YOUR VOICE. YOUR PROFESSION.

MICHIGAN PA

VOL. 39 NO.3

SEPTEMBER 2018

MICHIGAN PA

YOUR VOICE.
YOUR PROFESSION.

Contents

Your Newsletter Editor's Corner

DEAR PA FRIENDS,

I hope this letter finds you happy and healthy and that you are enjoying your summer! In the craziness of getting into the back-to-school/back-to-reality mode, please try to take a few moments to peek at our MAPA website (michiganpa.org) for Fall Conference details. The Grand Traverse Resort will be hosting us from October 4-7th and as usual, we have a fantastic lineup of speakers and topics for you. We would love to see you there!

We have a great collection of articles in this edition so please grab your favorite morning beverage, sit back, relax, and enjoy!

As always, I want to thank all those who contributed to this edition of the MichiganPA Newsletter. Also, please consider sharing your thoughts or opinions, a brief case report, essay or article for any of our newsletters. Articles for our next newsletter will be due by November 7th. Email me at kate.schisler@michiganpa.org or contact MAPA to get in touch with me.

Sincerely,

Kate Schisler, MSM, PA-C, MichiganPA Newsletter Editor-In-Chief,
MAPA Treasurer

From the President's Desk

This newsletter is going out to all the PAs in Michigan; MAPA members and non-members alike. I have been a MAPA and AAPA member since I was in PA school in the 1980's. We should be very proud of what we have accomplished in Michigan since then--but there is still much to do!

When I graduated PA school in 1990, Michigan PAs had prescriptive privileges but not for controlled substances. My first job was in the Detroit Receiving Hospital ER. The first day on the job I was handed a controlled substance pad from a physician. I wrote 6 Tylenol #3 prescriptions cosigned by the doctor over the next 2 months. Because I was a MAPA member, I drove to Bay City from Detroit to attend an event. There I learned we did not have the authority to prescribe controlled substances. When I returned to work I gave them the pad and said if you want me to use this then we should work together to convince the legislature to change the law and the medical boards to write the rules.

Now, Michigan PAs are full prescribers required to obtain state prescriber licenses similar to our physician colleagues. Michigan has the best PA practice law in the country. This is a result of hard work over many years of MAPA volunteer leaders made up of MAPA's board of directors, committee chairs and committee members, and let's not forget our staff team members Executive Director Thadd Gormas, and our Academy Administrator Alecia Powell, CMP, who is our champion.

I want to thank all our members who have been faithful members since joining MAPA. I also want to invite all Michigan non-members to join our cause. Some of you may not realize the benefits...but I have found many PAs are not aware of the changes in Michigan law or rules that occur over time. We all know ignorance of the law is no excuse. And there are unprecedented opportunities that follow these changes. MAPA is the best source for Michigan PAs in the changing healthcare landscape.

We welcome all our PA's in Michigan to attend our meetings, the fall and spring CME conferences, and our regional events throughout the year. Contact information for MAPA's leaders is easily accessed on our website—MichiganPA.org. We have concentrated historically on physical health, employment strategies and reimbursement. This year we plan to highlight the growing demand for PAs in mental health and professional enhancement opportunities for PAs interested in practice administration and/or ownership.

Thank you for taking time to read about Michigan PAs, and your academy at work for you and your patients.

Karl G. Wagner, Jr. PA
MAPA President

Ashley Malliett PA-C, MAPA 2018 CME Chair

Our annual Fall CME conference is right around the corner! We invite you to join us in Traverse City from October 4-7th, 2018 at the Grand Traverse Resort and Spa.

We are excited to offer you a program rich in sessions covering core competencies and as well as innovative sessions focusing on the issues today's practicing physician assistant may face. Please visit our website at ***www.mapafallevents.org*** to view our full schedule of events and see what MAPA has planned for you!

Some of the sessions that you can look forward to include:

Direct Primary Care: A Model for PA Practice Ownership with Stacy Waack, PA-C.
Stacy has created a successful model for PA practice ownership and is sharing this with us. Please come and learn the factors to consider and associated with PA practice ownership within the state of Michigan. Direct Primary Care as a patient-provider model will be detailed and how it fits well with practice by PAs and enables a smooth and easy transition to operating a practice for primary care within the state.

Medical Marijuana and the Healthcare Provider with Linsey Gold, DO, FACS, FACOS.
Ever wonder who should get a medical marijuana card or how well this treatment really works? Whether you are a firm believer in this or on the fence, Dr. Gold's lecture will be sharing with us the data behind the therapy and the benefits of medical marijuana. With a background in breast cancer she has seen the benefit such therapy can have and can speak first hand on the pro's and con's of this upcoming therapy option.

Fun with ECG's with Gurjit Singh, M.D
Does staring at ECG's give you palpitations or make your heart skip a beat? We have good news for you- they don't have to anymore! Come join Dr. Singh, Senior Electrophysiologist and Director of the Electrophysiology Lab at Henry Ford in Detroit, MI, and learn how to interpret complex ECG's easily and correctly. Whether it is a simple atrial arrhythmia or a complex block, we have you covered!

See the list of this year's conference Sessions on the following page...

MAPA FALL CME CONFERENCE SESSIONS

OCTOBER 4-7, 2018, TRAVERSE CITY, MI. FOR THE FULL AGENDA VISIT *MAPAFALLEVENTS.ORG*

THURSDAY, OCTOBER 4TH

2017 Tax Cuts and Jobs Act
Henry Guzzo, CFP, ChFC, CLU, REBC

Adverse Childhood Experiences (ACE) and Trauma-Informed Practice
Alison Arnold, Director Interdisciplinary Center for Community Health & Wellness

Block It or Infiltrate It? Local Anesthetic Techniques
Angela Braun, PA-C

Considerations for Starting Your Own Practice
Robin VeltKamp, Quality Assurance and Education

Diversion Control: Combating the Supply
Cathy Gallagher, Diversion Program Manager

Efficacious Pain Management Without Opioids! Attain Successful Outcomes and High Patient Satisfaction
Jessica Gayta, PharmD

Identifying and Preventing Health Care Fraud

No Bones About It: The Diagnosis and Treatment of Common Fractures
Bradley Coon, PA-C

Oh Crap! My Pt's coughing up Blood! Now What? A Realistic Approach to Hemoptysis
Sue Baker, PA-C

Promoting Vaccine Confidence - A New Approach to Vaccine Hesitancy
Joshua Meyerson, MD

Psychological Responses to Acute Illness: Identifying and Addressing Pathological Adjustment
David Moore, PSYD

Thinking Outside the Cup. Extra Genital Screening and PrEP
David Ponsart, Supervisor, Infectious Disease Prevention Programs

Vector Born Illness of Clinical Importance
Joel Fishbain, MD

FRIDAY, OCTOBER 5TH

AVERT / Basic Bleeding Control Workshop
Lindsay Gietzen, PA-C

Blink and You Will Miss It! A Visually Appealing Diagnosis
David Dumais, Jr., PA-C

