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FEATURES

PAragon Awards

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STEAD AWARD PHOTO: FRED GREAVES
LAS VEGAS PHOTO: SHUTTERSTOCK

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Read *PA Professional* Online!

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American Academy of PHYSICIAN ASSISTANTS
Connecting PAs, Transforming Care

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A Year of Lessons

AS I REFLECT ON THE 12 MONTHS I've spent as AAPA president, many things come to mind. It has been a challenge to balance the requirements of the job with my responsibilities as a PA in pediatrics, but the opportunities I had to meet with PAs from across the country were well worth the extra effort. As is the case with so many pursuits, the more I learn about our profession, the more enthusiastic I am about the work we're doing.

The thousands of PAs I've met with over the past year practice in nearly all specialties and see patients from every conceivable population. Whether they work in rural areas where they are the only clinician for 50 miles, or in densely populated metropolitan areas, they all seem to share the same spirited approach to their work. In many professions, idealism and enthusiasm are considered signs of inexperience. I've not found that to be the case with PAs. PAs who have been in practice for 20 years are just as excited about their work as those who are barely out of school.

What is it about our profession that leads to such a high degree of job satisfaction? The specific reasons most likely differ from person to person, but one of the underlying reasons is that our work is never short of challenges. I've found the same to be true in my role as AAPA president. The fact that our profession has grown from three to nearly 80,000 in about 45 years is impressive in itself. But consider the hurdles we've cleared along the way. There's a sense of accomplishment after each victory, but it's never long before the next challenge arises. After speaking with so many of you over the past year, I'm more confident than ever in our ability to meet any challenges that arise.

I sincerely thank you for giving me the opportunity to serve as your president. This has truly been a remarkable experience that has exceeded my expectations. I am prouder than ever to be a PA, in no small part because of the incredible work my fellow PAs are doing across the country. It's an exciting time to be part of our profession, and I look forward to working with all of you as we continue to achieve. **PA**

Patrick Killeen MS, PA-C

PATRICK KILLEEN, MS, PA-C
AAPA President, 2010–2011

BY AAPA STATE ADVOCACY AND OUTREACH STAFF

Latest PA Legislation Roundup

Legislative Session Ends in Six States

AS THE SECOND QUARTER OF THE YEAR DRAWS TO A CLOSE, so do a number of part-time state legislatures. While 39 states and the District of Columbia continue to debate and legislate, six state legislatures—Kentucky, New Mexico, Utah, Virginia, West Virginia and Wyoming—have closed the books on another legislative year.

AAPA state advocacy staff continues to monitor nearly 400 bills in over 30 states and work with state chapters on specific legislative and regulatory initiatives. For more information on a specific bill pending in a state legislature, or for more information on the services AAPA state advocacy staff can provide you and your chapter, please send an e-mail to Ann Davis, PA-C, senior director of state advocacy, at *ann@aapa.org.*

CALIFORNIA: The California Academy of PAs has a long history of stepping up to clarify complicated issues, and this year is no exception. SB 233 amends Section 1317.1 of the *Health and Safety Code* for the purpose of clarifying explicitly that a physician assistant can continue to provide care in an emergency care setting. Although the language of the PA practice act expressly permits PAs to perform any service for which the PA is adequately prepared by education and training in any setting as delegated by a supervising physician, a section of California law governing emergency departments included language that did not expressly authorize care provided by PAs. SB 233 expands the definition of emergency services and care to cover care provided by a PA. The bill also expands the definition of consultation to authorize physician assistants to conduct consultation. Sometimes laws that exist outside of the PA practice act require amendment to promote clear authorization for PAs to provide care.

COLORADO: Gov. John Hickenlooper recently signed two bills into law, both of which recognize PAs. Senate Bill 12 amends the education law to require schools to set policies regarding student self-administration of prescribed medication. Original language in the bill referred only to prescriptions written by a physician. However, the bill was amended to include medications prescribed by PAs.

Senate Bill 40 creates a new law requiring health care providers to assess and certify a student athlete's ability to return to play after a concussion. PAs are specifically listed in the definition of "health care provider." This new law takes effect Jan. 1, 2012.

GEORGIA: The Georgia Composite Medical Board recently adopted new regulations governing physician assistant practice that will implement changes made to both the state medical and PA practice acts via the passage of HB 509 during the 2009 legislative session.

IOWA: In a legislative session that has already been very productive for PAs in Iowa, two bills that improve the laws governing PA practice have been signed into law by Gov. Terry Branstad. HF 393 allows PAs to sign death certificates, and was signed by Gov. Branstad on April 6. SF 149 allows PAs to sign medical reports for the Iowa Department of Transportation, and was signed by Gov. Branstad on March 30. Three bills improving PA practice in Iowa have now been signed into law during the 2011 session. On March 17, Gov. Branstad signed SF 72, authorizing PAs to join limited liability companies. All three bills were strongly supported by the Iowa Physician Assistant Society and AAPA.

NORTH DAKOTA: The state legislature passed five bills that add PAs to existing laws, including signing death certificates and providing medical advice related to a person's ability to operate a motor vehicle. Most noteworthy, Senate Bill 2154 adds a PA seat to the North Dakota Board of Medical Examiners. All five bills await Gov. Jack Dalrymple's signature.

SHUTTERSTOCK

Sometimes laws that exist outside of the PA practice act require amendment to promote clear authorization for PAs to provide care.

RHODE ISLAND: A bill (H 5672) would clarify that PAs can provide care in natural disasters and emergency situations. Even though Good Samaritan laws in Rhode Island and other states protect all individuals from civil liability for trying to provide care in good faith during an emergency, PAs face an additional hurdle because of the requirement that PAs can provide care only with physician supervision. In many states, care must be provided with supervision from the specific physician who is authorized to supervise the PA. So if a PA treated a car crash victim on the side of a highway until emergency personnel arrived at the scene, the PA would be immune from civil liability, but if the supervising physician was not available at the time, the PA would potentially be vulnerable to professional sanctions. In a disaster or emergency situation, PAs may not be able to reach their supervising physician. H 5672 would specify that in such a situation, PAs would be allowed to provide care with supervision from any physician who is available or without supervision if no physician is available. The bill's language is based on AAPA Model State Legislation and is supported by the Rhode Island Academy of Physician Assistants. Rhode Island joins Oklahoma in considering legislation to address this issue in 2011.

VERMONT: On April 7, during a hearing of the House Committee on Health Care, Physician Assistant Academy of Vermont President John Bond, PA-C, delivered testimony in support of a bill to modernize the PA practice act. The bill, H 369, would make Vermont's laws more consistent with AAPA's Six Key Elements of a Modern PA Practice Act. Among the bill's most important changes are that it makes PAs in Vermont licensed, instead of certified. The bill also replaces an outdated requirement for detailed protocols to be approved by the Board of Medical Practice with a new requirement for a written delegation agreement that is approved by the PA and the supervising physician. Several members of PAAV's legislative committee were in Montpelier for the hearing. PAAV posted a video of their visit on YouTube at *http://bit.ly/hc5zTN*.

VIRGINIA: The outcome of the Virginia Academy of Physician Assistants' Advocacy Day at the state capitol in early January has proven successful three times over. Via the enactment of Senate Bill 1144, Senate Bill 1117, and House Bill 1968, effective July 1, 2011, PAs in Virginia will be able to perform DMV-required competency examinations, determine cause of death and sign death certificates, and be authorized to sign any form that requests a physician signature.

WEST VIRGINIA: PAs in West Virginia made legislative strides in provisions outside of the medical practice act that governs the profession. Through the enactment of Senate Bill 488, the state's HIV testing statute has been amended to conform with the most recent recommendations from the Centers for Disease Control and Prevention. As a result, effective June 10, 2011, PAs will be allowed to ask for targeted HIV testing of a patient when there is cause to believe that the test could be positive because the patient engages in high-risk behavior; cause to believe that the test could provide information important in the care of the patient; cause to believe that the results of HIV testing of samples of blood or body fluids from a source patient could yield information important in the care of medical or emergency responders or other identified persons provided that the patient whose blood or body fluids is being tested pursuant to this section must have come into contact with a medical or emergency responder or other person in such a way that a significant exposure has occurred; or when there is no record of any HIV-related testing during pregnancy and the woman presents for labor and delivery.

In addition, as a result of the enactment of Senate Bill 570, PAs rendering services in connection with events or programs offered by a nonprofit youth organization will be exempt from obtaining authorization to practice from the board of medicine or board of osteopathy while providing services within the limits of their authorization to practice, provided that they obtain a nonprofit volunteer permit.

For more state news about PAs, go to *http://bit.ly/StatePANews*. **PA**

AAPA's state advocacy and outreach staff are:
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LIZ ROE, director, at *eroe@aapa.org*.
STEPHANIE RADIX, JD, director, at *sradix@aapa.org*.
DAVID ASHNER, assistant director, at *dashner@aapa.org*.

BY MICHAEL POWE

Incident-To Billing

Still Relevant? Still Legal?

"INCIDENT-TO" is a Medicare program billing option that has been in place for decades. Originally established to account for the ancillary services provided by RNs, LPNs and medical assistants, such as injections and blood pressure readings, it was adapted to allow higher-level services delivered by PAs and NPs to be reported at a time when there was no payment category to cover those services.

Incident-to billing allows office or clinic services performed by a PA to be billed under the name of the PA's supervising physician. The bill for the PA's services is submitted to Medicare as if the service had been delivered by the physician. This allows the service to be paid at 100 percent of the Medicare physician fee schedule, as opposed to payment at 85 percent if the service is billed under the PA's name. Practices that utilize incident-to billing should be certain that the rules and additional supervision requirements are clearly understood and applied.

Medicare billing for incident-to services applies only to the private office or clinic setting. Under Medicare's rules, incident-to billing should not be used in the hospital or nursing home setting. In very rare instances, it may be possible to have a private office or clinic located in a nursing home or hospital setting.

Incident-to billing requires that the physician examine, diagnose and establish a treatment plan for a particular medical problem, or for an established patient who presents with a new medical problem. PAs can provide subsequent or follow-up care for the patient during future visits and bill those subsequent services under the physician's name as long as a physician is in the suite of offices. On that first visit, the PA or another member of the physician's staff may perform the past, family and social history and the review of systems. However, it is important that the history of present illness, the exam and the medical decision making be performed by the physician. (or repeated, if previously performed by the PA before the physician sees the patient).

In addition, the supervising physician (or another physician member of the same group) must be physically present in the office suite when the PA renders a subsequent service. Medicare does not require that a physician be in the same exam room or personally treat the patient when PAs deliver subsequent care. It would not be appropriate for the physician to be in another building or across the street at the hospital when the services of the PA are being billed incident to that physician.

If the practice meets the criteria, the visit may be billed under the physician's name. If you are working in a group, bill under the physician who is physically on site and providing supervision at the time of the PA service. For example, if Dr. Smith examined the patient on the first visit and developed a plan of care for hypertension, but Dr. Johnson is on site when the PA treats the patient on a follow-up visit for that same condition, bill the service under Dr. Johnson.

Medicare does not require that PAs bill their services under the incident-to provision. PAs can treat all Medicare patients (new patients or established patients with a new medical problem) and bill under their own provider numbers. When you bill under the PA's name, Medicare does not require that a physician be on site when care is provided. State law will determine supervision. Reimbursement is made to the PA's employer at 85 percent of the fee schedule. When billing

PAs can treat all Medicare patients (new patients or established patients with a new medical problem) and bill under their own provider numbers.

PHOTOS / TODD SPOTH

a service under the PA's name, always bill at the full physician rate. Use of the PA's name and national provider identification number will alert Medicare to pay at the 85 percent rate.

Medicare regulations also indicate that the physician should remain involved in the patient's ongoing care to demonstrate his or her participation in the care of the patient. While the program does not specify how that should be accomplished, it would be reasonable to suggest that a periodic examination by the physician would be appropriate. Some would also propose that having the physician review the patient's chart would also meet the standard.

Incident-to is a billing concept that is often misunderstood. Improper use of incident-to billing may lead to allegations of fraud and abuse. Because of potential confusion and concerns about fraud and abuse, many practices have decided not to use incident-to billing and simply allow PAs to bill under their own names. Under that scenario, billing is simplified, the potential for fraud and abuse reduced, and in many instances patients flow through the practice more efficiently. The belief is that patient volume grows and patient waiting time goes down. To those practices, those advantages make up for the 15 percent payment differential.

Finally, realize that incident-to is a Medicare term that is often used by private payers to mean something else. Private payers often don't have the same requirements as Medicare for the initial physician exam and the on-site presence of the physician. The majority of private payers use incident-to to indicate that the PA's services should be billed under the supervising physician's name. In most cases, the private payers defer to state law regarding the ability of PAs to perform the initial exam and physician supervision can be satisfied with cell phone access between the physician and the PA. However, Aetna, one of the larger private payers in the market, has adopted the Medicare incident-to billing requirements.

The key is to realize that there is not a one-size-fits-all model for reimbursement. It is essential that you know the specific billing rules for each payer in your market. **PA**

MICHAEL POWE is AAPA's vice president for reimbursement and professional advocacy. Contact him at *michael@aapa.org* or 571-319-4345.

The key is to realize that there is not a one-size-fits-all model for reimbursement. It is essential that you know the specific billing rules for each payer in your market.

The Votes Are In

Your votes for AAPA's 2011 general election have been counted and certified. Here are the newest members of AAPA's Board of Directors, who will take office June 10:

President-elect
James Delaney

Directors-at-large

Michelle DiBaise

Jeffrey Katz

John McGinnity

About 9 percent of the 31,381 eligible AAPA fellow members cast their ballots in the election, which was open from March 14 through April 14. The new board members will join the following individuals on the 2011-2012 AAPA Board of Directors:

- Patrick Killeen, Immediate Past President
- Robert Wooten, President
- Bruce Fichandler, Secretary-Treasurer (2011-2012)
- Larry Herman, Director-at-Large (2010-2012)
- Michael Doll, Director-at-Large (2010-2012)
- Peggy Walsh, Student Academy Representative
- Three House of Delegates officers who will be elected at the 2011 House of Delegates meeting in Las Vegas

For more on the election results, visit AAPA's Election 2011 page at *http://bit.ly/gpJr85*

The ABCs of Medicare Preventive Services

PAs may provide Medicare preventive services, including the initial preventive physical examination (aka "Welcome to Medicare" exam) and the annual wellness visit. There are many rules, requirements, limitations and screening schedules for these services.

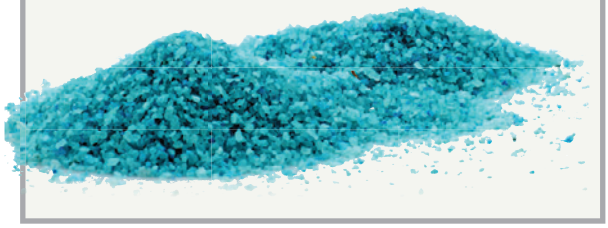
The Medicare Learning Network has released three new quick reference charts to help navigate the Medicare Preventive Services and Annual Wellness Visit benefit.

- The ABCs of Providing the Initial Preventive Physical Examination, *http://1.usa.gov/h8hzK5*
- The ABCs of Providing the Annual Wellness Visit, *http://1.usa.gov/flkZ3Z*
- Medicare Preventive Services, *http://1.usa.gov/fSgszZ*

For more information, contact Tricia Marriott, AAPA director of reimbursement advocacy, at *tmarriott@aapa.org*.

States Banning "Bath Salts"

Nine states have banned products labeled as bath salts and laced with a powerful synthetic stimulant that is eliciting extreme adverse events among those using them to get high. Still legal in much of the country, the product causes increased blood pressure and heart rate, agitation, hallucinations, extreme paranoia and delusions, reports the American Association of Poison Control Centers. For more information, go to *http://bit.ly/hSWxeo*.



New Chief Learning Officer Joins AAPA

MIKE SAXTON, AAPA'S CHIEF LEARNING OFFICER, has been active in the CME and continuing professional development profession for over 20 years, with a primary focus in the commercial support setting. During that time, he has been an advocate for transforming continuing education in the health professions so that it contributes to improved health care quality and safety.

At the Academy, he will work toward improving the quality of medical education, expanding practice-based learning and improvement opportunities, strengthening financial support and developing a higher level of team-based interprofessional education. All of these efforts will support the Academy's mission and the patient-centered medical home paradigm.

Saxton also has built a record of volunteer activities, including serving on the Alliance for Continuing Medical Education Board of Directors, the CME Advancement Task Force, and the AMA National Task Force on CME Provider & Industry Collaboration, and serving as chair of the 2007 ACME Annual Conference; being part of the editorial board of the *Journal of Continuing Education in the Health Professions;* and serving as co-chair of the Pharmaceutical Alliance for CME.

