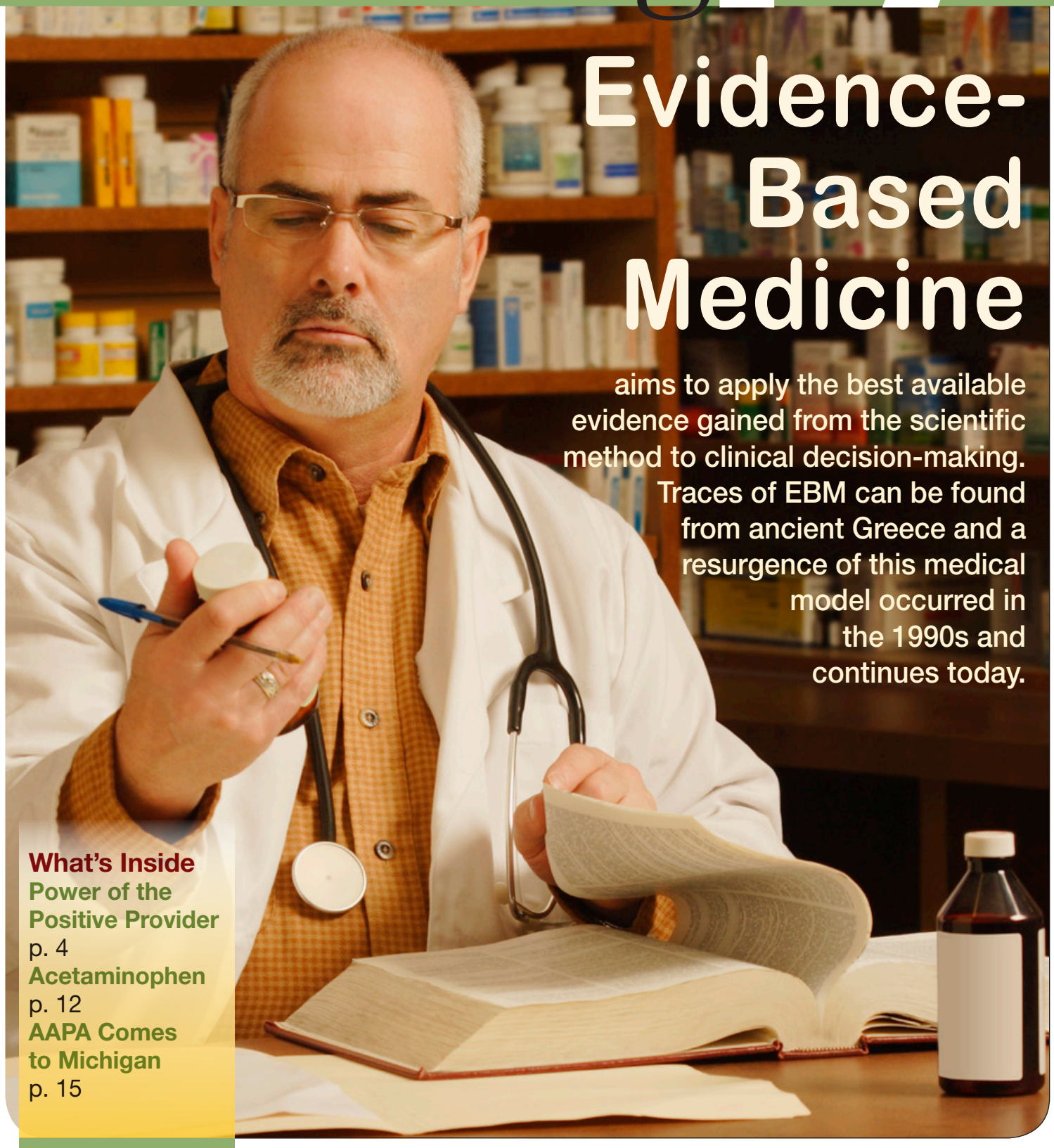
June 2012

The Only Informational Resource for Michigan Physician Assistants

Michigan PA



Evidence-Based Medicine

aims to apply the best available evidence gained from the scientific method to clinical decision-making. Traces of EBM can be found from ancient Greece and a resurgence of this medical model occurred in the 1990s and continues today.

What's Inside

www.michiganpa.org

MichiganPA

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

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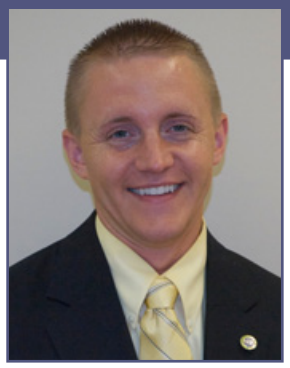
MAPA's Mission

The Michigan Academy of Physician Assistants is the essential resource for the Physician Assistant profession in Michigan and the primary advocate for PAs in the state.

MAPA's Vision

The Michigan Academy of Physician Assistants is committed to providing quality, cost-effective, and accessible health care through the promotion of professional growth, enhancement of the PA practice environment, and preservation of the PA/physician team concept.



Brian M. Gallagher, MSPA, PA-C

The Year in Review

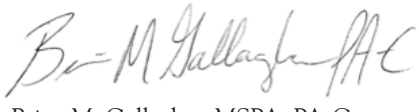
It has truly been an honor to serve the members of the Michigan Academy of Physician Assistants and the physician assistant profession during my year as President of MAPA. I have had the privilege of meeting many extraordinary PAs and students from across the state. Your volunteer Board of Directors has worked diligently advocating for the Academy and the PA profession. As I enter my last couple weeks as President, I want to take a moment to reflect on the past years' accomplishments:

