The Vanguard

Society of Physician Assistants in Otorhinolaryngology – Head and Neck Surgery

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UPCOMING EVENTS

2014 ENT for the PA-C
April 24-27, 2014
Westin Convention Center
Pittsburgh, PA

CONNECT WITH SPAO HNS

From the President

Hello to all of my fellow SPAO members. I hope that this finds everyone in good health and good spirits as 2013 winds down. I am sure most of us fall into the, "Where did the time go?" crowd to some degree or another. 2013 was another successful year for SPAO in terms of our annual conference and promoting our profession. We continue to garner support from multiple aspects of the health care industry, especially the American Academy of Otolaryngology.

From a financial standpoint we are in the best shape we have been in many years. Being financially stable and self-sufficient offers us the ability to consider all options when it comes to partnering with other entities such as AAO or AAPA. This also allows us the opportunity to do bigger and better things with our annual meeting, our website and our management company.

I am also happy to report that we have had a number of new faces step into volunteer roles with SPAO. This is very encouraging as our membership is the lifeblood of our organization. We are only as strong as those we represent. Ryan Marovich, our current Scholarship Committee chair, has been a huge asset in planning our meeting at the University of Pittsburgh. Erin Butler and Andrew Clark have also taken on roles as our new Secretary and Membership Committee chair, respectively.

One of our goals in the next couple of years is to contact members who have fallen by the way-side and those who may not know about SPAO or what we have to offer. One of the questions we often hear from past members or prospective new members is, "What do I get for my money?" Without taking up the remainder of the newsletter to answer this question, I would offer this: The

two biggest things SPAO provides for physician assistants working in Otolaryngology is advocacy on multiple levels and a collegial forum to interact with similar practice characteristics. Advocacy through AAO and the AAPA are crucial to the way we practice. Having a loud voice with these organizations allows us to be heard when detrimental decisions are being considered. There are a number of PAs working in ENT who have never been members of SPAO. They can expect to be hearing from us soon with an invitation to find out what it is we really do.

As 2013 draws to a close I want everyone to know about the exciting meeting we have planned for 2014 in Pittsburgh. We have been able to draw tremendous support from Dr. Jonas Johnson and his faculty at the University of Pittsburgh and Pittsburgh Children's Hospital. This year our meeting faculty will consist of world-renowned physicians from the University of Pittsburgh, West Virginia University, Weill-Cornell and UC-Davis to name a few. I feel this will be one of the most well-received and well-attended conferences to date.

This year we will be offering two educational tracks so that we can extend our knowledge and love of ENT to our primary care colleagues. When you consider how little time is spent in primary care education on ENT disorders, this will be a golden opportunity for us to educate a large audience of emergency medicine, urgent care and primary care practitioners. At the same time there certainly won't be a shortage of up-to-date information for even the most experienced ENT PA. We have added simultaneous lectures so that whether or not you are new to ENT, interested in ENT or an "old salt," there will be something for everyone. The work-shop component of the conference will once again be a major highlight. Jose Mercado has put in countless hours refining the work-shop program and as a result we have added additional specialty work-shops covering audiology, dizziness and airway management. Remember, registration is limited!

Check out the preliminary schedule on-line and spread the word to make 2014 in Pittsburgh our most successful conference to date!

Thank you all for your support and I hope to see everyone in Pittsburgh next April!

Jason Fowler, MPAS, PA-C

SPAO Establishes Page on LinkedIn

SPAO-HNS has finally entered the social media superhighway by establishing an interest group on LinkedIn®.

LinkedIn® has more than 225 million members in over 200 countries and territories. One purpose of the site is to allow registered users to maintain a list of contact details of people with whom they have some level of relationship, called Connections.

Users can invite anyone (whether a site user or not) to become a connection. However, if the invitee selects "I don't know" or "Spam", this counts against the inviter. If the inviter gets too many of such responses, the account may be restricted or closed. LinkedIn allows users to endorse each other's skills. This feature also allows users to efficiently provide commentary on other users profiles – network building is reinforced.