Saxton earned a Bachelor of Science degree in microbiology from Virginia Tech and a Master of Education degree in adult education from the University of Georgia.

DHANFORD / ISTOCK, DOBROSLAWA SZUK, APPLER / SHUTTERSTOCK

Tweeting IMPACT 2011

PA Twitter users may follow IMPACT 2011 activities and events with the following hash tags:

- IMPACT 2011: #aapaIMPACT
- AAPA Annual Town Hall Meeting: #aapaTH
- AAPA House of Delegates: #aapaHOD

AAPA Invited to "Join Forces" with White House

AAPA is participating in a new White House initiative, Joining Forces, to support and honor America's service members and their families. The initiative aims to educate, challenge and spark action from all sectors of our society, including the health care community, to ensure military families have the support they need and have earned.

Joining Forces was launched by President Barack Obama, Vice President Joseph Biden, first lady Michelle Obama and Jill Biden, PhD, during a news conference attended by AAPA President Patrick Killeen and other leaders from health care, business, nonprofit and philanthropic communities as well as faith-based organizations. The audience included Joint Chiefs of Staff Chairman Adm. Mike Mullen; Gen. David Petraeus, the former top commander in Afghanistan; and Eric Spiegel, president and CEO of Siemens Corp., the U.S. unit of Germany's Siemens AG.

"The Academy continues to investigate opportunities to partner with the White House and the Joining Forces campaign," Killeen said. "It's the Academy's goal to meet the educational needs of physician assistants caring for the physical and mental health of our service members and their families."

Joining Forces is designed to build upon the president's January 2011 directive to establish a coordinated and comprehensive federal approach to supporting military families. "Strengthening Our Military Families: Meeting America's Commitment" aims to improve the quality of life of our military families, veterans, and survivors of the fallen.

On March 29, AAPA was among the medical associations representing military and civilian providers of primary care and mental health services invited to a White House meeting called "Enhancing the Well-Being and Psychological Health of the Military Family," held prior to the announcement of the Joining Forces initiative. During the meeting, Killeen raised an issue related to military families' access to care. AAPA is concerned that TRICARE does not recognize mental and behavioral health services provided by a PA.

For more information, go to *www.joiningforces.gov*.

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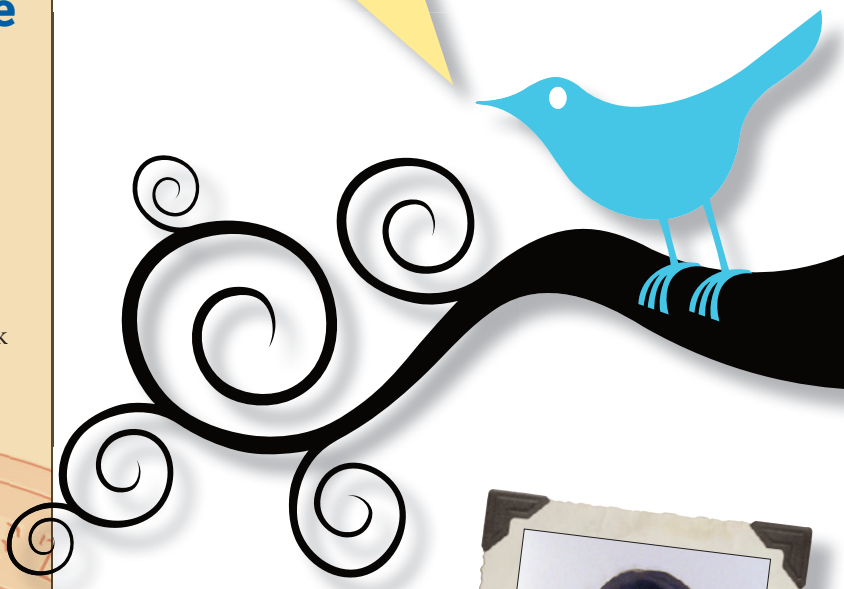


PAragon Publishing Award Winner

PA Katherine Footracer calls her professional background "eclectic," but has found a unifying theme of helping others in arts management, massage therapy and clinical care as a PA in urgent care and family practice. She began her medical career as an emergency medical technician and later worked as a massage therapist before becoming a PA in 2008. She is active in her community, serving as an LA County Surge Unit Disaster Volunteer, working at special events for the Los Angeles Chamber Orchestra, and working as a docent naturalist at the Eaton Canyon Nature Center. In the past, she has taught self-defense at a women's halfway house and first aid for the American Red Cross. She has been an active member of the AAPA House of Delegates and participates in several specialty organizations and caucuses. She won the PAragon Publishing Award for her article, "Travel-Related Infections: Diagnosis and Treatment of Exotic Fevers," published in the *Journal of the American Academy of Physician Assistants* in October 2010. She has served as a peer reviewer for JAAPA and AAPA's clinical and pofessional poster sessions since 2009, and is a contributor to "Classroom to Clinic Study System," published in 2011.

Constituent Beat

2011 Constituent Organization Awards of Achievement

The AAPA Constituent Relations Committee is proud to announce the 2011 Constituent Organization Awards of Achievement, or COAA, winners cited for their outstanding achievements. COAA recipients are recognized for outstanding and successful execution of programs that yield positive impact in health care and/or the PA profession while encouraging and demonstrating leadership and organizational growth.

The CRC reviewed and judged COAA submissions in five separate categories, including small state chapter (300 or fewer members), medium state chapter (301 to 799 members), large state chapter (800 or more members), specialty organizations and caucuses. While some categories did not receive award applications, the submissions received were first-rate. "This was a particularly challenging year for the CRC in our selections, as so many of the submissions were very deserving of the Constituent Organization Award of Achievement in their category. However, there could only be one winner," noted PA Eric Smith, CRC chair.

The Pennsylvania Society of Physician Assistants is the 2011 COAA large state chapter recipient for the PSPA Free Prescription Drug Card program, a free discount prescription assistance program. PSPA partnered with the Pennsylvania Drug Card company, a division of United Networks of America, to offer anyone, regardless of income, discounts on short- and long-term medications to help the underinsured afford their prescriptions. "The CRC was quite impressed with PSPA, whose Free Prescription Drug Card program was an innovative display of community patient outreach while also advancing awareness of PSPA and the PA profession in Pennsylvania," Smith said.

The CRC also wishes to commend the Mississippi Academy of Physician Assistants, winner of the small chapter category CO Award of Achievement, for its very effective and impressive 2010 PA Day at the Capitol, which resulted in the passage of three of four bills introduced by MAPA.

The CRC presented honorable mention to several CO award applicants for their outstanding work. The Alaska Academy of Physician Assistants received honorable mention in the small state chapter category for the public service video it produced to raise awareness and educate Alaskans on physician assistants' role in the delivery of quality health care. The California Academy of Physician Assistants received honorable mention in the large state chapter category for its work with the Medical Reserve Corps to raise awareness of the critical need for participation in this vital emergency health care resource. CRC also gave the Washington Academy of Physician Assistants honorable mention for its public relations and education efforts to make PA a household word in the state.

Award winners receive $2,500 and recognition at AAPA's Annual Conference. "This year's applicant pool was very competitive and inspiring, and they all displayed the altruistic, tenacious spirit of our wonderful profession," said Smith.

GOT STUDENT LOAN DEBT?

NO ONE WANTS TO BE STUCK WITH upwards of $60,000 in student loans. But many PA students are in that situation after they graduate. The National Health Service Corps, or NHSC, offers primary care providers financial support in the form of loan repayment or scholarships so they can practice in underserved areas of the country without the burden of education debt.

The NHSC is currently expanding to help meet the need for primary care professionals. The Patient Protection and Affordable Care Act increased the amount of money allocated to educate PAs, including debt loan repayment.

As the country faces a shortage of primary care providers, the NHSC plays a critical role in bringing primary care providers to underserved communities. In return, the NHSC offers help in repaying loans. For example, clinicians who join the corps can receive up to $60,000 for a two-year full time commitment and up to $170,000 for completing a five-year service commitment.

The current application cycle for loan repayment closes on May 26. For more information, go to *http://bit.ly/i21S5p*.

IN MEMORIAM: **Robert B. Howell Jr.**

ROBERT B. HOWELL JR., a PA and former member of the AAPA Board of Directors who was instrumental in passage of the Connecticut Prescriptive Practices Act for Physician Assistants, died April 15 in Milford, Conn. He was 62.

Howell was born on Dec. 3, 1948, in Daytona Beach, Fla. He earned an associate degree in nursing from Polk Community College, a bachelor's degree in chemistry from the University of Southern Mississippi and a bachelor's degree in medicine from the University of Florida. He was a member of the first cardiothoracic heart team at Bridgeport Hospital and was formerly employed as a PA at Charter Oak Health Care and Hill Health Center.

He was active in health advocacy and hosted a television show, "Health Care from the Hill," on Public Broadcasting Service. He was active in his community and was a dedicated parishioner of St. Gabriel Church in Milford. He enjoyed music, fishing, cooking, traveling, going to the beach, and spending time with friends and family.

Howell is survived by his loving wife of 29 years, Debra; his mother, Gladys Large Howell; three daughters, Carolyn Pass, MD, and Cheryl Howell-Williams, both of Florida, and Christina T. Howell of Stamford, Conn.; five grandchildren; and many nieces and nephews. Memorial contributions may be made to the American Heart Association, P.O. Box 417005, Boston, MA 02241-7005; AAPA, 2318 Mill Road, Suite 1300, Alexandria, VA 22314-6868; or the National Kidney Foundation of Connecticut, 2139 Silas Deane Highway, Rocky Hill, CT 06067.

PROJECT ACCESS Needs You!

A MAJORITY OF AMERICA'S CHILDREN will be minorities before the decade is out, a trend that could broaden the pool of underrepresented minority applicants interested in becoming PAs. The time is now for Project Access, a joint effort by AAPA and the Physician Assistant Education Association to inspire and motivate minority youth to pursue a career as a PA.

Project Access needs PAs and PA students to talk with children and youth about the profession during IMPACT 2011 in Las Vegas. Project Access volunteers are scheduled to go to six sites around the city in an effort to reach more than 300 students.

In 2004, the Institute of Medicine released a report that put forward that increasing "racial and ethnic diversity among health professionals is important because evidence indicates that diversity is associated with improved access to care for racial and ethnic minority patients, greater patient choice and satisfaction, and better educational experiences for health professions students, among many other benefits."

PHOTO / TAMI CHAPPELL

While African-Americans, Hispanics and American Indians make up more than 25 percent of the U.S. population, PAEA says these underrepresented minorities constitute less than 11 percent of PAs.

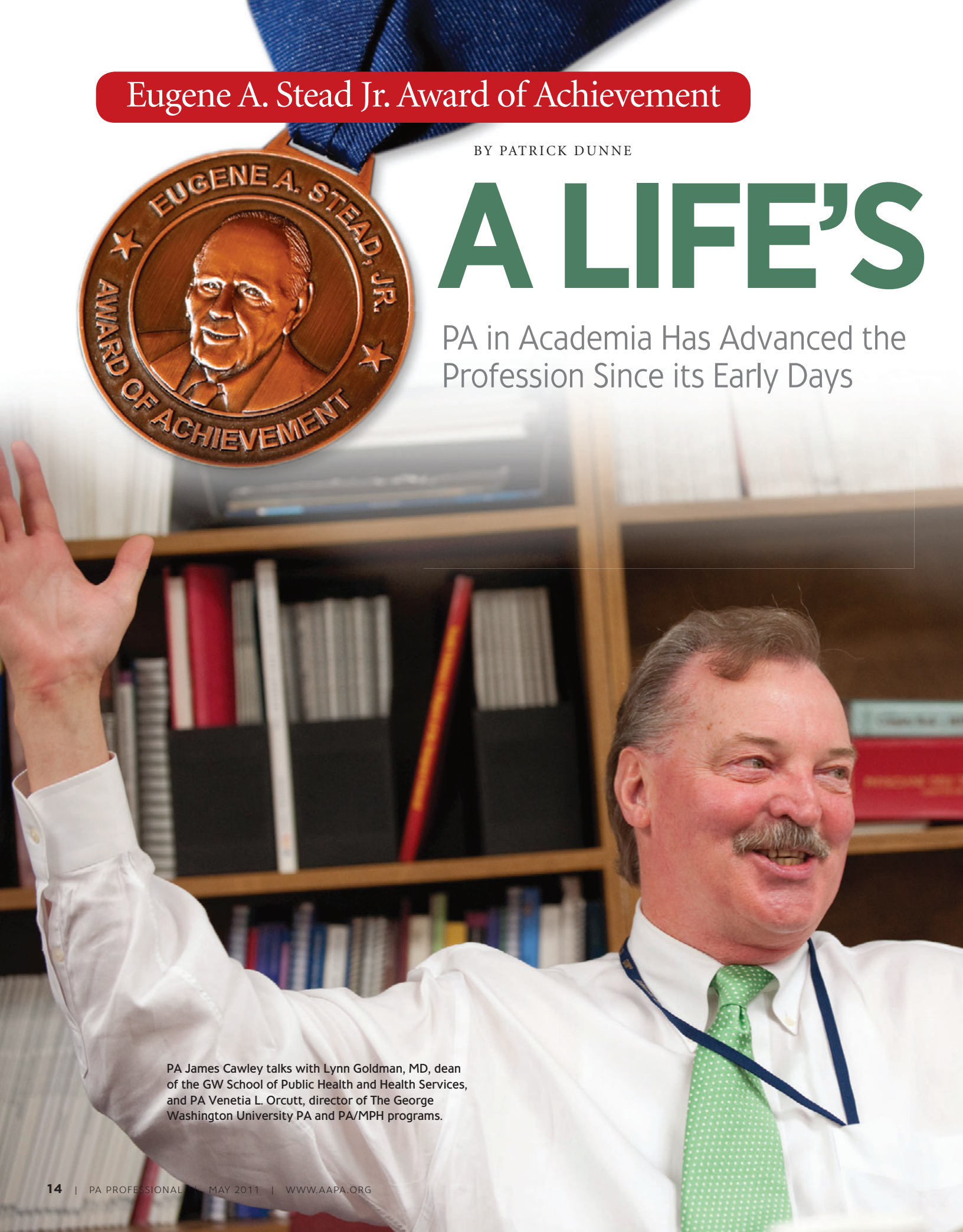
If you would like to contribute to the success of this year's Project Access outreach effort, go to *http://bit.ly/ProjectAccessForm*, or contact Cheryl Holmes, AAPA director of science and education, at 571-319-4374 or *cholmes@aapa.org*. The Project Access team will contact you to confirm logistics. **PA**

Eugene A. Stead Jr. Award of Achievement

BY PATRICK DUNNE

A LIFE'S

PA in Academia Has Advanced the Profession Since its Early Days



PA James Cawley talks with Lynn Goldman, MD, dean of the GW School of Public Health and Health Services, and PA Venetia L. Orcutt, director of The George Washington University PA and PA/MPH programs.

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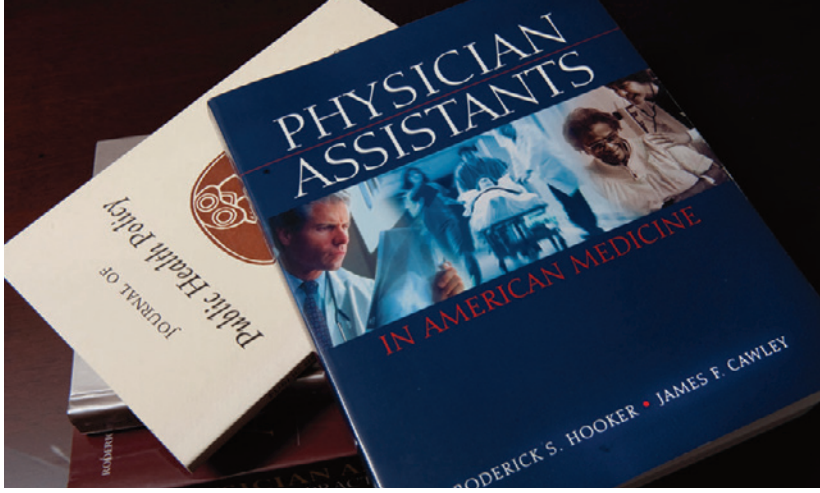

WHEN JAMES CAWLEY graduated from the Touro College physician assistant program four decades ago, he wanted to treat patients and be a family practice clinician. "I wanted to [practice] medicine and the PA program was an opportunity to enter into a profession that was new, exciting and developing back in 1972," he said.

PHOTOS / JENNA ISSACSON

His career soon moved into the academic world, where he would teach at notable institutions like Johns Hopkins, Yale and The George Washington University. He published several important PA profession research studies. Cawley also established a unique joint PA and Master of Public Health program at GWU in Washington, DC.