- 2011 Fall CME Conference – Growing as the best CME Conference in the Mid-West Region thanks to the hard work of the CME Committee and Chris Noth. The conference also helped Camp Quality Michigan, held one of the biggest fundraising evenings in PAMPAC history and supported the MI PA Foundation.
- Launched a completely renovated, fresh and relevant MAPA Website
- Public Act 210 of 2011 – On November 6, 2011, Governor Rick Snyder signed legislation developed in concert with our physician partners that allows a physician to delegate to a PA- the full prescribing of Schedule II medications, rounds on patients in hospitals, nursing homes, extended care facilities, the ordering of restraints and the ability to sign forms requesting physician signature. It also places both the physician and PAs name on prescription bottles.
- THREE full days of Strategic Planning that resulted in a clear direction for MAPA's future and a fully fleshed out and developed Strategic Plan that provides the steps for our progression.
- Association Management Resources – In January 2012, MAPA began a new relationship with AMR, hiring the company to manage the day-to-day business of MAPA, assist with conference planning and execution and serving as the cornerstone of the future for MAPA membership.
- The leaders of the Michigan State Medical Society, Michigan Osteopathic Association and Michigan Academy of Physician Assistants met for the second time in two years to address the looming physician shortage and the future of medicine in Michigan.
- 2012 Spring CME Conference – After suspending the Spring CME Conference last year, MAPA held a successful Spring CME Conference with leaders from AAPA in attendance.
- AAPA/MAPA Listening Session – In May, AAPA and MAPA held a Listening Session on the campus of Wayne State University to hear the concerns facing PAs today and how the organizations can help in the future.
- Executive Succession Planning – Thanks to Dan Ladd's leadership and the hard work of MAPA's Past-President's, MAPA now has policy in place to handle the emergency transition of power for the Executive Director/Lobbyist positions and for the planned retirement of current Executive Director and Lobbyist, Michael DeGrow.
- SB 1145– Introduced this year by Sen. James Marleau, this bill makes the D.O. section of the current law match the M.D. section in regards to PAs and also removes the ratios on how many PAs a physician can supervise.

MAPA's progress over the last year was exciting, however, there is still much work to be done; I encourage each of you to get involved in MAPA. Whether you serve on a committee or run for office, this organization offers rewarding experiences that allows you to help improve the PA profession for all Michigan PAs. Time spent with MAPA is an investment in your future and this is the ONLY organization that solely focuses on your ability to practice medicine in the state of Michigan.

It is with great honor and respect that I turn the reins over to President-Elect, Ron Stavale and I thank each and every one of you for the privilege of serving as your President.

Thank you and God Bless!



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

Power of the Positive Provider

by: Chris Slough, PA-S

It seems like it was in another lifetime, but it was really just 13 years ago. I was more than a decade away from even considering returning to school to become a PA. Instead, I was mid-career in my job as a scientist at a leading diagnostics company. My wife Marie and I had a fifteen month old son and were weeks away from receiving our second child. With a budding young family, all of our parental instincts and aspirations were running at full throttle. Like many couples, we selflessly aspired to provide a life full of opportunity, enjoyment, growth, fun, and protection to our children.

Since our first child had a large birth weight (10 lbs 5 oz.), breech and was delivered by C-section, we were planning on a scheduled C-section for our second baby. Two weeks before that date and while at work, I received a troubling phone call from my wife. Calling from her Ob/Gyn's office, crying and telling me that the ultrasound showed our baby's heart was enlarged. I drove a few blocks to the office and we met with the doctor. The unfamiliar terms "coarctation of the aorta" or "transposition of the great arteries" penetrated our ears (and hearts) for the first time. Since the baby had some form of congenital heart defect, it was decided that the C-section would be done at the Indiana University Medical Center, close to where we were living at the time.

On that day, I stood next to my wife and carefully watched the procedure. What would happen and what would we observe? Would our baby turn blue soon after the cord was cut? Would a medical crisis erupt with our child at the epicenter? Carefully, the doctor removed our new daughter from my wife's abdomen, cut the cord, moved her to a table and started evaluating and cleaning her. As far as I could tell, our new daughter had a good cry and had good color. However, it was only a minute or two before she was taken out of our sight into another room. Meanwhile, the Ob/Gyn worked to complete the surgery.

About 30 minutes later, while my wife was recovering and our daughter was still crying in a distant room, a pediatrician from IUMC came to speak with us. Sensitively, almost positively, the compassionate doctor delivered the difficult message: *"Your newborn daughter's heart is doing well. As you can hear, she has a good set of lungs and she is doing great. She displays some of the physical characteristics associated with Down Syndrome. We have ordered a genetic test to confirm this. She is a beautiful little girl. We will bring her out to you shortly so that you can begin to get acquainted with her."* His words contained an odd elixir of congratulations, difficult truthfulness, and optimism. They hit us like a velvet hammer – a shocking blow, but somehow softened. I dug through my memory banks looking for anything to help me understand what the words "Down Syndrome" might mean. I conjured up images of friendly, frumpy, mentally disabled bus boys in restaurants. Was that Down Syndrome? Or, more encouraging, Chris Burke from the TV show "Life Goes On." For the most part, memory banks were empty and the meaning of these words were disturbingly unclear. Our expected future had been changed, but what had it been changed too? Yet, somehow in that moment, the unspoken perspective of the doctor was one of hopefulness and joy affirming in one moment our daughter's value and our capacities as parents to meet whatever lay ahead. While he communicated truthfully difficult news that would certainly require some processing, his words did not carry unwarranted gravity or any sense that "something awful has happened." His words, or more importantly, his conveyed perspective, provided a great launch into the world of parenting a child with special needs.

I have often reflected on this patient-provider interaction. It was so superior to the way other families of kids with disabilities have received "the news." A generation ago, new parents would have likely heard talk about "not getting attached," "institutionalizing the child," or having a "mongoloid." While fortunately that crassness seems rare today, I have still heard stories of providers whose words and tones conveyed that the child with a disability is a sub-person, an error, a disappointment – something they are sorry about, which is inappropriate. The reality is that a person with a disability in any form, whether it is from an extra chromosome or from loss of a previously viable function, such as from a stroke or an accident, carries all of the rights, worth and dignity of any human being.

While relatively few people become "special needs parents", many, many people will receive some form of "the news" from their health care provider. It may be that the chest x-ray of the person with persistent cough shows a suspicious "coin lesion", or that the MRI of the patient with recent onset of double vision, impaired coordination and incontinence shows white matter plaques. In these moments where the patient is cast into a future of great uncertainty, both what the provider says and how they say it are tremendously important in helping the patient interpret what they are facing. At these times, both the words we providers use and the unspoken perspective that we hold will become hugely important.