It's a great place to list your job skills, connect with other medical and industry professionals and network as well as catch up on important news. It has "become the de facto tool for professional networking." "LinkedIn is, far and away, the most advantageous social networking tool available to job seekers and business professionals today," according to Forbes.

Everyone is invited everyone to join us and connect on LinkedIn®. Help us spread the word about our annual scholarship and CME meeting.

AAO Liaison Report

Marie Gilbert, PA-C, DFAAPA, AAPA Medical Liaison to the American Academy of Otolaryngology — Head & Neck Surgery

Pre-Meeting/Annual Objectives

- Continue to speak up for PAs in this powerful group of physicians, as they continue to pursue "truth in advertising" laws as they pertain to PhD non-physicians identifying themselves as "doctor" to patients.
- Address any Physician Resources Committee concerns with recent HHS interpretation of PAs' role in hospital

admissions.
- Continue to promote education of PAs.
- Attend a scheduled discussion on a postgraduate otolaryngology program for PAs.

Meeting/Event Highlights & Issues

- I was on the Physician Resource Committee's (PRC) subcommittee reviewing the AAO-HNSF Position Paper entitled, "Scope of Practice of Non-physician Providers." Although I was successful negotiating some improvement in the policy -- removing a negative quote about PAs incorrectly attributed to the American Medical Association and simplifying the language to include support for physician-directed, patient-centered teams -- the overall tone of the policy remains negative. The final policy reads as follows:

  "The American Academy of Otolaryngology-Head and Neck Surgery supports physician-directed collaborative and coordinated team care. However, all members of the healthcare team (Doctors of Medicine, Doctors of Osteopathic Medicine, and non-physicians) should clearly identify their training and/or credentials to avoid any confusion about who is providing the care within the healthcare team. We are in agreement with the American Medical Association definition of a physician as an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine. Non-physician doctoral trained members of the healthcare team should specify the field of their doctorate so as to avoid patient confusion. We strongly oppose state and federal legislation that would inappropriately expand the scope of practice of non-physician providers (those healthcare professionals who are not MDs or DOs) beyond their education and training. Permitting non-physician providers to independently diagnose, treat, and/or manage medical disorders could adversely affect quality of patient care." (Can be found online at Scope of Practice of Non-Physician Providers.)

  As an aside, I believe the source for the negativity is doctorate-level non-physician providers advertising and addressing themselves as "Doctor" to patients, without

clarifying that they are not physicians. So there is a concern that with more PAs attaining doctorates, we will follow suit in calling ourselves "Doctor" with patients. I have made clear several times that AAO-HNSF need not worry that PAs will open their own practices, and remain part of the physician-directed team. On a more positive note, I have invited AAO-HSNF to create a joint document with AAPA supporting team practice, much like those developed with the American Academy of Family Physicians and the American College of Physicians.

- The PRC meeting focused solely on methods defining the correct number of practicing otolaryngologists, with concern about a reduction in residency programs. No other topics were introduced at this event.
- The combined Education Committees meeting discussed continued support of the Cat I CME-earning program from AAO-HNSF's website, "COOL" (Clinical Otolaryngology OnLine), as well as continued sponsorship of the "ENT for the PA-C" conference in 2014. Two tracks will be run: one to focus on PAs in primary care, pediatrics, urgent care/ER and those new to ENT, and the other to meet the educational needs of PAs experienced in otolaryngology.
- The Mayo Clinic, Scottsdale Arizona, presented an instructional course on the postgraduate program they have developed for PAs in otolaryngology. Proprietary components cannot be listed here, but it was well-received as a great basis for plans to start similar programs elsewhere. At this time the Mayo and Air Force programs are the only ones available in this specialty, at a time when fewer residents are in the specialty, and healthcare needs are expanding.
- Other items:
    - A colleague from the Society of Physician Assistants in Otorhinolaryngology–Head and Neck Surgery (SPAO-HNS) and I met with leaders of the American Academy of Otolaryngic Allergy (AAOA), the allergy sub-specialty branch of AAO-HNSF. They agreed to provide speakers for AAPA's annual conference and for CME meetings for PAs in ENT and to work on a discounted PA membership category, which would include access to their online CME program. They are eager to promote allergy education to PAs in primary care and to utilize more PAs in their practices; "We want you to be a big presence," they said.
    - Dr. David Nielsen, CEO and EVP of AAO-HNSF,