The AAPA Awards Committee selected Cawley as the 2011 recipient of AAPA's Eugene A. Stead Jr. Award of Achievement. The honor recognizes his years of groundbreaking research on PAs that has advanced the profession and helped increase access to primary care through use of PAs.

Every profession needs statistics and measurements of growth to determine its success and impact. The studies and books Cawley published two decades ago continue to be the baseline measurement for the profession's impact on health care. His research interests focus on the PA profession, primary care, and health workforce policy. In addition to co-authoring four books on the profession, he has published extensively in the areas of preventive medicine, nonphysician health providers, and health workforce policy.

His early and timely papers about the budding profession helped policymakers recognize PAs as potential contributors to effective and efficient health care delivery. Cawley said the PA profession's growth has been a fantastic success story, from the very humble beginnings to having 79,000 PAs out there as a perfect fit for the U.S. health care system, patients and hospitals.

"I had the good fortune a few years ago to meet Eugene Stead," Cawley said. "I talked with him at length, and…he said the PA profession was successful beyond his wildest dreams."

Cawley has been at the forefront of educating future PAs, having established the first joint PA certificate and Master of Public Health degree program in the country at The George Washington University in Washington, DC. Currently, Cawley is a professor and vice chair in the Department of Prevention and Community Health at the university's School of Public Health and Health Services. He is also a professor in the Department of Health Care Sciences in the GWU School of Medicine and Health Sciences, and Director of the PA/MPH Program at GWU.

"There were not too many people exploring and describing our profession as it grew," said Cawley. "There was a great need for people to research

Eugene A. Stead Jr. Award of Achievement

From this profession's humble beginnings to where we are today, we should be excited about the future of PAs and the way they work with patients.

The books and articles co-authored by Cawley continue to shape the way policymakers see the PA profession.

Cawley with some of his GWU PA/MPH students.

and promote the profession, and being an academic gives you a chance to work with policymakers to educate them on the profession."

Cawley has worked with several high-ranking groups in the public sector to promote the value and essential nature of the PA profession. He previously chaired the U.S. Bureau of Health Professions' Advisory Group on Physician Assistants and the Work Force, and was principal author of its report to the Council on Graduate Medical Education.

He also served as a member of the U.S. Public Health Service National Coordinating Committee on Clinical Preventive Services and as a Primary Care Health Policy Fellow in the federal Health Resources and Services Administration. His public health endeavors include a stint with the Epidemic Intelligence Service of the CDC, where he was a fellow of the Association of Teachers of Preventive Medicine.

Yet not all of his advocacy work on behalf of the profession is centered on the United States. Cawley recently went to Australia to meet with health officials at several universities about ways to incorporate PAs into their health care system.

"Right now, they aren't producing enough physicians to address the health care needs of the country, so they're looking at new strategies," Cawley said. "There is no PA position in their current health care system, but there is a need to improve the quality and access to health car—and PAs have proven to be essential here in the U.S."

Yet as the profession continues to grow, he says PAs can continue to have an impact in preventing chronic diseases. There is a general understanding, he said, from government and industry experts that itis up to the primary care provider to intervene in the lives of patients and promote preventive medicine.

"Family physicians, general practice, pediatrics, PAs and nurse practitioners are the primary care providers, and often in the best role to intervene in the lives of patients," Cawley said. "Specialists sometimes are in a position to do that, but it's really primary care providers and PAs who say it's time for a colonoscopy, or time to get this immunization."

Because of a PA's generalist knowledge and education, they are uniquely qualified to work with patients to promote healthier lifestyles.

"I really think it's yet another way the PA profession can really grow," Cawley said. "From this profession's humble beginnings to where we are today, we should be excited about the future of PAs and the way they work with patients." **PA**

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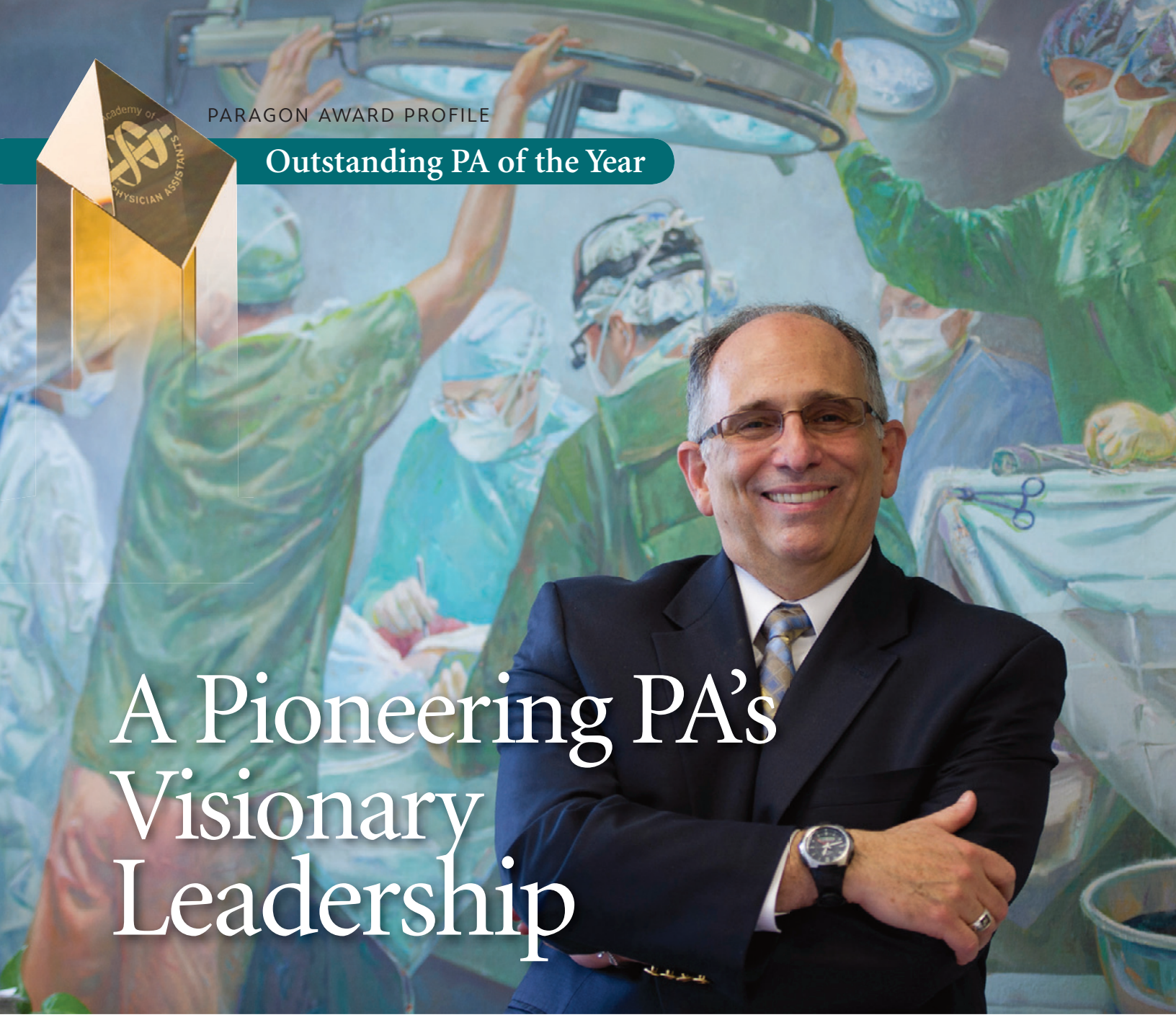


PARAGON AWARD PROFILE

Outstanding PA of the Year

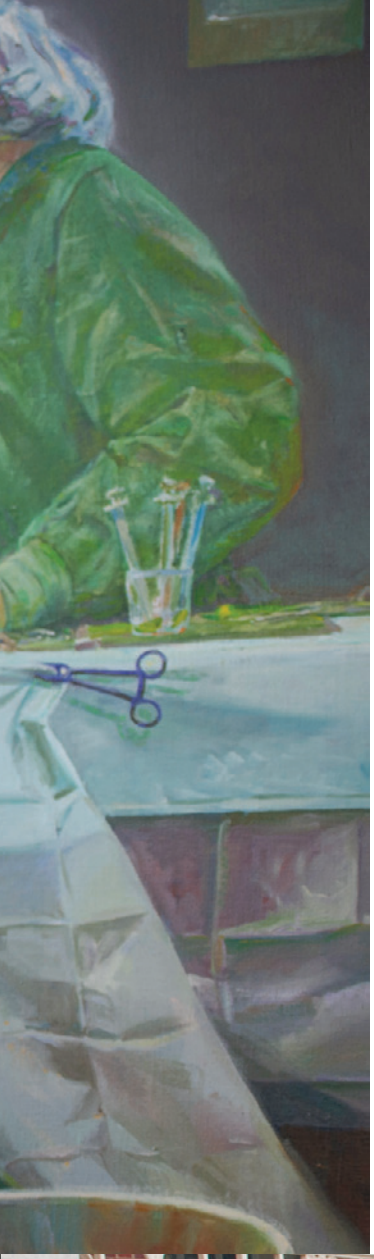
A Pioneering PA's Visionary Leadership

BY JANETTE RODRIGUES

Putting PAs at the Forefront of the Coming Genome Revolution

IN JUNE 2000, PRESIDENT BILL CLINTON and the leaders of the Human Genome Project held a press conference in Washington, D.C., to announce the completion of a working draft DNA sequence of the human genome, a scientific accomplishment that has the potential to change the way human disease is diagnosed, treated and—perhaps, one day—prevented. The HGP story dominated the news cycle, with articles appearing about how it would revolutionize medicine. In Philadelphia, PA Michael "Rocky" Rackover took notice.

PHOTOS / BARBARA JOHNSTON



PA Michael Rackover teaching Philadelphia University PA students about genetics.

Then an assistant professor and interim clinical and academic coordinator for the Philadelphia University PA program, Rackover had been a PA in radiation oncology for a decade before transitioning into academia. He was profoundly influenced by his work with cancer patients. "It always stood out to me when patients, and their families, would ask me, 'Why did I get this disease, and how does it evolve?'" he recalled recently. "We really didn't have a lot of information to give."

Later that year, Eugene Jones, PhD, PA-C, then the president of Association of Physician Assistant Programs, now the Physician Assistant Education Association, asked Rackover if he knew anyone who might be interested in serving on the Education Committee of the Human Genetics Curricula for the Health Professions. Rackover volunteered for the job.

In the ensuing decade, Rackover greatly increased PAs' awareness of genomic and personalized medicine, putting the PA profession at the forefront of the coming "genomic revolution" with his pioneering work at the National Human Genome Research Institute, or NHGRI. As the first non-physician to earn a sabbatical to the NHGRI Office of the Director, he convened a first-ever meeting of the four leading PA organizations with National Institutes of Health leadership at NIH.

For these and his many other accomplishments and contributions, Rackover was named AAPA's 2011 Outstanding PA of the Year. This honor is awarded to a PA who has demonstrated exemplary service to the PA profession and the community and has furthered the image of physician assistants.

Taking Up a Daunting Challenge

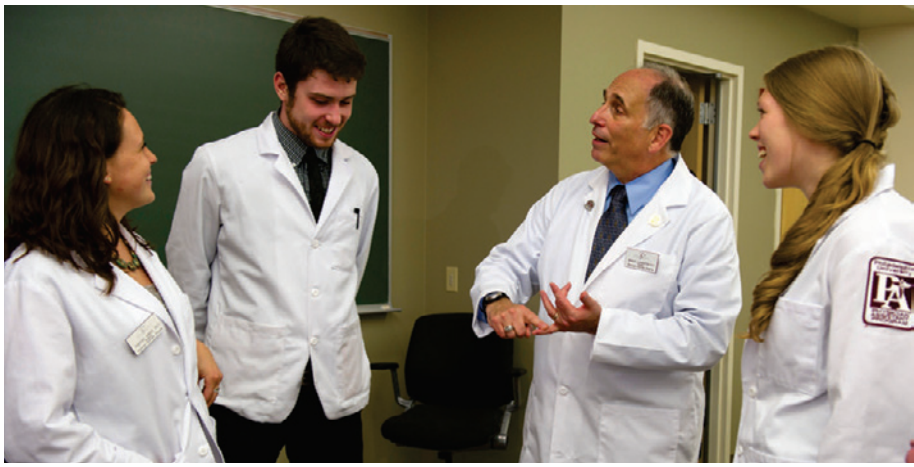
NIH Director Francis S. Collins, MD, PhD, called Rackover a nationally prominent leader in meeting the daunting challenge of drawing in and teaching both students and current practitioners about genetics, and not just for the PA community, but for all health professions.

"Rocky had the unusual wisdom a number of years ago to foresee the impact that the Human Genome Project

PA Michael Rackover, left, and NIH Director Francis S. Collins, MD, PhD, on the NIH campus in Bethesda, Md.

My involvement with the genetics community was a key to opening the door to the physician assistant profession.

—Michael "Rocky" Rackover, PA-C



and related developments in genetics and genomics would have on the daily care of patients," Collins said. "Characteristically, he followed up that foresight with an effort first to educate himself about genetics and genomics and then to interest and educate others—and did so in a thoughtful way most likely to achieve widespread success."

At the first meeting of the Education Committee of the Human Genetics Curricula for the Health Professions in November 2000, members of the body were asked to explain their professions.

"I realized that something major was going to happen here, and I couldn't [promote] any change until I took the time to understand genetics," Rackover said. "I had to go back and take a course in genetics, and then make sure that the people at the tables, and all the various different organization involved with genetics, [knew] who PAs were, and that is when the organizational dynamics started to take place. They didn't know who we were. Once they understood that we are licensed to practice medicine, and we are part of the package, and most other health professions, other than nursing, were not prepared at this time to reevaluate professional competencies, it was amazing how many phone calls started to happen and how many people wanted me to at least go to meetings to be able support their genetics education mission to help improve patient care. It opened doors."

At the gathering, Rackover met leaders in the field who would become his mentors: Collins, then the director of the Human Genome Research Institute; Alan Guttmacher, MD, the deputy director of NHGRI; and Joseph McInerney, executive director for the National Coalition for Health Professional Education in Genetics, or NCHPEG.

Winning Ways

Rackover won over his fellow committee members, in part, because he too saw the big picture and was willing to put in the time and work to seek buy-in from the PA community. The committee had the representatives from the health care professions look into the state of genetics education in their fields. Of the nation's then 123 PA programs, 54 programs responded to a survey Rackover sent out. He found there was an absence of genetics education being taught across the board on all levels.

The survey results motivated him to go forward with his efforts, presenting lectures and workshops on the HGP and its impact not just on the PA profession but all health care professions. He co-authored numerous articles over the years, and attended meetings of the genetics community to add to his understanding of genetics and genomics.

"My involvement with the genetic community was a key to opening the door to the physician assistant profession," Rackover said. "As they became more familiar with me, they became more familiar with the PA profession."

Bob McNellis, now AAPA's vice president of science and public health, asked Rackover to be the Academy's representative to NCHPEG. (He has since been nominated and served twice on the NCHPEG Board of Directors.)

"He raised the profile of genomics in the PA profession when he organized the meeting of the four PA organizations, and by doing that he raised the profile of PAs in NIH," McNellis said of the historic meeting. "It also created a model for the four organizations to work together. It set the stage for a new understanding of how the organizations can work together on important issues that affect patient care."

AAPA, PAEA, the Accreditation Review Commission on Education for the Physician Assistant and the National Commission on Certification of Physician Assistants were all in agreement with the need to augment the genetics curriculum.

It was a proud day for Rackover. Then Acting Surgeon General Kenneth P. Moritsugu, MD, who was supposed to attend the meeting for only a half-hour, ended up staying for a day and a half. "Francis Collins and these other major players were so impressed by the nimbleness—and that is the word that Moritsugu used—the nimbleness of our profession, and how we came together and said as one, 'Yes, we're on board,' " Rackover said. "That's where it came together for me."

