Bridge the GHAPP

Gastroenterology & Hepatology
Advanced Practice Providers

NEWSLETTER

VOLUME 7

LETTER FROM THE PD COMMITTEE

Dear GHAPP Family,

Conference time is here! We have been doing great with our Regional Conferences so far (there's a few left, if you have not yet been able to attend), and now we are looking forward to another successful National Conference this year, with perhaps our largest attendance and membership numbers to date. We have a great lineup, including the Bootcamps: MASH/MASLD (not the show! But a review of the newly named NASH/NAFLD) and IBD Bootcamps. We also have our Workshops, with two given by our own committee: How to Write a Research Abstract and How to Create a Research Poster. If you haven't signed up yet, what are you waiting for? The Bootcamps and Workshops are great places to dig into interesting topics and connect with your fellow APPs, too.

Volume 7 of the newsletter has more of our weight-loss medication series, as well as some helpful summaries from last year's conference lecture on A Professional Spin on the Life of an APP. All are worth a read, and we highly encourage you to peruse what these newsletters have to offer with each publication.

Lastly, we want to hear from you! If you have a question, a story, an idea, a critique, a research study, or anything potentially newsletter related, please send it along to the group. We will be happy to discuss it with you. Will you see your name in a byline on the next Volume? Only one way to find out.

In Health,
The Professional Development Committee

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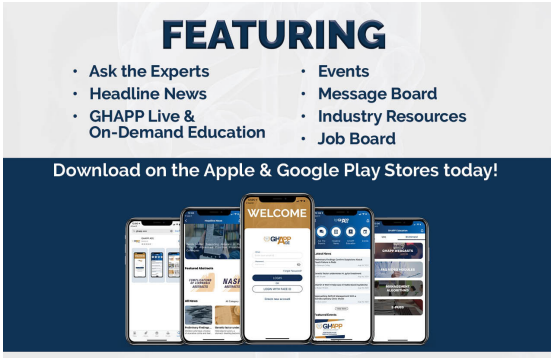

Weight Loss Medications for the Gastroenterology and Hepatology APP
Part 2: Obesity Medications and Their Considerations

Allysa D. Saggese, MSN, AGPCNP-BC

Each time we read about or discuss obesity, we are reminded that it is an epidemic with rising rates and that it is a root cause of a significant number of chronic and potentially fatal conditions (Apovian, 2016; Temple, 2022). Therefore, action to reverse it is necessary. We are all well aware that diet and exercise are the mainstays of weight management and weight-related treatment; however, as new anti-obesity pharmacotherapies are quickly emerging, medications are now being incorporated into patients' plans of care, in addition to advising lifestyle changes.

In Part 1 of this article series, we reviewed a brief history and some considerations about the most current weight loss medications on the market. In this Part 2, we will detail the options, their side effects, and how to choose an appropriate patient for the drug in question.

Chronologically, the first approved weight loss medication in the US was phentermine. A long time then elapsed before more drugs were made (Ryan and Bray, 2014; Rogers et al., 2012). In 1999, orlistat came onto the market, but it wasn't until 2012 that we had a reinvigoration of anti-obesity medications (AOMs) tested and approved. Since that time, we have seen phentermine/topiramate, naltrexone/bupropion, lorcaserin (recalled in 2020), liraglutide, and semaglutide get approved and prescribed.

Tables 1 and 2 below outline the important items to know about each medication, while the rest of this article is about the considerations taken when choosing a medication.

I want to note: each one of these medications carries the indication of "for adults with an initial BMI of 30 or more (obese) or 27 or more (overweight) with at least one weight-related medical condition, such as controlled high blood pressure, diabetes, or high cholesterol" unless otherwise specified (package inserts). All medications have the capability to interact with another medication, some of these interactions will be discussed here, but it is recommended to always do a thorough medication reconciliation and interaction check before prescribing. Lastly, none of these medications are approved for pregnancy, so they should not be given during pregnancy and should be stopped immediately upon discovery of a pregnancy, as some also carry a risk of fetal harm.