announced his impending retirement. Dr. Nielsen has been a staunch supporter of PAs, and it is unclear who his successor will be.
- The leadership now includes several PA supporters/employers: Dr. Richard Waguespack, AAO-HNSF President; and Drs. Wendy Stern, and Sanjay Parikh, who are on the AAO-HNSF board of governors.
- I attended a conference on ICD-10; it is clear PAs will need to be aware of what will be expected of them in documentation of care.

Did the pre-meeting briefing and any support provided (e.g. travel exhibit, materials for distribution) assist you in accomplishing your objectives? If yes, please describe how they were helpful. If no, what additional briefing or resources would you recommend?
The briefing and handouts made me well-prepared and comfortable with discussions in my meetings.

What future emerging trends, issues or opportunities did you glean from this meeting or do you potentially foresee with this physician/specialty organization that could impact PAs or PA practice?
Postgraduate programs for PAs in this specialty will become more commonplace as demands for care exceed the physician supply. However, the physicians are wary of losing the physician-directed model of care.

The coming of ICD-10 will be difficult for PAs unless they are given an opportunity to learn what we will be expected to do for compliance. Even in our "small" specialty, the differences in codes to be used, coupled with the guaranteed rejection of claims filed incorrectly, puts all our practices at financial risk.

What issues or activities would be helpful to coordinate with the related PA specialty organization?
A joint statement supporting team practice by PAs and ENT physicians by AAO-HNSF with AAPA.

Encouragement of specialty and subspecialty physician groups to become more involved in educating PAs in primary care, especially as more PAs will be de-facto primary care providers who are expected to refer to specialists less, and handle problems waiting for specialty care access.

Copy of minutes from BOG Grassroots Committee and General Education Committee are pending.

2014 ENT for the PA-C

April 24-27, 2014
Westin Convention Center
Pittsburgh, PA

The ENT for the PA-C Annual CME conference is co-sponsored by the American Academy of Otolaryngology - Head and Neck Surgery and the Society of Physician Assistants in Otorhinolaryngology / Head & Neck Surgery (SPAO-HNS). This continuing medical education activity is specifically designed for physician assistants, nurse practitioners and medical professionals working in ENT, or interested in learning more about otolaryngology in primary care, urgent care, pediatric, and emergency room settings. Students are also welcome.

The course is organized to provide attendees with an excellent and practical educational opportunity. There will be basic and advanced tracks in all topics. Hands-on workshops will be held on Thursday and lectures will be held Friday-Sunday. Workshops are designed to maximize hands-on learning with concise content and small group settings. This is also the ideal setting to meet, network and socialize with like-minded professionals from across the country.

For more information, visit www.entpa.org/ent_for_the_pac. Registration is now open!

Update on the "COOL" Program

Clinical Otolaryngology On Line is a web-based set of vignettes on various conditions in ENT, developed and published by several of the education committees of AAO-HNSF. To date, 31 articles have been approved by AAPA for credit. AAPA reports that just since May 2013, 384 certificates have been awarded to PAs for a total of 150 hours of Cat I CME. These CME offerings are **FREE!**

Here is the current list of available topics:

Mouth, Neck and Throat

- An Approach to the Pediatric Patient with a Neck Mass
- Chronic Cough
- Dysphagia
- HPV and Head and Neck Cancer
- Indications for Tonsillectomy
- Management of the Thyroid Nodule
- Non-Melanoma Cutaneous Malignancies
- Oral Cavity Lesions
- Pediatric Aerodigestive Tract Foreign Bodies
- Pediatric Neck Abscess due to MRSA
- Pediatric Stridor
- Pharyngitis
- Reflux
- Salivary Disease
- Upper Airway Obstruction - Obstructing Laryngeal Cancer **NEW**

