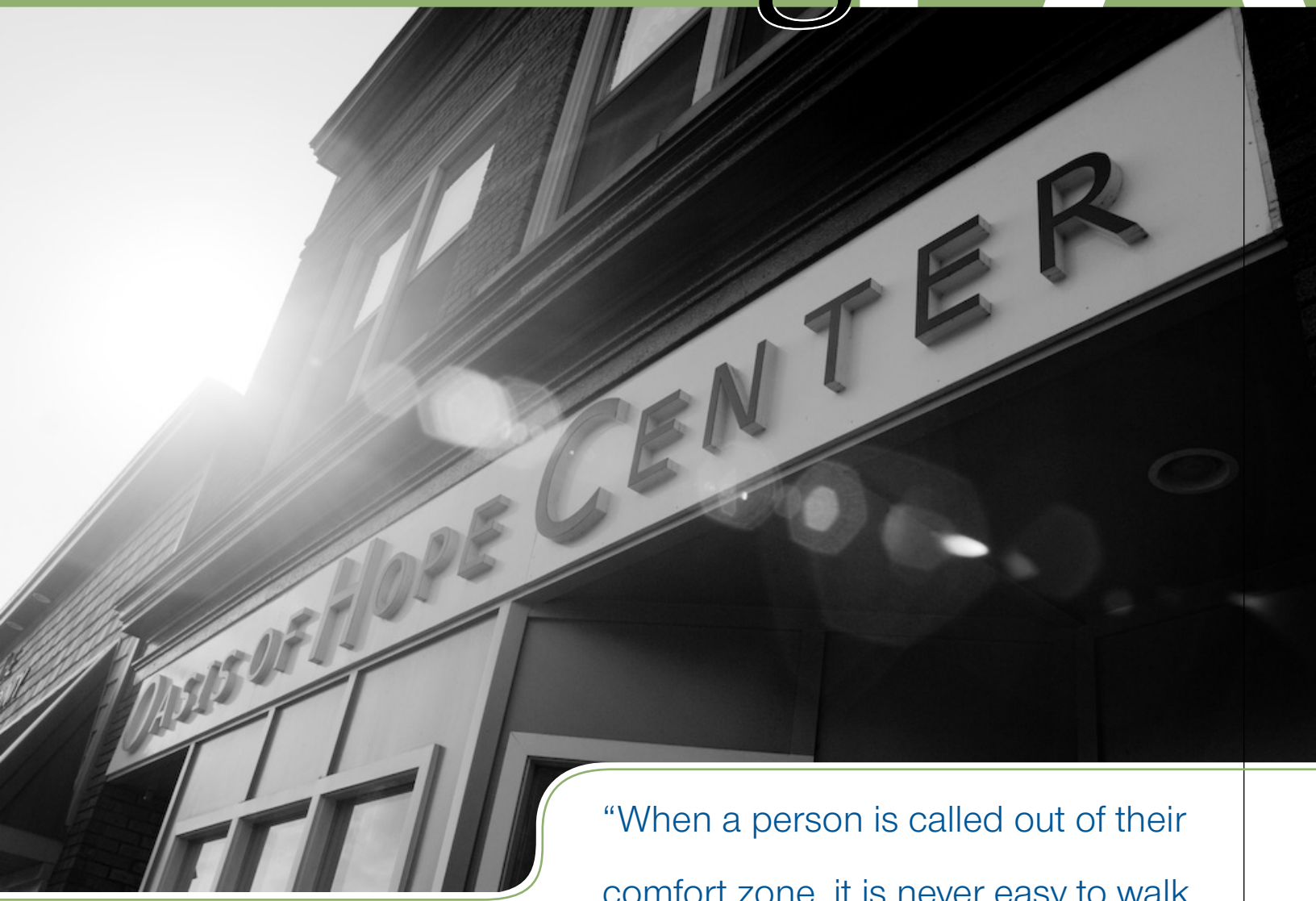
June 2010

The Only Informational Resource for Michigan Physician Assistants

MichiganPA



"When a person is called out of their comfort zone, it is never easy to walk the uncharted or unknown road, one that is stretched out endlessly, with no destination in sight. Five years ago, I took my first step..."

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What's Inside

Michigan PA
Michigan PA Newsletter
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PRIMARY CARE SERIES

This icon is the definition of a proposal that MAPA is adopting, the Green Initiative. This 'Go Green' guy will represent ideas submitted by PAs for going green. Ideas of recycling, reducing, reusing and repurposing are needed. Please submit your ideas to cjnoth@yahoo.com and the best will be nominated for an "Envy" Award.

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.

President's MESSAGE

Wallace Boeve, EdD, PA-C

A President's Reflections

Where has this past year gone? I am amazed at how quickly time continues to travel. Personally, as your academy's president, this past year has been both a humbling and exhilarating experience. As stated so well by Mark Batterson in his book, "In a Pit with a Lion on a Snowy Day", "You've got these options. You either live in an exhilarated state facing your fears, or you stay in a state of perpetual boredom." Needless to say, I was far from bored this past year. I had the distinct privilege of working alongside a team of excellent board members, who were committed to demonstrate daily routines that exuded success. Here is a small list of their accomplishments this past year:

- A successful 2009 Strategic Planning Session Board Retreat in September
- A strategic campaign to increase PA's voice and presence across the state (i.e. PA Week Activities & Rossman PR Group Contract) – to be continued
- A Legislative Committee and lobbyist who maintained strong efforts to stay connected with legislators regarding health care reform and PA practice issues (Thanks Mike DeGrow and Phil Schafer). Additionally, a well attended and highly successful Legislative Day was held recently in Lansing (Thanks Brian Gallagher, Christine Oldenburg-McGee, and others)
- A well attended Annual Fall CME conference, organized by a hardworking CME Committee, plus, the generous support showed for the 2009 AAPA Humanitarian PA of the Year, Michigan's own Julie Malacusky, PAC (i.e. The Dream Project; www.thedream-project.org).
- A historical presentation regarding MAPA's founding leaders in establishing PA practice in Michigan (Thanks Dan Ladd and John McGinnity)
- A calendar full of meetings to maintain a presence at all tables where PAs may be impacted to assure quality patient care (i.e. Michigan Health & Hospital Association, Michigan Primary Care Consortium, Michigan Department of Community Health, Michigan State Medical Society)
- A Membership Committee that has developed a plan of action to meet membership needs and increase membership participation (Thanks Committee)
- A Communications Committee and chairperson who clearly developed strategies to improve MAPA's website and refresh the newsletter, 'MichiganPA'(Thanks James Berg and Chris Noth)
- An excellent team of Regional Representatives who have actively sought to maintain quality communications with members and non-members in their respective regions (Thanks Regional Representatives)
- A concerted effort to secure and equip future leaders with the tools necessary to assure quality PA leadership in Michigan
- A leadership commitment for engaging all voices while maintaining a clear focus on the big picture, our patients

This past year has been both a humbling and exhilarating experience.

