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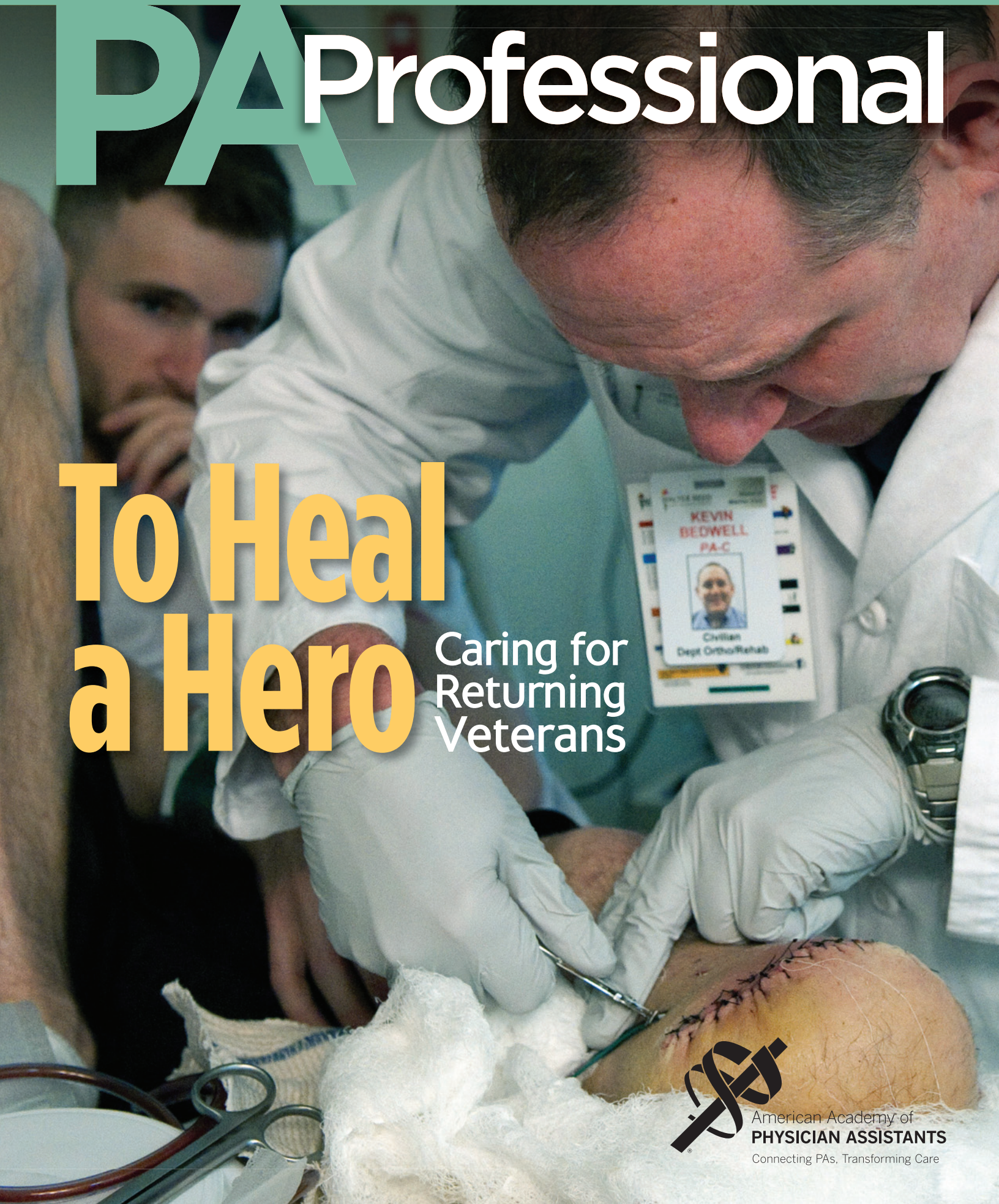
PA Professional



To Heal a Hero

Caring for Returning Veterans

American Academy of
PHYSICIAN ASSISTANTS
Connecting PAs, Transforming Care

Escalating PA Malpractice Exposure:

Expanding Scope of Practice

A report by the Institute of Medicine calls for the elimination of "regulatory and institutional obstacles" including limits on **Scope of Practice** which are state rules about what care practitioners who are not physicians can provide.

More Patients

With the new Affordable Care Act, the already over-stressed health care system will soon be adding 32 million patients.

Physician Shortage

Health care already functions with a shortage of MDs; in fact, the AAMC reports that in five years, there will be a shortage of 63,000 doctors across all specialties.

Physician assistants' role on the frontlines of health care has arrived. And the dramatically increased exposure to genuine or perceived negligent acts is VERY REAL and growing rapidly. That's why now, more than ever, you need top-rated AAPA-endorsed PA Protect ™.

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Connecting PAs, Transforming Care

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A PAramount Evening

2011 Awards Dinner

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Wednesday, June 1, 2011 | 8 p.m.
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For more information, contact
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Awards to be given include:

Eugene A. Stead Award of Achievement
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Outstanding PA of the Year
PA Service to the Underserved Award
Federal Service PA of the Year
Physician-PA Partnership Award
PAragon Publishing Award
PAF Caring for Communities Grant

HELD IN CONJUNCTION WITH IMPACT 2011—AAPA'S 39TH ANNUAL PHYSICIAN ASSISTANT CONFERENCE

The Leading News Resource for Physician Assistants

PA Professional

FEATURES

Correction: In the February 2011 issue of PA Professional the hospital where PA Jim Anderson works was misidentified. Anderson works as clinical informatics educator at the University of Washington Medicine Harborview Medical Center, Seattle.

CONTENTS

DEPARTMENTS

Read *PA Professional* Online!

Now, you won't have to wait for the mail. A full digital edition of *PA Professional* can be found online at *www.aapa.org/news/pa-professional*. Log on to get the entire reading experience, right down to turning the pages. Articles may also be downloaded as audio for those who prefer to listen to their news. We hope you enjoy our new digital edition.

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American Academy of PHYSICIAN ASSISTANTS

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PA Professional

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Time Well Spent

WE ALL NEED TIME AWAY FROM WORK to recharge, and that's not easy for a lot of us given the demands on our time. So when we have a week off, nobody would blame us for heading straight to a remote beach or the mountains, away from patients, the phones and e-mail. But every year, thousands of PAs choose to spend one of their well-deserved weeks off learning from and meeting their fellow PAs from across the country.

That time of year is upon us again. IMPACT 2011, AAPA's Annual Physician Assistant Conference, will take place from May 31 to June 4 in Las Vegas. I've spent the past year meeting PAs from different states and specialty groups, and I can't remember the last time PAs were this excited about AAPA's Annual Conference. For many, it's about the location. Catching up with longtime friends amidst the sights and sounds of Las Vegas is reason enough to make the trip. IMPACT 2011 allows you to combine that with unparalleled opportunities to learn from PAs and other medical professionals who are experts in their field. That is a combination you will not find anywhere else.

You will leave IMPACT 2011 as a better clinician. Often, what we need most is to step outside of our day-to-day lives and take a wider view of what our work means to patient care. IMPACT 2011 will help you do that. In addition to clinical knowledge, the conference will feature numerous sessions on the latest developments in health policy, reimbursement and state legislation. Are you struggling with a professional practice issue? AAPA has the answers to these questions. In addition, you'll very likely meet others who have encountered the same issues, and they may have the answer you're looking for. Perhaps that answer will come during one of the many social events that various constituent groups and PA programs plan to hold during IMPACT 2011.

As our profession grows, we become more valuable to the companies that make the medications and medical supplies and devices that we use to help our patients heal. An hour in the exhibit hall at IMPACT 2011 will expose you to all of the latest products and developments, and you won't even have to take time out from your workday.

While IMPACT 2011 may not meet the conventional definition of a vacation, I guarantee you will return home fully recharged and ready to tackle your next challenge. I will see you there! **PA**

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

BY ANN DAVIS, PA-C

Your Physician Assistant State License

It's Your Responsibility

AAPA STATE ADVOCACY STAFF members are frequently asked why PA practice is controlled by states and why a state license is required to practice. The answer comes from a case in West Virginia that was decided by the U.S. Supreme Court.

In 1889 the U.S. Supreme Court ruled in the case of *Dent v. West Virginia*. Frank Dent was a graduate of the American Medical Eclectic College of Cincinnati and practiced as a physician in Newburg, W.Va. The state found that Dent did not have a license to practice medicine and was not eligible for licensure as a physician. Dent was found guilty of practicing medicine without a license and fined $50.

Dent appealed the state's decision, maintaining that the state was interfering with his "vested right in relation to the practice of medicine." The U.S. Supreme Court ruled in favor of West Virginia, holding that the state indeed had the authority and responsibility to restrict medical practice to those who are licensed "in the exercise of its power to provide for the general welfare of its people."

So the state, in its power to provide for the welfare of its people, licenses health professionals.

Know the law, protect your license

Although your ability to practice is also determined by your PA education, unique specialty, training and experience and delegation by a supervising physician, unless you are exempted from state licensure as a federal employee, your professional identity and ability to provide care as a PA are dependent on your state license. You need to know its terms, when it expires, how to renew, and any specific renewal requirements, such as continuing medical education or current certification by NCCPA.

Much of this information, and links to each state's licensing board for PAs, is readily available on AAPA's website at *http://bit.ly/fpcAFy*. Academy staff members are available if you have questions. Be sure that your license is current and active if you are practicing. Check for yourself, even if your practice manager or hospital department assures you that "it's taken care of." Nearly all medical boards have licensee information available online, and it's easy to check your own information. Remember: Your license is your responsibility.

Have a question?

Many licensure questions can be handled by licensing agency staff. However, if your question involves clinical practice, an area of law that appears vague or a unique circumstance, start by asking a leader in your state constituent chapter or AAPA state advocacy staff to ensure you receive an accurate answer.

Practice acts across the country are improving and becoming more uniform. However, there is still work to do. The advent of health care reform and the emergence of new models of care—medical homes, accountable care organizations and health exchanges, for example—will put even more strain on the health care work force. PAs are a ready resource for meeting current and future work-force needs, but this requires that physician-PA teams are able to function at maximum efficiency. State law barriers that fill no public protection role must be repealed.

AAPA state constituent chapters across the country are hard at work improving state laws. Make this your year to lend a hand. To find out how to help, contact your state chapter leadership or Academy state advocacy and outreach staff.

ANN DAVIS, PA-C, is AAPA's senior director of state advocacy and outreach. Contact her at *ann@aapa.org* or 571-318-7359.

SHUTTERSTOCK

Insurance Exchanges—an Essential Facet of Health Care Reform

ONE OF THE CENTRAL TENETS of the Patient Protection and Affordable Care Act is the creation of health insurance exchanges. They are primarily state-regulated programs that will provide an assortment of health insurance plans to uninsured individuals, those who purchase individual health policies, and small group employers.

The exchanges will present an opportunity for consumers to review and compare health coverage options based on plans' benefit structure and on pricing information such as premiums, deductibles and co-insurance.

Simply put, an insurance exchange is the formation of a competitive marketplace allowing certain consumers to purchase health insurance policies, presumably at a more competitive price than what is available in a less regulated marketplace. In theory, the exchanges will have bargaining power with hospitals and health care systems that rival some of the largest employer group plans. How states choose to implement exchanges and whether the overall concept will work falls back on that well-worn idiom—the devil is in the details.

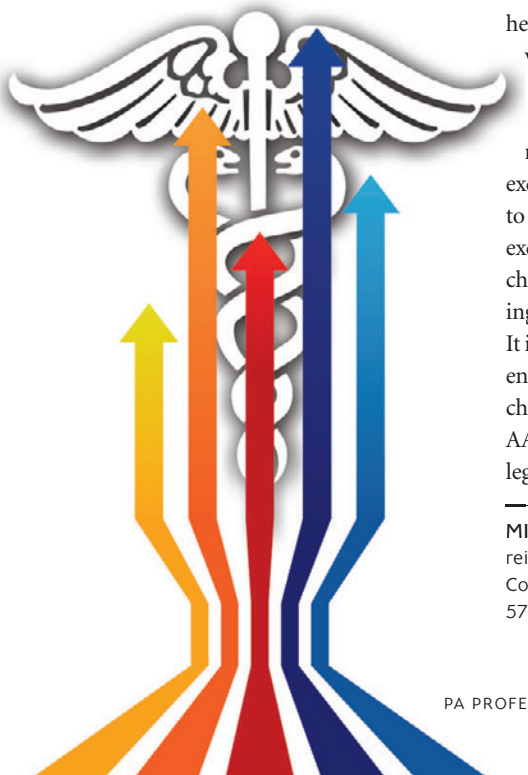
The PPACA requires that each state establish an American Health Benefit Exchange by Jan. 1, 2014. States are expected to set up exchanges, with the federal government maintaining the authority to establish an exchange if a state fails to do so. States can create multiple exchanges, as long as only one exchange serves a specific geographic area. States can also work together to form regional exchanges.