Direct Primary Care: A Model for PA Practice Ownership
Stacy Waack, PA-C

Do You Know When to Refer to PT? A Panel Discussion
Michael Shoemaker, DPT

Evaluation and Treatment of Latent and Active Tuberculosis
Nancy Ivansek, PA-C

Fundamentals of Neuropsychological Assessment
P. Tyler Roskos

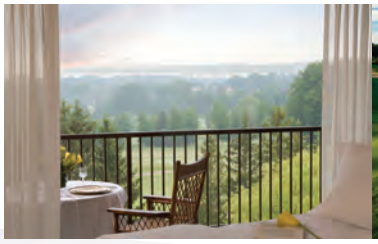
Getting to the Heart of Obesity
Eryn Smith, PD

HIV Pre and Post Exposure Prophylaxis
Nancy Ivansek, PA-C

Multiple Myeloma
Heather Emch, PA-C

Not Just A Knock on the Head: What Happened and How Do We Fix It?
Andrew Cole, MD

Parkinson's Disease and Therapeutic Rehabilitation
Andrew Cole, MD



Reimbursement Update
James Kilmark, PA-C

Updates on Sepsis: An ER Perspective
Nicholus Kopacki, PA-C

WOW! I Didn't Know Sleep Apnea Could Actually Kill You..
Sue Baker, PA-C

SATURDAY, OCTOBER 6TH

Advanced Suturing
Frank Nysowy, PA-C

Antimicrobial Therapy: Clues and Cases
Jim Lile, PharmD

Aortic Stenosis and Transcathedar Valve Replacement
Ben Burroughs, PA-C

Beginner Suturing
Frank Nysowy, PA-C

Domestic Violence for the Medical Provider: Recognizing the Signs and How to Help

Eat Sh*t And Live: Updates on Clostridium Difficile Management and its Associated Complications
David Dumais, Jr., PA-C

Evaluation and Management
Joseph Jacot, PA-C

Hypnotherapy for Pain Management and Smoking Cessation
Bob Huttinga, PA-C

Opioid Addiction: Who's Pain Is It Anyway?
Cara Poland, MD

PA and PT Perspectives on an Orthopedics Joint Replacement Pathway
Ryan Desgrange, APP Supervisor Orthopedic Surgery

Perinatal Mood Disorders: How to Screen, Diagnose and Treat our Patients at Risk
Erin Walker, Physician Assistant

Preventing the Downward Spiral of Osteoporosis
Avery Jackson, Board Certified, Fellowship trained Neurosurgeon

Spotting the Lesion
Amber Murphy, PA-C

Top 10 Costly Resume Mistakes all PAs Make
Marcos Vargas,MSHA, PA-C

Who Needs Stress Management These Days?
Bob Huttinga, PA-C

SUNDAY, OCTOBER 7TH

PANDAS: Is it a Zebra?
Lisa Barancin, PA-C

Update from NCCPA: Positive Changes to Certification Maintenance
Greg Thomas, PA MPH Director of External Relations, NCCPA

GRAND TRAVERSE RESORT AND SPA

2018 MAPA Fall CME Conference

October 4-7, 2018

GRAND TRAVERSE RESORT AND SPA • ACMI, MI

MAPAFALLEVENTS.ORG

MEMBERSHIP JOIN/RENEW OPTIONS

Join/renew your MAPA membership now to receive the discounted conference rates. *See MAPA website for membership category details.*

Fellow ☐ $190 New Graduate ☐ $115 Student ☐ $40
Associate ☐ $115 Affiliate/Pre-PA Student ☐ $65

TOTAL MEMBERSHIP FEE (A) $_____

FULL CONFERENCE REGISTRATION FEES

Early Bird Registration ends September 10TH

Registration fee includes scheduled breakfasts, breaks, & lunches.

*** MAPA Member**
☐ $395 Early Bird ☐ $420 Standard ☐ $445 Onsite

*** Student MAPA Member/ Pre-PA Student**
☐ $145 Early Bird ☐ $165 Standard ☐ $185 Onsite

Non-MAPA Member
☐ $645 Early Bird ☐ $670 Standard ☐ $695 Onsite

Non-PA Spouse
☐ $250 Early Bird ☐ $275 Standard ☐ $295 Onsite

☐ **Military/Veteran 20% Discount**

1 DAY CONFERENCE REGISTRATION FEES

Registration fee includes scheduled breakfasts, breaks & lunches.

SELECT DAY: ☐ THURSDAY ☐ FRIDAY ☐ SATURDAY ☐ SUNDAY

* MAPA Member ☐ $175 Early Bird ☐ $185 Standard ☐ $195 Onsite
Non-MAPA Member ☐ $275 Early Bird ☐ $285 Standard ☐ $295 Onsite
* Student MAPA Member ☐ $75 Early Bird ☐ $85 Standard ☐ $95 Onsite

TOTAL REGISTRATION FEE (B) $_____

* *Includes out of state PAs. Member verification of your state PA association is required.*

WORKSHOPS/EXTRA ACTIVITIES

Please Note: *Due to limited space, registration will be on a first-come, first-served basis for workshops and extra activities.*

Workshops

Thursday, October 4
Block it or Infiltrate It? Local Anesthetic Techniques ..... *$40* x ____(qty)=$_____

Friday, October 5
AVERT/Basic Bleeding Control (Limit 35) ..... *$40* x ____(qty)=$_____
Casting (Limit 30) ..... *$40* x ____(qty)=$_____

Saturday, October 6
Basic Suturing (Limit 35) ..... *$40* x ____(qty)=$_____
Advanced Suturing (Limit 35) ..... *$40* x ____(qty)=$_____

Extra Activities

Saturday, October 6 - 7:30 am - 9:00 am
5k Run, 1 Mile Wake-Up Walk and/or 1 Mile Kids Trot ..... *Complimentary* #____ *attending*
MAPA Mixer 7:00 pm - 9:00 pm ..... *$25* x ____(qty)=$_____

TOTAL WORKSHOPS/EXTRA ACTIVITIES FEE (C) $_____

REGISTRANT INFORMATION

☐ PA-C ☐ PA-S ☐ Other:_____

First Name _____

Last Name _____

Organization _____

Address_____

City _____ State ____ Zip _____

Phone _____

Fax_____

Email _____

☐ Special Dietary Needs_____

Please check: ☐ Alumni of: ☐ Current Student of:

☐ CMU ☐ EMU ☐ GVSU ☐ UDM ☐ WMU ☐ WSU

PAYMENT INFORMATION

TOTAL FEES ENCLOSED (A+B+C): $_____

☐ Check # _____ (Payable to: MAPA)

☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

Credit Card # _____

Exp. Date _____ CVV *(3 or 4 digit code on back of card)*_____

Billing Name_____

Billing Address_____

Billing City, State, Zip _____

Name as it appears on Card _____

Authorized Signature _____

Please mail registration form with payment to:

MAPA • 1390 Eisenhower Place • Ann Arbor, MI 48108 or
Fax to 734-677-2407

PAYMENT AGREEMENT: This registration form serves as a contract between the conference registrant and the Michigan Academy of Physician Assistants. Payment for the services provided by the Michigan Academy of Physician Assistants is the responsibility of the conference registrant. Payment in full will remain due if the registrant is absent or cancels after September 10, 2018. The conference registrant agrees to these terms and the contract becomes active upon receipt of the registration form to the Michigan Academy of Physician Assistants.