The above list is far from complete, however, all items were performed with volunteers that are humble and few in numbers, but who have made it their passion (their suffrage) to represent all PAs and assure a strong academy and profession for the future. All that was accomplished was a consummation of quality work done with efficiency and effectiveness. As stated so well by Peter Drucker, "Efficiency is doing things right, but effectiveness is doing the right things." May all of us continue to do the right things in our respective homes, work places, and for our profession; to ensure a lasting legacy for future generations. I am so thankful for the love and support which I received, especially this past year from my wife of 15 years and my three beautiful children (my future legacy). Now I leave you in the very capable and highly effective leadership hands of incoming president, Sue York. God's richest blessings to you all and thanks for this opportunity to serve you as your academy's president.

Wallace D Boeve, EdD, PA-C

Wallace Boeve, EdD, PA-C
MAPA President 2009 - 2010

by: Barbara A. Grinwis, M.A., PA-C
Co-Owner and Executive Director of OHC

PA Establishes Free Medical Clinic to Help Michigan's Underserved

In 2005, I began a journey into the unknown. After years of teaching PA students at Western Michigan University – I left education to return to clinical medicine. Not just any clinical medicine job, but a job of community service in a medically underserved area providing free health care to persons without medical insurance. The underserved area was not overseas, but right here in Michigan.

I learned as I put one foot in front of another, how to write articles of incorporation for the state of Michigan and how to write an application for 501(c)3 status with the IRS. These are not normal tasks that are required to become a PA, but were part of what it takes to create a domestic medical mission for God's glory called 'Oasis of Hope Center.'

My husband and I bought and totally refurbished a 2200 square foot store-front commercial building on a busy street in an impoverished urban area of Grand Rapids, Michigan. With the help of many volunteers and donated dollars, we created a warm, welcoming health center that honors the people that we serve. As the co-owner and Executive Director, I have a unique role as a PA, but would like to share with other Michigan PAs what "going above and beyond to deliver health care" in my part of the world looks like.

We opened the doors on April 30, 2007 and, after nearly three years of operation have recorded almost 6,000 patient visits. This is the first year Oasis of Hope Center (OHC) has been financially able to pay me a salary. This free medical clinic is not about money – we have everything we need and then some. We charge nothing for our services, people can and will give us donations if they are able.

The rewards come from seeing hope and wellness blossom as our clients discover what they are able to do to help themselves become healthy.

A couple of client stories…

Let me tell you about 'John', who was so sick when he was released from the county jail, the person releasing him encouraged 'John' to come to OHC. When he walked in, he was a rack of bones for which clothes to barely hang on and was marginally functional. After examining him, we did a random blood glucose and it was so high, it did not register on the meter. The doctor ordered a B12 injection, for which we had none at the time; 'John' was given a prescription and was to return the following week. A PA friend and volunteer at OHC arrived about a ½ hour after 'John' left with surplus medications, of which included B12 shots. And that is how God continually provides for our clients' needs. 'John' has gained 30 pounds and his diabetes is under control because we have been able to provide him with free medical care and supplies, like a glucose monitoring device, glucose strips and medication – enabling him to have hope and walk in wellness because he is not burdened by "no insurance and no money"; which is the sad state of affairs throughout Michigan.

Another client came in to OHC at the end of December and his complaint was that his eyes have been swollen for the past 3 years. Dr. Libra, our medical director, saw him and ordered a TSH, which came back severely elevated. I have never seen a case of myxedema except in textbooks; last week, after therapy, his TSH was normal and he now feels like a new person.

What has amazed me as we serve this community is how very sick many of the people are who come here. Blood pressures that used to cause me alarm for being so elevated, now are everyday occurrences. These people cannot afford an ambulance ride and the ED bill will cause them to lose so much, therefore, we do the best we can do for them with what we have.

What we encounter in our clients here at OHC is unparalled, because they pay nothing for their health care. There are people who say patients need to pay something so they take ownership of their health care, but that is backwards of what we see here. People do not come here with the idea that they are "paying us to fix them." Rather, they are told that because we charge nothing for their health care and everyone here is working for free because they care about the health of each person that comes to OHC, we expect them to be partners with us to get healthy.

Clients are told that we will help them with finding the right tools and provide what they need (if we can) without charge. For instance, we give them HTN meds and tell them their job is to check their blood pressure at various locations throughout the community and to return for a follow-up appointment. They are given a physiology lesson on how Na+Cl- takes water with it to increase blood pressure, how excess body weight, caffeine, nicotine and lack of exercise impact the vessels and organs that regulate blood pressure. Expectations of our clients are that they will quit smoking, cut down on caffeine and lose a couple of pounds by their next visit. We have very few failures, but you should see the successes! The people who return and have managed to take off a couple pounds or started exercising or have a record of their BP readings, are so excited to share what they have accomplished. They have never been given this control over their own health nor have they been told that the secret to wellness lies with them taking responsibility.

There are only 3 totally free medical clinics in the state and ours is the only PA owned and operated facility. That is not the only thing that makes us unique however; what we do here, we do in Jesus' name. The volunteers here must profess Jesus Christ as Lord and Savior because OHC's mission statement is: "Provide hope through low cost/free medical care and basic skills education to the uninsured and economically disadvantaged on the northwest side of Grand Rapids, Michigan, in Jesus' name." We are a domestic medical mission with a huge need right here in our own back yard, that rivals needs found abroad.

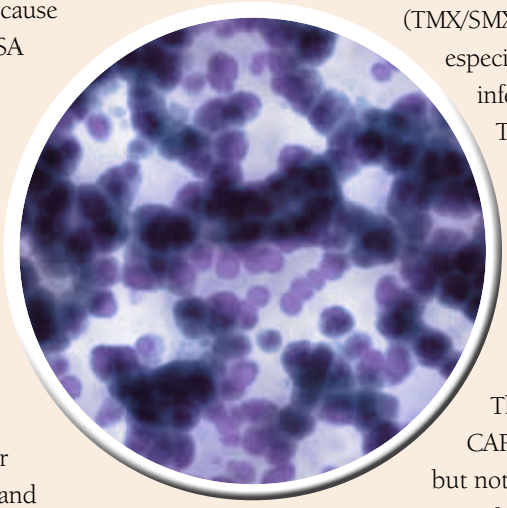
If you want to learn, want to serve or if you want to provide hope in a warm environment and to a people who are grateful for what you do, we welcome any Christian volunteers here at Oasis of Hope Center. There are stories too numerous to tell, but if you come and volunteer here, you will have miracle stories to share as well.