Nose and Sinus

- Allergy Emergency
- Chronic Rhinosinusitis
- Facial Soft Tissue Trauma
- General Exam of the Nose
- Management of Acute Rhinosinusitis
- Nasal Trauma
- Orbital Complications of Rhinosinusitis in Children

Ear

- Adult with Otitis Media due to MRSA
- Bloody Otorrhea
- Ear Canal Obstruction
- Dizziness in the Elderly
- Otalgia
- Otoscopy Cholesteatoma Part I
- Otoscopy Cholesteatoma Part II
- Sensorineural Hearing Loss
- Tinnitus

Use this free source of AAPA-approved CME hours by visiting http://www.entnet.org/EducationAndResearch/cool.cfm.

We All Need To Get Ready for ICD-10

First of all, what is it, and why all the fuss?

- It is an update of our diagnosis codes. The way we code diagnoses is not just for billing, but also to track disease and epidemiology. We have used the ICD-9 format longer much than we should have; ICD-10 has been used by many other countries for more than 20 years. The expense and complicated nature of our health insurance system exerted pressure to delay an update to this change, until now.

So why should I learn about ICD-10? Someone else in our practice codes for me.

- All your coder has to go on is your documentation. A recent audit shows that about 60% of us document well enough to support ICD-10 requirements. Which means 40% of us don't. So if you do not give enough of the required details in your documentation for your biller to code your services correctly, there will be significant delays and reductions in reimbursement to your employer. Any billing done after Oct. 1, 2014 has to be in the new diagnosis code format, or it will not be paid. And we all know what that means.

Okay, so what do I have to do?

- Simply start to document your services thoroughly; starting now will certainly help you make it a good habit by next October. And to those of you who believe do detailed charting, don't stop! But still read below to make sure.
- The documentation concepts are simple: Who, What, When, Where, Why, and How. In "medicalese," that means describing the patient (age/sex/occupation etc.), the complaint ("sacred seven"), acuity, site (LATERALITY IS REQUIRED ALWAYS). For etiology, detail it to the highest level possible (e.g., If you suspect infection, say viral, GABHS, MRSA, etc.). If the problem is related to an accident or injury, detail all the circumstances.
- It is also crucial to list any other medical issues the patient has that are pertinent to the problem you are treating; for example, a diabetic with otitis externa, an epistaxis patient with hypertension and on aspirin therapy. You should not try to "bulk up" your history with items not pertinent, like a broken leg of a cerumen patient.
- Never tell your coders to use an "unspecified" code, or GEMS based code. No payment.
- Be kind to your coders. They will still have to use ICD-9 for Worker's Comp claims, so they will be feeling a bit

crazy already. Just document well, so they don't have to hunt you down.

Where can I learn more? I don't have time for this!!!

- You can earn Category I CME for a 3-hour online ICD-10 program. They even have one for our specialty. See a demo at www.aapc.com/icd10physician.
- AAO-HNSF has a superbill template with many common codes, and a 200-code "crosswalk" from currently used codes to the newer ICD-10 codes, as well as many other good tips and resources for your practice. Go to their coding page: www.entnet.org/Practice/International-Classification-of-Diseases-ICD.cfm
- There are other good (and free!) sources, like CMS website www.cms.gov/ICD10. If you are a person who has to learn "in person," many hospitals, medical societies, and coding companies are offering regional meetings you can attend.

Is there an app for that?

- Yes. Several companies are coming out with an iPhone app for ICD-10, and some EMR companies are coming out with "ICD-10 calculators." You still need to document to support your level of claim and justify any testing you are doing.

Any other words of wisdom?