CANCELLATION POLICY: All cancellation requests must be submitted in writing to the MAPA office, postmarked by September10, 2018. All refunds are subject to a $50 processing fee. There will be No Refunds issued after the September 10, 2018 deadline. There are no refunds for membership dues or pre-paid/unattended Workshops or Extra Activities.

HOTEL RESERVATIONS: The Grand Traverse Resort and Spa will be offering a discounted room rate for MAPA conference registrants. Reservations can be made by either calling. Be sure to mention you are a MAPA conference attendee. Registrants are responsible for their own hotel reservations.

MILITARY/VETERAN (20% DISCOUNT): The military/veteran would be required to provide sufficient documentation to prove eligibility for this 20% discount.

PHOTO DISCLAIMER: Please be aware that this registration form also serves as an agreement to appear in photographs taken at the 2018 MAPA Fall Conference. And that these photos may be used for publicity or general information purposes and may be seen by the general public.

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UNDERSTANDING THE DUTY TO REPORT *Impaired* COLLEAGUES

Amy Fehn, Esq.

The current opioid crisis has raised awareness and questions regarding the duty of a physician assistant to report a colleague who appears to be impaired from substance abuse.

Section 16222 of the Public Health Code provides a general requirement that an individual licensed under the Public Health Code (a licensee) who has knowledge of another licensee's violation of the Public Health Code report such knowledge. A "substance abuse disorder" as defined by the mental health code is one of the grounds for personal disqualification under the Public Health Code as well as "any mental or physical inability reasonably related to and adversely affecting the licensee's or registrant's ability to practice in a safe and competent manner."

Section 16223 applies more specifically to impairment and requires a licensee to report another licensee, registrant, or applicant if there is "reasonable cause" to believe that the individual is impaired.

The penalty for failing to make the required reports is the potential for disciplinary action.

It is important to note that the identity of a reporter will, in most circumstances, be kept anonymous and the reporter will be protected from civil or criminal liability related to a report made in good faith. Recently, LARA addressed the following Frequently Asked Questions in order to provide additional clarification:

Question: Do I have to report a colleague who may have violated the Public Health Code?

Answer:
MCL 333.16222(1)

A licensee or registrant who has knowledge that another licensee or registrant has committed a violation under section 16221, article 7, or article 8 or a rule promulgated under article 7 or article 8 ***shall*** report the conduct and the name of the subject of the report to the department. Failure of a licensee or registrant to make report under this subsection ***does notgive rise to a civil cause of action*** for damages against the licensee or registrant, but the licensee or registrant ***is subject to administrative action*** under sections 16221 and 16226.

Question: Will my identity remain confidential?

Answer:
MCL 333.16222(2)

Unless the licensee or registrant making a report under subsection (1) otherwise ***agrees in writing***,

the identity of the licensee or registrant making a report under subsection (1) ***shall*** remain confidential ***unless disciplinary proceedings under this part are initiated*** against the subject of the report and the licensee or registrant making the report is required to testify in the proceedings

Question: Do I have to report a colleague who may be impaired?

Answer:
. . . a licensee or registrant who has reasonable cause to believe that a licensee, registrant, or applicant is impaired ***shall*** report that fact to the department. • A licensee or registrant who fails to report under this subsection is ***not liable in a civil action*** for damages resulting from the failure to report, but the licensee or registrant ***is subject to administrative action*** under sections 16221 and 16226. • A licensee or registrant who in good faith complies with this section is ***not liable for damages in a civil action or subject to prosecution in a criminal proceeding as a result of the compliance.***

About Amy Fehn, Esq.
Amy Fehn is a health care attorney in Southfield Michigan. She has been representing health care providers for over 20 years in areas such as regulatory compliance, Medicare appeals, contract review and HIPAA. More information on her firm can be found at www.healthlawoffices.com. She can be reached via email at amy@healthlawoffices.com or by telephone at (248) 602-3902.

MAPA Legislative Update

MAPA's legislative committee had a busy start to 2018. Our Mental Health Task Force has been meeting regularly and now has a bill that is ready to be introduced to the 2019 legislature after the November elections. The Mental Health Task Force is spearheaded by Michelle Reid, MD and consists of NP representatives and PAs from the legislative committee and several working in Psychiatry.

As mentioned before, our landmark Public Act 379 eliminated the terms delegation and supervision in the public Health Code but there are other codes in State Law that affect our practice. PA 379 did not directly affect the Mental Health Code (MHC) which actually doesn't even list PAs as mental health providers. The Public Health Code allows for PAs to practice psychiatric medicine and there are many of our psych PA colleagues in every type of behavioral health setting across the state.

Antiquated language in the Mental Health Code creates ambiguity and thus situations have occurred where the practice ability of PAs in psychiatry has been left up to interpretation by administrators or staff without referencing clearly defined code. This ambiguity has, and will continue to have the potential to limit the PAs ability to safely and effiecently care for their patients.

The Mental Health Task Force has been working on this for over 20 months now, initially collecting information regarding clinical situations where PAs are restrained or limited in their ability to practice to the full extent of their training, education or experience. The next step was to work with Senator Jim Marleau's staff in creating language in a bill that would clarify the language to eliminate any misinterpretations and also officially list PAs as mental health providers in the MHC.

In order to pass this bill it is very important for our organization to work with the physician organizations. MAPA has requested support of the Michigan State Medical Society and the Michigan Osteopathic Society. In meeting with the Michigan Psychiatric Society (MPS) their current Immediate Past President had misgivings about the bill. MAPA requested specific concerns from the then MPS president so we could work together to create language that would be supported by MPS and that would also attain the goals that MAPA had in creating this bill. After several meetings we were not able to elicit specific concerns from their society and we continued our work on the bill. MAPA is planning to support introduction of the bill in the new legislative session in January of 2019 with broad stakeholder support .

It will be most important for any Michigan PAs working in Psychiatry to discuss this issue with their physician colleagues so that MAPA will have even broader support of physicians and the psychiatric community when this is up for debate. MAPA cannot do this alone. Legislators are influenced by PAs

Michigan PAs attending MAPA's Leadership Summit in Lansing.

working in the area of practice being discussed and especially if they are constituents of the legislator or work in their district.

Other pressing issues are related to the new opioid laws and the issue of having another health care worker do the initial lookup of the patients profile in the MAPS system. The word 'delegate' seems to have created some confusion. PAs cannot delegate parts of our practice of medicine to another licensed or unlicensed individuals. Having another health care worker pull up the info for us to review is not considered part of the practice of medicine so hopefully that will clear up in time.