Certainly, not all forms of "the news" offer the possibilities present at the birth of a new child. However, since none of us know the future with certainty or the depths of resource another person can summon, we can have some optimism and confidence when we approach patients facing challenging new diagnoses. Even in the midst of unfavorable prognoses, we can approach patients with some sense of hope and confidence that they and their families can navigate the uncertain journey into their future.

As I reflect on the doctor's words and attitudes communicated on the day our daughter was born, clearly, there is no mystery how he knew that my daughter had 47 chromosomes. But what I don't understand is how did he know that this girl would capture her daddy's heart? How did he know of her mischievous sense of humor; her relative academic strength; her penchant for creating nicknames for family members (like calling her grandfather with peripheral neuropathy "Purple Feet")? How did he know about daddy-daughter dates and dances? Obviously, he did not know the specifics of these things, but rather bet on the side of our daughter's inherent value and our capacity to embrace our new, unexpected situation of a child with some unique challenges. He trusted that unexpected destinations can be every bit as rich as those reached by the best laid plans.

Thirteen years have passed since that physician gave us a favorable report on our new daughter. His words and the high, hopeful trajectory they seem to convey were the important starting point of a rich and challenging journey. As I prepare to be launched into service as a PA, the above example reminds me of important aspects of "giving care." While it is

essential to give clinically accurate information to patients, it is important to do so in a way that conveys a helpful and beneficial attitude toward what they are facing. It is important to sensitively and compassionately hold optimism that patients can rise to the occasion and constructively face the new circumstances before them. Will all patients appropriately rise? No… but, through our confidence, they can follow a constructive pathway through their present challenge and whatever assistance onto that path that we can give, we will be doing what is in our power to give very good care.

Chris Slough is a physician assistant student at UDM in his clinical year and will graduate in August.

Evidence-Based Medicine:

How to Use it in Practice

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

"Evidence Based Medicine," no doubt a phrase you've heard over and over in recent years. We see it pop up in POEMs, journal articles and from our administrators with changes to practice guidelines; but what is Evidence Based Medicine (EBM)? It is "the conscientious, explicit, & judicious use of current best evidence in making decisions about the care of individual patients" (Sackett, 1997). When we are using EBM, we are integrating the best research evidence with our clinical expertise and our patients' unique values and circumstances. The push for EBM in our practice has come because of inadequacies of traditional sources of information (i.e. outdated textbooks and articles that can be so great in number, we are overwhelmed in searching) and disparity between our diagnostic skills, clinical judgment, etc. We also work in a fast paced world and there is often little or no time to spend sifting through the information we look to for answers. And of course, EBM has been necessary to help with improving the quality of care to our patients.

How do we practice EBM? We can break this down into 5 steps:

1. Converting the need for information into an answerable question.
2. Tracking down the best evidence with which to answer that question.
3. Critically appraising that evidence for its validity, impact and applicability.
4. Integrating the critical appraisal with our clinical expertise and with our patient's unique biology, values and circumstances.
5. Evaluating our effectiveness and efficiency in executing steps 1-4 and seeking ways to improve them both for next time.

So we start with a question and I suggest using a "PICO" question. A PICO question is a foreground question that asks four parts: P-a Patient situation, Population or Problem of interest; I-the main Intervention (i.e. test, treatment, etc); C-Comparison of the intervention or exposure with another intervention if relevant; and O- clinical Outcome of interest, if relevant. An example PICO question would be as follows: 'When treating otitis media in children with an amoxicillin allergy, is treating with antibiotic drops better at resolving infection than oral azithromycin?'

Now that you have a well-formed question, the next step is to search for an answer. There are many places one could look to find an answer; but not all sources are helpful or evidence-based. Many courses on EBM preach a hierarchy or pyramid of sources. Most will agree that textbooks (unless online and updated frequently) are outdated, often by the time they go to print and there are too many articles out there to efficiently sift through for answers to our PICO questions. So the best place to look is the top of the pyramid, Systems (Systems are the ideal, but often don't exist). They are computerized supports systems built into Electronic Medical Records (EMR) systems which help point to the most up-to-date evidence for healthcare. So, because most of us don't work with such systems in place, often the most useful sources are Summaries. Examples of Summaries include evidence-based online textbooks (i.e. MDConsult, FirstConsult, UpToDate.com, etc.). If you don't have access to one of these sources (need subscriptions), Synopses of Syntheses are the next best choice. These sources are sites online that review several articles and give you a summary of the evidence that has been analyzed by experts and peers. A good source here is the Cochrane Library; an internet search for Cochrane Library often gets you to the site.

We live in a mobile world and many of us carry a smart phone of some type with apps that use EBM as well and can make our research very efficient in practice. Many that I use to reference questions are FirstConsult (subscription needed), UpToDate (subscription needed), Epocrates (free or subscription). There are countless more, but always look to see if topics are updated frequently and if the information is peer reviewed.

When you can't find what you are looking for in a higher tier source for information, individual studies will do, but you will have to appraise the article to see if the information is useful and if the findings are valid. A pharmaceutical representative will have a bias about a drug trial that yields a positive effect for their drug. I hope you are able to keep up with the ever-changing world of medicine and follow the evidence easily with mobile apps and internet sources listed above. PA

R. David Doan III, MS, PA-C *is a physician assistant at ProMed Family Practice in Portage and Richland. Dave also teaches part-time at WMU's PA program and is the MAPA Region IV Representative.*

Quote:

"A small body of determined spirits fired by an unquenchable faith in their mission can alter the course of history."

Mahatma Gandhi 1869-1948
Ideologist and Political Leader of India

Michigan PA Students Attend Cap Conn 2012

By Ashley Davis, PA-S WSU, Sarah Pankow, PA-S GVSU and Eric Kreckman, PA-S CMU

This past March, the 2012 AAPA Capitol Connection Conference was held in Washington D.C. Three Michigan PA students attended and represented the voice of students from across the state. From Central Michigan University, first year student Eric Kreckman, Grand Valley State University was represented by their MAPA student representative Sarah Pankow and Wayne State University was represented by first year student Ashley Davis.

