YOUR VOICE. YOUR PROFESSION.

MICHIGAN PA

VOL. 40 NO. 1

MARCH 2019

MC3 Program Offers Psychiatric Help for Primary Care Providers

— Page 14

MICHIGAN PA

YOUR VOICE.
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MICHIGAN ACADEMY of PHYSICIAN ASSISTANTS

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Contents

Your Newsletter Editor's Corner

DEAR MAPA MEMBERS,

I hope you are doing well and getting through this awful winter! Hopefully a beautifully warm spring is right around the corner...

Your newsletter team has worked hard to put together another great edition! We've included articles helpful in daily practice including an introduction to the Michigan Child Collaborative Care (MC3) program which is a great tool for primary care providers who treat patients with mental health disorders. Our very own Julia Burkhardt PA-C, puts a spotlight on PA John McGinnity giving us a peek into his amazing career as a PA leader. An update from Michigan's Department of Licensing And Regulatory Affairs (LARA) regarding their new PA licensing system is detailed and much more!

We are always looking for articles to include in the newsletter and we want to hear from you! Please consider sharing your thoughts or opinions, a brief case report, essay or an article for any of our newsletters. Also, if you know of a unique PA to put the spotlight on please contact me or Julia Burkhardt (julia.burkhardt@michiganpa.org). I can be reached at kate.schisler@michiganpa.org.

As always, we love hearing from Michigan PAs who want to volunteer for a MAPA committee (hint-hint).

Best,

Kate Schisler, MSM, PA-C, MichiganPA Newsletter Editor-In-Chief,
MAPA Treasurer

From the President's Desk

We are well into the first quarter of the new year and the executive board and the committee on MAPA management evaluations have been quite busy. Our look at our Fall Conference has continued to draw more attendees and help us to provide the services and value to our members, with the financial support we get from putting on a great conference each year. CME Chair Ashley Malliet, PA-C, Event Manager Erin McLaughlin, and Academy Administrator Alecia Powell, CMP from AMR have been amazing thank you again for all you do. The work of our Region Representatives who attend board meetings and conference calls; host region meetings; assist their members; and help with PA 379 and rules being implemented by the Medical Board, Pharmacy Board, and Osteopathic Board is truly appreciated!

MAPA is having a membership drive and we are asking our members to connect with their colleagues and encourage them to become members. If you are looking for leadership development or looking to get involved with committees, events, or other volunteer work, we have a place for you at MAPA. We expect all members of our committees to become MAPA members. Ronna Zeluff, PA-C, Membership Committee Chair can be contacted at ronna.zeluff@michiganpa.org.

Our Spring Conference at Eastern Michigan University was an incredible time for learning, networking, and fun. Please feel free to email me at karl.wagner@michiganpa.org if you have any questions or are interested in getting involved.

Karl G. Wagner, Jr. PA
MAPA President

CALL FOR CANDIDATES

to the 2019-2020 MAPA Board of Directors

Are you interested in becoming involved in Michigan's PA leadership? If so, MAPA wants you! There is no better way to develop both personal and professional leadership skills than by serving on the Michigan Academy of Physician Assistants Board of Directors. This volunteer leadership commitment challenges you to go beyond the required ideals for your profession and provide ideas and solutions that make an impact to the Academy that represents Michigan PAs. Board service allows you to hear different perspectives on issues and helps you form contacts for your professional growth. Volunteer participation on MAPA's board will allow you to meet and work with professionals who have similar interests and help to advance our State Academy.

MAPA is seeking nominations for the following positions for the 2019 - 2020 term:

President-Elect (total 3 year term: President-Elect, President, Immediate Past President)
Secretary (2 year term)
Regional Representatives - Regions 1, 3, 5 (2 year term)
Chief Delegate to AAPA's House of Delegates (1 year term)
Delegates to AAPA House of Delegates (1 year term)

Candidates seeking to be placed on the election ballot must submit a statement of interest to the Nominations Committee C/O the MAPA office ***no later than April 1, 2019.***

Submitted information in the form of a cover letter with resume should include: biographical data, eligibility for office, credentials, and election platform. This information will be distributed electronically to the voting MAPA members along with the ballot.

To view nomination requirements and duties for all open positions, please visit the Elections page on the MAPA website.

To sustain the atmosphere of MAPA's BOD, we need creative and energetic individuals that will help promote quality health care delivery to the PA profession in the State of Michigan. Join us and help make a difference in our chosen profession!

E-mail your completed submissions to:

mapa@michiganpa.org. Or mail paperwork to:

Nominations Committee
C/O MAPA
1390 Eisenhower Place
Ann Arbor, MI 48108

PSYCHIATRIC PAs AND THE ASSERTIVE COMMUNITY TREATMENT (ACT) TEAM

SARAH SCANTAMBURLO, MSW, MS, PA-C

"*…there are not schizophrenics, there are people with schizophrenia. And each of these people may be a parent, may be your sibling, may be your neighbor, may be your colleague*".

