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MICHIGAN PA

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Do You Have a Bona Fide Relationship with Your Patients?

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MICHIGAN PA

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Your Newsletter Editor's Corner

DEAR MAPA MEMBERS,

I hope this letter finds you well and that 2018 was a happy, healthy and successful year for you! As always, this edition is full of valuable information to help you in daily practice and to learn more about your profession as well as the work MAPA does for you.

With 2019 already here, I want to encourage all of you to make a commitment to get involved with MAPA for the coming year. We are always looking for energetic PAs who are willing to volunteer. Your time will be well spent and you will make valuable connections with other PAs in Michigan. You just never know what life will bring, who you will meet, and what doors may open for you in the future by making that connection.

Finally, we are always looking for newsletter contributions, both clinical and non-clinical articles. Submissions should be double spaced, 1-3 pages in length, and include written permission to reprint the article from the author. Please note that MAPA and its Communications Committee reserves the right to edit articles as needed.

If you are interested in submitting an article or have questions about the MichiganPA Newsletter, please feel free to contact me at kateschisler40@gmail.com or call 989-415-2200.

I wish you all a very Happy New Year!

Sincerely,

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

From the President's Desk

It is time for another newsletter and your Academy has been busy. In September John Young, Thadd Gormas, and I re-negotiated the contract with AMR our management support for the PAs in Michigan.

MAPA audit of our finances was completed and Kate Schisler, PA-C is a new Treasurer and did a great job while working with staff and the board. She is also the Editor-in-Chief of our newsletter and does a great job wearing two hats for MAPA. Our Volunteer Chair Felicia Shaya, held a mixer at Mon Jin Lau on one of the worst weather days of this year so far and it was a good time for all. Pre-PA students, PA students, PAs and MAPA board members and committee chairs all had a great time and the food was wonderful. I met some of my former students that I had not seen in 10 years. This is a great opportunity to say thank you for all the volunteers who have helped this year. Thadd Gormas, Ron Stavale and the Legislative committee have been working to prepare for the change in Lansing coming the first of the New Year.

I would like to send out a call for MAPA members who would like to improve your leadership skills to contact Jodi Zych, PA-C our President-elect or myself, so we can show you the resources we have available to develop your skills to their full potential. We have state and national programs to help you to work with MAPA or AAPA opportunities.

I have developed a Pre-PA program to help the next generation of PAs coming behind us. Anyone interested in this endeavor please contact me to show you the process.

Karl G. Wagner, Jr. PA
MAPA President

MAPA MIXER

On Thursday, November 29th, over 100 prospective PA students, current PA students and PAs gathered for the second annual MAPA mixer in Troy, Michigan. It was a wonderful evening of networking, good food, and conversation.

This event assisted in providing further updates on the PA profession and was an opportunity for mentorship for all within the PA community. MAPA is dedicated to the PA profession, and it is our hope to collectively provide members with more networking opportunities, social gatherings, and volunteer events. Attending these events helps us to appreciate the strengths within our profession and allows us the opportunity to communicate ways we can continue to remain competitive and strong within all domains of medicine. Thus far, the feedback from such events has been very positive, as they have allowed for further collaboration among PAs and professional networking, but most of all developing lasting friendships.

There are so many opportunities to become further engaged in your community in whichever way you can through attending social events, volunteerism, student precepting, guest lecturing, leading outreach efforts, mentoring, research opportunities or lending a helping hand to those in need. If you are interested in being part of the MAPA Volunteer Committee please don't hesitate to email me anytime!

Please consider attending these events as our success as a profession is dependent upon and reflective of all of us. Thank you for all of your time and dedication to the profession, as well as the care you provide your patients on a daily basis.

Stay tuned for future events!

Felicia Shaya, PA-C
MAPA Volunteer Director
felicia.shaya@michiganpa.org

VAGINAL DISCHARGE

JULIA BURKHARDT, PA-C

Vaginitis, a collective term for disorders caused by infection, inflammation, or changes in vaginal flora, is the most common gynecologic condition encountered in the outpatient setting.1, 2 Due to this, it is pertinent that PAs working in the outpatient, emergency, and urgent care settings know the signs, symptoms, diagnostic studies, and treatments for the most common causes of vaginitis.

Physiology, Epidemiology & Etiology

The vaginal ecosystem is characterized by nonkeratinized stratified squamous epithelium of the vagina in normal, estrogenized premenopausal women. The glycogen rich sloughed cells convert glucose into lactic acid, creating an acidic vaginal environment (pH 4.0 to 4.5).2 Disruption of the acidic environment can lead to conditions that increase the likelihood of developing vaginitis.[2]

Eight percent of Caucasian women and 18 percent of African American women report an issue with vaginal symptoms in the past year.2 Out of the women who experienced these symptoms, 55 percent of Caucasian women and 83 percent of African American women sought medical attention.[2]

There are a variety of etiologies that could cause vaginosis and vaginal discharge. Bacterial vaginosis (BV), candida vulvovaginitis, and trichomoniasis cause over 90 percent of infectious symptoms.2 Cervicitis, often caused by Sexually Transmitted Infections (STIs) can also cause nonspecific vaginal discharge and associated symptoms. Finally, there are also noninfectious etiologies including vaginal atrophy/atrophic vaginitis in postmenopausal women, foreign bodies, irritants and allergens.[2]

Symptoms

Women generally present with a chief complaint of vaginal discharge including changes in volume, color, or odor of discharge.2 Women generally experience physiological leukorrhea which is white or opaque, thin or thick, and odorless.2 Any changes in this discharge can represent a pathophysiological process. The type of discharge can help clinicians to discern what the likely cause of the symptoms is. The three major etiologies of vaginitis can be characterized by their discharge:[2]

- Bacterial Vaginosis (BV): Generally has a malodorous (fishy), thin, grey discharge.
- Vaginal Candidiasis: Scant thick, white, odorless, curd-like discharge
- Trichomoniasis: purulent, malodorous, accompanied by burning, dysuria, frequency, and/or dyspareunia.

