Primary, Secondary and Tertiary Prevention: Important in Certification and Practice

by Margaret A. Fitzgerald, DNP, FNP-BC, NP-C, FAANP, CSP, FAAN, DCC

The NP certification exam is a test of the broad-based knowledge needed for practice. Primary, secondary and tertiary prevention activities, or promoting health, early disease detection and treatment of established disease are crucial parts of the NP role. This is typically reflected in exam content. A sound understanding of these concepts is important to being successful in your pursuit of certification and will also help you in clinical practice.

The US Preventative Services Task Forces’ Guide to Clinical Preventive Services (USPSTF) defines primary prevention measures as those provided to individuals to prevent the onset of a targeted condition. Primary prevention measures include activities that help avoid a given healthcare problem. Examples include passive and active immunization against disease as well as health-protecting education and counseling promoting the use of automobile passenger restraints and bicycle helmets. Since successful primary prevention helps avoid the suffering, cost and burden associated with disease, it is typically considered the most cost-effective form of healthcare.

Secondary prevention measures are those that identify and treat asymptomatic persons who have already developed risk factors or preclinical disease but in whom the condition is not clinically apparent. These activities are focused in early case findings of asymptomatic disease that occur commonly and have significant risks for negative outcomes without treatment. Screening tests are examples of secondary prevention activities, as these are done on those without clinical presentation of disease that have a significant latency period such as hyperlipidemia, hypertension, breast and prostate cancer. With early case finding, the natural history of disease or how the course of an illness unfolds over time without treatment can often be altered to maximize well-being and minimize suffering.

Tertiary prevention activities involve the care of established disease, with attempts made to restore to highest function, minimize the negative effects of disease, and (Prevention: Continued on Page 11)
Breastfeeding News

Is it Possible to be Allergic to Breastfeeding? by Marie L. Bosco, BSN, RNC, IBCLC

The health benefits of breastfeeding for both mothers and their infants have been well identified in research and fully supported by multiple health organizations including the World Health Organization, Baby Friendly Hospitals USA, The American Academy of Pediatrics, The US Centers for Disease Control and Prevention, and Healthy People 2020. At the same time, there are occasional reports of a woman being allergic to breastfeeding, a normal physiologic activity. How is this possible?

The groundwork for milk production begins long before the delivery of a baby. Beginning around the 24th week of pregnancy, hormones are produced that stimulate the growth of milk ducts in the breasts. Estrogen, prolactin and progesterone support the growth of milk ducts and alveoli within the breasts. Late in pregnancy, the breasts begin to produce colostrum; full lactation remains inhibited secondary to high progesterone levels. Following delivery of the infant and the placenta, the progesterone levels drop dramatically while prolactin levels remain high. Prolactin supports lactation along with other hormones such as insulin, thyroxin and cortisol. Oxytocin contracts the uterus following birth and also causes the alveoli in the breasts to contract causing milk let-down also known as the milk ejection reflex.

There is some controversy over whether or not a woman can be allergic to breastfeeding. There are women who have allergy-like symptoms associated with the milk ejection reflex during breastfeeding. These symptoms can include itching, redness, rash, or hives on the trunk, arms or legs. These symptoms can also represent adverse reactions to the synthetic forms of oxytocin such as oxytocin (Pitocin, Syntocinon). Injectable oxytocin is used to induce labor and prevent bleeding following delivery; in its nasal spray form (Syntocinon), oxytocin is used by women who have an inhibited let-down reflex thought to be from lack of natural oxytocin release during pregnancy. While counterintuitive that a woman could be allergic to herself, many immune responses and inflammatory responses in the human body remain unclear. Although a reaction to lactation let-down has been seen in breastfeeding women, this is quite rare. Women who appear to have a reaction during let-down can treat the symptoms with a topical corticosteroid and an oral antihistamine.

