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AAPA NEWS

American Academy of Physician Assistants

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July 15, 2008

Ranks of Underinsured Increase 60 Percent Since 2003

BY CHRISTOPHER DOSCHER

The number of adults who are underinsured increased by 60 percent from 2003 to 2007, a trend that has caused millions of insured adults to spend large portions of their incomes on health care, according to a recent study conducted by the Commonwealth Fund and published in June in the journal *Health Affairs*.

Researchers who conducted the study estimated that 25 million insured people between the ages of 19 and 64 were underinsured. The rate of increase in the underinsured, the study said, was greatest among those with incomes above 200 percent of the federal poverty level. At that level of income, the rate of underinsurance nearly tripled.

“Underinsured” was defined in the study as having out-of-pocket medical expenses amounting to 10 percent or more of total income, or at least five percent of income for low-income adults, and deductibles equaling or exceeding five percent of income.

The study’s results indicated that both uninsured and underinsured were more

likely than those who had “adequate insurance” to have problems with communication and coordination of care.

“Nearly half of each group reported a time when test results or medical records were not available during an appointment, a doctor ordered a medical test that had already been done, or they had experienced delays in being notified about abnormal test results,” the study said. “Among those uninsured, these findings likely reflect disrupted care and lack of care continuity. For the underinsured, the coordination findings may reflect more frequent contacts with multiple sources of care.”

Both underinsured and uninsured adults reported that they frequently had a hard time paying medical bills, according to the study. While the underinsured adults in the study had insurance coverage for a full year, nearly half of them “reported difficulty paying bills, being contacted by collection agencies for unpaid bills, or changing their way of life to pay their medical bills,” the study said.

See **UNDERINSURED** on page 4

Grants Available for Families with Child Health-related Expenses

The UnitedHealthcare Children’s Foundation (UHCCF) has announced that new grants are available to help children who need critical health care treatment, services, or equipment not covered or not fully covered by their parents’ health benefit plans. The foundation aims to fill the gap between what medical services or items a child needs and what their commercial health benefit plan will pay for.

UHCCF, a nonprofit 501(c)(3) charity, provides grants to families to help pay for child health care services such as speech therapy, physical therapy, occupational therapy sessions, prescriptions, and medical equipment such as wheelchairs, orthotics, and eyeglasses.

Parents and legal guardians may

apply for grants of up to \$5,000 each for child medical services and equipment by completing an on-line application on the UHCCF Web site.

To be eligible for a grant, children must be 16 years of age or younger. Families must meet economic guidelines, reside in the United States, and be covered by a commercial health benefit plan. The family’s health care provider must submit a letter to the foundation that defines the child’s medical condition and supports what the family is requesting. The family, however, must apply for the grant themselves.

To learn more and to apply, go to www.uhccf.org.

VA Health Care Gets Good Marks, But Gender and Racial Disparities Exist

BY JANETTE RODRIGUES

A new “health care report card” has given the Department of Veterans Affairs (VA) health care system good marks overall for delivering high quality care to patients, but it suggested that gender and racial disparities exist in the care delivered to female and minority veterans.

The internal report, released last month by the Veterans Health Administration (VHA), was compiled at the request of the House Appropriations Committee and 40 members of Congress. Legislators issued the directive in February after public outcry about long delays in disability payments to veterans, gaps in care offered female veterans, and substandard conditions at Walter Reed Army Medical Center.

“This report is a comprehensive snapshot of the quality of care VA provides our veterans,” said James B. Peake, M.D., secretary of Veterans Affairs. “From waiting times and staffing levels to hospital accreditation and patient satisfaction, this report demonstrates VA is providing high quality care to the veterans we serve.”

The VA has made some recent strides in providing health care to female veterans, such as creating women’s health clinics at major facilities, and offering breast and cervical cancer screening services, but the report acknowledged the system is facing some challenges.

Currently, the number of women veterans receiving care has reached a historic level of 5 percent of the VA’s population of about 23.5 million veterans. VHA treated more than 255,000 women veterans last year.

VHA expects the percentage of female veterans who receive care from VA facilities to double by 2013.

With almost 2,000 PAs on staff, the VA system is the single largest employer of the nation’s nearly 70,000 PAs eligible to practice. So PAs will play a role in meeting the needs of this influx of female veterans.

While the report found that VHA facilities often outscore private-sector health plans in standards commonly accepted by the health care industry, it also showed that female veterans lag behind their male counterparts in some quality measures. And minority veterans are generally less satisfied with inpatient

and outpatient care than are whites.

“Disparities in treatment and satisfaction based on gender or ethnic background are unacceptable,” Peake said. “The VA has a robust program to look at disparities and to deal with the underlying causes.”

Other issues related to gender and racial disparities noted in the report included the following:

- Fragmentation of care is among the barriers to women veterans receiving the same quality of care as males. Recent restructuring of the women’s clinics to provide integrated care may help alleviate this problem.
- VHA does not have enough clinicians on staff trained or experienced in women’s health issues. The health care system is actively recruiting health care providers with the needed training and offering in-house training.
- A lack of mammography and other gender-specific equipment limits the care that some VA Medical Centers can directly deliver to women veterans.
- Women as a group receive fewer influenza vaccinations than men, possibly due to gaps in focus by both patients and clinicians for the need to deliver preventive health measures to women. Modifications have been made to counter this trend.
- VA does not have systemwide clinical quality data that are stratified by ethnic or racial groups.

The report included information about waiting times, staffing levels, infection rates, surgical volumes, quality measures, patient satisfaction, service availability and complexity, accreditation status, and patient safety.

Congressional critics and some female veterans say the VA is woefully unprepared for the influx of women veterans with physical injuries and mental disorders, such as Military Sexual Trauma (MST) and Post-traumatic Stress Disorder.

“The huge number of women who have responded to the call of duty in Iraq and Afghanistan has created new challenges that the VA must step up to meet,” said Sen. Patty Murray (D-Wash.) earlier this year when she

See **VA REPORT CARD** on page 10



Calendar

Announcements of upcoming events and CME opportunities hosted by PA organizations are welcome. To submit your conference listing, please complete the on-line form located at www.aapa.org/cme/AddToCalendar.html.

For the most up-to-date list of CME opportunities, go to www.aapa.org/cme/approvedcat1.html.

July

17-19 • 2008 Annual Summer CME, Wyoming Association of PAs. Casper, WY. Contact: Val Goen, 307/233-6018; vgoen@chccw.org; www.wapa.net.

17-20 • Primary Care Update, Missouri Academy of PAs. Branson, MO. Contact: Ryan Pock, 417/335-7556; rpock@skaggs.net; www.aapa.org/moapa.

21-25 • 33rd Annual GAPA Summer CME Conference and Exhibition, Georgia Association of PAs. Sandestin, FL. Contact: GAPA, 888/811-GAPA; info@gapa.net; www.gapa.net.

23-27 • PA Leadership Summit. Arlington, VA.

27-28 • AAPA Liaisons meeting. Alexandria, VA.

28-August 1 • VAPA's 26th Annual CME Conference, Virginia Academy of PAs. Virginia Beach. Contact: Jennifer Wohl, 757/288-6495; jmwohl@yahoo.com; www.vapa.org.

30-August 3 • FAPA Summer Symposium, Florida Academy of PAs. Marco Island, FL. Contact: Tina Kautter, 407/774-7880; tkautter@kmgnet.com; www.fapaonline.org.

31-August 3 • NCCPA Board of Directors meeting. Banff, Canada.

August

6-9 • MTAPA 18th Annual CME conference, Montana Academy of PAs. Helena, MT. Contact: Linda Hanson or Holly Brester, 406/652-0027; holly@cynroc.com or www.mtapa.com.

7-10 • 2nd Annual Allergy/Asthma/ENT Conference, American Academy of PAs in Allergy, Asthma, and Immunology and Society of PAs in Otorhinolaryngology, Boston. Contact: Jessica Cosgriff, 703/836-2272, ext. 3418; jcosgriff@aapa.org; www.aapa-aai.com; www.entpa.org.

11 • Deadline for September AAPA Board of Directors meeting agenda items and reports.

12-15 • 12th Annual Certification Review for PAs, Oregon Health and Science University Division of PA Education. Portland. Contact: Katie Jones, 503/494-7439; pareview@ohsu.edu; www.ohsu.edu/pa/pareview.

13-17 • 33rd Annual Board Review and Postgraduate Program for PAs, Stony Brook University PA Program. Stony Brook, NY. Contact: 631/444-3190; paprogram@stonybrook.edu; www.hsc.stonybrook.edu/shtm/pa/boardreview.cfm.

17-22 • 32nd Annual NCAPA Summer Conference, North Carolina Academy of PAs. Myrtle Beach, SC. Contact: Erin Wilson, 800/352-2271; conference@ncapa.org; www.ncapa.org.

18-22 • PA Certification and Recertification Exam Review, Western Michigan University PA Program. Kalamazoo, MI. Contact: Cheri Lay, 269/387-4174; cheryl.lay@wmich.edu.

22-24 • 16th Annual PA Certification/Recertification Review Course, University of Oklahoma PA Program.

Oklahoma City. Contact: OUHSC, 405/271-2058; linda-atkins@ouhsc.edu.

24-31 • Nephrology Update 08, American Academy of Nephrology PAs and Scott & White Hospitals. Miami, FL. Contact: Laurie Benton, 254/724-2620, ext. 1736; lbenton@swmain.sw.org; www.world2sea.com.