Phentermine is an anorectic monotherapy Schedule IV controlled substance designed to be used short term for weight loss (Package insert for Lomaira and Adipex). A patient's cardiac and pulmonary history must be reviewed before prescribing because of its serious side effects of primary pulmonary hypertension and valvular heart disease. The most common side effects seem to be the "overstimulation" side effects, including palpitations, dizziness, etc., and may be a common reason for discontinuation of the medication (Adipex-P and Lomaira Package insert). Phentermine also interacts with SSRIs and over-the-counter herbal preparations, as well as other weight loss preparations, and so should not be used in combination, or the patient should be considered for another AOM.

Orlistat is available in both prescription and over-the-counter forms. It is an inhibitor of pancreatic and gastric lipases; therefore, it causes low absorption of fats and will induce steatorrhea in the setting of high fat intake (Ryan, 2021). A patient may take fiber such as psyllium to help mitigate this side effect, as well as sticking to a low-fat diet (Ryan, 2021). Other side effects include decreases in vitamin absorption, increased risk of renal stones, or decreases in medication absorption (Ryan, 2021). This is one of the less prescribed weight loss options, not only because it is available OTC but because it is less tolerated overall; however, it is one of the only medications approved for long-term use (Ryan, 2021; Medscape). For a patient already suffering from bowel disorders or vitamin deficiencies, orlistat is not an ideal choice.

Qsymia and Contrave are both oral combination medications. Qsymia combines phentermine with topiramate, which affects GABA receptors, and both are taken at lesser doses together than they would be alone (Qsymia package insert). While phentermine has a stimulating effect, topiramate has a sedating effect; therefore, the combination may be better tolerated in patients who are sensitive to this. Topiramate is also thought to help curb cravings and impulsive eating habits, so patients with some identified disordered eating would potentially benefit from phentermine/topiramate (Butsch, 2015).

Table 1: Medication Basics

Name	Brand Name	Doses	Instructions
Phentermine	Adipex, Adipex-P, Lomaira	8mg, 15mg, 37.5mg	8mg doses (Lomaira): take one pill three times a day with meals 15mg or 37.5mg (Adipex): Take one pill once a day 1-2 hours before meals
Orlistat	Alli, Xenical	60mg, 120mg	Take one pill 3 times a day with meals
Phentermine/topiramate	Qsymia	3.75mg/23mg, 7.5mg/46mg, 11.25mg/69mg, 15mg/92mg	Take one pill once a day with or without food.
Naltrexone/bupropion	Contrave	8mg/90mg	Take one pill in AM for 1 week, increase to one pill twice a day for 1 week, increase to two pills in AM and one pill in PM for 1 week, then two pills twice a day for maintenance dosing. Can do titration every 4 weeks for better tolerability (Ryan, 2021)
Liraglutide	Saxenda	0.6mg, 1.2mg, 1.8mg, 2.4mg, 3.0mg	Inject daily lowest dose for 1 week, then uptitrate each week as tolerated.
Semaglutide	Ozempic, Wegovy	0.25mg, 0.5mg, 1mg, 1.7mg, 2.4mg	Inject weekly starting with lowest dose, then uptitrate monthly as tolerated.

Contrave, on the other hand, is a combination anti-depressant (bupropion) and opioid agonist (naltrexone), so this medication is a good consideration for someone who may have some underlying depression or may even want to quit smoking, as bupropion alone is used for these indications (Ryan, 2021). Bupropion/naltrexone is contraindicated for those on opioid pain medications, as this will suddenly stop their effectiveness (Package insert). However, it also carries a risk of suicidal ideation (SI), which is an important consideration in someone who has a history of SI or who has bipolar disorder, as not all anti-depressants can be used in these patients.

Perhaps the most well-known of these medications are liraglutide and semaglutide (Saxenda and Wegovy, respectively). Both are subcutaneous injections, with liraglutide being a daily injection and semaglutide being a weekly injection. Both are inhibitors of Glucagon-like peptide-1 (GLP-1), "an incretin hormone with important effects on glycemic control and body weight regulation" (Knudsen and Lau, 2019). They act by extending the half-life of GLP-1s, thereby reducing food intake and increasing energy expenditure without changes in activity (Ryan, 2021; Package insert; Drucker, 2021). The main considerations for these medications are to avoid their use in those with a familial or personal history of medullary thyroid cancer, Multiple Endocrine Neoplasia 2, and gastroparesis, as it causes delayed gastric emptying as one of its mechanisms of action (Ard et al., 2021).