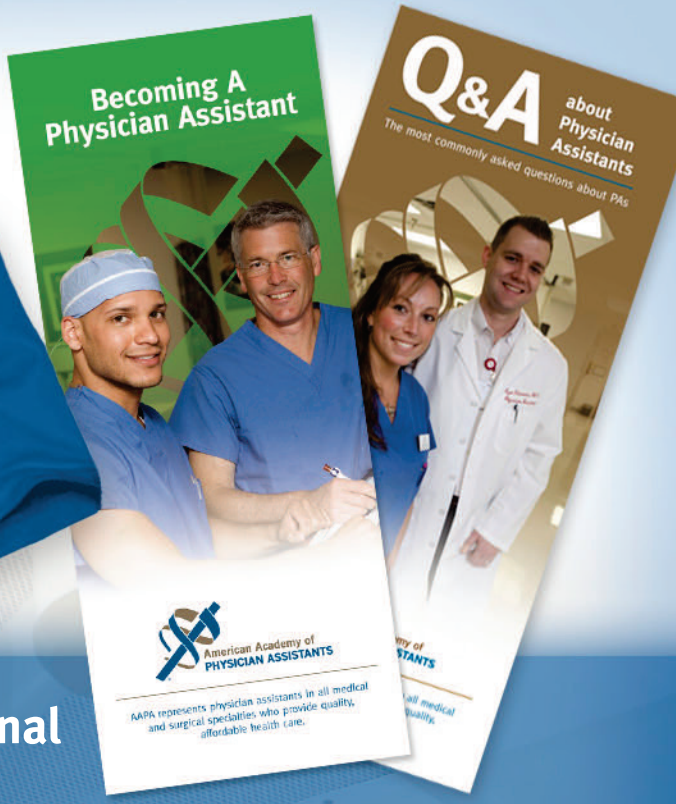
From the Vietnam War to NIH and Beyond

Rackover, a Distinguished Fellow of AAPA, has come a long way since his days as an Air Force medic and radiologic technologist during the Vietnam War. He's worked for the noted radiation oncologist Luther W. Brady, and earned a governor's nomination to the Pennsylvania Cancer Control, Prevention and Research Advisory Board. He was named Physician Assistant of the Year by the Pennsylvania Society of Physician Assistants PA of the Year, and PAEA's Outstanding Service Award.

In 1995, he helped start and was the program director of the second PA program in Philadelphia at Philadelphia College of Textiles & Science, now Philadelphia University. He is currently the associate program director and an associate professor. He has served on the National Coalition of Health Professional Education in Genetics Board of Directors, and been a Collaboration, Education and Test Translation Program for Rare Genetic Diseases committee member.

Rackover served on the NCCPA Physician Assistant National Recertifying Examination Committee, and on the PAEA Board of Directors as well as the organization's Blue Ribbon Panel on the Future of PA Education and chaired its Education Committee.

When Rackover takes the stage to accept AAPA's Outstanding PA of the Year Award, he will not be standing alone. "It's not just me getting this award," he said. "It's the profession getting this award because without their support, I would not have been able to move forward in my endeavors." **PA**



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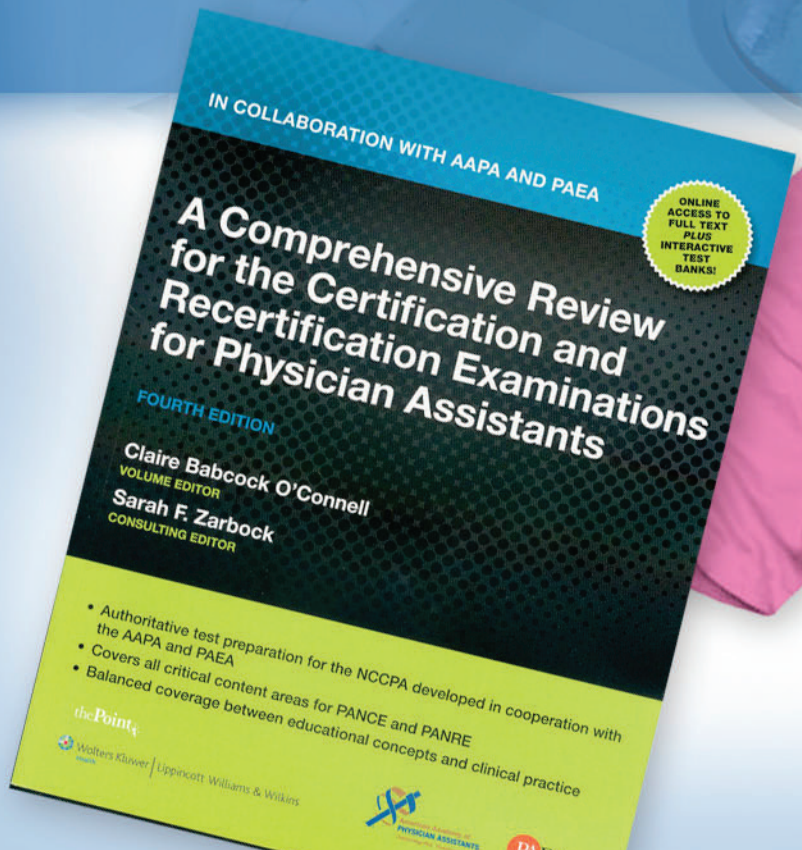

Attaining the Impossible

PA's Efforts Bring Care and Hope to Haitians

BY JANETTE RODRIGUES

SHORTLY AFTER THE NEWS BROKE that an earthquake caused the ground in Port-au-Prince, Haiti, to convulse, buildings to collapse and people to drop to their knees in prayer, PA Mary Fargen was on the telephone in Minnesota organizing a humanitarian relief trip to the Caribbean country. Within 24 hours of the first tremor, she had a medical team ready to drop what it was doing to head into the heart of the devastation.

PHOTOS / MARY FARGEN AND KEN KLOTZBACH

"I received a call from Mary, stating that 'we need to get down there to help people as soon as we can," recalled Steve Weis, a registered nurse who has gone on two medical trips to Haiti with Fargen through a small, nonprofit humanitarian group called the Haitian and Caribbean American Organization of Texas, or HACAOT.

It took two weeks to arrange transportation to Haiti, courtesy of the angel investors who chartered two private jets for HACAOT. The delay was especially frustrating for Fargen, who began making medical trips to the country in 2004. After years of going back to the same communities twice a year, she has become "Mother Mary" or "Dr. Mary" to her patients. But the delay gave her enough time to rally her colleagues at the Mayo Clinic System's Austin Medical Center.

Fargen, 56, who began her medical career as an 18-year-old combat medic in Vietnam, is seemingly tireless when it comes to her patients. She was chosen AAPA's Humanitarian PA of the Year for demonstrating an outstanding commitment to human rights and providing accessible, quality health care to the medically underserved outside the United States. She's gone on medical trips to Russia, Vietnam, the Dominican Republic, India and the hurricane-ravaged parishes of Louisiana.

PA Mary Fargen reviews a chart with a colleague.

PA Mary Fargen in Haiti after the earthquake.

Humanitarian PA of the Year

She is one of the rare and dedicated people on this planet who really tries her best to help those in need.

—David Ferere, HACAOT board member

"She takes the difficult as an opportunity and makes the impossible attainable," said retired Army Command Sgt. Maj. Thomas L. Hundt, of Onalaska, Wis., a friend and fellow volunteer. "Her dedication and commitment have been an inspiration to those of us who have worked with her."

Legendary among her fellow medical volunteers for her fundraising and procurement skills, Fargen helped raise $12,000 to take roughly 1,500 pounds of bandages, dressings and antibiotics, painkillers and other medications to the island in the two weeks after the earthquake. She and the rest of HACAOT's emergency medical response team landed in Haiti Jan. 23 and began treating patients the next day.

The Fargen-led HACAOT group treated at least 2,000 patients in the eight to nine days they spent in Haiti after the earthquake. While Fargen is used to working in difficult and often challenging conditions, ready to hike a goat trail into a remote area with her medical supplies on her back when called for, Haiti after the earthquake was especially heart wrenching.

PA Mary Fargen shares a light moment with some patients in Haiti after the earthquake.

"Once to go to Haiti, you either love it or it's OK, and I just fell in love with it," Fargen said recently. "I fell in love with the people. I fell in love with the culture. I have a T-shirt that says "American Born—Haitian by Choice."

HACAOT CEO Alain Ferere sincerely believes that Fargen's dedication, sacrifices and love for her patients epitomize the true spirit of PAs. "She has volunteered herself and spent thousands and thousands of dollars out of her own money to help the people of Haiti with yearly medical missions. She has saved many lives."

Fargen wants to leave a footprint of something positive in Haiti, whether that means helping Haitians interested in pursuing a medical career, helping to train the nation's health care workers or helping to build a clinic in a rural area of the country.

Haiti has embraced Fargen—and she returns that embrace. "The people take you into their homes, and there is just something about that," she said when asked why she is so dedicated to the country and serving the underserved in the developing world. "Maybe it's because of the way I was brought up. I didn't come from a rich family. I don't need all the high-tech stuff to do medicine. I like using my clinical skills. I like thinking with my brains, and if I have to jury rig something to make it work, that's all right because I like to do that."

Since 2004, Fargen has made 13 medical trips to Haiti to treat those with little to no access to the type of medical care people in the United States take for granted. And after the clinic closes for the day, she heads out into the village or countryside to do house calls at night. "She is a tireless, compassionate person whose biggest problem is to *stop* working before she becomes exhausted herself," said Raymond Moon, who has been her co-leader on seven trips to Haiti.

A 1981 graduate of the University of Washington MEDEX PA program, Fargen has been a practicing PA since 1982. She and her supervising physician, Richard J. Schindler, MD, have been a team in a rural clinic for nearly 30 years, which is almost unheard of in the PA profession. He can think of no one more deserving of the recognition that comes with receiving a PAragon Award.

"Her skills in managing the mundane and the critical, the simple or the complex, have been notable," Schindler said. "In addition to her back-home work, she has found time to work with the public health free clinic, the area high school sporting events and church activities. I have worked with her on three [medical] trips and found that her leadership skills match her work at home. Her energy is boundless when working for the care of others."

A longtime preceptor to PA and medical students at home, Fargen believes that medical volunteers need to help train local health care providers in the developing world so patients can continue to receive the care they need after the volunteers leave. "She takes every opportunity to teach local medical personnel, and their medical teams, the procedures or treatments that she uses," said Yvonne DuCharme, a medical volunteer.

In February, a few days after Fargen returned from a trip to Haiti to help out with the cholera epidemic, she learned that she was receiving one of AAPA's highest honors for her humanitarian work. She's still in shock. Those who know her aren't.

"She is one of the rare and dedicated people on this planet who really tries her best to help those in need, especially in my home country of Haiti," said David Ferere, a HACAOT board member. **PA**

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PA Service to the Underserved Award

Empowered to Thrive

A PA's Journey from Welfare to CEO

BY ASHLEY KENT

THERE ARE SOME MOMENTS in life when you realize things will never be the same. For PA Rachel Farrell, that moment happened as soon as she drove off the lot after purchasing her first pickup truck. She didn't make it a block before she had to pull over and collect herself.

"I was so overwhelmed with the fact that I was able to have that independence and that financial security. My epiphany was that I had to pay it forward, that I had to somehow inspire other young women to become independent and self-sufficient."

PHOTOS / FRED GREAVES

A little more than 20 years earlier, at age 17, Farrell had dropped out of high school to move to San Francisco. A year later, she gave birth to her first son. After a traumatic birth experience at a local hospital, where she said she felt a lack of dignity and autonomy, she began researching home births. Farrell gave birth to her second child, a daughter, at home with her husband.

"Nobody had ever done that in my world, so people started coming to me and saying, 'You had your baby at home; can you come to my birth?' And lo and behold, I became a midwife."

With no formal training, Farrell kept delivering babies, including three more of her own, and joined a midwifery group to learn what she could about the process. But she still felt limited by her lack of education and challenged by the home births she was performing in remote locations with no access to electricity or water. After earning her GED, Farrell enrolled in Yuba College in Marysville, Calif. It was there that she learned about a career called physician assistant.

"When they described the PA program to me, it just seemed like the perfect solution. My husband had left, so I was a single mom with five kids now. We were dirt poor, on welfare, and we lived out on 10 acres in one one-room cabin with no electricity because we were off the grid."

She applied to both Stanford and UC Davis's PA programs, and to her surprise, she was accepted to both. She chose Stanford's because it was a shorter program that would accept junior college fees. As a single parent of five children, there were always challenges. But Farrell said her close network of friends made sure she finished the 15-month program. "With that safety net of people, there was no way I *couldn't* succeed," she said.

And succeed she did. Farrell graduated from the program, an accomplishment she said transformed her world. "Suddenly I was empowered, independent. I didn't have to depend on assistance. I didn't have to depend on a man. I could support my family, take care of my children, earn a good living, and do it at something that I really, really loved," she said.

Opposite page: Farrell sits in the Eating Well Café, which offers healthful cooking classes to teen parents.

Above: She conducts a routine examination of a patient.

Below: Farrell examines a pregnant patient.

PA Service to the Underserved Award

Part of the work that I do is to hire local people and inspire them. I try to lead by example by always having something new that I'm trying to accomplish and learn.

—Rachel Farrell, PA-C

After a four-year stint providing care at a local jail, where the daily sick call was 85 inmates, Farrell felt as if she needed a new challenge. She saw an ad for a PA position at a clinic on wheels in Linda, Calif., an unincorporated area outside Marysville and one of the poorest counties in the state.

"My goal had always been to work in the Third World," Farrell said. "Then I came down here to interview for the job, and I sort of went like, 'You know, this *is* the Third World.'"

Almost immediately after getting the job, she realized the need was even greater than she had imagined. She began performing women's health exams in a space in a nearby strip mall, but Farrell said she and her supervising physician were forced out by another nearby provider who was affiliated with a local hospital.

After a yearlong partnership with another physician who didn't share her care philosophy, Farrell learned about a form of incorporation called a professional association, which would allow her to own and run a management company and choose her own physician partner. The idea for Harmony Health Medical Clinic was born.

She found a vacant space in a strip mall, and used money from a Small Business Administration loan to transform it into a clinic, which opened in 1997. Two years later, after a stint with another physician, she brought on supervising physician Roger Hicks, MD, and the team has worked together ever since.

"Rachel makes unbelievable personal sacrifices of time, money and seemingly limitless energy to support Harmony Health and make its services available," said Hicks, who owns the clinic. "Ever since I have known her, Rachel has wanted to do more than just provide medical care to Yuba County. Her dream is to give people the tools to improve their lives and thereby help transform the community. And she is doing it."

The clinic obtained rural health status in 2000. With help from First 5 Yuba grant funding, which uses California's tobacco tax money to fund services for children ages 5 and under, Farrell launched the clinic's Family Resource Center. Friend and former colleague PA Margie DiFelice described the center as a mini county health department, providing services such as support groups for substance abuse and anger management, classes for the large teen parent population, family therapy, lactation education and an after-school teen support group. Trained home visitors check in with families and help them stay on track with their life goals.

"Any life situation you can imagine, we've probably encountered," Farrell said. "Sometimes people just get so overwhelmed, especially when they're low income and they don't have transportation and they don't have the support. And there's a language barrier, and they have a bunch of kids already. This is all the stuff that's so dear to my heart because that was me. I see myself in every one of my patients."

"I believe Rachel allows her patients to be empowered and partner in their health care," said DiFelice, who worked as a midwife with Farrell in the 1980s. "One woman told me she received prenatal care at Harmony Health, attended classes, had natural childbirth, breast-fed her baby, found a way to attend community college and plans to enroll in a nursing program. She said she owes it all to her health care providers, and especially Rachel, who has served as a role model for her."

Farrell believes this kind of well-rounded support encourages people to pay it forward. "It becomes like a whole community spirit, or I would even say global spirit. It just grows and grows," she said.

Farrell is perhaps most proud of her success in making sure low-income women have childbirth choices she didn't have with her first baby. Harmony Health offers the Baby Buddies Lactation Station, a social business that sells, rents and lends breast-feeding products and equipment and offers related education. The clinic is on the verge of launching the Baby Buddies Birth Center to offer women an alternative to giving birth at a hospital.

The clinic has another business called Eating Well Café, which offers healthful cooking classes funded by the American Recovery and Reinvestment Act. It is run by area teenagers, many of whom are parents. Graduates of the program receive a commercial food safety certificate they can use to get a job elsewhere, or work at the café when it opens as a retail business. It's an opportunity Farrell hopes will help teen parents realize what they can accomplish.

"I [asked myself], why did I have so many kids? One of the reasons that people do that is because that's what they *can* do. They don't even know what else they can do because no one's ever offered them that other world of possibilities," she said.

Farrell plans to use the money from the 2011 PA Service to the Underserved award to begin paying the teens for their work.

"I am so honored," she said of receiving the award. "I hope that it can inspire some other PAs." **PA**

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Federal Service PA of the Year

The Standard of Success

Air Force PA Leads Push for Uniform Medical Device Standards

BY ASHLEY KENT

AAPA'S 2011 FEDERAL SERVICE PA OF THE YEAR Award winner, Col. Douglas "Boots" Hodge, is good at tackling a crisis. He's had plenty of experience since his early days as a Navy corpsman. It was the mid-1970s, and he was a hospitalman, third class serving at the U.S. Naval Hospital in Guam. His command received a total of 100,000 Vietnamese refugees, and Hodge organized triage and supervised shifts of corpsmen to provide 24-hour care to the injured and diseased.