25-28 • PA Board Review, Touro College PA Program. Ronkonkoma, NY. Contact: Touro College, 631/665-1600; www.touro.edu/shs/pa.asp; jtpaphd@aol.com.

26-29 • Advanced Orthopedic Topics on the Great Lakes, PAs in Orthopedic Surgery. Chicago. Contact: Elizabeth Darr, 800/804-7267; info@paos.org; www.paos.org.

26-29 • Veterans Affairs PA Association Annual CME Conference, Veterans Affairs PA Association. San Antonio. Contact: John Fields, 210/487-9722; Conference@VAPAA.org; www.vapaa.org.

September

3-5 • Indiana Academy of Physician Assistants Fall CME Conference, Indiana Academy of PAs. Columbus, IN. Contact: Marta Ortegón or Lori Faqhuer, 812/279-6460; meosmpac@aol.com; www.aapacoms.org/iapa/iapa.htm.

4-6 • ARC-PA meeting. Kennebunkport, ME.

6-7 • Trends in Patient Management, Maryland Academy of PAs. Ocean City, MD. Contact: Krisi Gindlesperger, 410/290-7798; mapacmedirector@hotmail.com; www.mdapa.org.

6-7 • PA Board Review Course, DeSales University PA Program. Center Valley, PA. Contact: Patricia Siegfried, 610/282-1100, ext. 1457; patricia.siegfried@desales.edu; www.desales.edu/mspas.

11-14 • AAPA Board of Directors meeting. Arlington, VA.

18-20 • Fall Primary Care Update, New Mexico Academy of PAs. Albuquerque, NM. Contact: Stacey Smith-Lujan, 505/681-7201; pa12sms@aol.com; www.nmapa.com.

19-21 • TAPA Fall Regional CME Conference, Texas Academy of PAs. Galveston, Texas. Contact: Kristina Haley, 800/280-7655; kristina.haley@texmed.org; www.tapa.org.

20 • 21st Century Neurosurgery — The Team Approach, Association of Neurosurgical PAs. Orlando, FL. Contact: Linda Kotrba, 866/844-4880; theanspa@aol.com; www.anspa.org.

23-27 • 18th Annual Certification/Recertification Review for PAs. Emory University PA Program. Decatur, GA. Contact: Barbara Jones, 404/727-7827; bjone08@LearnLink.emory.edu; http://emorypa.org/pa_board_review.htm.

26-27 • AAPA Professional Practice Council meeting. Alexandria, VA.

30-October 2 • Iowa PA Society Fall CME, Iowa PA Society. Coralville, IA. Contact: LeAnn Ely, 515/282-8192; leann@iapasociety.org; www.iapasociety.org.

Coming in JAAPA

Look for articles on the following topics in the July issue of *JAAPA*, the official journal of the American Academy of Physician Assistants:

- Inherited epidermolysis bullosa (CME)
- The Surgical Patient: Kyphoplasty
- Case Report: Pericardial tamponade
- Insomnia (CME)

October

1 • Deadline for PA Foundation Community-based Projects grant applications.

1-4 • New Jersey State Society of PAs 10th CME Conference, New Jersey State Society of PAs. Princeton, NJ. Contact: Theresa Madden, 732/822-8484; conference@njsspa.org; www.njsspa.org.

1-4 • 33rd Annual Pennsylvania Society of PAs Fall CME Conference, Pennsylvania Society of PAs. Valley Forge, PA. Contact: Susan DeSantis, 724/836-6411; conference@pspa.net; www.pspa.net.

2-4 • WAPA's Annual Fall Conference, Washington Academy of PAs. Spokane, WA. Contact: Linda Krause, 206/956-3624 or 800/552-0612, ext. 3006; LMK@WSMA.org; www.WAPA.com.

2-5 • 32nd Annual CAPA Conference, California Academy of PAs. Palm Springs, CA. Contact: Jennifer Deane, 714/427-0321; capa@capanet.org; www.capanet.org.

2-5 • 11th Annual Association of PAs in Oncology Conference, Association of PAs in Oncology. Denver, CO. Contact: Susan Easter, 813/766-8807; seaster@focus-ed.net; www.apao.cc.

3-4 • JAAPA Editorial Board meeting. New York, NY.

6-10 • Fallfest 2008, Tennessee Academy of PAs. Gatlinburg, TN. Contact: Penny Gaillard, 615/443-3052; tapadirector@msn.com; www.tnpsa.com.

6-12 • National PA Week.

7-10 • All-Alaska Medical Conference, Alaska Academy of PAs. Anchorage, AK. Contact: Steve Gonzalez, 907/646-0588; info@akapa.org; www.akapa.org.

9-12 • AASPA 8th Annual CME Meeting & Surgical Update, American Association of Surgical PAs. San Francisco. Contact: Linda Kotrba, 866/844-4880; executivedirector@aaspa.com; www.aaspa.com.

9-12 • 2008 Fall CME Conference, Michigan Academy of PAs. Traverse City, MI. Contact: Cindy Wikstrom, 877/937-6272; cwikstrom@msms.org; www.michiganpa.org.

11-15 • SCAPA Fall CME Conference, South Carolina Academy of PAs. Kiawah Island, SC. Contact: Janet Jordan, CAE, 803/356-6809; scapa@sc.rr.com; www.scapapartners.org.

15-17 • 2008 Fall Conference, Wisconsin Academy of PAs. Appleton, WI. Contact: Julie Lederhaus, 920/560-5630; julie@badgerbaymanagement.com; www.wapa.org.

17-19 • SAAAPA Board of Directors meeting. Alexandria, VA.

17-23 • Heart to Heart 2008 — Cruising Cardiology Caribbean Style, Association of PAs in Cardiology. Western Caribbean cruise. Contact: APAC, 866/970-2272; apac@aapa.org; www.cardiologypa.org.

18-19 • Global Health for Medical Professionals: Tropical Medicine, Infectious Disease, and Wilderness/Emergency Medicine, PAs for Global Health. Albuquerque, NM. Contact: Bill Taylor, 505/994-0556; cwtaylor@salud.unm.edu; www.pasforglobalhealth.org.

AAPA



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Poster Highlights Need for PAs to Learn More about CKD, KDOQI Guidelines

Renal Physicians Association Honors Best Nephrology Student Abstract

BY JANETTE RODRIGUES

The Renal Physicians Association (RPA) knows that many clinicians outside their specialties have limited knowledge of chronic kidney disease (CKD) and the revised early detection and screening guidelines from the Kidney Disease Outcomes Quality Initiative (KDOQI).

But RPA officers were stunned by a 2007 study by a University of North Texas Health Science Center (UNTHSC) researcher that suggests that 77.3 percent of PAs may not be familiar with the updated KDOQI guidelines.

"RPA was surprised by the incredibly poor distribution of the KDOQI information," said PA Kim Zuber, American Academy of Nephrology PAs (AANPA) vice president and former AAPA liaison to RPA. "They had expected it to be low, but not that low."

The study was conducted by Elisha Hatfield, a recent UNTHSC PA Program graduate, who looked at a cross-section of PAs to evaluate their clinical awareness and usage of the KDOQI guidelines. Some 246 PAs responded to a 10-question survey sent to 25 AAPA state chapters in 2006.

While nearly 88 percent of respondents agreed that early screening and detection of CKD is as important as screening for other more prevalent diseases, a majority of them were unable to correctly select the KDOQI recommended lab measures for initial screening for CKD. The study found that instead of using the albumin-specific dipstick recommended measure, most respondents chose either the standard urine dipstick or a serum creatinine level for initial screening.

"When RPA was asked to review the student posters [submitted to AAPA's 2008 Clinical and Professional Poster Session], we were thrilled that there were such strong renal posters," Zuber said, adding that Hatfield has set the bar high for the PA students that follow her.

Hatfield received Best Nephrology Student Abstract at the Poster Session at AAPA's annual conference in San Antonio in May. The RPA award included a \$250 travel stipend.

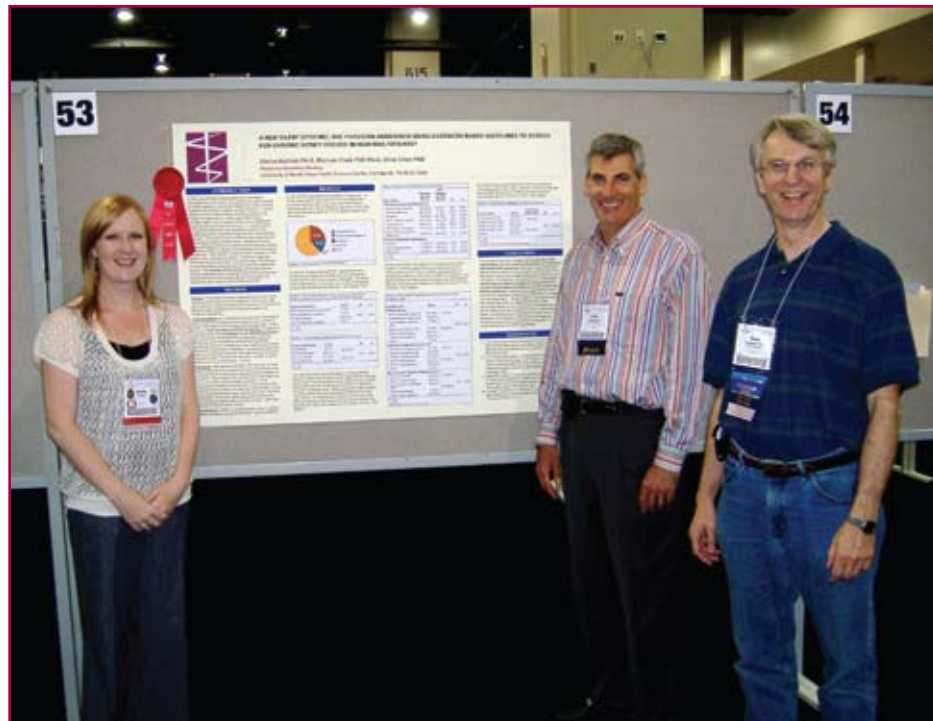
RPA was impressed with the study, entitled "New Silent Epidemic: Are Physician Assistants Using Evidence-based Guidelines to Screen for Chronic Kidney Disease in High-risk Patients?" But it was dismayed by the results.