To learn more about Oasis of Hope Center, you can go on our website: www.oasis-of-hope-center.org and click on "Our Story" – it's a wonderful pictorial presentation of what we do. PA

by: Melissa Graham, PA-C
Infectious Disease

MRSA Skin Infections and New Approaches

MRSA (Methicillin-Resistant *Staphylococcus aureus*) is a form of Staph spp. bacteria that has become resistant to or does not respond well to antibiotics called beta-lactams, which include Methicillin. MRSA was first recognized and diagnosed in 1961 and has become a major healthcare concern. Several different strains of Staph bacteria live symbiotically on a persons' skin, and only become a problem when they cause infection in high-risk patients. MRSA skin infections are very common, especially in a healthcare setting. As 25-30% of us carry Staph bacteria in our nasal secretions, yet rarely do we ever develop infection. Risk factors for MRSA infection include current or recent hospitalization, weakened immune system, breaks in the skin from IV sites, feeding tubes, indwelling catheters, central lines or surgical wounds, along with burns and co-morbid conditions like diabetes. MRSA is commonly spread by- casual contact from healthcare workers, engaging in contact sports and using unsanitized exercise equipment. Military recruits and prison inmates are particularly high risk due to close proximity.



Currently, less than 5% of clinical isolates remain sensitive to Penicillin and 50% are resistant to Methicillin. Vancomycin is still considered the 'drug of choice' for hospital acquired MRSA infections. It has proven effective and can still be used in renal compromised patients. A smoldering concern is MRSA infections that are resistant to Vancomycin; there have been reports of such cases, and the numbers are slowly increasing. A synthetic version of Vancomycin was recently approved by the FDA in Sept. 2009, called Vibativ (Telavancin) and is recommended for Vancomycin-resistant MRSA infections. Vibativ differs from Vancomycin in that trough levels are not needed, but renal function remains a concern. Other side effects include QT prolongation, nausea/vomiting and foamy urine.

Other antibiotic choices for MRSA infections include Zyvox (Linezolid), Tygacil (Tigecycline) or Cubicin (Daptomycin). There are also some new recommendations for using higher doses of Bactrim (TMX/SMX) or Septra for MRSA infections, especially on community acquired infections. Two Bactrim DS BID or TID is now being recommended, but side effects need to be monitored, like GI upset, rash and bone marrow suppression. Community acquired MRSA skin infections can also be treated with Doxycycline, Clindamycin or Minocycline.

The FDA has approved Tigacil for CAP non-ICU hospitalized patients, but not as a first line choice; use is for resistant infections. Tygacil also covers VRE, Streptococcal pneumoniae and the atypicals. Mupirocin is a topical ointment/cream that is used to treat both nasal colonization of MRSA and Impetigo. A newer alternative to Mupirocin, Altabax (Retapamulin), is available to use for MSSA therapy in patients' with Impetigo, but is not approved for use in nasal passages. Oral antibiotic therapy is still recommended for patients with multiple lesions or those who have failed Altabax or Mupirocin therapy.

In conclusion, we need to educate patients with community-acquired MRSA skin infections and also, healthcare workers, to keep wounds covered and wash hands often, especially before and after dressing changes. Furthermore, instruct patients to finish the antibiotic course as prescribed, even if the wound looks resolved. Healthcare workers need to be aware that MRSA skin infections are on the rise and that there are several antibiotics choices available for effective treatment.

And the Winners are…..

MAPA 2010-2011 Election Results

Thanks to all of you who submitted your vote by the June 7th deadline date.

Congratulations to the following candidates:

President Elect
Brian M. Gallagher, MSPA, PA-C

Secretary
Jay Kaszyca, BA, MPAS, PA-C

Region 2
Kevin Browkaw, PA-C

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

Region 6
Jenny Grunwald, PA-C

Chief Delegate
Andrew Booth, PA-C

AAPA 2011 Delegates
Brian M. Gallagher, MSPA, PA-C
Donna Hines, PA-C
Jay Kaszyca, BA, MSPA, PA-C
Karl Wagner, PA-C
Gregory F. Bennett, PA-C
Molly Paulson, PA-C

AAPA 2011 Alternate Delegates

Phil Schafer, PA-C
Marc Moote, PA-C
James Kilmark, PA-C
Mary Huyck, PA-C

All candidates are MAPA members in good standing.

MAPA Region 1 Update

by: Jan Ryan-Berg, PA-C; Reg. 1 Rep.

Region 1 held their Spring meeting/dinner in Marquette on April 30th.

There were 13 PA attendees from the surrounding areas that met at UP Front & Company Restaurant. A lecture sponsored by GSK and Takeda Pharm. was given on evidence-based treatment of asthma.

Members discussed several job opportunities, membership recruitment and retention, plus issues that have recently affected practice in the U.P., such as ability to order Physical Therapy. This issue at a local hospital was recently resolved through intervention by Phil Schafer, MAPA's LGA chair. It was also noted that there have been posted and advertised PA jobs without candidates, and several positions have been filled with NP's. This is crucial to PAs as there is NP training available at NMU in Marquette. Any down-state PAs who may be interested in relocating to the U.P. are encouraged to contact the Region 1 representative for information (cell 906-399-3425 or work 906-789-4466).

The dinner group also had a lively discussion about the recertification cycle of 6 year v 10 year and other current AAPA news. Members in this region are separated by great distances, so any opportunity to network is always welcome.

by: Folusho Ogunfiditimi, MPH, PA-C
Manager- MLP's HFHS

Henry Ford Health System MLP Retreat 2010

Timing is everything! The 2010 HFHS Mid-Level Providers (MLP) Retreat was held on March 20, 2010 in Detroit with the billed guest being the honorable Michigan Senator Debbie Stabenow. The week preceding this retreat, the debate on national health care reform had been heating up and the reform passed the day following this retreat. The retreat had a goal of stimulating participation of MLPs within HFHS and across the state. The event was attended by over 130 MLPs and several prominent physician and administrative leaders.

The retreat had both a morning and afternoon session; the morning was a collective information session for Physician Assistants, Nurse Practitioners, Nurse Midwives and Nurse Anesthetist while the afternoon session was for clinical continuing education. The Retreat opened by a message from the CEO of HFHS, Nancy Schlichting, thanking every MLP within the system for their daily hard work and she reemphasized her support for the continued growth of MLPs within HFHS. Sen. Stabenow spoke next; her message was to the MLPs and their roles as health care providers within the proposed health care reform proposal. Sen. Stabenow followed with the highlight of the event by describing the details of Senate Bill (HR3590) with changes to the bill that will have a direct correlation to MLPs; some of the changes are listed here...

- The reauthorization of Title VII Public Health Service Act which provides a 15% increase in funding for PA and APRN programs
- The allocation of PAs/NPs to order Skilled Nursing Facility care and hospice care for Medicare patients
- The full integration of PAs and NPs into medical Home and Chronic Care models
- The exploration and allocation of funds for education and research specific to MLPs
- The inclusion of PA/NP/CRNA/CNM groups in the HER incentive program as stipulated in the Stimulus bill

Sen. Stabenow alluded to the fact that the proposed 21% tax to the physician payment fees has been delayed until October. The Senator expressed her gratitude to all health care providers for their dedication to quality healthcare delivery to patients.