The direct cause of this reaction, whether it be the oxytocin itself or a side effect of this hormone or another hormone present during lactation, has not been researched thoroughly. If a woman is experiencing any new symptoms during breastfeeding it is important that she seek attention from her healthcare provider where a complete history along with a differential diagnosis and treatment plan can be made.

References:

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Wintertime Fun with Fitzgerald Health Education Associates, Inc.

Dr. Margaret A. Fitzgerald and FHEA CEO Marc Comstock find some time to go snowshoeing after our January Pharmacology Update in Mount Snow, Vermont.
HIPAA Compliance Issues on the Rise
In the age of technology where nearly everyone carries a smart phone and hospitals and practices are switching to electronic health records, health insurance portability and accountability act (HIPAA) compliance issues are rampant. The Office for Civil Rights (OCR), a sub-organization of the US Department of Health and Human Services (HHS) is required to conduct audits within the healthcare field to evaluate HIPAA compliance. In 2011, healthcare organizations and professionals made waves as the number of violations increased, according to the Second Annual Benchmark Study on Patient Privacy and Data Security conducted by Ponemon Institute, LLC. The study involved 72 healthcare organizations and revealed that 96% of them had a minimum of one data breach per 24 months, with each breach costing an average of $2.2 million, an increase of $200,000 since the previous year’s study. An average of 2,575 records per breach were lost or stolen, an increase of more than 800 since the 2010 study. Breaches were defined as the loss or theft of a computer and mix-ups caused by employees or a third-party. Notable breaches that made headlines in 2011 included a Rhode Island physician who was fired and fined for discussing patient information via a social media website, a breach at Stanford University in California that made 20,000 emergency department records public and a Massachusetts General Hospital employee who abandoned patient records on a train.

Missouri Hospital Develops Compassion Fatigue Program
Compassion fatigue, the gradual loss of compassion associated with working in high-stress environments, is common among healthcare professionals who work in trauma centers or hospitals and practices that care for terminally ill patients. It is characterized by anxiety, loss of sleep or self-esteem, anger, and an inability to emotionally connect with patients and peers. In 2010, the Siteman Cancer Center at Barnes-Jewish Hospital in Missouri developed a program to help healthcare providers cope with compassion fatigue. The program will soon be made available to all staff members at the hospital. According to the program, compassion fatigue can be managed by adopting stress-reducing techniques, being mindful of your own values and ethical codes, having a strong network of supportive colleagues, and recognizing your efforts to make a positive impact on the lives of patients. It is important for healthcare professionals to be mindful of the symptoms of compassion fatigue so that they can take steps to avoid negative emotional repercussions.

2014 ANCC Recertification Requirements
Certification through the American Nurses Credentialing Center (ANCC) must be renewed every 5 years. As of January 1, 2014, the newest requirements for ANCC certification renewal will become effective. Applicants are obligated to complete category 1 and at least one other category. Category 1, which calls for 75 hours of continuing education including 25 pharmacology hours, must be completed by all advanced practice nurses who are recertifying. In total, advanced practice nurses must earn 150 continuing education hours to recertify. To make up the additional 75 hours, applicants must fulfill the requirements of at least one other professional development category and are permitted to double up on all categories with the exception of category 6. At least 51% of all hours for category 1 must be relevant to the individual’s professional role. Some types of certification have more specific considerations. Fitzgerald Health Education Associates, Inc., offers live, on-line and audio CD continuing education courses that are accepted for credit by the ANCC. Click here to view FHEA course offerings.
Record-Breaking Prescription Drug Shortages Carry into New Year

by Jasmin Pastrana, Assistant Editor

Over the last 5 years, prescription drug shortages have become an increasingly pressing issue nationwide causing several patients to switch to comparable medications or forgo treatment altogether. The drug shortages, which have impacted the distribution of life-saving oncology medications and several sterile injectable drugs among others, show no signs of imminent availability as drug manufacturers and government organizations continue to negotiate the root of the problem to find a resolution.