The revised guidelines that prompted Hatfield's research were released in 2002.

Hatfield became concerned about clinicians' knowledge gap when she worked as a clinical research coordinator for a Dallas nephrology group prior to PA school. "I noticed that patients were being referred to us at a later stage than they should be," she said. "So we were getting a lot of them who had already progressed into CKD, and some of them were almost in end-stage renal disease (ESRD).

Hatfield, who also had some continuing education duties at the practice, was surprised at the number of primary care physicians, internists, and PAs she came across who had never heard of the updated guidelines.

"That is what started me thinking about what kind of project I could do when I was in PA school," she said. Now she plans to



PA Elisha Hatfield (l), the recent University of North Texas Health Science Center graduate who won Best Nephrology Student Abstract at AAPA's annual conference in May, discusses her poster with Keith Bellovich, M.D., of the Renal Physicians Association, and Peter Juergensen (r), president of the American Academy of Nephrology PAs.

focus on kidney disease research.

Those sentiments are music to Zuber's ears. She said that the PA profession is desperate for more nephrology PAs, which is why RPA decided to use the new award and travel stipend as a way to get more students interested in the specialty.

She said that one of the reasons why people should take more of an interest in nephrology is because one out of every nine Americans has CKD.

"People don't know they have it," Zuber said. "The student poster showed that the general practice and specialty PAs are actually seeing renal patients and not realizing it. They don't have an idea of what to look for, how to diagnose, how to treat, and how to keep kidney disease from progressing."

For more information on the KDOQI guidelines and RPA Clinical Collaboration in CKD Care Educational Seminars for PAs, go to www.renalmd.org.

New Dialysis Rules Allow Flexibility, Require Interdisciplinary Teams

BY ELLEN RATHFON

In the first total overhaul since the federal government began regulating kidney dialysis facilities in 1976, the Centers for Medicare and Medicaid Services (CMS) on April 15 published a final rule that "focuses on the patient and the results of care provided." The agency's intent was to modernize the regulations, emphasizing patient rights and safety, while allowing facilities much more flexibility in how they meet the requirements.

More than 336,000 Medicare beneficiaries with end-stage renal disease (ESRD) receive dialysis treatment from more than 4,700 Medicare-approved renal dialysis facilities across the United States. The percentage of PAs working in nephrology is small (0.6%) but growing.

These regulations serve as minimum standards that dialysis facilities must meet in order to receive Medicare payment for ESRD care. In addition to stronger regulation of patient rights and safety, the rule emphasizes the patient's participation in the development of his or her own plan of care.

"This rule was designed with patient care in mind," said Barry M. Straube, M.D., CMS chief medical officer and director of CMS's Office of Clinical Standards & Quality. "We've added requirements for facilities to conduct a comprehensive assessment of the patient's health condition when starting dialysis treatment, as well as to work with an interdisciplinary team to develop an individualized care plan for every patient. We've also added important protections to assure that all facilities develop a quality improvement system that helps them better assess patient outcomes and make changes that will improve health care," Straube noted.

Peter Juergensen, president of the American Academy of Nephrology Physician Assistants, described the update as good for patients. "This is a great regulation for improving patient access to care. The excellent clarifying language that CMS included should eliminate any question about utilization of PAs in caring for this growing population of patients with serious chronic needs," Juergensen said.

CMS Endorses PA Role

The regulation specifies that "the interdisciplinary team consists of, at a minimum, the patient or the patient's designee (if the patient chooses), a registered nurse, a physician treating the patient for ESRD, a social worker, and a dietician." In commentary accompanying the final rule, CMS staff noted: "We expect every patient to be assessed by the interdisciplinary team physician or "physician extender" (that is, a nurse practitioner, clinical nurse specialist, or a physician assistant), if a state practice act allows such physician extenders to conduct the physician portion of the patient assessment." CMS noted that if a nurse practitioner (NP), clinical nurse specialist (CNS), or PA performs the medical assessment, "the physician providing ESRD care must participate in the assessment by reviewing and approving the assessment."

The "patient plan of care" includes a requirement that "all dialysis patients are seen by a physician, nurse practitioner, clinical nurse specialist, or physician's assistant (sic) providing ESRD care at least monthly, as evidenced by a monthly progress note placed in the medical record, and periodically while the hemodialysis patient is receiving in-facility dialysis." Medicare pay-

ment rules in place since 2004 specifically allow PAs, NPs, and CNSs to provide ESRD patient visits. This new regulation brings Medicare's ESRD quality and safety rules into alignment with its ESRD payment policies.

Other points of interest in the rules are as follows:

- Under "medical staff appointments," the regulations specify that the governing body is responsible for all "medical staff appointments and credentialing in accordance with state law, including attending physicians, physician assistants, nurse practitioners, and clinical nurse specialists."
- Under "patients' rights," the regulations require that the facility inform patients (or their representatives) of their rights when they begin their treatment, including "the right to be informed by the physician, nurse practitioner, clinical nurse specialist, or physician's assistant (sic) treating the patient for ESRD of his or her own medical status as documented in the patient's medical record, unless the medical record contains a documented contraindication."

The new regulations take effect October 14, with the exception of electronic reporting requirements and provisions relating to isolation rooms and certain fire safety codes. The reporting, isolation, and fire safety requirements take effect in February 2009. The final regulations are available at <http://edocket.access.gpo.gov/2008/pdf/08-1102.pdf>.

PA's Find Much to Learn at New Johnson & Johnson Diabetes Institute

By DOUG SCOTT

PA Rick Kilgore was always resistant to the idea of bringing in a certified diabetes educator to talk with his diabetic patients about their diets.

"I never really had the opportunity to interact with the dietitians that closely and learn what they can bring to the table," confessed Kilgore, a PA who practices internal medicine at Alabaster Primary Care in Birmingham, Alabama.

He also had reservations about organizing group therapy sessions for his diabetic patients.

"I could see the stumbling blocks of having all the patients in the same room together, sharing their medical problems at the same time, and that is something that I did not think would work," acknowledged Kilgore, who is also president of Clinical Research Consultants Inc., a pharmaceutical research support company. "In my mind, it was one practitioner, one patient."

After only two days at the Johnson & Johnson Diabetes Institute this spring, Kilgore's views on using group therapy and certified diabetes educators have changed for the better.

"When I got back from the Johnson and Johnson Diabetes Institute, I had a situation where a number of my patients were not doing real well with their diabetes control, so I asked them if they would all meet with me and talk about diabetes and diabetes treatment," recalled Kilgore. "They all had similar problems, and we actually got together and had a small group discussion. I found that working as a group, rather than as individuals, they were now communicating together and were more open to talking about their problems."

"Similarly, after working alongside certified diabetes educators at the diabetes institute, I learned that getting them involved in the patient's treatment plan earlier can make my job a lot easier. Like most of us, I was not really privy to their dietary treatment plans, but now I feel that I have far more resources available to be successful with my diabetic patient."

"Those were definitely two things that I learned from going to the institute that opened my eyes about diabetes treatment."

After working alongside certified diabetes educators at the diabetes institute, I learned that getting them involved in the patient's treatment plan earlier can make my job a lot easier ... Now I feel that I have far more resources available to be successful with my diabetic patient.

— Rick Kilgore



PA Rick Kilgore

families, blood glucose pattern management and software solutions, reimbursement for diabetes care, and an introduction to the chronic care approach to treating diabetes.

"What we are doing at the Johnson & Johnson Diabetes Institute is teaching health professionals how to empower their patients, how to use an improved level of health literacy to be able to communicate information to their patients effectively," explained Rear Adm. Kenneth Moritsugu, M.D., chairman of the Johnson & Johnson Diabetes Institute and former acting U.S. surgeon general, "so that patients not only can manage their diabetes but, with counseling from health professionals like PAs, they can actually master their diabetes."

"By the end of the two days, a PA will come away with a better appreciation of new and emerging diabetes standards and an opportunity to actually utilize new diabetes technologies, including wearing an insulin pump for a 24-hour period to get a sense of what it really means to the patients when you prescribe it."

The Johnson & Johnson Diabetes Institute is not just two days of lectures and PowerPoint presentations, but rather an interactive experience where PAs are working with nurse practitioners and certified diabetes educators in a team approach to design improved treatment plans for patients with diabetes. When attendees

first arrive at the institute, they find out what it is like to be a diabetes patient — including wearing an insulin pump for the full two days.

"Very early on you are introduced to the insulin pump," said Larry Herman, clinical coordinator at the New York Institute of Technology PA Program in Old Westbury, New York, and one of the creators of the curriculum for the diabetes institute. "You will insert the tiny little catheter into your abdomen and wear it as a patient would

to have a full appreciation of what the patient goes through — because there is nothing like experiencing it for real.

