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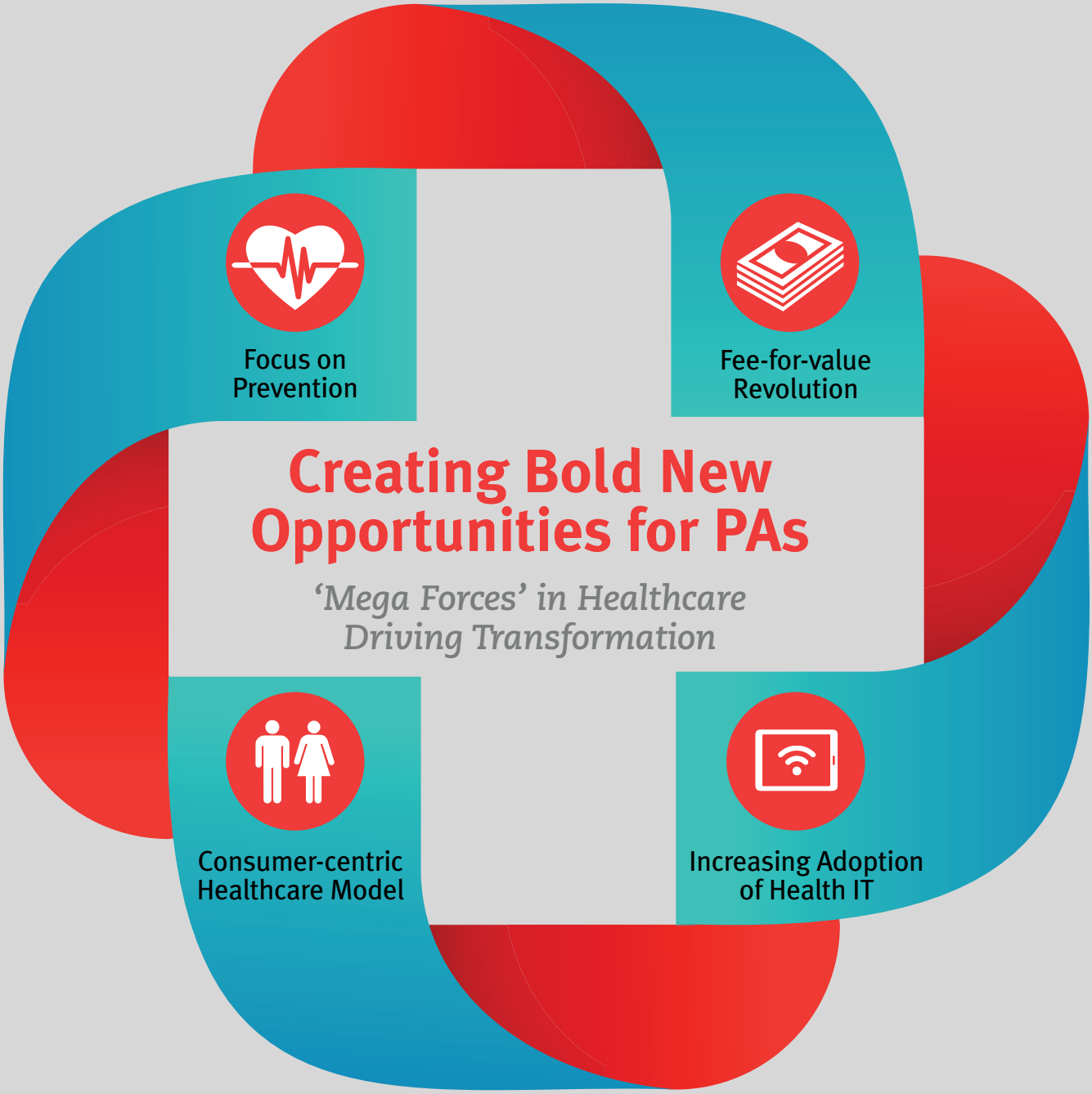

Creating Bold New Opportunities for PAs

'Mega Forces' in Healthcare Driving Transformation

BY JOHN TRUMBO

AMERICA'S HEALTHCARE SYSTEM IS FACING A TOP-TO-BOTTOM MAKE-OVER RIGHT NOW. Dan Forsberg, MPH, PA-C, CPH, one of the PAs profiled in this special issue says, "I don't think anything [in healthcare] has changed this much since 1965," referring to the year when Medicare and Medicaid were introduced. New legislation—such as the Affordable Care Act (ACA), which begins implementation in early 2014—and consumer demand for easier, more affordable access are combining to reshape the way PAs care for patients. Yet, in the eye of the storm, PAs can discover groundbreaking opportunities.