In the midst of a busy semester, we had the privilege to represent our peers and the opportunity to attend workshops in order to build our understanding of the intricacies and immense responsibilities that our senators and representatives encounter on a daily basis. In addition, we had the honor to hear from AAPA President Robert Wooten, PA-C as well as the first physician assistant in congress, Karen Bass, PA-C, who both passionately spoke about the importance of lobbying for our profession. The workshops and lectures taught us about the issues pertaining to the PA profession; including Title VII for PA program funding, PA incentive payments for electronic health records, PA reimbursement for hospice care and compensation for on-the-job care provided to Federal workers by PAs. Beyond the experience and knowledge gained from the informative lectures and the inspiring speakers, having the opportunity to lobby our representatives and senators in D.C. was an invaluable experience.

Our group met with nine congressmen/women from Michigan; they listened to our concerns and were very receptive to the PA profession and the issues that we presented. Attending a national conference and lobbying for a profession that we are not officially active members of can be an intimidating experience for a student. However, once the conference began, our confidence was quickly restored. Numerous speakers pointed out the impressive number of students in attendance and the importance of students taking an interest in the profession. The staff of the congressmen/women was also very pleased to have students present, in addition to the practicing PAs. As students, it is essential that we take an active role in order to show that the issues at hand are truly important and meaningful to the future of the PA profession. The representatives' staff also expressed how excited and appreciative they were to have constituents of the profession take the time to lobby. The staff often indicated how crucial it is that we lobby our representatives and senators so that the important role of current and future PAs is not forgotten amidst the myriad of issues being presented in Washington.

If PAs and PA students lack an interest in the future of our profession, why should our congress listen to our concerns? Patients are relying on physician assistants to advocate for them in order to have better access to care. The future of our profession is in our hands; we are the only ones who will work to improve our scope and abilities. The advancement of the PA profession from the trenches of war to where we are today would not have been possible if PAs had not spoken up for their profession. The information presented to us made this experience invaluable and we hope that through having had this opportunity, we can encourage others to pursue ways to become involved in the future of their profession as a physician assistant.

WHO AM I?

I function normally, but have a bulge
Stress is a large contributor to my development
I'm pumped up on adrenaline and hence, cause chest pain
Ice debris from a Red Wings' game goes into my 'octopus pot'
I am simply referred to as a 'broken heart'.

(answer in next 'MichiganPA') *(previous Q_3 answer: Scurvy)*

"Is the Grass Truly Greener | on the Other Side?"

PART 1

It's the question everyone wants to know the answer to, but is not to sure where to get the much needed information in order to make that informed career decision when choosing or changing employers. Especially when at a quick glance there might not be differences between a private practice *v* hospital-based PA positions. Taking a closer look will reveal a whole different story. Based on my own personal professional experience, I can reasonably attest to the fact that the grass is not necessarily greener on either side. This article is the first of a two-part series where this subject matter from a comparative perspective, will be dissected and exposed from various angles. Hopefully, I will give you an insider's view about these two types of employment modalities encountered in the PA marketplace today.

Before we delve into the topic at hand, let's provide some basic definitions. First, let's define what ***hourly*** (aka as "non-exempt") and ***salaried*** (aka "exempt") employees means. The two employment classifications recognized and governed by the Fair Labor Standards Act (FLSA) are based on agreed employer pay structure. ***Non-exempt*** employees are typically paid by the hour and are entitled to overtime pay if they work over 40 hours a week. ***Exempt*** employees on the other hand, do not get paid overtime *per se*; normally they are paid based on an annual amount instead of hourly wages. Keep in mind that every field, every company and job is very different, so a lot of variability comes into play with respect to these predominant compensating modalities.

For this article, I will be basing my experiential observations on the ***Exempt* PA** (privately contracted by a physician or a group) and translating these into insights for you when considering potential employment opportunities as such. Highlighted will be 3 major categories, focusing on the benefits and drawbacks of each so you can make an informed decision.

Guaranteed Wages / Working Hours:

The big selling point here is the guaranteed certain dollar amount per paycheck. Moreover, oftentimes salaried positions are presented by employers to would be employees as if the position implies a "higher status" type than the hourly paid job. An upside of this is that technically you could work for less than 40 hours –if you're having a slow day or week-- and yet still be paid for forty. Well… this is seldom the case in a hurried medical practice nowadays where PAs are utilized.

The reality is that you could work many more than the forty hours most folks usually work; the employer has already figured this out. For instance, if you worked 55 hours one week, your employer gained 15 hours of your

overtime at zero cost to them. If you routinely work over 40 hours weekly, then your "high pay salary" wouldn't be as attractive when broken down on an hourly basis.

The Benefits Package:

As a rule (and in my opinion) most medical private practices exceeded my hourly counterpart employers when providing a non-salaried comprehensive competitive benefits package. In my early and recent past employment salaried experiences, my employers provided their salaried staff with generous perks in many categories. A significant benefit of this working arrangement was receiving quarterly and/or year-end bonuses in addition to your actual salary. That meant extra income during the holidays or other times during the year.

Another tangible benefit was the CME monies or budget was two to three times the amount provided when compared to hourly-paid employers. Increased time off, flexible working schedules, practice investment opportunities along with better medical and/or dental insurance policies were among the many perks as an ***Exempt*** employee. Plus, better tuition reimbursement and better relocation assistance packages. This category has few, if any drawbacks.

Miscellaneous Work Issues:

Having experienced both types of employment, I must say that "work cultures" and "job security" are more tenuous or unstable for the salaried PA. Why is this so? Well for starters, you don't have much of a voice or representation if you find yourself caught or tangled in office politics. Plus, you can find yourself "micromanaged" to death by a physician or office manager. Either way, being an Exempt employee not only calls for tact and diplomacy, but strong negotiating skills when the workload appears unreasonable or the boss is critical or less supportive of your efforts or implies you're not a team player.

Sometimes if the working relationship becomes strained, chances are that you will not have much recourse or resources to mediate or arbitrate the conflict objectively. Often times what it comes down to is "their way" or "the highway". Obviously this drawback negates some of the upsides of being a salaried PA. Before you reach a definitive conclusion on this question, you must save this first article because the second article will make you ponder where the grass is greener.