"For the first time, you have an idea what it would be like to be told that you have diabetes, that you have a chronic disease for which there is currently no cure, and for which you will require daily treatments of injectable medications. So there is a bit of an epiphany that occurs when that happens and it truly allows you to walk a



PA Larry Herman

mile in your patient's moccasins."

"You are a patient with diabetes for two days," echoed Kilgore.

Another unique aspect of the institute is that the diabetes learning process does not end when the two-day course concludes, but is designed to be an ongoing self-evaluation and practice improvement experience. An on-line alumni association for members who have gone through the institute provides access to a closed chat room or "professional community" where

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— Kenneth Moritsugu, M.D.



Kenneth Moritsugu, M.D.

improve diabetes patient outcomes.

Herman believes that the institute fills a need for diabetes education that PAs are not getting

in their clinical practices.

"There is really no training provided to primary care providers as to the state-of-the-art care for diabetics," said Herman. "You can seek out the American College of Clinical Endocrinology or the American Diabetes Association, but there is probably a huge chasm between what the primary care providers are doing and what the endocrinologists, are doing. So this program was designed to bridge that

chasm, not to make you an endocrinologist, but to allow you to deliver state-of-the-art diabetes care in a primary care setting."

To make it a truly interactive learning experience, class size is restricted to no more than 25 people per session. Classes, which are designed to be an equal mix of PAs, nurse practitioners, and certified diabetes educators,

are held twice a week, 50 weeks a year, with the goal of training approximately 2,500 health professionals a year. Program costs — housing, transportation, and meals — are underwritten by the institute for all those who attend. Participation is by invitation only, but Moritsugu encourages all PAs who are interested in the program to apply by going to the Johnson & Johnson Diabetes Institute Web site at www.jjdi.us.

According to Norma Dodson, program manager of the institute, selection of PAs in the program are based on (1) being a member of AAPA and (2) the number of patients they see a month, their geographic location, their practice setting, and their credentials. Moritsugu said they are trying to increase the number of PAs participating in the institute.

"The entire experience," said Moritsugu, "is meant to provide a higher level of confidence on the part of the health professionals, not only in terms of understanding some of the nuances of diabetes, but what to prescribe and how to prescribe it."

UNDERINSURED from page 1

Some were even forced to take out loans, additional mortgages on their homes, or credit card debt to pay medical bills, which the study said is an indication "that these financial difficulties had the potential to linger into the future."

Annual premium costs for the underinsured were similar to those incurred by adults who were more adequately insured, but annual premiums paid by the underinsured tend to account for a much larger percentage of their incomes. "An estimated two in five underinsured adults spent 5 percent or more, and one-fifth spent 10 percent or more of family income on premiums," the study said. That is more than three times the percentage of income paid

by more adequately insured adults. Fifty-one percent of the underinsured reported earning wages of less than 15 dollars an hour, versus 21 percent of those with more adequate insurance. Twenty percent in each group reported earning between 15 and 20 dollars an hour, and 43 percent of adults in the group with more adequate insurance reported earning more than 20 dollars an hour, which compares to 22 percent in the group classified as underinsured.

The underinsured adults were more likely to have a negative view of their insurance, the study said. "Lower ratings [of insurance] also correlate with less confidence in receiving high quality care when it is needed," the study said.

AAPA policy, reaffirmed in 2007, states

that AAPA "recognizes and encourages medical providers to provide care to needy patients," and that the Academy "supports the development of programs and elimination of barriers to care for underinsured and uninsured patients. Any incentives offered by government or private entities promoting such care should be available to all health care practitioners."

Academy policy also states that all PAs should "become knowledgeable of programs sponsored by local governments, the private sector, and pharmaceutical companies that make prescription medications free of charge or at a reduced cost for underinsured, uninsured, or underserved patients."

Japanese Delegation Visits AAPA to Learn about PA Profession

PAs Could Help Stabilize Failing Japanese Health Care System

By DOUG SCOTT

In Japan, there is no such thing as a physician assistant.

Compared to a U.S. hospital, a Japanese hospital employs fewer cleaning staff, secretaries, administrative assistants, and billing staff. This means nurses are often assigned to distributing food trays, changing bed sheets, and cleaning up spills.

Similarly, a physician's time is often consumed by tasks that do not require his or her specialized knowledge, such as providing preoperative counseling and physicals, suturing, and postoperative monitoring in addition to the surgery itself. Often, physicians and nurses are forced to work overtime without pay, therefore job satisfaction is low and burnout is pushing skilled workers into quitting medicine altogether.

Not surprisingly, the Japanese are experiencing an iryo-Hokai, or a "health care system collapse." Its universal health care system, which once was highly rated by the United Nations in terms of quality and cost-effectiveness, has come under tremendous strain in recent years due to a combination of factors. Relying on heavily overworked and under-compensated health care workers, a rapidly aging population, and a decision by Prime Minister Junichiro Koizumi to sharply reduce health care system costs while adapting a more "pro-market" approach to health care, has severely weakened the foundations of the once-strong health care system.

"As a result," wrote Tadao Kakizoe, chair of the Health, Labor, and Welfare Ministry's Council for Cancer Control in *The Yomiuri Shimbun*, one of Japan's leading newspapers, "The medical care

system, which once was seen as the best in the world, is now collapsing at a terrifying speed."

Supported by a grant from the Japanese Ministry of Health, a delegation of three Japanese cardiovascular surgeons arrived in the United States for a two-day visit in early June to learn firsthand about the PA, nurse practitioner, and advance practice nurse professions and whether they can be adapted for the Japanese health care system.

The Japanese delegation included Hiroshi Nishida, M.D., assistant professor, Department of Cardiovascular Surgery, The Heart Institute of Japan, Tokyo Women's Medical University; Ryuji Tominaga, M.D., professor and chair, Department of Cardiovascular Surgery, Kyushu University Medical Science Research Unit; and Tadaaki Maehara, M.D., professor and chair, Department of Surgery II (cardiovascular, respiratory, and upper GI surgeries), National Defense Medical College. Included in the delegation was Sayaka Ogata, a U.S.-trained Japanese-American RN and NP, who served as guide and interpreter.

The quest by the Japanese to understand more about the PA profession was the result of a keynote presentation made to the 60th Annual Meeting of the Japanese Association for Thoracic Surgery (JATS) in Sendai, Japan, last October by PA Marie-Michèle Léger, AAPA director of clinical and international affairs. Among the topics she touched on were history of the PA profession, qualifications, provision of care, work setting, PA development in other countries, and PA professional organizations.

"The reason we came to the United



A delegation of three Japanese cardiovascular surgeons and an interpreter recently visited AAPA to learn more about the PA profession. They are (l to r) Hiroshi Nishida, M.D., Ryuji Tominaga, M.D., Tadaaki Maehara, M.D., and Sayaka Ogata.

States," said Maehara, "is we want to try to efficiently introduce this good system of using PAs into Japan through the support of our government."

"I was at the [JATS] meeting in Octo-

I learned a lot of things about PAs in this meeting at AAPA. First, having PAs in our system can be very good because they help fix the shortage of doctors that we are now facing. Also, PAs can help us improve patient safety, our cost-effectiveness, and our patient satisfaction. Thanks to AAPA, we have a lot of information to take back to Japan.

— Tadaaki Maehara, M.D.

ber and I was very deeply impressed to hear about the PA system," added Nishida. "Marie-Michèle's presentation was very useful and made us very interested in finding out more."

On the first day, the delegation toured the facilities at Yale-New Haven Hospital in New Haven, Connecticut, and met with faculty and staff of the Yale PA Program and Yale School of Nursing, including Mary Warner, a PA and assistant dean of the Yale PA Program; Ginny Hilton, a PA and director of the PA residency program at Norwalk Hospital; and David Brissette, a PA in internal medicine at Yale-New Haven Hospital. The delegation also visited Fair Haven Community Health Center to observe certified nurse midwives and nurse practitioners in an outpatient setting.

On the second day, the delegation flew to Washington, D.C., for a meeting with senior AAPA staff, including APPA Executive Vice President/CEO Bill Leinweber; Senior Vice President, Education, Membership, and Resource Development Greg Thomas; Senior Vice President,

Advocacy and Government Affairs Nicole Gara; Vice President, Science and Education Bob McNellis; Vice President, Health Systems and Reimbursement Michael Powe; Director, Alliance Development and Education Sharon Kulesz; and Léger. Also participating were Physician Assistant Education Association Executive Director Timi Agar-Barwick and Karen Rosenfeld-Dean, a PA with 20 years of surgical experience who works at the Shady Grove Adventist Hospital in Maryland.

Among the subjects discussed were the history of establishing the PA system in the U.S., why people became PAs, how they are utilized in surgery and hospital settings, relationships with other professional health care providers, education, salary structure, who determines whether to hire a PA or NP, the national examination process and license renewal, working conditions, employment patterns, reimbursement, and suggestions about how to introduce the PA system in Japan in a speedy and realistic way.

"I learned a lot of things about PAs in this meeting at AAPA," said Maehara. "First, having PAs in our system can be very good because they help fix the shortage of doctors that we are now facing. Also, PAs can help us improve patient safety, our cost-effectiveness, and our patient satisfaction."

Pausing to reflect for a moment, he continued, "Thanks to AAPA, we have a lot of information to take back to Japan."