> — *Elyn Saks,* Associate Dean and Orrin B. Evans Professor of Law, Psychology, and Psychiatry and the Behavioral Sciences at the University of Southern California Gould Law School, & Person with Schizophrenia

For just shy of a decade, I have worked in the Community Mental Health (CMH) arena as a Psychiatric Physician Assistant. The profession has been an honor and a lesson in reward and humility. There have been wildly amazing days when a patient moves into their own apartment or lands their first job, finally getting to celebrate the autonomy that they yearned so long to procure. These are tempered with the days where we lose amazing souls to the cruelty of the streets, or they succumb to the immeasurable depths of their symptoms and die by suicide. I have grappled over the years how we as a profession can best serve those that the disease appears to engulf.

Regardless of where we were reared, we all came from the same block of dreams for a future. While these aspirations are wildly different, the common theme is everyone yearns for love, happiness, and a sense of community. Life is never a straight trajectory. There can be twists, turns, and life circumstances. During those moments we all have choices. This tends to the roadmap of our lives.

One thing I can boldly guarantee is that no one ever chose to have schizophrenia. No one ever chose to have myriad other mental health disorders that mentally and physically malign themselves from the community where they once belonged. A cursory glance in the media shows that it is more than evident that mental health services are sorely needed and there is a large disparity between the amount of people that desperately need to be served and available medical providers. The numbers alone indicate we are in a crisis and the gap only continues to widen.

Within CMH, the patients with the highest acuity are aligned with the Assertive Community Treatment (ACT) team. It is also utilized for those that may have transferred out of an inpatient setting, yet may necessitate a higher level of care, but would benefit from a more autonomous, quality focused life than a hospital setting. This is an evidence-based program that provides patients with intensive community treatment, as well as developing and coordinating natural supports, in a multi-disciplinary team approach with frequent community contacts to achieve movement towards recovery and an improved quality of life. A key component is its flexibility and the mobile services are available on a 24/7 basis.

ACT team services truly embody a holistic approach by assisting the patient in any variety of spheres where the patient would benefit, including, but not limited to, therapy, evaluation and management, housing, or even employment services. The ultimate goal of the program is to empower patients with a diagnosis to live their most autonomous and goal-oriented life as possible and utilize coping skills and the community in which they reside.

"Those receiving ACT were more likely to remain in contact with services than people receiving standard community care (OR 0.51, 99%CI 0.37-0.70). People

allocated to ACT were less likely to be admitted to hospital than those receiving standard community care (OR 0.59, 99%CI 0.41-0.85) and spent less time in hospital. In terms of clinical and social outcome, significant and robust differences between ACT and standard community care were found on i. accommodation status, ii. employment and iii. patient satisfaction" (Lockwood & Marshall, 2000).

The patient to staff ratio is small, typically about 1:10, staff are cross-trained with each other as is feasible and readily available to consult with one another, and interventions are monitored and adjusted to meaningfully ensure that the support of patient oriented and appropriate to the circumstances (Phillips, et al., 2001). The team may consist of a RN, QMHP (SUD specialist, LLMSW, LMSW, LPC, LLPC, and Certified Peer Specialist), and a clinical provider (MD, PA, NP). Of note, Psychiatrists, Nurse Practitioners, and Physician Assistant positions are exclusive of the ratio.

To better serve patients in the CMH system, and aptly reflect the contributions and skillset of Physician Assistants in Psychiatry, the State of Michigan has recently amended the Medicaid (MSA) that now allows Physician Assistants to employ services as ACT providers.

"A physician assistant may perform clinical tasks under the terms of a practice agreement with a participating physician. The physician assistant must hold a current physician assistant license and a controlled substance license in Michigan. The physician assistant is not counted in the staff-to-beneficiary ratio. Typically, although not exclusively, physician assistant activities may include team meetings, beneficiary appointments during regular office hours, evaluations, psychiatric meetings/consultations, medication reviews, home visits, telephone consultations and telepractice".

The MDDHS establishes the guidelines for approval and certification for all members of an ACT team. To become ACT certified, a Physician Assistant in the SOM would complete the course, 'ACT for Physicians and Nurse Practitioners' on the website: improvingmipractices.org. This is a one-time completion.

While dichotomized, physical health and mental health are in the same arena: health. As with many diagnoses in either sphere, there may not be cures, but rather best evidence-based practices and modalities. Allowing physician assistants the same clinical tasks as psychiatrists and nurse practitioners with ACT, the SOM is employing a greater number of providers to care for patients with severe mental illness. Those allocated to an ACT team program, versus those receiving standard community care, were more likely to be living independently (Marshall & Lockwood, 2000). There are solid indications that this program is not cost-prohibitive. There have been over 25 randomized controlled trials that ACT is "effective in reducing hospitalization, is no more expensive than traditional care, and is more satisfactory to consumers and their families than standard care" (Phillips, et al., 2001). To reflect again to the sentiments of Ms. Elyn Saks, it is about time we move to meet our parents, siblings, neighbors, and colleagues, where they are and help empower and reintegrate them back into the community fold where we all originally harkened our hopes and dreams.

SOURCES:

- https://www.cnn.com/2012/08/12/opinion/saks-mental-illness/index.html (Retrieved February 7, 2019).
- Marshall, Max & Lockwood, Austin. (2000). Assertive Community Treatment for People with Severe Mental Disorders. Cochrane database of systematic reviews (Online). 2. CD001089. 10.1002/14651858.CD001089.
- Phillips, S.D., Burns, B.J., Edgar, E.R., Mueser, K.T., Linkins, K.W., Rosenheck, R.A., et al. (2001). Moving assertive community treatment into standard practice. Psychiatric Services, 52(6), 771779.