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

SOURCES/LINKS/CONTACTS:

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

MAPA FALL 2012

Saturday Evening
Member's Banquet

THURSDAY EVENING
'WELCOME RECEPTION'
WITH PAMPAC

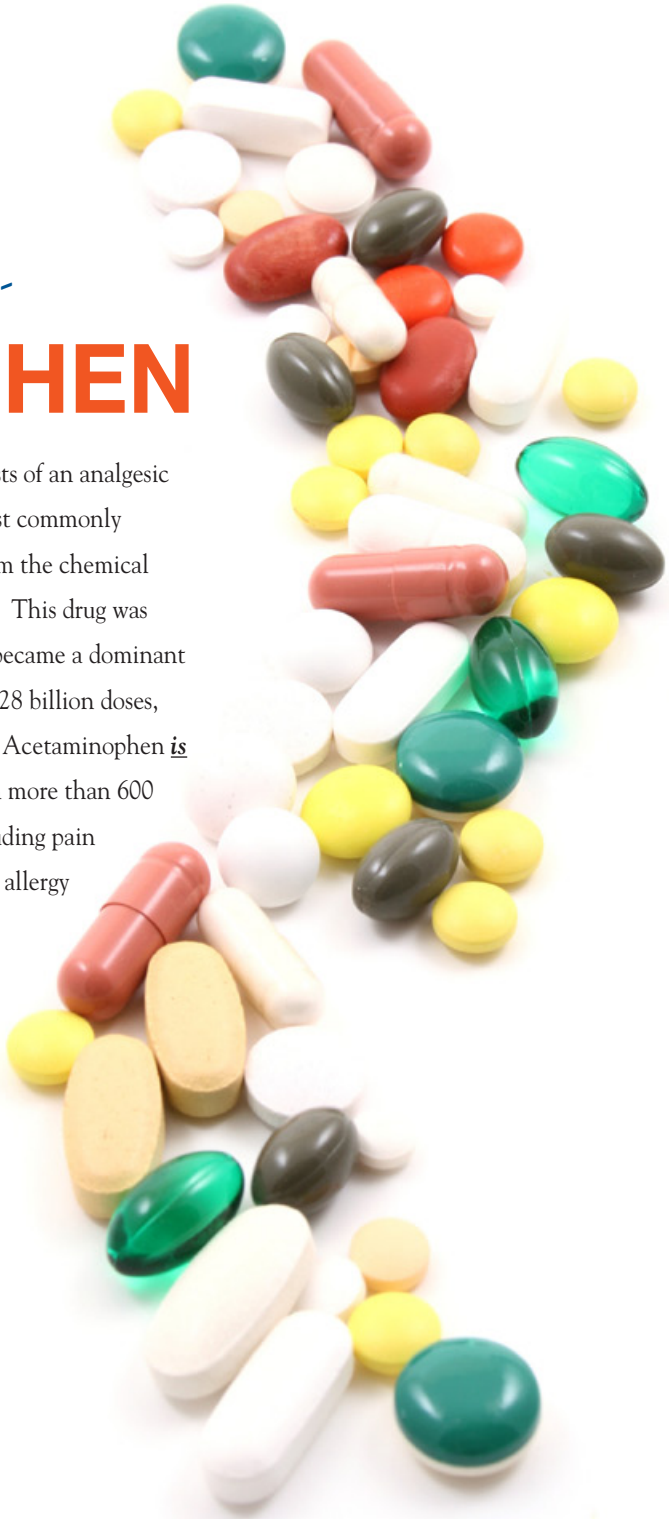
Expanded Exhibit Hall

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



It's Here, There, Everywhere-

ACETAMINOPHEN

Acetaminophen is a dual functioning medication that consists of an analgesic (pain reliever) and antipyretic (fever reducer) and is the most commonly prescribed drug in the world. The brand name is derived from the chemical name for the compound, *N-acetyl-para-aminophenol* (APAP). This drug was first developed in 1955 as an elixir for children, but quickly became a dominant pain-killer in America. In 2005, Americans consumed over 28 billion doses, 10 billion of which were OTC (over-the-counter) products. Acetaminophen ***is*** the most common drug ingredient in America. It is found in more than 600 different prescriptions and over-the-counter medicines, including pain relievers, fever reducers, sleep aids as well as cough, cold and allergy medicines.

There are many forms of Tylenol: tablets, Gel Tabs, Caplets, suppositories, chewable tablets, liquid (elixir), powder, dissolving strips and newly approved IV solution (OFIRMEVä). Below is a *partial list* of medications that contain acetaminophen. Because so many medications contain an amount of acetaminophen, you should always check the label to see the ingredients.

Common Rx that contain APAP

Endocet®
Fioicet®
Hycotab
Hydrocet®
Hydrocodone Bitartrate
Lortab®
Percocet®
Phenaphen®
Sedapap®
Tapanol®
Tylenol® with Codeine
Tylox®
Ultracet®
Vicodin®
Zydone®