Four 'mega forces' are driving healthcare transformation: (1) the shift from volume care to value care; (2) increasing adoption of information technology; (3) consumer-centric health markets; and (4) the science of prevention. The ACA refocuses the payment structure from fee-for-service to an emphasis on value and outcomes. Forsberg, executive director of an ambulatory surgery center in New York, says his patients are looking for alternatives to expensive, inpatient models of care.

As the nation's healthcare system evolves from volume care to value care and bundled payments, PAs such as Garry J. Schwall, MBA, RPA-C, chief operating officer of Winthrop-University Hospital in Mineola, N.Y., are overseeing the hospital's participation in a Centers for Medicare & Medicaid Services (CMS) bundled payment pilot program, which allows hospitals to work with physicians to reduce costs and pass some of the cost savings back to physicians.

Retail health clinics (RHCs) are sprouting up all over the country, and as PAs fight outdated state regulations to allow for greater flexibility in their practice settings, RHCs are becoming an exciting new frontier for PAs. Gina Venditti, MS, PA-C, a regional training manager for CVS MinuteClinic, says that her patients like RHCs for their accessibility, convenience and affordability.

Finally, Benjamin Franklin was right when he said, prophetically, "An ounce of prevention is worth a pound of cure." Preventive medicine is also a lot less draining on a healthcare system plagued with a shortage of providers, especially those practicing in rural America, such as Karyn Thornton, PA-C. She contracts her services to nine different hospitals, clinics and "one-doc shops" on a locum tenens basis in Montana, where she's usually the only provider in an emergency room.

During this turbulent time in healthcare, PAs can be a force for change—challenging outdated regulations and setting off on unpaved career paths. Read this edition to learn about PAs who are already on their way.

PHOTO COURTESY OF GARRY SCHWALL.

PAs Poised to Make an Impact Across Healthcare

PA Garry Schwall

"I joined the Air Force right out of high school," says Garry J. Schwall, MBA, RPA-C, "because I wasn't quite sure what I wanted to do [with my life]. But I always had a desire to get into the health field." After meeting a PA in the Air Force, Schwall decided that he wanted to explore the PA profession and enrolled in PA school once his service was completed. He admits that "back in the early 1980s, the world didn't quite know what PAs did, what their function was, or whether this profession was going to grow."

After years of clinical practice and surgery, Schwall thought his career would lead him into academics after being offered a full-time faculty position in a PA program. But in 1993 he joined Winthrop-University Hospital in Mineola, N.Y., as administrative director of physician assistant and nurse practitioner services. He was promoted to various positions in senior administration before being named chief operating officer (COO) of Winthrop in March 2010. He oversees an annual budget of more than $1 billion and 7,000 employees.

Garry Schwall, MBA, RPA-C

In addition to his responsibilities as COO, Schwall was an adjunct faculty member for the PA programs at both Touro College and Stony Brook University. He is deeply involved with a number of professional organizations including the New York State Society of Physician Assistants, where he has served on many committees and as the society's past president, as well as AAPA, for which he served as a New York delegate to the House of Delegates.

"I think my background as a PA gave me advantages in many different ways," he explains, including a strong clinical understanding, effective working relationships with many of his physician staff, and an ability to get things accomplished in administration. He tells prospective students that "as long as they develop a good

clinical background it can give them a lot of different avenues and career paths to go into."

He advises PAs that "regardless of what discipline you're going into, try to learn all you can about the other disciplines you're exposed to during your training. You might not know every detail [about a specialty] but you can give your patients a comfort level and explain to them [details about a procedure] and answer a lot of their questions."

Plus, a graduate-level business degree, such as an MBA or a degree in public health, will help PAs wishing to pursue an administrative track. "You can take an MBA degree anywhere you go; it just gives you more options in life."

As healthcare organizations and providers around the country struggle to understand and prepare for the implementation of the Affordable Care Act, Schwall says that his hospital is not yet participating in an accountable care organization (ACO), but they are preparing for various options. "There's going to be a void, especially in the primary care arena, with accountable care coming through; that's going to be your gatekeeper.

"You're going to need a lot of people to manage that [new] broad-based population going forward. The broad base, which you need to grow, are your young, healthy patients who don't take up a lot of resources, but you may not have a lot of resources [in place] to support them and grow them. That's where a lot of [nonphysician] providers are going to play a vital role from an economic perspective. It could be more efficient to have [nonphysician providers] manage that broad-base population, which could be more than 60 percent of your patient base," and Schwall sees PAs playing a major role in this area.

