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Membership dues go directly to promoting the NP profession. We encourage you to participate actively in your professional specialty organization. We need your help to move your profession forward. Collectively, we can make a difference while protecting the progress we make in Mississippi's healthcare.

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MISSISSIPPI ASSOCIATION OF NURSE PRACTITIONERS

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https://www.msanp.org/home

MS Association of Nurse Practitioners is a non-profit 501 (C)6 professional organization founded in 2014. MANP's mission is to serve as the professional association for Nurse Practitioners of MS. This organization works diligently providing advocacy, education, and networking to nurse practitioners throughout the state. Our Board is comprised of volunteer nurse practitioners elected by the organization's members. We recognize the importance of NPs in the provision of healthcare, the need for enhanced visibility, and legislative influence at local, state, and federal levels. We provide you with the highest continuing educational opportunities. Our members participate in key NP decision-making roles across the state. Mississippi Association of Nurse Practitioners is *your* specialty association devoted entirely to Nurse Practitioners. Join us today and make a difference in Mississippi.

MISSISSIPPI BOARD of NURSING

It has come to our attention that individuals are contacting Mississippi-licensed healthcare professionals, posing as regulatory investigators or state and federal law enforcement. These callers typically threaten arrest and/or licensure action against the licensee. To appear credible, the callers may provide specific information related to the licensee, such as a nursing license number or NPI number.

Please be aware that such information is publicly accessible and does not confirm the caller's authenticity. The caller may also claim that the licensee is under investigation and attempt to obtain non-public personal information.

Do not share personal information over the phone without verifying the caller's identity. It is not the protocol of the Mississippi Board of Nursing for an investigator to inform a licensee of an investigation or to request non-public personal information over the telephone.

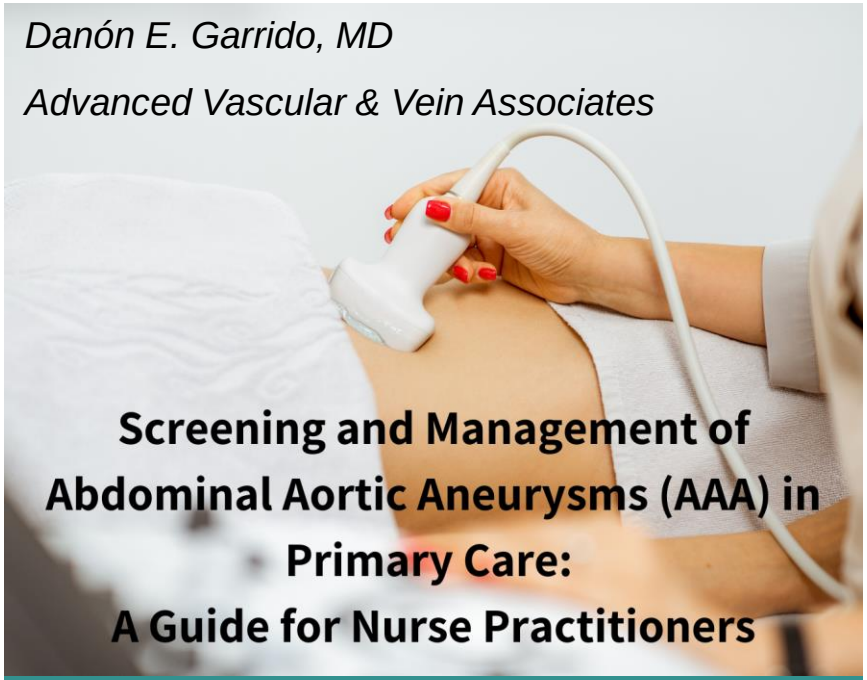
If you receive such a call, please immediately contact the Mississippi Board of Nursing. To verify the identity of an investigator or another representative of the Mississippi Board of Nursing, please call 601-957-6300 and ask for the Investigative Division.

Sincerely,

Phyllis Johnson
Executive Director
Mississippi Nursing Board

Danón E. Garrido, MD

Advanced Vascular & Vein Associates



Screening and Management of Abdominal Aortic Aneurysms (AAA) in Primary Care: A Guide for Nurse Practitioners

Introduction

Abdominal Aortic Aneurysm (AAA) is a critical yet often silent condition that poses a significant risk to patients. Nurse practitioners (NPs) are on the front lines of primary care and play a pivotal role in the early detection and management of AAA, especially in underserved regions where access to care is limited. This article provides an overview of AAA, current screening guidelines, and practical management strategies tailored for NPs working in rural settings.

Understanding Abdominal Aortic Aneurysms

AAA is characterized by the abnormal bulging or dilation of the abdominal aorta, the largest artery in the body. This condition is most commonly found in older adults, particularly men aged 65 and older. Risk factors include smoking, hypertension, atherosclerosis, family history, and being male. Although AAAs are often asymptomatic, they can lead to catastrophic outcomes if they rupture, with mortality rates exceeding 80% in such cases. Given the silent nature of AAAs, many patients remain unaware of their condition until it is too late. This underscores the importance of proactive screening and monitoring, particularly in high-risk populations.

Screening for AAA in Primary Care

Early detection of AAA is crucial, and NPs in primary care settings are well-positioned to identify at-risk individuals. The United States Preventive Services Task Force (USPSTF) recommends one-time screening for AAA using abdominal ultrasound in men aged 65-75 who have ever smoked. While the evidence for screening in women and non-smokers is less clear, individual risk factors should guide decision-making.

Screening Methods:

Abdominal Ultrasound: This non-invasive and cost-effective imaging modality is the gold standard for AAA screening. It can accurately measure the size of the aorta and identify aneurysms.

Challenges in Rural Areas:

Access to ultrasound equipment and trained personnel can be limited in rural settings. NPs can overcome these challenges by partnering with vascular surgery practices, utilizing mobile screening units, or advocating for telemedicine consultations to facilitate timely screening.

Management Strategies for AAA

Once an AAA is identified, the NP's role in management becomes critical. Management strategies vary depending on the size of the aneurysm and the patient's overall health.

Initial Management in Primary Care:

Small AAAs (3.0-4.0 cm): These typically require regular monitoring (once per year) through periodic ultrasounds, lifestyle modifications (e.g., smoking cessation, blood pressure control), and patient education on the importance of follow-up.

Moderate AAAs (4.0-5.5 cm): More frequent monitoring is necessary. The NP should ensure the patient understands the risks and signs of rupture, such as sudden, severe abdominal or back pain.