Physical Exam and Diagnosis

Although the diagnosis can often be presumed from taking a thorough patient history, it is important to validate this diagnosis through physical exam findings. A thorough physical exam including an external exam, speculum exam, and bimanual examination should be performed. Common findings for the conditions that commonly cause vaginitis are discussed below.[2]

If microscopy is negative or unavailable, rapid antigen and nucleic acid amplification tests (NAAT) are available for Candida species, BV, and trichomoniasis.[2]

Additionally, Neisseria gonorrhea and Chlamydia trachomatis should always be evaluated for in sexually active women with vaginitis symptoms.3 These differential diagnoses should especially be considered in women with new or multiple sexual partners and symptomatic sexual partners. Signs and symptoms of acute cervicitis include purulent or mucopurulent discharge and/or intermenstrual and postcoital bleeding.[3] NAAT testing should be performed.

	Bacterial Vaginosis	Vulvovaginal Candidiasis	Trichomoniasis
Symptoms	Malodorous discharge	Pruritus, soreness, dyspareunia	Malodorous discharge, burning, postcoital bleeding
Signs	• White/gray thin discharge coating vagina	• Vulvar erythema or edema. • White/Clumpy discharge	• Thin green-yellow discharge • Vulvovaginal erythema
Wet Mount	Clue cells comprise >/= 20% of epithelial cells	Pseudo hyphae, budding yeast	Motile trichonomads
Vaginal pH	pH > 4.5	pH 4 to 4.5	pH 5 to 6

Treatment

Treatment can be based on symptoms, physical exam, and diagnostic testing. If suspicion of acute cervicitis caused by a sexually transmitted infection (i.e., Gonorrhea or Chlamydia), empirical treatment should be started prior to receiving the results from the NAAT testing.

	Treatment
Bacterial Vaginosis[4]	**Nonpregnant women** Metronidazole 500 mg BID x 7 days OR Metronidazole gel 0.75%, 5g, intravaginally QD x 5 days **Pregnant women** Metronidazole 500 mg BID x 7 days OR Metronidazole 250 mg TID x 7 days OR Clindamycin 300 mg BID x 7 days
Vulvovaginal candidiasis[6]	Diflucan 150 mg tablet, single dose by mouth Monistat (Miconazole): , 1 and 3 day formulations available - Monistat 1: 1200 mg vaginal suppository x 1 dose - Monistat 3: 200 mg vaginal suppository QHS x 3 doses Terazole (Terconazole), 80 mg vaginal suppository QHS x 3 days
Trichomoniasis[5]	**Nonpregnant women** Tinidazole or Metronidazole 2 g (one time dose) OR Metronidazole 500 mg PO BID x 7 days **Pregnant women**: treatment recommended as above, multi-day dosing recommended for those with nausea/vomiting
Gonorrhea (always give co-treatment for Chlamydia)[3]	Ceftriaxone 250 mg IM with azithromycin 1 g PO
Chlamydia[3]	Azithromycin 1 g or Doxycycline 100 mg PO BID x 7 days

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MAPA's Political Action Committee

MAPA's Political Action Committee (PAMPAC) would like to thank the PAs who took the time to contribute to our PAC at the MAPA Fall CME Conference in Traverse City, the Spring CME Conference in Novi, and the Capitol Leadership Summit in Lansing.

The fact that MAPA has a PAC was critical in the development of our groundbreaking Michigan PA Law--PA 379 of 2016. Our PAC was able to support the sponsor of the bill, State Rep. Ned Canfield, D.O., in his initial run for the legislature and his re-election.

Being able to support legislators who understand medicine and support PAs is critical! By helping to elect Rep. Canfield, we were able to have someone in the legislature who knew what PAs do and was willing to improve our professional practice in Michigan. Not all legislators understand every aspect of health care, small business, education or farming for that matter. Legislators rely on their staff and their colleagues in the House or Senate to help inform them on what's best for our State. Without Dr. Canfield Michigan would not have the best practice environment in the U.S.!

Political Action Committee donations must come from individuals. MAPA cannot use your membership dollars for PAC contributions. That is why it is so important that you understand how we continue to develop and maintain a great practice environment like you have in Michigan.

Thanks to your colleagues who support your PAC!

The following are the 2018 PA of Michigan PAC donors:

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Jodi Zych

MAPA's PAC will be at all of our CME conferences so please stop by and contribute. If every PA in Michigan donated just $20, we be among the most influential professions in Michigan. Your ability to practice in the best practice environment in the country is a direct result of PAMPAC.

Help us help you! Be a member of the only organization that advances and protects your practice environment in Michigan!!!

Ron Stavale, PA-C
MAPA Legislative Chair

BOARD OF MEDICINE HONORS PA MEMBER

LARA DAVIS, PA-C

The Michigan Board of Medicine (BOM) is one of the most active licensing boards in Michigan. Other medical licensing boards like the PA Task Force and the Michigan Board of Osteopathic Medicine and Surgery often review policy recommendations from the BOM. In fact, the BOM is currently reviewing a final draft of rules updating practice requirements for APRNs and PAs.

Michelle Gormas, PA-C has served on the Michigan Board of Medicine since she was appointed by Governor Snyder in 2015 for the term that expired in 2018.