Schwall also acknowledges that urgent care centers will help manage the burgeoning patient population. "We're going to see more of those satellite facilities for minor injuries and medical issues, and that's a good thing for PAs," because it demonstrates the impact the PA profession has across the entire healthcare environment.

Winthrop-University Hospital has been accepted into a Centers for Medicare & Medicaid Services (CMS) bundled payment pilot program, which allows hospitals to work with physicians to reduce costs and pass some of the savings back to physicians. According to the CMS website, under the Bundled Payments for Care Improvement Initiative, organizations will enter into payment arrangements that include financial and performance accountability for episodes of care. These models may lead to higher-quality, more coordinated care at a lower cost to Medicare (Read more at http://1.usa.gov/13IfIPC).

"We have to do something to curb the cost of healthcare," Schwall concludes. "We can't continue on [the current] track—something needs to be done. Regardless, we're all going to be involved in some type of population management program."

Serving the Underserved in Rural America

Karyn Thornton, PA-C

Karyn Thornton, PA-C, fell in love with Montana during a teenage camping trip and knew she would eventually live there. She practices there today, and because she works in such a rural area—and one in need of qualified healthcare providers—she contracts her services to nine different hospitals, clinics and "one-doc shops" on a *locum tenens* basis designed to fill staffing gaps for regular physicians or PAs who are on leave. "In a lot of these towns, if a doctor or a PA wants to go on vacation, they can't because they're the only provider," she says.

How does she manage her hectic, often unpredictable schedule? "I operate on a first-come, first-served basis, and everybody knows I'm going to say yes to the people who call first. I'm always a sucker for private practices that have emergencies. I always try to make those things work because if you have a death in the family, for example, what do you do? You can't abandon your patients.")

Thornton maintains an ongoing contract with Mineral Community Hospital in Superior, Mont., as her base income source. "At Superior, I work every Wednesday, a 24-hour hospitalist/ER/clinic shift, and on Thursday I see clinic patients for eight hours and cover the emergency department," she explains. "That gives me the flexibility for the rest of the week and weekend to work elsewhere. Doing family practice every week gives me some continuity with my patients."

PHOTOS / WISCONSIN STATE JOURNAL

CREATIVE CARE FOR RURAL LIVING

All of the hospitals that Thornton works for are critical access hospitals (CAH). According to the Health Resources and Services Administration (HRSA), "Some of the requirements for CAH certification include having no more than 25 inpatient beds; maintaining an annual average length of stay of no more than 96 hours for acute inpatient care; offering 24-hour, seven-day-a-week emergency care; and being located in a rural area, at least 35 miles away from any other hospital or CAH (fewer in some circumstances). The limited size and short stay allowed to CAHs encourage a focus on providing care for common conditions and outpatient care, while referring other conditions to larger hospitals."

When Thornton covers for a physician or PA who is away from a CAH, she is responsible for the clinic, the hospital and the emergency department. "I have clinic patients scheduled at least an hour apart because you have to make up for the fact that someone's going to end up waiting, whether it's the emergency department patient, the clinic patient or the hospital patient. You're constantly juggling acuity and dealing with a triage system of who needs you the worst *now*."

In a rural area where providers are responsible for everything, she says, "one of the biggest things I see here is that family practice physicians get burned out. They [aren't] prepared to do emergency medicine when they get out of residency, and they constantly have more demands placed upon them than is fair for anybody."

Above: Karyn Thornton, PA-C, wheels an elderly patient out to a family member's truck in rural Montana. Left: Thornton tries to calm a young patient in the emergency room at one of several hospitals where she works in rural Montana.

RECOGNIZING AND AVOIDING BURNOUT

Thornton admits that she was burned out when she decided to leave her PA position at a residency-teaching program in Wisconsin for the wilds of Montana. "I was there from 6 a.m. to 10 p.m. a lot of times, and because I was associated with the residents, people forgot that I was something other than a resident. After working for seven surgeons as the only PA I finally said, 'I gotta start over.'"

Now, she's learned to pace herself, say no when she has to, and take advantage of all that her beautiful location has to offer. "You hike, you do [outdoor] things, and you're not just at home. You have to get away from pagers and cell phones." And thanks to sporadic cell phone service, "those things don't work at my house."

"I think it's very important for people to draw that line in the sand and create an environment where home is a getaway from work," she recommends to other healthcare providers. "Because when you can't

get away from [work], that's when people get burned out and get compassion fatigue."