The plans offered by the exchange will have to meet minimum essential benefit standards developed by the federal government. Those standards are expected to be released no later than September 2011.

Some of the expected benefits of an insurance exchange include

- **Increased selection:** Consumers will have access to a choice of health plans.
- **Portability:** Because health insurance coverage won't be linked to employment, it will be easier for individuals to maintain coverage even when they change employers.
- **Information:** Consumers will be able to more directly compare plans and potential government subsidies, making it simpler for them to determine if they qualify for financial assistance.
- **No discrimination:** Insurers won't be able to discriminate or deny coverage based on health history.
- **Competitive pricing:** Health plans within the exchange will disperse risk in a manner similar to large group plans, causing premiums to be more competitive.

Starting in 2014, most people will be required to have health insurance or pay a penalty. Coverage may include employer-provided insurance, coverage people buy on their own, or Medicaid. Several groups are exempt from the requirement to have-coverage, based on income and other factors. The penalty for people who do not obtain insurance is the greater of two amounts: a certain percentage of income or a specified dollar amount.



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States Moving Rapidly

It is likely that most states have or will soon create agencies to run the exchanges. Oregon set up the Oregon Health Authority to implement health care reform legislation. In Pennsylvania, the Health Care Reform Implementation Advisory Committee oversees reform activities. Legislation passed in California established the California Health Benefit Exchange and an independent, five-member oversight board.

At least two states, Massachusetts and Utah, have formed state-based insurance exchanges. The Massachusetts exchange is a state-administered plan known as the Connector. The state of Utah's exchange is designed to provide consumers with the knowledge they need to make informed health care choices by establishing a market environment in which private insurers compete.

While the federal government is providing general guidelines regarding exchanges, states retain a high degree of flexibility as to how the exchanges will be run. States are moving rapidly to establish exchanges or the framework for their exchanges. Even states that have engaged in court challenges opposing health care reform are moving forward to plan for the insurance exchanges. It is vital that these activities be closely watched to ensure that PAs are appropriately included in exchanges and other health care reform programs. AAPA is constantly monitoring state and federal legislative activity in this area. **PA**

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

Constituent Beat

Finally: A Bill To Update Vermont's PA Practice Act

AFTER TWO YEARS OF TOIL, PAs in Vermont are beginning to see the fruits of their labor, a bill to update a PA practice act that hasn't been significantly updated in more than 25 years.

In early 2009, the Physician Assistant Academy of Vermont's legislative committee teamed up with AAPA state advocacy staff and other stakeholders to build support for legislative changes to the state's PA Practice Act. Earlier this year, Vermont State Rep. George Till, a board-certified OB-GYN, introduced H. 369, a bill that would make the state's PA Practice Act more consistent with AAPA's Six Key Elements of a Modern PA Practice Act, or 6KEs.

The bill seeks to change PAs from certified to licensed, and would remove an outdated requirement for detailed clinical protocols defining PA practice that need to be approved by the Board of Medicine. The protocols would be replaced by a written delegation agreement bertyween the physician and the PA. The Vermont Board of Medical Practice voted unanimously to support the legislation. Obtaining that endorsement was a key step the Vermont Academy took to clear the way for this bill to be introduced with no opposition, said David Ashner, AAPA's assistant director of state advocacy and outreach.

The bill has been read once and is in the Vermont House Committee on Human Services. PAAV President John Bond said, "PAs are poised to play a critical role in meeting our nation's health care needs. H. 369 will make sure that physician-PA teams in Vermont have the flexibility we need to do our part. We remain optimistic that it will be passed in this session."

U.S. Smoking Rates Down From 1960s

Between 1965 and 2007, the number of people who smoke a pack a day dropped from 56 percent to 40 percent in the United States, finds a new study recently published in the *Journal of the American Medical Association*. Read more at *http://jama.ama-assn.org/*.

Will It Work Here?

THE AGENCY for Healthcare Research and Quality's "Will It Work Here? A Decisionmaker's Guide to Adopting Innovations" helps users determine if an innovation would be a good fit—or an appropriate stretch—for their health care organization by asking a series of questions. It links users to actionable Web-based tools and presents case studies that illustrate how other organizations have addressed these questions. Read more at *http://bit.ly/esQ3NJ*.

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And the 2011 PAragon Awards Go To…

PARAGON AWARD WINNERS are PAs who have distinguished themselves in service to patients, their community and the PA profession. Please join us in congratulating the 2011 winners, and make sure to see the documentary about the PAragon Award winners at AAPA's 39th Annual PA Conference in Las Vegas. The documentary will premiere during the General Session from 9 to 10:30 a.m. on Tuesday, May 31, in the Barron Room of the Las Vegas Hilton. PAragon Award recipients will accept their awards during a dinner fundraiser for the PA Foundation, "A PAramount Evening: Celebrating Those Who Heal, Educate, Lead and Provide." The dinner is at 7 p.m. on Wednesday, June 1, in the Barron Room. Tickets to the PA Foundation fundraiser are $150.

Outstanding PA of the Year
Michael A. Rackover, PA-C, MS, West Chester, Pa.

Humanitarian PA of the Year
Mary L. Fargen, PA-C
Austin, Minn.

Federal Service PA of the Year
Col. Douglas C. Hodge, PA-C,
Fairborn, Ohio

PA Service to the Underserved
Rachel Stark Farrell, PA-C, Marysville, Calif.

Physician-PA Partnership Award
Christopher E. Sadler, PA-C, San Diego, Calif.

Daniel Einhorn, MD, FACP, FACE, La Jolla, Calif.

Publishing Award 1st Place
Katherine Footracer, PA-C,
Pasadena, Calif.

Are You E-Prescribing?

If not, you'd better start. The deadline to avoid Centers for Medicare & Medicaid Services penalties for not e-prescribing is June 30. Beginning in 2012, PAs and other eligible professionals who are not e-prescribing may be subject to a payment adjustment or penalty. The payment adjustment in 2012, with regard to all Part B-covered professional service claims, will result in the eligible professional or group practice receiving 99 percent of the Physician Fee Schedule, or PFS, amount that would otherwise apply to the services (a 1% penalty).

In 2013, EPs will receive 98.5 percent of their covered Part B-eligible charges if they are not e-prescribing. In 2014, the penalty for not e-prescribing is 2 percent, resulting in payment of 98 percent of covered Part B charges. CMS will analyze claims data from Jan. 1 - June 30, 2011, to determine if the practitioner has submitted at least 10 electronic prescriptions during the first six months of calendar year, or CY, 2011. Those practitioners who have not e-prescribed the requisite number by June 30, 2011, will be subject to the penalty.

It is not too late to get with the program. To provide more information, including system capabilities and e-prescribing reporting rules, Medicare has published several resources:

- "How to Get Started," *http://1.usa.gov/iciB09*.
- NEW! 2011 Electronic Prescribing (eRx) Incentive Program Update—Future Payment Adjustments, *http://1.usa.gov/epJsnk*.
- "Medicare's Practical Guide to the Electronic Prescribing (eRx) Incentive Program," *http://1.usa.gov/gb24lj*.

For further information, contact Tricia Marriott, AAPA Director of Reimbursement Advocacy, at *tmarriott@aapa.org*.

PAs Needed for TeenScreen Registry

THE COLUMBIA UNIVERSITY TEENSCREEN® National Center for Mental Health Checkups recently announced the creation of a new, first-of-its-kind registry, an honor roll of sorts for physicians, PAs and nurse practitioners who offer mental health screening during routine adolescent care and a resource for information sharing among those providers.

Signing up for the Columbia University TeenScreen Registry is free. PAs and other primary care providers enrolled in the registry receive free evidence-based screening questionnaires, patient education materials, access to a private online community to share information about mental health screening in primary care and a certificate from Columbia University. Registrants will also have their profile information listed on the public page of the registry website, which will launch in June.

Providers may enroll now, or request more information about adolescent mental health screening in primary care practice, by going to *http://bit.ly/TeenScreen*.

SHUTTERSTOCK

Latest Hypertension Stats from AHRQ

More than 59 million American adults were diagnosed with high blood pressure in 2008, according to the latest News and Numbers from the Agency for Healthcare Research and Quality. Read more at *http://bit.ly/eqEGVT.*

PA Students Pitch In

The U.S. Department of Health and Human Services Office of the Inspector General found that the Centers for Medicare & Medicaid Services paid more than $3 million in 2007 and 2008 for erectile dysfunction drugs, even though it is against the law for CMS to pay for these prescriptions. Read more at *http://1.usa.gov/elEq43*.

April marks the Student Academy's third annual National Service Month. PA students around the nation will be participating in service activities to promote healthy living, projects that make an impact on the lives of the people in the communities they will soon be serving as practicing PAs.

In addition to the National Service Month activities, the PA Foundation will host a national texting campaign. The school that receives the greatest number of texts will be awarded a $5,000 grant. This event is open to anyone. Support the school of your choice by texting during the month of April!

For more information about National Service Month, visit the Student Academy online at *www.aapa.org/student-academy.* For more information on the texting campaign, please see the PA Foundation website at *www.aapa.org/pa-foundation*.

Children's Jewelry Alert

Young children who chew or swallow jewelry containing cadmium may be exposed to as much as 100 times the recommended maximum exposure limit for the toxic metal, according to research published in the journal *Environmental Health Perspectives*. Read more at *http://bit.ly/gSSRji*

PA APPOINTED TO NATIONAL PSORIASIS FOUNDATION BOARD

PA SARAH KURTS, OF DENVER, was recently appointed to the National Psoriasis Foundation Board of Trustees in recognition of her longtime service to the Psoriasis Foundation as a member and volunteer.

A PA in dermatology, Kurts has participated in numerous research studies of new drugs in development for skin conditions, including psoriasis, and she has helped lead the Psoriasis Foundation's affiliated support network in Denver since 2008. She was instrumental in starting the Psoriasis Foundation's Walk to Cure Psoriasis in Denver, serving as its chair for 2009 and 2010.

Randy Beranek, Psoriasis Foundation president and CEO, is delighted to have her leadership and expertise on the board. He said that she has "a tremendous passion for our cause and will bring invaluable knowledge to our Board of Trustees."

Kurts is a member of the American Academy of Physician Assistants, the Colorado Association of Physician Assistants and the Society of Dermatology Physician Assistants; she is the treasurer of the Colorado Society of Dermatology Professionals (PAs and NPs).

A 1999 graduate of the child health associate/physician assistant program at the University of Colorado Health Sciences Center in Denver, she was the recipient of scholarships from both the Physician Assistant Foundation and the Colorado Academy of Physician Assistants Student.

Kurts, who has also worked as a PA in pediatrics, has been a PA in dermatology since 2001. She has worked with the Dermatology & Laser Institute of Colorado in Lone Tree, outside of Denver, since 2005.

Asthmatic Kids Bounce Their Way to Health

PA Lonna Bloom helped launch a pilot project at the Kids' Care Clinic at Sunrise Community Health Center in Evans, Colo., to help Latino children in grades 3 to 5 with obesity and asthma develop healthful habits. Students attended two sessions per week: one with their families that included bilingual lessons in nutrition, exercise and asthma management, and another kids' only midweek session at school.

During the second session, kids met with a behavioral health counselor, had their vital signs and asthma symptoms checked, and participated in 20 minutes of outdoor play that could be replicated at home, such as jumping rope, using hula hoops and joining in beach ball games. Family education sessions focused on the link between poorly controlled asthma and obesity in children.

At the end of the monthlong project, Bloom reported that all students had learned to use their asthma medication correctly and that some of them had lost weight.