Left to Right: Board of Medicine Chair Dr. Mohammed Arsiwala; Michelle Gormas, PA-C; and Lara BPL Director Cheryl Pezon

The BOM Chair and LARA Bureau of Professional Licensing (BPL) Director presented Michelle with a resolution for her dedication the the Board of Medicine--she rarely missed a meeting. This outstanding recognition from the Chair and LARA BPL Director is typically reserved for unique occasions. The resolution states,

> ***"WHEREAS, Michelle A. Gormas gave untiringly of her time, vigor, zeal, enthusiasm, energy, and knowledge; and WHEREAS, in recognition of her loyal, conscientious, faithful, and outstanding service in fulfillment of her professional office; now therefore,***
>
> ***BE IT RESOLVED that the Board of Medicine gives a statement of gratitude to Michelle A. Gormas, for her contribution of time, energy, and unselfish service to the people of the State of Michigan in her capacity as a professional member of the Board of Medicine during her time of professional service."***

Thank you, Michelle Gormas, PA-C (wife to MAPA's Executive Director) for representing PAs on the Michigan Board of Medicine. Your dedication to our profession has clearly made an impact. We wish you the best as you take much deserved time to pursue new professional ventures.

2019 MAPA SPRING CME CONFERENCE

Join us Saturday, March 2, 2019
for the 2019 MAPA Spring CME Conference
at the Student Center at Eastern Michigan
University in Ypsilanti, MI

Registration is open!
Visit MAPAEVENTS.ORG

Lecture Topics Include:

- *Update on Opioid Laws*
- Infectious Disease HIV
- Neuropsychology
- Pulmonary Hypertension
- Shoulder Injuries
- Substance Abuse

THE BONA FIDE PRESCRIBER-PATIENT RELATIONSHIP

RON STAVALE, PA-C

As a result of the increasing prevalence of opioid use disorders, the Governor and Michigan Legislature has made attempts to quell this devastating epidemic through a number of new laws.

One of the attempts to remedy this situation was to state that a provider could not write for Schedule 2-5 medications for a patient unless they had a 'bona fide' relationship with that patient. The effective date of this new law was postponed for up to a year early in 2018 due to confusing interpretations of what a 'bona fide' relationship meant. The possible consequences to providers are severe if these standards are not strictly met.

According to MCL 333.7303a, beginning March 31, 2019, or upon the promulgation of rules if sooner, a licensed prescriber shall not prescribe a controlled substance listed in schedules 2 to 5 unless the prescriber is in a "bona fide prescriber-patient relationship."

The rules defining the exemptions to a bona fide relationship will be promulgated by the end of December so these protocols need to be implemented in your practice as soon as possible.

The statute defines "bona fide prescriber- patient relationship" to mean "a treatment or counseling relationship between a prescriber and a patient in which both of the following are present:

a) The prescriber has reviewed the patient's relevant medical or clinical records and completed a full assessment of the patient's medical history and current medical conditions, including a relevant medical evaluation of the patient conducted in person or via telehealth.

b) The prescriber has created and maintained records of the patient's condition in accordance with medically accepted standards.

This creates several situations where a provider may consider themselves not in accordance with these laws and patient care could suffer due to the limitations imposed by these new laws. For example, what happens in the following circumstances?

- On-call, coverage and cross-coverage situations in which the prescriber with the bona fide prescriber-patient relationship is not available.
- Transitions of care from one setting to another such as from hospital to nursing home or hospice.
- Another licensed health professional completes the medical evaluation, but is not the one who will be issuing the prescription.
- Medical emergencies in which the patient needs to be stabilized.

PA Task Force Chair Lara Davis, PA-C, Board of Medicine Member Michelle Gormas, PA-C, Board of Osteopathic Medicine Board Member James Kilmark, PA-C, submitted comments to the Licensing and Regulatory Affairs (LARA). The comments outlined concerns specific to PAs and suggested alternative language.

These PA licensing board leaders worked with MAPA to offer alternative language that would allow for prompt care of patients and mitigate the exposure providers

would face if put in a position where patient care would suffer.

Thanks to the PA licensing board leaders, the proposed rule includes the following exemptions to a bona fide patient/prescriber relationship:

(a) The prescriber has reviewed the patient's relevant medical or clinical records, medical history and any change in medical condition, is acting on behalf of a prescriber described in subrule (2) who is not available, and provides documentation in the patient's medical record in accordance with medically accepted standards of care.

(b) The prescriber is following or modifying the orders of a prescriber who has an established bona fide prescriber-patient relationship described in subrule (2) with a hospital in-patient, hospice patient, or nursing home resident and provides documentation in the patient's medical record in accordance with medically accepted standards of care.

(c) The prescriber is prescribing for a patient for whom the tasks listed in subrule (2)(a) and (2)(b) have been performed by an individual licensed under article 15 as authorized by law and documentation is provided in the patient's medical record in accordance with medically accepted standards of care.

(d) The prescriber is treating a patient in an emergency medical situation. For the purposes of this subdivision, «emergency medical situation» means a situation that, in the prescriber's good faith professional judgment, creates an immediate threat of serious risk to life or health of the patient for whom the controlled substance prescription is being prescribed.

Failure to adopt the language outlined in this new rule would have resulted in patients going to emergency departments or suffering needlessly. The refined approach to a bona fide relationship is in line with our training, education and experience. This allows for appropriate flexibility as we collaborate with our prescriber and non-prescriber colleagues to deliver safe care.

The bottom line is this new language allows for PAs to provide timely, appropriate care for their patients within the parameters of these new laws.

UPDATE: ACUTE FLACCID MYELITIS *(POLIO LIKE ILLNESS)*

JOHN R. YOUNG, PA-C

For those of us who did not grow up in the 1950's during the polio epidemic which spawned the advent of the iron lung; it may be difficult to truly understand the severity of and detriment caused by the polio virus around the world.

At its height in the U.S. in 1952 the polio virus accounted for almost 60,000 infected, over 3,100 deaths, and left over 20,000 with permanent paralysis. The effects of poliomyelitis were felt worldwide and researchers raced to provide the world some relief. Finally in 1953 U.S. researcher Jonas Salk developed the first inactivated poliovirus vaccine. Once research trials confirmed the vaccine to be 85-90% effective there was a national and worldwide concerted effort for mass vaccination. Currently, poliomyelitis infections are said to be eradicated worldwide with an incidence in developed countries less than 1%. The last recorded case originating in America was in 1979 (migration has led to some isolated cases).