Common OTC that contain APAP

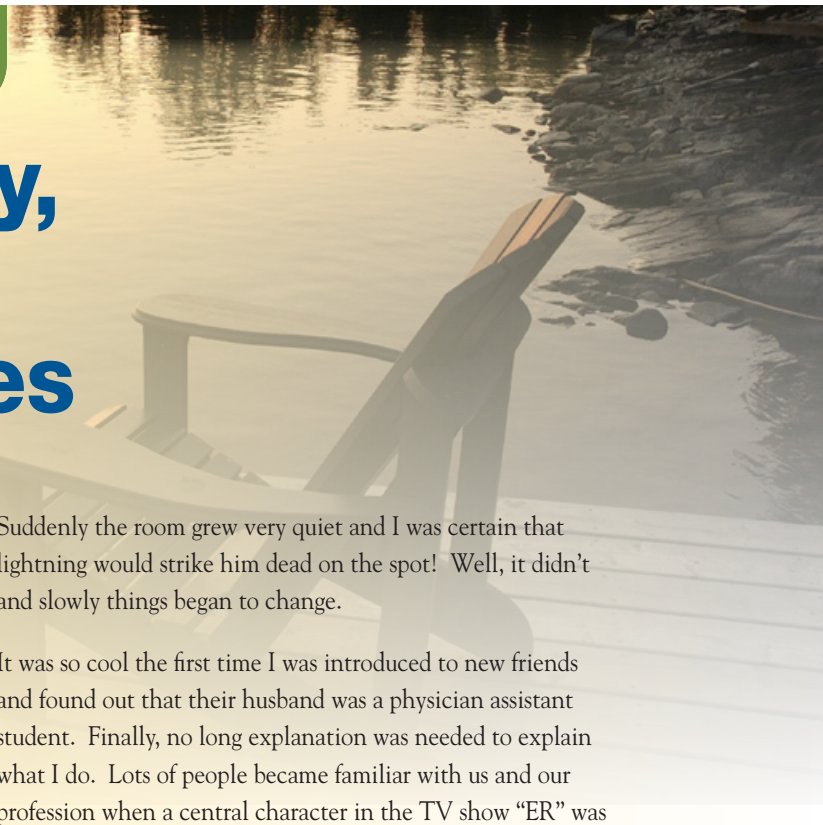
Acifed® Anacin®
Alka-Seltzer Plus Liquid Gels®
Benadryl®
Cepacol®
Contac®
Coricidin®
Dayquil®
Dimetapp®
Drustan®
Excedrin®
Feverall®
Formula 44®
Goody's® Powders
Liquiprin®
Midol®
Nyquil®
Panadol®
Robitussin®
Saint Joseph® Aspirin-Free
Singlet®
Sinutab®
Sudafed®
Theraflu®
Triaminic®
Vanquish®
TYLENOL® Brand Products
Vicks®
Zicam®

The Acetaminophen Awareness Coalition is a campaign that is trying to identify and make known, how widespread the use of acetaminophen is and identify medications that contain this as an ingredient. The website: www.knowyourdose.org has useful information to help guide health care workers and the public about the appropriate use of acetaminophen. When used as directed, acetaminophen is safe and effective, but there is a limit as to how much you can take in a 24 hour period. The current maximum allowable daily dose of acetaminophen is 4 grams (4000mg) in adults and 90mg/kg in children. Because of the unknowingly ubiquitous nature and wide spread use of acetaminophen, it has been recommended that the maximum daily dose be decreased to 3 grams (3000mg). This proposed reduction will help alleviate the chances of serious side effects.

All medications have potential side effects and dangers associated with their use. The concern over acetaminophen is in response to the over 42,000 people who are admitted each year to the emergency department for acetaminophen overdose. Approximately 50% of these ER visits are because the patients did not know how much of the drug they had been taking. Acetaminophen poisoning is the *most common* cause of acute liver failure in the U.S. (accounting for 39% of the cases) and killing more people each year then all prescription medications combined. Acetaminophen overdose in the U.S. has overtaken viral hepatitis as the main cause of acute liver failure. The toxicity of acetaminophen increases when combined with alcohol and to a lesser extent, with high caffeine intake. Symptoms of an overdose typically appear >24 hours and can be reduced by the antidote, *N-acetylcysteine* (NAC). Patients on the antibiotic isoniazid should avoid using concomitant acetaminophen and patients should be made aware that cholestyramine decreases the body's absorption of acetaminophen. Lastly, patients taking large doses or long term acetaminophen use can increase the effects of anticoagulants like warfarin (Coumadin).

> *"Acetaminophen is the most common drug ingredient and poisoning from this is the leading cause of acute liver failure."*

As with any medication, carefully read the label for proper use, dosing and ingredients; talk to your patients about the safety and efficacy of medications- *right drug, right use.*



From invisibility, to villain, to advocates

Some details of the story didn't seem right. This happens sometimes when getting medical information secondhand, you are often left with more questions than answers; but this account didn't make much sense. The story was that the trauma victim vomited *en route* to the hospital and thus required an emergency tracheotomy, which was supposedly performed in the ambulance by the EMT. As I said, I just can't buy it. But what really riles me about this mystery novel - a prime suspect is the "materialistic" and "smarmy" physician assistant![1]

What ever happened to those days of professional invisibility when hardly anyone knew who or what a physician assistant was? After graduating in 1978, the first half of each patient encounter was often spent explaining my profession, credentials and relationship to other health care providers. Introducing me as a Physician Assistant wasn't often understood. "Oh, I know someone else who is a medical assistant" was not unusual for me to hear. There were times I'd find myself hesitating after people asked my profession, because it seemed there wasn't an answer that didn't involve a lengthy discussion. As a new PA, there were so few members in our state academy, that at conferences, I'd know every PA in the room - all sixteen of them!

Our state academy didn't require a hired staff or computer; we carried all of our records around in a shoebox.

An incident that stands out in my mind occurred while serving as a member on our state licensing board. This board was comprised of physicians, PAs and public members. Not surprisingly for those days, the physicians wielded most of the power and often set the political agenda. At one meeting, a fellow PA board member finally became very frustrated. He pounded his fist on the table and stated that physician assistants in our state were licensed to practice medicine and it was about time that we stopped being afraid to say so out loud. Suddenly the room grew very quiet and I was certain that lightning would strike him dead on the spot! Well, it didn't and slowly things began to change.

It was so cool the first time I was introduced to new friends and found out that their husband was a physician assistant student. Finally, no long explanation was needed to explain what I do. Lots of people became familiar with us and our profession when a central character in the TV show "ER" was a physician assistant. As time went on, someone said to me, "PA? The person I see at my doctor's office is a PA!" Recently, a volunteer surprised me at the hospital where I work when they came up and said, "You're a PA? - I want to become a PA too." We sure have come a long way, baby!

No longer do we practice in professional obscurity or invisibility. Physician Assistants now have a history with some colleagues having been in practice long enough to retire. There are over 150 PA programs credentialed and the number of new PAs keeps growing. We practice medicine and prescribe in every state across the country. PAs are in the armed forces, urban and rural communities, specialty practices, industries, universities, on medical boards, legislatures and on staff at the White House. The PA concept has been recognized around the world and we're practicing in Canada, Liberia, Guam, the U.S. Virgin Islands and Great Britain. We have built alliances and have become advocates for comprehensive and cost-effective health care. Our professional vision of being worldwide leaders in the delivery of healthcare is being realized. People actually understand who we are and what we do. We're also popular enough that we can be casted as the villain in a murder mystery. I guess it comes with the territory.