Referral Guidelines:

Large AAAs (>5.5 cm) or Symptomatic AAAs: Urgent referral to a vascular surgeon is critical. Symptoms include but are not limited to abdominal and or back pain. NPs should establish clear referral pathways with trusted specialists to ensure timely intervention.

Emergency Management:

Suspected Rupture: Immediate transfer to an emergency department is critical. Symptoms include but are not limited to unrelenting abdominal and or back pain in association with syncopal or near syncopal episodes. NPs should be familiar with local protocols for stabilization and rapid transfer.

Case Study Example: Consider a 70-year-old male patient with a history of smoking who presents for a routine check-up. An abdominal ultrasound reveals a 4.2 cm AAA. The NP educates the patient on the importance of lifestyle changes and schedules follow-up ultrasounds every six months. The NP also coordinates with a vascular surgeon for a consultation should the aneurysm increase in size or become symptomatic.

Surgical Repair of Abdominal Aortic Aneurysms: Emphasizing Endovascular Techniques

When an Abdominal Aortic Aneurysm (AAA) reaches a critical size (typically greater than 5.5 cm) or becomes symptomatic, surgical intervention is often necessary to prevent rupture and its associated high mortality risk. There are two primary surgical approaches: Open Surgical Repair (OSR) and Endovascular Aneurysm Repair (EVAR).

Open Surgical Repair (OSR) involves a large abdominal incision to directly access the aorta, replacing the affected portion with a synthetic graft. While effective, OSR is highly invasive, requiring extended recovery time, with hospital stays ranging from 7 to 10 days. This approach also carries a higher risk of complications, particularly in older patients or those with significant comorbidities.

Endovascular Aneurysm Repair (EVAR), on the other hand, is a minimally invasive technique that has revolutionized the management of AAA. In EVAR, a stent-graft is inserted into the aorta via small incisions in the groin and guided to the site of the aneurysm using imaging technology. Once in place, the stent-graft expands to reinforce the weakened area of the aorta, effectively excluding the aneurysm from blood flow.

The benefits of EVAR are particularly significant in terms of patient recovery.

Most patients undergoing EVAR experience significantly shorter hospital stays, often as brief as 2 to 3 days, compared to OSR. This shorter stay is crucial in rural settings or facilities focusing on short-length-of-stay protocols, where quick recovery and reduced hospital resource utilization are priorities. Additionally, EVAR is associated with lower perioperative risk and faster return to normal activities, making it a preferred option for patients at higher surgical risk.

However, EVAR requires careful patient selection and long-term follow-up to monitor for potential complications such as endoleaks or graft migration. Nurse practitioners play a critical role in the perioperative care of EVAR patients, ensuring proper patient education, postoperative monitoring, and adherence to follow-up imaging, thereby optimizing outcomes in this life-saving procedure.

The Role of Nurse Practitioners in Rural Settings

NPs in rural areas are uniquely positioned to make a significant impact on the detection and management of AAA.

Proactive Patient Education:

Educate patients on the importance of AAA screening, particularly those with risk factors like smoking and advanced age. Many patients may be unaware of AAAs and the associated risks.

Collaboration with Specialists:

Establish a network of vascular specialists who can help construct clear referral protocols. Telemedicine can be a valuable tool in facilitating consultations and ensuring that patients in rural areas receive the care they need.

Community Outreach:

Lead community health initiatives to raise awareness about AAA. Hosting screening events or partnering with local health departments can improve early detection rates in underserved populations.

Conclusion

Abdominal Aortic Aneurysms are a significant health concern. Nurse practitioners are essential in screening, managing, and educating patients about this potentially life-threatening condition. By staying vigilant and utilizing the resources available, NPs can improve outcomes for patients with AAA, ensuring that more lives are saved through early detection and appropriate management.

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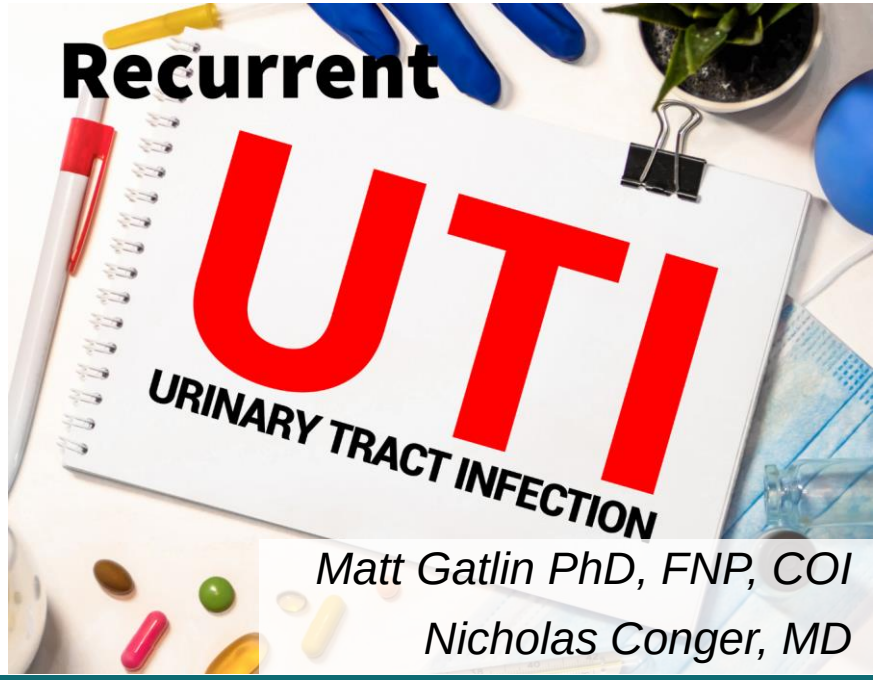
Photo Credit: submitted by author

Danón E. Garrido, MD

Dr. Danón E. Garrido, a board-certified vascular and endovascular surgeon, is renowned for his treatment of Peripheral Arterial Disease (PAD), carotid disease, aneurysmal conditions, and vein disorders at Advanced Vascular & Vein Associates in Central Mississippi. His approach prioritizes minimally invasive techniques, including same-day lower extremity angioplasty, to ensure immediate access to treatment and swift patient recovery. Dr. Garrido's commitment to advanced vascular care makes him a key asset to the regional medical community. Dr. Garrido was an honored guest speaker at the MS Association of Nurse Practitioners' 10th Annual Conference and Membership Meeting held July 15-17.