"We will report what we learned to the government," said Maehara. "And also we will begin the planning process on how to introduce PAs in Japan, and that begins with talking to all the other important stakeholders in our health care system. But I must emphasize that we really want to introduce PAs in Japan because we have such a problem with our health care system, which right now is collapsing. We have to do that."



Back row (l to r): Timi Agar-Barwick, PAEA; Ken Brady and Bob McNellis, AAPA. Front row (l to r): Ryuji Tominaga, M.D.; Hiroshi Nishida, M.D.; Sharon Kulesz, AAPA; Marie-Michèle Léger, AAPA; PA Karen Rosenfeld-Dean; and Tadaaki Maehara, M.D.

CSAC Alert

CSAC Alert is a regular feature brought to you by the members of and staff to the AAPA Clinical and Scientific Affairs Council. This column intends to alert you to important new clinical information and how to learn more about it.

New USPSTF Recommendations on Type 2 Diabetes, Lipid Disorders

The U.S. Preventive Services Task Force recommends screening for type 2 diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg. The Task Force also concludes that current evidence is insufficient to assess the balance of benefits and harms of routine screening for type 2 diabetes in asymptomatic adults with blood pressure of 135/80 mm Hg. or lower. The Task Force encourages clinicians to look at a patient's total risk for heart disease in determining whether to screen patients. Screening may be considered on an individual basis if knowing whether a patient has type 2 diabetes helps clinicians decide on strategies to prevent coronary heart disease, including the possible use of lipid-lowering medications or aspirin. This

updates the 2003 recommendation. The recommendation and accompanying summary of evidence can be found at www.ahrq.gov/clinic/uspstf/uspdiab.htm.

The Task Force also updated its 2001 recommendations on screening for lipid disorders in adults. The Task Force strongly recommends screening all men aged 35 and older and women aged 45 at increased risk of coronary heart disease for lipid disorders. Younger men and women over age 20 should also be screened if they are at increased risk. The Task Force does not recommend for or against screening those who are not at increased risk of coronary artery disease. The recommendation statement and summary can be found at www.ahrq.gov/clinic/uspstf08/lipid/lipidrs.htm.

Salmonella Infection Outbreak Information

The Centers for Disease Control and Prevention (CDC), the Indian Health Service, and the U.S. Food and Drug Administration (FDA) continue to investigate the multi-state outbreak of *Salmonella* Saintpaul. As of June 12, the outbreak had infected 228 persons in 23 states with 25 hospitalizations.

The investigation has revealed consumption of raw tomatoes as the likely source of illnesses. For more information check the CDC's Web site at www.cdc.gov/salmonella/saintpaul and the FDA's Web site at www.fda.gov/oc/opacom/hottopics/tomatoes.html.

Clinical Meetings

An important role for AAPA is building relationships with other health care organizations. Through these relationships, the Academy advocates for the role of the PA and gathers information to help improve the quality of care for patients. Often, this is done by members and staff attending clinical meetings. Here is an update on recent meetings where AAPA was represented.

AAPA staff were busy in May representing the Academy at several meetings. Staff joined other national leaders in health care, business, government, and education at a meeting entitled **Changing Diabetes in America: Transforming Awareness into Action**. During this meeting, the National Changing Diabetes Program (NCDP) launched the National Diabetes Goal, which calls for all sectors of society to work together so that 45 percent of Americans at risk for type 2 diabetes will know their blood glucose level by 2015 and will know the appropriate next steps to take to prevent or manage their diabetes. Former Arkansas Gov. Mike Huckabee, who gave the keynote address, shared his personal experience with diabetes. NCDP is a program of Novo Nordisk.

Also in May, staff attended the **National Influenza Vaccine Summit** hosted by the Centers for Disease Control and Prevention and the American Medical Association (AMA). Participants included more than 200 private and public health providers, professional organizations, and vaccine

manufacturers. Participants discussed challenges of the 2007-2008 influenza vaccination season, including the vaccine mismatch, oversupply, and expanded recommendations.

In addition, staff attended the first meeting of the **African Diaspora Health Initiative**, sponsored by the National Medical Association. A year earlier, the African Union Ministers of Health had released a framework entitled *Africa Health Strategy: 2007-2015*. The framework proposes strengthening of health systems with the goal of reducing disease burden through improved resources, systems, policies, and management. Africa accounts for 24 percent of the global burden of disease, is home to 3 percent of the global workforce, and represents 1 percent of global health care spending. The African Diaspora Health Initiative hopes to support the African Union's goals by linking specific health expertise within the African Diaspora with specific health needs in specific geographical locations in Africa.

Staff also attended the **Seasonal and**

ACCP, AHRQ Offer Disaster Preparedness Resources

The American College of Chest Physicians has published the *Definitive Care for the Critically Ill During a Disaster* as a supplement to the May issue of *CHEST*. The supplement offers guidance for hospitals, health care professionals, and public health authorities on how to prepare for and provide essential critical care when the need for resources exceeds availability. Link to the supplement at www.chestjournal.org/content/vol133/5_suppl.

The Agency for Healthcare Research and Quality (AHRQ) has a new Web page to help community and emergency

planners prepare for hurricanes and other natural disasters. The tools and resources provide guidance on how to reopen shuttered hospitals to meet casualty demand; use community call centers for crisis support; provide mass medical care with scarce resources; evaluate hospital disaster drills; and locate nursing homes, hospitals, and available resources within communities or in nearby states. The material will be available through hurricane season, which ends November 30. Go to www.ahrq.gov/prep/hurricane.htm for more information.

New Consumer Guide on Anticoagulant Therapy

AHRQ released a new consumer publication, *Your Guide to Coumadin®/Warfarin Therapy*. This 20-page, easy-to-read patient brochure explains what patients should expect and watch for while undergoing Coumadin®/warfarin therapy. This brochure educates patients about their medication and its potentially dangerous side effects, explains how to communicate effectively with their health care providers,

and provides tips for lifestyle modifications. It also provides information on remembering when to take the medicine, learning how to stay safe while taking the medicine, maintaining a consistent diet, and alerting health care providers to concurrent drugs and/or supplements patients are taking to avoid any potential adverse interactions. The guide is available at www.ahrq.gov/consumer/coumadin.htm.

Other Anticoagulants in the News

Please help FDA spread the word about recalls of injectable heparin products and heparin flush solutions that may be contaminated with oversulfated chondroitin sulfate (OSCS). Affected heparin products have been found in medical care facilities since the recall announcement. Although product recall instructions were widely distributed,

they may not have been fully acted upon at all sites where heparin is used. There have been more than 200 deaths associated with allergic or hypotensive symptoms after heparin administration. Health professionals and facilities are asked to review and examine all drug/device storage areas, including emergency kits, dialysis units, and automated drug storage cabinets to ensure that all of the recalled heparin products have been removed and are no longer available for patient use. In addition, FDA would like to inform health professionals about other types of medical devices that contain, or are coated with, heparin. For more information, go to www.fda.gov/cdrh/safety/heparin-healthcare-update.html.

Pandemic Influenza Meeting, sponsored by the Infectious Disease Society of America. Attendees included leaders from government, academia, professional organizations, clinical medicine, and industry, all of whom are involved in some aspect of influenza pandemic planning, research, and treatment. The program goals are to improve overall preparation for a potential flu pandemic and foster communication among all stakeholders.

Finally, staff represented AAPA at the **release of the new tobacco cessation guidelines** at AMA headquarters in Chicago. The lead author, Michael Fiore, M.D., reviewed the updates to the guidelines and personalized them by noting that one of his favorite uncles died from tobacco-related illness. Several other experts spoke eloquently about the importance of the new guidelines and coordination of efforts to eradicate nicotine addiction, which several characterized as a pediatric disease since most smokers begin in childhood. The last two speakers were former U.S. Surgeon General C. Everett Koop and AMA President Ron Davis. Davis closed the event by presenting a call to arms to American physicians, imploring them to have the same determination as Koop in helping their patients kick the habit. AAPA was one of several dozen organizations to endorse the guidelines, which are available at www.ahrq.gov/path/tobacco.htm.

New Report on Pharmacogenomics

The Secretary's Advisory Committee on Genetics, Health, and Society (SACGHS) recently published a new report *Realizing the Potential of Pharmacogenomics: Opportunities and Challenges*. The report explores the potential for pharmacogenomics (PGx) to advance the development of diagnostic, therapeutic, and preventive strategies to improve the safety, effectiveness, and quality of health care and makes 35 policy recommendations aimed at enhancing the development and integration of PGx applications. In writing and distributing this report, it is SACGHS's intent to provide policy-relevant information about PGx to inform the decisions of clinicians, policymakers, and other stakeholders. The report is available at www4.od.nih.gov/oba/SACGHS/reports/sacghs_pgx_report.pdf.

It's the Final Countdown to HFA Inhaler Transition

40 Million Asthmatic Patients Forced to Switch, PAs Asked to Help Educate Them

By DOUG SCOTT

To help consumers switch from analog to digital television by February 17, 2009, the federal government has created a \$1.5 billion program that includes consumer education and a \$40 government coupon to help TV owners subsidize the cost of the digital converter box.

To help the 40 million asthmatic patients switch from using the chlorofluorocarbon (CFC) propellant inhalers — which will be banned by December 31 — to the hydrofluoroalkane (HFA) propellant inhalers, the federal government has allocated zero dollars for consumer education or to cover the cost of the potentially more expensive HFA inhalers.