MAPA SPRING CME CONFERENCE HIGHLIGHTS

On March 2nd, MAPA hosted their 8th annual Spring CME Conference at Eastern Michigan University. This event drew over 110 attendees from across the state of Michigan. Educational presentations such as "The Opioid Crisis and New Opioid Guidelines" presented by Dr. Carl Christensen and "Cognitive and Psychological Evaluation of Patients with Suspected Dementia" by Dr. Tyler Roskos were just a few of the engaging topics!

"Great conference! Speakers were wonderful and informative!"

The CME Committee is hard at work planning for the 2019 Fall Conference. If you are interested in presenting, exhibiting or volunteering please contact us at events@michiganpa.org. Mark your calendars for October 10-13, 2019 at Grand Traverse Resort & Spa. Visit www.mapaevents.org for information as it becomes available!

WHAT'S THE RECIPE FOR MAKING GABAPENTIN A CONTROLLED SUBSTANCE?

RON STAVALE, PA-C

Gabapentin is not a narcotic nor a benzodiazepine, it does not bind to mu receptors, it is reportedly not addictive and was thought to be a safer alternative to opioids yet "you can buy "gabbies" or "johnnies" on the street and "people who don't need it are starting to use it," says Steven Evans, MD, medical director of American Addiction Centers/Nevada. (1)

"Gabapentin is an anticonvulsive medication which was first discovered in the 1970s in Japan. It was originally used as a muscle relaxer and anti-spasmodic medication, but later, in 1974, it was sold to Warner-Lambert/Pfizer, a company that later discovered the potential of the medication as an anti-convulsive medication and as an adjunct to stronger anticonvulsants"..... "It also has off-label use for neuropathic pain, fibromyalgia, bipolar disorder, postmenopausal hot flashes, essential tremors, anxiety, resistant depression and mood disorders, irritable bowel syndrome (IBS), alcohol withdrawal, postoperative analgesia, nausea and vomiting, migraine prophylaxis, headache, interstitial cystitis, painful diabetic neuropathy, social phobia, generalized tonic-clonic seizures, pruritus (itching), insomnia, post-traumatic stress disorder (PTSD), and refractory chronic cough."(2) In fact, according to the Canadian Pharmacists Journal article in 2012, 83 percent of gabapentin prescriptions were for off-label use! (3)

So why is gabapentin a controlled medication in Michigan? Well, let's back up a minute! The FDA approved the drug pregabalin (Lyrica) in 1994. Pregabalin was also a Pfizer product and in the US pregabalin was classified as a schedule V controlled substance right out of the gate, while gabapentin was not "despite having similar pharmacological properties to pregabalin."(4) Pregabalin was more specifically studied in diabetic peripheral neuropathy and postherpetic neuralgia.(5) Incidentally, but perhaps not coincidentally, Pfizer's gabapentin patent expired in 2003 and it was now open to generic competition. So why is pregabalin a scheduled drug?

From the DEA's site https://www.deadiversion.usdoj.gov/fed_regs/rules/2005/fr05132.htm

"Pregabalin has been shown to produce effects that are similar to other controlled substances. In a study with recreational users of sedative/hypnotic drugs, a 450 mg dose of pregabalin resulted in subjective ratings of "good drug effect," "high," and "liking" similar to 30 mg of diazepam. In clinical studies, pregabalin showed an adverse event profile similar to other central nervous system depressants. Some of these effects included dizziness, somnolence, ataxia, and confusion. Following abrupt or rapid discontinuation of pregabalin, some patients reported symptoms suggestive of physical dependence." This is why Pfizer's 'second generation' gabapentin came out as a Schedule V medication. (6)

So now back to the earlier question; why is gabapentin now a scheduled drug in Michigan? It seems that it is a matter of circumstance and the combined effect when multiple drugs are being used together. In March of 2016 CMS listed gabapentin as an 'Opioid Potentiator.'(7) And, it's not just a US thing! The Scottish Information Services Division reported the presence of gabapentin and pregabalin (Lyrica) in 21 percent of their post- mortem death reports from overdose and that finding had increased from 4 percent in 2009 to 21 percent in 2016.(8) In Kentucky, gabapentin was listed as a contributing drug on the death certificate in 40 percent of the overdose deaths with gabapentin-positive toxicology; in North Carolina this percentage was 57 percent..(9)

So since the DEA has not listed gabapentin as a scheduled drug, different states have listed it as a controlled substance in order to corral its availability. Why the different approach between the State and Federal Governments? Here is the rationale for an individual state listing gabapentin as a controlled medication: In an article by Peckham, Ananickal and Sclar published from the Department of Pharmacy Practice, Midwestern University College, the author's point out "To date, and in spite of empirical evidence suggestive of diversion and abuse with opioids, gabapentin remains a non-controlled substance at the federal level." This has forced individual US states and jurisdictions – often significantly impacted by the opioid epidemic – to forge ahead with legislative initiatives designed to reclassify and/or monitor the use of gabapentin."(10)

Also, in an article in May 2018 called "The Law of Unintended Consequences" the author, Dr. Ramirez states, "Even more concerning, in patients on suboxone for drug addiction, it (gabapentin) can paradoxically block naloxone activity at the opioid receptor which then allows the buprenorphine to cause an unintended high. In drug monitoring programs that are not testing for the presence of gabapentin—which is not a routine screen—participants can have a completely clean drug screen and still be abusing buprenorphine."(11) I was not able to find other studies or articles specifically addressing the problem with blocking naloxone's effect.