Matt Gatlin PhD, FNP, COI

Nicholas Conger, MD

Methenamine Hippurate: An option for Recurrent UTI's

Studies indicate that approximately 50-60% of women will experience at least one UTI in their lifetime, with a significant proportion facing recurrent infections. The recurrent nature of UTIs poses a substantial burden on healthcare systems and patients with increased antibiotic use, which in turn fosters antibiotic resistance. Standard treatment typically involves antibiotics; however, increasing antibiotic resistance has necessitated exploring alternative preventative measures. The urgent need for effective non-antibiotic alternatives has renewed interest in treatments like methenamine hippurate. Methenamine hippurate is a urinary antiseptic that works by decomposing into formaldehyde in acidic urine, exerting a bacteriostatic effect. It has been used for decades as a preventative measure for UTIs, particularly in patients with recurrent infections. Recurrence is defined as having at least two infections in six months or three within a year. Recent studies have reaffirmed its efficacy and safety, positioning it as a promising alternative to antibiotic prophylaxis.

A systematic review and meta-analysis examined the effectiveness of methenamine hippurate compared to placebo and antibiotics. The results demonstrated that methenamine hippurate significantly reduced the incidence of symptomatic UTIs, comparable to antibiotic prophylaxis, without the associated risk of developing antibiotic resistance. The ALTAR trial, a multicenter, randomized, open-label study, compared methenamine hippurate with low-dose antibiotic prophylaxis in women with recurrent UTIs. Over a 12-month treatment period followed by a six-month follow-up, the study found that methenamine hippurate was non-inferior to antibiotics in preventing recurrent UTIs. Importantly, it also showed a lower incidence of antibiotic resistance in the methenamine group.

Methenamine hippurate adult dosage is 1 (one) gram taken twice daily by mouth. This dosage can be adjusted based on the patient's needs and health condition. The duration varies depending on the individual's history. Long-term use is often recommended for prophylaxis of recurrent UTIs, extending over several months to years. Clinical trials have shown that extended treatment durations, such as 6-12 months, are effective. It is generally well-tolerated. The most reported side effects include gastrointestinal disturbances. Long-term use has not been associated with severe adverse effects, and it is considered safer compared to long-term antibiotic prophylaxis due to the lower risk of developing antibiotic resistance.

Methenamine hippurate should not be used in patients with severe renal impairment or renal failure, severe hepatic impairment, pregnancy, or breastfeeding, though no significant teratogenic effects have been noted. It requires an acidic environment in the

urine to be effective. Patients on prolonged low-carb diets or with a chronic foley catheter might experience reduced efficacy. Interactions with other medications that affect urine pH may occur. Of importance, the concurrent use of antibiotics, especially sulfonamides, should be avoided.

Given the escalating issue of antibiotic resistance, methenamine hippurate offers a viable and effective non-antibiotic alternative for UTI prevention. Its efficacy in reducing UTI recurrence, combined with a lower risk of fostering antibiotic-resistant bacteria, makes it a valuable option in the prophylactic treatment of recurrent UTIs.

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Photo Credit: submitted by author

Matt Gatlin PhD, FNP, COI

Dr. Matt Gatlin has been involved in various areas of healthcare for 27 years and is a Family Nurse Practitioner working at Memorial Hospital Gulfport. His current practice and research interests are Infectious Diseases and nursing education. He is also a graduate-level nursing instructor and serves as a peer reviewer for The Nurse Practitioner, a Wolters Kluwer publication. He is an active member of MS Association of Nurse Practitioners and a frequent author for Advancing Practice publications.

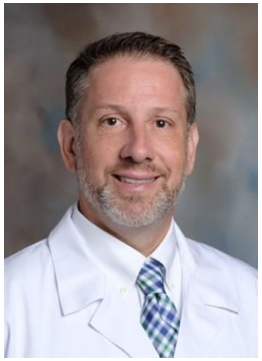
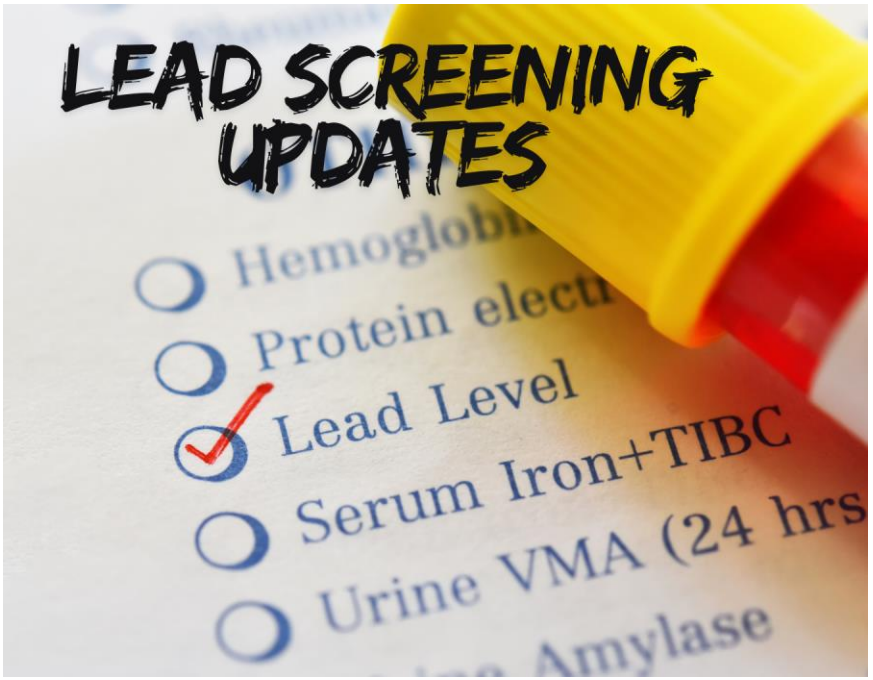


Photo Credit: submitted by author

Nicholas G. Conger, MD

Dr. Nicholas Conger is Board-certified in internal medicine and infectious disease. Born in Oklahoma City and raised in Edmond, OK, he moved to Texas to attend the University of Dallas. He earned his Medical Doctorate at the University of Texas at Houston. He completed his residency and internship in Internal Medicine; and fellowship in infectious diseases at Wilford Hall Medical Center, San Antonio, TX. Dr. Conger served in the United States Air Force for 21 years and has over 25 years of practice experience. He is the Chief of Infectious Disease at Memorial Hospital and the Medical Director of Gulf Coast Consultants, Infectious Diseases.