As always, MAPA is here for you so don't hesitate to call or email MAPA with any questions or concerns. AND…..continue to support the only organization that protects your practice environment in Michigan.

Ron X. Stavale PA-C
Chair, Legislative Committee
Past President

MEET YOUR 2018-2019 LEGISLATIVE COMMITTEE

Introducing your new Legislative Committee for 2018/2019! When you see them, please take a moment to thank your colleagues for volunteering their personal time to support your practice ability!

Alison Badger, PA-C
Samanatha Danek, PA-C
Jim Kilmark, PA-C
Dan Ladd, PA-C
Marc Moote, PA-C
Michelle Petropoulos, PA-C
Natasha Smith, PA-C
Chair: Ron X. Stavale, PA-C

2018

HOUSE OF DELEGATES, NEW ORLEANS, LA

Jodi Zych, MS, PA-C, MHA, MAPA President-Elect, AAPA Chief Delegate (2017/2018)

The MAPA delegation travelled to New Orleans, LA for the 2018 House of Delegates (HOD) meeting. 8 Delegates participated in the HOD: Janet Burns, Julia Burkhart, Donna Hines, Mary Huyck, Steve Myers, Zarna Patel and Molly Paulson. Jodi Zych acted as Chief Delegate. The HOD allows for 8 representatives from Michigan based on our MAPA membership, so we were fully represented. This was very beneficial, as this year the HOD performed clicker votes instead of voice voting so this ensured that Michigan's voice was heard!

There were 59 resolutions considered by the HOD this year. 29 were adopted on the consent agenda, so no voting was needed, the body considered those to be non-controversial and didn't need to be discussed. An example of a consent agenda item would be clarification of the process to replace board members who resign.

Ten resolutions were adopted as written and 16 were amended then adopted. One resolution was rejected and 3 were referred for more information to be gathered and the motions will be reconsidered next year.

The highlights of the resolutions passed include updates to policies to reflect non- binary gender identities and the clarification of definitions for APP and APC. There was a resolution proposed to assure the AMA that PAs were not seeking independent practice which was rejected. The HOD felt that it was unnecessary to reassure the AMA because the language of the Optimal Team Practice resolution was clear.

The big resolution that was approved by the HOD directs AAPA to convene a focus group to begin to look at changing the name of our profession. Many have suggested that "Physician Assistant" doesn't accurately capture the evolving role of the PA and should be changed. AAPA will employ a public relations firm and seek legal consultation to determine what names the profession might consider and what the ramifications of change would be. The results will be shared once they are available.

The resolutions referred for further study included one regarding federally employed PAs and the impact of certification requirements, one on the use of codeine containing medications in children and one suggesting that on line PA programs be banned. All resolutions needed more information before the HOD felt it could make an informed decision. Those resolutions will be considered at the 2019 HOD!

The 2019 HOD will take place in Denver CO, and will start a day before the AAPA conference (On May 18th) to enable delegates to participate more fully in the AAPA conference. If you are in Denver from May 19th through the 22nd of 2019, stop by the HOD so you can see how it works!

ACQUIRED
LONG QT SYNDROME, A REVIEW

Fred Clifford, PA-S, Central Michigan University Class of 2019

Acquired long QT syndrome (LQTS) occurs when the QT interval prolongs due to either a disease pathology or medications. LQTS carries a significant risk for the development of torsades de pointes (TDP) and ventricular fibrillation (VF). This article focuses on the acquired form of LQTS. For a discussion of inherited LQTS, please see the author's article in the 2018 second quarter MichiganPA Newsletter.

ETIOLOGIES

Acquired LQTS occurs secondary to a disease process, metabolic derangement, or medication. CredibleMeds.org is a free service that provides updated lists of common medications and conditions that can lead to LQTS. Table 1 lists some of the common causes of LQTS, however this list is far from complete as CredibleMeds currently lists over 150 medications that are either known or suspected to prolong the QT interval. Not every patient that receives these medications will develop LQTS and currently there is no reliable way to predict which ones will. There is some evidence that susceptible patients have an underlying channelopathy that is exaggerated by the medication, however this has not been proven.

Table 1. Medications and conditions commonly associated with acquired LQTS

MEDICATIONS	CONDITIONS
Class IA antidysrhythmic - Quinidine - Procainamide Class III antidysrhythmic - Amiodarone - Sotalol Macrolides Clindamycin Trimethoprim-sulfamethoxazole Tetra/tricyclic antidepressants Phenothiazine Haloperidol	Hypokalemia Hypomagnesemia Hypocalcemia Hypothermia Hypothyroidism Starvation Myocardial infarction Cardiomyopathies Subarachnoid hemorrhage Thalamic hematoma

PRESENTATION

Acquired LQTS presents in older adults since they are more likely to develop diseases or be prescribed medications known to cause LQTS. The pediatric or young adult presenting with LQTS must be evaluated for the inherited form. This is not to say that a pediatric cannot have acquired LQTS or that inherited LQTS cannot be diagnosed in adulthood. Any patient with LQTS must be identified as having either inherited or acquired as the treatment for each form differs significantly.

Acquired LQTS can be difficult to discover since it has no characteristic presentation or tell-tale sign. For example, the patient with LQTS secondary to hypocalcemia will present with signs and symptoms of hypocalcemia whereas the patient with drug-induced LQTS may be completely asymptomatic. The patient may have signs and symptoms of TDP such as palpitations, dizziness, syncope or sudden cardiac death. They may have recently started a prescription however drug-induced LQTS may not develop for several years on a stable prescription.

IDENTIFICATION AND DIAGNOSIS

The characteristic shared by all forms of LQTS is a prolonged QT interval discovered on a surface 12 lead EKG. Since the QT interval is dynamic and inversely related to the heart rate, the QTc (QT interval corrected for heart rate) should be used for evaluation of LQTS. The QTc is calculated from the QT interval and the R-R interval. For adult men a QTc > 440 ms and for adult women a QTc > 460 ms are considered prolonged though the risk of TDP does not generally occur until a QTc > 500 ms.

To determine the QTc, it is crucial that the clinician manually measure the QT and then determine which formula should be used. The most reliable method

continued

LONG QT SYNDROME *CONTINUED*

for measuring the QT interval is the maximum slope intercept method discussed in my previous article about inherited LQTS. A concise review and demonstration of this method can be found at lifeinthefastlane.com/ecg-library/basics/qt_interval/.

After measuring the QT interval using the maximum slope intercept, the clinician has four formulae from which to choose. These are Bazett's, Fredericia's, Framingham, and Hodges (see Table 2). Numerous online resources provide QTc calculators such as MDCalc.com, however at the time of writing this, MDCalc only uses Bazett's. CliniCalc offers an online calculator that reports all four values and uses the QT interval and either the R-R interval or heart rate. This can be found at clinigate.com/clinicalc/corrected-qt-interval-qtc.php. Whichever formula is used should be reported with the documented QTc value.