The tasks of explaining to your asthmatic patients why the federal government has

get that anymore' or the pharmacy will just substitute one of the HFA brands without calling the clinician," said Tera Crisalida, a PA employed by the Allergy Associates and Lab in Tempe, Arizona. "The pharmacist is going to give the patient whatever HFA is the cheapest or whatever is authorized by their insurance. So it is important for us to tell our patients that they are not going to get the albuterol [CFC] anymore and train them to use the different HFA inhalers."

Restoring the Ozone

For more than 50 years, medical grade CFCs have been used as propellants in pressurized metered-dose inhalers (MDI). But the 1987 Montreal Protocol, signed and ratified by 140 countries, including the United States, aims to repair and restore the

protective stratospheric ozone layer by banning CFCs and other aerosols. The treaty provided a temporary exemption for MDIs until pharmaceutical companies could develop, test, manufacture, and distribute suitable alternatives. After many years of research and development, a new propellant, HFA, was identified. Today, there are four HFA inhalers on the market: Proventil HFA, ProAir HFA (formally albuterol sulfate HFA), Ventolin HFA, and Xopenex HFA.

In the past, although CFC albuterol MDIs were sold under both brand and generic names, they were virtually identical. Now, there are four distinctly different HFA albuterol and levalbuterol bronchodilators MDIs that patients and clinician can choose, but no generic. So if one brand doesn't relieve the symptoms, another is available.

"Even if the CFC and HFA inhalers contain the same active ingredients, they are very different from one another," said Sander. "One [HFA] is not substitutable for the other [HFA], so it is more imperative than ever for PAs to write the specific name of the [HFA] drug they want the patient to receive and explain to them how to use it. Otherwise, if the patient goes to the pharmacy and picks up a different HFA inhaler than they are used to, they may or may not have the same experience that the PA is expecting them to have.

"A case in point is that there are specific priming, shaking, inhalation, and cleaning instructions on each particular HFA that impact a patient's experience. So, if the patient has training on one HFA, it may not be identical for another. It's all unique and

PAs need to familiarize themselves with all the different HFA package inserts."

Strength of the Puff

One of the major differences between the CFC and HFA inhalers is the amount of spray or puff that comes out. Many patients who have already switched to HFA inhalers insist the force of the spray is not strong enough to "push open" their airways during an attack.

Some patients who use the HFA inhaler think that it is not working because the strength of the puff is less than the CFC inhaler," said Crisalida. "So we need to tell our patients that just because you feel like you are not getting as much, you are. The other practical thing is the little hole that the spray comes out of tends to clog more on the HFA inhaler, so you might want to let patients know that they need to clean the HFA inhaler more often than they did their previous CFC inhaler."

The new federal mandate to stop manufacturing and selling CFC inhalers has forced the pharmaceutical industry to develop new manufacturing facilities and, in addition, go through the U.S. Food and Drug Administration's approval process to demonstrate safety and efficacy. This translates into higher out-of-pocket costs for consumers and, in some cases, higher deductibles and co-pays for patients with prescription coverage health plans. In

some instances, the choice of HFA inhaler is made by the insurance company without consulting the clinician or the patient.

"PAs need to be talking to their patients about cost issues because, in the past, you could get a generic CFC albuterol for \$4.00, whereas with the HFA, the co-pay could be much higher," said Sander. "So if cost is an issue, the PA needs to be familiar with where the patient can get coupons or free medications."

Easily downloadable HFA coupons that you can give your patients can be found by going through the RxAssist Patient Assistance Program Center at www.rxassist.org or the Partnership for Prescription Assistance at www.pparx.org. Also, with four new HFA inhalers on the market, Crisalida said, drug representatives will give out free samples that can be distributed to patients.

"The way that I look at this situation is that this is a really good opportunity for PAs to spend time talking to their patients about asthma education in general," said Crisalida.

For more information on how to help your patients make the transition from CFCs to HFAs, go to www.breatherville.org/pharmacy/ph_mdi_transition.htm.

To purchase a wall poster of all the inhalers from the Allergy & Asthma Network, Mothers of Asthmatics, go to www.aanma.org/generalstore/catalog.asp?id=BG,BP,BF,BC&sec=pubs.

Take a Breather
What's inside your inhaler?

After December 31, 2008, pharmacies will no longer dispense albuterol inhalers containing CFC propellants.

Know your options.
Make informed choices.

www.breatherville.org/MDITransition

Allergy & Asthma Network
Mothers of Asthmatics
2751 Prosperity Avenue, Suite 150
Fairfax, VA 22031
800.878.4403
Fax: 703.573.7794

switched from CFC to HFA, training them to use the new HFA inhalers, and helping them maneuver through the different cost and insurance co-pay options for the different HFA inhalers is left to the clinicians on the front lines.

Change Is Mandatory

"It's a mandate, so to make the transition from one type of inhaler to another type of inhaler, it requires that PAs know the difference between the two types of inhalers and then teach those differences to patients who have been using CFCs in the past," said Nancy Sander, president of Allergy & Asthma Network, Mothers of Asthmatics, a consumer advocacy group. "PAs need to explain to their patients why the CFC inhalers are changing, that the change is mandatory, and that there are important decisions to be made about their treatment options that require thoughtful consideration of the patient's medical history and current respiratory health status."

"If you write a prescription for plain albuterol [CFC] after December 31, either the pharmacy will call and say 'we can't

Dues Increase to Allow Improved Services for Profession

For the first time in eight years, the AAPA House of Delegates (HOD) has approved a dues increase for fellow AAPA members. The increase, which will go into effect on September 1, will raise the annual cost of AAPA fellow membership from \$215 to \$250.

The increase was approved during the 2008 meeting of the House of Delegates, held during AAPA's annual conference in San Antonio. The House is made up of 250 AAPA members who are selected by chartered constituent organizations, recognized specialty organizations, the Caucus Congress, the Student Academy, and the PA Education Association to vote on matters of AAPA policy.

The AAPA Board of Directors (BOD), at its February meeting, requested a \$25 increase, but the House voted to add \$10 to the increase, as the additional funds will allow AAPA to improve its services while keeping pace with the rapidly rising cost of energy and other daily expenses. AAPA staff and the BOD have demonstrated sound fiscal oversight of AAPA finances, which delayed the need for an increase until now. However, in the eight years since the last increase, inflation has risen by more than 24 percent.

Further information on implementation of the dues increase will be available on www.aapa.org.

AAPA Member Dues Increase: What YOU Need to Know

- House of Delegates approved dues increase at annual conference in May
- Fellow member dues rising to \$250
- Dues increase takes effect **September 1, 2008**
- First dues increase in eight years
- Increase allows for continued and improved services for AAPA membership

AAPA appreciates and thanks its members for their continued support.

Have questions or concerns? E-mail membership@aapa.org. Please put dues increase in the subject line.

Playing a Role in Stemming School Violence

By DOUG SCOTT

School shootings are not a new phenomenon.

Using dynamite and hundreds of pounds of pyrotol, Andrew Kehoe, a member of the Bath (Michigan) Township School Board, blew up the Bath Consolidated School on May 18, 1927, killing 45 people and injuring 58, most of whom were second to sixth graders, seven to 12 years old. According to the FBI, this act constituted the deadliest act of mass murder in a school in U.S. history.

“When I looked back into all the school shootings, the one thing that hit me is that this is nothing new,” said Heidi Vermette, M.D., forensic psychiatrist and assistant professor of psychiatry at the University of Texas Southwestern Medical Center at Dallas. “While it is right to be concerned about this, we also have to be responsible about how we respond to tragedies.”

Over the past year, the FBI identified seven major school shootings in the United States: Delaware State University; Success Tech Academy in Cleveland; Notre Dame Elementary School in Portsmouth, Ohio; Louisiana Technical College in Baton Rouge; Mitchell High School in Memphis, Tennessee; E.O. Green School in Oxnard, California; and Northern Illinois University in DeKalb.

“When most people think of school violence, they think of violence related to drugs and gangs in inner-city schools, but these shootings are different. They

occur in middle-class neighborhoods and schools. It seems as if there is no rhyme or reason. People say things like, ‘Gosh, he was such a nice boy, the parents were good, and I saw nothing wrong. He must have just snapped,’” said Vermette, who is medical director for mental health at the Dallas VA Medical Center. “The reality is that when you

go back and look at it, nobody snaps. There are risk factors and warning signs.”

“School shooting” is defined by the FBI and other law enforcement agencies as violence involving guns and/or explosives committed at educational institutions, resulting in mass murders or spree killing by people connected with the institution. History shows that school shootings are typically perpetrated by disgruntled students, alumni, faculty members, or those who are alleged to have a mental disorder. Unlike other acts of homicide, school shootings are usually intended to involve multiple victims, often randomly targeted, with the perpetrators eventually killing themselves.

In a CME session at AAPA’s annual conference in May entitled School Shootings: Multiple Victim Homicide in the School Setting, Vermette explained the problems health care providers encounter

when attempting to predict multi-victim homicide shootings, identified factors when evaluating the risk of multi-victim homicide, and discussed how these risk factors may be applied to recent examples of school shootings.

Vermette found that homicide is the second leading cause of death among children age five to 18, yet surprisingly, statistics show that school-related homicide is down in the last 15 years.

“The rate of school-associated homicide decreased from 0.07 per 100,000 students to 0.03 per 100,000 students,” said Vermette. “These numbers were lower than I expected. And although homicide is high as far as the cause of death among children, less than one percent of child homicides are associated with schools.”