Lead Screening Updates

MS Association of Nurse Practitioners received an email communication on August 20, 2024, from the Mississippi State Department of Health's Program Director of the Lead Poisoning Prevention and Healthy Homes Program. To ensure all providers across the state are aware of the current lead screening, testing and follow-up guidelines, and reporting requirements, the Mississippi State Department of Health's director would like healthcare providers to be aware of recent changes. It has been brought to the MSDH's attention that some providers are still not aware of these changes.

- **Blood Lead level of concern reduced from 5 to 3.5.**
- **Requirement to confirm an elevated capillary lead level of 3.5 or higher with a venous.**
- **Requirements for reporting all blood lead levels.**

According to the MSDH's website, "Mississippi's Lead Poisoning Prevention and Healthy Homes Program coordinates statewide efforts to eliminate lead poisoning in children less than 72 months of age, and to reduce the exposure of families to health hazards in the home environment."
(continued page 13)

Sources of Lead

Children can be exposed to lead from any of the sources below. Children are at higher risk of lead exposure if they frequent older homes that contain lead in pipes, mini-blinds, or that have chipping and peeling paint.

Possible sources of lead are:

- Soil and dust
- Tap water
- Glazed pottery
- Electrical cords
- Garden hoses
- Lead-based paint
- Keys
- Batteries
- Imported canned foods
- Imported spices, candies
- herbal medicines
- Metal jewelry
- Outside water faucets

Signs & Symptoms

Lead poisoning may occur without any signs or symptoms.

It can take a long time for symptoms of lead poisoning to appear. Your child may be at risk long before you see any effects. Some signs to look for are:

- Irritability
- Frequent tiredness
- Behavioral problems
- Stunted growth
- Learning problems
- Hyperactivity
- Decreased appetite
- Developmental delay
- Hearing loss
- Convulsions, coma, and death can occur at very high levels, which are extremely rare

Reporting Requirements:

According to the Mississippi State Department of Health (MSDH) List of Reportable Diseases and Conditions, Blood Lead Poisoning is considered a Class II and Class III reportable disease.

- **Class II** requires that all venous elevated blood lead levels ≥3.5µg/dL in patients less than or equal to six years of age must be reported to the Mississippi State Department of Health Lead Poisoning Prevention and Healthy Homes Program

- **Class III,** for laboratory-based surveillance (also includes ESA Leadcare Providers), requires that ALL blood lead level results in patients less than or equal to 6 years of age must be reported to the Mississippi State Department of Health Lead Poisoning Prevention and Healthy Homes Program. Please follow the link below for a copy of the MSDH List of Reportable Diseases and Conditions

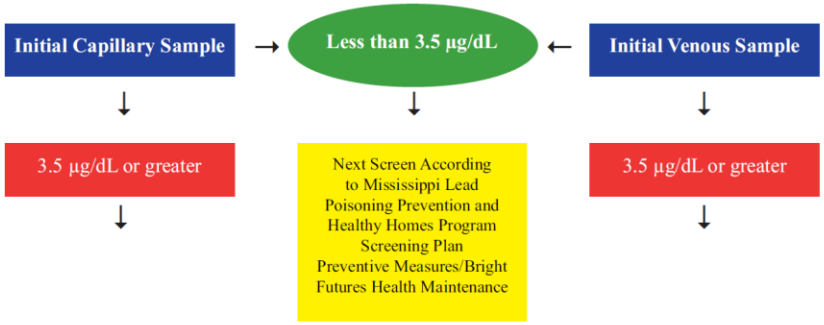
Report of Lead Level Form:

Providers must complete and submit this form on a weekly or monthly basis to the Mississippi State Department of Health (MSDH) Lead Poisoning Prevention and Healthy Homes Program by either fax, email, or mail; Fax: 601-576-7498,

Email: Crystal.veazey@msdh.ms.gov or Mail: Mississippi

State Department of Health Lead Poisoning Prevention and Healthy Homes Program

570 E Woodrow Wilson • Osborne 200 • Jackson, Mississippi 39215



Schedule for Obtaining Venous Sample	
Capillary Blood Lead Level*	Confirm with Venous Test Within
3.5-9 µg/dL	Within 3 months
10-19 µg/dL	Within 1 month
20-44 µg/dL	Within 2 weeks
≥ 45 µg/dL	Within 48 hours

Schedule for Venous Re-testing	
Confirmatory Venous Blood Lead Level	Follow-up Venous Testing
3.5-9 µg/dL	3 months**
10-19 µg/dL	1-3 months**
20-44 µg/dL	2 weeks - 1 month
≥ 45 µg/dL	As soon as possible

**Any child identified with a capillary lead level of ≥ 3.5µg/dL must receive a confirmatory venous test in the time frame shown above based on the blood lead level (BLL).*

***Some providers may choose to repeat blood lead tests on all new patients within a month to ensure the BLL is not rising more quickly than anticipated.*

3.5-19µg/dL	20-44µg/dL	≥45µg/dL
Report test to LPPHHP	Report test to LPPHHP	Report test to LPPHHP
• Ensure iron sufficiency via testing and treatment per AAP guidelines • Nutritional counseling related to calcium and iron intake • BLL ≥10 refer to Early Intervention • BLL ≥15 refer for home visit and environmental assessment • Assess development per AAP guidelines • F/U venous retesting and monitoring based on chart above.	• Follow recommendations for BLL 3.5-19 • Complete history and physical exam assessing for signs and symptoms related to lead • Consider obtaining an abdominal X-ray to evaluate for lead-based paint chips and other foreign bodies • Contact UMMC Poison Control Center for guidance • F/U venous retesting and monitoring based on chart above.	• Follow recommendations for BLL 20-44 • Complete history and physical exam including detailed neurological exam • Obtain abdominal X-ray and initiate bowel decontamination if indicated • Contact UMMC Poison Control Center for guidance • F/U venous retesting and monitoring based on chart above.