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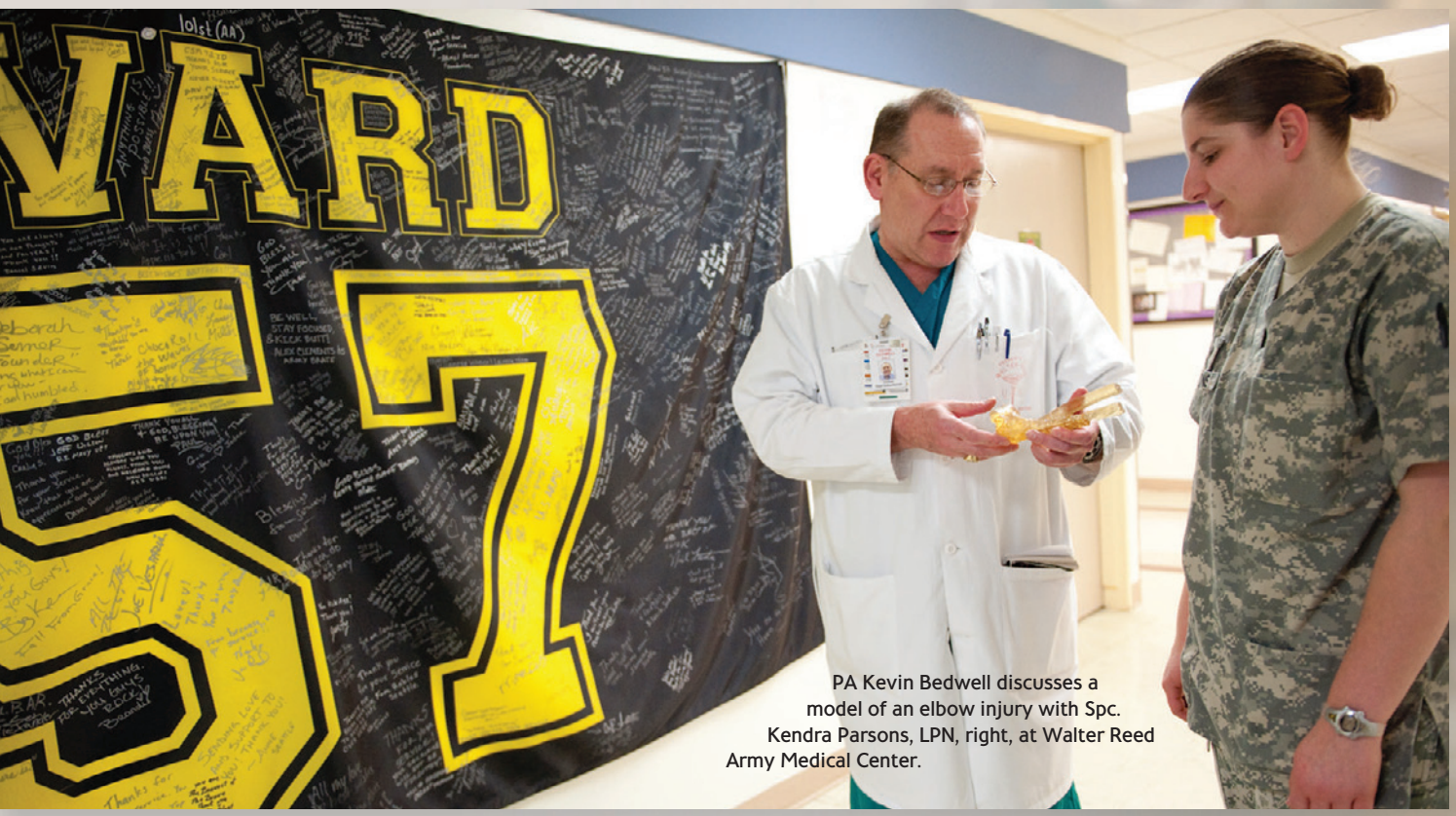
BY JANETTE RODRIGUES

Healing Heroes

Caring for Returning Veterans

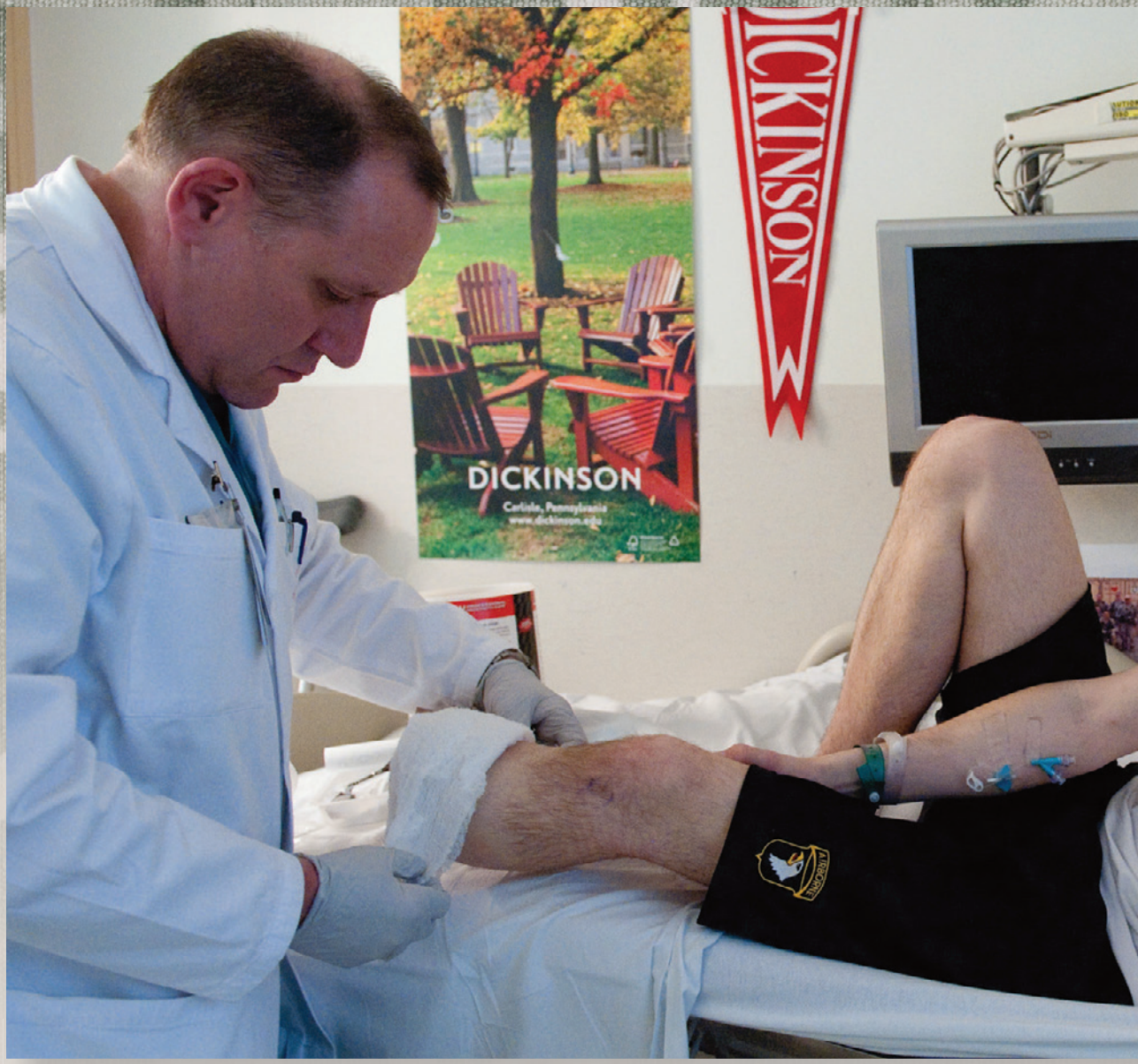
PHOTOS BY JENNA ISSACSON

PA KEVIN BEDWELL stopped in the hallway of Walter Reed Army Medical Center to look over a model of an elbow injury with Army Spc. Kendra Parsons, a licensed practical nurse. Behind them hangs a floor-to-ceiling cloth sign that reads, "WARD 57." Known as "the amputee ward," it's the first stop for many wounded service members returning home from Iraq and Afghanistan.



PA Kevin Bedwell discusses a model of an elbow injury with Spc. Kendra Parsons, LPN, right, at Walter Reed Army Medical Center.

Bedwell, a PA in orthopedics, jumped at the chance to work at the nation's premier military medical center.



"A lot of our warriors have had skin grafts and flaps, and parts of theirbody may be scarred or burned and they might have chronic wounds. So [PCPs] might consult a wound care specialist or familiarize themselves with chronic wound care and know that the skin isn't always going to be normal skin. If they see an infection, if they suspect an infection, they would want to be more aggressive with treatment."

—PA Kevin Bedwell, Walter Reed Army Medical Center

A PA in orthopedics, Bedwell began working at Walter Reed a little over 18 months ago. He's assigned to Ward 57 as a member of a multidisciplinary team, treating some of the most severely injured service members. These are men and women who have sustained traumatic musculoskeletal injuries, fractures and amputations in combat situations that may have involved a rocket-propelled grenade, improvised explosive device, or IED, or a land mine. His typical patient is an amputee who has lost more than one limb.

In a perfect world, returning service members would seamlessly go from the U.S. Department of Defense Military Health System and back on active duty, or separate from the military and go into the Veterans Health Administration system of the U.S. Department of Veterans Affairs. There would be no red tape or undiagnosed conditions and every veteran would sign up to receive VHA services.

But it's not a perfect world, which is why DOD and VHA are reaching out to the civilian health care community to educate PAs and other providers about the multiple health issues associated with military service and how to screen for them. The federal government is looking to civilian health professionals to help inform veterans and their families about these health issues and the benefits available to them.

"I don't know that a lot of civilian physician assistants will be seeing these warriors because they probably will be treated by military personnel for the rest of their lives," Bedwell said recently of his patients. "But if they do see them, I would say that these are the best patients I have ever had the privilege of treating. The guys are very grateful for what we do, and they're very gracious and appreciative, and they will tell you exactly what is going on."

The VHA faces the daunting task of providing care and treatment for tens of thousands of returning veterans in coming years. Meeting the health care needs of this population is going to require a joint effort of medical professionals, health care nonprofits and private and public medical facilities, because those that specialize in caring for wounded warriors have difficulty doing it alone.

Stepping Forward for Health Care

America's veterans receive a world-class quality of health care at VHA medical facilities, and barriers to access continue to come down, but only about 20 percent of all U.S. veterans receive medical care from the VHA, according to the Veterans

Bedwell picks up some supplies (below) before checking on patients, such as 1st Lt. Cameron Kerr, of Stowe, Mass (left).

Health Council. (AAPA is an original member of the council.)

A nonprofit formed to educate veterans and health care professionals about the complex medical problems associated with military services, the council reports that veterans may not know that their health conditions are related to military service, making them eligible for VHA coverage of health care and other VA benefits. Some veterans go to civilian providers or receive no health care at all.

Improving veterans' health care safety net will likely take a coalition, and collaboration, such as the Joining Forces education campaign and curricula created by the American Hospital Association and HealthPartners to educate medical professionals about the health issues of returning servicemembers.

AAPA is offering a continuing education credit on caring for returning veterans that PA Denni Woodmansee, the VA's new director of PA services, will present at the Academy's 39th Annual Physician Assistant Conference in Las Vegas.

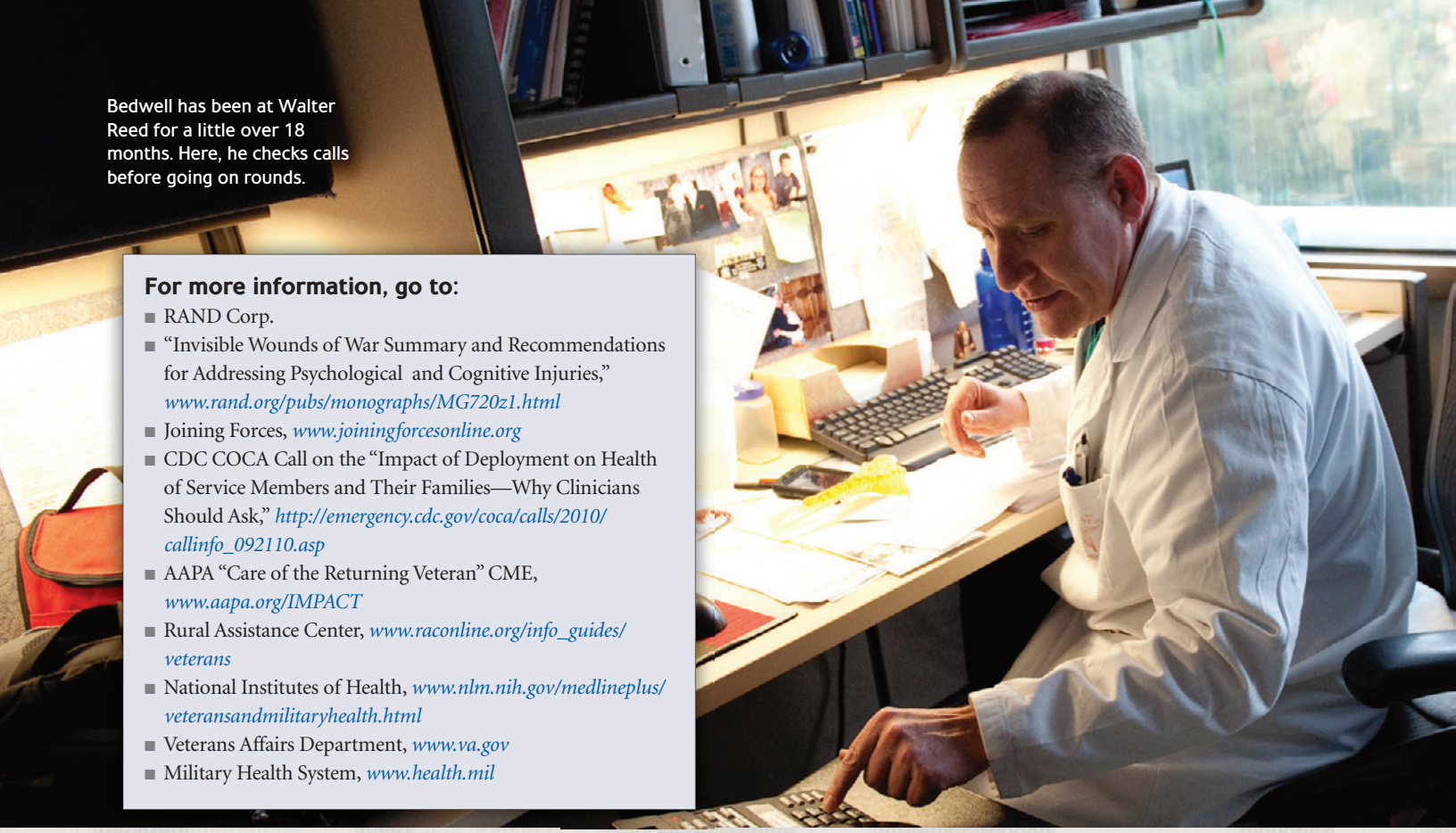
According to Shelley L. Hicks, AAPA's senior manager of conference education, the last time the Academy offered such a CME was 2008. Based on what participants learn in the "Care of the Returning Veteran" CME, they should be able to do the following at the conclusion of the session:

- Recognize the basic signs and symptoms of post-traumatic stress disorder, or PTSD.
- Utilize screening methods to identify traumatic brain injury, or TBI, and be knowledgeable of the basic severity categories and their basic treatment components.
- Identify basic screening methods for suicide prevention and appropriate referral.
- Identify basic screening methods for identifying military sexual trauma history and appropriate referral.
- Discuss challenges in evaluating returning veterans due to certain aspects of military culture.

Not Every Wound is Visible

Along with the bad backs and knees, shrapnel and migraines, some returning veterans may be suffering from "invisible wounds," such as exposure to environmental hazards, depression, PTSD, and TBI, the signs of which might not show up immediately or be readily apparent. In recognition of this need, Congress approved a large infusion of new funds into DOD and VHA to support continuing efforts to improve care.

A 2009 RAND Corporation white paper on "Improving Mental Health Care for Returning Veterans" reports that a sub-



Bedwell has been at Walter Reed for a little over 18 months. Here, he checks calls before going on rounds.

For more information, go to:

- RAND Corp.
- "Invisible Wounds of War Summary and Recommendations for Addressing Psychological and Cognitive Injuries," *www.rand.org/pubs/monographs/MG720z1.html*
- Joining Forces, *www.joiningforcesonline.org*
- CDC COCA Call on the "Impact of Deployment on Health of Service Members and Their Families—Why Clinicians Should Ask," *http://emergency.cdc.gov/coca/calls/2010/callinfo_092110.asp*
- AAPA "Care of the Returning Veteran" CME, *www.aapa.org/IMPACT*
- Rural Assistance Center, *www.raconline.org/info_guides/veterans*
- National Institutes of Health, *www.nlm.nih.gov/medlineplus/veteransandmilitaryhealth.html*
- Veterans Affairs Department, *www.va.gov*
- Military Health System, *www.health.mil*

stantial number of the 1.7 million returning military service members "may face mental health problems." A comprehensive 2008 RAND study found that "an estimated 18.5 percent of those back from deployment reported symptoms consistent with a diagnosis of [PTSD] or depression."

The RAND study also looked at veterans' access to quality mental health treatment, identified gaps in the military and veterans health care systems, problems veterans experience when trying to access mental health services in a community setting, and suggested opportunities for improvement.

A reluctance to seek mental health care seems to be an aspect of military culture. PA Cynthia T. Vincent, who works as a primary care provider at VHA's Braxton County Community Based Outpatient Clinic in Flatwoods, W.Va., believes empathy goes a long way toward breaking through with veterans who might otherwise close themselves off to the idea of receiving mental health care services.

"It is important to connect with the returning veteran, gain their confidence and trust so that as a PCP, I can peel back the layers to ensure that the veteran is treated holistically," she said recently. "This is readily accomplished through a veteran-centered approach. For the most part, the veterans I have encountered are more respectful, have a keen sense of duty and obligation and are more thankful for the medical services received than the general population. By placing the veteran first, the PCP reciprocates that respect, which is imperative."

When screening returning veterans for PTSD, she uses a VA clinical practice guideline algorithm. She added that the common presenting symptoms of PTSD include physical changes, mental health changes, behavioral changes and/or functional changes. Physical changes can include vague somatic complaints. Mental health changes can include intoxication, anxiety or depression. Behavioral changes can include irritability, anger or risky behavior. Functional changes can include alterations in the activities of daily living.

Vincent uses electronic medical records, which she considers an invaluable tool in ferreting out a myriad of potential problems, including TBI. All returning service members complete a post-deployment screening during triage. "This tool assists me in obtaining a detailed history about injuries from arms fire, blasts or explosions," she explained. "A thorough physical examination with a neurological exam, coupled with a high index of suspicion, leads one to recognize the probability of TBI. Once I suspect TBI, a specialty consultation is placed for definitive diagnosis."

Another helpful tool is something called the Patient Health Questionnaire, or PHQ-9. She said that at the Braxton clinic, veterans complete a PHQ-9 as a quick depression assessment during triage. "The PCP then reviews the depression severity score and determines the need for suicide screening," she said, adding that if the PCP determines there is a suicide risk, then he or she determines the urgency with which this must be managed. Depending on the severity of the crisis, the veteran may be referred to behavioral medicine or the VA Medical Center Suicide Coordinator if immediate intervention is needed.

The influx of female returning veterans is changing the face of the VHA. In the past 30 years, the number of women in the services has doubled, and they now compose 14 percent of the active-duty force, 17.5 percent of the reserves and 20 percent of new recruits. While both women and men can experience sexual harassment or sexual assault during their military service, the public seems to be becoming more aware of the issue of military sexual trauma, or MST.

Vincent said that the basic screening method for identifying MST is to obtain a good history, which includes questions about unwanted sexual attention or trauma during the veteran's service. If the service member indicates the possibility of MST, the PCP refers him or her to the appropriate specialist for their specific needs.

Helping to Heal Heroes

PA Ken Harbert, Ph.D., dean and program director of the South College School of Physician Assistant Studies in Knoxville, Tenn., has taught primary care practitioners about PTSD since the early 1980s. While he sees the education efforts of DOD, VA and others as a step in the right direction, he believes it's time for PA programs to devote more instruction to PTSD and TBI.

"If you look at any PA curriculum today, there is less than an hour dedicated to each of those subjects," said Harbert, a former corpsman. "When in reality, it is like HIV was 20 years ago. What we are now learning about these conditions is important for PAs to know about regardless of what [specialty] we go into. Very few PAs know how to deal with PTSD—it's a baseline that needs to be added to their skill set."

Harbert is qualified by the American Academy of Experts in Trauma Stress to teach military and civilian medical professionals about PTSD. In his experience, very few civilian clinicians know anything about veterans' health issues or how to treat them.

PTSD affects about 9 percent of the general population, he said, adding that number goes up to 20 to 25 percent in the military population. He said it is a sad statement that many of the academic programs that educate PAs are not paying more attention to that fact.

Back at Walter Reed Army Medical Center, PA Kevin Bedwell gathered supplies before going to see a patient, 1st Lt. Cameron Kerr, of Stowe, Mass. Wounded in Afghanistan in February, Kerr had to have his left leg amputated below the knee.

Bedwell took great care in removing a drain from Kerr's leg. The PA considers it a privilege to work at the nation's premier military medical facility and serve vetertans, such as the young man from Massachusetts.

Walter Reed isn't just the U.S. Army's flagship medical center. It's a teaching and research facility, where medical professionals are furthering the world's understanding of musculoskeletal medicine and surgery. When a job opened up in the medical center's department of orthopedics and rehabilitation, Bedwell jumped at the chance to work there as a PA in orthopedics.

"My typical patient is an amputee, and some of them are triple amputees," Bedwell said. Lately it seems that it's two legs and an arm. We have had a couple of quad amputees, and one of the challenges for the quad amputees is that though they can be fitted for prosthetics for their legs, they can't get them on by themselves. So that is something primary care physician assistants would want to consider [when seeing a returning veteran] that chances are good that they are going to be treating an amputee."

Bedwell explained that amputees are more at risk for weight gain, skin breakdown on the residual limb and that their life expectancy is shorter. "There's just more stress on the body, [such as] the effort they have to make to just get dressed in the morning. It's just greater than someone with all their limbs intact."

Kerr will probably be outpatient at Walter Reed for months. He has a long, physically and emotionally taxing road ahead of him. To a lesser extent, so do the nation's health care providers—many of whom are not prepared to become the patient-centered medical home for returning veterans.

As an activist for returning veterans recently said, "We are going to have to think about their health for a generation." PA

The VA PA Director Is Now In

DENNI J. WOODMANSEE, PA-C, was recently named director of physician assistant services for the U.S. Department of Veterans Affairs. The new full-time senior executive service level position was established last year by congressional legislation.

The Academy believes that having a knowledgeable resource on the PA profession at this senior leadership level in the VA's central office will improve PAs' ability to do their jobs effectively, efficiently and fully.

With nearly 2,000 PAs on staff, the VA system has been a major employer of PAs since the late 1960s when the then Veterans Health Administration hired one from Duke University's first graduating class of PAs. Today, the VA system is the single largest employer of the nation's nearly 75,000 practicing PAs. About a quarter of all primary care patients treated by the VA are seen by a PA.

Woodmansee, a former president of the Veterans Affairs Physician Assistant Association, became VA director of PA services in late February after serving as interim director. Prior to that, he was the PA advisor to the VA under secretary for Health. He will be based in the VA's central office in Washington, D.C.

AAPA and the VAPAA worked for years to get Congress to create the VA PA director position. While progress was made on how the VA used PAs under the PA advisors, there were inconsistencies in the way PAs were used by local VA medical facilities. AAPA believes that unnecessary restrictions on PAs that limited the access of VA patients—veterans and their dependents—to quality medical care will decrease now that the VA system has a PA director.

The VA PA director provision was originally introduced in the House by Reps. Phil Hare, D-Ill., and Jerry Moran, R-Kan., as H.R. 1302 and merged into a larger VA committee bill that was passed by the House in July 2009. The Senate companion bill, originally introduced by Sens. Susan Collins, R-Maine, and Daniel Inouye, D-Hawaii, as S. 1155, was merged into S. 1963.

Woodmansee, a graduate of the Northeastern University PA program in Boston, is on the board of directors of the National Commission on Certification of Physician Assistants. PA

The Calm During the Storm—

Hospital disaster response plans

In the Face of Disaster, Are You Prepared

BY KAREN APPOLD

LAST SEPTEMBER, a gunman supposedly upset over news about his mother's medical condition wounded a surgeon at Johns Hopkins Hospital before fatally shooting his inpatient mother and then killing himself.

Howard Gwon, senior director, Johns Hopkins Medicine, Baltimore, Md., said internal security responded to the incident within three minutes of receiving the call. The shooter was contained in the room where he barricaded himself. This allowed inpatient staff to protect patients and themselves. Police responded within five minutes to take charge of the response.

A trauma team removed the victim so he could be treated. Inpatient staff evacuated patients. The Hospital Incident Command System, or HICS, which outlines an organization's command roles, responsibilities and response during an emergency, went into effect. A HICS works in conjunction with a community's incident command system, or ICS, a systematic tool used to command, control and coordinate emergency response.

Johns Hopkins' emergency alert system, Web-based communication system and broadcast e-mail capability informed more than 30,000 hospital and university employees of the shooting. After a two-hour wait, a police robot found the gunman and his mother dead from gunshot wounds.

"If pre-established plans [i.e., emergency operations plan, or EOP, standard operating procedures, unique procedures in response to specific types of disasters] did not exist, the response by internal security and the hospital incident command team would not have been as efficient or effective," Gwon says.

While events like the one at Johns Hopkins and larger events, such as terrorist attacks and natural disasters, are not regular occurrences, it's important for PAs to learn what actions they should take and what their role would be in the aftermath of a disaster or other emergency situation.

Emergency Plans: What's Required?