“Because this is such a rare event, attempting to profile the school shooter is essentially a little bit better than trying to read a crystal ball.”

Citing several studies, including the Monahan Study of 1984 and the second generation of violence risk assessment studies, Vermette concluded that it is difficult for health care practitioners to establish patterns for rare events such as multiple-victim school shootings. Thus, it is important to remember that the majority of children with risk factors for violence will *not* go on to become school shooters.

Universal school-based violence and aggression programs, identification and reduction of bullying, connecting parents

and schools, and mentoring at-risk youth are potentially effective ways to reduce violent behavior in children and teenagers, as opposed to instituting zero-tolerance policies, which Vermette said ends up having “unintended consequences, such as the six-year-old girl who was thrown out of school because her mom put a plastic knife in her lunch box to cut her brownie.”

“Based on my review, multi-victim homicide in middle and high school settings may be different than in the college setting. In middle and high school settings, the seeds of violence can be planted when bullying leads to depression and thoughts of revenge,” said Vermette. “In the college setting, mental illness may play a larger role.”

“Where PAs and other health care providers can have the biggest impact is in the recognition and treatment of violence risk factors and the education of their patients. This might mean talking with parents about appropriate discipline for their kids or talking with children about bullying. But PAs also can serve as community leaders and role models to advocate not only for addressing the problem of violence in the child but also the problem in the community.”

To read the Centers for Disease Control and Prevention’s recent report on *The Effectiveness of Universal School-Based Programs for the Prevention of Violent and Aggressive Behavior*, go to www.cdc.gov/mmwr/preview/mmwrhtml/rr5607a1.htm.



Heidi Vermette, M.D.

Walking the Walk

Despite Disability, PA John Welton Walks Tall Among His Patients

By KENYA MCCULLUM

You might think that someone who spent a lot of time in hospitals as a child would do everything he could to avoid them — and certainly not choose to work in one as an adult. But for physician assistant John Welton, who contracted polio in the early 1950s and now walks on crutches and uses a leg brace, the experience gave him an appreciation for the medical profession that has guided his career.

“My exposure to hospitals, nurses, and doctors — for both inpatient and outpatient care — gave me an interest in medicine and good feelings about doctors and nurses,” he explained.

Now Welton, who graduated from the Long Island University PA Program in 1982, returns the favor by passing on those same good feelings to his patients and their families at the Palliative Care Unit of Montefiore Medical Center in New York. Although he began his medical career as an epidemiologist at the New York City Department of Health, Welton says that working directly with sick patients is much more rewarding for him.

“Back in my days as an epidemiologist, I got a paper published in *The Lancet*, which turned out to be a seminal piece for a number of other research papers that came out,” said Welton. “I probably affected tons more people through that one paper than anything I would do in the rest of my lifetime, but it didn’t give me the satisfaction that you get from working with people one on one.”

Since his time as an epidemiologist, Welton has worked with numerous patients and has focused on both inpatient and outpatient care during his PA career.

The enjoyment he feels when working with his patients — many of whom he considers his friends — is clear from his empathic bedside manner that he says was in part developed through his own medical challenges. In fact, he’s so well liked that it’s not uncommon for him to receive greeting cards from former patients thanking him for his care.

Welton is popular with his palliative patients and their families. “I have the sense that some families seek me out to speak with,” said Welton. “There are people who come to me regularly and want to talk about things or people who have called on the phone, and I’ve been told that they will only speak to me.”

Welton’s story was recently featured in *The New York Times*, which has further increased his popularity. A reluctant celebrity of sorts, Welton is not basking in the glow of all the attention he has been receiving lately — in fact, he is quite embarrassed by it because he has spent his life trying not to stand out because of his disability.



PA John Welton

“Practically my whole life was focused on not being someone special; it was focused on just trying to be normal and like everybody else,” he said. “Much of the focus was that no one’s going to do anything special for me and whatever it is that I want to do, I need to be able to do it for myself.”

Likewise, throughout his career, Welton has worked hard to be treated like the rest of his colleagues. Although he has to make certain adjustments in order to do his job while balancing on his crutches, he doesn’t want or expect any preferential treatment. That’s not to say that others never felt reservations about his ability to do his job, but Welton says that when people see his performance, their doubts are soon put to rest.

“During the course of my career, I’ve had the feeling that there were people who would say, ‘what makes him think he can do this?’ or ‘how is he going to do this?’ It kind of spurred me to work even harder to say, ‘I’m going to show you how I can do this.’ Then after a year or so when they get to know me, things relax and we work everything out.”

And for the patients he treats, who often feel marginalized because of their physical limitations, things have worked out quite nicely.

“It’s really surprised me that a lot of the people I have taken care of over the years disparage themselves. They don’t really feel a sense of being worthwhile as people and they get surprised that someone would even care about them,” said Welton. “It seemed to make a big difference to a lot of them that they saw me caring about them as an individual person. To me, that’s the biggest part of medicine — the ‘art’ part of medicine.”

PA Helps Bring Smiles to Children in Guatemala

By Christopher Doscher

Being part of a medical mission trip was something Kristina Marsack had wanted to do since she began working as a PA in plastic surgery three-and-a-half years ago. Her supervising physician, Larry H. Hollier Jr., M.D., recently became the chairman of a Houston-based organization called Surgical Volunteers International (SVI). Hollier had been on several medical missions with the group over the previous year.

Last winter, he inquired about her desire to volunteer in another country. Marsack immediately responded, "Absolutely. I'd love to." Marsack had previously struggled to find a missionary group in her specialty that would accept PAs.

In April, Marsack joined Hollier on a trip to Guatemala City, Guatemala, that focused on repairing craniofacial deformities in children. The majority of the mission was funded by the Smile Train, an international charity dedicated to helping children in poor countries obtain surgery to repair cleft lips and palates.

As it turned out, accompanying her supervising physician on the trip was key, because like many other organizations, the coordinator of the trip wasn't completely familiar with the extent of PAs' skills.

"The coordinator wasn't sure what types of duties I could perform," Marsack said. "Plus, he had to get permission to bring a PA from the host group in Guatemala. Each country is different in its regulation of medical volunteers. They don't want untrained people 'practicing' on their children."

Unlike some international medical volunteers, Marsack, Hollier, and the rest of the SVI team, which included another surgeon, three anesthesiologists, a pediatrician, a medical student and a staff of nurses, were able to do their work in a modern medical setting. "There is a special hospital in Guatemala City designed purely for medical missions," Marsack said. The Pediatric

Foundation of Guatemala pre-screened patients and assigned times for the different mission groups to be on-site. The foundation also provided follow-up care for patients treated by the mission volunteers.

"The patients were so well-screened that we only turned about three kids away due to illness or inoperable conditions," Marsack said. She estimated that, in a week, the team operated on about 50 patients. The majority of the children had cleft lips, cleft palates, or both. These particular conditions tend to be more apparent in poorer countries of Asia and Latin America because of a combination of genetic and nutritional factors. Additionally, there are fewer medical resources available to repair the defects early in sufferers' lives. While children with cleft lips endure social obstacles because of their appearance, children with cleft palates may suffer from abnormal speech development and nutritional problems. A cleft palate can make it physically difficult for them to eat and drink due to nasal regurgitation, which can also be a cause of ridicule for older sufferers.

"Speech patterns are affected in children with unrepaired cleft palates, and it becomes uncorrectable if the defect isn't repaired early enough," Marsack said.

In the United States, only a few large institutions provide reconstructive surgery for the majority of the children with cleft lips and palates. As a result, Marsack had never been involved in the type of surgery the team conducted in Guatemala. During the mission, she provided first assist services and, under the guidance of her supervising physician, was able to make markings and perform some of the surgery.

"It's very challenging, because no two surgeries are the same," Marsack said. "Each child has a different deformity. For the surgeon, it's an interesting field to be in. You have to be adaptable."

Marsack recalled one surgery the team performed on a three-month-old child.



PA Kristina Marsack (left), on a medical mission in Guatemala with a group from the Smile Train, assists with one of the approximately 50 surgeries her group performed to repair cleft lips and palates in children.

"The surgeon immediately said, 'That is the widest cleft lip I've ever seen,'" she said. "He was concerned the sutures wouldn't hold, but, as we did the surgery, it all came together beautifully."

Postoperatively, Marsack carried the baby to its mother, and asked in Spanish what the mother thought. "The mother looked down and said 'Bien (good).' Honestly, I was disappointed that her response was so dispassionate; however, when one of the Spanish-speaking nurses took the mother and her child to the inpatient unit, the mother broke down in tears. She told the nurse that she had been too embarrassed to cry in front of me."

Children who had had surgery for a cleft lip spent one night in the hospital. Those who had cleft palates repaired stayed for two nights.

Marsack, treasurer and incoming president elect of the Association of Plastic Surgery Physician Assistants (APSPA), encourages other PAs to get involved in mission

work. She is creating a database on www.apspa.net where APSPA fellow members who are interested in missions can report their interest and add the name of an interested physician as well.

"My goal is to get more PAs involved in this type of trip," Marsack said. "There were plenty of smaller surgeries that were performed. If we could increase our role to help with these patients, we would be able to free up surgeons to do more complex surgeries and help more children overall."

For PAs who are considering medical mission work, Marsack believes that there are three major rewards. "First and foremost is the personal joy of serving others who are unable to help themselves," she said. "Second is the unique medical training that you receive as you advance your skills under new working conditions. Third is the rare opportunity to experience another culture or country in a way that no tourist can."