So it's not like a straight line connection or a clearly defined rationale that says gabapentin should be a controlled or scheduled medication in and of itself. It appears however, kind of like a confluence of circumstances that becomes greater than its individual parts. The side effects of gabapentin include "dizziness, drowsiness, unsteadiness, memory loss, lack of coordination, difficulty speaking, tremors, double vision, unusual eye movements and jerky movements."(12) Combine that with a statement from the Department of Pharmacy Practice, Midwestern University "The abuse potential of gabapentin is well documented; with gabapentin having been noted as an agent highly sought after for use in potentiating opioids...respiratory depression and opioid-related mortality increases significantly."(13)

Additionally, gabapentin is showing up in an increasingly higher percentage of overdose deaths around the world. Throw in a pinch of society's inability to have any meaningful impact on this substance-use disorder (which many consider is destroying our society from within!) and it seems we now have the recipe for how a medication like gabapentin has become a controlled substance and will likely become a federally scheduled drug by the DEA in the future.

REFERENCES

The personal insight into this article are solely mine and do not represent the BOD of MAPA, MAPA members or the Health Professional Recovery Program Committee for the State of Michigan.

1- Gabapentin's Secret: The Drug Opioid Abusers Crav ; Published: April 16, 2018; By Ronni Gordon

2-https://www.ncbi.nlm.nih.gov/books/NBK493228/

3- Prescribing gabapentin off label: Perspectives from psychiatry, pain and neurology specialists, Can Pharm J (Ott). 2012 Nov
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6153543/

4-https://www.bmj.com/content/363/bmj.k4364/rr-1

5- https://www.centerwatch.com/drug-information/fda-approved-drugs/drug/900/lyrica-pregabalin

6- https://www.deadiversion.usdoj.gov/fed_regs/rules/2005/fr05132.htm

7- https://www.affirmhealth.com/blog/the-law-of-unintended-consequences-gabapentin-meets-the-opioid-crisis

8- Gabapentinoids prescribed prior to a fifth of drug-related deaths in Scotland; The Pharmaceutical Journal18 JUN 2018

9- https://www.ncbi.nlm.nih.gov/pubmed/29554591

10-- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6103607/

11- https://www.affirmhealth.com/blog/the-law-of-unintended-consequences-gabapentin-meets-the-opioid-crisis

12-https://www.rxlist.com/neurontin-side-effects-drug-center.htm

13-https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6103607/

A Physician Assistant Student's Perspective on

CARDIOVASCULAR RISK AND GLUCOSE-LOWERING AGENTS

CHRISTOPHER STALEY PA-S

It has been long established that patients with Diabetes Mellitus type II (DMII) are at a greater risk for Cardiovascular Disease (CVD) than those who do not have DMII. Some studies can be cited stating that the CVD risk for these patients is as high as 65 percent.1 As providers and patient educators, it would behoove us to inform our patients about this risk and other common sequelae of DMII. Due to the increased risk of developing further comorbid conditions like CVD in this patient population, it would be beneficial to understand the current landscape of blood sugar lowering agents and their effects. As a student, I found this topic overwhelming at first because while guidelines such as AACEs are beneficial, it was difficult to tailor the correct glucose-lowering agent with patient comorbidities. Discussions with my preceptor during my family medicine rotation have heightened my interest in understanding this topic more. Specifically, we discussed the sodium glucose cotransporter 2 (SLGT-2), Empaglifozin which received recent FDA approval for primary cardiovascular outcomes.6 I have outlined three of the glucose lowering agents that are at the top of the discussion regarding improving cardiovascular outcomes.

GLP-1 agonist: Glucagon-like peptide 1 agonists work to improve blood sugar levels by stimulation of insulin through ß-cells and the reduction of glucagon. Primarily, the side effect profile of GLP-1 agonists includes weight loss totaling 1.5-2.5kg and gastrointestinal discomfort (nausea, vomiting, and diarrhea). More seriously, this class can increase the chances of acute pancreatitis and therefore is contraindicated in those with a history of pancreatitis.[2] Reduction of HgbA1c is possible with this class, as on average, one can expect about a 1 percent decrease.

Several studies have been conducted looking at GLP-1 agents and its ability to reduce primary outcomes. Specifically, Liraglutide and Semaglutide were shown to decrease primary and secondary cardiovascular outcomes.6 However, a study using Lixisenatide did not show any benefit for improving primary or secondary outcomes.6 It is important to note that Lixisenatide did not have a negative effect on these outcomes.