PHOTOS / TY GREENLEES

"At some point in those long six months, when I was working 18 to 20 hours a day, it just kind of crystallized that I definitely wanted to be a health care provider. That's what I was good at," Hodge said. "And I was following mentors like those crusty old warrant officer PAs that were there. [They] were the ones who set me toward the mark of going to PA school."

Hodge graduated from Kettering College of Medical Arts PA program in 1979, and set out to provide health care to rural communities. He and his wife, Gina, eventually ended up in Waterville, Wash., a town of about 2,000 in a 500-square-mile district populated by wheat farmers and migrant families. Immediately, he found a crisis to tackle. He bought a computer, asked his nurse to begin tracking appointments, and turned the clinic from a cash drain to a moneymaker.

But Hodge wasn't done yet. He found out the ambulance department had only two EMTs, not enough to run the service properly. "So I put an ad in the paper and started working, and six months later, we had 18 EMTs and a nurse. And a year or two [after that] we were successful enough that we brought a brand-new ambulance. So we had three ambulances and a support vehicle and got radios, and it became a very vibrant city asset to that little town."

By that time, Hodge was in his ninth year of working alone in a small town, and he needed a change. He worked in civil service for both the Navy and the Air Force for a while, and then in 1993, decided to join active duty in the Air Force. He was about to become an expert at handling crises.

'Problem-Solving at Its Finest'

His first assignment was at Andersen Air Force Base in Guam. From there, he was assigned to Geilenkirchen Air Base in Germany. While he was there, he was deployed to Croatia, the site of his next crisis.

"We were really there to help NATO military," he said, adding that he spent much of his time providing health care and renovating living facilities of the hundreds of war orphans in a village near Zagreb. But it's the life of one premature 3-day-old Bosniak infant that Hodge will never forget.

"She had a pneumothorax; she had cardiac myopathy, just all kinds of things. I took the baby in an incubator up to the hospital, and they re-

A portion of Hodge's collection of military mementos

Hodge stands in front of a training projection screen at the Battlefield Air Targeting Man-Aided Knowledge, or BATMAN, Lab at Wright-Patterson Air Force Base.

If you just go study the crisis, you're going to provide yourself, by volunteering, an opportunity to go fix it. That helped me get promoted, get recognized.

—Col. Douglas Hodge, PA-C

fused to take care of her because of her ethnicity," Hodge said. "So I took her back and tried to keep her warm and tried to assist her breathing, and we got her medevaced, and I actually went with her to Slovenia. It was fortunate that she survived and they were able to do surgery."

"That is problem-solving at its finest, in a hostile environment," said Lt. Col. Terry Mathews, president of the Society of Air Force Physician Assistants.

Throughout the late 1990s and into the 2000s, Hodge worked at Air Force bases in Texas, Alabama and Georgia, all the while serving various deployments around the world, rising in rank and receiving numerous recognitions for his efforts, including two United States Air Force Physician Assistant of the Year awards.

Hodge tries on a helmet that can view information stored on a PC using a tiny screen in front of the soldier's eyes.

Setting Standards to Save Lives

In February 2004, Hodge was assigned to Fort Detrick, Md., where he was charged with launching a medical research and development testing program for the Air Force. His team was the test group for new equipment that was slated to go out to Air Force support hospitals around the world.

"There was just so much confusion about requirements and standards and what worked and what didn't work," Hodge said. "We [had seen] many, many examples of equipment that was thrust upon us by leaders or those that thought they knew, and we would get there and the equipment was dysfunctional or unable to be used in the environments that we needed it to work in, whether it was at night or in the desert or in the jungle. And it became very frustrating as a provider to have all this gear and it was just the wrong stuff. That became kind of my driving force when I went to that medical testing program."

After building that program, Hodge had a thought: Why didn't these kinds of testing and standards exist for the entire military? "The problem is there's enough variation in the equipment that we saw the equipment applied inappropriately," Hodge said. "The bottom line is, we make mistakes, and a lot of times those are based on the equipment and packaging."

And that, to Hodge, constituted a crisis that he needed to address. He pitched the idea of starting a Joint Medical Test and Evaluation division at the Department of Defense to his boss. "She liked it, and, you know, when the boss likes something, you usually get it," Hodge said with a laugh. And he did.

Sometimes Hodge's findings were met with skepticism by those who preferred the status quo. But he has never been one to hold back on ruffling a few feathers. Maj. Brandi Ritter, a PA who completed a fellowship created by Hodge at Fort Detrick, said she learned more than just medical testing techniques during the five years she worked for him.

"He teaches that we should not just accept the way things have always been as an answer. He teaches us to prove that answer, and if it is not backed up by evidence, to find the evidence or prove how the change… should be made," she said. She cited Hodge's work with the FDA to ensure safety parameters were evaluated for hemostatic agents.

"Through his leadership, the primary investigator of the safety evaluations on hemostatic agents was brought into the FDA to brief the FDA on [its] findings. This briefing, and further discussions with the FDA, prompted the FDA to evaluate the toxicity testing required for hemostatic agents," Ritter said.

For years, Hodge has served as a subject matter expert for the DoD on several topics, including a national response plan for the H1N1 virus, the design and development of the next generation of biological contaminant detectors, and the requirements for the next generation of pandemic flu ventilators. He has briefed White House medical staff, congressional staff and U.S. and international military leaders on critical medical issues.

In the Now

Hodge currently serves as deputy director of the Air Force Research Laboratory's Human Effectiveness Directorate at Wright-Patterson Air Force Base, where he oversees more than 1,000 researchers, scientists, engineers and others who study the human element of war fighting.

While Hodge is proud of his accomplishments, he credits his desire to learn and his ability to detect and respond to an impending crisis as the top qualities that have made him successful.

"If you…look at the organization you're in, I guarantee you'll always find a crisis. If you just go study the crisis, you're going to provide yourself, by volunteering, an opportunity to go fix it. And when you work that crisis, basically you're stratifying yourself. You're starting to get leadership to recognize that you can work harder problems. Pretty soon you're doing the nontraditional jobs. That helped me get promoted, get recognized. It wasn't self-promotion. It was just grabbing the next crisis."

For Hodge, the motivation for his years of hard work is clear. Fighting back emotion, he explained: "Almost every day there are young kids that are dying. It's just a hard thing. When you've taken care of them, you take it very personally. So that becomes your motivating factor. That's somebody's kid out there." **PA**

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Physician-PA Partnership Award

PA Chris Sadler (right) shares a laugh with his supervising physician, Daniel Einhorn, MD. The two have practiced together for 25 years.

A Philosophical Connection

Longtime Partners Are Leaders in Endocrinology

BY CHRISTOPHER DOSCHER

PA CHRIS SADLER WAS WORKING as an exercise physiologist when he met Daniel Einhorn, MD. It was 1986, and Sadler had been asked to spend 10 hours a week in the diabetes department of the local hospital. Through the work, Sadler became fascinated with diabetes, so much so that he became a certified diabetes educator and took on the duties of outpatient coordinator of the department. As head of the center, Einhorn treated many of the patients and did rounds with Sadler every day, and the two worked in that capacity for several years. Einhorn looked at Sadler and recognized what he described as Sadler's "great potential" as a clinician.

PHOTOS / FRED GREAVES

PA Chris Sadler

Daniel Einhorn, MD

"I got to watch him think and relate to patients and other team members," said Einhorn, who is immediate past president of the American Association of Clinical Endocrinologists. "He's such a smart guy and a caring human being." At first, the two talked about Sadler attending medical school. Sadler, then 36 and with a wife and two young children to support, was understandably leery about returning to school, particularly with the costs and time involved. "We made a practical decision for him to go to PA school," Einhorn said. "The key for me was that we were going to work together forever; PA training was part of the larger plan to have the best endocrine practice anywhere. We were going to maximize the way we worked together."

Einhorn and his medical partners helped remove some of the financial burden from Sadler when they co-signed for his student loans. "He said, 'We can make it work,'" Sadler recalled. Sadler continued to work with Einhorn as a student, and the physician made the necessary accommodations to allow the future PA to balance work, school and family. "I don't know if I would have had the guts to go back to school without [Einhorn] behind me," Sadler said.

Einhorn was grateful to be able to help. "I certainly never regretted or doubted it for a moment," he said. "When he graduated, we had two other partners who didn't know Chris as well, but once they got to know him, there was no doubt they made the right decision." After Sadler finished his PA education, he wondered whether he'd be able to shoulder the approximately $1,100 a month in loan repayments that were about to begin. Einhorn again demonstrated his support. "[Einhorn] said, 'Don't worry about the loan. I'll take care of it. You can pay when you're able to.' I paid him back over four or five years," Sadler said.

The initial skepticism about adding a PA to the practice faded quickly, and today, each physician in the practice works regularly with a PA.

After working together for 25 years, the two are recognized experts in

PA Chris Sadler, left, and Daniel Einhorn, MD, conduct an ultrasound on a patient's thyroid.

Physician-PA Partnership Award

When I can empower patients to take care of their own disease, it's amazing to see them transform before my eyes.

—Chris Sadler, PA-C

During a follow-up visit, PA Chris Sadler checks a patient for a carotid bruit.

the field of endocrinology, practicing together at Diabetes and Endocrine Associates in La Jolla, Calif. and delivering educational seminars across the country and internationally. It's typical of their relationship, which is built on a foundation of deep mutual respect, that each gives the other credit for the 2011 Physician-PA Partnership of the Year PAragon Award.

"[Einhorn] has been promoting me and has been my No. 1 fan my whole career," said Sadler, who is president-elect of the American Society of Endocrine Physician Assistants. "I wouldn't be anywhere without him. He keeps saying it's my award, but it's his award."

Einhorn claims that he is "just along for the ride. I see this as Chris's award. It's very meaningful to have your peers notice and honor you. I consider it a highest achievement. Chris is so modest, he would not ever mention this achievement to anyone. My staff and myself, however, will let our pride show for him. When any of our patients find out, the universal response is "Of course. What took so long to recognize Chris?"

Diabetes continues to be a major interest of Einhorn and Sadler, and the nature of the disease's treatment lends itself well to their patient-centered style of care delivery. In addition, many new types of treatment have been developed over the years. When Sadler began working with diabetic patients, only two classes of oral medication existed to treat diabetes. Now, there are 11 classes, with more to come, and clinicians must consider how to combine treatments to achieve the best possible results. Sadler and Einhorn have spent a large part of their careers in the research and education of these advances in diabetes and they are in constant demand to do more.

"It's such an insidious disease, and it can cause such dramatic complications," Sadler said. "When I can empower patients to take care of their own disease, it's amazing to see them transform before my eyes." Einhorn points out that diabetes requires that clinicians spend extra time educating patients, and that Sadler is always willing to spend extra time doing so, "intensely and lovingly."

Einhorn's philosophy of care is simple: He wants his patients to walk out of the office feeling that they just received the best medical care of their lives, that they know what to do, and that things are going to be OK. Respect for the individual is a priority in the practice, both toward patients and among colleagues.

Sadler and Einhorn recognize the value of mutual respect to a successful partnership. "If you're going to live together every day and see each other more than any human being, you had better start from a position of deep respect for one another," Einhorn said. "Chris is a very receptive student, and it's fun to teach him, but for years now, the mentoring has gone both ways. He's better than I am at doing certain things in the general physical exam room, he is so good at thyroid ultrasound and fine needle aspiration that he's the clinician to see in our whole community. If something comes back from radiology, he sees three or four times the level of detail and nuance that others don't seem to find." Sadler has such a solid reputation in the endocrinology field, Einhorn said, that he often is called upon to deliver lectures to primary care physicians, cardiologists, and endocrinologists. "Chris is modest to a fault," he said. "You'd never know that he's a nationally sought-after speaker who always gets asked back. When Chris teaches, you feel his long experience and clinical wisdom, and he tells it like it is without hyperbole. And he's the same when he teaches patients or academic endocrinologists; he speaks from what he has firsthand knowledge of and he communicates that authority so the audience actually learns something."

Sadler appreciates Einhorn's longtime support of the PA profession. "He would always put up a picture of me when he lectured, and he always mentions my name," Sadler said. "He has said that he relies on me to do a lot in the office. It's wonderful to work for someone who is always out selling me. Locally, as well as nationally, it gives both of us a higher profile." Einhorn, in turn, says "Chris is the one who makes the rest of us look good. Just ask any of our patients."

Though Sadler was fortunate to already have a strong relationship with his supervising physician when he became a PA, it was Einhorn's commitment to his development that helped the most. He thinks that sort of relationship is important for all new PAs. "Too many young PAs get thrown into a practice where they don't really have a mentor," Sadler said. "It's important to have a physician who is willing to invest some time in you and agree with the way you want to take care of patients. When you're on the same page, it makes for a great partnership." He suggests that PAs ask a physician, prior to starting work together, what the physician's philosophy of care is, and decide whether they agree with that philosophy. "If it's all about numbers and dollars, you have to think twice," Sadler said. "At the end of the day, you have to think about patient care." **PA**

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AAPA Partners with HHS to Reduce Health Disparities

Increasing

FROM THE CRADLE TO THE GRAVE, America's racial and ethnic minorities still lag behind their white counterparts in many health outcome measures. They are less likely to receive the preventive care they need to stay healthy and are more likely to suffer from serious chronic illnesses. And when they do get sick, they are less likely to have access to quality health care.

BY JANETTE RODRIGUES

Last month, the U.S. Department of Health and Human Services released two strategic plans to reduce health disparities and increase health equity in the United States. The *HHS Action Plan to Reduce Health Disparities* is designed to limit health disparities among racial and ethnic minorities and the medically underserved. It outlines goals, strategies and actions HHS will take to decrease health disparities.

"For the first time, the United States has a coordinated road map designed to give everyone the chance to live a healthy life," said HHS Secretary Kathleen Sebelius. "We all need to work together to combat this persistent problem so that we can build healthier communities and a stronger nation."

The first-of-its-kind plan builds on the provisions of the Patient Protection and Affordable Care Act, which will help address the needs of racial and ethnic minority populations by bringing down health care costs, investing in prevention and wellness, supporting improvements in primary care and creating linkages between the traditional realms of health and social services.

The plan also acknowledges that unconscious bias—of health care providers and federal health officials—plays a part in whether ethnic or racial minorities and medically underserved populations receive equal access to the same type of health care as other Americans.

Disparities are documented in many conditions, including cardiovascular disease, asthma, diabetes, flu, infant mortality, cancer, HIV/AIDS, chronic lower respiratory diseases, viral hepatitis, chronic liver disease, behavioral health and oral health.

"Where people live, learn, work and play affects their health as much as their access to health care," said Garth Graham, MD, MPH, deputy assistant secretary for minority health and director of the HHS Office of Minority Health. "We have to confront the social, economic and environmental factors that contribute to health disparities if we are to fulfill the president's goal of winning the future." HHS also released the National Stakeholder Strategy for Achieving Health Equity, a common set of goals and objectives for public- and private-sector initiatives and partnerships to help racial and ethnic minorities and other underserved groups reach their full health potential. A product of the National Partnership for Action to End Health Disparities, or NPA, the strategy incorporates ideas, suggestions and comments from thousands of individuals and organizations across the country, including the Physician Assistant Education Association and AAPA.

AAPA welcomed the HHS strategic plans to build health equity. "AAPA has long advocated for improving access to quality health care in underserved communities and addressing health disparities," said AAPA President Patrick Killeen. "We are pleased that our colleagues

PHOTOS / TODD SPOTH AND TAMI CHAPPELL

Health Equity

For the first time, the United States has a coordinated road map designed to give everyone the chance to live a healthy life.

—HHS Secretary Kathleen Sebelius

in HHS are committing to those ideals, and look forward to continuing to work with them in the future."

The Academy is a partner with NPA, which is coordinated by the HHS Office of Minority Health. In 2008, AAPA signed a groundbreaking memorandum of understanding on health literacy with the Office of Minority Health. The Academy and HHS agreed to work together on projects to decrease racial and ethnic health disparities. AAPA will continue this work with HHS as the initiatives are rolled out, while furthering long-standing programs that seek to end disparities.

"PAs often serve as the patient-centered medical home for racial and ethnic minorities and other underserved populations in rural and urban America," said Killeen. "PAs are uniquely qualified to support this effort to address the needs of racial and ethnic minority populations by providing quality, affordable care, promoting prevention and wellness and supporting improvements in primary care."