Patients may be adverse to giving themselves injections, which would influence a provider's choice for the once-weekly injection over the daily injection, or they may choose an oral medication instead, if possible, for the patient. The most common side effects of GLP-1s are nausea, vomiting, and diarrhea. This becomes a significant consideration for patients with obesity, as they are more likely to have some gastrointestinal symptoms at baseline, and this medication will likely exacerbate them (Change and Friedman, 2014). Before starting either medication, patients should be counseled on side effects and have a plan of action in place if these side effects happen. This could include prescribing a proton-pump inhibitor or anti-nausea medications, or deciding on a slower titration schedule overall so that the patient can get used each dose over a longer time.

At the time of this article's writing, the most recent news about semaglutide is twofold: it has been shown to reduce cardiovascular risks that are often associated with metabolic-related disorders, but it is also under review for potential SI side effects (Zoler, 2023; Youmshajekian, 2023). While the SI side effects are still under review and not yet confirmed, both of these possible complications are more factors to take into consideration when prescribing semaglutide to patients. The potential for cardiovascular benefit will likely become a significant choosing factor for most providers, even with the possible risk of SI.

In my practice, I have a focus on Steatotic Liver Disease and Metabolic Dysfunction-Associated Steatotic Liver Disease, the newly named Non-Alcoholic Fatty Liver Disease, and so our approach to the patient in need of weight loss medications keeps this in mind. We attempt to have semaglutide approved first, as it is most promising for both weight loss and a reduced occurrence of hepatic steatosis (Fraile et al., 2021). However, this is not always the right approach for all patients. We take into consideration all of the severe and common side effects noted in Table 2, as well as differences between medications and their mechanisms of action, in order to choose the right starting medication for our patients. This, however, does not account for the struggles with insurance approval and coverage, which can also dictate our course with medications, nor does it consider current pharmacy stocks. The approach to insurance and getting the medication into the hands of the patient, as well as continued medication compliance, will be the subject of the next article in this series.

Table 2: Medication Side Effects and Considerations

Name	Severe Side Effects	Common Side Effects	Considerations
Phentermine	Primary pulmonary hypertension; valvular heart disease	Insomnia, dry mouth, palpitations, dizziness, tremor, headache, diarrhea, constipation	Those with a cardiac or pulmonary history should avoid, those taking SSRIs, certain herbal supplements or other weight loss medications cannot take this medication
Orlistat	Steatorrhea	Steatorrhea, renal stones, hepatoxicity, decrease in vitamin absorption, decrease in medication absorption, flatulence, bloating, abdominal pain, dyspepsia (Rogers et al., 2012)	Patients who take other medications need to closely read the package insert as to timing or interactions with other medications; can take psyllium to help with steatorrhea. May be good for those with hypertension (Cohen and Gadde, 2019)
Phentermine/topiramate	Embryo-Fetal Toxicity, Suicidal Ideations, acute myopia or acute glaucoma; also as above with phentermine	Dizziness, dry mouth, paresthesias, dysgeusia, insomnia, constipation	Good for those with cravings/impulsive eating habits. Interacts with many other medications; consult list before prescribing
Naltrexone/bupropion	Suicidal thoughts or behaviors, seizures	Nausea, vomiting, constipation, diarrhea, headaches, dizziness, insomnia, dry mouth, increase in blood pressure	Cannot be used in those with uncontrolled hypertension, seizure disorders, or chronic opioid use; consider for those who may benefit from an anti-depressant
Liraglutide	Acute pancreatitis, acute gallbladder/ gallstones, thyroid C-cell tumor, hypoglycemia, depression or thoughts of suicide, kidney problems	Nausea, vomiting, delayed gastric emptying, constipation, dizziness, injection site reactions, abdominal pain, increased heart rate	Should not be given to those with a personal or family history of medullary thyroid cancer or Multiple Endocrine Neoplasia Syndrome 2. This is a daily self-injection. Those with gastroparesis should avoid this medicine. Needs to be kept refrigerated.
Semaglutide	Acute pancreatitis, acute gallbladder/ gallstones, acute kidney injury, diabetic retinopathy, hypoglycemia	Nausea, diarrhea, vomiting, constipation, abdominal pain, headache, fatigue, dyspepsia, dizziness, abdominal distension, eructation, hypoglycemia in patients with type 2 diabetes, flatulence, gastroenteritis, gastroesophageal reflux disease, and nasopharyngitis	Should not be given to those with a personal or family history of medullary thyroid cancer or Multiple Endocrine Neoplasia Syndrome 2. This is a weekly self-injection. Those with gastroparesis should avoid this medicine. Needs to be kept refrigerated.