SGLT-2 inhibitor: These blood sugar lowering agents exert their effects through the sodium glucose cotransporter 2 which decreases the amount of glucose reabsorption in the kidneys.4 Due to the renal excretion, one would expect to find increased glucose in the urine. The side effect profile for this class is both beneficial and detrimental depending on the patient's past. SGLT-2 inhibitors will lower HbgA1c roughly 1 percent, generate weight loss of 2-3kg, reduce blood pressure, and reduce serum uric acid levels.4 This class has also been shown to slightly elevate low density lipoprotein (LDL) and high density lipoprotein (HDL)

cholesterol levels. Because of the increased glucose excretion in the urine, there is a greater incidence of urinary tract infections. Based on recent evidence SGLT-2 inhibitors, specifically Empagliflozin can lower the rate of primary cardiovascular outcomes.7 The same study stated that Empagliflozin did not have a significant difference in reducing secondary outcomes when compared to placebo.7 Lastly, Empagliflozin is currently the only FDA approved medication for prevention of cardiovascular death.6

DPP-4 inhibitor: This class of agents work via enzyme inhibition. They affect an upstream enzyme DPP-4 that degrades GLP-1 which increases insulin secretion within the ß-cells in the pancreas. DPP-4 inhibits the enzyme responsible for GLP-1 degradation; thus, increases the GLP-1 levels and insulin secretion .6 DPP-4 inhibitors do not influence weight, but common adverse reactions are upper respiratory infections, diarrhea, abdominal pain, and headache. More severe reactions include pancreatitis, Stevens-Johnson syndrome, and renal failure. DPP-4 inhibitors do reduce HgbA1c levels but not to the extent of the other two classes. Studies showed that DPP-4 inhibitors do not decrease negative cardiovascular outcomes.6 In fact, patients taking Saxagliptin actually resulted in more hospitalizations for heart failure than placebo.5 The same can be said for Alogliptin.5 It is important to note that this class did not increase the rate of primary and secondary outcomes when compared to placebo.

It is difficult to label one class superior. It is apparent is that GLP-1 agonists and SGLT-2 inhibitors reduce poor cardiovascular outcomes. A patient's medical history and comorbid conditions should be the determining factor when choosing a glucose lowering agent. A limitation for this brief summary article would be that I only looked at articles specific to cardiovascular risk. Anecdotally I found that the AACE guidelines were helpful conceptualizing the various glucose lowering agents.3 The guidelines have many useful tables and charts that can help drive treatment.

A special thank you to Michigan Academy of Physician Assistants and R. David Doan III, PA-C for the opportunity to write this article.

DEFINITIONS:

1. Primary outcomes: Death via cardiovascular etiology, nonfatal myocardial infarct or nonfatal stroke.

2. Secondary outcomes: Primary outcomes with resulting hospitalization for unstable angina.

REFERENCES:

1. Alvarez C, Lingvay I, Vuylsteke V, Koffarnus R, Mcguire D. Cardiovascular Risk in Diabetes Mellitus: Complication of the Disease or of Antihyperglycemic Medications. Clinical Pharmacology & Therapeutics. 2015;98(2):145-161. doi:10.1002/cpt.143.

2. Bethel MA, Patel RA, Merrill P, et al. Cardiovascular outcomes with glucagon-like peptide-1 receptor agonists in patients with type 2 diabetes: a meta-analysis. The Lancet Diabetes & Endocrinology. 2018;6(2):105-113. doi:10.1016/s2213-8587(17)30412-6.

3. Garber AJ, Abrahamson MJ, Barzilay JI, et al. Consensus Statement By The American Association Of Clinical Endocrinologists And American College Of Endocrinology On The Comprehensive Type 2 Diabetes Management Algorithm – 2019 Executive Summary. Endocrine Practice. 2019;25(1):69-100. doi:10.4158/cs-2018-0535.

4. Marx N, Mcguire DK. Sodium-glucose cotransporter-2 inhibition for the reduction of cardiovascular events in high-risk patients with diabetes mellitus. European Heart Journal. 2016;37(42):3192-3200. doi:10.1093/eurheartj/ehw110.

5. Scheen AJ. Cardiovascular outcome studies with incretin-based therapies: Comparison between DPP-4 inhibitors and GLP-1 receptor agonists. Diabetes Research and Clinical Practice. 2017;127:224-237. doi:10.1016/j.diabres.2017.03.009.

6. Secrest MH, Udell JA, Filion KB. The cardiovascular safety trials of DPP-4 inhibitors, GLP-1 agonists, and SGLT2 inhibitors. Trends in Cardiovascular Medicine. 2017;27(3):194-202. doi:10.1016/j.tcm.2017.01.009.

7. Zinman B, Wanner C, Lachin JM, et al. Empagliflozin, Cardiovascular Outcomes, and Mortality in Type 2 Diabetes. New England Journal of Medicine. 2015;373(22):2117-2128. doi:10.1056/nejmoa1504720.

WHAT PA'S NEED TO KNOW ABOUT LARA'S NEW LICENSING SYSTEM

On May 6, 2019, the Michigan Bureau of Professional Licensing (BPL), a division of the Department of Licensing and Regulatory Affairs (LARA), will launch a new more efficient licensing platform to make it easier to obtain, renew, and modify licenses. The Michigan Professional Licensing User System (MiPLUS) is the Bureau's new online licensing and regulatory database application for health and occupational professionals in Michigan. All PAs will be required to utilize this new online platform by registering with MiPlus whether applying for a new license or renewing a current license. This new system will allow for individual online tracking of each step of the application in real-time and will also send notifications regarding exam requirements and licensure completion. Once registered, each PA will receive an electronic copy of their license to print, a paper copy will still be mailed. MiPlus will also provide an improved interface for consumers to: file and track complaints against licensees, allow licensees to self-report convictions and disciplinary actions from other states, verify the status of a licensed professional, file a complaint against a licensed professional, or report a change in staff privileges. Licensees will also have the option to delegate the renewal process to another individual (Details Below)

In the coming months, Michigan PAs will receive communications from LARA with updates on the new system and what that means for the PA licensing process. LARA will provide detailed instructions, how-to guides, and videos on how to register and use the new platform.