According to data from the University of Utah Drug Information Service, prescription drug shortages reached record-breaking numbers in 2011, with 267 unavailable medications, which is 50 more than 2010. It is also more than four times the amount of national drug shortages in 2004, when the US experienced a shortage of 58 medications. The lack of critical medicines has compromised patient care, even forcing some healthcare facilities to delay chemotherapy treatments. Last year, at least 15 deaths were attributed to the national drug shortage crisis, setting a new record. Unable to get a hold of pain medications used frequently in hospitals, including anesthesia drugs, have caused several postponed or cancelled surgeries. According to the US Food and Drug Administration (FDA), about 80% of the prescription drugs that were unavailable last year were those administered by sterile injection.

A study performed by the US Department of Health and Human Services (HHS) revealed that the main cause of the mass shortages occurs at the manufacturing level. Drug manufacturing facilities have continually operated at a pace that is inconsistent with the demand, causing delays in distribution. Other factors, including contamination and quality violations, contribute to the setback with restrictions on active pharmaceutical ingredients (API) being an issue 10% of the time. Representatives from pharmaceutical companies said that the shortages are due to the caps put in place by the US Drug Enforcement Administration (DEA) in distributing APIs for medications in high demand.

A major cause for concern has been the ongoing shortage of amphetamine/dextroamphetamine (Adderall), a stimulant used to treat Attention Deficit Hyperactivity Disorder (ADHD). An independent study conducted by IMS Health revealed that the number of prescriptions written for Adderall jumped 13.4% in 2010 from the previous year, totaling 18 million.

Mixed amphetamine salts, the API in Adderall, are regulated by the DEA, which determines the amount of a drug's API that is distributed to manufacturers based on estimates of the country’s demand. It is at the discretion of the manufacturer to decide how much of a given API is used to produce name-brand medications versus generic alternatives. Fast-acting generic versions of Adderall have been in short supply since last summer.

Going into the new year, drug makers warn that even with a new allowance of active ingredients for 2012, the time table for producing enough will be lengthy as they scramble to work quickly enough to fill the gap from last year's shortage. President Barack Obama issued an executive order last October addressing the drug shortage and calling the FDA into overdrive to relieve the burden that has been placed on patients, pharmacists, healthcare facilities, and stakeholders. The order stated that the FDA will expedite the process of regulatory reviews and take necessary measures to obtain information about potential shortages in advance, among other actions. The FDA's actions have prevented 137 drug shortages since 2010.

Contributing to the setbacks, several manufacturers have been ordered to halt production altogether by government organizations because of quality violations that include instances of contamination. These shut-downs wreak havoc on the drug industry's flow of production, particularly in cases where only one or two facilities are responsible for a prescription drug.

(Drug Shortage: Continued on Page 8)
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University Faculty: To obtain additional information on university resources and discuss how FHEA can work for you, please contact Kimberly Dempster-Gonzalez, Director of Academic, Corporate & Government Marketing at 623.826.4010 or kimberly@fhea.com.
Tips for the New NP Graduate

Advice for New Grads from FHEA Faculty

with FHEA Senior Lecturer Wendy L. Wright, MS, ANP-BC, FNP-BC, FAANP.

For more than 13 years, Wendy L. Wright, MS, ANP-BC, FNP-BC, FAANP, has been presenting the Nurse Practitioner Certification Exam Review and Advanced Practice Update for adult and family nurse practitioners (NPs) as a senior lecturer with Fitzgerald Health Education Associates, Inc. (FHEA). Wright has been actively involved in clinical practice as a certified family and adult NP for more than 19 years, giving her the hands-on experience that is necessary when preparing new graduates for NP certification and helping practicing NPs study the latest guidelines in healthcare. She is the owner and operator of Wright and Associates Family Healthcare, PLLC, Amherst, New Hampshire, and co-owner of Anderson Family Healthcare, PLLC, Concord, New Hampshire. Here, Wright shares her top tips for new or soon-to-be NP graduates who are about to enter practice.