With that historical perspective it is most understandable that when we hear of a "polio like illness" affecting even a very minute cohort of individuals, the mere mention of "polio" brings about a visceral concern and angst of past memories.

Acute flaccid myelitis (AFM) is not new, the term describes the most severe outcome or sequelae of polio but is not specific to one virus or etiology. In 2014, the incidence rate of acute flaccid myelitis increased above baseline in the U.S. which warranted an investigation by the CDC. Currently the incidence of AFM is very, very low at 1 in one-million. The majority of cases investigated by the CDC have occurred in children, and as of October 2018 there have been 80 cases in 25 states reported.

The cause of this current variation of acute flaccid myelitis is not well understood and may be multifactorial. Potential viruses may be Poliovirus, enteroviruses D68, West Nile virus, and adenoviruses. In addition, environmental toxins may also contribute to the illness.

SIGNS AND SYMPTOMS OF AFM INCLUDE:

"Most patients will have sudden onset of arm or leg weakness and loss of muscle tone and reflexes. Some people, in addition to arm or leg weakness, will have:

- facial droop/weakness,
- difficulty moving the eyes,
- drooping eyelids, or
- difficulty with swallowing or slurred speech.

Paresthesia is rare in people with AFM, although some people have pain in their arms or legs. Some people with AFM may be unable to pass urine. The most severe symptom of AFM is respiratory paralysis that requires urgent ventilator support. In very rare cases, it is possible that the process in the body that triggers AFM may also trigger other serious neurologic complications that could lead to death."(CDC)

DIAGNOSIS:

- Neurological exam findings of: weakness, poor muscle tone, and decreased reflexes
- MRI and nerve conduction testing may also provide helpful in ruling out other etiologies
- No one single organism/pathogen has been consistently identified in patient samples to date

Diagnosis of acute flaccid myelitis can be difficult to diagnose because the symptoms mimic other neurologic diseases, like transverse myelitis and Guillain-Barre syndrome.

SPECIMEN COLLECTION RECOMMENDATIONS BY THE CDC

In order to better understand the cause and investigate potential treatments the CDC has issued guidelines in specimen collection.

If you believe your patient to be infected, clinicians should FIRST contact your County Health Department. Then collect specimens from patients under investigation (PUIs) for AFM as early as possible in the course of illness, preferably on the day of onset of limb weakness. Early specimen collection has the best chance to yield a cause of AFM. The CDC has a handout to assist in patient identification and specimen collection on their website (https://www.cdc.gov/acute-flaccid-myelitis/downloads/job-aid-for-clinicians-508.pdf).

Specimens

-CSF
-Serum
-Stool
-Respiratory (NP)/ Oropharyngeal (OP) swab

TREATMENT

- There is no treatment for acute flaccid myelitis
- Clinicians should first rule out any other potential etiology for limb weakness (herpes virus encephalopathy, bacterial infections of the central nervous system, Guillain-Barre syndrome)
- Consider ICU admission for patients demonstrating: hypoxia, hypercarbia, vital capacity < 15 mL/kg, impaired airway protection due to bulbar weakness, altered mental status, autonomic instability, cervical lesion(s) on MRI, or rapidly progressive course.

For more information please visit the CDC website.

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accessed 11/2018

Why does Getting Your X-waiver have to be seen as so X-rated?

SAMANTHA R. DANEK, PA-C

The reaction and responses I received were interesting when I first told people I was working towards completing my DEA license X-waiver. It always started with "the surprised, cautious look" (think raising of the eyebrows) followed by one of the following questions or statements:

- "I guess someone has to treat addicts."
- "PAs can obtain an X-waiver?"
- "Do you work in a Methadone clinic?"

I moonlit in the ER while working in a long-term acute care hospital (LTACH). In both settings, it is common to see the same patients with a differential diagnosis related to opioid addiction known as opioid use disorder (OUD). These diagnoses can range from endocarditis from intravenous drug use (IVDU) to overdoses resulting in anoxic encephalopathy.

Treatment for OUD would often last for six weeks or longer. I saw the impacts on patients including their crying children, shame, failure, distraught family members, and interactions with Child Protective Services (CPS). It ripped at my soul when I discharged my patients to an outpatient rehab only to see them back before long with another diagnosis related to addiction.

Table. DSM-5 Diagnostic Criteria for Opioid Use Disorder[a]

1. Opioids are taken in larger amounts or duration than intended
2. Persistent desire/unsuccessful efforts to cut down or control opioid use
3. A great deal of time is spent obtaining, using, or recovering from the effects of opioids
4. Craving
5. Recurrent use of opioid results in failure to fulfill major role obligations at work, school, or home
6. Continued use despite social/interpersonal substance-related problems
7. Important social, occupational, or recreational activities are given up or reduced because of substance use
8. Recurrent use in hazardous situations
9. Continued use despite knowledge of having a persistent or recurrent opioid-related physical or psychological problem that is likely caused or exacerbated by opioid use
10. Tolerance[b]
11. Withdrawal[b]

Severity: Mild: 2-3 symptoms, Moderate: 4-5 symptoms, Severe: ≥ 6 symptoms

[a] The information above is only an overview of the criteria used. Consult the DSM-5 before making a diagnosis.
[b] Note: This criterion is not considered to be met for patients taking opioids solely under appropriate medical supervision
Source: American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. Washington, DC: American Psychiatric Association; 2013:541.

After Michigan adopted stringent controlled substance prescribing requirements last year, many prescribers resent having a DEA license. Some providers no longer take patients with conditions that required an opioid prescription, many patients do not qualify for other pain management modalities, and pain clinics are often booked out six months.