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Professional Development

The following article is summarized from notes from the last conference lecture of A Professional Spin on the Life of an APP

Inpatient Coding and Updates

Allysa D. Saggese, MSN, AGPCNP-BC

We are all currently using ICD-10. However, ICD-11 has passed, and we will be seeing it shortly. The most common issues in coding are under-coding and over-coding. Under-coding results in lost revenue, and over-coding is considered fraud, so paying attention to an appropriate level of service and additional codes for performed procedures is essential.

What may not be well known is using incident to and shared visits coding. Incident to is outpatient, established with the physician on-site, and when this kind of coding is allowed, it results in a 15-20% increase in reimbursement. This is because, as we know, billing under the NPI of an NP or PA is usually for less than billing under an MD NPI. This kind of visit must be one by a patient who is an established follow-up, and there is no change to the plan of care. A shared visit is inpatient, where you must have a face-to-face visit conducted. This model is most frequently used for attendings/trainees. The choice for billing is either MDM- or time-based, and that choice will go to the person who spent the most time with the patient.

For the inpatient side of medicine, diagnosis-related groups (DRGs) were discussed, as well as MCD 6 and MCD 7 tiered systems for assessing complexity. The key concepts here are: the severity of the illness justifies inpatient care, if the disease was present on admission or prior to admission; hospital acquired conditions (HAC) or complications increase DRG weight, but payers are penalized for HAC unless these were documented as 'present on admission'; defining if a patient is being admitted or staying for observation is key; however, observations are going to be discontinued next year.

The pearls from this discussion were: good coders in the billing department are extremely helpful. You can request audits to ensure that you are coding and billing properly and to optimize your documentation so that it captures chronic conditions and the severity of illness.

The following article is summarized from notes from the last conference lecture of A Professional Spin on the Life of an APP

Making an Impact on Healthcare Professional Audiences

Allysa D. Saggese, MSN, AGPCNP-BC

Two main ideas to keep in mind that an audience is assessing are: Are you likeable and are you competent? Nonverbal skills set the tone for all communication settings, and when used effectively, they convey confidence and competence. These nonverbal cues include eyes, voice, gestures, posture, and attitude. Use pauses to pace your talk, as this also helps you avoid "creep" words like "um." Making eye contact with your audience members imparts the feeling that you are conversing with them, so you can keep eye contact until the thought is completed. Use your natural hand gestures as you review your material, and avoid the more common and "stiffer" ones that seem unnatural.

When moving through your slides, own it. Do not read off the slides to the audience, but instead guide them through your material. You can be specific in your language and visually orient the audience to the location of the information you are discussing on the slide. Giving the audience the gist or critical points of the information on the slide, rather than describing it all, is helpful and will keep your audience engaged. It has been noted that an audience's attention span is best at the beginning and end of a talk, so it may be helpful to switch up your approach in the middle to prevent audience "drift." At the end of a talk, working through the question-and-answer section by acknowledging a questioner's main idea, repeating their question, rephrasing it, and answering by finding support in your data in your slides were the main points discussed in this presentation.

Membership Committee Notes

GHAPP membership continues to grow, and if you have colleagues who still need to join, encourage them to join over 3000 APPs. Membership remains free, so take advantage of this great opportunity.