- Yes. Typos will make your life more miserable, now that codes will be alphanumeric after Oct. 1, 2014. This means if a zero is mistakenly typed with the letter O, or a capital letter I is mistaken for a one, your code is wrong. So brush upon your handwriting or typing, and take a minute to proofread!

SPAO Hosts Booth at 2013 AAO-HNSF Annual Meeting & Oto Expo

Special thanks to Marie Gilbert for organizing and staffing SPAO-HNS' exhibit booth during the American Academy of The American Academy of Otolaryngology—Head and Neck Surgery (AAO-HNS) Annual Meeting and Oto Expo held Sept. 29-Oct. 2 in Vancouver, BC. SPAO also thanks Linda Smith, Myra Baker,

Suzanne Lee, Christine Packer and Kim Lakhan for helping to staff the booth.

AAO reports over 5,500 attendees to this year's meeting with 300 industry exhibitors. Attendees were able to earn up to 27.5 hours of cat I CME.

AAO is the world's largest organization representing specialists who treat the ear, nose and throat related disease. The Academy represents approximately 12,000 otolaryngologist and is also a cosponsor of ENT for the PA-C. All SPOA members are encouraged to join AAO-HNSF.

Pearls from the AAO Meeting

Submitted by SPAO Member Myra Baker Epperson, PA-C

Special thanks to Myra for sharing her lecture notes!

Dysphagia

- FEES - better for liquid dysphagia
- MBS - better for food dysphagia

Multidrug Resistant Infections

- MRSA - always try Clindamycin, Bactrim before Linezolid or Vanco
- Abcess under age 2 - suspect staph
- Clinda becoming more resistant, use clinda + ancef together
- Otorrhea - may be able to overcome resistance with drops.
- If fail drops and oral antibiotic then pull tube
- Consider adenoidectomy in those with chronic rhinorrhea
- Biofilms

Laryngeal Inflammation

- *Causes:*
    - Neurogenic cough
    - LPR/GERD- may have globus and sore throat
    - Chronic cough- ACE-I, lung disease, asthma, reflux, allergic, neurogenic
    - Must suppress cough as cough itself continues to agitate structures
    - Laryngeal allergy – berries can cause histamine

release
    - CRS and reflux- treat reflux even if no sx of LPR, treat minimum of 6-8 weeks before assess efficacy
    - 60% of PND pt had improvement on PPI in absence of reflux sx
    - Reflux and muscle tension dysphonia- co-exist 35%- do PPI and speech

Neurootologic Emergencies

- **Temporal Bone fx**
    - Check facial nerve, audio (conductive loss)
    - 80% of CHL will resolve spontaneously with no intervention
    - If SNHL- no intervention as there is no recovery
- **Facial nerve injury**
    - Most regain full function if partial paralysis without surgery
    - If complete paralysis- better recovery if delayed onset with no surgery
    - If nerve transsected- do surgery
    - If immediate onset and complete paralysis- do surgery
- **CSF fistula**
    - Majority close in 7 days, menigitis risk increases after 7 days
    - Elevate head of bed, bedrest, stool softeners, lumbar drain, closure after 7 days
    - Anitbiotics- no role if no fistula
- **Facial Paralysis**
    - *Viral:*
        - Bells Palsy- rapid onset, pain , taste, hearing distortion
        - Audio, MRI if no recovery after 1 month
        - Steroids, antivirals, eye care, PT
        - Surgery only in poor outcome
    - *OM related paralysis:*
        - Usually neuropraxia
        - Abx and tube
    - *Trauma:*
        - Usually non surgical, steroids, temporal bone CT
        - EMG may show if nerve intact
    - *Facial nerve damage after ear surgery:*
        - Decompress
- **Acute mastoiditis/meningitis:**

    - 67% have normal TM, 15% post auricular swelling, 26% pain, +/- fever
    - Look for breakdown of air cells in mastoid, coalescence
    - Abx, mastoidectomy
- **SSNHL**
    - MRI not urgent
    - Steroids +/- benefit