MISSISSIPPI STATE DEPARTMENT OF HEALTH

Revised 5/31/23

Resources:
Quick Guide https://msdh.ms.gov/msdhsite//_static/resources/19264.pdf
Lead Risk Screening Questionnaire:
https://msdh.ms.gov/msdhsite/index.cfm/41,2270,176,62,pdf/Form%20222%20.pdf
Reporting Form: https://msdh.ms.gov/page/resources/6612.pdf

MS Association of Nurse Practitioners
Annual Award Recipients

10th Anniversary Conference & Membership Meeting
The Lodge at Gulf State Park, Gulf Shores, AL
July 15, 2024

2024 Brenda Hood NP Award
Excellence in Clinical Practice

Margaret (Peggi) Seaman, MSN, FNP-BC

2024 NP Preceptor of the Year

Gena Vail, MSN, FNP-BC

Jennifer L. Lemacks, PhD, RD, LD

Nurse Practitioners are needed to improve the health Central-South Mississippi

My Brother's Keeper, Inc. (MBK) is leading a multi-stakeholder partnership with the Mississippi Department of Health and The University of Southern Mississippi to achieve optimal sexual and reproductive health for Black men and women in the state. The award is up to a 10-year initiative that was funded by the NIH Common Fund Community Partnerships to Advance Science for Society (ComPASS) Program in 2023. The NIH ComPASS Program is a pioneering community-led research program aimed at investigating ways to address the underlying structural factors within communities that impact health. These factors encompass access to safe spaces, healthy food, employment

The MBK-led initiative aims to promote health equity and lasting change in Mississippi by addressing the reproductive healthcare needs of adults 18 to 45 years of age. The program engages multiple stakeholders with varying perspectives on the structural issues that prevents Mississippians from accessing safe, non-discriminatory, and best-practice sexual and reproductive healthcare. Organized as the Health Equity Research Assembly (HERA) the following organizations are represented to lead the charge to identify actionable structural changes that can improve healthcare in Mississippi: Broadband Expansion and Accessibility of Mississippi, Community Health Center Association of Mississippi, Converge Access, Mississippi Board of Nursing, Mississippi Center for Justice, Mississippi Department of Health, Mississippi Division of Medicaid, Mississippi House of Legislators, Mississippi Medical Association, Open Arms Healthcare Center, and the University of Mississippi Medical Center. Patient populations are also engaged as representatives on the HERA and by participating in the project planning, implementation, and evaluation processes.

We are looking for nurse practitioners in Clairborne, Forrest, Harrison, Hinds, Holmes, Jackson, Jones, Warren, or Yazoo Mississippi counties to share their views on sexual and reproductive health access and utilization in Mississippi. If you would be willing to share your experiences and views or support a listening session in your community, please contact JGipson@mbk-inc.org or complete the interest form at https://fs6.formsite.com/junegipson/s3fhdmjt77/index

Photo Credit: submitted by author

Jennifer L. Lemacks, PhD, RD, LD

Dr. Jennifer L. Lemacks is a Professor in the School of Health Professions and Associate Dean for Research in the College of Nursing and Health Professions at the University of Southern Mississippi; she is also a registered dietitian. Her research is driven by a passion to reduce preventable chronic disease disparities in underserved populations by addressing multi-level determinants of nutrition behaviors and diet quality. She serves as co-director of the Mississippi INBRE Community Engagement and Training Core and director of the Telenutrition Center (https://telenutritioncenter.com/). She has used community-engaged approaches to implement multiple projects funded by the National Institutes of Health and the National Science Foundation that address priority health issues among racial/ethnic/sexual/gender minorities and underreached, underserved, underrepresented populations. She is one of the founding organizers of the Mississippi Health Disparities conference (https://www.mississippihealthdisparities.org/).

Jonathan T. Hontzas, DNP, NP-C

Screen Today, Breathe Tomorrow: The Impact of Lung Cancer Screening

November is Lung Cancer Awareness Month

Introduction

Lung Cancer Screening (LCS) is the use of low-dose computed tomography (LDCT) to detect lung cancer at its earliest stages. It was first, officially recommended in 2013 when the U.S. Preventive Services Task Force (USPSTF) issued guidelines recommending LCS and was subsequently updated in 2021. Since that time, Nurse Practitioners have played a vital role in its roll-out to the community.

The Tobacco Impact

Cigarette smoking is directly responsible for at least 80% of lung cancers while the risk of developing a lung cancer is more than 14% if you smoke cigarettes. The national smoking rate is under 14% while Mississippi (MS) sits at 17.4%. The measures that have been implemented both at the national and state level over the past few decades are working and providers must continue to make cessation a high priority in the clinical setting. The long term self-quit rate is a measly 3-5% while a healthcare provider brief intervention escalates that rate to 12-18%. In addition, participation in a quit program results in rates as high as 45%.

Mississippi's Lung Cancer Burden

The 1,500 lung cancer deaths Mississippians experience each year is more than breast, colon, and cervical combined. Our incidence rate of new lung cancer cases is 70 per 100,000 and is significantly higher than the national rate of 55. MS ranks 46th amongst all states. The 5-year survival is 21% compared to the national rate of 27%. Again, ranking us near the bottom of all states. Lastly, early stage disease results in a 5-year survival rate of 63%, but only 27% of MS lung cancer cases are detected early. In stark contrast, 44% of cases present with distant disease when the 5-year survival is 8%.

Clinical Trials

In 2011, the National Lung Screening Trial was published in The New England Journal of Medicine. This major trial enrolled 53,454 patients and sought to determine whether screening with a LDCT would reduce mortality from lung cancer. Half of participants were placed in the LDCT arm and the other half a single-view posteroanterior chest radiography arm. It discovered 1,060 lung cancers in the LDCT group and 941 in the CXR group. More importantly, it discovered a stage shift that showed a relative reduction in lung cancer mortality of 20% and an all-cause mortality reduction of 7% when compared to the CXR group. It found that CXR does not reduce mortality associated with lung cancer when compared to community care.

Guidelines and Coverage

USPSTF recommends the annual use of a LDCT in those aged 50-80 years who have a minimum 20 pack-year smoking history and currently smoke or have quit within the past 15 years. In addition, it is covered by Medicare, Medicaid, and private insurers in MS. However, Medicare requires a shared-decision making (SDM) visit prior to the beneficiary's first screening. The SDM visit must cover determination of eligibility, use a decision-making-aid, provide counseling on the importance of adherence to annual screening, and counseling on the importance of cessation.

Billing

Lung cancer screening services, like other services, have specific billing guidelines attached. Medicare requires the use of "Personal hx of tobacco abuse

hazardous to health" (z87.891) for former smokers and "Cigarette Smoker" (F17.21) for current smokers. In addition, BCBS requires the use of "Screening for malignant neoplasm of respiratory organ" (Z12.2) for all beneficiaries. This applies to both the LDCT order itself (71271) and the SDM visit. The SDM visit is also billable using G0296 and it can be used in combination with an additional E/M visit code when using a 25 modifier.