Earl Stoddard, PhD, public health program manager at the University of Maryland Center for Health and Homeland Security in Baltimore, helped to develop the citywide medical surge plan (which covered security provisions) in conjunction with Baltimore hospitals, including Johns Hopkins. "In my estimation, Johns Hopkins did a fine job with a very difficult situation," Stoddard said.

The Joint Commission requires all hospitals to have an ICS. A HICS is a specific ICS that is well recognized in hospitals throughout the United States. An ICS supports a hospital in coordinating emergency response efforts with its community. For disasters that overwhelm communities and require a coordinated regional response, the Department of Homeland Security has established the National Incident Management System, or NIMS. It provides a framework for response and recovery across all levels of government, the private sector and essential response disciplines and functions—such as aviation, law enforcement, public works, hazardous materials, search and rescue, public health and medicine. Medical care is one component of NIMS, and health care organizations that use an ICS are positioned to plan, respond and recover in a coordinated effort with other services and disciplines that would be activated under the NIMS during a disaster.

The Joint Commission defines an emergency as an "unexpected or sudden event that significantly disrupts the organization's ability to provide care, or the environment of care itself, or that results in a sudden significantly changed or increased demand for the organization's services. Emergencies can be either human-made or natural."

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to Step Up?

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Taking Action

When a hospital is faced with an emergency, its ICS is activated by hospital leadership. An organization's ICS will define who is in authority as well as a chain of command that is expandable or collapsible, depending upon a situation's complexity, scope or duration. "A PA could work for two hospitals two miles apart and have two very different roles in a disaster," said Leonard J. Weireter Jr., MD, medical director, shock trauma center at Sentara Norfolk General Hospital in Norfolk, Va., and chair of the American College of Surgeons Committee on Trauma's Ad Hoc Committee on Disaster and Mass Casualty Management.

"Basic disaster management education is the first step in understanding the emergency situation process," Weireter said.

"After PAs understand their positions in the chain of command, they should take action to protect themselves [during a disaster], such as putting on personal protective equipment, or they won't be able to benefit anyone else," Weireter explained. PAs who are well prepared for an emergency will also have a basic understanding of decontamination and triage.

"While PAs don't have to be experts in chemical or nuclear decontaminiation, they should understand what both dry and wet decontamination mean and when they generally occur," Weireter continued. "At minimum, they should know basic vocabulary and some methodology."

According to Johns Hopkins' disaster plan, in the event of a hostile occurrence, PAs and other health care providers are responsible for the following:

- Enroll to receive emergency alerts from the hospital and/or university.
- Protect oneself by sheltering in place, hiding in a secure location when possible.
- Report any salient facts on a shooter and/or incident to internal security.

All providers should encourage their institutions to give clear guidance on responding to emergency situations.

- Protect patients.
- Listen to instructions from hospital or department incident command centers.

"The greatest role for a PA or any direct provider of care is the recognition of potential issues in advance of them happening," Stoddard said. "If an arriving patient or visitor is behaving erratically, it is incumbent upon all medical personnel to recognize the potential risks to patients, themselves and others in the facility."

In addition, all providers should encourage their institutions to give clear guidance on responding to emergency situations. "If you can envision it happening, you should ask how you should reasonably respond," Stoddard said.

An ICS plan is intended to be applicable to any type of hazard, whether it occurs inside or outside of a facility and regardless of the cause. An ICS plan names those in charge and gives them the tools they need to offer leadership.

Going Above and Beyond

PA Craig DeAtley, co-executive director, HICS Center for Education and Training, Institute of Public Health Emergency Readiness, Washington, D.C.; director for public health emergency readiness, Washington Hospital Center; and a PA at Inova Fairfax Hospital, Fairfax, Va., said despite the type of disaster, a PA's role would be to see patients. Some may also serve in an emergency department leadership role such as a triage or treatment officer.

Depending on their training, PAs may be appointed to serve in a broader command role. For example, if an emergency occurred at Washington Hospital Center, DeAtley could be asked to serve in the position of liaison or safety officer or hazmat branch director.

PAs might also be asked by the government to serve as a consultant or agent to assist communities that are affected by a disaster. DeAtley was attending a meeting at the World Trade Center on Sept. 11, 2001, when terrorists struck the towers. For four subsequent days, he served as a consultant to the Federal Emergency Management Agency, or FEMA, to help coordinate its urban search and rescue teams responding to assist.

Be Prepared to Step Up

PAs who are interested in responding to disasters can become Medical Reserve Corps members and/or members of National Disaster Medical System teams. Information is available at *www.phe.gov*.

NEW YORK ISSUES DISASTER MEDICINE LEGAL GUIDANCE

An official New York state legal manual was published in February to serve as a guide for courts, lawyers, public health officials and medical professionals who could face tough questions if an event occurred such as a terrorist attack or pandemic. Called the "New York State Public Health Legal Manual," its creation was prompted by a series of events, including the Sept.11, 2001, attack on the World Trade Center, the anthrax attacks that followed 9/11, the SARS outbreak and the H1N1 influenza pandemic.

"These incidents made us aware that our courts might be called upon to handle cases involving widespread threats to public health," said Ronald P. Younkins, chief of operations for the New York State court system. "In addition to court operational concerns, these cases would present unique legal issues because the tools of disease containment—including isolation, quarantine, and mandatory examination and treatment—directly present a clash between individual rights and societal needs."

The manual presents a discussion of the jurisdiction over public health law issues, including the authority and responsibilities of doctors and other health care professionals, and the respective roles of local and state health departments.

Visit *www.cdc.gov* for links to similar manuals that other states follow. PA

PHOTO COURTESY FEMA/JOCELYN AUGUSTINO

THE NUTS AND BOLTS OF AN EOP

The Joint Commission requires an organization to have an emergency operations plan, or EOP, that clearly defines its response to six critical areas:

1. **Communications**, both internally and within the community.
2. **Resources and Assets**, the EOP defines resource needs, consumption and replenishment at the start of the emergency and as the emergency evolves.
3. **Security and Safety**, protecting the well-being of patients, staff and visitors, and managing the building's integrity.
4. **Staff**, including roles and responsibilities, training, reporting relationships and staff support needs.
5. **Utilities**, including contingency plans for various utility failures or consumption issues.
6. **Patients**, such as care, medications, clinical records and transportation needs in the event of an evacuation.

The EOP requires that the roles and responsibilities of staff are clearly defined. Furthermore, the EOP provides specific guidance to hospitals that choose to utilize volunteer licensed medical practitioners during a disaster. Particularly in these cases, licensed independent practitioners and volunteer licensed practitioners should be aware of the reporting structure, where to report, their specific role in the event and how they will be identified.

"An organization must have a process established if it is going to grant disaster privileges when the EOP has been activated and the organization is unable to meet immediate patient needs," said George Mills, senior engineer, Standards, Interpretation Group, Accreditation & Certification Operations, the Joint Commission. "This process should be defined in the organization's bylaws."

Before the volunteer practitioner is considered eligible to function as a volunteer licensed independent practitioner, the hospital must obtain his or her valid government photo identification and at least one of six items as described in the Emergency Management Chapter of the Joint Commission's standards manual. Confirmation must occur within 72 hours of the volunteer's arrival.

The EOP is tested twice annually, through emergency response exercises and/or responses to actual emergencies, in order to evaluate its effectiveness. **PA**

PAs can obtain continuing education in emergency preparation by taking classes offered through:

- American College of Surgeons, *www.facs.org*
- American Medical Association, *www.ama-assn.org*
- CDC, *www.cdc.gov* (free online courses for basic incident command control)
- FEMA, *www.fema.gov* (incident command courses)
- Wilderness Medicine Society, *www.wms.org* **PA**

KAREN APPOLD is an editorial consultant. Visit *www.WriteNowServices.com*.

BY ASHLEY KENT and JANETTE RODRIGUES

We know you're busy. And we know that, for a variety of reasons, you might not have gotten around to registering yet for **AAPA's 39th Annual Physician Assistant Conference**. But here are 10 reasons why you should register for **IMPACT 2011**.

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10 You'll learn something.

Where else can you earn up to 40 hours of Category I CME credit in one location? This year, we're offering brand-new sessions on returning to clinical practice and preparing for the Physician Assistant National Recertifying Exam. Also new this year: Chapter Lecture Series on hereditary angioedema, type 2 diabetes, improving HIV diagnosis and co-management, and HCV for primary care.

How about some FREE small group learning activities? Carve some time in your schedule on the afternoon of Tuesday May 31 and all day Wednesday, June 1, for case-based studies in secondary hypertension, headache, asthma, dyslipidemia, syncope in emergency medicine and common hospital medicine cases.

Plus, talking back to your instructors is not only allowed, it's encouraged! Many presentations will include the interactive Audience Response Systems so that you can respond to questions during the session.

9 New Exhibit Hall and PAvilion

IMPACT 2011's exhibit hall will be as high-energy as Vegas itself, and kicks off with an opening reception on Tuesday, May 31, from 5 to 7 p.m. with food and drink and a host of daring acrobatic performers. Once the hall is open, you'll get to meet over 200 medical technology, service and product exhibitors, many of them brand new to IMPACT!

This year's PAvilion will be completely redesigned. There's even a designated AAPA Member Service Area where you can find out how to make the most of your membership. Have a billing and coding question? AAPA reimbursement staff will be on hand in the PAvilion to answer it. And while you're at the member center, be sure to stop by the Social Media Lounge to take advantage of the FREE Wi-Fi. New this year, lounge computers will have full Internet access and links to the Online Scheduler.

Say cheese! IMPACT 2012 will be held in Toronto, Canada. We're making it easy to get your passport photo. Just stop by the passport photo booth located in the PAvilion, Hall N1.

8 Face time with friends.

We know that half the fun of attending IMPACT 2011 is meeting up with other PAs. Find out what they've been up to by attending a few of the dozens of state chapter receptions, PA program alumni reunions, specialty area receptions and meetings, and regional meetings scheduled at IMPACT 2011.

7 Run, PA, run!

There's nothing like going for an early morning run with 500 of your closest friends to make your trip to Vegas complete. You'll need a midweek exercise break from all that CME, so make plans to participate in AAPA's Annual 5K Fun Run / Walk on Wednesday, June 1. Sign up on your conference registration form. Ready…set…go!

6 Channel your inner Oprah.

You've got a lot to say, and a few questions, about what's happening in your profession. Make sure your voice is heard at the Third Annual AAPA Town Hall Meeting on Tuesday, May 31, from 4 to 5 p.m. in the PAvilion, Hall N1.

5 Celebrate your peers.

It's time to give the PA profession the recognition it deserves. So, pull out your best cocktail attire and purchase a ticket for A PAramount Evening, a dinner fundraiser sponsored by the PA Foundation. Then join in the applause as we recognize the winners of the PAragon Awards, including Outstanding PA of the Year, PA Service to the Underserved, the PAF's Caring for Communities award, the prestigious Eugene A. Stead Award of Achievement, and many others. Purchase tickets at *www.aapa.org/pa-foundation/a-paramount-evening*.

4 Two words: Challenge Bowl.

Vegas won't know what hit it when hundreds of PA students from across the country descend on the City of Lights for the SAAAPA National Medical Challenge Bowl. Come root for your alma mater, and test your own medical knowledge in this high-energy night of fun. Don't forget the face paint!

3 Good eats.

Fifteen or so years ago, Vegas underwent a food revolution. Yeah, you can still belly up to an all-you-can-eat buffet, but why go for quantity when you can go for quality at L'Atelier de Joël Robuchon or Tom Colicchio's craftsteak? Las Vegas has become the place to open an outpost for the likes of Bobby Flay, Hubert Keller and Mario Batali. Why? The casinos give them carte blanche, baby.

2 You'll be entertained.

It wouldn't be Vegas without some great entertainment, and IMPACT 2011 will deliver! The week will kick off at the General Session with a heart-stopping acrobatics show and also a performance by Frankie Valli and the Four Seasons tribute band The Unexpected Boys, who were recently featured on Bravo Network's The Real Housewives of New York City. Emcee Mark Walberg, host of the PBS hit show "Antiques Roadshow" is back by popular demand for IMPACT 2011 and will make several appearances as a moderator throughout the conference.

1 It's Vegas!

You've heard it said that what happens here, stays here. But with so many things to do and see from morning to night, you might never want to leave! Whether you're into concerts, comedy, theater or sports, you'll find it in the City of Lights. Viva Las Vegas!

To register, go to www.aapa.org/IMPACT

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Register as a group. Are multiple PAs in your practice attending **IMPACT 2011**? By registering together, you can save on registration fees. Visit our registration page, complete registration for the first person and then use the code provided for each additional registrant. *Please note: The multi-registrant discount only applies to AAPA Fellow Members. To be considered a group, each person must share the same physical work address.*

Let us spring for lunch. Head over to the **Product Theaters** (held May 31–June 4 from noon to 1 p.m. in the Las Vegas Hilton) and enjoy a complimentary lunch while learning about the newest and most innovative medical products on the market.