When I asked providers how this will affect their patients, I would hear, "*we know the amount of people who overdose will go up", "we hope it's short-term but no one can be sure" and "at least we are doing something."*

It's as if no one is responsible for the outcome. This epidemic is too big to treat. It has become the new "normal" instead of an urgent health crises.

What if we debunk this powerless perspective and embrace empathy? What if we believe that our patients do not have to die or suffer? What if providers destigmatize the disease of addiction? I hope we will learn to do just that.

U.S. COMPREHENSIVE ADDICTION AND RECOVERY ACT (CARA)

CARA (Public Law 114-198) was signed into law on July 22, 2016. Under this federal law, PAs who completed 24 hours of approved training were eligible for a DEA-X waiver to prescribe medication-assisted treatment (MAT) of opioid use disorder (OUD). Comprehensive MAT is clearly the most effective treatment for addiction. To understand the potential impact of CARA, we have to understand the scope of the disease of addiction:

THE ADDICTION EPIDEMIC

MAPA's fall conference hosted a presentation by Dr. Cara Polland, MD, addiction specialist and past-president of the Michigan Society of Addiction Medicine. She started her presentation stating, "Everyone in medicine treats addiction." Looking at the facts, we see why.

1,2 In 2015, drug overdoses accounted for 52,404 deaths in the United States, 63.1% of which involved an opioid:

(1). Among opioid-related deaths, approximately 15,000 involved a prescription opioid

(2). An estimated 2 million people had opioid use disorder (addiction) associated with prescription opioids

(3). The economic burden of prescription opioid overdose, abuse, and dependence is estimated to be $78.5 billion each year

(4). Prescription opioid-related overdose deaths and admissions for treatment of opioid use disorder have increased in parallel with increases in opioids prescribed, which quadrupled from 1999 to 2010

(5). This increase was primarily because of an increase in the use of opioids to treat chronic non-cancer pain.

FACT: *In 2016, there were 1,786 opioid-related overdose deaths in Michigan—a rate of 18.5 deaths per 100,000 persons compared to the national rate of 13.3 deaths per 100,000. Preliminary data for 2017 will be around 1,941 deaths. 2,6 In response to this epidemic, Lieutenant Governor Calley signed into law multiple public acts to combat the opioid epidemic that affected healthcare and how prescribers like PAs practice.*

MICHIGAN PUBLIC ACTS IN 2017[3]

The Michigan Legislature supported by the Governor's Prescription Opioid Task Force adopted a number of controlled substance prescribing regulations in 2017 to address the growing opioid epidemic.

Public Act 246 requires a prescriber to discuss certain issues and obtain a signed parental consent form before issuing the first prescription to a minor in a single course of treatment for a

continued

X-WAIVER *CONTINUED*

controlled substance containing an opioid. It also required prescribers or health professionals to provide certain information and obtain a signed acknowledgment before prescribing an opioid to any patient.

Public Act 247 requires a bona fide prescriber-patient relationship before a licensed prescriber could prescribe a Schedule 2 to 5 controlled substance, with certain exceptions to be adopted by rule.

Public Act 248 requires a licensed prescriber to obtain and review a patient's Michigan Automated Prescription System (MAPS) report before prescribing a Schedule 2 to 5 controlled substance[1] to the patient, with certain exceptions.

Public Act 249 prohibits a licensed provider from prescribing a controlled substance listed in Schedules 2 to 5 unless the prescriber is in a bona fide prescriber-patient relationship with the patient being prescribed the controlled substance.

Public Act 250 requires a licensee or registrant who treats a patient for an opioid-related overdose to provide information to the patient on substance use disorder services.

Public Act 251 allows a pharmacist to incrementally fill a prescription for a Schedule 2 controlled substance in certain situations. It limits the supply of an opioid a prescriber could prescribe to a patient being treated for acute pain.

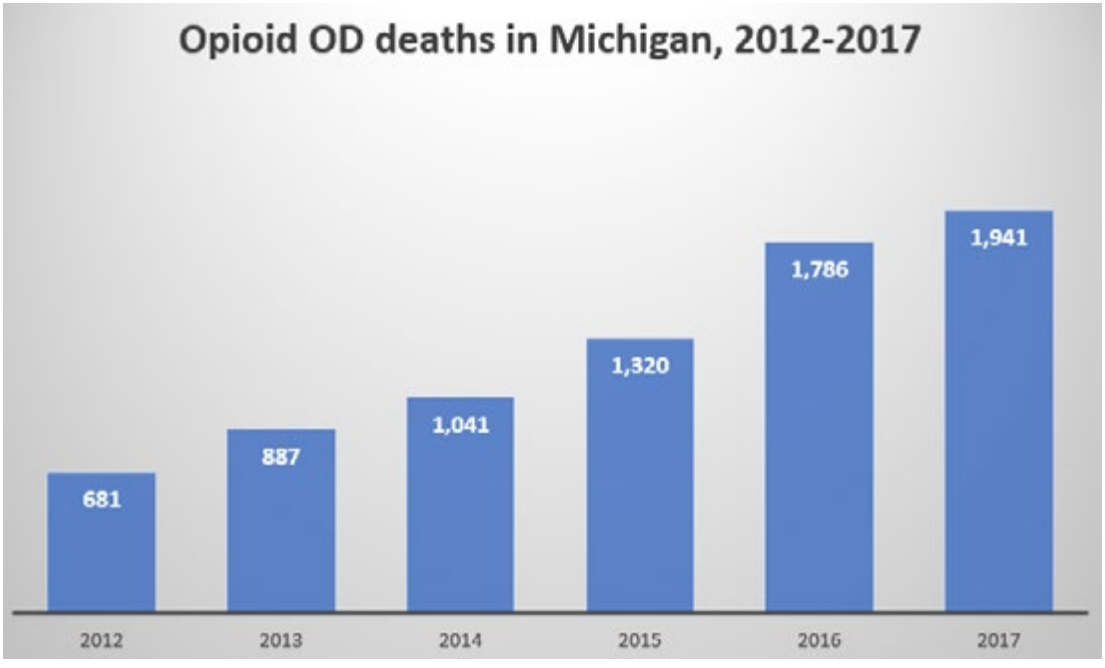
Public Act 252 requires the Department of Licensing and Regulatory Affairs (LARA) to establish an electronic system for monitoring the dispensing of Schedule 2 to 5 controlled substances by pharmacists, dispensing prescribers (i.e. physician assistants), or veterinarians.