Lung Rads

As with BI-RADS for mammography, lung cancer screening has its own reporting and data system called "Lung RADS" through the American College of Radiology (ACR). The scoring system is categorized using numbers 0-4 and each numerical category has a recommendation attached. The overwhelming majority of scores are a "1" (39%) or a "2" (45%) with an annual LDCT recommended. However, 9% of results are a score of "3" recommending a repeat LDCT in 6 months. More aggressively are scores of 4A (4%) or 4B (2%) that have recommendations such as repeat LDCT in 3 months, PET, or tissue sampling.

Abnormal Findings

Lung cancer screening has a high rate of positive findings, but also a high rate of false positive results. It is important to follow the Lung RADS guidelines as laid out by the ACR when determining follow-up. Mississippi is fortunate to have a number of thoracic oncology specialists across the state that manage lung cancer screening and lung nodule patients. Identifying those specialists and shuttling patients to the needed resources is paramount to not only identifying suspicious findings, but appropriately managing them.

Current State: Call to Action

Despite lung cancer screening being identified as a life-saving tool, the uptake nationally is a mere 4.5%. Within MS, our rate sits at 4%. The opportunity to force a steep dive in the mortality rate of a cancer that kills more Mississippians each year than breast, colon, and cervical is there. There are nearly 8,000 Nurse Practitioners in MS and it is largely up to us to act. It is up us to not only identify those eligible, but to take the time to enact a plan that results in patients being screened for this disease.

References

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Reduced Lung-Cancer Mortality with Low-Dose Computed Tomographic Screening. (2011). New England Journal of Medicine/the New England Journal of Medicine, 365(5), 395–409. https://doi.org/10.1056/nejmoa1102873

Lung cancer: screening. (2021, March 9). https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/lung-cancer-screening

Lung Rads. (n.d.). American College of Radiology. https://www.acr.org/Clinical-Resources/Reporting-and-Data-Systems/Lung-Rads

Burden of tobacco use in the U.S. (2023, October 26). Centers for Disease Control and Prevention. https://www.cdc.gov/tobacco/campaign/tips/resources

Join us October 8th and 6:00pm for a Live Webinar on Lung Cancer Screening presented by Dr. Hontzas. Scan the QR code below to register. MANP Members $20, Non-member rate $35. MANP is accredited by the American Association of Nurse Practitioners® as an approved provider of nurse practitioner continuing education. Provider number:1640685. Activity# 2024-1008-01. This activity has applied for 1 contact hour of credit. This activity was planned in accordance with AANP Accreditation Standards and Policies.

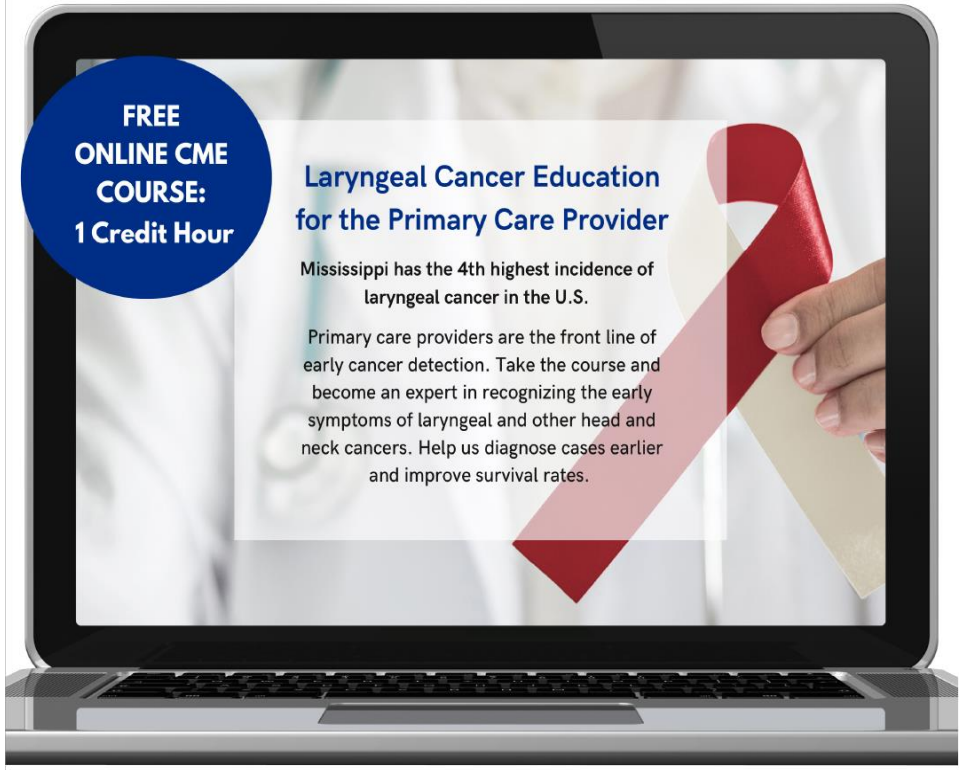
Photo Credit; submitted by author

Dr. Jonathan Hontzas, DNP, AGACNP-BC, TTS

Dr. Hontzas is a practicing nurse practitioner at the University of Mississippi Medical Center. He graduated from the University of Mississippi Medical Center's Adult-Gerontology Primary Care Nurse Practitioner Program in 2017, and subsequently completed the Doctor of Nursing Practice Program in 2022. He serves as Director for the ACT Center for Tobacco Treatment, Education, and Research, as well as, the Lung Cancer Screening Program. He serves on the Mississippi Lung Cancer Roundtable's Steering Committee, the Vice-Chair of the Lung Cancer Screening Workgroup, the Chair of the Smoking Cessation Workgroup, and the Chair of the Mississippi Tobacco Control Advisory Council.

November is Lung Cancer Awareness Month

Conferences- click here to learn more



To register and take the course, scan the code below.

This free online course is available now through June 20, 2025.
Questions? Email ent@umc.edu.

Course director:
Anne Kane, MD
Head & Neck Surgeon, Assistant Professor,
Department of Otolaryngology -
Head & Neck Surgery,
The University of Mississippi Medical Center

UMMC
Department of Otolaryngology
Head and Neck Surgery

October 22, 2024

CERTIFIED MEDICAL EXAMINER QUALIFICATIONS

Be licensed, certified, or registered in your state where laws and regulations to perform physical examinations are allowed. These include nurse practitioners, physician assistants, physicians, osteopaths, and chiropractors.