1. Although salary is very important when looking for your first NP job, it is essential that the new graduate really look for a practice that supports mentorship. The questions that will arise while practicing as a new NP are significant and require a colleague who will answer questions willingly while reviewing notes, labs, etc., to ensure that nothing is overlooked. In my practices, the minimum mentorship is 1 year. During this time, all charts are reviewed and suggestions are provided by senior NPs. Charts can be reviewed for as long as the new graduate desires after the first year. Remember, money isn’t everything – be conscious of the environment of your new position.

2. Always ask the RN and NP staff at the hospitals how the practice is and how the physicians interact with the nursing staff. Our nursing colleagues are often very forthcoming and will provide you with significant insight into the providers within the practice. Hint: If colleagues are treated poorly by the healthcare providers within the office, it may be reflective of how the RN and NP will be treated within the office.

3. When interviewing for an NP position, ask how many patients you will be expected to see per day during your orientation period, after practicing for 3 months, 6 months, 12 months, and 2 years. This will give you a sense of the demand that will be placed upon you. You should understand clearly what will be expected of you when you negotiate your position. In the clinics where I practice, the new grad NPs see 5–8 patients per day for the first 3–6 months. After 6 months, new grad NPs will see 12-15 patients per day, which is the maximum for all NPs in our clinic. We believe that providing comprehensive care is the best model of care for our practice.

4. Visit salary.com and plug in your city and NP information to see salaries for your community. Your community may have lower or higher salaries than other communities.

Click here to find NP Review Courses presented by Wright.

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(Drug Shortage: Continued from Page 4)

According to the executive order, the FDA and the US Department of Justice (DOJ) will review market behavior with a higher standard of scrutiny to dissolve the practice of price gouging certain medications to protect their own profits. The two organizations are also in the process of investigating prior instances of price gouging that worsened the 2011 shortages, including a case where a $12 drug was offered to a hospital with a price tag of more than $990.

References:

Dr. Fitzgerald Earns DCC Certification

Dr. Margaret A. Fitzgerald recently completed and passed the American Board of Comprehensive Care’s (ABCC) certification exam; she will earn recognition as a Diplomate of Comprehensive Care (DCC). This unique certification was first offered in 2008, and is available for doctor of nursing practice (DNP) graduates who are licensed advanced practice registered nurses (APRN) and nationally certified in an APRN specialty. In November 2011, Dr. Fitzgerald completed the computer-based test, which is held over the course of 2 days with 5 hours of testing each day. Test questions are focused on evaluation, assessment and management of a wide variety of clinical problems with emphasis on mainstream scenarios and patients in an ambulatory care setting. An induction ceremony for applicants who passed the exam will be held later this year. The next ABCC exam is scheduled for November 12-13, 2012. For additional information about the ABCC certification exam, please visit: www.abcc.dnpcert.org/index.shtml. Watch for a future article on suggestions for preparing for the ABCC examination.

Congratulations, Dr. Fitzgerald!
FHEA Presents Psychiatric and Mental Health NP Review Course

FHEA is offering our first Psychiatric and Mental Health Nurse Practitioner Certification Exam Review and Advanced Practice Preparation course this year on April 20-22 in Waterloo, Iowa, and on May 22-23 in Boston, Massachusetts. The course is presented by FHEA Associate Lecturer Teresa Judge-Ellis, DNP, PMHNP-BC, FNP-BC. Dr. Judge-Ellis practices as a psychiatric mental health nurse practitioner at Meadowlark Psychiatric Services, PC, North Liberty, Iowa, and as a psychiatric mental health nurse practitioner and family nurse practitioner at Winfield Community Clinic in Winfield, Iowa. She is an associate clinical professor for the University of Iowa’s College of Nursing and teaches adult health and mental health disorders in the doctor of nursing practice NP program. This 2-day course is available to NPs and NP students who are interested in getting a comprehensive review of psychiatric/mental health clinical guidelines and those preparing for a psychiatric and mental health certification exam. NPs will earn 20.5 contact hours that can be applied toward recertification, 10.25 of which are pharmacology related.