CHALLENGES OF FRONTIER MEDICINE

Poverty and the lack of accessible healthcare services are common hurdles that Thornton and other rural physicians, PAs and NPs must confront every day. "I practice in five different counties and all of them are far above the national poverty level," she explains. "When I last looked it up, the highest poverty level in the state is in Glacier County at 30 percent, and that's where one of my hospitals is located. I think the lowest county where I work is 18 percent, which is still pretty high." That means that many, if not most, of the patients that Thornton treats don't have insurance. And even if they're covered under Medicaid, they often cannot even afford their co-pay amount.

One of the biggest obstacles to effective rural medicine is transportation. Thornton realizes that her patients often need the care of a trained specialist. But she acknowledges, "The reality is that person doesn't have gas money to drive an hour and a half to go see [a doctor], and that specialist won't take patients who don't have insurance. So, I do a lot of phone consultation with doctors and surgeons to help manage a patient's care where they live instead of shipping them down the road."

Other challenges, though not limited to rural areas, include narcotic pain medication abuse, high teenage pregnancy rates and educating overworked hospital staff. "At the hospital I'm at today," she says, "there's only one night nurse who has to cover everything: the emergency room, the inpatients, the phones, everything. I'm often teaching them how to deal with that [patient or situation] first, and what their resources are. It's odd to think my trauma team with the surgical service had more people than could fit in a room and now it's often a team of two or three individuals."

FUTURE OF THE PA PROFESSION

Thornton is outspoken when asked where the PA profession is headed. "Becoming a PA is the greatest thing I've ever done. I always had a passion for emergency medicine and I love the value of assessment and hands-on care. The fact that we follow a medical model is the way it needs to be. But we have to be careful because I see us getting farther and farther away from touching the patient, and doing more CT scans and MRIs and tests like that, which we do for medical and legal reasons, but maybe we do [them] because it's simpler than taking the time to put that big clinical picture together."

She also advocates for change in state regulations to allow for more flexible PA practices. "Say I want to do a free clinic [for] patients who can come and see me at the fire station in my rural community for four hours every Thursday. I can't do it without having a physician who wants to do it with me. I think there needs to be some latitude. I can check patients' blood pressure and do generalized health maintenance and education without a physician looking over my shoulder. There's even more we could do if the individual states make that sort of thing possible."

In the end, Thornton says she chose to become a PA. "I didn't want to be stuck in a niche of always having to do a certain kind of patient care. The knowledge base that you get in the PA educational program made me a better provider."

PHOTO / WILL VRAGOVIC

Quality Healthcare On the Go

Gina Venditti, MS, PA-C

With a degree in physical therapy, Gina Venditti, MS, PA-C, always knew she wanted to help people. She became a physician assistant in 2003 in Florida working in various medical fields including emergency medicine, family practice and oncology. Now, she's a pioneer in retail healthcare. "Retail medicine has really only been around for about 10 years," she explains. Venditti was a provider then became the state practice manager for Parekh MinuteClinic of Nevada, but recently became a regional training manager for MinuteClinic.

Gina Venditti, MS, PA-C

Though still in its infancy, retail medicine has taken off in a big way. With growing strains on the U.S. healthcare system—potentially tens of millions of newly insured patients when the Affordable Care Act is fully implemented, matched with fewer primary care physicians (PCPs)—creative alternatives to the traditional practice model are becoming more and more attractive to patients who can't wait weeks or months for an appointment with their PCP.

According to a Porter Research report, "Retail health clinics (RHCs) are flourishing. In a healthcare environment where greater access is often the name of the game, a growing number of industry leaders now see these clinics as valued partners in providing preventative and primary care services."

According to Venditti, patients like coming to retail clinics for the accessibility and convenience, including evening and weekend appointment times and "because [PAs] spend more time with them." RHCs are also more affordable for patients with or without insurance. "For somebody with a sinus infection, they could spend hundreds of dollars in an emergency room or urgent care [facility], or about $80 to $100 with us."

She added that MinuteClinic offers affordable, convenient, quality healthcare, and treats minor medical problems, performs vaccinations, U.S. Department of Transportation physicals and school, sport and camp physicals. MinuteClinic is also focused on wellness initiatives including hypertension evaluation, diabetes screening and hyperlipidemia screening. RHCs are partners in healthcare. MinuteClinic has 27 affiliates throughout the country including the University of California at Los Angeles and Cleveland Clinic.

Though RHCs seem to offer promising options for patients, the options for PAs can be much more limited. Because of state regulations and the interpretation of those regulations (many retail clinics are considered ambulatory care sites), it is difficult, if not impossible, for PAs to practice at RHCs in most states. Venditti says that MinuteClinic currently employs PAs in five states: Nevada, Texas, Minnesota, North Carolina and Rhode Island. Almost every week, she hears from PAs who want to work in RHCs but cannot because of state limitations. "My biggest advice to them is to get involved with the legislative process. It's slow, archaic and sometimes antiquated, but you have to."