ACCREDITATION

ACCREDITATIONMANP is accredited by the American Association of Nurse Practitioners® as an approved provider of nurse practitioner continuing education. Provider number: 1640685. This activity has applied for up to 9 contact hour(s). This activity was planned in accordance with AANP Accreditation Standards and Policies.

COST

MANP members:	$275
Non-members:	$375
Join & Go:	$475- get 1-year annual membership and take the course.

A cancellation charge of $50.00 will be applied to refund requests in writing prior to course deadline as provided at registration. NO REFUNDS will be granted after the cancellation deadline. The cancellation policy is strictly enforced. Join & Go annual of membership ($300) is non-refundable.

MANP can only award continuing education credit to Nurse Practitioners. Other disciplines will receive a certificate of completion bur are not awarded CE credit. The individual may apply to their certification board for CE credit approval.

MANP's training course is designed for healthcare providers meeting state requirements, including nurse practitioners (NPs), physician assistants (PAs), physicians (MD or DO) and chiropractors (DCs). The curriculum for this course is provided in accordance with the Federal Motor Carrier Safety Administration (FMCSA) to prepare candidates for the National Registry of Certified Medical Examiners (NRCME) certification examination. This course includes course materials, forms, FAQs and sample questions in preparation and review for the examination. FMCSA regulations and guidelines are reviewed regularly and the training is updated as required to maintain training curriculum.

Virtual (Live) Event
Not Pre-Recorded
Not available for On-Demand Learning
800am to 5:30pm

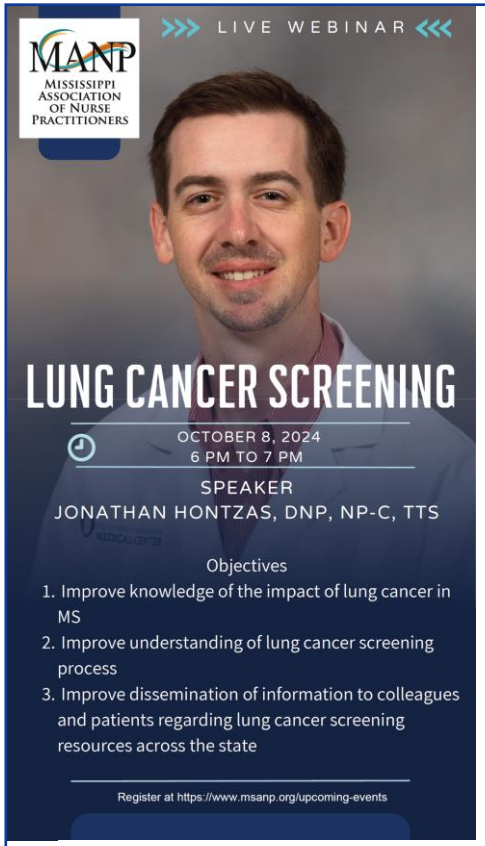
COURSE CONTENTS

- Background, rationale, mission and goals of the FMSCA
- CME's roles and responsibility
- FMCSA certification testing and recertification for the Examiner
- Responsibilities of commercial motor vehicle operators
- Procedures for proper operator identification, medical history, medication history and document review
- DOT examination and documentation
- Knowledge of waivers, exemptions, and referrals
- performing and obtaining diagnostic testing or medical opinions from a specialist or treating provider for driver clearance
- Educating and informing the driver about disqualifications, abnormal findings that may require additional follow up or clearance
- Determination of the driver's certification, outcome and period of time valid for certification
- FMCSA login, reporting, and filing
- Navigation of the FMCSA website for helpful information and reporting

email: msanp@msanp.org
Website: https://www.msanp.org

Mississippi Association of Nurse Practitioners

Scan the QR Code to Register Now



Accreditation:

MANP is accredited by the American Association of Nurse Practitioners® as an approved provider of nurse practitioner continuing education. Provider number: 1640685. Activity# 2024-1008-01. This activity has applied for 1 contact hour of credit. This activity was planned in accordance with AANP Accreditation Standards and Policies.

Cancellation Policy for this event:

Refunds must be requested in writing to msanp@msanp.org on or before 08/26/2024. No refunds after this date.

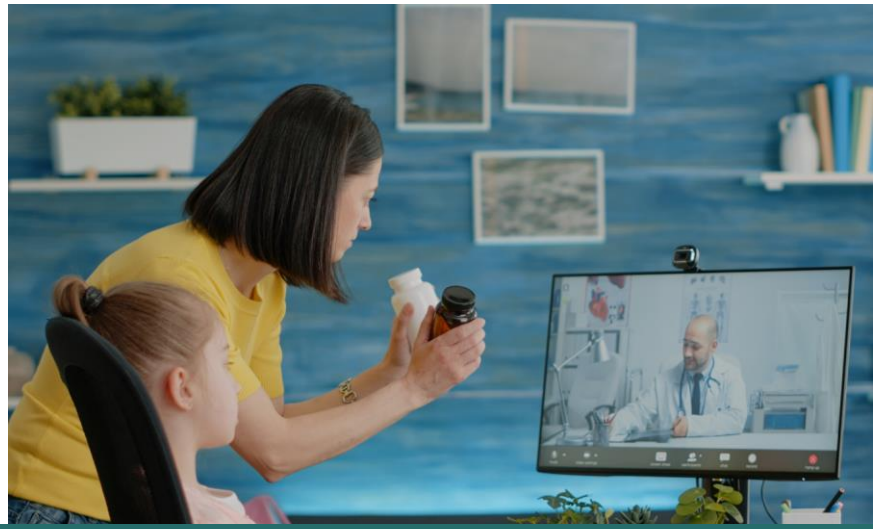
Access Link: An access link will be sent to the registered email. Remember to check the spam and junk folder.

Our speaker for this event is

Dr. Jonathan Hontzas, DNP, AGACNP-BC, TTS.

Dr. Hontzas is a practicing nurse practitioner at the University of Mississippi Medical Center. He graduated from the University of Mississippi Medical Center's Adult-Gerontology Primary Care Nurse Practitioner Program in 2017, and subsequently completed the Doctor of Nursing Practice Program in 2022. He serves as Director for the ACT Center for Tobacco Treatment, Education, and Research, as well as, the Lung Cancer Screening Program. He serves on the Mississippi Lung Cancer Roundtable's Steering Committee, the Vice-Chair of the Lung Cancer Screening Workgroup, the Chair of the Smoking Cessation Workgroup, and the Chair of the Mississippi Tobacco Control Advisory Council.