The retreat continued with focused discussions on health care reform and how MLPs can contribute on a local, state and national level. A panel of local experts, including several physicians and MLPs, discussed issues germane to MLPs of how we as a body of providers can contribute to the goal of providing quality health care to all patients. Dr. Doug Weaver presented the current status of HFHS and expressed the importance for MLPs to remain committed to developing quality standards and patient education opportunities. Dr. Weaver stated that within our region, HFHS delivers 20% higher quality care at 20% lower comparable costs to other regional health systems, and this is in part due to the diligence of MLPs. He also celebrated the healthy relationship between HFHS MLPs and physicians within the system and encouraged continuing this relationship. This message was followed by a group discussion on the Doctorate degree (DNP) for NPs; a similar idea for PAs has had few positive discussions.

Dr. Marwan Abouljoud gave a physician's perspective to the topic of Doctorate degree MLPs and highlighted the importance of focusing on quality practice standards and establishing effective measurable clinical competencies that will define MLPs as quality practitioners. He concluded his discussion by stating that the PA/APRN organizations should not follow the same erroneous steps taken by medicine and medical training.

The final topic discussed with the panel and audience was the reference to MLPs as a collaborator of the idea for integrated health care teams. The MLP council along with other institutes is addressing this issue and a Task Force was formed to develop appropriate nomenclature for integrated PA/NP/CRNA/CNM teams. Breakout sessions for PAs and APRNs were held to discuss profession specific challenges and opportunities. Wallace Boeve, EdD, PA-C (current MAPA President) chaired the discussion for the PA group and Dr. Nancy George (state leader in NP education) led the APRN session. The discussions in both of these groups centered around the importance of contributions of time and resources to local, state and national organizations, to foster professional growth and ultimately, improve healthcare delivery.

In conclusion, the retreat was very successful in accomplishing its major goal of stimulating participation of MLPs within HFHS and across the state. This year's retreat was designed to engage MLPs in health care reform, define their collective and individual roles within healthcare, and generate interest and awareness of the critical elements involved in delivering healthcare. By creating this level of understanding needed to deliver healthcare to our patients through the collaborative efforts of MLPs, the retreat evaluations revealed that this goal was achieved. Our challenge as MLPs is to now take this shared information and cultivate long-lasting policies and procedures that would enhance our abilities as practitioners to provide quality healthcare to our patients.

by: Lauren Miller, PA-S
President, CMU PAS Class of 2011

When our program director introduced the idea of attending the February AAPA Capitol Connection in DC, I was instantly excited about applying. The opportunity to travel to DC with fellow MAPA members and other PAs from across the nation was one I didn't want to pass up. I knew there would be a lot to learn, and I was right. To prepare us all for our big day on Capitol Hill, we learned how to develop our message from Soapbox Consulting. From talking points for the day to ways to create relationships with our Congressmen and Senators, we were introduced to the issues being faced by PAs across the nation. I learned that creating and maintaining relationships with our elected officials could make all the difference, because after all, advocacy is about relationships.

Having several PA-Cs with us for guidance was reassuring and educational. Also, having healthcare reform described to me by a person who deals with patient access and insurance complaints every day, makes the issue more real than gleaning information from MSNBC or CNN reports. I learned about the Federal Employee Compensation Act and the unfortunate omission of PAs from its pages. This, from a PA who can no longer treat one of the patients he has seen the longest, because she is a postal worker. Nothing could have replaced the knowledge held by these accompanying professionals, who will someday be my peers; learning about these issues from their perspectives, makes abstract issues become concrete. They were welcoming, friendly, and encouraging, remembering what it was like to be a student, worried about the PANCE.

My average day as a student revolves around lectures and exams, mentoring and taking a good History of Presenting Illness. Attending the Capitol Connection allowed me to step out of the 'student' and 'class president' role and into the role of a healthcare professional; something I will soon become. The issues I learned about at Capitol Connection won't wait until I'm graduated to be resolved. Getting involved as a student makes me more knowledgeable and prepared for my future career as a PA; something I hope to encourage other students to consider. This will also help me to make a difference in the professional world I will be joining- for me, for my classmates, and for my future colleagues.

MAPA's Annual Legislative Day a Big Success!

On Wednesday, May 12, sixty eight PAs and PA students attended MAPA's 2010 Legislative Day in Lansing. The morning session featured talks from MAPA's Immediate Past-President John McGinnity, MAPA's Executive Director Michael DeGrow, AAPA Vice-President and Current Speaker of AAPA's House of Delegates William Fenn, AAPA's Assistant Director of State and Governmental Affairs Liz Roe, and PAMPAC Chair Ron Stavale. Members in attendance received five hours of Category 1 CME credits.

During the lunch hour, we were joined by 32 Senators, Representatives and their staff to discuss the impact of and advancing the PA profession in Michigan. Following lunch, everyone had the chance to meet with his or her legislators. We met with over seventy members of the Michigan Legislature to discuss two key elements. With members of the House, we were seeking support of Senate Bills 26, 27, 28 to allow PAs to form Professional Service Corporations (PC) and Professional Limited Liability Corporations (PLLC). These bills had passed the House Health Policy Committee the day before our visit. With members of the Senate, we focused on PA awareness and the limitations of the current rules guiding the ability of PAs to prescribe Schedule II medications.

The day provided a unique insight into the current issues facing PAs in Michigan, as well as the role we can play to resolve these issues. We took our solutions to the legislature and worked to make a positive impact on the State of Michigan and Physician Assistants.

by: Phil Schafer, PA-C

Michigan PA Helps in Haitian Earthquake Relief

Dr. Tipu Kahn and I

00:35 That's how long it took for the earthquake that hit Port-au-Prince on January 12th to kill over 250,000 people, seriously injure 300,000 and leave over 1.5 million homeless. For an already fragile and medically underserved country, this disaster created a crisis and scars that will remain for a very long time to come.

On March 6th, approximately 100 of us arrived at the field hospital in PAP by charter flight from Miami, provided by Project Medishare. This compound had been established on the grounds of the international airport to provide trauma care to earthquake victims. This remarkable place is a 120 bed hospital that has a 4 station OR, adult and pediatric wards, adult ICU, two wound care tents, and the only neonatal ICU the country has ever had. All this was accomplished without running water! Supplies and staff from all over the world were arriving at the Medishare compound for the relief effort.

We all put down our bags, received a briefing by the chief medical officer, and then went to work. The pace was chaotic and work continued to pour in day and night. As many as 400 patients arrived in a single day. A triage area and an eight station ER controlled the flow of patients into the compound. By this time, the hospital had become the referral center for the city hospitals that remain at least partially open. We had a small lab that would do basic labs, Malaria and TB slides, and pregnancy tests. There were pharmacists on duty to get our patients the correct medications, which were sometimes in different languages.