The payoffs could be significant for PAs as patient access to healthcare is set to increase. "Retail healthcare is strategically aligned to help the tens of millions of new patients who will be getting healthcare next year," she explains, adding that MinuteClinic is expanding by opening in three new states this year, including Hawaii, New Hampshire and Louisiana and expanding in current states and markets requiring recruitment and hiring of hundreds of new providers.

Venditti loves the flexibility and career options that retail medicine has presented her. "Most often, whether you're a PA or an NP, after you graduate you go to work at a doctor's office or a hospital, but there aren't many managerial roles out there for us. This is a great opportunity for a PA to get into leadership, management or even corporate positions."

GET INVOLVED!

Earlier this year, Gina Venditti formed her own special interest group called the **Society for PAs in Retail Healthcare (SPARH)** to advocate change in state regulations and help get more PAs working in retail medicine. Interested in learning more and joining her effort? You can contact Gina at *Gina.Venditti@CVSCaremark.com*.

To learn more about AAPA's state and federal advocacy programs, visit us at *http://bit.ly/NWRSbk*.

Filling the Void in Primary Care

Verdale N. Benson, PA-C

Verdale Benson, PA-C, is one of the first PAs to take advantage of a new Physician Assistant Residency Pilot Program in Primary Care at the Atlanta Veterans Health System. He began his one-year PA residency at the Atlanta Veterans Affairs Medical Center (VAMC) in January 2013, having just graduated from Emory University's PA program in December 2012.

One of only six such programs in the country, the residency was developed by a former Emory PA program director, Virginia Joslin, PA-C, MPH, in partnership with Atlanta VAMC Associate Chief of Staff Norberto Fas, MD, MBA. The two proposed a residency program designed to help PA graduates become effective leaders and primary care team members in the VAMC system of community-based outpatient clinics (CBOC) delivering care to the patient population of the U.S. Department of Veterans Affairs (VA) using the patient-centered medical home (PCMH) model.

This training program, "the first PCMH-focused and primary care PA residency in the country," features 12 months of didactic and clinical education including "PCMH concepts, clinical leadership, systems-based practice, chronic disease management, practice process improvement, patient engagement in their own care, and seamless, timely transitions of care between primary and specialty care" (Learn more at http://bit.ly/17K4Dka).

"The reason for the PA residency," Benson explains, "was the disparity between healthcare need and the ability to meet that need, even out of the private sector, with a shortage of primary care physicians and providers across the board. The primary care clinics, the CBOCs, are being overrun [by limited resources]. The thought was to use this residency to recruit more PAs into the VA system in order to help bridge those needs."

He adds, "It's both sad and exciting. Sad that the need is not being currently met but exciting if you look at this problem as an opportunity—an opportunity to bring more healthcare providers into the system, specifically mid-level providers, to help meet that need. The opportunity for us as PAs is out there."

CHARTING NEW TERRITORY

Benson is charting new ground not only as a PA but as a veteran of the U.S. Army as well. "One of the big reasons I chose to do this residency was not *just* to make myself a better provider but, obviously, I have a passion for the patient population." As a medical platoon leader, Benson deployed with his first unit to Kandahar, Afghanistan where he served for 12 months supporting combat operations.

After earning the rank of captain, he deployed a second time for 15 months in Kirkuk, Iraq, providing logistics support and operations planning. After getting out of the service and beginning his medical training, Benson loved working with the fellow veterans he encountered at the VA hospital. "I did a [student] rotation here at the VA, and I found that it really made my day whenever I [met] a veteran patient."

He is also taking advantage of his VA residency to explore other specialties in depth, an opportunity that most PA students don't get "because you only have 10 rotations and you can't do everything while you're in school. For example, I did a month in gastroenterology where I worked alongside a first- or second-year GI fellow and a resident. I saw patients and consulted the medical teams, and did colonoscopies and endoscopies [which gave me] advanced training that you don't have time to get when we're students."

He goes on to explain that certain specialties, such as surgery or emergency medicine, want PAs to have two-to-three years of experience. Because a residency provides a concentrated amount of hands-on training, a PA can accumulate two or more years' worth of experience in a single year. Emphasizing the didactic as well as clinical requirements, Benson says, "Being in an academic environment, constantly learning, constantly having different staff teaching me medicine from their different points of view has given me an edge in this field. You're more marketable."