Table 2. Currently accepted QTc formula.

Bazett's[A]	$QTc = QT \div RR^{1/2}$
Fridericia	$QTc = QT \div RR^{1/3}$
Framingham[B]	$QTc = QT + 0.154 \times (1 - RR)$
Hodges[B]	$QTc = QT + 1.75 \times (\text{heart rate} - 60)$

A) Should only be used if the heart rate is 60 - 100 beats per minute

B) These provide the most accurate QTc across all heart rates and are preferred by the American College of Cardiology

A common question is "Why not just use the computer-generated QTc or diagnostic statement rather than waste all this time with measuring and math?" Modern monitors often use their own proprietary measurement and calculation techniques and as such they are difficult to independently verify or study. Garg and Lehman (2013) revealed that in 16,235 EKGs where the reported QTc exceeded standard duration cut-offs, only 47% included language on the diagnostic statement to indicate that the QT was prolonged. Many even reported that the EKG was overall "normal." As such, the provider has a responsibility to always verify that a "normal" QT interval is in fact normal. Figures 1 and 2 demonstrate a case of a monitor's inaccurate QTc calculation. This patient is **an elderly female that** presented with syncope during a bowel movement. The monitor reported her QT/QTc as normal (474/442 ms) while manual measurement and Bazett's formula reveal a QT/QTc of 630/575 ms. The patient had hypomagnesemia (1.2 mEq/L) and a 12 second run of TDP (Smith, 2014).

TREATMENT

Discovery of LQTS in an adult does not prompt any specific therapy other than identification and treatment of the cause. If the patient with acquired LQTS develops TDP they should be treated with IV magnesium 1-2 grams over 30-60 seconds which may be repeated in 5-15 minutes. TDP is usually self-limiting and in an otherwise stable patient electrical therapy may not be required. However, if the patient becomes unstable or develops VF then DC defibrillation is indicated. Synchronized cardioversion can be attempted if the patient with TDP has a pulse, however the monitor may not be able to synchronize due to nature of TDP. If this happens, defibrillation is indicated even if the patient has a pulse. Other possible therapies include temporary transvenous atrial (ventricular if there is an AV block) pacing at a rate of 90 - 110 bpm or isoproterenol since these will increase the heart rate and shorten the QT interval. Agents that slow the heart rate should be avoided in acquired LQTS. This is a major distinction between treatment of inherited vs. acquired LQTS. The primary treatment of inherited LQTS (depending on the specific phenotype) is beta blockade and avoidance of tachycardia whereas cases of acquired LQTS are more likely to develop TDP if they become bradycardic.

In drug-induced acquired LQTS the causative agent must be stopped and not used again. A potential pitfall can occur in a patient with LQTS secondary to an antidysrhythmic agent, especially if the patient was being treated for a ventricular dysrhythmia. Imagine the case of an elderly patient presenting with ventricular tachycardia and being prescribed amiodarone. If the patient develops TDP or VF after starting the amiodarone it would seem reasonable to think this was due to inadequate pharmacological control and that the amiodarone dose needed to be increased. However the TDP or VF may be

due to drug-induced acquired LQTS in which case increasing the dose would worsen the patient's condition. The appropriate treatment in this case would be discontinuation of amiodarone and transition to another antidysrhythmic. Be cautious of any patient that presents with a new or worsening ventricular dysrhythmia after starting a class Ia or III antidysrhythmic, as it may be a manifestation of acquired LQTS.

Long-term treatment of acquired LQTS is rarely required because there should be resolution once the cause is addressed. If there is not resolution then the clinician should consider a couple different options. First it is possible that the suspected agent was not in fact the cause of the LQTS or the patient has multiple factors contributing to their LQTS. Second the patient may fail to respond to appropriate interventions or it may not be possible to remove the offending agent, though this is less likely with today's plethora of pharmaceutical options. These patients may benefit from implantation of a permanent pacemaker or AICD.

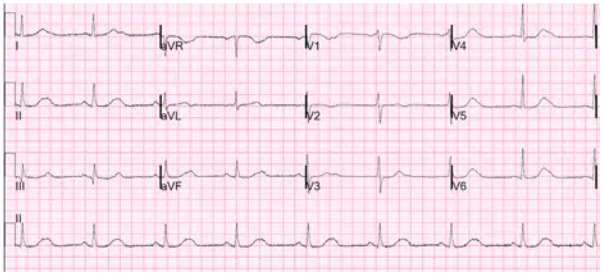

Figure 1. Computer values: PRI 174ms, QRS 106ms, QT 474ms, QTc 442ms. Source: Dr. Smith's ECG blog, reproduced unaltered under Creative Commons license.

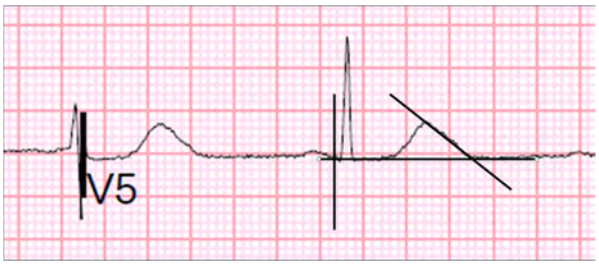

Figure 2. Manual measurement using the maximum slope intercept method reveals QT of 630ms and calculation using Bazett's shows a QTc of 575ms. Source: Dr. Smith's ECG blog, reproduced unaltered under Creative Commons license.

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LICENSED TO PRACTICE MEDICINE, PRESCRIBE & DISPENSE

Michelle Gormas, PA-C, Member, Michigan Board of Medicine

I am honored to serve the Michigan Board of Medicine representing Michigan's 5,670 licensed PAs. The Board of Medicine routinely receives updates from the Michigan Department of Licensing and Regulatory Affairs (LARA) regarding changes impacting the practice of medicine. There have been many updates for PAs since our practice laws changed last year including updated rules, regulations and reimbursement protocols.

Michigan law now defines PAs along with our physician colleagues as the only prescribers licensed to practice medicine.

LARA recently notified MAPA that PAs are eligible (and required) to receive an additional prescriber license for prescribing controlled substances in a drug treatment program. This is the third prescriber license Michigan PAs are able to obtain since being defined in the law as prescribers. The three prescriber licenses available to PAs are the Controlled Substance License (CSL) for prescribing controlled substances, the Drug Control License to dispense drugs from a medical practice, and now a separate Controlled Substance License for prescribing in an approved drug treatment program.

Failing to follow license requirements could result in disciplinary action from the PA Taskforce including the loss of your PA license. Some of these rules are highly nuanced so it is important to understand all the requirements when you dispense or prescribe controlled substances. Here are the requirements LARA outlines in each of their license applications.