Newer APPs can take advantage of many opportunities, including mentorship, networking, and educational resources.

The annual GHAPP conference is just around the corner, and over 755 registrants have signed up to date. We look forward to engaging with everyone, especially new members and those coming for the first time. **The Membership Engagement Committee will host the annual new attendee social hour at Pose Rooftop Lounge at 7 pm on Friday, September 8.** The yoga hour has already proved to be popular and is at capacity!

Don't forget to add **#GHAPP2023** to all your social media posts about the event. Share your insights, network with peers, and keep updated on conference happenings.

The GHAPP LinkedIn account has over 200 followers!
https://www.linkedin.com/company/ghapp

Spread the word and join today!

Regional & National Conference News

Regional

Congratulations to the excellent presenters at our Regional Conferences! The meetings have been a grand success. The evaluations completed by the attendees show outstanding ratings. We have three more meetings scheduled. If you can attend, please visit **https://www.ghapp.org/regionals** for details!

	Gastroenterology	Hepatology	Confirmed Date	Confirmed Venue
Scottsdale, AZ	Sharon Rimon, FNP-BC	Ann Moore, NP	Thursday, October 19, 2023	Hilton Scottsdale Resort & Villas
New Orleans, LA	Stephanie Eschete, PA-C	Jeremy Davis, ACNP-BC	Thursday, October 26, 2023	New Orleans Marriott
Miami, FL	Carol Antequera, DMSc, PA-C	Melissa Franco, PA-C	Thursday, November 16, 2023	Hotel Colonnade

National

Keynote Speaker

New this year to the national conference is a Keynote Speaker lecture. We are excited to welcome Rachael L. Fleurence, Ph.D., MSc., who will present the ***National Initiative to Eliminate Hepatitis C in the United States***.

Dr Fleurence is currently a Senior Advisor at the National Institutes of Health, where she works on a national elimination plan for Hepatitis C under the leadership of Dr. Collins. Previously, Dr. Fleurence served as a senior health policy advisor at the White House, during which time the national elimination program was first developed. Prior to her role at the White House, Dr. Fleurence served as a Senior Advisor to the Director at the NIH, where she led several of the first COVID-19 home-testing programs.

Boot Camps and Workshops

Have you registered for a Boot Camp and your Workshops? If not, please go to the registration page and sign up! **https://www.ghapp.org/annual-conference**

Boot Camps

Boot Camps are more in-depth, topic-specific, and well worth your valuable time.

MASH/MASLD Boot Camp National Harbor	IBD Boot Camp (General GI Novice APP)
	IBD Boot Camp (Advanced to Expert)

Workshops

Over 30 workshop options are available Friday and Saturday! Check out all the great topics.

Welcome Student Scholarships Recipients!

We have awarded **30 APP student scholarships** to attend the conference this year. Thank you to all who recommended them. We are confident their experience will be highly beneficial.

Thank you to all the GHAPP Supporters and Sponsors!

Please be sure to visit their exhibits at the Regional and National Conferences.

Would you like to host a CME Lunch and Learn?

Since March 2023, GHAPP has hosted a nationwide lunch-and-learn series at community and institution group practices. They have been exceptionally well received and provide valuable education and credits in a convenient location!

The GHAPP Breaking Boundaries in Hepatic Encephalopathy (HE) Educational Series aims to facilitate discussion for smaller groups of APPs, allied healthcare professionals, claims specialists, and office personnel. APPs can join as faculty, where they present and engage in their own practice or other local practices. The program format is designed to be informal, promoting an atmosphere conducive to education and interactive Q&A.

If you wish to host a lunch and learn on this topic, please email Christine at **cpolicastro@focusmeded.com**.

New E-PUBs on GHAPP ACE APP & Website

https://www.ghapp.org/e-newsletters

Newest Edition – Volume 8
Recommendations on Hepatic Encephalopathy Guidelines for APPs

Thank you to the GHAPP Roundtable attendees who authored the latest E-Newsletter providing expert opinions on the AASLD guidelines for Hepatic Encephalopathy.

For more information, please visit:

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