Our comprehensive Psychiatric/Mental Health review course will cover:
- Preparing for Exam and Test Taking Strategies
- Primary Prevention: Health Promotion and Immunization
- Review of Theories and Models with Application to Practice
- Therapeutic Communication Principles and Cultural Competence
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- Assessment, Diagnosis, Pharmacologic and Non-pharmacologic Treatment of Mental Health Conditions
- Suicide Assessment, Risk Strategies, Treatment/Management
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- Prescribing in the Elder

Click here for more information on our Psychiatric and Mental Health NP Certification Exam Review course.

Question and Answer with Dr. Fitzgerald

Recommended Treatment for Bacterial Pharyngitis

Question: For children and adults with bacterial pharyngitis (strep throat) confirmed by rapid strep screen or culture, is a seven day course of penicillin recommended?

Answer: The main reason bacterial pharyngitis caused by group A beta-hemolytic streptococcus (GABHS) is treated with an antimicrobial is to minimize risk of sequelae, particularly rheumatic fever. The older studies done on eradicating GABHS from the pharynx demonstrated that 10 days of penicillin therapy was more effective than shorter courses, hence the current recommendations. With other medications, such as select cephalosporins and macrolides, shorter courses have been studied and deemed efficacious in GABHS eradication. The impact of use for these alternative products has not been well studied in minimizing the risk of rheumatic fever. The organism will be eradicated from the oropharynx in about two weeks without an antimicrobial or special intervention.

I advocate for shorter course antimicrobial therapy whenever possible and safe. With that said, I stick to 10 days with penicillin (not amoxicillin with its unneeded broader antimicrobial spectrum) for adults and older children who can swallow pills. For the little ones who need a liquid or any whose throat is really sore and cannot envision swallowing a pill, I will give liquid amoxicillin; liquid penicillin has a rather bitter taste. While injectable penicillin is also an option, its parenteral use carries approximately the same treatment failure rate as oral therapy with a greater risk of anaphylaxis in the presence of unknown or undetected beta-lactam allergy.

As a reminder, per Sanford Guide, the GABHS resistance rate to the macrolides (azithromycin, clarithromycin and erythromycin) is up to 35% nationwide. Therefore, azithromycin is not a first-line strep throat drug and should only be used in beta-lactam (penicillin/cephalosporin) allergy.

Editor’s Note: Dr. Fitzgerald recently released a new version of her continuing education lecture Bacterial Pharyngitis, Conjunctivitis, Acute Otitis Media: A Focus on Latest Treatment Recommendations. This program is available on-line and on audio CD through FHEA.

References:

Fitzgerald Health Education Associates, Inc. NP Certification Exam Preparation & Continuing Education (978) 794-8366
Visit us on-line at: www.fhea.com

Click here for more information on our Psychiatric and Mental Health NP Certification Exam Review course.
Medicare to Cover Obesity Counseling

Reprinted with permission from Carolyn Buppert, NP and Attorney

The Centers for Medicare & Medicaid Services (CMS) announced on November 29, 2011, that Medicare will cover preventive services to reduce obesity. Both screening and counseling are covered under this new benefit. For the press release and link to the related decision memorandum, visit https://www.cms.gov/apps/media/

Nurse practitioners and physicians may be reimbursed for obesity counseling for Medicare beneficiaries who:
- screen positive for obesity with a body mass index (BMI) greater than or equal to 30 kg/m²
- are competent and alert at the time that counseling is provided.

Counseling must be furnished by a qualified primary care physician or other primary care practitioner and provided in a primary care setting.

CMS covers:
- One face-to-face visit every week for the first month
- One face-to-face visit every other week for months 2-6
- One face-to-face visit every month for months 7-12, if the beneficiary meets the 3 kg weight loss requirement as discussed below.