CONTROLLED SUBSTANCE LICENSE

A controlled substance license is required for every person who manufacturers, distributes, prescribes, or dispenses any controlled substance in Michigan as described in Article 7 of Public Act 3.68 of 1978, as amended. A separate controlled substance license is required for each business location from which you manufacture, distribute, or dispense controlled substances. If you only prescribe controlled substances at more than one location, you only need one controlled substance license. All practitioners, and veterinarians who dispense controlled substances in Schedules 2-5 must report this prescription data to the Michigan Automated Prescription System (MAPS) as stated in Board of Pharmacy Rules 338.3162d. YOUR ADDITIONAL CONTROLLED SUBSTANCE LICENSE WILL EXPIRE ON THE SAME DATE AS YOUR PROFESSIONAL LICENSE.

Cost: $88.40

DRUG CONTROL LICENSE

A drug control license must be obtained by all licensed medical doctors, doctors of osteopathic medicine, podiatrists, optometrists, dentists, and physicians assistants WHO ROUTINELY DISPENSE DRUGS from their principal place of practice. A drug control license is not necessary if the dispensing involves only the issuance of complimentary starter dose drugs. YOUR DRUG CONTROL LICENSE WILL EXPIRE ON THE SAME DATE AS YOUR PROFESSIONAL LICENSE. All practitioners who dispense controlled substances in Schedules 2-5 must report this prescription data to the Michigan Automated Prescription System (MAPS) as stated in Board of Pharmacy Rules 338.3162b(d).

Cost: $46.80

CONTROLLED SUBSTANCE LICENSE APPLICATION PRESCRIBING IN A DRUG TREATMENT PROGRAM

P.A. 368 of 1978, as amended, requires a separate controlled substance license for physicians prescribing, dispensing, or administering controlled substances in an approved drug treatment and rehabilitation program.

Cost: $88.40

MAPA is in the process of updating the member FAQs related to each of these prescriber licenses at MichiganPA.org. It would not be possible for me to effectively represent PAs on the Board of Medicine without the support of MAPA's leaders and staff. Thank you MAPA Members for providing Michigan PAs with the resources necessary for us to practice medicine and serve our patients.

No Medical Insurance?

No Problem at Direct Pay Primary Care Practice

Sharon Dargay, hometownlife.com Published 12:45 p.m. ET Dec. 13, 2017 | Updated 10:33 p.m. ET Dec. 13, 2017

Tara Taylor (left) and Stacy Waack offer patients memberships in their new direct pay primary care practice in Milford.(Photo: Submitted)

At Benessere Wellness Center, there's no waiting, no insurance needed and no problem calling the medical providers after hours.

"When you get here at a scheduled appointment time, we get you seen immediately," says Stacy Waack, a physician assistant who opened the new family medicine practice at 1181 N. Milford Road, Suite 207, in Milford.

In some cases, patients don't even need to show up for a diagnosis. They can teleconference, send photos via email or use FaceTime or Skype.

"If you call the office and need to speak with one of us, you'll speak with us directly," she said. "After hours, you'll speak with us directly as well."

Waack and Tara Taylor, also a physician assistant, run a direct primary care practice that accepts monthly membership fees instead of insurance company reimbursements and co-pays. Adults pay $69 per month and a family of four spends $149 per month for unlimited visits, exams, urgent care and some tests.

Families pay $10 per month for each additional child. Plans also are available for children, young adults and senior citizens.

Waack, who previously worked at a medical practice that accepted insurance, came across information about direct pay while researching names for the center she planned to open.

continued

NO MEDICAL INSURANCE *CONTINUED*

More: Guess how many adults are underinsured

More: A brief explainer on Obamacare enrollment for 2018

"I came upon a clinic in the country doing a direct pay for primary care. I read more and more. The more I read, the more exciting and intrigued I was," Waack said.

"The thing about direct primary care is that, unlike traditional practices — which a lot of times have 2,000-4,000 patients on a roster — you limit it to 500-600 people. My life is so much simpler doing this. It allows me to spend more time with patients and less time doing the billing side."

PA PRACTICES

Physician assistants have been allowed to run private practices for more than a decade in Michigan, according to John Young, president of the Michigan Academy of Physician Assistants and a cardiovascular surgery physician assistant in the Beaumont Health System.

"PAs are trained in the medical model like physicians," he said. "PAs have partnered with physicians across the state to own medical practices. (Benessere) is the first time we've heard of a PA-run or PA-owned direct primary care practice."

Michigan has more than 5,400 licensed physician assistants and the number is growing, according to MAPA. Six schools offer physician assistant programs and two universities, Concordia University in Ann Arbor and the University of Michigan-Flint, are poised to offer physician assistant training.

"Michigan is the best place in the U.S. for a PA to practice," Young said. "We are proud of our proven track record of providing high-quality care with our physician colleagues."

Pairing direct primary care — which focuses on high-value services such as disease management, prevention and mental health — with a "high-value provider," such as a physician assistant, "makes a lot of sense," Young said.

Waack noted direct primary care works best for patients that don't have insurance, have insurance with high deductibles or those with chronic health conditions that need frequent monitoring. She has patients of all ages.

PREVENTION, WELLNESS

"When they come in, we do a full medical history, a family history, their personal and surgical medical history," she said. "We talk about symptoms and their mental health history. We do a full head-to-toe physical exam. We look at their skin, We run an EKG to look for immediate heart concerns and we do a urine dip. We recommend patients do comprehensive blood work. We look at health concerns and come up with a plan."

That plan might include sending the patient to a specialist, additional testing or follow-up appointments to work on weight loss or smoking cessation.

"Our goal is to focus on prevention and wellness," she said.

Waack recommends that patients get insurance for hospitalization and specialist visits.

"(Direct pay) partners well with catastrophic insurances, which has the lowest premiums, typically," she said. "If you combine the two, you can save."

Its office hours are 9 a.m. to 7 p.m. Monday; 9 a.m. to 5 p.m. Tuesday and Wednesday; 7 a.m. to 5 p.m. Thursday; 9 a.m. to 2 p.m. Friday; and 9 a.m. to 1 p.m. by appointment, Saturday.

sdargay@hometownlife.com

Read or Share this story: https://www.hometownlife.com/story/money/business/2017/12/13/no-medical-insurance-no-problem-direct-pay-primary-care-practice/927949001/

Stacy Waack PA-C will be presenting a talk about her practice at our Fall CME Conference in Traverse City.

PAs IN MICHIGAN MEDICAID MANUAL

Jim Kilmark, PA-C

Michigan's new PA law allows for PAs to be recognized for their quality of patient care. Now supervision and delegation requirements hid the PA's quality behind the supervising physician who was ultimately responsible for the patient's care. Now, Participating Physicians are only required to be consulted by a PA if patient care exceeds the PA's education, training and experience.

Payers like Blue Cross Blue Shield are now (re) credentialing and measuring PAs to better understand their quality of care based on payer metrics. Value-based payment incentives are based on these metrics. Michigan Medicaid released a draft policy which could continue PAs as "hidden providers" by reimbursing the Participating Physician for a PA's services.

MAPA submitted the following public comment response to the draft Medicaid policy. These public comments are intended to enhance PA transparency, improve quality of care and expand access for Michigan's Medicaid eligible residents.