"It's a pilot so we're building this as we go along, changing the minds of physicians and other medical professionals within the VA, because this is really new to them as well. What exactly is a PA resident? Are you certified? Are you a student?" That confusion, he says, can be mitigated once PAs start filling urgently needed healthcare positions. "The size of our profession is going to reflect the size of the problem we fill, or help correct, or solve. If we increase our numbers and [help] fill that void, you're not going to have to feel like you have to explain what a PA is any more—everyone's going to know."

A BRAVE NEW WORLD

Benson warns PA students considering a post-graduate residency to be clear about their goals and expectations. "You're going to see your [former] classmates making two-to-three times more money than you." But as the American healthcare system continues to wrestle with change and provider shortages, the rewards can be great. "The future is very bright," he says. "Our profession fills a need, and that's the most exciting place to be in a career. We have the training, we have the ability."

"My favorite part of a patient encounter," he continues, "is the patient education, explaining to the patient why this medicine works, why you have this symptom, what's going on. You really need to approach it as a *team* aspect, it's not just me the medical provider telling [a patient] to take this or do that. Once we give ownership to the patient, I think we'll see an increase in things like compliance, taking their medications, and making lifestyle changes because they have the power, they have the knowledge, they know *why*."

PAs: The Perfect Bridge Between Medical and Mental Health

Tracy Keizer, PA-C

Tracy Keizer, PA-C, practices in the 100-bed adult psychiatry unit of the Regions Behavioral Health System in St. Paul, Minn. Regions is a safety-net hospital providing care for patients with limited or no access to healthcare because of financial circumstances, insurance status or health conditions. "The specific unit where I work focuses on mental illness and chemical dependency," Keizer explains. "I see patients with co-occurring medical and psychiatric diagnoses, and work alongside a psychiatrist on a team." She's also in charge of the administrative duties of the PAs and NPs within her psychiatric services unit.

Keizer and her psychiatrist partner share responsibility for the 20 patient beds in their unit. She becomes the primary provider for the patients under her care, performing an intake and admission interview, managing their progress, planning follow-up appointments, and arranging for their eventual discharge. "I'm the one on the team making decisions about medications, referrals, family meetings, motivational intervening," she says, "and if someone needs to be committed through the civil courts I initiate that process along with my supervising psychiatrist."

In addition to her clinical practice, Keizer directs Regions' psychiatric fellowship program—a 12-month, postgraduate course for PAs and NPs that began in 2008. She was a fellow herself before being asked to direct the program, which currently only accepts two fellows each year. "I get a lot of interest from PAs who have done primary care for 10 or 15 years and want to do a psychiatry fellowship because they realize how much of their practice involves mental health," she says. "They're coming to learn psycho-pharmacology, therapy, how to understand medication management and how to meet those needs in their primary care practices."

COUNTING ON YOUR TEAM

Keizer was taking premedical courses at Dordt College in Sioux Center, Iowa, when one of her classmates introduced her to the idea of becoming a PA. "When I started looking at PA schools and what a rich education they offered, I thought it would be a great role for me. And as I went through school, it was continually reinforced to me that [our] team-based approach is really going to be the answer to a lot of the [challenges] we have in healthcare, and the shortages we face, so I felt more and more convinced that this was the role for me."

Tracy Keizer, PA-C

PHOTO COURTESY OF TRACY KEIZER

She adds, "I went into psychiatry because I think that the patient population is a fascinating one. It's the idea of not being black and white; there's no lab order [to determine] if somebody has schizophrenia. Learning about the mind is fascinating."

Each morning, Keizer and her psychiatrist partner meet to discuss patient progress, and collaborate on medications, different approaches to therapy or methods of engaging with patients. Nursing staff, social workers and occupational therapists round out the psychiatry team. Keizer notes that the general medicine training she received in PA school helps her provide key clinical support to her team, including medication options and potentially dangerous drug interactions. "Having a PA on our team with a general medicine background who understands both [the clinical side as well as the specialty side] makes it easier, more efficient and is a good use of resources."

Being able to count on the members of your team is equally vital, especially in situations with patients who are mentally unstable. "It's knowing where your boundaries are, knowing your comfort level and being able to communicate well with your team. You have to feel confident—in yourself, in what you're doing and in your team."

FILLING THE GAPS IN HEALTHCARE

Keizer hopes that more PAs consider practicing in psychiatry, explaining that "there's a huge need for more psychiatric providers in the mental health field—in big cities but also in rural areas. There are people waiting months and months to see a psychiatric provider. It's a huge crisis, and I think PAs are a great way to fill this gap."