Overall, the new interface will make it easier to manage licensing issues online. Resources and information are available at Michigan.gov/MIplus.

KEY POINTS:

· Controlled substance license numbers will not change for PAs

· The delegation feature in MiPLUS allows a registered user to grant another registered user access to their account to upload documentation and pay appropriate licensing fees (either party can remove this access at any time).

· Individuals can verify the status of a licensed professional, file a complaint against a licensed professional, or report a change in staff privileges.

· All Michigan PAs are required to register with this new system beginning May 6, 2019.

MC3 Program Offers Psychiatry Help for Primary Care Providers

R. DAVID DOAN III, MS, PA-C

I work in primary care, and like many others, I spend my days treating patients for a myriad of health issues. While treating cardiovascular, pulmonary and endocrine related illnesses take up a large chunk of my time, mental health and pain management have become increasingly more common on my schedule. Today was no exception. At least a third of my schedule consisted of chief complaints directly related to the management of ongoing mental health issues, new mental health issues, or "add-on" complaints related to mental health issues.

The patients I see for mental health conditions (usually Major Depressive Disorder (MDD), Generalized Anxiety Disorder (GAD), Attention Deficit Disorder (ADD) or Bipolar Disorder) come from all walks of life and span the entire age spectrum. I treat and counsel patients who are dealing with mental health complications from major life changes such as divorce or bereavement; from longer standing issues like MDD, GAD, ADD or Bipolar Disorder, and often find myself looking for guidance on treatment beyond my "go-to" medications.

PA schools offer some mental health training, but let's be honest, it isn't really all encompassing. Most programs offer a month dedicated to psychiatry with some emphasis on basic treatments and medications as well as a rotation in psychiatry (often inpatient). There just isn't much emphasis placed on mental health care in school as evident by the NCCPA 2019 blueprint listing psychiatry/behavioral health at only 6 percent of the material in the PANCE. In primary care, we are seeing more mental health issues as our patients find it difficult to get into psychiatry or refuse to go to psychiatry based on negative stigmas placed on behavioral health conditions. Primary care providers could certainly use a little help and guidance with caring for our mental health patients.

I recently learned of the Michigan Child Collaborative Care (MC3) program that provides psychiatry support to primary care providers who manage patients with behavioral health problems. The program provides psychiatrists for free consultations who offer guidance on diagnosis, medications, and psychotherapy interventions. There are some stipulations: the patients must be children, adolescents, young adults through age 26, or women who are contemplating pregnancy, pregnant or postpartum with children up to one year. The support is available through same-day phone consultations to referring providers as well as video psychiatric evaluations in select counties to patients and families. This program is a great resource for primary care providers who feel their training may not be enough for some patients.

To use the program, sign up on their website at (https://mc3.depressioncenter.org/pcp/enroll/) and request the consultation by phone. There is a tab on the MC3 website for "Request Consultation" that will route you to a Michigan county map. Click on your county to get the name and number of the Behavioral Health Consultant (BHC) in your county. They are available for consultation Monday through Friday, 9-5pm (except holidays). They will triage the referral, respond to any questions within the scope of their expertise, and forward appropriate cases to the MC3 psychiatrist for a consultation.

The MC3 is an extremely useful and FREE service that can help you better manage difficult mental health patients. If you work in one of the blue counties shown in the image below, I encourage you to sign up and call them; for your patient's mental health… and yours!

REFERENCE:

(https://mc3.depressioncenter.org/pcp/enroll/)

MICHIGAN ACADEMY of PHYSICIAN ASSISTANTS

MAPA MISSION

The Michigan Academy of Physician Assistants is the essential resource for the PA profession in Michigan and the primary advocate for PAs in the state.

MAPA VISION

The Michigan Academy of Physician Assistants is committed to providing quality, cost-effective and accessible health care through the promotion of professional growth and enhancement of the PA practice environment.

MAPA VALUES

- PAs are advocates of accessible and compassionate health care
- PAs promote improved health in our communities through a team-based approach
- PAs have a commitment to lifelong personal and professional learning
- PAs adhere to the AAPA Code of Ethical Conduct
- Promote the acceptance and utilization of PAs
- Instill the values of accountability and transparency in the work environment
- Promote excellence and equity in the delivery of cost effective quality health care
- Foster mutual support and inclusion of all PAs

AN INNOVATIVE APPROACH TO PTSD

JOHN R. YOUNG PA-C

Post-traumatic stress disorder (PTSD) among our military veterans is estimated at a staggering 20 percent of recent and 15 percent of Vietnam era combat veterans.4 This puts the number of military personnel affected with PTSD at well over 1 million individuals, and anecdotal responses from some military counselors suggest that the rates are even higher!