The National Partnership for Action to End Health Disparities' five overall goals and associated strategies include:

1. Awareness: Increase public understanding of health disparities by developing partnerships, communications strategies, and new approaches to putting the issues prominently on organizational agendas.
2. Leadership: Build the capacity to create community solutions, improve the coordination of funding, and set priorities. Invest in youth, preparing them to be future leaders.
3. Health System and Life Experience: Improve access to quality care, including: children's services for mental health, oral health, vision, hearing, nutrition, and physical activity; and services for older adults. Address social determinants of health through work on issues such as improved high school graduation rates and policies intended to create social, physical, and economic environments in which children can succeed.
4. Cultural and Linguistic Competency: Improve diversity in the work force, increasing opportunities to recruit minorities into the health professions. Also, improve cultural competency by supporting better interpreting and translation services and training more community health workers to serve as liaisons between patients and clinicians.
5. Data, Evaluation and Research: Acquire and analyze data to enhance decisions through better research coordination, and promote the translation of evidence-based research into practice.

For more information, please contact Marie-Michèle Léger, AAPA director of clinical and international affairs, at *mleger@aapa.org*.

To read more, go to *http://minorityhealth.hhs.gov/npa/*. **PA**

PHOTOGRAPHY BY TAMI CHAPPELL

21ST ANNUAL STUDENT ACADEMY NATIONAL MEDICAL CHALLENGE BOWL

Round 1

1. Drexel
2. Harding
3. Wake Forest
4. Touro-Mare Island

5. MCPHS-Boston
6. Salus
7. Rocky Mountain
8. Midwestern-Glendale

9. Seton Hall
10. DeSales
11. University of Mount Union
12. University of Florida

13. Charles Drew
14. University of Toledo
15. Idaho State University
16. Nova Southeastern-Ft. Lauderdale

17. Western Michigan
18. AT Still University-AZ School of Health Science
19. Mercer University
20. MCPHS-Manchester

21. Chatham University
22. MCPHS-Worcester
23. South University
24. Quinnipiac University

25. Baylor
26. Pace University
27. MEDEX-University of Washington
28. UMDNJ

29. Le Moyne College
30. Jefferson College of Health Science
31. Miami Dade College
32. Rosalind Franklin

33. Midwestern-Downers Grove
34. George Washington
35. Methodist
36. Emory

37. Univ of Oklahoma-Tulsa
38. Barry-Miami Shores
39. Duke
40. Yale

41. Des Moines
42. University of Oklahoma
43. NOVA Southeastern-Southwest FL
44. Texas Tech

45. Shenandoah
46. Philadelphia University
47. Missouri State
48. University of Utah

Round 2

Round 3

2011 BRACKET

Waiting List

49. Nova Southeastern-Orlando
50. Marquette
51. Louisiana State University
52. University of Southern California
53. Touro-Nevada
54. Northwestern University
55. Riverside
56. CUNY Medical School at Harlem Hospital
57. Butler University
58. Stony Brook University
59. University of South Dakota
60. Stanford
61. San Joaquin Valley College

BY JANETTE RODRIGUES

COPD Education for Clinicians

Disease Is Often Misunderstood and Misdiagnosed

CHRONIC OBSTRUCTIVE PULMONARY DISEASE, or COPD, is a major cause of disability and the leading cause of death in the United States behind heart disease and cancer. Last year, AAPA and four other multidisciplinary medical societies—representing 300,000 primary care and specialty clinicians—formed the COPD Alliance to provide primary care clinicians with a timely tool kit to help in the recognition, diagnosis and treatment of the disease.

The COPD Alliance's goal is to help primary care clinicians achieve better outcomes for their patients with COPD. Along with AAPA, the other founding members of the group are the American Academy of Nurse Practitioners, the American College of Chest Physicians, the American College of Osteopathic Family Physicians and the American College of Osteopathic Internists.

COPD is no longer an "old man's" disease. According to the American Lung Association, COPD is affecting a growing number of both middle-aged men and women. While hospitalization rates for the disease may be on the decline, regional trends show an uptick in emergency departments visits. Additionally, the lung association found in a recent COPD surveillance study that many patients are not properly diagnosed or treated for the disease, causing high readmission rates and a need for doctor and patient education.

The COPD Alliance is taking a unique approach to COPD education by targeting primary care clinicians. It is estimated that 24 million Americans may have COPD, with only 50 percent having been diagnosed. The total economic cost of COPD is expected to be more than $49.9 billion by the end of 2011. This includes $29.5 billion in direct health care expenditures and $20.4 billion in indirect costs.

Brian Carlin, MD, FCCP, and COPD Alliance chairman, and calls primary care clinicians the gatekeepers of our health. "If they are unable to recognize the signs of COPD or high-risk individuals, the disease may remain undiagnosed and untreated," he said. "By providing relevant COPD education for the country's primary care clinicians, we give them the tools to identify high-risk patients, confirm a diagnosis and provide effective treatment."

STEP Forward Against COPD

There is no cure for COPD. But the symptoms can be controlled to improve a patient's quality of life. The COPD Alliance is asking primary care clinicians to step forward in the fight against COPD and focus on the four keys to identify patients with COPD and help them live well with the disease:

S—Screen patients at risk
T— Test and diagnose using spirometry
E—Educate patients about COPD
P—Provide care and support

COPD Resources and Education

In order to keep COPD information at clinicians' fingertips, the COPD Alliance has launched *www.COPD.org*, a free website with new and existing COPD tools that are accessible to medical professionals and the public. The website includes a COPD patient screening tool, the Tobacco Dependence Treatment Toolkit, and several patient education guides that clinicians can download and distribute to patients.

The COPD Alliance has developed, and is delivering, an education program tailored to the knowledge and awareness level of their members that has a consistent message about the importance of COPD identification and diagnosis. AAPA is conducting such a session during IMPACT 20111 on Saturday, June 4, from noon to 12:45 p.m. in the Las Vegas Hilton.

"A main focus of the alliance is collaboration between organizations and among different types of clinicians," said Marie-Michèle Léger, PA-C, AAPA's representative to the alliance. "By working together as equal members of a team, we can quickly access and act on the most current research, build consensus, and educate and motivate clinicians, all with the patient in mind."

For more information on the COPD Alliance, contact Marie-Michèle Léger, AAPA director of clinical and international affairs, at *mleger@aapa.org*, or go to the COPD Alliance website, *www.copd.org*.

The COPD Alliance contributed to this report. **PA**

COPD Events at AAPA's IMPACT 2011

Visit the **COPD Alliance** booth in the AAPA Partner Pavilion in the Exhibit Hall, Las Vegas Convention Center.

Attend the CME **"Chronic Dyspnea in an Older Smoker: Asthma, COPD or Heart Failure?"** at 4 p.m., June 3, Room N245-251, Las Vegas Convention Center.

Visit product theaters: **"The Next Flare-up Might Be Around the Corner: Reducing the Risk of Exacerbations Is Important for Your Patients with COPD,"** noon–12:45 p.m., June 2, Ballroom B, Las Vegas Hilton; or **"COPD: Priorities for Detection and Management,"** noon–12:45 p.m., June 4, Ballroom A, Las Vegas Hilton.

Research Symposium a Highlight at IMPACT 2011

Agenda for Study of PA Work Force Will Be Unveiled

THIS IS YEAR IS AN EXCITING "FIRST" for AAPA's department of research and statistics. Stemming from the results of AAPA's November 2010 Research Steering Committee meeting,and AAPA's Research Summit in March of 2010, AAPA will be holding its first ever Research Symposium at IMPACT 2011. The two-part symposium will consist of an open discussion session on June 2nd and a structured research forum on June 3rd.

During the two sessions, Raymond Fang, AAPA's vice president of research and statistics, will present AAPA's Research Agenda. The Research Agenda represents the culmination of several years of work and anticipation as well as the start of a new beginning for in-depth PA-focused research. The Research Agenda was commissioned by AAPA's Board of Directors in response to the overall need for growth in PA focused research. While the PA profession has grown rapidly,health workforce research on PAs is lacking.

AAPA convened a Research Summit in March of 2010 to develop the framework for a comprehensive research agenda. After identifying 20 research topics of interest, the AAPA Board of Directors commissioned an expert group of health workforce researchers to form the Research Steering Committee. The final product of these directives was the identification of 4 priority research areas: PA Roles, PA Value, PA Workforce, PA Education. AAPA has formally incorporated all four into its strategic research agenda, the purpose of which is to provide guidance in producing accurate, relevant and useful research.

At IMPACT 2011, Thursday's discussion will focus on incorporating the four priority research areas into formal research work groups. Fang and others will highlight several research areas that warrant in-depth investigation. AAPA is excited to have attendees join in the discussion and provide valuable input. Discussion will also include the framework and structure of the work groups.

On Friday, June 3rd, Fang, in conjunction with PA Christen Kutz,DHSc, founder and president of Physician Assistants in Research, will moderate the first annual Research Forum. Topics will include the role of PAs in research, gender-based salary discrepancies in PAs, and a presentation on the role of medical anthropology and qualitative research in clinical PA practice and research. The forum will conclude with a literature review on PA research.

AAPA is looking forward to imPActing and equipping all attendees with a greater understanding of the varied work that exists in health workforce research on PAs as well as providing a wealth of resources to move forward our collaborative research agenda.

PHOTO / TODD SPOTH

About R. Paola Daly

R. Paola Daly, AAPA's new survey research analyst, is eager to contribute to the growth and development of health care research as it pertains to PAs at a time when research is at the forefront of AAPA's agenda. Prior to coming to AAPA, Daly worked in the field of health education, nutrition and maternal and child health.. She holds a master's of health sciences degree from the Johns Hopkins Bloomberg School of Public Health and a bachelor's degree in public health-natural sciences from the Johns Hopkins University. PA

BY BY GARY MCCAMMON, AAPA INSURANCE SERVICES

For PAs, It's Always Personal

Why You Need Comprehensive Personal Liability Insurance

OFTEN, THE TERMINOLOGY WE USE IN EVERYDAY LIFE and the terms used in specific trades or professions can be quite different. For example, the definition of "personal injury" in the legal world differs quite a bit from its definition in the insurance industry. Personal injury coverage protects the policyholder and any insured persons from allegations of libel, slander, invasion of privacy or false arrest. This coverage is commonly (but not always) included in a business commercial general liability policy or an individual professional liability policy. It can be enhanced to cover other things like trademark infringement or malicious prosecution.

This may seem esoteric, but consider that an offhand comment you make to a colleague about Dr. Smith's work habits could get back to him and result in a lawsuit against you. Maybe the fussy patient you did not discharge claims unlawful detention in a lawsuit against you and the hospital. Since it's easy to find professional liability insurance that automatically includes personal injury, there is no reason for you not to have this protection for yourself.

Just to add to the confusion, "personal injury protection" is a completely different type of insurance. It is an option with automobile policies that protects the policyholder against the costs of injuries suffered by the policyholder regardless of who is at fault. In some states, this is "uninsured motorist" coverage and only applies when another driver causes an accident and does not have liability insurance to cover it.

Getting back to personal injury coverage: If you have it and your neighbor sues you for bad-mouthing him at the last condominium association meeting, you're covered, right? Wrong! Personal injury coverage is part of a business or professional policy that responds to claims based on the operation of the business or the practice of the profession. The condo association meeting is neither.

You need "comprehensive personal liability" insurance, or CPL, for that. This covers injury to persons or property committed by you in your nonbusiness life, including the alleged slander. Fortunately, CPL is included in the homeowner's policy that you buy to protect your home against fire and other hazards. If you do not own your home, a renter's policy will also have this. Even if you are renting and not concerned about a potential loss of your property, CPL is a very good reason in itself to have such a policy.

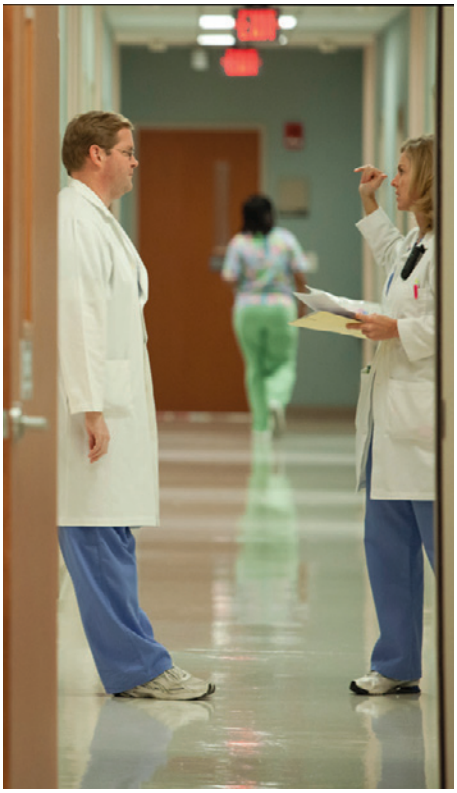

PHOTO / TODD SPOTH

As you can see, the insurance industry throws around the word "personal" a lot in describing very different coverages. No matter what it's called, your concern is whether your personal (as in the dictionary definition: "of, relating to, or affecting a particular person") liability is covered. First, separate your business from your nonbusiness life. When it comes to business, for most people it does not overlap with the personal from a legal/insurance perspective. However, you are not most people. Because you are a medical professional, you have personal (again, in the dictionary sense) liability for your actions. Legally, you cannot transfer liability for your own professional actions to another party or entity. If not for this distinction, you could merely form a corporation with yourself as the sole officer and limit your liability to the assets of the corporation, shielding your personal assets.

Instead, your personal assets are technically at risk for your own negligent acts, errors and omissions in treating patients. This is true regardless of whether your employer also committed such acts or provides you with insurance protection through a corporate policy. Don't be unduly alarmed. If your employer maintains a healthy amount of insurance protection on your behalf and/or possesses substantial assets, you are about as well protected as you can be. It's when the employer does not maintain adequate insurance and/or lacks the assets to materially protect you that a problem can arise.

As we always recommend, though, having your own personal (in the dictionary sense) professional liability insurance policy that you obtain and can carry from job to job precludes concern about the employer's coverage and provides the best career protection. **PA**

AAPA-sponsored insurance plans are offered by insurance professionals and companies (distinct from AAPA) that are solely responsible for all insurance communications. AAPA Insurance Services can be reached at 877-356-2272, via e-mail at *info@professionalriskadvisor.com* or on the Web at *www.pavalue.com*.

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Third Annual Adult Hospital Medicine Boot Camp

Aug. 9–13, 2011: Westfields Marriott, Chantilly, Va.

This highly specialized and educationally intense boot camp immerses PAs and NPs in some of the most important topics in adult hospital medicine. Designed specifically for PAs and NPs, this very popular course takes place at the luxurious Westfields Marriott Resort and Conference Center in Chantilly, Va., and features cutting-edge topics and issues facing the hospital medicine clinician in day-to-day work.

Small group breakout sessions, three sumptuous meals, flash drives with course materials, endless networking opportunities and a fun-filled evening with the Capitol Steps on Friday, Aug. 12, are included in your registration fee. New this year: a Bedside Ultrasound Skills workshop will be offered on Aug. 9. Registration for this workshop is very limited, so don't wait. No exceptions can be made.

Register at *www.aapa.org/bootcamp*.

Veins, Vessels and Vascular Updates

Sept. 16–18: Ritz-Carlton, Tysons Corner, Va.

Vascular diseases represent the single most important cause of death and disability in our nation and will remain so for the decades ahead. AAPA and the Society of Vascular Medicine have created this course to give health care providers some of the most up-to-date information on a variety of vascular topics.

Held at the Ritz-Carlton Hotel outside Washington, D.C., this course includes discussion on peripheral artery disease, ischemia and current interventions for the treatment of thrombolytic stroke, among many other topics. Join your colleagues at an evening reception to discuss "cases over cocktails," and on Sunday morning take advantage of the limited-registration hands-on vascular skills lab.

This unique course is pertinent to any PA who is practicing in the following specialty areas: family practice, internal medicine, hospitalist, general cardiology, wound care, home care, invasive cardiology, invasive peripheral vascular, invasive radiology, vascular surgery, orthopedics—hip or knee joint replacement, endocrinology, venous ablation, gynecology (patients over 50 at risk)

Registration for this course is now open at *www.aapa.org/vascular*. Don't delay!

Get More From IMPACT 2011

IMPACT 2011 On Demand will include 75 hours of sessions from AAPA's 39th Annual PA Conference in a digital library. Sessions are captured as presenters' slides with fully synchronized live audio. Conference registrants can take advantage of special discounts.

With this valuable digital library you can:

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You can order IMPACT 2011 On Demand by visiting *www.aapa.org/IMPACT*. **PA**

Important Health Disparities Sessions during IMPACT 2011

Over the past year, AAPA has reached out to several medical organizations as we continue to work on strengthening the physician-PA team delivery of health care. With growing concerns about racial and ethnic disparities in health and the need for health care systems to accommodate increasingly diverse patient populations, cultural competence has increasingly become a matter of concern and attention.

