin in their body; therefore, administration of leptin would not be an effective appetite suppressant in the obese.

**Society & Culture -** As of 2008, the WHO estimates that at least 500 million adults (~10%) are obese, with higher rates among women than men; this rate increases with age. Obesity was recognized as early as the Greeks, but did not gain weight to the discussion until the onset of the industrial revolution. As the increasing wealth of developing countries occurred, so did the increasing size of the populous. During the 1950s, this led insurance companies to realize a connection between weight and life expectancy, and subsequent increases in premiums for the obese. Besides the discrimination that is associated with obesity- both socially and economically, there are significant medical costs associated to obese individuals. In 2005, estimated costs attributable to obesity in the U.S. were $190.2 billion or 20.6% of all medical expenditures. In the past 30 years, the percentage of American adults who are obese has doubled, yielding a sharp rise in chronic medical conditions as diabetes, heart disease and hypertension. This rise has serious ramifications for health spending; annual health costs for these obese individuals are more than $2700 higher than for non-obese people. According to projections, if obesity continues to expand, about 42% of Americans may end up obese by 2030.

**In June of this year, the American Medical Association (AMA) decided to recognize obesity as a '*disease*', requiring a range of medical interventions to advance obesity treatment.** Previously, the AMA and others had referred to obesity as "*a major public health problem*."

## Numbers

The per capita dietary energy supply (or the amount of food bought) varies markedly across the world. The U.S. had the highest supply at 3754 calories per person in 2003, followed by the Europeans at 3394 calories and the lowest was in sub-Saharan Africa with 2176 calories per person. Most of the extra food energy came from an increase in carbohydrate consumption rather than fat consumption. The primary sources of these extra carbohydrates were sweetened beverages (accounting for almost 25% of daily food energy in young American adults) and potato chips.

**From 1971 to 2000, obesity rates in the U.S. increased from 14.5% to 30.9%.**

## Childhood Obesity

If the adult obesity problem is such a concern, the fact that childhood obesity rates have doubled in children and tripled in adolescents over the past 30 years (6% to 18%) is to say the least, alarming. Studies revealed that children and adolescents, who are obese, are likely to be obese as adults; they will also be more at risk for adult health problems. Obese adolescents are more likely to have pre-diabetes,

are at a greater risk for bone & joint problems, sleep apnea and social and psychological problems (poor self-esteem and stigmatization). Most childhood obesity stems from poor nutritional choices and inactivity. Children have had easy access to fats, sugars and other carbohydrates at home, school and in public settings. Having an after school snack of chips and pop or buying unhealthy products from school vending machines, couple that with little to no physical activity (social media or TV watching/gaming) and the problem grows.

## What is the Problem?

A 2011 survey of U.S. high school students revealed some alarming facts:

- 13% of students were obese
- 5% did not eat fruit or drink 100% fruit juices during the 7 days before the survey
- 6% did not eat vegetables during the 7 days before the survey
- 11% drank a can/bottle/glass of pop ≥3 times per day during the 7 days before the survey
- 48% did not attend physical education (PE) classes in an average week, while in school
    - 32% watched TV ≥3 hrs/day on school days
    - 31% used computers ≥3 hrs/day on school days

## What are the Solutions?

- Better health education: the government has incentivized schools to have students to receive instructions on health topics, nutrition & dietary behavior and physical activity topics.
- Physical Education and physical activity: requiring students to take and participate in PE and not allow students to be exempt from PE for certain reasons.
- School Environment & Nutritional Services: encourage students to purchase fruits/vegetables as alternatives to candy or foods high in fat, sodium or added sugars. Remove unhealthy snacks and pop from vending machines and replace these products with healthy nutritional alternatives.

## Prevention

Healthy lifestyle habits of healthy eating and physical activity can lower the risks of becoming obese and associated diseases. The dietary and physical activity behaviors of children/adolescents are influenced by many sectors of society: family, communities, schools, medical care

# What Is Obesity? *continued*

providers, religion, government agencies, ***the media and marketing of foods & beverages***, and the entertainment industry. Children will follow the lead of their parents, peers and role models, so having a dialogue with children will help to instill healthy choices and ideals. Schools also play a critical role by establishing a safe and supportive environment, giving students an opportunity to learn positive choices and engage in physical activity.

## So What Needs to be Done?

If obesity continues to grow at its current rate in the U.S., about 42% of Americans may end up obese by 2030. This will only add excess weight to the overall health care bill and exacerbate obesity-related diseases. There is no magic pill, diet or procedure; it takes many factors to decrease the upward trend of obesity in the U.S. The culture and mind-set regarding their health concerns needs to change before we will see a decline in obesity rates.

The main focus of treatment of overweight/obesity revolves around dietary and physical exercise. Americans spend billions of dollars a year on pills, diets, exercise and weight-loss products. Diet programs will produce weight loss over the short-term, but the key is maintaining a program for life-long weight control. It often requires a continued healthy food choices thinking and making an effort to exercise regularly and permanently change a persons' lifestyle. Medications available for weight loss include: Xenical, Belviq or Qsymia, but these only give a modest 5-10lbs weight loss and can have some side effects. The most effective treatment for obesity is bariatric surgery. Surgery for severe obesity is associated with long-term weight loss and decreased overall mortality. One study found a weight loss of 14% to 25% (procedure dependent) at 10 years; however, costs and surgical risks can be significant.

Obesity is difficult to treat and has a high relapse rate, greater than 95% of those who lose weight, regain the weight within five years. Even though the short-term 'fix' of medications and diets can help in the treatment of obesity, a life-long commitment to proper diet habits, increased physical activity and regular exercise is the solution. The goal of treatment should be to achieve and maintain a 'healthier weight', not necessarily an ideal weight. Even a modest weight loss of 5% - 10% of initial weight and the long-term maintenance of that weight loss can bring significant health benefits; lowering blood pressure and the risks of diabetes and heart disease.

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## WHO AM I?

**- S/Sx: Most occur within 24 hours- shoulders in divers and legs in flyers**
**- S/Sx: Aphasia, personality changes, HA, scotomata**
**- Skin S/Sx: rashy marbling of torso, formication**
**- Nitrogen is the main culprit**
**-Treatment: 100% oxygen, immediate HBO2, copious fluids, aspirin**

*(answer in next 'MichiganPA')* *(previous $Q_3$ answer: Fibromuscular Dysplasia)*

QUARTERLY QUIZ QUESTION

# www.michiganpa.org


'Be sure to check out the NEW MAPA WEBSITE at **www.michiganpa.org**. There are many useful bits of information that can be of a benefit to you as a Michigan PA!'

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