Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

Election Day is Upon Us

By MaryAnne Sapio, VP, AANP Federal Government Affairs

Tuesday, November 3, 2020 is Election Day, representing an incredibly important opportunity to engage in the democratic process and decide who will govern our nation. We will be deciding who will serve as our president for the next four years, as well as who will represent us in the U.S. Senate and House of Representatives. It is my sincere hope that you have taken the opportunity to engage with and educate those on the ballot on the issues of importance to nurse practitioners (NPs) and your patients. Your voice is critical to ensuring our leaders understand the vital role of NPs in our nation's health care system.

By voting in November, you have the opportunity to help ensure the lawmakers we send to Washington D.C. will legislate in a manner that continues to advance your profession and ability to provide care to patients. I urge you to vote on Election Day and ensure NPs are a powerful force at the ballot box as our country elects its leaders.

The ABCs of DME

by Laurel Short, DNP, FNP-C; Co-chair, AANP Orthopedic SPG

Durable medical equipment (DME) is an underrecognized, though important area in which nurse practitioners (NPs) can positively impact patient function and quality of life. This article will highlight definitions, benefits, and evaluation requirements for DME.

DME is any equipment that provides therapeutic benefit due to a medical condition or illness.[1] The item serves a specific medical purpose and is appropriate for use in the home. There are a wide variety of DME, and this article is focused on types related to mobility. Primary categories are orthotics, prosthetics, and wheelchairs (WC). Orthotics support, align, or correct biomechanics. Examples include an ankle foot orthosis (AFO), knee brace, or scoliosis support. A prosthetic is an artificial substitute for a missing body part, which is used for restoring function or cosmetic purposes.[2]

The most obvious benefit of DME for mobility is to allow ambulation or transport. However, there are multiple other benefits including improved endurance and pain management, as well as reduced musculoskeletal stress and fall risk. Patients are often unaware of these benefits, and NPs are in prime position to identify when patients are candidates for DME. For example, if a patient is not properly identified for use of an AFO, there is high risk of altered gait, falls and lower limb joint problems. An individual who ambulates with a foot drop is likely to suffer issues such as hip flexor tendinosis from hip-hiking or knee pain due to hyperextension. Uncontrolled pain and fatigue from ambulating in an inefficient manner can also lead to deconditioning and injury. A patient with multiple sclerosis or osteoarthritis may appreciate gains in energy level and pain control through alternating short distances of walking with use of a WC. This illustrates a primary concept of pacing for those with chronic neurologic or orthopedic conditions. From a financial standpoint,

appropriate orthotic and prosthetic services save over $200 million annually by preventing co-morbidities and complications.[3]

The next step after identification is assessment and documentation. A face-to-face exam (also referred to as FTF) is required for some orthotics and all prosthetics or wheelchairs to be authorized by Medicare, Medicaid and private insurance. Consider scheduling a separate appointment to comprehensively address the components of a required FTF. An organized clinic visit allows the patient to obtain proper DME in an efficient manner.

The general requirements for DME include patient history and condition(s) relevant to functional deficits, how activities of daily living (ADLs) are impacted, and thorough musculoskeletal and neurologic exam. AFO documentation also requires the patient is ambulatory, has a diagnosis of weakness or deformity, and a description of how function will be enhanced with the AFO. For both orthotics and prosthetics, the NP should outline general medical condition, etiology of the disability and prior level of function. Describe employment, recreational pursuits, patient goals and family or caregiver support. Specific to prosthetics, functional levels K0-K4 are used to detail potential activity level.[2] The K level is used to match lower limb prosthetic components with the patient's ambulation potential. The lowest activity level is K0, and K4 is the highest. Detailed descriptions of these levels are available at cms.gov, and a certified prosthetist is an excellent resource for becoming comfortable with this language.

When completing a WC exam, the same general requirements are applicable. Additional documentation should include what specific ADLs the WC allows the patient to perform in the home, why walking aids such as a cane or walker are not appropriate, and whether the WC should be manual or power. If a power WC is recommended, there must be documentation on why the patient cannot propel a manual WC. When replacing a WC, the existing chair must be at least five years old.