The ER received patients by all means possible, either by ambulance, military transport, helicopter, motorcycle, and quite often, in the back of a truck or on foot. Here it was, weeks after the quake and hundreds of people were still being seen for the first time for their injuries. There were many infections and poorly healing fractures. Some patients had received emergency surgery after the quake and now had post-operative complications, such as Tetanus and presumed DVT/PE. The earthquake has left Haiti with a frightening new patient population, an estimated 5,000 new amputees. We cared for conditions you would come to expect from a city of 3 million people, such as CVA, MI, Malaria, TB, HIV, gunshot wounds, and childbirths. We also treated pedestrians struck by vehicles almost every day, they were almost always children.

The hardest thing for me was the death of a child, which sometimes occurred multiple times in a day. This tended to leave a mark on the psyche of all the staff. The teamwork was inspiring; everyone in the compound learned new skills and took on new roles at some point. Military from all over the world would arrive to help out. We had people bearing machine guns who were feeding neonates and learning to suture. The local Haitians were a big help, interpreting for us, transporting patients from tent to tent, comforting families, and anything else that needed to be done. Words that come to mind from this experience include devastating and creative, horrific and beautiful, terrible and wonderful; these words on the surface seem contradictory, but they share the emotions felt by all who gave relief effort.

It was an incredible experience and I hope to return soon. Colleagues that have been back to the compound hospital since that time have reported that supplies and staff are markedly reduced and the need remains great. If you would like to donate money or supplies, or volunteer your time, please visit the Project Medishare website at www.projectmedishare.org or the Red Cross. I assure you, the money or time will be well spent and appreciated.

Left: Military in the NICU
Below: Surgery by handheld light

by: Suzanne York, PA-C
President Elect, MAPA

Advocacy for Michigan Physician Assistants

It is the end of May as I write this and even though nearly half of the calendar year has passed, the start of a new year for MAPA begins. Come July 1st, I along with the newly elected MAPA board, will carry on the responsibility of leading our Academy and continue to be the essential resource and primary advocate for the Physician Assistant profession in Michigan.

This board year will be commencing at a time when nationally, the health care system reform, recently signed into law, will begin to bring millions of additional patients into the health care system. This means that we as PAs will have an increasing role in keeping up with the flood of 'newly insured' patients seeking care for long-neglected health problems. This will take a lot of time and energy, but fortunately, we as PAs have been trained and are prepared for this task.

The practicing volunteers that make up MAPA's board will also be spending a lot of time and energy, with teaching, administrative duties, taking care of patients and constantly working to improve how the PA/physician team delivers care. In the coming year, MAPA's board and committees will continue to support the membership, expand access, lower costs, improve the quality of health care and advocate for PAs in Michigan.

To accomplish these tasks, MAPA's strategy has been to work with a public relations firm over the past 2 years to develop plans to increase the visibility of PAs across the state. This accord has also let MAPA maintain a presence with key health stakeholders in Michigan and make our organization transparent to its members. To allow PAs and their employers to fully benefit from our efforts, MAPA advocates that all third party payers reimburse appropriately and we will continue educational efforts for PAs and their office staff on reimbursement issues. MAPA is committed to educate membership and students on the legislative process and issues. We continue to explore opportunities to interact with key legislators regarding health care and have become a strong patient advocate in regards to health care legislation. Finally, MAPA will continue to provide PA CME within the state; plans for a fun and education packed Annual Fall Conference at the Grand Traverse Resort and Spa are set for October 14-17, 2010.

Accomplishing these tasks requires continued support from all PAs in the state of Michigan. We invite you to join MAPA and volunteer on the Board or one of the various committees, to help create positive change in our health care delivery system. I look forward to serving as your president and working with all of you as members of MAPA.

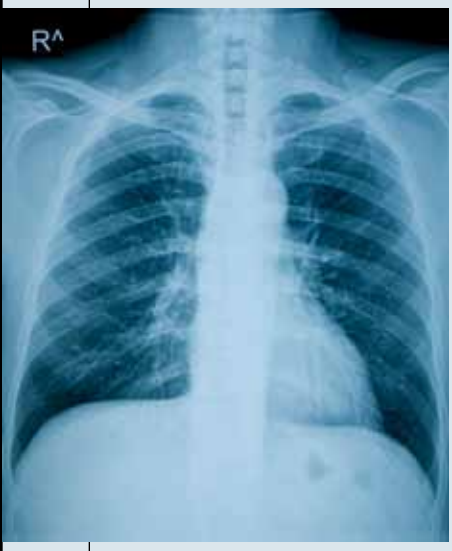
WHO AM I?

I can have liver and neuropsychiatric symptoms
The composition of my two cents worth is enough for a Dx
Tom Hanks starred in two movies with my name referenced
I can make you clumsy and shake
MRI will show characteristic 'face of the great panda' pattern
Eye might have rings to give you a clue

(answer in next 'Michigan PA') *(previous Q_3 answer: Pneumothorax)*

quarterly quiz question

by: Steve Galliway, PA-C
Interventional Radiology, RMI



How to Approach a Chest X-Ray (CXR)

The most important concept to remember for interpreting CXR's is to have a uniform system that you can use consistently for any film. Before you begin to evaluate a film, verify that the film is the correct for the patient in question. The name, date, age, ID number, and body part should all correlate for the selected patient. The next step is to 'hang' the films appropriately and in the correct projection. A film obtained in the radiology department will appear different from a film obtained at the bedside. A film taken in radiology is taken in the PA (posterior to anterior) upright projection with the heart shadow closer to the film to decrease magnification. Whereas films obtained at bedside are obtained in the AP (anterior to posterior) projection with some degree of angulation and thus structures in the mediastinum will appear magnified and /or distorted. The film should be placed as if the patient was facing you with the heart shadow on the left side of the film. Always check the marker to determine left vs. right side anatomically. Upon review of the film, it is important to note the quality, rotation, angulation, penetration, and inspiration of the image. Rotation can be detected by evaluating the position of the sterno-clavicular joints and the spinous processes of the vertebrae, as they should appear equidistant from the midline. Films that are over penetrated will affect the interpretation of the lung parenchyma. A CXR should be taken at full inspiration with breath held and the diaphragm should appear below the level of the 10th rib (posterior aspect). Any variation of these parameters can influence your ability to interpret a film accurately.

The scope and intent of this article is not for you to be able to diagnose any and all ailments that may be present, but rather for you to note anything that does not appear to be normal. Remember, the less dense an object being exposed to x-rays, the less bright it will appear, because the object does not absorb as much of the beam. As a result, bone/metal objects appear white, soft tissue shows up as shades of gray and air appears black. At this point, you can start to interpret the film, begin by focusing on the soft tissue structures. Tissue density should appear uniform in opacity, bilaterally. Observe for evidence of calcifications, foreign bodies, prosthetics, IV lines/wires/tubes, and symmetry between right and left. If the film was obtained upright, than you may note the gastric bubble of the stomach, and observe for free air evident under the diaphragm (typically on the right side, at the apex of the diaphragm). Note that the right hemi-diaphragm should be slightly higher than the left. Both diaphragms should exhibit a smooth rounded appearance.