Mission in Guatemala Gives PA New Meaning for 'Basic' Care

Even after working as a PA for 26 years in two of the largest level one trauma centers on Long Island, Edward Giarrusso said that "nothing" could have prepared him for what he experienced during a recent medical mission to Guatemala.

Giarrusso, who teaches at the Stony Brook University PA Program, took part in a mission through the Glens Falls Medical Missionary Foundation, which since 1999 has offered two second-year PA students at Stony Brook the opportunity to participate in a mission trip to Guatemala.

The mission trips have expanded beyond medical care over the years, Giarrusso said. "It had become obvious to the mission that providing only medical care is, quite literally, a band-aid approach to the extensive needs of a community that does not have access to some basic needs like clean water, sewage treatment, and emergency services," he said.

Stony Brook faculty in 2008 decided to support the participation of a faculty member in the mission. Giarrusso had thought for some time about participating in a mission trip and indicated that he would like to participate.

Giarrusso, having been informed by organizers of steps mission volunteers would have to take to prevent mosquito bites, bed bugs, dengue fever, and malaria, was pleasantly surprised when he arrived at his hotel, Turicentros Los Esclavos, in Cuilapa, a two-hour ride from the airport in Guatemala City. "It was clean and had a restaurant and a pool. I thought that maybe my initial expectations were wrong." The next day, the group rose at 5:30 a.m., had breakfast at 6:00, and were on the bus to the clinic by 7:00. What he saw along the way caught him off guard.

"I have vacationed in the Caribbean Islands with my family and have seen many poor communities, but I have not seen homes as simple and as poorly built as the homes



PA Edward Giarrusso meets with a patient in a makeshift clinic during a recent medical mission to Guatemala.

I saw on our travels to the clinic," Giarrusso said. The team worked out of a building that was once a school attached to a Catholic Church. Volunteers set up rooms for different services — women's health, pediatrics, general medicine, dentistry, pharmacy — as well as an auditorium for triage, eye examinations, and fluoride treatments.

"The exam rooms were in what at one time was a classroom, with minimal lighting, small windows, and dirty cement floors," Giarrusso said. The team picked up supplies at Cuilapa Hospital and were given a tour of the emergency room and medical and surgical floors.

"I thought I was in a time warp," Giarrusso said. "The hospital was like something out of the 1940s. All patient areas were wards, without curtains between beds. The beds were old and the mattresses were two to three inches thick on spring bases. The sheets were bloodstained, and there were no screens on the windows. We visited the pediatric ward and saw a set of five-month-old twins who weighed six pounds. The mother didn't have enough money to feed

the children, who were two of her five children."

The volunteers traveled to the clinic the following day escorted by six armed military personnel, as it is common in Guatemala for bandits to stop buses and rob the passengers. The group began seeing patients, and many in the group redefined their previous notions of what "poverty" meant. Some patients walked two to three hours each way, carrying their young children, to be seen at the clinic.

"I treated an 82-year-old woman who weighed 68 pounds and patients with venous stasis ulcers of the lower leg that were three, four, or five years old," Giarrusso said. "I gave a mother antibiotics for her child's ear infection and told her to keep it cold in the refrigerator when she got home. She told me that she did not have a refrigerator."

Some of the patients told Giarrusso that most families did not have running water, electricity, a stove for cooking, or enough money to buy food to feed themselves and their children. "There are no toilets, the water is not purified, and much of the population has diarrhea from giardia or amoeba infections," Giarrusso said. "The Guatemalans are very proud people, though. Many of the women we saw that week wore their best clothes to the clinic. Their very colorful, traditional clothing was but one reflection of their heritage and pride."

Although he regularly treats trauma patients and is involved in lifesaving procedures, most of the treatment Giarrusso provided during the mission was routine. "To me, it was the most basic of care, but to our Guatemalan patients, it was meaningful, appreciated, and necessary."

Some of the returning mission volunteers told Giarrusso that they had seen an improvement in the health care system in Guatemala over the years. Giarrusso plans to return on another mission. "Hopefully, I too will see that change," he said.

Be Prepared for In-flight Emergencies

BY JANETTE RODRIGUES

Record fuel prices may be causing the number of vacation travelers taking to the friendly skies to decrease this summer, but the number of passengers is increasing overall, so PAs and other health care providers need to be prepared to help out during in-flight medical emergencies.

In-flight emergencies occur often, but the majority do not end in fatalities, said PA Jeff Hinshaw, during a CME session on In-flight Medical Emergencies (IMEs) at AAPA's annual conference. And, more often than not, an IME will occur on a long-haul flight.

He experienced one firsthand a few years ago when he was over the North Atlantic on an international flight to Manchester, England. He and another passenger treated the patient, but he didn't like "being caught with my britches down."

Hinshaw, a certified National Registry of Emergency Medical Technicians paramedic, wants PAs to be prepared when the call bell rings and the announcement "Is there a medical provider on this flight?" comes over the aircraft speaker.

Some 825 million travelers are expected to pass through the nation's airports this year, and more sick people are traveling. The Federal Aviation Administration (FAA) reports that about 3,000 IMEs happen annually. One passenger in 40,000 will have an IME; one passenger in 150,000 will require medical equipment or drugs.

The FAA estimates that 15 IMEs happen daily; 75 fatalities occur annually, 80 percent of which are due to cardiac events. Syncope is one of the most common IMEs.

Federal regulations require all U.S. flights to carry

an enhanced on-board medical kit, or physician's kit, with an automated external defibrillator (AED). He described the first-aid kit as "Boy Scout quality," with none of the bells and whistles available in an emergency room.

"The take-home message is to expect the unexpected," said Hinshaw, of Wake Forest University School of Medicine in Winston-Salem, North Carolina, and an assistant medical director of Forsyth County, North Carolina, Emergency Medical Services (EMS).

IME manufacturer MedAire has physicians at its Global Response Center to advise volunteers.

Attendees left the session informed about what will happen if they step forward, the legal implications of getting involved, and the contents of the on-board medical kit, such as a stethoscope, oxygen, intravenous-infusion kit, gloves, and epinephrine.

PA Kathy Swindle, of St. Louis, was aware that there are now AEDs on board large commercial flights, but she learned a lot from Hinshaw's session.



PHOTO COURTESY OF MEDAIRE.

"I would not have known about all the medical equipment on the plane; it's a good thing to know," said Swindle, a PA in the St. Louis University Hospital Department of Orthopedics. "I appreciated the part where he talked about the orthopedic surgeon putting in the chest tube."

Before the flight crew will allow a passenger to intervene, the medical professional will be asked for state-issued medical credentials identification card. Here are some other things to keep in mind from Hinshaw.

- The captain and crew are in charge of the situation.
- Assist the crew — don't take control of the IME.
- Fear of liability should not be an issue.
- Stabilize the patient until landing (simple interventions). If you can't treat the patient in the seat, move the passenger to the front or rear galley or to first class, where there is more room.
- Contact ground medical control if available, such as MedAire, a health and security company.
- Recommend diversion as necessary.
- You cannot pronounce death if the patient dies in flight.

In-flight and hospital diagnosis dovetail 79 percent of the time, Hinshaw said, citing FAA data on IMEs. Passengers' conditions improve 60 percent of the time. On average, physicians respond to IMEs 40 percent of the time and nurses, 25 percent.

There were no statistics available for PAs, he said, because they are included in with physician and "other" categories.

Changes to e-prescribing requirements under Medicare are coming.

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Take the E-Prescribing Readiness Assessment at www.GetRxConnected.com/AAPA



2008 AAPA Census Needs You!

A second mailing of the 2008 AAPA Physician Assistant Census went out to members in early July. If you have not completed the census, please do so. If you have, we thank you.

AAPA also offers an on-line version of the survey for those who prefer this format. The on-line version can be accessed through the Academy's Web site at www.aapa.org. There you will find detailed instructions on how to log in and complete the survey.

If you opted to fill out the on-line survey, you did not receive a paper survey, saving AAPA the cost of postage and printing.

VA REPORT CARD from page 1

and a bipartisan group of senators introduced a bill to improve care for women veterans.

"As more women transition home with the physical and mental wounds of war and step back into lives as mothers, wives, and citizens, the VA must be there for them."

About 180,000 female soldiers have been deployed to Iraq and Afghanistan since 2001. Women make up 14 percent of the active duty, guard, and reserves.

The Women Veterans Health Care Improvement Act of 2008 is aimed at equipping the VA for the long-term needs associated with serving a greater women veteran population, according to Murray's Senate Web site.

PA Kathy Adamson, a retired Air

AAPA's annual census collects a wide range of information, including information about income and fringe benefits. AAPA uses this information to create state and specialty reports that are published on-line for all to access.

To show our appreciation for your participation, AAPA will conduct a random drawing to select three winners from those who participate. Each winner will select from a choice of prizes (including a check for \$500).

To view the results of the AAPA's 2007 census, visit www.aapa.org/research.

Force lieutenant colonel, and former president of the National Commission on Certification of Physician Assistants, was not shocked by the report's findings.

"If you have returning female active duty personnel coming back from [Iraq] with serious injuries, they will get medical retirement and then they will be eligible for care in that facility," she said. "Because of the history, it is not surprising that [the VA] is not prepared to take care of females."

"Historically, women didn't get hurt," Adamson added. "We lost plenty of women in Vietnam, but they were primarily nurses. This is the first time we have had women in combat. They say we aren't in combat, but we are because there is no front line."

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