For all mobility DME, verbalize if the patient has the cognitive ability and motivation to utilize the item. To optimize the value of DME, utilize additional modalities such as physical or occupational therapy, as well as general lifestyle counseling. For example, a male patient with left above knee amputation and right knee osteoarthritis resumed golf and walks long distances with a well-fitting prosthesis, intermittent right knee viscosupplementation injections and weight management. Incorporating DME assessment is an excellent tool for the NP toolkit, reducing orthopedic co-morbidities and optimizing patient function. For more practical orthopedic content, please consider joining the AANP Orthopedic Specialty Practice Group (SPG). A presentation version of this topic with audio content is available on the SPG site.

Resources:

1. Centers for Medicare & Medicaid Services. Durable medical equipment coverage. https://www.medicare.gov 2020.
2. Godfrey Bradeigh S. Lower Limb Prosthetics. PM&R Knowledge Now. https://now.aapmr.org/lower-limb-prosthetics/ 2019, September 20.
3. DaVanzo D, Dobson A, El-Gamil A, Shimer M, DaVanzo JE. Retrospective cohort study of the economic value of orthotic and prosthetic services among medicare beneficiaries. http://mobilitysaves.org/docs/Dobson_Davanzo_Study_on_Cost_Effectiveness.pdf 2013.

Major Depressive Disorder: Treatment in Primary Care

By Leigh Schmidt, MSN, RN, CHCP, CNE; Director, AANP Education & Accreditation

Major depressive disorder (MDD) is the most common mental health disorder in the U.S., accounting for an average of 8 million ambulatory care visits per year.[1,2] Depression historically carries a stigma that can prevent proper and timely identification and treatment; additionally, barriers such as inadequate patient-provider symptom communication, time constraints, and lack of referral services contribute to a deficit of quality mental health care in the nation.[3]

One method for reducing stigma and barriers to care is the use of routine screening, which guides clinical evaluation when symptoms of depression are present or to assess treatment response. Current guidelines recommend routine screening of all adults for depression in primary care. The Patient Health Questionnaire-9 (PHQ-9) and the PHQ-2 have demonstrated good clinical utility as screening instruments for depression.[4] Other effective methods to reduce barriers to care include motivational interviewing (MI) and shared decision making.[5]

Once a diagnosis of MDD is made, there are many pharmacologic treatment options for the clinician to choose from. While the numerous options may make selection more difficult, the availability of multiple treatments allows for individualized regimens.[6] Treatment choices include a wide range of antidepressants, many of which are selective serotonin reuptake inhibitors, serotonin-norepinephrine reuptake inhibitors, or otherwise target the serotonin-norepinephrine system.[7] When choosing a treatment for a patient with MDD, nurse practitioners (NPs) must carefully consider patient factors including comorbid conditions, patient history, medication efficacy, safety and cost.

Primary care is the one place within the health care system that has consistent contact with patients. Up to 25% of primary care visits involve depression, and primary care providers deliver 50% of behavioral health services in the U.S.[8] Therefore, NPs are very likely to encounter patients who are experiencing MDD, and through education and training, can be prepared to meet the needs of patients with depressive disorders.

The AANP CE Center offers several continuing education activities that cover a range of psychiatric and mental health care topics, including two recent additions: *Major Depressive Disorder: Screening Strategies & Treatment Options for the Nurse Practitioner in Primary Care* and *Treatment Resistant Depression: Guidelines and New Treatment Options*.

Mental Illness Awareness Week:
October 4-10, 2020
National Mental Health Screening Day:
October 8, 2020

References:

1. Qaseem A, Barry MJ, Kansagara D. Clinical Guidelines Committee of the American College of Physicians. Nonpharmacologic versus pharmacologic treatment of adult patients with major depressive disorder: a clinical practice guideline from the American College of Physicians. *Ann Intern Med.* 2016 Mar 1;164(5):350-359.
2. Ferrari AJ, Charlson FJ, Norman RE, et al. Burden of depressive disorders by country, sex, age, and year: findings from the global burden of disease study 2010. *PLoS Med.* 2013 Nov;10(11), e1001547.
3. Yokoya S, Maeno T, Sakamoto N, Goto R, Maeno T. A Brief Survey of Public Knowledge and Stigma Towards Depression. *J Clin Med Res.* 2018 Mar;10(3):202-209. https://doi.org/10.14740/jocmr3282w; Epub 2018 Jan 26.
4. Colligan EM, Cross-Barnet C, Lloyd JT, McNeely J. Barriers and facilitators to depression screening in older adults: a qualitative study. *Aging Ment Health.* 2018 Dec 27:1-8. https://doi.org/10.1080/13607863.2018.1531376.
5. Siu AL, USPSTF, Bibbins-Domingo K, et al. Screening for Depression in Adults: USPTF Recommendation Statement. *JAMA.* 2016 Jan 26;315(4):380-387. https://doi.org/10.1001/jama.2015.18392.
6. Lin P, Campbell DG, Chaney EF, et al. The influence of patient preference on depression treatment in primary care. *Ann Behav Med.* 2005;30(2):164-173.
7. Ceskova E, Silhan P. Novel treatment options in depression and psychosis. *Neuropsychiatr Dis Treat.* 2018;14:741-747.
8. Kennedy SH. A review of antidepressant therapy in primary care: current practices and future directions. *Prim Care Companion CNS Disord.* 2013;15(2).

Telehealth in the Pandemic Landscape

By Ashley Shew, MPA, MA; Policy Analyst, AANP State Government Affairs

As American Association of Nurse Practitioners® (AANP) State Government Affairs analysts, we often find opportunities for improved patient access to nurse practitioner (NP) care at the intersection of practice, policy and reimbursement. The new health care reality sees lawmakers, patient advocates, providers and health systems all looking to remote, digital health visits as a solution to increased demand for care *without* unnecessary risk of in-person coronavirus transmission. Telehealth care is perhaps one of the fastest-growing areas along all three important dimensions in the current COVID-19 health care landscape.

TELEHEALTH PRACTICE, PREPARATION, EDUCATION AND TRAINING

An important aspect of delivering quality care in the age of video visits is ensuring that providers have the tools to adapt practice to new technologies. Recent months have seen a surge in new resources for NPs to incorporate or expand virtual services. AANP members can access continued education offerings and the Specialty Practice Group (SPG) - Health Informatics and Telehealth, as well as a recent video from AANP Region 8 Director and chair of the AANP Telehealth Expert Panel Robin Arends highlighting best practices for NPs skilling up to go online to meet the evolving needs of patients.

STATE PRACTICE POLICIES DESIGNED FOR DIGITAL

In addition to measures to suspend supervision requirements, states have also looked to authorize out-of-state providers and re-activate the retired health care workforce to alleviate strain and capacity challenges. Some measures like those in Maine and South Carolina, specifically target opportunities for expanded prescribing authority via telehealth and access to out-of-state providers and virtual care across state lines.

Telehealth has traditionally been defined by the *location of the patient*. NPs are typically licensed in the jurisdiction where the patient is seen at the time of care. But new policies in the wake of COVID-19 increasingly acknowledge that patients and providers are mobile and online, and that good health is not confined to geographic borders. AANP members can get started accessing our latest telehealth and COVID-19 policy resources. The boards of nursing in all states and territories NPs hold a license and/or wish to serve patients are the official authorities for guidance on new telehealth policies that may impact NP practice.

INSURERS AND PLANS STEPPING UP TO COVER CARE

Great patient care happens when NPs have the tools they need and a supportive policy practice environment to best serve their community. Whether in-person or virtual, patients deserve to see the provider of their choice in safe and accessible settings, *as well as* assurance that needed services will be covered by their insurers. Private and public payer programs alike are taking note. For example, new guidelines issued from Centers for Medicare and Medicaid Service temporarily expand state waivers for telehealth services for eligible beneficiaries and participating providers. Moves like these also spur investments in broadband infrastructure needed to supply virtual care to even the most remote, rural and traditionally underserved communities. For more, AANP members can check out the latest reimbursement COVID-19 resources on new opportunities for telehealth billing and coverage.

Virtual visits are not a complete replacement for everything a real-time physical assessment can provide for some patients and conditions. However, telehealth offers a complementary solution as part of the NP's entire toolkit: one that helps manage the risk to benefit analysis inherent in some care settings for the appropriate patients and diagnoses.

The current moment requires innovation to manage short-term capacity strain that also maintains long-term quality care for patient physical and mental health and well-being. Telehealth expansion brings 21st century solutions to NPs and patients facing today's health care challenges.