She goes on to say, "Training PAs to feel more comfortable in the psychiatric setting is a great idea as well as getting psychiatrists more comfortable with a team-based approach [in order to] supervise more patients with the help of a PA. I think PAs are the perfect bridge between medical and mental health."

IMPROVING CONTINUITY OF CARE

At Regions, Keizer has been working closely with the hospital medical director to begin providing seven-day care for psychiatric patients. "We are moving toward a model of having a psychiatrist and a PA work together on each unit to extend the services of each psychiatrist," she says. "Having seven-day-a-week coverage at a psychiatric hospital is huge; it's not something that's done around the country, but we're hoping that it catches on because it's better for patient care, families appreciate it, providers are there all day long to answer calls, answer questions, and it will improve continuity [of care]."

She emphasizes the growing shortage of psychiatrists, which mirrors other areas of practice. "We do have quite a few psychiatrists in residency who then move onto subspecialty fields like child psychiatry or forensics or geriatric psychiatry and move out of general psychiatry. Also, many of them want to work in urban areas, and we just don't have enough in rural areas. It's very similar to primary care, which makes PAs in psychiatry [all the] more necessary."

A passionate advocate for her profession as well as her area of practice, Keizer says, "Psychiatry has been the ugly stepsister of medicine and it's time for that to stop. Psych patients are dying far too young because of their comorbid medical conditions. PAs, with our strong background in medicine, can treat both medical and psychiatric diagnoses. Our strong commitment to the physician-PA team is what makes this model work."

PHOTOS / P24: BRAD BARKETT, P25: FRED GREAVES

Discovering the Breadth of the PA Profession

PA Dan Forsberg

"My initial draw to the world of the PA was, and still is, the breadth of information required to practice," says Dan Forsberg, MPH, PA-C, CPH. Eager to enhance his own understanding of medicine, Forsberg entered a surgical residency program after graduating from PA school.

Forsberg's career took a turn toward administration several years later while he was practicing plastic and reconstructive surgery. When the department's director needed to take an extended absence, Forsberg suddenly found himself responsible for the department's budget, duty schedules and day-to-day operations of the medical staff.

In January 2013, after more than years as administrative director of surgery at Forest Hills Hospital in Queens, N.Y., Forsberg was named executive director of Melville Surgery Center in Melville, N.Y.

With a career featuring an eclectic mix of private practice, higher education instruction and admin-

Dan Forsberg, MPH, PA-C, CPH

istration, he believes that the broad-based training PAs receive equips them to understand and manage many different aspects of healthcare, which is attractive to many employers as the profession continues to be transformed.

Forsberg uses the analogy of a restaurant when describing the depth of knowledge that PAs bring to a practice or facility. "Someone who has worked in a restaurant as a dishwasher, prep cook, busboy, wait staff and bartender knows what each of those [positions requires], and you understand the business from a deeper level. I think that's what clinically active PAs bring to a practice or a facility that perhaps those who remain isolated in other realms [of healthcare] may not."

As executive director of a free-standing ambulatory surgery center, Forsberg has noticed an increase in its use and in patients' desire to be cared for in an outpatient setting. "It's safer, cleaner and more efficient. Patients are happier being cared for in this type of setting, people are happier to be rehabbing at home, there are fewer complications when they take their own medications. This is where healthcare should be going.

"I think you'll find there are more and more health organizations looking to develop accountable care models and joint venture situations, or some sort of ambulatory surgery center as part of their ACO," he explains, "because they are not going to be able to keep patients happy, healthy and safe with just the current inpatient, tertiary care kind of model." Forsberg's facility is not currently involved with an ACO but is in negotiations with various organizations.

When asked what advice he would offer PAs—either those getting ready to graduate from their PA program or even PAs who have been practicing awhile and may be looking for a new direction—Forsberg recommends learning every detail of where they work and how the "business of medicine" is paid for in that practice setting. "If you do, you'll gain a better understanding of what your employer needs, and you'll become a far greater asset to your practice or institution."

"This is a particularly tenuous time in medicine," Forsberg notes. "I don't think anything has changed this much since 1965."

He encourages PAs to become more engaged with professional societies and to take part in molding the political landscape to the benefit of patients and the profession. "If we want to practice in the future, we're going to need to be engaged in this political climate to ensure that we're not dismissed [in the conversation]. We really should be focused on caring for our communities; because of our training and how we practice, we know all of those aspects [of healthcare practice] and we have a lot to bring to the table. We shouldn't be afterthoughts."