Leave the driving to us. AAPA offers **complimentary shuttle service** during the conference from AAPA's block of hotels to the Convention Center and Las Vegas Hilton. Check the daily shuttle schedule in the conference Final Program to get the hours of operation, and be sure to have your badge handy at all times so our shuttle drivers know you're an **IMPACT 2011** attendee.

Borrow our bandwidth. There's no need to pay for Internet service at **IMPACT 2011**. Just drop by the Social Media Lounge, located in the PAvilion, to sink into our comfy chairs and surf on our Wi-Fi. PCs will be available, or use your own laptop.

Party-hop. Check the conference Final Program for a schedule of alumni, **specialty and state chapter receptions** taking place each night of the conference. Drop by to network with colleagues and enjoy the complimentary beverages and appetizers provided by these generous organizations.

For further details, visit *www.aapa.org/IMPACT*.

BY BOB MCNELLIS, MPH, PA

Obesity Epidemic Continues to Spread

Addressing a Complex, Costly Problem

COLORADO IS THE ONLY STATE IN THE U.S. with an obesity rate less than 20 percent in 2009, according to the most recent data from the Centers for Disease Control and Prevention. In an adult, a body mass index of 30.0 or above is defined as obese. The rates of adult obesity were greater than 30 percent in Oklahoma, Arkansas, Missouri, Kentucky, West Virginia, Louisiana, Mississippi and Alabama!

No state met the Healthy People 2010 goal of 15 percent. The increasing prevalence of overweight and obesity has been recognized for many years. However, rates continue to rise. Between 2007 and 2009, the national prevalence of obesity increased 1.1 percent, up to 26.7 percent of the U.S. population.

Why care about overweight and obesity rates? It's a lifestyle choice, right? Obesity itself is not a disease, and does not necessarily equate to poor health. But obesity can reduce quality of life, lead to social stigmatization and discrimination, and is a risk factor for a number of chronic conditions including diabetes, hypertension, hyperlipidemia, heart disease, stroke, arthritis and some cancers. Diabetes is the disease most closely linked to obesity, and the prevalence curves have paralleled each other over the past decade. The medical costs associated with obesity have been estimated at approximately $147 billion. Significant health disparities are associated with obesity rates. Blacks had 51 percent higher prevalence of obesity, and Hispanics had 21 percent higher obesity prevalence compared with whites.

Obesity is best addressed through a comprehensive approach that modifies individual behaviors to improve nutrition and physical activity, and modifies the environment to reinforce healthful choices. Clinicians can help patients by following the U.S. Preventive Services Task Force recommendations for adults and children. The USPSTF recommends screening all adult patients for obesity, and offering intensive counseling and behavioral interventions to promote sustained weight loss. For children, the task force recommends screening patients 6 years and older for obesity and offering or referring them to comprehensive, intensive behavioral interventions.

The CDC's Task Force on Community Preventive Services has reviewed a variety of interventions to prevent and control obesity in the clinical setting, in the community and in the workplace. It found insufficient evidence to recommend any health care provider-oriented recommendations such as provider education, feedback or reminders. However, the task force does recommend several interventions in the community setting: behavior interventions, reduced screen time and coaching or counseling sessions. The task force also recommends a broad range of workplace nutrition and physical activity interventions. The effective interventions can be educational (lectures or written materials), behavioral (individual or group counseling) or environmental (exercise facilities, healthful eating options, etc).

First lady Michelle Obama's "Let's Move" campaign targets children to help them eat more healthful and be more active. The campaign encourages health care providers to implement simple steps to help make a difference in childhood obesity. These steps include making BMI screening a standard part of care, talking to patients about breast-feeding and first foods,; and prescribing activity and healthful habits. The 2008 Physical Activity Guidelines for Americans list recommendations and tools to help make physical activity an integral part of life. The guidelines are science-based recommendations describing the health benefits of physical activity. A major conclusion of the guidelines is that most health benefits occur with at least two and one half hours of moderate physical activity (such as brisk walking) per week. Those health benefits can be accrued by any group regardless of age, gender or race. And, additional benefits result from increased intensity, duration and frequency.

Finally, the new dietary guidelines for Americans (see the March 2010 issue of *PA Professional*) provide recommendations for healthful food choices. By using all the tools available to PAs, you can help make a difference in the epidemic of obesity facing the nation. **PA**

Resources:

- Centers for Disease Control and Prevention U.S. Obesity Trends—*www.cdc.gov/obesity*
- U.S. Preventive Services Task Force recommendations on screening for obesity *www.uspreventiveservicestaskforce.org*
- Task Force on Community Preventive Services obesity prevention and control recommendations—*www.thecommunityguide.org/obesity*
- Let's Move campaign—*www.letsmove.gov*
- Dietary Guidelines for Americans—*www.dietaryguidelines.gov*
- 2008 Physical Activity Guidelines for Americans—*www.health.gov/paguiderlinesd*

BOB MCNELLIS, MPH, PA, is AAPA's vice president of science and public health. Contact him at bmcnellis@aapa.org or 571-319-4372.

SHUTTERSTOCK

An Invitation for You

First PA Research Symposium Set for Las Vegas

WE HAVE A COUPLE OF HISTORIC "FIRSTS" to share with you this month, both of which have to do with AAPA's Annual Conference in Las Vegas, rom May 30 to June 4.

Research Symposium

The AAPA research department will be sponsoring the conference's first-ever full-day Research Symposium on Friday, June 3. Its contents will go far beyond our typical poster session, as Raymond Fang, AAPA's vice president of research, will kick off the session by publically unveiling our research agenda. After that, a wide variety of experts will give 30-minute presentations on topics of interest:

- **PA Christen Kutz, DHSc**, will discuss the role of PAs in research, and the historical and ethical perspectives leading to current research regulations.
- **Lisa Henry, PhD**, will present an anthropological view of the PA movement in North America and discuss the role of medical anthropology in the analysis of health care
- **PA Roderick Hooker, PhD**, will speak about the data resources available for PA research and about attempts to forecast the PA work force.
- **PAs Bettie Coplan**, **Alison Essary, MHPE**, and **James Stoehr, PhD**, will spend one session discussing the salary discrepancies between male and female PAs.
- **PAs Tamara Ritsema, MPH, MMSc**, and **Ian Jones, MPAS, CCPA**, will give their thoughts on early survey data about where the profession stands in Canada and the U.K.
- **Debra Roter, DrPH, MPH** and **Emily Edelman, MS, CGC**, will explore the different ways PAs communicate with patients about risk.
- **PAs Folusho Ogunfiditimi, MPH**, and **Timothy McElmurry**, will discuss Service Value Units, or SVUs, as a supplemental model for measuring PA productivity.
- **PA James Cawley, MPH**, will review the year in PA research literature.

We believe this symposium will help focus attention on PA research topics, and help PAs who attend to feel more comfortable about participating in research in the future. However, our department didn't stop there.

Research Working Groups

We have also secured space at the conference to explore the implementation of topic-based research working groups to help guide and inform AAPA's research activities. These groups will be composed of panels of experts in each of three broad topics: PA value, PA roles and the PA work force. They will discuss how to move forward on producing and sustaining original, first-rate research on the topics unveiled from the agenda. Data infrastructure and funding will also be addressed.

However, we cannot rely only on experts if we are to create a healthy environment for PA research. That's why you are invited to both of these events! Come participate and give your feedback, and make sure we hear your perspective.

In the meantime, the AAPA research department continues to work on projects such as our annual census and salary profile. We recently welcomed to our research team Survey Analyst Paola Daly. She can be reached at *pdaly@aapa.org* and 571-319-4332. **PA**

JOSHUA UMAR is AAPA's research assistant. Contact him at *jumar@aapa.org* or 571-319-4330.

SHUTTERSTOCK

Telepsychiatry in Rural Iowa

Making Mental Health Services Accessible

IOWA IS AMONG THE TWO-THIRDS OF STATES that have decreased mental health care in the past three years—even though the nation's economic distress and troops returning home from war have led to an increased need for services. But Iowa is also among the states making an effort to improve the delivery of mental health services.

Iowa PA Albert Okine is part of that effort; he uses telemedicine to treat medically underserved patients living in rural areas of the state. He sat down with *PA Professional* to talk about "telepsychiatry," the application of telemedicine to the field of psychiatry.

What is telemedicine?

Telemedicine, also known as telehealth, is a technology that employs videoconferencing to do medical assessments and offer treatment. It has opened up doors to provide much-needed psychiatric services for patients in Iowa, where I practice. Patients in underserved rural areas get seen in real time, with little to almost no delay in communication feedback. There is a huge shortage of psychiatric providers in Iowa and neighboring states, and telemedicine has paved the way to increase mental health accessibility.

Was applying telemedicine to the field of psychiatry a no-brainer?

This technology seems to have found a good niche in psychiatry since a lot of the provider-to-patient interaction is hands-off, mainly taking history and observing behavior and mannerism. Because of the huge shortage of psychiatric providers in Iowa and neighboring states, telemedicine is increasing mental health accessibility overall.

Why did your clinic start using telemedicine?

Our clinic is committed to providing psychiatric services to underserved areas. Rodney J. Dean, MD, who started the practice, had for years run satellite clinics in different community mental health centers across Iowa. For three years, at least twice a month, Dr. Dean and I have driven 75 miles to our satellite clinic in Denison, Iowa, to see patients all day. Our office has had many requests from numerous mental health centers, psychiatric hospital units, residential care facilities, nursing homes, a VA home and others. But unfortunately, we have had to turn some down due to the lack of providers, stretched resources, and most often driving distances.

GERRY MENNENGA

Our clinic was one of the first in the region to sign on to do "telepsych" when Magellan approved of telemedicine as a reimbursable medium. In the spring of 2009, Kunal Patra, MD, an psychiatrist, was the first in our clinic to see patients from his office through this videoconferencing. A year later, I started to see patients by way of telemedicine one to one and a half days a week.

How have patients responded to the practice of using "telepsych" instead of in-person visits?

Surprisingly, patients have been very receptive to this media. I am able to see a lot more patients from underserved communities in Iowa. Our clinic currently has one set of equipment that is on a cart, and we wheel it from one office to the other. The cost of using midlevel providers, such as PAs, is more attractive to these mental health centers.

What are some of the other benefits to using telemedicine?

I am able to evaluate, diagnose and treat with medications. Most medications get called to the pharmacy by the nurse. Schedule II drugs, such as stimulants, either get sent by mail, or Dr. Dean, my supervising physician, writes those when he is physically present at those sites for clinic. Other benefits are that we can see more patients, and we can avoid long-distance driving in treacherous winter conditions to see patients and vice versa. Telemedicine has allowed some psychiatrists to see patients from their homes. This also creates opportunities for retired psychiatric clinicians to return to the profession to render care on a more flexible work schedule. **PA**

CME at Impact 2011

Plan Ahead to Maximize Credit

AAPA's 39th Annual Physician Assistant Conference

May 30—June 4—Las Vegas

You truly can experience it all in Las Vegas this spring at the world's largest PA conference. IMPACT 2011 features more than 200 educational sessions, an opportunity to earn 35 to 40 hours of Category I CME credit and meetings of more than 40 PA caucuses, specialty groups, PA program alumni groups, PA students and much more. New in 2011 are educational sessions for PAs returning to clinical practice and for those preparing for the Physician Assistant National Recertifying Exam. Register now! *www.aapa.org/IMPACT*

IMPACT 2011 CME 101

Know the ins and outs of the education offerings of IMPACT 2011 before you arrive so you can make the most of your experience in Vegas. Head to *www.aapa.org/IMPACT*. Check out course offerings, and plan your days ahead of time to maximize the number of hours you can earn!

MARK YOUR CALENDARS for two exciting CME sessions

Aug. 10-13, 2011—Adult Hospital Medicine Boot Camp, Chantilly, Va.

New lecture topics and new pre-course, hands-on workshops! Don't miss one of AAPA's most popular CME courses. Registration opens in mid-April at *www.aapa.org/BootCamp*.

Veins, Vessels and Vascular Updates

Sept. 16-18, 2011—Washington, D.C.

Co-sponsored by AAPA and the Society of Vascular Medicine, "Veins, Vessels and Vascular Updates" will provide an in-depth review of some of the most challenging issues and critical decision making that PAs encounter on a daily basis: diagnosis and treatment of peripheral artery disease, treatment and prevention of DVT, treatment options for limb ischemia, stroke prevention and treatment and hands-on vascular skills lab. Register starting in late April at *www.aapa.org/vascular*. **PA**

BY JENNIFER ANNE HOHMAN

Trust, Respect & Communication

Keys to a Healthy PA Career and Team Practice

THE UNIQUELY COLLABORATIVE NATURE OF PHYSICIAN-PA PRACTICE underscores the need for that professional relationship to be respectful, collegial and positive in order for your career to flourish.