AAPA is delighted to announce that the presidents of both the National Hispanic Medical Association and the National Medical Association will be making presentations during **IMPACT 2011**.

Make sure to add these important presentations to your Thursday schedule during **IMPACT 2011**.

THURSDAY, JUNE 2, 2011

4:00-4:45 P.M. CULTURAL COMPETENCY AND DIVERSITY IN PHYSICIAN ASSISTANT HEALTHCARE DELIVERY

Speakers: Leonard J. Weather Jr., RPh, MD, president, National Medical Association; Anita L. Jackson, MD, MPH, FACS, FAAOA, CEO of Carolina Family and Urgent Care; and Stuart M. James, chief information officer, University Health Systems of Eastern Carolina

5:00-7:00 P.M. HEALTH CARE DISPARITIES IN THE LATINO COMMUNITY

Speaker: Elena Rios, MD, MSPH, president and CEO of the National Hispanic Medical Association

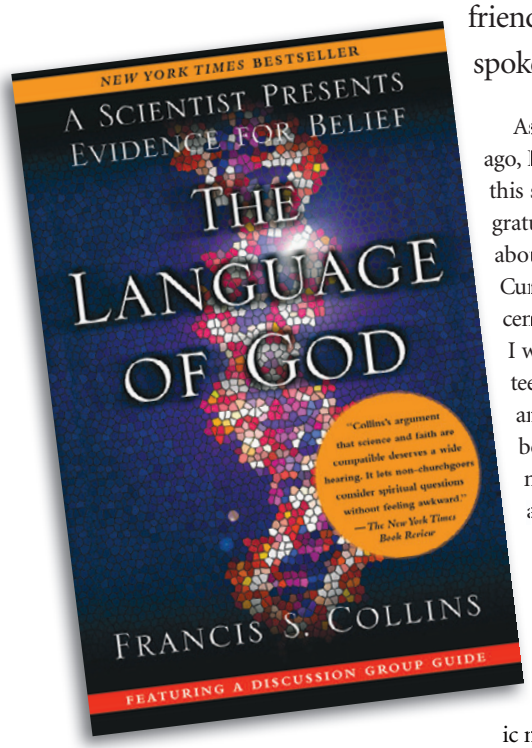
Followed by a reception in the rear of the room.

BY LAWRENCE M. HERMAN, MPA, RPA-C, DFAAPA

A Double Helix of Faith

Renowned Genetics Expert Takes on Science vs. Religion

I WENT TO HIGH SCHOOL IN A TINY WHALING VILLAGE on the North Shore of Long Island. My high school graduated 176 students. And 15 of my classmates' parents had won Nobel Prizes. I was blessed to attend Cold Spring Harbor High School. At the time, I didn't grasp the significance of somebody named Francis Collins. He was just a guy who, like so many of my friends' parents, worked at what we called "the bio lab" in our tiny village, and who spoke at my National Honor Society induction assembly.



Collins attempts the great synthesis of dichotomies: the empirical and the spiritual, pure versus practical reason.

As a high school junior three decades ago, I was oblivious to the significance of this stranger getting up on stage to congratulate the winners and wax incessantly about something called a "double helix." Curiously, when I was perhaps only 1 percent wiser, our paths again crossed when I was privileged to serve on a committee for AAPA under Collins' leadership, and during a break, to my shock he was both amused and incredibly thirsty for me to explain our previous contact and especially my experiences with all of his colleagues 30 years ago.

Now I believe we all recognize Francis S. Collins, MD, PhD, the author of the *New York Times* bestseller "The Language of God," the man who first discovered the genetic misspellings that cause cystic fibrosis, neurofibromatosis, Huntington's disease and other diseases.

But what many of us do not know is that he has a long-standing interest in the boundaries between science and faith. He is an accomplished geneticist, and initially homeschooled. Ultimately, he received his PhD from Yale and his MD from the University of Virginia School of Medicine. He was first a chemist and mathematician, and later a biologist and geneticist. Of course, he is also very unassuming and introduced himself as "Francis," although I have never been foolish enough to call him that. I'm told he introduces himself this way commonly, most often when riding his motorcycle. Incredibly likable, he leads monumental projects with confidence. A pioneer gene hunter, he led the Human Genome Project from 1993 until 2008, and the single bravado I have heard come from his mouth is that this was accomplished "ahead of schedule and under budget." He was awarded the Presidential Medal of Freedom in 2007 for his revolutionary contributions to genetics, and the National Medal of Science in 2009. He now heads the National Institutes of Health.

"The Language of God" is a deeply personal book for Collins. He tackles Immanuel Kant's "science vs. religion" debate. Collins attempts the great synthesis of dichotomies: the empirical and the spiritual, pure versus practical reason. Like Kant before him, Collins is sure to raise the ire of both proponents. Clearly, Collins does something very right to accomplish this.

Collins begins the first part of the book with his personal journey from atheism toward a theistic worldview, and the classical objections against it. The second part of the book is a popular science exposé, where Collins draws extensively on his considerable scientific background in both physics and biology and the role he played in the Human Genome Project. In the third part of the book, Collins tries to reach a conclusion about the issue of "faith in science and faith in God." He reviews his options, from creationism to atheism, and settles on the middle-of-the-road worldview he calls "BioLogos." He expounds this theistic evolutionary view, according to which orthodox evolution theory is a fact but also a divine means of creation.

In the end, how can he reconcile these opposites? Using his personal faith in God and his professional expertise, Collins presents a very common-sense case for the integration of science and Scripture. Both disciplines require the use of reason and logic, as well as faith and experience. Both must interpret the facts. In Collins' prose, "The Language of God" is sure to challenge the intellectually honest reader who will read it with a receptive mind rather than a cynical heart. This is a fascinating book that just might change your perspective on religion and the world. Collins does a great job explaining some complex areas of science, and this is a must-read. **PA**

LAWRENCE M. HERMAN, MPA, RPA-C, DFAAPA, is a member of the AAPA Board of Directors and an assistant professor, academic coordinator and director of admissions at the New York Institute of Technology PA program.

SIMON & SCHUSTER

How to Prepare for the PANRE

Passing the Test Without the Stress

WHEN THE TIME COMES for the recertifying examination, cold shivers often run down the spines of PAs in clinical practice. But following some simple strategies can help you approach the physician assistant national recertification examination, or PANRE, with confidence.

NATA-LIA / SHUTTERSTOCK

It is helpful to divide your approach for successfully passing the PANRE into two primary strategies: preparation and participation. Preparation strategies are employed before the exam, and participation strategies are employed during the exam. It is important to consider cognitive aspects (those dealing with knowledge) as well as affective aspects (those dealing with the emotions) of preparation and participation.

Preparation Strategies

■ **SELF-ASSESS.** Determine subject discipline areas that are unfamiliar or difficult. For example, if you work in cardiology, you may need less time for this topic but have little exposure to OB/GYN and find nephrology difficult to grasp. These areas will require more study time. Many of the review books on the market offer a self-assessment examination that will help you map out fields for concentrated study.

■ **RESEARCH THE EXAMINATION.** Visit the National Commission on Certification of Physician Assistants (NCCPA) Web site at *www.nccpa.net* for up-to-date information on examination content and procedures. Recently, NCCPA revised its PANRE examination content, and PAs can now choose to focus 40 percent of their questions in the areas of adult medicine, surgery or primary care.

■ **PREPARE AND EXECUTE A STUDY PLAN.** Establish a calendar to study by discipline over several weeks. Allow yourself about seven hours per week for discipline subjects you find challenging and four to five hours for areas you find easier. Spread out your study schedule, and do not cram.

■ **DEVELOP A HEALTHY FRAME OF MIND.** A negative attitude will result in poorer performance. Instead of viewing the exam as an intrusion or burden, think of it as an opportunity to identify your strengths and weaknesses and ultimately ensure quality care for patients and continued respect for the PA profession.

Participation Strategies

■ **REVIEW LOGISTICS.** Be sure you have the correct date, time and location for the examination. Some PAs have found it helpful to spend the evening before the exam at a hotel near the test center. This avoids being late because of unexpected traffic patterns, allows a good night's sleep and an opportunity for a few additional hours of review without distractions of home. Be sure to check test center policies regarding required identification documents.

■ **PREPARE YOURSELF.** Be sure you begin the examination well rested, well nourished and in a good frame of mind. Do not stay up cramming the evening before, and be sure to eat a healthful but not overly heavy breakfast. Some individuals have found a reasonable amount of exercise or meditation will help relax them and diminish pre-test anxiety. Dress in layers so you are able to adjust to the environment of the test center.

■ **READ DIRECTIONS CAREFULLY.** NCCPA allows you to take an examination tutorial before the examination.

■ **EMPLOY TEST-TAKING TECHNIQUES.** NCCPA uses sophisticated techniques to develop and vet test items, so it is not likely that strategies used to "psych out" the exam will be useful. The best approach to ensuring a passing score is to know the material. However, a few techniques are helpful when you encounter questions that are challenging. First, anticipate the correct answer. Then, carefully read the question while covering the potential answers on the screen. If your answer is found when you uncover the screen, it is likely that it is the correct one. **ELIMINATE CHOICES.** The most difficult aspect of developing multiple-choice test items is to identify incorrect but plausible discriminators. If you can eliminate two of the four items, your odds of selecting the correct answer by guessing improves from 25 percent to 50 percent.

■ **DON'T RUSH.** NCCPA allows one minute per question. Generally, candidates who have prepared for the examination will not run out of time.

■ **DON'T DWELL ON DIFFICULT QUESTIONS.** It is likely that you will encounter some test items where you are unable to determine a correct answer. Instead of spending excessive time (more than two minutes) trying to figure out an answer and raising your stress level, mark the question for later review. Once you finish that section of the examination, you can come back to the ones you marked for review.

■ **LOOK FOR CLUES.** Often, clues from other questions or simply time will help you select the correct answer. Use common-sense techniques that you employ every day in your clinical practice.

■ **ANSWER EVERYTHING.** Be sure to answer all questions before closing the section and moving on.

■ **TRUST YOUR GUT.** Do not change answers unless you have a good reason (e.g., you misread the question). Generally, your first impression is the correct one. **PA**

ANTHONY A. MILLER, MEd, PA-C, is a professor and the director of the Shenandoah University PA Studies program. An educational consultant in the area of PA program accreditation and outcomes assessment, he is the recipient of the Physician Assistant Education Association Master Teacher Award. He will teach the CME "Tips and Techniques to Prepare for the PANRE" during AAPA's 39th Annual Physician Assistant Conference in Las Vegas.

EATING WELL

When we think of Las Vegas and food, we think of celebrity chefs like Tom Collichio or Alain Ducasse. But beyond the Strip's glitz and glamour, Vegas is a city where Southwest food traditions reign. The *Las Vegas Review-Journal*'s food editor says that one of the best places to get an authentic taco in the city is Lindo Michoacan Restaurant, *www.lindomichoacan.com*. If you can't make it to Vegas for IMPACT 2011, give this recipe a try. For more heat, use a whole jalapeño and a dash of cayenne.

PHOTO / JENN HOHMAN

Fish Tacos with Mango Salsa

Ingredients

1 mango, chopped

1 cup of plum tomatoes, seeded and diced

½ jalapeño, seeded and diced (or serrano for more heat)

¼ red onion, diced

juice of 1 lime, zest of 1/2 lime

1 clove of garlic

½ cup plain, low-fat yogurt, strained

½ tsp chili powder or fajita seasoning

½ lime

1 package of 6-inch corn tortillas

1 cup red cabbage, shredded

½ cup cilantro, leaves only

about 2 to 3 pounds of tilapia fillets (or halibut, orange roughy or mahi mahi)

1 tablespoon of extra virgin olive oil

salt and pepper

Directions

1. Preheat broiler for fish (or cook it on a grill).
2. Line a wire strainer with a paper towel. Place the yogurt in strainer and let drain for two to three hours in the refrigerator (the yogurt's consistency will thicken to that of a soft cheese). Add fajita seasoning, mix, and return to the refrigerator. Rinse and pat fillets dry. Place fish in a shallow baking pan and brush with olive oil and season with salt and pepper. Broil fish three to four inches from heat, without turning, until opaque and just cooked through, about four minutes. Mix the mango, jalapeño, red onion, lime juice and zest in a bowl.
3. **Making the Tacos.** Heat tortillas to soften. Place about 2 to 3 ounces of fish in the middle of the tortilla. Top with 2 tablespoons mango salsa, small handful of cabbage, 1 tablespoon of the creamy topping and sprinkle with cilantro.

Recipe adapted from "Healthy and Light Fish Tacos" by Rebecca Scritchfield, MA, RD. For more recipes, go to *www.rebeccascritchfield.com*.

BY ELLEN D. MANDEL, DMH, MPA, MS, PA-C

Humanism

Use It or Lose It

PREACHING, LET ALONE BROACHING THE CONCEPT of humanism to humans, is risky business. How can humans actually lose humanism? Well, it is not as hard as it might seem. For the cynics out there, if it is natural for humans, in particular PAs, to behave with humanism in mind, why would we put methods in place to remind us how to do it? Many professional groups address this concept in one way or another. Most do not use the actual term "humanism" but choose to couch the concepts in behavioral terms. We have the Competencies for the Physician Assistant Profession.

Initiated in 2003, the Competencies for the Physician Assistant Profession responded to a "growing demand for accountability and assessment in clinical practice." They cover important areas related to providing safe and effective medical care, but they go much further, delving into ethical and moral aspects of patient care. We are expected to demonstrate caring and respectful behavior with patients and their families; exercise respect, compassion and integrity; participate in self-reflection; and recognize our physical limitations. This sounds like a humanism primer.

There is new and budding interest in humanism because the health care provider "oldtimers," myself included, observed a diminution of common human courtesy as concerns surfaced that humanism was being confused with another buzzword, professionalism. Jordan J. Cohen, president emeritus of the Association of American Medical Colleges, neatly clarifies their differences: Professionalism is a way of acting, and humanism is a way of being. Humanism is manifested by altruism, integrity and compassion, while professionalism is codified as a social contract. Humanism works without laws and fear of retribution. It's similar to doing the right thing even if no one is watching.

Humanism, or the lack thereof, has long-term consequences. As practicing clinicians, educator and student preceptors, we mentor each other and new generations of PAs. Jack Coulehan, MD, MPH, succinctly writes about the difference in what we desire versus what we do: the proverbial "monkey see, monkey do" idea. So, although we believe in the values of altruism, honor and excellence, for a variety of reasons we fall short of our ideals. Now, no one is perfect, and to err is human, but sometimes we grant ourselves too much latitude. Those we mentor observe our words and our actions, and the actions speak far louder.

Our patients also weigh in on PA humanism, especially as they observe our white coats. Donning our short and then full-length white coats as we begin our workday once had a special feeling, a sense of disbelief that we had come so far, maybe achieved a professional dream. Yet, Delese Wear, PhD, has described how patients have different hopes for us, as this woven mantle represents clinical competence and training, and permits access to their innermost fears and concerns. The wearer is not entitled to feelings of fatigue or uncertainty. But we know we are not perfect as we do experience fatigue and difficult medical decision-making at times. However, with humanism in places we can honestly admit our fallibilities while retaining our patients' respect and our own self-respect.

Ellen D. Mandel, DMH, MPA, MS, PA-C

Rachel Naomi Remen, MD, author of "Kitchen Table Wisdom: Stories that Heal," writes about recapturing the soul of medicine. Research supports that removing humanism from medicine promotes job dissatisfaction, burnout, depression, substance abuse and even suicide. It is our responsibility as professionals to fight for our sense of meaning, not by ignoring pain or problems, but working out solutions to them. We are in charge of our own integrity and the decisions we make.

Consider how humanism is the path of least resistance. It rings true on many levels and ultimately increases our chances for rewarding professional and personal lives. **PA**

ELLEN D. MANDEL, DMH, MPA, MS, PA-C, is an associate professor with the Seton Hall University PA program. A health care provider for more than 30 years, she's interested in endocrine disorders, nutrition, complementary and alternative medicine and the medical humanities. She publishes and lectures on these topics.

PHOTOS / ELLEN MANDEL AND TODD SPOTH

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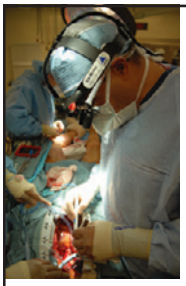

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FROM AAPA

BY AAPA STAFF

2011–2013 Commission and Work Group Chairs

This year, AAPA is launching a new volunteer leader governance structure of commissions and work groups, which will replace the previous committee and council structure that dates back to the late 1970s. (For more on these changes, go to *http://bit.ly/ehW77G*.)