COMMENTS

A. The Proposed Policy references PA enrollment in Community Health Automated Medicaid Processing System (CHAMPS) as an "Associate Billing Provider" (rendering/servicing -only provider) to a Participating Physician in that PA's Practice Agreement.

The Draft Policy requires PAs enrolling in CHAMPS to include the NPI of a Medicaid-enrolled Participating Physician in their Practice Agreement and identify that Participating Physician in the "Associate to Billing Provider" step in CHAMPS. This does not consider circumstances when a PA's services should not be billed to the Participating Physician in their Practice Agreement. For example: A physician-owned PLLC employs a PA who's Practice Agreement is with a different (Participating Physician) physician.

A Participating Physician is defined in the Public Health Code Section 17001(D):

> (D) "PARTICIPATING PHYSICIAN" MEANS A PHYSICIAN, A PHYSICIAN DESIGNATED BY A GROUP OF PHYSICIANS UNDER SECTION 17049 TO REPRESENT THAT GROUP, OR A PHYSICIAN DESIGNATED BY A HEALTH FACILITY OR AGENCY UNDER SECTION 20174 TO REPRESENT THAT HEALTH FACILITY OR AGENCY.

To assure payment is not misdirected to an inappropriate party, we recommend that PAs be enrolled as rendering/servicing and billing providers to include the ability of PAs to reassign payment to his/her participating physician, employer or other cost-bearing entity.

B. "Delegation" under MCL 333.16215 does not apply to a written Practice Agreement as defined in Public Act 379 of 2016.

The Draft Policy implies the Practice Agreement delegates the performance of medical care services or the prescribing of schedule 2 to 5 controlled substances. Delegation implies Supervision as outlined in the MHA memo referenced above. However, requiring PA Delegation and Supervision by a physician has been replaced in Michigan Law with the requirement of a Practice Agreement. The Practice Agreement is defined in Section 17047 of the Public Health Code as:

> SEC. 17047. (1) A PHYSICIAN'S ASSISTANT SHALL NOT ENGAGE IN THE PRACTICE AS A PHYSICIAN'S ASSISTANT EXCEPT UNDER THE TERMS OF A PRACTICE AGREEMENT THAT MEETS THE REQUIREMENTS OF THIS SECTION.
>
> (2) A PRACTICE AGREEMENT MUST INCLUDE ALL OF THE FOLLOWING:
>
> A. A PROCESS BETWEEN THE PHYSICIAN'S ASSISTANT AND PARTICIPATING PHYSICIAN FOR COMMUNICATION, AVAILABILITY, AND DECISION

continued

MEDICAID MANUAL *CONTINUED*

MAKING WHEN PROVIDING MEDICAL TREATMENT TO A PATIENT. THE PROCESS MUST UTILIZE THE KNOWLEDGE AND SKILLS OF THE PHYSICIAN'S ASSISTANT AND PARTICIPATING PHYSICIAN BASED ON THEIR EDUCATION, TRAINING, AND EXPERIENCE.

B. A PROTOCOL FOR DESIGNATING AN ALTERNATIVE PHYSICIAN FOR CONSULTATION IN SITUATIONS IN WHICH THE PARTICIPATING PHYSICIAN IS NOT AVAILABLE FOR CONSULTATION.

C. THE SIGNATURE OF THE PHYSICIAN'S ASSISTANT AND THE PARTICIPATING PHYSICIAN.

D. A TERMINATION PROVISION THAT ALLOWS THE PHYSICIAN'S ASSISTANT OR PARTICIPATING PHYSICIAN TO TERMINATE THE PRACTICE AGREEMENT BY PROVIDING WRITTEN NOTICE AT LEAST 30 DAYS BEFORE THE DATE OF TERMINATION.

E. SUBJECT TO SECTION 17048, THE DUTIES AND RESPONSIBILITIES OF THE PHYSICIAN'S ASSISTANT AND PARTICIPATING PHYSICIAN. THE PRACTICE AGREEMENT SHALL NOT INCLUDE AS A DUTY OR RESPONSIBILITY OF THE PHYSICIAN'S ASSISTANT OR PARTICIPATING PHYSICIAN AN ACT, TASK, OR FUNCTION THAT THE PHYSICIAN'S ASSISTANT OR PARTICIPATING PHYSICIAN IS NOT QUALIFIED TO PERFORM BY EDUCATION, TRAINING, OR EXPERIENCE AND THAT IS NOT WITHIN THE SCOPE OF THE LICENSE HELD BY THE PHYSICIAN'S ASSISTANT OR PARTICIPATING PHYSICIAN.

F. A REQUIREMENT THAT THE PARTICIPATING PHYSICIAN VERIFY THE PHYSICIAN'S ASSISTANT'S CREDENTIALS.

Therefore, we recommend that the first sentence in the second paragraph under the heading Practice Agreement be replaced with, "A PA may perform clinical tasks under the terms of a practice agreement with a participating physician per section 17047 of the Public Health Code. The PA must hold a current physician assistant license and a controlled substance license in Michigan in order to prescribe controlled substances."

C. The Draft Policy Identifies PA as a Rendering/ Servicing Only provider not eligible to receive direct reimbursement.

Access for Michigan's Medicaid-eligible population may be improved by enrolling PAs as Billing Providers in some circumstances. PAs are eligible for the Medicaid primary care rate uplift as approved in the MDHHS budget, but the impact of this incentive may be difficult to measure without identifying PAs as billing providers in Medicaid. Michigan PAs have the ability to engage in the corporate practice of medicine by owning (up to 99%) a Professional Limited Liability Company (PLLC) to treat Medicaid eligible residents.

Two state Medicaid programs surrounding Michigan, Ohio and Indiana, authorize PAs as billing providers. Forty-three states enroll PAs as Medicaid providers like Michigan. Direct payment, and the concomitant ability to reassign benefits, provides the necessary flexibility to meet the clinical needs of patients in a variety of practice settings while assuring that the most appropriate cost-bearing entity (i.e. employer, PA, practice setting) receives payment for services provided. Measuring PA value as a billing provider in Michigan Medicaid is something we welcome, particularly if there is an opportunity to better measure the impact of primary care access through PA incentives and for PAs to enter into a value-based contracts with Medicaid and/or a Medicaid Health Plans.

PAs are well positioned to transition into areas of provider shortages and share risk through value-based Medicaid reimbursement. PAs represent over 10% of providers practicing medicine in Michigan. This is an opportunity to measure and impact PA quality to ensure safer patient care.

Thank you for the opportunity to provide comments regarding this Proposed Policy.

MICHIGAN ACADEMY of PHYSICIAN ASSISTANTS

MAPA MISSION

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

MAPA VISION

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

MAPA VALUES

- PAs are advocates of accessible and compassionate health care
- PAs promote improved health in our communities through a team-based approach
- PAs have a commitment to lifelong personal and professional learning
- PAs adhere to the AAPA Code of Ethical Conduct
- Promote the acceptance and utilization of PAs
- Instill the values of accountability and transparency in the work environment
- Promote excellence and equity in the delivery of cost effective quality health care
- Foster mutual support and inclusion of all PAs

PROTECTING ADULTS:
ARE YOU MEETING THE STANDARDS FOR ADULT IMMUNIZATION PRACTICE?