At the six month visit, a reassessment of obesity and a determination of the amount of weight loss must be performed. To be eligible for additional face-to-face visits occurring once a month for an additional six months, beneficiaries must have achieved a reduction in weight of at least 3 kg over the course of the first six months of intensive therapy. This determination must be documented in the physician office records for applicable beneficiaries consistent with usual practice. The beneficiary may receive one face-to-face counseling visit every month for an additional six months (for a total of 12 months of counseling) if he or she has achieved a weight reduction of at least 6.6 pounds (or 3 kilograms) during the first six months of counseling. For beneficiaries who do not achieve a weight loss of at least 3 kg during the first six months of intensive therapy, a reassessment of their readiness to change and BMI is appropriate after an additional six month period.

For more information on reimbursement for nurse practitioner and physician services, visit www.buppert.com.

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<td>Minnesota Nurse Practitioner and Nurse Midwife Student Conference Minneapolis, MN</td>
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<td>April 10-11, 2012</td>
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prevent disease-related complications. Since the disease is now established, primary prevention activities may have been unsuccessful. Early detection through secondary prevention may have minimized the impact of the disease.

Consider the following situations.

Ms. Leonard is a 72-year-old woman with chronic bronchitis who is a former cigarette smoker. Her medications include ipratropium bromide (Atrovent) and albuterol. Her primary prevention needs include:
A. Reviewing appropriate use of her medications.
B. Receiving an annual influenza immunization.
C. Obtaining spirometry measurement.
D. Periodic colonoscopy.

Ms. Giordano is a 68-year-old woman with hypertension who resides alone in a private home. Her secondary prevention needs include:
A. Administration of pneumococcal vaccine.
B. Mammography.
C. Discussion of home safety to minimize fall risks.
D. Assessment of the presence of S4 heart sound.

The correct response in Ms. Leonard’s scenario is B. Influenza vaccine is the only activity that is aimed at disease prevention. Medication teaching and assessment of pulmonary function are part of treating her established disease. Periodic colonoscopy is an example of secondary prevention as it is a screening test for colorectal cancer.

The correct response in Ms. Giordano’s scenario is B. Secondary prevention activities are aimed at early disease detection; mammography is an example. Pneumococcal vaccine is an example of primary prevention as is education to minimize falls. The presence of S4 heard sound, indicative of diastolic dysfunction and frequently found in the presence of protracted blood pressure elevation, is part of the ongoing evaluation of the person with established hypertension. The goal of treating a person with hypertension is not simply to achieve normotensive status. Rather, tertiary prevention measures for Ms. Giordano include avoiding or minimizing damage in the target organs of hypertension; brain, eye, cardiovascular system, and kidney.

Whether preparing for NP certification or practice, keep in mind the patient’s primary, secondary as well as tertiary prevention needs. These concepts help prioritize and guide care.

Reference:

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**New and Updated Products**

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What are the most common risk factors for acute bacterial rhinosinusitis (ABRS)? What are the leading pathogens causing acute sinusitis? What are the current recommendations for assessment and treatment of bacterial sinusitis? Learn the answers to these questions in this case-based program presented by Margaret A. Fitzgerald, DNP, FNP-BC, NP-C, FAANP, CSP, FAAN, DCC. This program is available on-line and on audio CD.

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**Presented by:**

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**Earn 45 Contact Hours!**

This 5 ¾ day course addresses the growing need for a thorough course in the principles of pharmacotherapeutics. Prescribing has become a major part of the role of advanced practice nurses while at the same time, prescribing has become more complex and polypharmacy is more prevalent with the possibility of adverse interactions. Thus, a course of this caliber is critical to the preparation of advanced practice nurses. Because states’ requirements vary, it is important that you contact your state board of nursing for details regarding educational requirements for prescriptive authority. This course is also available on-line. (Contact hours differ from the live course.)

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