AAPA President Patrick Killeen, President-elect Robert Wooten and Vice President/Speaker of the House of Delegates Alan Hull have announced the results of the commission and work group chair appointments. To read a list of the new chairs, go to *http://bit.ly/ef2u7m*.

Please join us in congratulating the new chairs, who will assume their roles on June 10, 2011. Between now and late May, the chairs will interview potential members who submitted their applications to the Academy by March 15, 2011.

All Politics Is Local

PAs interested in following suit to improve state PA practice laws and state implementation of health care reform should attend the annual State Legislative Leaders meeting from 8 to 10 a.m. on Friday, June 3, in Room N223-226 of the Las Vegas Convention Center at AAPA's 39th Annual Physician Assistant Conference.

The meeting will include a federal update, news on emerging trends and strategies, and an opportunity to share and debrief with like-minded colleagues and Academy staff. Immediately following, the Consortium of PA Representatives to State Regulatory Agencies will hold its annual meeting from 10 a.m. to noon.

All conference attendees interested in state regulation of the PA profession are invited to attend. For more information, please contact Ann Davis, PA-C, AAPA senior director of state advocacy and outreach, at *ann@aapa.org*.

Picture Yourself in Canada!

Don't forget: If you plan to attend IMPACT 2012 in Toronto, you'll need a valid U.S. passport to travel to Canada.

AAPA is pleased to offer you a complimentary passport photo in Las Vegas. Simply stop by the "Visit Toronto" booth in the PAvilion, Hall N1, of the Las Vegas Convention Center, and within minutes you'll have a valid U.S. passport photo. For more information on IMPACT 2011, go to *www.aapa.org/IMPACT*. For details on passports and international travel, go to *http://travel.state.gov/passport*.

2011 HOD Resolutions Announced

The House of Delegates, AAPA's policymaking body, recently announced a list of 44 formal resolutions it will review during IMPACT 2011.

Some of the hot-button topics to be discussed include paying clinical preceptors and/or clinical training sites; a statement on PA-to-MD/DO "bridge programs"; and advocating that the National Commission on Certification of PAs give PAs a choice of having a six- or 10-year recertification cycle as soon as possible.

The HOD runs Tuesday, May 31, through Thursday, June 2, in the Conrad Room of the Las Vegas Hilton.

To review the HOD agenda, go to *http://bit.ly/gwaGu1*. For more information on the HOD, go to *http://bit.ly/gP4zVl*. PA

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Limitations of Use

Treatment with ZYCLARA has not been studied for prevention or transmission of HPV.

Unevaluated Populations

The safety and efficacy of ZYCLARA Cream have not been established in the treatment of:
- urethral, intra-vaginal, cervical, rectal or intra-anal human papilloma viral disease.
- actinic keratosis when treated with more than one 2-cycle treatment course in the same area.
- patients with xeroderma pigmentosum.
- superficial basal cell carcinoma.
- immunosuppressed patients.

CONTRAINDICATIONS None.

WARNINGS AND PRECAUTIONS

Local Skin Reactions

Intense local skin reactions including skin weeping or erosion can occur after a few applications of ZYCLARA Cream and may require an interruption of dosing. ZYCLARA Cream has the potential to exacerbate inflammatory conditions of the skin, including chronic graft versus host disease.

Administration of ZYCLARA Cream is not recommended until the skin is healed from any previous drug or surgical treatment.

Systemic Reactions

Flu-like signs and symptoms may accompany, or even precede, local skin reactions and may include fatigue, nausea, fever, myalgias, arthralgias, malaise and chills. An interruption of dosing and assessment of the patient should be considered.

Lymphadenopathy occurred in 2% of subjects with actinic keratosis treated with ZYCLARA Cream. This reaction resolved in all subjects by 4 weeks after completion of treatment.

Ultraviolet Light Exposure Risks

Exposure to sunlight (including sunlamps) should be avoided or minimized during use of ZYCLARA Cream. Patients should be warned to use protective clothing (e.g., a hat) when using ZYCLARA Cream. Patients with sunburn should be advised not to use ZYCLARA Cream until fully recovered. Patients who may have considerable sun exposure, e.g. due to their occupation, and those patients with inherent sensitivity to sunlight should exercise caution when using ZYCLARA Cream.

In an animal photo-carcinogenicity study, imiquimod cream shortened the time to skin tumor formation. The enhancement of ultraviolet carcinogenicity is not necessarily dependent on phototoxic mechanisms. Therefore, patients should minimize or avoid natural or artificial sunlight exposure.

Increased Risk of Adverse Reactions with Concomitant Imiquimod Use

Concomitant use of ZYCLARA and any other imiquimod products, in the same treatment area, should be avoided since they contain the same active ingredient (imiquimod) and may increase the risk for and severity of local skin reactions.

The safety of concomitant use of ZYCLARA Cream and any other imiquimod products has not been established and should be avoided since they contain the same active ingredient (imiquimod) and may increase the risk for and severity of systemic reactions.

Immune Cell Activation in Autoimmune Disease

ZYCLARA Cream should be used with caution in patients with pre-existing autoimmune conditions because imiquimod activates immune cells.

ADVERSE REACTIONS

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice.

Clinical Trials Experience: External Genital Warts

In two double-blind, placebo-controlled studies 602 subjects applied up to one packet of ZYCLARA Cream or vehicle daily for up to 8 weeks.

The most frequently reported adverse reactions were application site reactions and local skin reactions. Selected adverse reactions are listed in Table 1.

Table 1: Selected Adverse Reactions Occurring in ≥2% of ZYCLARA Treated Subjects and at a Greater Frequency than with Vehicle in the Combined Trials (EGW)

Preferred Term	ZYCLARA Cream 3.75% (N=400)	Vehicle Cream (N=202)
Application site pain	28 (7%)	1 (<1%)
Application site irritation	24 (6%)	2 (1%)
Application site pruritus	11 (3%)	2 (1%)
Vaginitis bacterial*	6 (3%)	2 (2%)
Headache	6 (2%)	1 (<1%)

*Percentage based on female population of 6/216 for ZYCLARA Cream 3.75% and 2/106 for vehicle cream

Local skin reactions were recorded as adverse reactions only if they extended beyond the treatment area, if they required any medical intervention, or they resulted in patient discontinuation from the study. The incidence and severity of selected local skin reactions are shown in Table 2.

Table 2: Selected Local Skin Reactions in the Treatment Area Assessed by the Investigator (EGW)

All grades*, (%)	Severe, (%)	ZYCLARA Cream 3.75% (N=400)	Vehicle Cream (N=202)
Erythema*		70%	27%
	Severe erythema	9%	<1%
Edema*		41%	8%
	Severe edema	2%	0%
Erosion/ulceration*		36%	4%
	Severe erosion/ulceration	11%	<1%
Exudate*		34%	2%
	Severe exudate	2%	0%

*Mild, Moderate, or Severe

The frequency and severity of local skin reactions were similar in both genders, with the following exceptions: a) flaking/scaling occurred in 40% of men and in 26% of women and b) scabbing/crusting occurred in 34% of men and in 18% of women.

In the clinical trials, 32% (126/400) of subjects who used ZYCLARA Cream and 2% (4/202) of subjects who used vehicle cream discontinued treatment temporarily (required rest periods) due to adverse local skin reactions, and 1% (3/400) of subjects who used ZYCLARA Cream discontinued treatment permanently due to local skin/application site reactions.

Other adverse reactions reported in subjects treated with ZYCLARA Cream include: rash, back pain, application site rash, application site cellulitis, application site excoriation, application site bleeding, scrotal pain, scrotal erythema, scrotal ulcer, scrotal edema, sinusitis, nausea, pyrexia, and influenza-like symptoms.

Postmarketing Experience

The following adverse reactions have been identified during post-approval use of imiquimod. Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to drug exposure.

Application Site Disorders: tingling at the application site.

Body as a Whole: angioedema.

Cardiovascular: capillary leak syndrome, cardiac failure, cardiomyopathy, pulmonary edema, arrhythmias (tachycardia, supraventricular tachycardia, atrial fibrillation, palpitations), chest pain, ischemia, myocardial infarction, syncope.

Endocrine: thyroiditis.

Gastro-Intestinal System Disorders: abdominal pain.

Hematological: decreases in red cell, white cell and platelet counts (including idiopathic thrombocytopenic purpura), lymphoma.

Hepatic: abnormal liver function.

Infections and Infestations: herpes simplex.

Musculo-Skeletal System Disorders: arthralgia.

Neuropsychiatric: agitation, cerebrovascular accident, convulsions (including febrile convulsions), depression, insomnia, multiple sclerosis aggravation, paresis, suicide.

Respiratory: dyspnea.

Urinary System Disorders: proteinuria, urinary retention, dysuria.

Skin and Appendages: exfoliative dermatitis, erythema multiforme, hyperpigmentation, hypertrophic scar, hypopigmentation.

Vascular: Henoch-Schonlein purpura syndrome.

USE IN SPECIFIC POPULATIONS

Pregnancy Pregnancy Category C:

There are no adequate and well-controlled studies in pregnant women. ZYCLARA Cream should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

The animal multiples of human exposure calculations were based on daily dose comparisons for the reproductive toxicology studies described in this label. The animal multiples of human exposure were based on weekly dose comparisons for the carcinogenicity studies described in this label. For the animal multiple of human exposure ratios presented in this label, the Maximum Recommended Human Dose (MRHD) was set at 2 packets (500 mg cream) per treatment of actinic keratosis with ZYCLARA Cream (imiquimod 3.75%, 18.75 mg imiquimod) for BSA comparison. The maximum human AUC value obtained in the treatment of external genital and perianal warts was higher than that obtained in the treatment of actinic keratosis and was used in the calculation of animal multiples of MRHD that were based on AUC comparison.

Systemic embryofetal development studies were conducted in rats and rabbits. Oral doses of 1, 5 and 20 mg/kg/day imiquimod were administered during the period of organogenesis (gestational days 6 – 15) to pregnant female rats. In the presence of maternal toxicity, fetal effects noted at 20 mg/kg/day (163X MRHD based on AUC comparisons) included increased resorptions, decreased fetal body weights, delays in skeletal ossification, bent limb bones, and two fetuses in one litter (2 of 1567 fetuses) demonstrated exencephaly, protruding tongues and low-set ears. No treatment related effects on embryofetal toxicity or teratogenicity were noted at 5 mg/kg/day (28X MRHD based on AUC comparisons).

Intravenous doses of 0.5, 1 and 2 mg/kg/day imiquimod were administered during the period of organogenesis (gestational days 6 – 18) to pregnant female rabbits. No treatment related effects on embryofetal toxicity or teratogenicity were noted at 2 mg/kg/day (2.1X MRHD based on BSA comparisons), the highest dose evaluated in this study, or 1 mg/kg/day (115X MRHD based on AUC comparisons).

A combined fertility and peri- and post-natal development study was conducted in rats. Oral doses of 1, 1.5, 3 and 6 mg/kg/day imiquimod were administered to male rats from 70 days prior to mating through the mating period and to female rats from 14 days prior to mating through parturition and lactation. No effects on growth, fertility, reproduction or post-natal development were noted at doses up to 6 mg/kg/day (25X MRHD based on AUC comparisons), the highest dose evaluated in this study. In the absence of maternal toxicity, bent limb bones were noted in the F1 fetuses at a dose of 6 mg/kg/day (25X MRHD based on AUC comparisons). This fetal effect was also noted in the oral rat embryofetal development study conducted with imiquimod. No treatment related effects on teratogenicity were noted at 3 mg/kg/day (12X MRHD based on AUC comparisons).

Nursing Mothers

It is not known whether imiquimod is excreted in human milk following use of ZYCLARA Cream. Because many drugs are excreted in human milk, caution should be exercised when ZYCLARA Cream is administered to nursing women.

Pediatric Use

Safety and efficacy in patients with external genital/perianal warts below the age of 12 years have not been established.

Geriatric Use

Clinical studies of ZYCLARA Cream for EGW did not include sufficient numbers of subjects aged 65 and over to determine whether they respond differently from younger subjects. Of the 400 subjects treated with ZYCLARA Cream in the EGW clinical studies, 5 subjects (1%) were 65 years or older.

OVERDOSAGE

Topical overdosing of ZYCLARA Cream could result in an increased incidence of severe local skin reactions and may increase the risk for systemic reactions.

Hypotension was reported in a clinical trial following multiple oral imiquimod doses of >200 mg (equivalent to ingestion of the imiquimod content of more than 21 packets of ZYCLARA). The hypotension resolved following oral or intravenous fluid administration.

Rx Only

GRACEWAY® PHARMACEUTICALS

Manufactured by
3M Health Care Limited
Loughborough LE11 1EP England
Distributed by
Graceway Pharmaceuticals, LLC
Bristol, TN 37620

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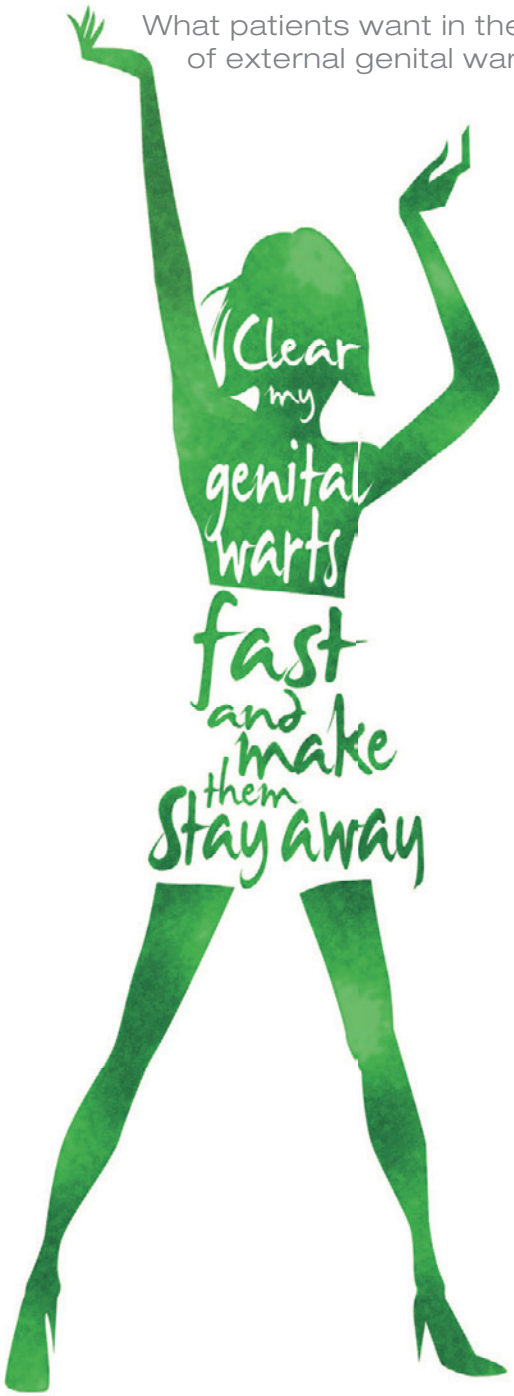
What patients want in the treatment of external genital warts (EGW)...



Effectively clears genital warts and keeps patients clear

Short treatment, daily dosing

- Applied once daily for up to 8 weeks

Significant clearance in females

- 37% complete clearance, 48% partial clearance
  - Partial clearance defined as ≥75% reduction in EGW count from baseline

Patients who clear with Zyclara can expect to remain clear

- Only 15% of patients had a recurrence at 12 weeks posttreatment[1]

Tough on warts, easy on patients

- Low incidence of treatment-related adverse events at the application site: itching (3%), irritation (6%), or pain (7%)[1]
- Local skin reactions, most of which were mild to moderate, included severe erythema (9%) and severe erosion/ulceration (11%)[1]

Zyclara®
(imiquimod) Cream
3.75%

Zyclara Cream is indicated for the treatment of external genital and perianal warts/condyloma acuminata in patients 12 years or older.

In clinical studies, the most frequently reported adverse reactions were local skin and application site reactions. These reactions included erythema, edema, erosion or ulceration, and exudate at the genital wart site. Most local skin reactions were rated as mild to moderate. Intense local inflammatory reactions and/or flu-like systemic signs and symptoms can occur. Dosing interruptions may be required.

Avoid concomitant use of Zyclara Cream and any other imiquimod cream because of increased risk for adverse reactions.

Zyclara Cream is not recommended for the treatment of urethral, intra-vaginal, cervical, rectal, or intra-anal human papilloma viral disease as it has not been studied.

The effect of Zyclara Cream on the transmission of genital warts is unknown. Zyclara Cream may weaken condoms and diaphragms. Sexual contact should be avoided while the cream is on the skin.

Please see Brief Summary of Prescribing Information on adjacent page.

Reference: 1. Data on file. Graceway Pharmaceuticals, LLC.