His specialties include Surgical Oncology, Endocrinology, Lung Cancers, and Mesothelioma.



Telehealth, Risks, Cybersecurity

Tina Highfill, DNP, FNP-BC, CCM, CRHCP, LNC

If there were positive outcomes from the Covid pandemic 2020-2022, one would be the growth and normalization of incorporating telehealth as standardized means to provide healthcare. With the advancement of technology and artificial intelligence (AI) in healthcare also comes added risks and potential for cybersecurity breaches.

Have you reviewed your current medical professional liability policy to learn if your telehealth practice is covered by your current policy?

Did you notify your professional liability carrier when you added telehealth or virtual care to your practice?

Oftentimes, telehealth is not covered in the traditional professional liability policy, which requires in some cases a separate policy. Cybersecurity is another item that usually needs to be added to traditional policies. Artificial Intelligence programs and platforms increase the potential risks of cyber threats.

Some telehealth policies will combine coverage for virtual healthcare services, patient communications, portals, software protection, and cyber liability all in a single policy.

According to most professional liability carriers, one of the greatest risks for small practices or 109-contract providers is the lack of monetary investment and knowledge to adequately implement security measures accurately. This makes the small business owner an easy target.

CM&F Group suggests a checklist for protecting your practice from cyber threats.

- Be cautious about unfamiliar sources or unexpected emails that ask you to click on a link or download a file.
- Don't use USB drives from others.
- Use VPNs on public networks.
- Set up continuous or daily backups.
- Use a secure Web Application Firewall (WAF).
- Enable multi-factor authentication (MFA)
- Set high-level spam filters on email.
- Train your yourself and your staff
- Conduct a simulated cyber attack to detect vulnerabilities.
- Install antivirus software.
- Keep firmware up to date and install patches and updates immediately.
- Use secure, password-protected Wi-Fi.
- Encrypt your devices.
- Restrict access to cloud infrastructure attacks to admin rights only.
- Keep a disaster recovery plan up to date.

Reference:

https://www.cmfgroup.com/blog/liability-insurance/secure-virtual-care/?utm_source=salesforce_marketing_cloud&utm_medium=newsletter&utm_campaign=q2&sfmc_profession=general&sfmc_email_cadence=q2

Resource:

Privacy and Security for Telehealth

https://telehealth.hhs.gov/providers/best-practice-guides/privacy-and-security-telehealth?utm_campaign=OATannouncements20240820&utm_medium=email&utm_source=govdelivery

Member Benefit with CM&F

If you are a member of MS Association of Nurse Practitioners, you may be eligible for 10% off certain policies with CM&F insurance. You can get a free quote or the contact information is available on our website to speak with a CM&F representative. MS Association of Nurse Practitioners does not receive funds for your participation. This is strictly a membership benefit.

CM&F "New to Practice" credit for those that have graduated within the last year (365 days) which is applied if the members select they have graduated within the last year and provide their graduation date and are an MANP member

Year 1	80% Off
Year 2	60% Off
Year 3	40% Off
Year 4	20% Off
Year 5	Phase into full premium

MS Telehealth Providers DID YOU KNOW?

Practitioners and/or organization providing telehealth services in MS

Effective April 5, 2021.

Pursuant to Mississippi Code Annotated §41-3-15, Providers/organizations that practice telehealth in the State of Mississippi shall comply with standards.

Each provider entity/organization conducting telehealth services in Mississippi are required by law to submit an application for registration to the Mississippi State Department of Health, Office of Licensure, including information about the type of telehealth services offered as well as the providers that will be performing services. Proprietary information may be asked but will not be required for approval. An applicant shall not provide telehealth services in the State of Mississippi without first registering with the Department.

In addition to the registration application as referenced above, the registering entity shall submit at the time of registration:

1. A copy of the Mississippi Secretary of State Business Services Form as evidence of the entity's registration with the Mississippi Secretary of State to conduct business in the State of Mississippi.

2. Proof of Professional and General Liability Insurance

Each registration issued shall be valid for a period of twenty-four (24) months and shall be issued for the registration period of July 1 of the registration year and shall expire on June 30 two calendar years later.

Registration Form and Regulations may be found at

https://msdh.ms.gov/msdhsite/_static/resources/15495.pdf

Technology.
Practitioners and/or organizations providing medical/health services via telehealth shall ensure equipment and technology be adequate to provide information necessary to meet the in-person standard of care.

Standard of Care. Practitioners and/or organizations providing medical/health services via telehealth shall ensure that the standard of care is maintained for a telehealth encounter consistent with the expectation of in-person care.

Health Professional(s). Refers to individual(s).

Provider Entity/Organization. Includes organizations, institutions, and business entities, including online service entities.

Telehealth. The use of technology to deliver healthcare. Telehealth includes telemedicine, mHealth, eHealth, and Tele-Education.

Telemedicine. As defined in Section 25-15-9 (1) (c) of the Mississippi Code of 1972, Annotated, "telemedicine means the delivery of healthcare services such as diagnosis, consultation, and treatment through the use of interactive audio, video or other electronic media.

DO SOMETHING TODAY THAT YOUR FUTURE SELF WILL THANK YOU FOR.

Join us today & make your voice heard.

Our actions and decisions today will shape the way we will be living in the future.

MANP
MISSISSIPPI ASSOCIATION OF NURSE PRACTITIONERS

Advanced Vascular & Vein Associates

PAD Screening Questionnaire

Advanced Vascular & Vein Associates Patient Referral Form

4436 Mangum Drive, Flowood, MS 39232 601-586-7070 (Office)
601-586-7071 (Fax)

MS Association of Nurse Practitioners' key initiatives include

- We advocate for NPs with policymakers, and other healthcare entities both in the state and nationally
- Full Practice Authority allows NPs to practice to the fullest extent of their education and training *without* expanding their respective scopes of practice
- Increase access to care for patients across Mississippi
- NP orders for durable medical equipment and devices
- NP signature recognition on legal documents and eliminating co-signatures by physicians
- NP Income tax incentives & exemptions for underserved practice areas & NP owned businesses
- NP reimbursements and inclusion in insurance networks
- Recognize NPs as primary care providers (PCP)
- Increased faculty salaries