Unfortunately, these well-intentioned public acts do not address the growing number of diagnosed people already suffering from an opioid use disorder (OUD).

MEDICATION ASSISTED TREATMENT (MAT): BUPRENORPHINE

Comprehensive MAT with Buprenorphine (aka Suboxone) can be used as an opioid maintenance therapy for people diagnosed with OUD.

Distinct from methadone, Buprenorphine may be prescribed by an X-waiver provider in a prescriber's office or a federally authorized opioid treatment clinic. It is an opiate partial agonist that binds to the mu



receptor with great avidity. Because of its increased affinity for the mu receptor, it will block other opiate agonists from binding to the same (mu) receptor, therefore, alleviating withdrawal and cravings.

When patients and physicians were surveyed by SAMHSA about the effectiveness of Buprenorphine, they reported an average of an 80% reduction in illicit opioid use, along with significant increases in employment and other indices of recovery.

Nationally, Michigan ranked sixth lowest for its ratio of Buprenorphine providers per overdose death in 2017.[4]

BUPRENORPHINE PEARLS[5]

- It is a partial μ-opioid antagonist approved for the treatment of opioid dependence.
- It is available as a sublingual tablet or film formulation to treat opioid dependence
- Generic Buprenorphine is available as a mono product in 2- or 8-mg doses, or as a combination product with 0.5- or 2-mg naloxone in a 4:1 ratio, respectively
- The potential for overdose and respiratory suppression is limited owing to the ceiling effect of μ-agonist activity
- It inhibits the effects of exogenously administered opioids owing to a high affinity for the μ-opioid receptor
- The side effects include headache, constipation, drowsiness, nausea and sleep problems

OBTAIN FREE X-WAIVER AND 24 HOURS OF CATEGORY 1 CME CREDITS!

To prescribe Buprenorphine, you must obtain an X-waiver by completing an eight-hour DATA-waiver course for treatment of opioid use disorder, and an additional 16 hour course. These online courses are offered by SAMHSA through the Providers Clinical Support System. Other courses are offered through other websites.

"I never plan to prescribe Buprenorphine. Why do I need to take the course?

Addiction is prevalent in almost every setting and almost every population. This training will help every PA identify and understand the disease of addiction even if you do not intend to treat OUD. It describes addiction as it relates to changes in the brain and how to approach a patient you suspect of an OUD. Additionally, the training reviews at-risk populations, and reviews non-pharmacological treatment modalities.

So…

Why does obtaining an X-waiver seem so X-rated? **Stigma**.

Why does it sound so taboo? **Comprehensive MAT is a relatively new and growing type of addiction treatment.**

How can we change it? **With PAs. We have proven that we deliver high quality care with positive outcomes for our patients.**

We are on the front lines of an epidemic and we owe it to our patients to lead, reduce the stigma, and to be educated on a disease that affects us all, no matter where

continued

X-WAIVER *CONTINUED*

we practice. Obtaining or completing the DEA X-waiver training can be an instrumental part of the solution, a solution that will save lives. So, let us get to work!

WEBSITES FOR FREE X-WAIVER TRAINING

https://pcssnow.org/education-training/mat-training/

American society of addiction medicine https://www.asam.org

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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

REGENERATIVE MEDICINE IS ELEVATING THE STANDARDS OF PATIENT CARE

After a decade of working in emergency rooms, Danielle Stabley, PA-C, brought her expertise to Allure Medical in 2017, becoming deeply involved with Allure's regenerative medicine treatments. The transition from treating red-button emergency issues to treating patients with long-term chronic diseases has been a rewarding one—Danielle says that the type of transformations she sees now often involve patients saying "I never thought I could get better, but now I am."

Her patients often suffer from chronic diseases like MS and COPD, while others have arthritic knees or have undergone a traumatic event, like a sports injury. For all cases, Danielle administers stem cell treatments to prompt the patients' own bodies to spur their own stem cells into action. "Regardless of your age, you still have stem cells," she points out. "We used to think that the injected stem cells turned into cartilage and tissue, but now we know that the injected cells are giving off signals that prompt your body's stem cells to regrow cartilage and tissue." Stem cell treatments are especially effective for arthritic knees, she says, with over 90% of patients reporting an improvement in their pain levels within 4 to 6 months.

Adipose-derived stem cells are autologous cells separated from the patient's own fat. "It's a new, innovative technology, and it's very effective—once the cartilage regrown, patients are able to resume doing activities they had previously given up." Stem cells can also be derived from bone marrow and umbilical cords, but researchers are still trying to determine which is the most effective. "In terms of tolerability, umbilical stem cells are easier for patients because they don't have to have liposuction done," Danielle says. Allure offers umbilical-cord-derived stem cell treatments as well as adipose-derived treatments.

Although regenerative medicine outcomes are difficult to predict because they depend on the individual patient, Danielle has seen stem cell treatments put patients into remission within a year after treatment. That translates to a lot less pain…and a lot fewer patients ending up on potentially addictive opioid painkillers. Many patients with arthritic knees have such a marked improvement that they're even able to avoid surgery.