The NCCPA Foundation's Physician-PA Teams project has identified five key success factors in creating effective and enduring PA-supervising physician teams: frequent communication, mutual trust and respect, shared priorities, physician accessibility and approachability, and consistency in the delivery of patient care (*www.paexcellence.org/programs/programs_best_practices.html*).

This article explores the relationship among three of these success factors—communication, trust and respect, and the quality of a PA's employment and professional life.

Communication: The heart of team practice

Excellent communication is at the heart of effective PA-physician clinical team practice and ideally begins during the interview process with an in-depth discussion of your role, your responsibilities and how the team will practice. Do you and the physician(s) employer share the same expectations? If possible, take an active role in shaping your job description, especially with employers who are new to PAs. AAPA's sample delegation template can help you do so (*http://bit.ly/erlj16*). Frequent communication helps most teams thrive. Are your prospective supervising physicians prepared to be accessible and available? Do you feel comfortable with them, and vice versa? Like any relationship, there will be elements of personal chemistry that help determine a good fit of personalities and communication styles.

Revisit your contract once a year—preferably in the context of your annual review—to discuss elements of your compensation, job description and evolving role in the team practice. This will help keep communication clear, vital and supportive of your best practice. It's also a good time to discuss how the team's practice might be improved. AAPA offers members an evaluation template that includes team practice in its practice assessment "umbrella."

Trust and respect: Core professional values

How do you find an employer who will be a reliable, trustworthy partner in medicine? Ask about the employer's view of patients and philosophy of medicine. Does it resonate with the PA profession's team-based, patient-centered approach?

Ethical employers will make quality of patient care their highest priority, and they will care about your professional well-being. If you find indications that employers view patients and employees with a "bottom line" or authoritarian mentality, chances are they will not be the most respectful or trustworthy people to work with.

Contract negotiation is an essential litmus test for the quality of a potential employment relationship. A PA recently negotiated with a surgeon who refused to draft a written contract guaranteeing the PA's pay and benefits, telling the PA to "just trust him," instead.

Wisely, the PA negotiated a contract with another employer who was ready to treat him as a professional colleague as well as clinical partner. Together they established a mutually beneficial written agreement (nicely illustrating the relationship between respect and trust).

Contract negotiation puts the concepts of professionalism and collegiality into practice. A professionally respectful contract—a healthy one—would include competitive pay and benefits designed to support your personal and professional well-being, a reasonable schedule, duties that encourage your clinical growth and sufficient vacation and CME leave.

A fairly negotiated employment contract establishes a foundation for effective team practice by integrating communication, trust and respect into the fabric of your professional relationship.

With a positive employment agreement in place, your focus can be on treating patients as a united and effective team!

AAPA Resources

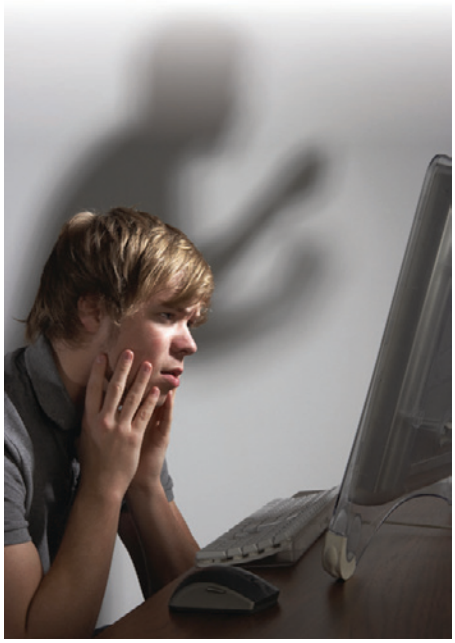
AAPA has a number of resources to help keep your PA career thriving. These include a sample contract, an evaluation template with team practice in its assessment, individualized contract guidance and the latest data on PA salaries and benefits via the Salary Profile. Please contact the Academy's professional advocacy team for your professional practice needs. **PA**

JENNIFER ANNE HOHMAN is AAPA's assistant director of professional affairs. Contact her at *jhohman@aapa.org* or 571-319-4351.

TODD SPOTH

Addressing Bullying Behaviors

Clinicians Need to Weigh In



BEING A BULLY, BAD. BEING NICE, GOOD. If only it were so simple. When I was a young girl, my mom used to tell me when Anna socked me on the arm, or Ben pulled my hair, it meant that they really liked me. Being that those actions hurt both physically and emotionally, and that Anna or Ben never showed kindness toward me, I always wondered if Mom was right. She wasn't. Anna and Ben were bullies, and I was their victim.

Bullying is a pervasive issue, and becoming more so. The new issue of cyberbullying has blossomed at an exponential rate. Intimidators not only have those around them as an audience, but also have the capability of exhibiting their behavior on a global scale. The world can now, potentially, view the intimidated's victimization. One click, and the pictures are on thousands, or more, phone and computer screens.

Children are not just tormented because they are smaller, female, smarter, a different culture or more. Gay teens are terrorized routinely. Disabled children are intimidated at a steadily increasing level. Without intervention, those who bully are more apt to have serious antisocial behavior that extends into adulthood. The targets of bullying are more prone to depression, anxiety, poor self-esteem and thoughts of suicide. Harassed gay teens are two to three times more at risk of suicide than heterosexual teens.

As PAs, no matter what specialty, we need to be aware of those children in our practices who perpetrate or are at the receiving end of bullying. We need to be the patient advocates that we are and help with early intervention proactively. Whether in our practice setting, in our community or through political activities, we can help and need to address this vast problem more effectively.

Here's what we can do:

1. IN OUR PRACTICES, help to identify signs of bullying and implement appropriate referrals. Use screening questions during wellness and episodic exams that elicit responses about fights, injuries, anxiety/depression, suicidal thoughts, substance abuse, weapon use, truancy, stressors, family history and the presence or lack of support networks. Become aware of and refer as appropriate to therapists, support programs and dialogue groups that are youth centric.

2. IN OUR COMMUNITIES, help parents and caregivers in recognizing signs of bullying.

Partner with schools. Speak about bullying; visit with student and parent groups. Help schools develop safe zones and after-school activities. Assist schools in the development of anti-bullying policies. Many schools do not have these important policies in place and thus no guiding documents that will help them to address bullying events. A recent survey published in the January 2011 *Children & Schools* found that almost half of school social workers (for those schools lucky enough to have social workers) find themselves ill equipped to address intimidation, especially cyberbullying. I shared this study report with one of our staff in the clinic where I work. She then told me about her own daughter receiving death threats online from a fellow student. She informed the school administrators, who stated there was nothing they could do unless there was a physical assault. This mom tried to make a police report, and the police essentially had the same response. This is unacceptable and dangerous. All schools, all communities must have a policy about and resources to address intimidation of all forms.

3. IN OUR PROFESSION, promote CME and training that will help us develop our skills to recognize those who bully and those bullied. Work with our professional organizations to develop policy to promote PA awareness and capabilities in addressing of this crucial issue. Help to implement policies that deal with this behavior.

There are a multitude of resources online to assist us that I'll list below. Educate yourselves, your colleagues, your communities, the patients that we serve and their families. It's not OK for Anna to punch or for Ben to pull hair. They are not trying to be friends; they are bullies. It's not OK to be their victim. Bullying is indeed bad, and being nice is truly the way to be.

- Health Resources and Services Administration (HRSA) *www.stopbullyingnow.hrsa.gov*
- American Academy of Child and Adolescent Psychiatry, "Facts for Families" *www.aacap.org*
- Medscape Pediatrics: "Cyberbullies and Cybervictims—What's the Clincian's Role?" (Posted 12/25/2010) *www.medscape.com*
- *American Family Physician*, "Childhood Bullying: Implications for Physicians," Am Fam Physician, Nov. 1 2004 *www.aafp.org*
- Bully Stoppers *www.bullystoppers.com*
- Students Against Violence Everywhere *www.nationalsave.org*
- Education.com *www.education.com*
- Family Lives, "A guide for dealing with bullying: for parents of disabled children" *www.parentlineplus.org.uk*
- Mental Health America, "Bullying and Gay Youth" *www.nmha.org*
- GreatSchools, "Invisible Targets" *www.greatschools.org* PA

JULIE A. THERIAULT, PA-C, is AAPA liaison to the American Academy of Family Physicians. She lives and practices family medicine with Sutter Medical Group in Sacramento, Calif.

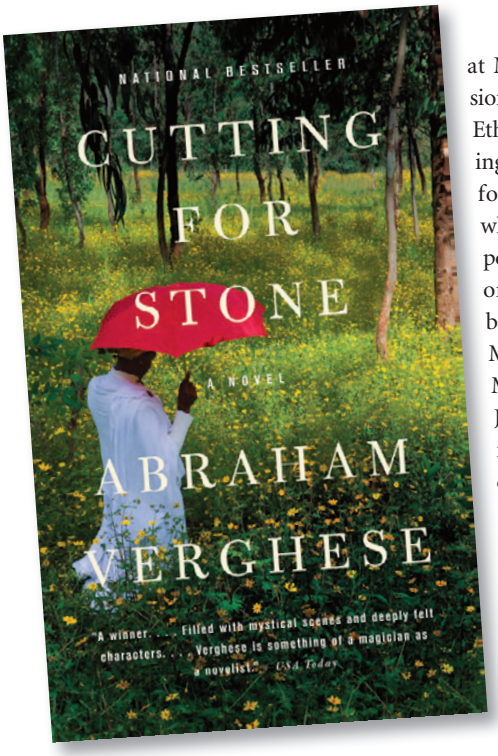
SHUTTERSTOCK

BY KARI B. SHMUL, PA-C

A Moving and Richly Detailed Epic Novel

Book Takes Readers on a Medical Thrill Ride

AS A PA IN EMERGENCY MEDICINE, reading "Cutting for Stone" brought me a large amount of guilty pleasure. Author and physician Abraham Verghese describes the medical encounters in his book with a detail and accuracy that left me enthralled. He also gives the novel historical credibility by setting the story in the backdrop of heated political times in midcentury Ethiopia, and further interweaving character development in both India and the United States. But unique to his book are the factors necessary for a blockbuster hit: heart-pounding action, awe-inspiring adventure and complex emotional drama.

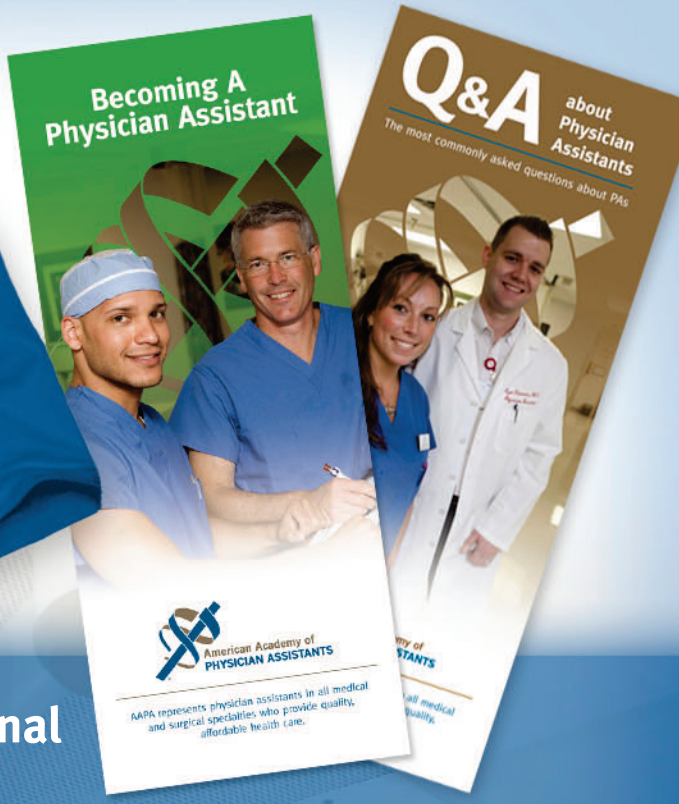


The story begins in 1954 at Missing Hospital, a mission hospital in Addis Ababa, Ethiopia. The fictional Missing is home to a handful of foreign-born physicians who serve the poorest of the poor. The drama is centered on the illicit relationship between Thomas Stone, MD, a British surgeon at Missing, and Sister Mary Joseph Praise, an Indian nurse and Stone's closest colleague. When Stone finds Sister Mary Joseph desperately ill one morning, he quickly discovers that she is pregnant and on the verge of delivering. As he rushes her to the operating suite, it begins to sink in that he is most likely the father of her unborn twins and yet he cannot remember when the conception occurred. Missing's obstetrician Hema, as she is affectionately known, arrives in the operating suite in time to save Sister Mary Joseph's boys, but not the sister herself.