Next you should observe the bony skeleton to include the shoulder girdles, spine, clavicles, and ribs. The cortex of the bones should be smooth and continuous. Survey not only for fractures, but also note bone-opacity, this should be consistent throughout the bone and variations could indicate blastic or lytic lesions. Proceed to structures of the mediastinum, including the heart. The heart shadow (on a PA view) should be less than half the diameter of the thoracic cage, from rib margins. The tissue edges of the heart border and mediastinum should have a smooth appearance with the exception of the hila. The hila should exhibit a similar shape bilaterally, with the left hilum slightly higher than the right. You should note the trachea as being darker in appearance at the midline overlying the spine. The trachea bifurcates at the carina, into the right and left mainstem bronchi. When confirming endotracheal tube placement, the tip should be just superior to this bifurcation. The final step is to observe the lung fields. Compare both fields for uniform opacity and size. If one side appears smaller, observe if the structures within the mediastinum are deviated toward one side or the other, as this could indicate atelectasis or a pneumothorax. A pneumothorax will present as darker than the adjacent lung

tissue and appear devoid of lung markings. The pulmonary vasculature (also known as the lung markings) should taper from the midline (hilum) all the way to the periphery. Observe for nodules, calcifications, or abnormal tissue densities. The margins and angles of the lungs should be smooth and continuous along the rib margins and diaphragm. If the angles are not sharply demarcated, this could indicate fluid in the pleural space.

The purpose of a lateral CXR is to observe the hidden areas within the lung fields. On a lateral CXR, you should concentrate on the costophrenic recesses around the diaphragm to help identify pleural effusions, the retrocardiac space and the retrosternal space. You may also note the overall shape and appearance of the chest.

Over the course of time your diagnostic acumen will improve, so take advantage of any and all opportunities to observe films with experienced physicians, radiologists or even fellow PAs. Regardless of the setting in which you find yourself interpreting films, as long as you can recognize that something is not normal, will serve you well. For now, don't worry about the diagnosis, worry about the 'missed' diagnosis.

CXR Review Checklist

- Correct patient, film, orientation
- Evaluate soft tissue structures
- Observe for foreign objects
- Evaluate bony structures
- Evaluate mediastinum/heart
- Trachea midline?
- Observe lung fields

Professional Issues Symposium Review

On April 17th, MAPA held its Annual Spring Professional Issues Symposium, this year at Motor City Casino & Hotel in Detroit. A variety of talks were given on practice issues pertinent to PAs. As part of MAPA's efforts to get PAs engaged in legislative and health care issues, State Representative Marc Corriveau addressed the assemblage of PA attendees and gave the audience an overview of the legislative happenings in Lansing. Representative Corriveau, the House Health Policy Committee Chairman, discussed key health issues facing Michigan and outlined the tough decisions that have to be made in order to balance the state's budget. The discussion soon turned to the merits of term limits of state elected officials and Rep. Corriveau explained that the short terms of House and Senate members don't foster the institutional knowledge and experience needed for solving important issues in a timely manner. The audience echoed his concerns and, when asked what could be done to remedy the effects of term limits, he explained that a ballot effort was underway to extend the length of legislative terms. Rep. Corriveau also acknowledged receipt of Senate Bills 26, 27 and 28, the PA corporation bills, in his committee and recognized the need for this legislation to address access to care.

Update: On May 11, 2010, Representative Corriveau held a Health Policy Committee hearing to address the PA professional corporation bills. With the expert testimony of Phil Schafer, PA-C, the bills passed out of committee and currently await action on the floor of the House.

Rep. Corriveau addresses the attendees

Physician Assistants

Changing the Landscape of Health Care

MICHIGAN ACADEMY OF PHYSICIAN ASSISTANTS
MAPA

35TH ANNUAL CME CONFERENCE
TRAVERSE CITY, MI

October 14-17, 2010

UD Mercy PA Students and Professors Shine at Scholarship Fair

On April 20th, students from the college of health professions recently hosted a scholarship fair in the student union ballroom. For an afternoon, the rather mundane world of evidence based research came alive as UD Mercy PA Students and Professors presented their research topics to their peers. Research topics ranged from smoking cessation strategies to prophylactic use of 'statins' to prevent strokes in high risk patients.

UDM PA students Shawn Coleman and Sally Khemmoro addressed the prophylactic use of 'statins' for stroke prevention. "Our main focus was to explore the benefits versus risks in using 'statins' to prevent recurrent ischemic strokes. We based our research on several sources, one of which was the Stroke Prevention by Aggressive Reduction in Cholesterol Levels (SPARCL) trial," added Coleman. The research revealed that patients with prior stroke or transient ischemic attack (TIA), but with normal cholesterol levels and no evidence of coronary heart disease, who took Atorvastatin 80 mg daily, had a 16% relative reduction in risk of recurrent stroke. When asked about their overall interpretation regarding 'statins' and their potential efficacy in preventing strokes, Khemmoro added, "Other research sources confirmed that 'statins' used as a prophylactic agent showed a modest reduction in ischemic strokes; however, our research also elicited that 'statins' may slightly increase the chances of having a hemorrhagic stroke." The results were not entirely conclusive, but the research practices our students are developing will change the way clinicians practice medicine.

PA Students - Robert DeCoste, Karin Lewandowski and Jennifer Whaley explored the efficacy of Chantix as a more effective smoking cessation option when compared to nicotine patch. Our research centered around six clinical trials where over 3500 smokers, smoking 10 cigarettes or more/day, were treated with Chantix. In one clinical trial, patients were either treated for 12 weeks with 2 mg of Chantix/day or placebo. Outcomes demonstrated that 51% of participants taking Chantix daily abstained from smoking during weeks 9 to 12; whereas, only 12% of the placebo group was able to abstain from smoking during the same timeframe. "One of the interesting caveats to Chantix is that patients must smoke for the first week while they are taking Chantix. This overloads receptors and creates an aversion to smoking," noted DeCoste. Even if a patient lapses and has a cigarette, brain receptors are not stimulated as in the past. Cigarettes become much less pleasurable and your desire to return to smoking again may be reduced. "From what our research uncovered, when compared to all available nicotine replacement products, Chantix was a more effective smoking cessation strategy and cost effective," added Lewandowski and Whaley. Ultimately, UD Mercy PA Students are learning to incorporate the wealth of evidence-based research to provide sound clinical advice to their future patients.

The research fair included work from Professors Dereczyk, Higgins and Moser, who looked at several indicators that may better predict how successful incoming and graduating students will be when taking the PANCE exam. Leading the 7 colleges in this research was UD Mercy; specifically, four criteria were examined: GRE scores, undergraduate GPA, PACKRAT scores and interview scores. According to Professor Moser, higher scores on the GRE and PACKRAT translated into accurate predictors of how well students perform on the PANCE exam. Interestingly, four out of six universities noted that higher interview scores were a positive predictor of student success on the PANCE exam.