Finally, Forsberg stresses that even if a PA chooses to go into a career in administration like he did, "You don't need to entirely remove yourself from clinical practice. You can do volunteer work, or you can go on medical missions. You can cover a practice part time, or do any number of clinical things. There are plenty of people in the world who need providers to care for them."

There are many ways you can increase your involvement in the PA profession no matter where you are in your career. AAPA gives members easy access to a variety of activities that help strengthen the profession and spread the word about the important work that PAs do. Plus, it just feels good to volunteer your time and give back to your community.

Take a moment and visit: *http://bit.ly/14uqS0H*

Aerospace Medicine: The Final Frontier for PAs?

Randall Owen, MEng, MSHS, PA-C, CST

Randall L. Owen, MEng, MSHS, PA-C, CST, has gone where few PAs have gone before—NASA. In April of this year, just weeks before graduating from The George Washington University PA program, he became the first PA student to complete a four-week clerkship in aerospace medicine at NASA's Johnson Space Center (JSC) in Houston, Texas. The clerkship gives five or six students in their final year of medical school the opportunity to work alongside NASA flight surgeons, attend lectures and become familiar with the medical aspects of International Space Station (ISS) operations, design and function.

Randall Owen, MEng, MSHS, PA-C, CST

He is also the first PA to be offered a spot in the "Principles of Aviation and Space Medicine" course given each summer at the University of Texas

PHOTO / COURTESY OF RANDALL OWEN

Medical Branch in Galveston, Texas.

After receiving his bachelor's degree in physics, Owen planned to go to medical school, but starting a family sent him in a different direction. After working for 25 years working in engineering and information technology, he realized it was time for a change. It was a chance to finally get into medicine. He enrolled in a full-time, one-year course to become a certified surgical technologist while simultaneously taking prerequisite courses for PA school at night. "When the time came for me to decide what to do next," he says, "there was no question in my mind: I wanted to become a PA."

Owen brought a wealth of unique experience to his PA training including advanced degrees in electrical and mechanical engineering as well as four years as an adjunct professor in computer science. Along the way, he worked for Hughes Aircraft, StorageTek (now a subsidiary of Oracle), Cisco, IBM and Amgen. This background, while atypical for PAs, was very similar to that of NASA flight surgeons and astronauts.

"NASA is fundamentally an engineering organization," he says, "and I think when they looked at my resume they saw a guy with 20-plus years of engineering experience as well as significant midlevel medical training." While a few astronauts are trained physicians, all astronauts receive EMT-paramedic-like training so they have basic medical abilities to help stabilize a crew member in an emergency situation. Plus, approximately 65 percent of the research conducted aboard the ISS is medical or life science related.

Participants in the aerospace medicine clerkship are required to complete a research project based on an area of space medicine. Owen focused his research on entry motion sickness (EMS), which astronauts often experience when returning from the microgravity environment of space to Earth's one G-force atmosphere. EMS can produce an array of debilitating symptoms including dizziness, nausea, headache, fatigue, reduced muscle strength, impaired coordination, and even changes in vision and the size of an astronaut's heart as it adjusts to the pull of gravity.

The longer astronauts are away from Earth's gravitational field, the longer it takes for them to return to normal. Owen's research found that "for three-to-six-month missions, the EMS symptoms seem to require a minimum of a few days to up to 30 days to fully resolve." He explains that "EMS will become an even greater concern when we start going off on longer-duration missions to other bodies, whether it's the moon or Mars or some other distant place. Once astronauts arrive, they will have limited medical resources available to them so we need to be sure they can remain healthy and complete the mission."

While he may not realize his ultimate dream of becoming the first PA in space, Owen has realized his dream of practicing aerospace medicine: He recently accepted a position as a medical operations specialist with NASA working in JSC space flight operations. His responsibilities will include performing duties as the lead for space medicine training for assigned ISS expeditions, training astronauts and flight controllers on various medical procedures, working in the Houston Mission Control Center guiding the astronauts in performing in-flight medical procedures (such as phlebotomy, ocular health or ultrasound), supporting EVAs as a medical monitor (e.g., vital signs, electrocardiograms), and serving as the subject matter expert (SME) for all space medicine remote guidance activities.

In addition to his aerospace medicine clerkship, Owen's broad-based PA training included clerkships in surgery, OB/GYN, psychiatry, internal medicine, neurosurgery, emergency medicine, primary care and pediatrics. He is quick to encourage practicing PAs and students that "if there's an area of medicine where PAs haven't historically practiced, or if there's an area that you're interested in, research as much as you can and go for it. I ran into obstacles along the way, but it's like anything in life: It's a question of desire and perseverance. Set a goal and stay focused."

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