While many patients receiving regenerative treatments can benefit from lifestyle changes, Danielle focuses on helping patients with autoimmune diseases adopt healthier habits. Research is showing that there's a link between the microbiome and autoimmune diseases. Danielle teaches patients how to be more aware of what they eat, encouraging them to consume foods that help increase friendly gut bacteria and decrease foods that increase harmful bacteria. Because low levels of testosterone are linked to autoimmune diseases, Danielle checks her patients' hormones and puts them on hormone replacement therapy as needed. "For a lot of patients, testosterone helps create more muscle mass and bone density, so we couple stem cell treatments with testosterone replacement."

Patients with long-term diseases may not have a lot of treatment options, and when these patients see success with stem cell treatments, Danielle is even more thrilled. One patient with cystic fibrosis has found that the treatments have decreased her rate of hospitalizations and infections and have increased her pulmonary function. Another patient, who was a paraplegic as the result of a car accident, has started to walk again after three treatments.

Whether her patients come in because they're suffering from a debilitating condition or showing arthritic symptoms, Danielle says that the work she's doing is rewarding and fascinating. All 7 of Allure Medical's Michigan offices provide umbilical stem cell treatments. Danielle thinks that regenerative medicine and gut biome studies are the two biggest things on the horizon right now, and she's eager to see where that path will lead next.

ALLURE medical

STRATEGIC THINKING + COMPASSIONATE CARE = SATISFIED PATIENTS + INDUSTRY INNOVATION

Theresa LaBranche, M.S. PA-C, has worn many hats during her 11 years at Allure Medical: beginning as a clinician and now Executive Director. "Because I'm also a clinician, I understand how my leadership decisions will affect frontline employees," she says. "After so many years of working in the business, now I work on the business." Theresa started honing her leadership skills as the cosmetic director, when she built Allure's nonsurgical cosmetics into $6 million a year business. As clinical director, she continued her trajectory, overseeing Allure's 5 service lines and aided in expansion. The business is now in four states, with seven locations in Michigan and seven more locations spread across the country with plans to double the number of offices by the end of 2019.

With that kind of growth, Theresa created a talent acquisition department to handle recruiting needs. "We're being creative in the process of recruiting and building an accredited school for Registered Phlebology Sonographers," she explains. "We've exhausted the tech pool in Michigan, so we're creating our own program to meet our needs. The RHPS path is one of the two career training paths we have for our employees." "The other path," she says, "is the front desk team. Those employees can set up new offices and become regional liaisons for out-of-state practices, providing acquired offices with administrative and cultural support."

Along with strategizing new service lines and pricing for existing lines, Theresa defines and analyzes KPIs, negotiates compensation packages and vendor contracts. Theresa has also created an employee engagement team that provides coaching and allows employees to provide input into how the business is run. "During the quarterly coaching sessions, we can help them assess where they are and where they'd like to go," she says.

Given the ongoing support and encouragement employees receive, it's not surprising that Allure Medical has won awards such as Detroit Free Press' Top Places to Work, Crain's Cool Places to Work and one of Inc 5000's Fastest Growing Companies, a national achievement. The company has 200+ employees, including over 20 medical doctors and midlevel practitioners. "We're a PA- and NP-driven practice, and our founder, Dr. Charles Mok, is a true innovator who will impact healthcare across the country," Theresa says. Allure's current goal is to save the healthcare industry $10 billion a year, which they plan to achieve by expanding their nonsurgical varicose vein treatments. Wound care for varicose veins costs the US $16 billion a year, but if damaged veins are treated with laser ablation, surrounding veins can restore proper blood flow, preventing ulcers (and the need for wound care) from forming in the first place.

Another venous insufficiency condition that causes patients chronic pain is pelvic congestion syndrome. Millions of women have PCS and are currently being given opiates for chronic pain management. "You can treat it the same way as you do varicose veins," Theresa says. "Our next focus is going to be treating PCS—by freeing PCS patients from chronic pain, we hope to make an impact on the opioid crisis, which will massively impact healthcare costs."

Allure also offers hormone replacement, regenerative stem cell, nonsurgical cosmetic enhancement, and cosmetic surgery. It's easy to see why they needed to hire 30 employees just in the month of September! The on-boarding process is extensive: the talent acquisition team sources the candidates who perform a skills screening, then a culture screening, and finally come in for a walking interview, where they spend a couple of hours with the team they would be joining. Afterwards, the team votes as to whether a candidate is a good fit. "It's a win all the way around," says Theresa. "Thanks to the walking interview, candidates can see if the environment appeals to them. That, plus the positive work environment and excellent employee benefits, is why we have low turnover."

Allure Medical is actively recruiting talent for all positions. As a PA with management experience who's also getting her MBA, Theresa thinks that the combination of PA/NP credentials and leadership skills is invaluable. "We have a unique perspective," she says. "And that perspective translates to a lot of opportunities in business."

ALLURE medical

MNI GREAT LAKES MICHIGAN BONE HEALTH PROJECT ECHO

AVERY M. JACKSON III, MD FAANS FACS, CEO/FOUNDER MNI GREAT LAKES ECHO

LAUNCHED: FEBRUARY 24, 2017

DESCRIPTION

On innovation – MNI Great Lakes ECHO, LLC is the first practice public venture, the first Bone Health ECHO replicatee worldwide, and the first Project ECHO hub in the state of Michigan (outside of the VA system).