***Barbara Wolk, PA-C** is 2-time Past-President of MAPA, from 1994-1996 and currently works as a medical house staff at Huron Valley Sinai Hospital.*

1 Fatally Flaky, by Diane Mott Davidson, 2009, Harper Collins

AAPA Comes to Michigan

In a unique effort, coordinated by the faculty of the Wayne State University and University of Detroit Mercy PA programs, the Eugene Applebaum College of Pharmacy and Health Sciences at Wayne State University welcomed the leaders from the American Academy of Physician Assistants and the Michigan Academy of Physician Assistants for a Listening Session on May 4, 2012.

A packed auditorium of PAs and PA students from Michigan, Ohio and Indiana greeted AAPA CEO- Jenna Dorn, AAPA President- Robert Wooten and MAPA President- Brian Gallagher. All were there to share experiences and concerns regarding the PA profession and its future. Questions on the name change, specialty certifications and current activities for advocacy at the state and national levels were entertained.

AAPA's Audience Response System allowed those in attendance to respond to a series of interactive questions and Wayne State University technology allowed for the event to be streamed live across the worldwide web. This allowed over 175 additional PAs to view the event and interact using MAPA's facebook page.

Overall, the event was an extreme success with both organizations appreciating the honesty of the audience and the information provided. Wayne State University proved to be an excellent host for the leaders of the national and state organizations to interact with the audience. AAPA and MAPA look forward to implementing the ideas discussed to better serve the members of their organizations and the PA profession in the future.

And the Winners are …

MAPA 2012-2013 Election Results

Thanks to all of you who submitted your votes by the June 11th deadline date.
Congratulations to the following candidates:

President-Elect
Jay Kaszyca, PA-C

Treasurer
Tom Plamondon, PA-C

Region 2 Representative
Kevin Brokaw, PA-C

Region 4 Representative
R. David Doan III, PA-C

Region 6 Representative
Barbara Wolk, PA-C

Chief Delegate
Karl Wagner, PA-C

AAPA 2012 Delegates
Jay Kaszyca, PA-C
Marc Moote, PA-C
Molly Paulson, PA-C
Jan Ryan-Berg, PA-C
Mary Huyck, PA-C
Christine Oldenburg-McGee, PA-C

AAPA 2012 Alternate Delegates
Donna Hines, PA-C
Barbara Wolk, PA-C

(All candidates are MAPA members in good standing)

PAMPAC Update

The tri-annual donations statements from the state of Michigan were posted on their web site and cover the period from Oct 2011 until April 2012. From this statement, PAMPAC ended up with a total of $5,088.77 in donations. Last year, donations were made to the campaigns of Representative Gail Haines and Senator Jim Marleau. Sen. Marleau sponsored our Senate Bill 384 which was voted into law as Public Act 210 last year. PAMPAC also made donations to Representative Jim Stamos of Midland and Mike Shirkey of Clark Lake.

All money coming into PAMPAC is used to donate to legislators who are important to or supportive of Michigan PAs. We have had a fairly successful year at MAPA regarding our legislative issues and donations to PAMPAC helped make that possible. We hope that you will continue your efforts at keeping our profession strong by donating to PAMPAC.

PAMPAC would like to thank the following PAs for their generous donations. If you have donated to PAMPAC since the 2011 MAPA Fall CME Conference and your name is not on the list below, please contact me at rxvalle@yahoo.com.

Anthony Santini, PA-C
Melissa Broeders, PA-C
Daniel Ladd, PA-C
Douglas Howell, PA-C
Eric Vangsnes, PA-C
Karen Harkins, PA-C
Sharon Smith, PA-C
Deanna Dillon, PA-C
Mike DeGrow
Gregory Mindock, PA-C
Heather Klopp, PA-C
Marie Stockdale, PA-C
Gale Easton, PA-C
Debra Knight, PA-C
James Berg, PA-C
Nancy Zucker, PA-C
Irene Wintermyer, PA-C
Jill Tallman, PA-C
Ruth McDowell, PA-C
Gregor Bennett, PA-C
Kathleen Faulkner, PA-C
William Palazzolo, PA-C
Vaughn Begick, PA-C
Marc Eichenlaub, PA-C
Rene Hernandez, PA-C
Marcos Vargas, PA-C
Jessica Wilson, PA-C
Brian Gallagher, PA-C
Jay Kaszyca, PA-C
David Doan, PA-C
Christine Oldenburg-McGee, PA-C
Melissa Glasser, PA-C
Samantha Myers, PA-C
Lydia Bolen, PA-C
Steven Mulrenin, PA-C
Phil Schafer, PA-C
Rose Marie Higgins, PA-C
Amber Gustafson, PA-C
Chris Noth, PA-C
Jennifer Eashoo, PA-C
Andrew Booth, PA-C
Jeff Collinson, PA-C
Sharon Moser, PA-C
Sue York, PA-C
Jim Frick, PA-C
Kelly Teft, PA-C
Tom Plamondon, PA-C
Donna Hines, PA-C
Theresa Radde, PA-C
Dennis Marian, PA-C
Christina Munn, PA-C
Kevin Brokaw, PA-C
James Kilmark, PA-C
Ron Stavale, PA-C

Respectfully submitted, Ron X. Stavale, PA-C
President-Elect, MAPA PAMPAC Chairperson

MAPA Reimbursement Update

MAPA members often bring specific issues and questions regarding reimbursement for physician services provided by PAs. Recently, a meeting was held with BCBSM officials to clarify the following issues.

MAPA requested clarification of BCBSM's policy regarding reimbursement for Technical Surgical Assisting (TSA) performed by PAs that are hospital employed.

Their response was that BCBSM will not reimburse for TSA services provided by hospital employed PAs as they feel that the PAs salary is already included in the negotiated payment for services provided to the hospital.