Veterans affected by PTSD suffer from symptoms such as intrusive memories, nightmares, anhedonia, depression, hypervigilance, and aggression. For many, the inability to cope with these feelings lead to self-medicating with drugs and alcohol and may lead to suicide. Studies investigating the link between PTSD and suicide are mixed. However, the rates of suicide among veterans account for 20 percent of all suicides in the U.S. [2] Suffering from PTSD is in itself a very challenging issue to cope with, but veterans also encounter barriers to care when seeking help with mental health issues. Veterans who seek treatment often face a Veterans Affairs (VA) medical system that is fraught with physician shortages, lack of access to primary care, and wait times that can exceed 2 months.

Veterans suffering from PTSD are diagnosed with the aid of a questionnaire and standard treatment includes an SSRI as well as behavioral therapy. Diagnosis of PTSD with the use of a questionnaire is helpful to identify the symptom category or "cluster" and the frequency at which symptoms occur. When utilizing the questionnaire, it is important to take the time to understand the context of the patient's symptoms and what the psychosocial impact is. Provided below are commonly utilized questionnaires and diagnostic criteria.

PTSD DIAGNOSTIC QUESTIONNAIRE

- The Clinician-Administered PTSD Scale for DSM-5 (CAPS-5)
- PTSD Checklist for DSM-5 (PCL-5)
- Mississippi Scale for Combat-Related PTSD
- DSM-5 categorizes the symptoms that accompany PTSD into four "clusters" [1]
- Intrusion—spontaneous memories of the traumatic event, recurrent dreams related to it, flashbacks, or other intense or prolonged psychological distress 1
- Avoidance—distressing memories, thoughts, feelings, or external reminders of the event[1]
- Negative cognitions and mood—myriad feelings including a distorted sense of blame of self or others, persistent negative emotions (e.g., fear, guilt, shame), feelings of detachment or alienation, and constricted affect (e.g., inability to experience positive emotions)1
- Arousal—aggressive, reckless, or self-destructive behavior; sleep disturbances; hypervigilance or related problems.[1]

"PTSD can be either acute or chronic. The symptoms of acute PTSD last for at least one month but less than three months after the traumatic event. In chronic PTSD, symptoms last for more than three months after exposure to trauma."[1]

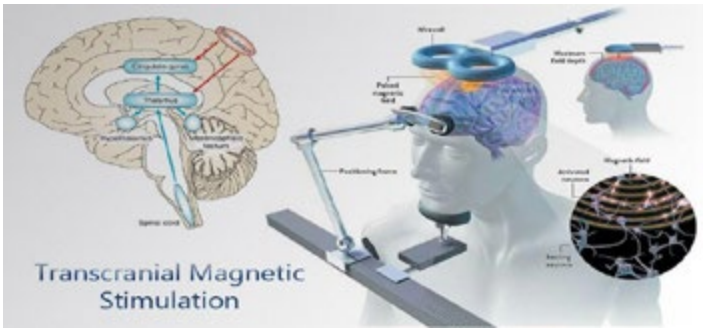
There are three main categories of behavioral psychotherapies utilized to treat the various PTSD classifications, all of which center around treatment with trauma–focused psychotherapies.

The trauma-focused psychotherapies with the strongest evidence are:

- **Prolonged Exposure (PE)3**
  Teaches you how to gain control by facing your negative feelings. It involves talking about your trauma with a provider and doing some of the things you have avoided since the trauma.
- **Cognitive Processing Therapy (CPT)3**
  Teaches you to reframe negative thoughts about the trauma. It involves talking with your provider about your negative thoughts and doing short writing assignments.

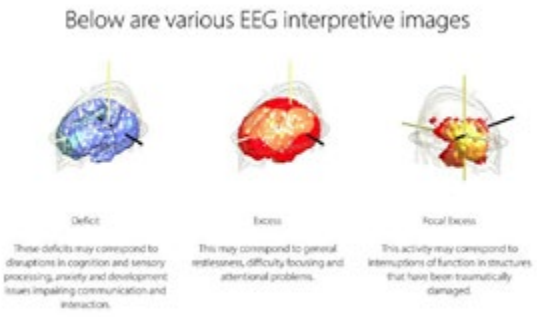
- **Eye Movement Desensitization and Reprocessing (EMDR)3**
  Helps you process and make sense of your trauma. It involves calling the trauma to mind while paying attention to a back-and-forth movement or sound (like a finger waving side to side, a light, or a tone).

An emerging treatment for PTSD stems from an older technology which was originally created in the 1980's but now coupled with advanced computers and software to produce advanced brain mapping and treatment localization. Repetitive Transcranial Magnetic Stimulation (rTMS), initially invented in



1985,5 is similar to an MRI machine but on a small scale. Instead of utilizing an electromagnetic pulse (EM) to generate an image, the pulse is directed at specific areas of the brain. The EM pulse is directed at areas of the brain deemed by electroencephalogram (EEG) to be under or overactive.

"Through the interactions between the induced EM currents and neuronal electrical activity, TMS can temporarily disrupt the ongoing cortical activity, leading to macroscopic deactivations or excitations of the affected brain regions" (Allen et al., 2007).



In other words: the EM pulse can help kick start a hypoactive region or attempt to slow down a hyperactive region of the brain by modulating the frequency of the EM field toward the target area.

A treatment center based in California (Brain Treatment Centers) utilizes a proprietary software program which analyzes a pre-procedural EEG and EKG to generate a 3D map of the brain.