BPPV

- If Epley doesn't work try Semont. If neither work try headshake +prolonged positioning
- After maneuvers have pt continue with Brandt-Darnoff exercisies for 7-10 days
- Dix Hallpike
- Posterior canal
- Torsional beating to upper eyelid when head turned to affected side
- Posterior canalolithasis in wrong limb may be confused with ant canal
- Anterior canal
- Beating to lower eyelid when head turned to non-affected side
- Do "bend over" technique
- Lateral canalolithasis
- Geotropic nystagmus- stronger to affected side
- Do Gufoni maneuver
- If doing manuever and get continous nystagmus- do head shake
- Lateral cupulolithasis
- Apogeotropic nystagmus, stronger to non-affected side, doesn't fatigue
- Vivid head shaking 10-20 seconds- convert to canalolithasis
- Anterior cupulolithasis
- Down beat nystagmus that doesn't fatigue on Dix to healthy side
- Posterior cupulolithasis
- Up beat or windshield wiper nystagmus that doesn’t fatigue after Dix to affected side
- **Phobic postural vertigo**
    - Fluctuating unsteadiness for sec-min
    - Normal tests
    - Attacks are more common with perceptive or social stimuli

- "What happens if you have 2 glasses of wine?"
- Vestibular rehab, SSRI, Behavioral therapy

Ear Pressure and Pain

- **History important**
  - Otalgia, fullness, pressure, autophony, tinnitus
  - Can they clear with valsalva
  - vertigo
  - Tulio phenomenon- sound induced vertigo
  - Hyperacusis
  - Photo/phonophobia
- **Exam**
  - TM movement with respiration- patulous ET
  - Palate- myoclonus
  - TMJ
  - Allergies, polyps
  - Audio
  - Reflex testing
  - In SSCD reflex present most cases
  - In otosclerosis- absent reflexes
  - VNG if balance complaints
  - Local anesthetic injection of EAC/middle ear- neuralgia
  - Imaging
  - MRI with contrast- unilateral otalgia
  - CT Temporal bone with 0.5mm cuts, with plane of canal- SSCD
- **Differential/Treatment**
  - Space occupying lesion
  - Otic neuralgia
  - Migraine/tension headaches
  - Patulous ET- hx of wt loss common
  - Tx- SSKI, Premarin, PatulEND
  - ETD- can try ear popper
  - Try myringotomy before tube to see if benefits
  - If tube- should be placed anteriorly over ET
  - Cochlear hydrops- low freq fluctuating SNHL
  - SCCD- autophony
  - Otosclerosis
  - TMJ- Bilateal otalgia is TMJ unless proven otherwise
  - Bullous myringitis- mycoplasma
  - Myoclonus- pulsatile tinnitus, myoclonic
  - Try muscle relaxers
  - Perilymph fistula- trauma

Renew Your Membership With SPAO-HNS

A new year starts soon and you have an important decision to make - **should you renew your SPAO-HNS dues?**

Whether it's the educational opportunities; the access to information relevant to PAs; the representation and promotion of ENT PAs in the political, clinical, and regulatory arenas; or for professional development, we hope you will continue to make the investment in your profession and in SPAO-HNS.

You will receive a dues renewal notice via email in mid-November with instructions for how to renew. If you have any questions, contact admin@entpa.org.

AAOA & SPAO 2013

Marie Gilbert and Jose Mercado sat down with Drs. Steven Houser and David Palmer as well as with Jami Lucas, CEO of AAOA during the 72nd Annual Scientific Meeting in Vancouver, BC to discuss ways to increase collaborate on future educational projects.

Mercado was part of a panel discussion, "Building efficiencies in allergy practice" moderated by Dr. Michael Parker, where he highlighted the advantages of utilizing a PA in an ENT Allergy practice. AAOA leadership recognized the significant contribution SPAO plays in providing specialty specific education to physician assistants and offered to help advance this endeavor by providing speakers for AAPA's Annual CME Meeting and ENT for the PA-C.

The meeting was very productive as both groups expressed the desire to work together and develop a mutually beneficial relationship.