MAPAs argument against this policy is that in the case of Medicare, PA salaries have not been a part of negotiated payment for services to the hospital since 1997 and are to be billed as physician services under Medicare part B. It is also not clear that hospitals would include employed PA salaries as part of their costs in negotiation with BCBSM.

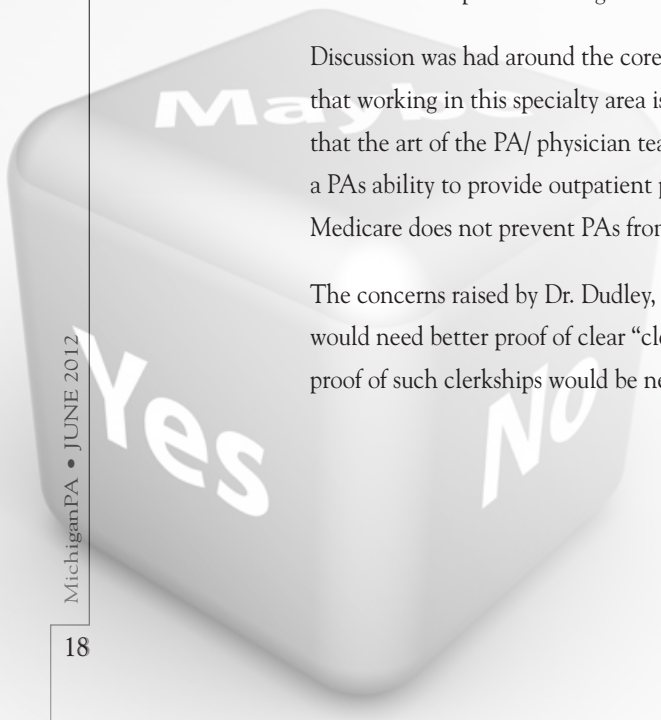
Ultimately, officials suggested that individual hospitals could request clarification with their BCBSM representatives on whether their individual negotiated payments for services include PA salaries and if not, then billing for the employed PA services may be performed. In addition, it was suggested that MAPA should work through the Michigan Hospital Association towards a possible change to BCBSM policies excluding hospital employed PAs being billed as physician services.

Clarification was requested regarding BCBSM's policy on reimbursement for outpatient psychiatric services provided by a Physician Assistant.

BCBSM clarified that they will not reimburse a practice or psychiatrist for psychiatric services provided by a PA in the outpatient setting.

Discussion was had around the core curriculum provided to PAs in the area of psychiatry and the fact that working in this specialty area is no different than working in any other specialty area. In addition, that the art of the PA/ physician team is supervision, which is required by state law and does not prohibit a PAs ability to provide outpatient psychiatric services. It was also pointed out to BCBSM officials that Medicare does not prevent PAs from providing psychiatric services.

The concerns raised by Dr. Dudley, a BCBSM medical director for psychiatric services, outlined that they would need better proof of clear "clerk ship" training in psychiatry beyond the generalist training and proof of such clerkships would be necessary. He also felt that their customer base or psychiatric physician



groups would need to express a need for PAs providing such services. Dr. Dudley was interested in more information on the fundamental training of PAs in psychiatry as well as Medicare's' policies on PAs providing outpatient psychiatric services.

Clarification was also requested on whether a PA could provide the appropriate documented weight loss visits necessary to be approved for Bariatric surgery.

BCBSM did clarify that a physician could delegate to a PA the ability to provide the appropriate necessary documented weight loss counseling/ visits necessary to be approved for Bariatric surgery.

The meeting between MAPA reimbursement officials and BCBSM was historic in that there had not been such dialogue and that it would be helpful to continue periodic meetings in the future to provide better dialogue about PA specific reimbursement policies. MAPA reimbursement officials will continue to work with BCBSM to ensure that physician services provided by PAs will be reimbursed in all facets of medicine.

James A. Kilmark, PA-C *is lead clinical physician assistant at St. Joesph Mercy Hospital ER Physician Medical Group. Jim is a Past-President of MAPA and is currently Chair of MAPA's Reimbursement Committee.*

Supporting Testimony for SB 1145

On Wednesday June 6th MAPA President Brian Gallagher and President-Elect Ron Stavale were joined by Greg Baran from the Michigan Pharmacist's Association to testify on Senate Bill 1145.

Senate Bill 1145 was introduced by Sen. James Marleau to correct the language from Public Act 210 and allow Doctors of Osteopathy (DO) to delegate to PAs, the ability to round on patients in hospitals, nursing homes, extended care facilities, etc. The SB 1145 will also remove the restriction on the number of PAs a physician (MD or DO) can supervise. The testimony was well received and we are proud to announce that the Senate Health Policy Committee UNAMIMOUSLY voted to support SB 1145 and the bill was sent to the full Senate to be taken up next week!

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

PLANNER

EVENTS / SEMINARS / CLASSES / CONFERENCES

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...'

Addiction comes in many forms- drugs, alcohol, shopping and even the late Robert Palmer sang about being 'Addicted to Love.' But in this day and age, the most prevalent addiction seems to be towards technology. Whether it's surfing the internet, communicating with people via facebook, twitter, blogging, spamming, email or conducting business on your I-pad- we are all techno-junkies. Our smart phones are just that, replacing desktop computers with 'crack-berry's' and apps galore; making us more productive, less adherent to a workspace, yet tethered to our addiction. And we don't dare leave home without it and if we do, we feel lost and insecure.

The four questions you need to ask yourself to see if you are addicted to technology are:

C- You ever felt you should cut-down on your technology use?

A- Have people annoyed you by criticizing how much you use your phone?

G- Do you ever feel guilty about texting all the time?

E- Do you feel better if you send an email first thing in the morning?

This tongue-n-cheek editorial may seem outdated to some, but is technology an addiction that we have to be aware of and not let it dictate our lives? So far, it is an elixir that we can't get enough of and is only temporizing our connectivity to others. Addictions are consuming and most people who need help have a difficult time finding their way. It takes a strong person to put aside technology for a time, but it takes a much stronger person to face their addiction and overcome it.

Chris Noth, PA-C
Editor, 'MichiganPA'
cjnoth@yahoo.com