With this map the team is able to create an individualized treatment plan to target areas of the brain that are hyper or hypoactive. While clinical results and personal testimonies from this technique are very encouraging, there has not been any controlled trials to validate this treatment process.

In 2008 the FDA approved rTMS for the treatment of depression. A recent meta-analysis shows that rTMS is effective in 30 to 40 percent of individuals with treatment-resistant depression.6 It is currently being utilized off-label for the treatment of PTSD and autism.

WORKS CITED:

1. Tull, Matthew, and Steven Gans. "The Criteria for Diagnosing PTSD in DSM-5." *Verywell Mind*, Dotdash, www.verywellmind.com/ptsd-in-the-dsm-5-2797324. Accessed February 9th, 2019.

2. Reisman, Miriam. "PTSD Treatment for Veterans: What's Working, What's New, and What's Next" P & T : *a peer-reviewed journal for formulary management* vol. 41,10 (2016): 623-634.

3. "PTSD: National Center for PTSD." Treatment of PTSD - PTSD: National Center for PTSD, 8 Aug. 2018, www.ptsd.va.gov/understand_tx/tx_basics.asp.

4. "Veterans Statistics: PTSD, Depression, TBI, Suicide." *Veterans PTSD Statistics | Statistics: Depression, TBI and Suicide*, www.veteransandptsd.com/PTSD-statistics.html.

5. "Brain Stimulation Therapies." *National Institute of Mental Health*, U.S. Department of Health and Human Services, www.nimh.nih.gov/health/topics/brain-stimulation-therapies/brain-stimulation-therapies.shtml

6. Lam RW, Chan P, Wilkins-Ho M, Yatham LN. Repetitive transcranial magnetic stimulation for treatment-resistant depression: a systematic review and metaanalysis. *Can J Psychiatry*. 2008;53:621-631

PA Spotlights

JULIA BURKHARDT, PA-C

Michigan Academy of Physician Assistants (MAPA) will focus on shining a spotlight on Michigan PAs who hold unique positions in leadership or clinical practice. In this issue we are highlighting the illustrious career of John McGinnity, MS, PA-C.

Leadership — John McGinnity

PA John McGinnity graduated from University of Detroit Mercy PA program in 1994. He practiced for a number of years in primary care and cardiology. He has been an indispensable part of MAPA serving in several leadership roles including MAPA President from 2008 to 2009. He has acted as the Director at Large and then President of the American Academy of Physician Assistants (AAPA). He has also been an integral part of the Michigan PA educational system for decades through his work as a clinical professor and then Program Director at Wayne State University. Most recently, John was appointed to the Michigan State Board of Medicine and he will now be sharing his education and experience as the Inaugural Director of the Michigan State University's PA Program.

Question: What has been your favorite position during your career so far?

John's first job at a cardiac catheterization laboratory at Harper Hospital in Detroit, Michigan was his favorite position. John said, "Working in the cath lab with a physician that was well known in the clinical world gave me a foundation for intellectual curiosity." He said his experience taught him the critical thinking skills to know when to ask important questions such as is this practice evidence based? This sparked his passion for research, leading him to participate in many research studies and publications.

Question: What do you recommend for early career PAs to get involved in leadership or administrative duties?

John said that early Career PAs must "be the first to recognize your value to the practice on the team." Too often early in our career we are hesitant to stand up for ourselves and the values we bring. As PAs, we are the most flexible healthcare profession, we lead in team based care and provide significant value in an ever-consolidating healthcare system. We need more PAs in hospital administration, we need more people to step up. We should have a Chief PA officer in every health system." He also recommended that PAs become active in committees and other administrative roles early on to gain meaningful experiences to attain leadership roles later on in their careers.

Question: What is the most rewarding and most challenging part of being a PA educator?

John said the most rewarding part of being a PA educator has been to see how the students have evolved in the last 20 years. He described a transition from a one-way transfer of information via pontificated lectures to an interactive conversation between educators and students. He felt this was due to the availability of peer reviewed research and evidence-based medicine which is now easily accessible through technology. He said the most challenging part of being a PA educator is "academentia," what he calls the slow-moving bureaucracy that dominates the world of academia.

Question: Where do you see the PA profession in 20 years?

"For a long while now we have been happy to have a seat at the table. In the next 20 years I want us to lead and have full integration in our academics and clinical practice. We need to worry about scope of care and shift our focus to quality outcomes for our patients and delivering quality, cost effective care."

Do you have a PA leader and or clinically practicing PA that deserves to be featured? Please send your recommendations to *julia.burkhardt@michiganpa.org*.

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31

MAPA PLANNER

EVENTS/ CONFERENCES

MAPA 2019 BOARD OF DIRECTOR ELECTION
Letters of Intent due to MAPA office: April 1, 2019
Election ballots sent via email: May 1, 2019
Ballot submissions due: June 1, 2019

MAPA LEADERSHIP SUMMIT

DATE: May 1, 2019

SITE: Michigan Capital Building
Lansing, Michigan
michiganpa.org

MAPA BOARD MEETING

DATE: June 12, 2019, 6:00pm- 8pm

SITE: AMR Okemos Office
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MAPA FALL CME CONFERENCE

DATE: October 10-13, 2019

SITE: Grand Traverse Resort and Spa
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