Guest Contributor: **Jacklyn Chandler, M.S., Outreach Coordinator, MDHHS Division of Immunization**

Making sure your adult patients are up-to-date on vaccines recommended by the Centers for Disease Control and Prevention (CDC) and the Michigan Department of Health and Human Services (MDHHS) gives them the best protection available from several serious diseases and related complications. The National Vaccine Advisory Committee (NVAC) recently revised and updated the Standards for Adult Immunization Practice to reflect the important role that all healthcare professionals play in ensuring adults are getting the vaccines they need.

These new standards were drafted by the National Adult Immunization and Influenza Summit (NAIIS) of over 200 partners, including medical associations, state and local health departments, pharmacists associations, federal agencies, and other immunization stakeholders[1]. What makes adult immunization a priority for leaders in medicine and public health?

Every year, tens of thousands of adult Americans suffer serious health problems, are hospitalized, and even die from diseases that could be prevented by vaccines[2]. These diseases include shingles, influenza, pneumococcal disease, hepatitis A, hepatitis B-related chronic liver disease and liver cancer, HPV-related cancers and genital warts, pertussis ("whooping cough"), tetanus and more. Yet, adult vaccination rates remain extremely low. For example, coverage rates for Tdap and zoster vaccination are less than 30% for adults who are recommended to receive them[3]. In Michigan, even high risk groups are not getting the vaccines they need – only 30.6% of adults younger than 65 years old who are high risk for complications from pneumococcal disease are vaccinated[4].

It is imperative to let your patients know that vaccination is important, because it not only protects the person receiving the vaccine, but also helps prevent the spread of certain diseases, especially to those that are most vulnerable to serious complications- such as infants, young children, the elderly, and those with weakened immune systems. Immunizing adults creates healthier communities and protects the places in which we live, work and play.

Adult patients trust their healthcare provider to advise them about important preventive measures. Most health insurance plans provide coverage for recommended adult vaccines. Furthermore, research indicates that most patients are willing to get vaccinated, if it is recommended by their provider[5,6]. However, many patients report their healthcare providers are not talking with them about vaccines, missing critical opportunities to immunize[7].

MDHHS and MAPA are calling on all Michigan PAs to make adult immunizations a standard of routine patient care in their practice by integrating four key steps[8]:

1. **ASSESS immunization status of all your patients at every clinical encounter**. This involves staying informed about the latest CDC recommendations for immunization of adults and implementing protocols to ensure that patients' vaccination needs are routinely reviewed.

2. **Strongly RECOMMEND vaccines that patients need**. Key components of this include tailoring the recommendation for the patient, explaining the benefits of vaccination and potential costs of getting the diseases they protect against, and addressing patient questions and concerns in clear and understandable language.

3. **ADMINISTER needed vaccines or REFER your patients to a provider who can immunize them**. It may not be possible to stock all vaccines in your office, so refer your patients to other known immunization providers in the area to ensure that they get the vaccines they need to protect their health. Coordinating a strong immunization referral network will reduce a substantial burden on your adult patients and your practice. If your adult patients do not have insurance, or if their insurance does not cover any of the cost of an immunization, check with your local health department to see if your patient qualifies for the following public vaccines: Td, Tdap, MMR, Hep A, Hep B or Zoster.

4. **DOCUMENT vaccines received by your patients.** Help your office, your patients, and your patients' other providers know which vaccines they have had by documenting in the Michigan Care Improvement Registry (MCIR). And for the vaccines you do not stock, follow up to confirm that patients received recommended vaccines.

Want to learn more? MAPA is hosting a CME lecture on Adult Immunizations Update at the 2016 MAPA Fall CME Conference in October. For more information, please refer to the MAPA website for a link to the CDC and for Fall Conference registration and conference schedule at: www.michiganpa.org . There will also be an adult immunization vaccine schedule in the registration material for all conference attendees. MAPA is a participant in the Adult Immunization Multi-Stakeholder Initiative with a stipend to support programs and information to increase awareness and implement standards for adult immunization at Michigan health care practices. Other participating organizations include: ACOG, ACP, HCA, MAFP, MAOFP, MCNP, LARA, MHA, MNA, MOA, MSMS, MPA and MPCA.

Additional educational resources are available to provider offices, including free immunization educational sessions through the MDHHS Immunization Nurse Education program and the Physician Peer Education Project on Immunization. The educational sessions through both educational programs are approved for continuing medical education credit. Visit www.aimtoolkit.org – click "Information for Health Care Professionals" and "Education & Training" for more complete information[9].

Informational brochures about immunization topics are available free of charge from MDHHS. A variety of materials is available and can be ordered online at www.healthymichigan.com – click "Enter Site" and "Immunizations" to begin adding resources to your cart. In spring 2016, the "AIM Packet – Adult" was added- the contents focus on adults and include the immunization schedule, brochures, posters, and other educational flyers and resources for your practice.

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2nd Annual Henry Ford Health System Advanced Practice Provider CME/CE Symposium

November 10, 2018, Henry Hotel, Dearborn, MI

Henry Ford Health System is offering an Advanced Practice Provider CME/CE Symposium on November 10th, 2018 at The Henry Hotel, Dearborn, MI. This CME/CE conference is geared toward Advanced Practice Providers (NP, PA, CNM, CRNA) and offers a variety of presentations for clinical practice. Keynote Speaker Colonel Kathleen Flarity, DNP, PhD, CEN, CFRN, FAEN whose topic "Igniting Passion in Practice" will suggest a path toward improving your personal / professional resiliency. Additional presentation topics include: Functional Medicine, Living Organ Donation, Drug Resistance in ID, Hair Loss and Hyperhidrosis, Osteoporosis and the Aging, Oncology Immunotherapy, Structural Heart Disease, Multi-nodal Pain Management. Pre-registration required: Cost $100 and includes breakfast, lunch, CE/CME. Discounted hotel room rates are available for those requiring overnight accommodations.

Preceding the symposia will be an optional free non-CME dinner (November 9th, 6-8pm) offered by Boston Scientific who will present information on the Watchman Device. Separate registration is required.

Registration & details: 21183-11/10/18 Advanced Practice Provider Fall Symposium Registration Link Questions:vgraves1@hfhs.org

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MAPA PLANNER

EVENTS/ CONFERENCES

MAPA FALL CME CONFERENCE

DATE: October 4-7, 2018

SITE: Grand Traverse Resort and Spa
Acme, Michigan

mapafallevents.org

MAPA LEADERSHIP SUMMIT

DATE: Spring 2019

SITE: Lansing, Michigan

michiganpa.org

MAPA SPRING CME CONFERENCE

DATE: TBD

SITE: TBD

mapaevents.org