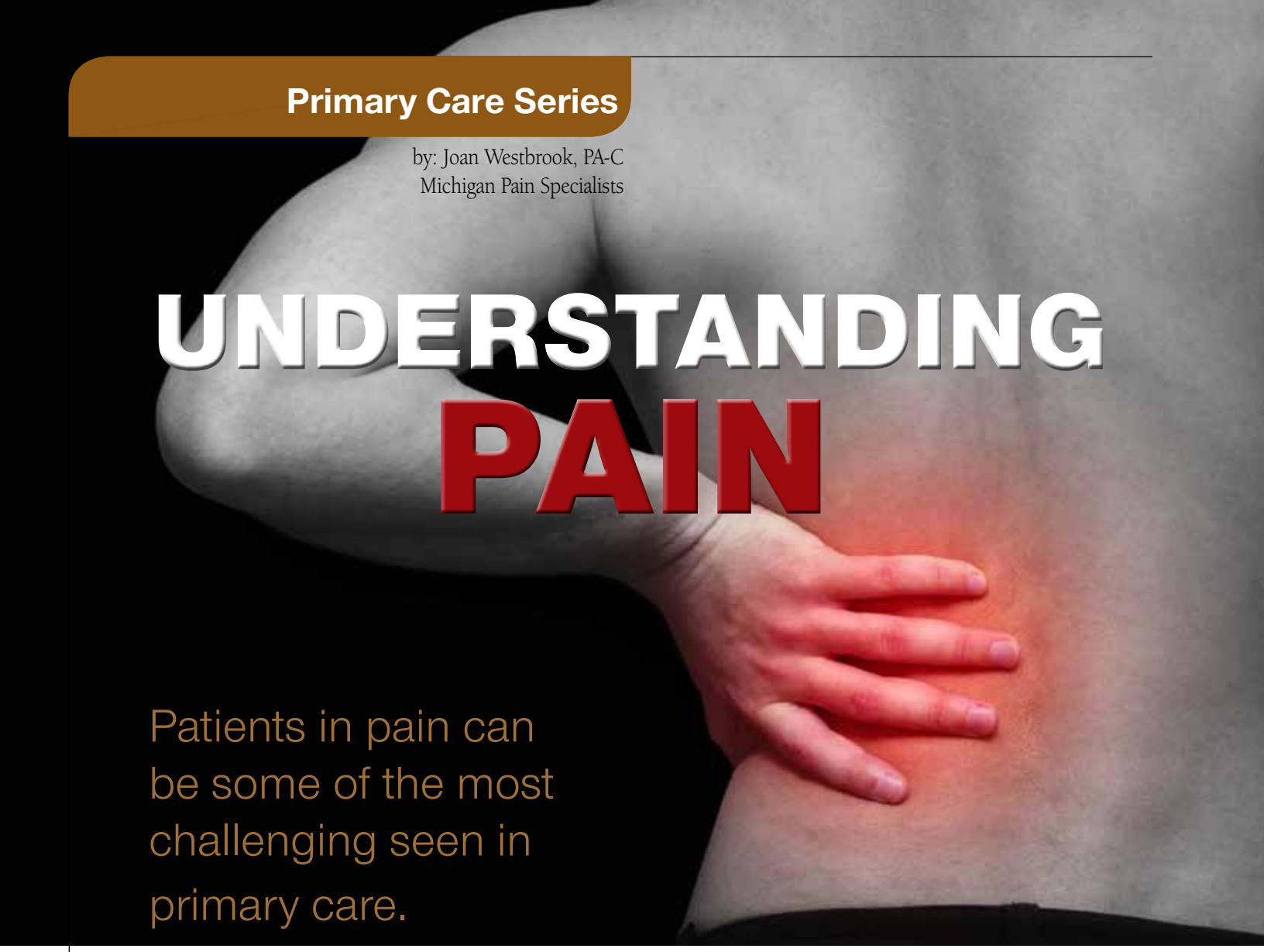
The research fair was a great way to highlight how UD Mercy PA Students and Professors are utilizing evidence-based research to support best practices in medicine and better patient outcomes.

PA FAST FACT

There are over 140 accredited PA programs in the United States

by: Joan Westbrook, PA-C
Michigan Pain Specialists

UNDERSTANDING PAIN



Patients in pain can be some of the most challenging seen in primary care.

In between dealing with their other chronic ailments, primary care providers need to address the one issue that the patient is most vocal about. In order to address pain, we need to understand it.

Pain can be a common symptom of a disease. Pain can fall under several categories, including somatic, visceral, neuropathic and psychogenic. Somatic is sharp and well-localized, i.e. skin, deep tissue, joint or muscles, while visceral originates from deep structures (organs or fractures) and can be referred; both respond well to NSAIDs or narcotics. Neuropathic pain, i.e. injury to nerves, spinal cord or thalamus, is usually not well localized; the patient has a different perception of pain and this type of pain does not respond well to narcotics. Think of nerve pain when the complaint follows a pattern consistent with neuroanatomy, crosses multiple joints and is described as not like anything they have ever felt before. Psychogenic pain is a pain disorder associated with physiological factors and complaints are in absence of organic disease. Another definition of pain is the duration; it can be either acute, that has easily and sometimes not so easily identifiable origins or chronic, if the symptoms and complaint lasts over 6 months.

Chronic pain can be troublesome for the practitioner, as there can be psychological component overlapping the pain. It can be hard for a patient to accept that pain will be a part of their world, with resultant limitations in func-

The origin of Morphine was found as a by-product of Heroin, from the poppy seed plant. It was once called Laudanum and sold over-the-counter (OTC) in general stores back in the 19th century, for anyone to purchase.

tion. Young people in particular struggle with the concept and that the disease or injury is not 'curable.' Depression and substance abuse is an often resulting issue and can be problematic. Some examples of chronic pain are cancer, arthritis, surgical changes, migraines, neuropathy and accident injuries. It can be a shock to people after a MVA or motorcycle accident that they will probably never get back to their functional baseline again.

Primary care has the difficult job of trying to manage these challenging patients. The first issue is to have an accurate diagnosis or cause. There are tools available to start with, but a good physical exam is essential. Does the chief complaint match the physical exam findings and the imaging, plus, does the clinical picture make sense? Don't assume that the last practitioner was correct in diagnosing the patient; make your own judgment. If the clinical picture does not make sense, further testing or referral may be in order. Also consider psychological influences like mental illness, drug-seeking or secondary gain.

Once a diagnosis is made as to which type of pain, then it is time to consider treatment options, one being medications. For example, shingles or lumbar radiculopathy are neuropathic, an anticonvulsant drug would be first line, i.e. gabapentin or pregabalin. Also consider SNRI's as they have a nerve modulating action and this can be helpful when there is a concomitant mood disorder along with pain. Also, a TENS (transcutaneous electrical nerve stimulator) unit is an excellent non-pharmaceutical method of treating pain and muscle spasms. Physical therapy is an important component, but frequently, if the pain is disabling, it is not as effective until the pain burden is reduced. As a rule, patients do benefit from an exercise-based program; the therapist will need to do more passive and less active therapy.