This scene, which unfolds over several gut-wrenching chapters, sets the stage for the rest of the story. As Stone walks out of the operating suite to abandon both Ethiopia and his twin boys, Hema becomes the boys' adoptive mother. From here the twins, Shiva and Marion, begin a childhood at Missing Hospital, where medicine is the language on which they are weaned. At very young ages, the boys naturally migrate into Missing's clinical settings. Shiva, the socially inept but supremely intelligent twin, becomes an integral part of Hema's obstetrics and gynecology practice. Marion, the less intelligent but incredibly diligent twin, works himself into the general surgery practice of Dr. Ghosh, his adoptive father.

As Marion and Shiva approach manhood and their careers take shape, personal differences begin driving a wedge between them. While Shiva remains in Ethiopia to apprentice himself with Hema, Marion is forced to leave for the United States when political upheavals hit too close to home. The medical backdrop of "Cutting for Stone" will charm the PA reader. From very young ages, Marion and Shiva are immersed in medicine at its most raw. Starving Ethiopians walk miles to Missing Hospital because it is their last or often only hope of finding a cure for the advanced conditions ailing them. Through their stories, the reader will witness the most intimate details of disease gone awry. As the story unfolds, this book will have the PA reader referring to old PA school notes about common conditions seen in their most advanced forms in Ethiopian patients, and also rare diseases once studied but never seen. It will simultaneously tug at the heartvictims of strings of PA readers as Stone abandons his sons, and as the boys grow up, grow apart and ultimately reunite in the direst of circumstances. The gripping stories of medical emergencies brought back from the brink of death and political dramas played out at the personal level will inject enough adrenaline to keep the PA reading well into the night. **PA**

KARI B. SHMUL, PA-C, practices emergency medicine at Banner Gateway, Baywood and Ironwood medical centers in Mesa and Queen Creek, Ariz.



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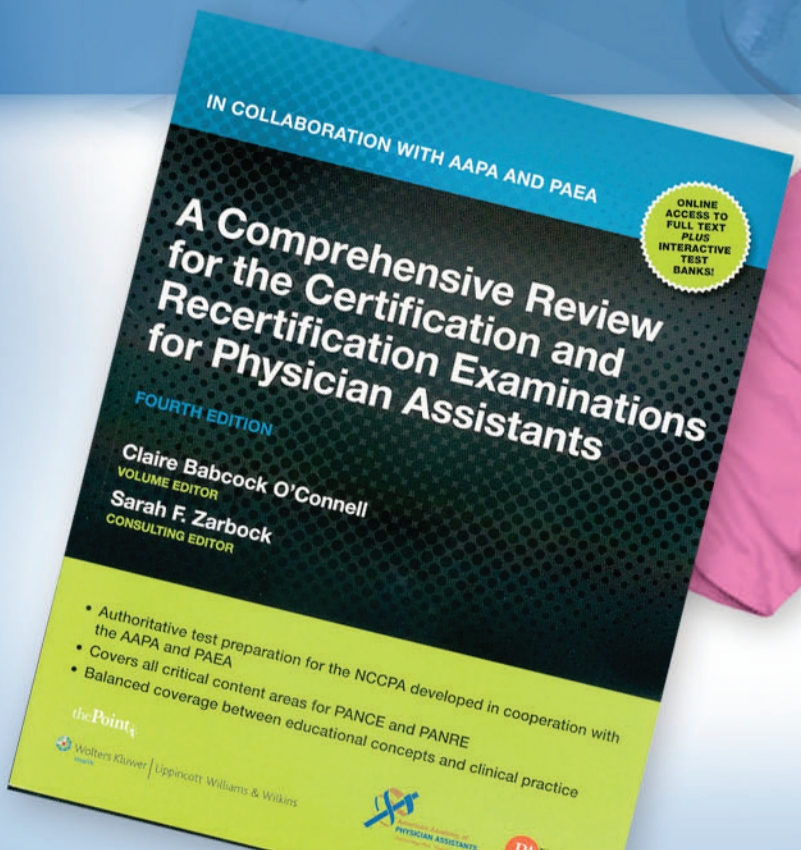


Don't let the name fool you—the *tortilla* in *tortilla española* has nothing to do with a Mexican pancake. But it has everything to do with the delicious alchemy of eggs, caramelized onions and potatoes. Chef Gigi Gaggero of Kids Culinary Adventures, a cooking school for children and teens, created this easy recipe for kids to make for a tapas party. Cooking with children can be a great experience, not only for the child but for you too. So go make some magic!

JENN HOHMAN

Tortilla Española

Ingredients

1/3 cup olive oil
4 large potatoes, peeled and sliced 1/8-inch thick
Coarse salt
Fresh cracked pepper
1 large onion, thinly sliced
4 eggs or egg substitute
½ cup shredded low fat white cheese (optional)

Kids Culinary Adventures
where math, science, reading + art mix with kids
www.kidsculinaryadventures.com

Directions

1. Heat three tablespoons of the oil in a 9-inch nonstick skillet and add the potato slices and onions, salting lightly. Cook slowly, lifting and turning occasionally, until tender but not brown. Remove and cool.
2. In a bowl, beat the eggs, then add the eggs to the potatoes and let the mixture sit for a few minutes. Add the remaining oil to the skillet, heat until very hot, and add the potato and egg mixture, spreading it with a pancake turner. It will sizzle and puff up.
3. Lower heat to medium, shake pan to keep potatoes from sticking, and when brown underneath, place a plate on top and invert, then slide back into the skillet and brown the other side. Top with grilled red bell peppers, or drizzle with Thai sweet chili sauce.

Recipe printed with permission from Kids Culinary Adventures, *www.kidsculinaryadventures.com.*

Practicing Medicine in Its Truest Form

A PA Returns to Haiti

AFTER THE 2010 EARTHQUAKE, I was looking for a way to get back to Haiti to volunteer in a medical capacity. Fortunately, a friend of mine was a member of a New York City-based global disaster response team, NYC Medics. He knew that I had previously been to Haiti and recommended me to the leadership of that organization.

ERIC HOLDEN

In contrast to my two-year background check and credentialing for my state Disaster Medical Assistance Team, getting onboard at NYC Medics took two days. It is an incredible organization of dedicated and highly skilled volunteer paramedics, physicians, nurses and PAs. My experience with them could not have been better. They coordinated every aspect of our trip in a seamless fashion. I was never concerned for our safety or had to worry about housing, food or any other logistical issue. NYC Medics got us on the ground in the hardest-hit areas within days after the earthquake, and we were able to get right to work doing what we do best: taking care of patients.

Since then, I have returned to Haiti twice with my DMAT. I have been told that 80 percent of those displaced by the earthquake are still living in internally displaced person camps. These camps have been improved with donated tents instead of tarps, but aside from this the conditions remain much the same as they did a month after the earthquake. Food and water distribution is no longer a serious issue, but now cholera has been added to the equation with more than 4,000 deaths to date and many more ill from this disease. Most of the donated money appears to be going to repair infrastructure: roads, schools, hospitals, etc.

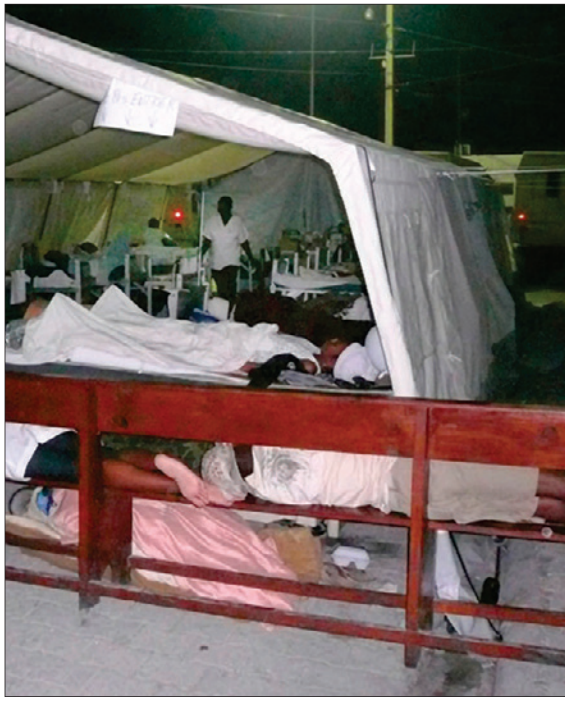
The quality of medical care being delivered in Haiti today is excellent. Teams of highly trained volunteers from all over the world are staffing clinics and hospitals, delivering primary, specialty and surgical care. The primary issue still seems to be resources. There just are not enough medications and supplies on the ground. Despite excellent clinicians on site, the ongoing shortage of critical medications and supplies makes managing routine issues, such as hypertension and diabetes, challenging. The entire health care system needs to be rebuilt literally from the ground up.

Care in Haiti is very fragmented, with certain services offered in only one or two locations in the entire country. A nationwide system of hospitals offering a wide array of services would go a long way to improving things. Currently, the country's hospital system is in disarray. Hospitals are staffed by volunteers and excellent Cuban physicians-in-training, and the care is free. But many hospitals still require patients' families to purchase every item required for their care up front, including needles, medications, IV supplies, bandages, etc. When my DMAT ends someone two to three hours to the nearest hospital for a needed surgical procedure, we also need to send them with cash or a letter of sponsorship to cover expenses associated with their care.

Working in Haiti for me is practicing medicine in the truest sense without administrative hassles of any kind. The patients are very grateful for anything we do for them. People will walk all day for 30 Tylenol tablets for their back pain and be happy to receive them. If I could find such a clinical setting in the U.S., I would work there.

My experience in Haiti has given me a new appreciation for life and the practice of medicine. It has changed the way I see the world. **PA**

ERIC HOLDEN, PA-C, MPA, EMT-P, DFAAPA, has worked in emergency medicine for 24 years, 15 of those as a PA. He works in the Pacific Northwest. For more information on NYC Medics, visit *www.nycmedics.org*.



PA Eric Holden (upper left) in Haiti a week after the earthquake struck in 2010. An inpatient ward set up outside to treat patients after the earthquake.

MEDICAL EDUCATION

MEDICAL EDUCATION

FROM AAPA

BY AAPA STAFF

Speak Like a Pro

IMPACT 2011 is the third year of the Speak Like a Pro (SLaP) program, which provides an opportunity for PAs to refine and reinvigorate their presentation skills. Individuals interested in participating are expected to attend "Presentation Skills for Physician Assistants: Making Your Next Teaching Presentation Go Better than Your Last" on Friday, June 3, from 8:00 to 8:45 a.m. by master teacher and public speaking coach Scott Litin, MD, of the Mayo Clinic in Rochester, Minn.

Participants will be individually videotaped making a short presentation of their choice, and then participate in a group critique session with other learners. Group sessions are scheduled on Friday, June 3, from 11:00 a.m. to 2:00 p.m. and Saturday, June 4, from 11:00 a.m. to 2:00 p.m. Participants should bring a 2-gigabyte USB to download their personal videos should they wish to review them in the future. For more details, go to *http://bit.ly/SpeakLikeAPro*.

IMPACT 2011 Poster Session

Showcase your high-quality posters that reflect the diversity of interests and talents of the physician assistant community. This year's Clinical and Professional Poster Session marks 20 years featuring unique research accomplished by PAs, PA faculty and PA students. More than 95 posters will be on display in the PAvilion/Hall N1 at the Las Vegas Convention Center, June 1 through June 4. Plus, you do not want to miss the excellent opportunity to engage in one-on-one discussions in an informal atmosphere with presenters scheduled for Friday, June 3, from noon to 1 p.m.

This event is sponsored by AAPA Clinical and Scientific Affairs Council.

PA Research Forum

Stay up-to-date on the latest developments in research on the PA profession. AAPA will hold a forum on PA data and research on June 3 during IMPACT 2011 in Las Vegas. The forum will be held from 7:45 a.m. to 4:30 p.m. in Conference Room 11/12 of the Las Vegas Convention Center. In addition, a separate meeting will be held for PA researchers who have an interest in establishing three permanent working groups on the PA work force, PA roles, and PA value on June 2 from 2 p.m. to 5 p.m. in Ballroom D of the Las Vegas Hilton. **PA**

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Visit the **"Find a Job" section of AAPA's Web site at *www.aapa.org*** to access The PA Job Link and utilize the many additional resources including salary profiles, interviewing tips and contract templates to assist in negotiating an employment package.

Check back frequently for new enhancements and professional development tools to make your job search even easier!

American Academy of PHYSICIAN ASSISTANTS
Connecting PAs, Transforming Care

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