- *Hub: MNI Great Lakes ECHO and the Michigan Neurosurgical Institute, Grand Blanc, MI*
- *Strong advanced provider presence with experts and learners worldwide*
- *Some unique discussion around surgical treatment of vertebral osteoporotic fractures as well as nonprocedural treatment solutions*
- *Participants in the US and other countries represent a broad range of specialties and levels of expertise.*

1. SCHEDULE

Monthly – every 4th Friday, 12-1pm ET (11am-12pm CT, 10-11am MT, 8-9am PT)

2. EXECUTIVE AND MEDICAL DIRECTOR

Avery Jackson III, MD

3. REGISTRATION

Contact the academic coordinator – Caramarie Brock, PA-C @ mnigreatlakesecho@gmail.com or 248-331-7880

4. COST OF PARTICIPATION

1) *Companies or entities: (fair market value)*

2) *Licensed individual practitioners: $0*

5. BENEFITS OF PARTICIPATION

1) *Share cases in a safe, best practice, sharing environment with two-way learning*
2) *Hear a cutting edge, timely didactic by an expert in the field monthly on specific topics related to Bone Health*
3) *Earn CME credit (1 hour of Category 1) per session*
4) *Develop the "joy of work" as you get to befriend and collaborate with colleagues from all over the region and world in a supportive atmosphere from your laptop or cell phone on lunch break!*
5) *Research opportunities*
6) *Have the ECHO group help do the heavy lifting of the day-in and day-out work of your decision-making and management process! Join this independent, non-biased, and free-standing operation ("Only ECHO all the time") in order to help address these touch issues together in the spirit of true collaboration! Join this friendly guided "virtual Grand Rounds" today!*

MAPA'S PERSISTENCE PAYS OFF!

Michigan PAs to Prescribe Physical Therapy

PHIL SCHAFER PA-C, LEGISLATIVE AFFAIRS CHAIR

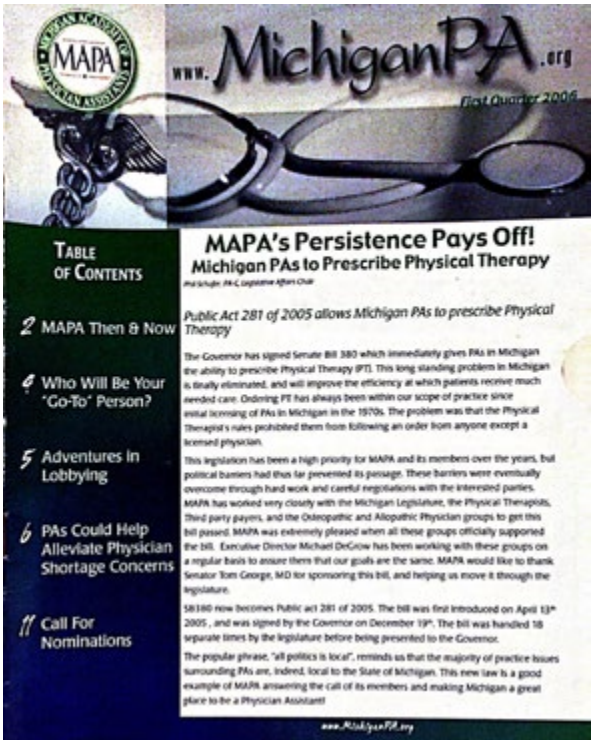
EDITOR'S NOTE: ***This headline may have surprised you but it was greeted with great excitement in 2005 as PAs had been restricted from writing orders for physical therapy orders since the inception of PAs in the mid 70's. BTW; physicians were given the ability to delegate controlled med prescriptive privileges 3-5 to PAs in the outpatient setting and a 7 day supply upon discharge yet we couldn't write for Physical Therapy care for our patients.***

PUBLIC ACT 281 OF 2005 ALLOWS MICHIGAN PAS TO PRESCRIBE PHYSICAL THERAPY

The Governor has signed Senate Bill 380 which immediately gives PAs in Michigan the ability to prescribe Physical Therapy (PT). This long standing problem in Michigan is finally eliminated, and will improve the efficiency at which patients receive much needed care. Ordering PT has always been within our scope of practice since initial licensing of PAs in Michigan in the 1970s. The problem was that the Physical Therapists' rules prohibited them from following an order from anyone except a licensed physician.

This legislation has been a high priority for MAPA and its members over the years, but political barriers had thus far prevented its passage. These barriers were eventually overcome through hard work and careful negotiations with the interested parties. MAPA has worked very closely with the Michigan Legislature, the Physical Therapists, third party payers, and the Osteopathic and Allopathic Physician groups to get this bill passed. MAPA was extremely pleased when all of these groups officially supported the bill. Executive Director, Michael DeGrow has been working with these groups on a regular basis to assure them that our goals are the same. MAPA would like to thank Senator Tom George, MD for sponsoring this bill, and helping us move it through the legislature.

SB380 now becomes Public act 281 of 2005. The bill was first introduced on April 13th, 2005 and was signed by the Governor on December 19th. The bill was handled 18 separate times by the legislature before being presented to the Governor.



The popular phrase, "all politics is local", reminds us that the majority of practice issues surrounding PAs are, indeed, local to the State of Michigan. This new law is a good example of MAPA answering the call of its members and making Michigan a great place to be a Physician Assistant!

This is an example of the work that MAPA has been doing for over 30 years now to improve and protect the practice environment for all Michigan PAs!

MICHIGAN ACADEMY
of PHYSICIAN ASSISTANTS

1390 Eisenhower Place
Ann Arbor, MI 48108

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MAPA PLANNER

EVENTS/ CONFERENCES

MAPA BOARD MEETING

DATE: January 12, 2019
SITE: Okemos, MI

CALL FOR CANDIDATES

DATE: February 1, 2019

MSU/MAPA HEALTHCARE LEADERSHIP ACADEMY

DATE: February 22-23, 2019 (Module I)
March 18-20, 2019 (Module II)

MAPA SPRING CME CONFERENCE

DATE: March 2, 2019

SITE: Eastern Michigan University
Ypsilanti, MI

mapaevents.org

MAPA LEADERSHIP SUMMIT

DATE: May 1, 2019

SITE: Michigan Capital Building
Lansing, Michigan

michiganpa.org

MAPA FALL CME CONFERENCE

DATE: October 10-13, 2019

SITE: Grand Traverse Resort and Spa
Acme, Michigan

mapaevents.org