Narcotics can be useful, but in this day and age, care must be taken to ensure that misuse and diversion are not a factor. It is important to know that psychologically disturbed patients will use these drugs as a mood stabilizer. 'Red flags' to look for are things like running out early, losing prescriptions, asking for drugs by name, severe depression (suicide risk), self pay, clinical picture does not support the history and others. It may be necessary to refer to a pain psychologist for assistance, especially if long term use is anticipated. There are measures in place that guard against misuse, such as random urine drug screens, MAPS and narcotic agreements. With marijuana recently being legalized in Michigan, it can be present in the urine drug screen, but is never mixed with other narcotics. Urine testing can also help identify diversion, especially if a drug prescribed is not present in the screen. The patient is asked when the last dose was taken prior to testing, but unfortunately, people are getting more sophisticated about how to obtain drugs to divert. This can make it hard to balance good needful treatment with guarding against potential abuse. Pain clinics that are multidisciplinary can help to assess appropriateness of opiates, in addition to interventional treatments that may reduce the need of opiate therapy. Pain therapy may require referral to state of the art clinics that use fluoroscopy and have training in diverse techniques to get the best possible care for your patients.

Diversion… *a change in purpose or use of something from what was intended or from what it was previously.*

QUESTION PA

Q: I work as a PA in the ER, can I write a prescription for Schedule II medications without a physician co-signature?

A: According to a May 19th, 2010 opinion by the Michigan Bureau of Health Professions and its Licensing Division, the Emergency Department is considered part of the hospital, not an outpatient clinic or setting. Thus, PAs practicing in ER's are allowed to write prescriptions for Schedule II medications for a 7 day supply without a physician co-signature, and they must have a current DEA license and delegated authority.

Call For Content

The Editorial staff at 'MichiganPA' newsletter is looking for enthusiastic contributors to help give life and variety to this resource. The overall goal of this PA newsletter is to have a collaborative and collective input and spirit that is "By PAs, For PAs." The PA profession is continually growing and expanding to all areas and levels of medicine, the new 'MichiganPA' should mirror this expansion.

This request is put forth for any Michigan PA to submit articles, stories or vignettes about specific items of interest that would appeal to other PAs. If you have previous professional experience in medicine, at any level or branch, it will be of benefit. Especially since the PA profession requires recertification that is applicable to all branches of health care.

Of special interest is community service or humanitarian efforts of Michigan PAs, going above and beyond to deliver health care. These efforts are not for glory or recognition, but because they felt it was necessary and the right thing to do. We hope that you will help us in this endeavor and give back to the profession that you are a part of. If you have any questions, concerns, articles, ideas, suggestions, or editorials, please forward them to the editorial staff at either e-mail: cjnoth@yahoo.com or mapa@michiganpa.org We want to hear from YOU!

Did you know?

The PA profession in Michigan ranks 8th for 'Tomorrow's High Demand, High Wage' careers, through the year 2016.

Quote:

"Without courage, all other virtues lose their meaning."

Winston Churchill

British Prime Minister and Minister of Defense, WWII

SOURCES/LINKS/SPONSORS/CONTACTS:

Michigan Academy of Physician Assistants- MAPA at 1-517-336-1498 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

New MEMBERS

Members who have joined since 3/1/10:

Kelsey Brown, PA-S	STU	Royal Oak, MI
Ashley Colbert	AFM	Washington, MI
Kathryn Cpak, PA-S	STU	Roseville, CA
Marcie Crandall	AFM	Shelby Township, MI
Eric Firstenberg, PA-S	STU	Ann Arbor, MI
Michael Francisco	AFM	Portage, MI
Gina Green	AFM	Clawson, MI
Melina Holyszko, PA-S	STU	Redford, MI
Carly Kmiecik	AFM	Sterling Heights, MI
Nicole Kuzminski	AFM	Armada, MI
Brietney Lewis, PA-S	STU	Grand Rapids, MI
Crosby McDowell	AFM	Rochester Hills, MI
Tiffany Medler	AFM	Morley, MI
Bradley Mescher, PA-S	STU	Walled Lake, MI
Julia O'Malley, PA-C	ASM	Fort Worth, TX
Tom Plamondon	AFM	Caro, MI
Doug Reincke, PA-C	FEL	Royal Oak, MI
Jonathan Smiley, PA-S	STU	Macomb, MI
Ashly Stoudt, PA-S	STU	Carson City, MI
Katherine VanderLaan, PA-S	STU	Howell, MI
Dana Vollmer	AFM	Columbus, MI

A total of 21 people have become members of MAPA since 3/1/10:

ASM – 1	STU – 9
AFM – 10	FEL – 1

ASM - Associate Members
AFM - Affiliate Members
STU - Student Members
FEL - Fellow Members

PLANNER

EVENTS / SEMINARS / CLASSES / CONFERENCES

MAPA Board of Directors Meeting

Come and see how the MAPA BOD works for you!

DATE: Wednesday June 16, 2010
TIME: 7pm – 9pm
LOCATION: MSMS Building
120 W. Saginaw St.
East Lansing, MI
FEE: FREE

MAPA's 35th Annual Fall Conference

"Physician Assistants, Changing the Landscape of Healthcare"

DATE: October 14 – 17, 2010
LOCATION: Grand Traverse Resort & Spa
Traverse City, MI
FEE: Refer to Registration Form
INFO: 1-877-YES-MAPA or www.michiganpa.org

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Website: www.michiganpa.org

'The Last Word...'

Time... it waits for no one. It can be used as a measure or as a reference of past deeds. At times, life may seem difficult or trying and may drag on forever; especially if as a patient, you are waiting for key results. *Tempus fugit* is usually the case when you are engaged in some activity which you gain satisfaction from and yet the time seems to go by so quickly. Timelines are sometimes necessary to see the path to the future or to visualize the steps needed to achieve the end result, from the past. Time is also said to 'heal all wounds', but how much time does it take for this to happen? Some wounds take a longer time to heal than others, large surgical wounds v small cuts; some emotional wounds can take a lifetime to resolve.

In our busy lives, it behooves us to take time; and when I say this, I have several points in mind. When you have to have a discussion with a patient about any medical decision or diagnosis, taking time to inform them of treatment options or prognosis is key. The more time spent with a patient and the better informed they are about their medical condition, the more appreciative they are and the less work for you in the future with this patient. Next, taking the time to explain your ideas or treatment plan with your supervising physician will help to formulate a direction for your patients' management more effectively. Effective communication is time well spent. Lastly, you have to remember, with all the stressors and time constraints on you as a PA, take some time for yourself. It's one thing to take care of other people, but you need to be cognizant to the fact that time is precious and you should not let it vanish without allowing some for yourself.

Time is a commodity, it is always available and yet, it can slip through your fingers just as easy. So as we move through our daily lives, a balance of time is necessary; time for work, family and yourself.

Chris Noth, PA-C
Editor, 'MichiganPA'