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INSIDE

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Acute, Hospital-Level Care in the Home: A Glimpse of the Future

The Mayo Clinic has unveiled an ambitious new model designed to deliver hospital-level acute care to patients whom program administrators determine can be cared for in their homes safely.

Called Advanced Care at Home (ACH), the model seems ideally timed to respond to the COVID-19 pandemic-related demand for more virtual care options. However, plans for the approach were set in motion in 2019, well before COVID-19 was identified, explains **Margaret Paulson**, DO, chief clinical officer for ACH in the Mayo Clinic's Northwest Wisconsin region.

"Dr. [Gianrico] Farrugia, MD, the president and chief executive officer of Mayo Clinic, and his team were planning out the 2030 vision of how they were going to care for our patients in the future, and this idea really rose to the top," she says. "In other systems, [hospital-at-home models] have been shown to improve outcomes and decrease costs, all while delivering high patient satisfaction. Certainly, at a time when patients are demanding more choices in their healthcare, there were a lot of great reasons why our executive leadership wanted to roll out the project."

THE MODEL SEEMS IDEALLY TIMED TO RESPOND TO THE COVID-19 PANDEMIC-RELATED DEMAND FOR MORE VIRTUAL CARE OPTIONS.

Two Mayo Clinic sites were selected for the initial implementation of ACH: the health system's Jacksonville, FL, medical campus, which is a destination medical center, and Mayo Clinic's community specialty system in Northwest Wisconsin, which includes four critical access hospitals and a hub hospital in Eau Claire, WI.

Paulson notes the model went live in Jacksonville in July, and it began serving patients in Wisconsin in August. This gave emergency providers in both regions a fresh option to

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consider for some patients who meet the criteria for inpatient hospitalization.

Leverage Technology

A signature feature of the new model is that care for patients at both sites is driven out of a command center located on the Jacksonville campus. "This is a little bit of a nod back to the way that the Mayo brothers practiced 150 years ago where they would do house calls, going to [the homes of] their patients who were sick," Paulson says. "We can do that now pretty instantaneously with the power of technology."

To deliver this type of care, Mayo Clinic has partnered with Medically Home, a Boston-based technology company that specializes in innovations designed to help medical providers deliver advanced care in the home. This includes an integrated technology platform as well as a network of in-home services directed by Mayo Clinic providers.

The ACH program is focused on two patient groups, including what program administrators refer to as the "reduced length-of-stay" group and the "acute substitution" group. "Reduced LOS is basically where we identify patients who are already hospitalized and would be appropriate to continue their acute hospitalization in their homes," Paulson shares. "They no longer need any invasive procedures or testing. They are safe to go home, continue their acute hospitalization in the home, and then transition to a restorative phase."

Patients identified for acute substitution have been identified in the ED as requiring inpatient hospitalization. However, they are safe to receive their acute hospitalization level of care in their homes through the ACH model. "These patients end up in the ED, and then they go straight to their home for home hospitalization in that acute phase. Then, they transition to the restorative phase," Paulson explains. "It's nice for the patients because they never need to be hospitalized in a brick-and-mortar hospital."

Establish Criteria

Working a new option into the workflow and processes of the ED can be challenging. To head off any potential problems, the ED was involved early on in the planning for the ACH model. **Susan Cullinan**, MD, an emergency physician at the Mayo Clinic in Eau Claire, WI, took a leading role in making sure the ACH option would be set up for success in the emergency environment.

"Early on, [Paulson] got my concerns and was willing to work with us," Cullinan notes. "She included me in the [planning] meetings, and I think that was very helpful so I could give feedback to our ED team as this was coming out and moving ahead. I would talk about it at our monthly ED meetings so that people were aware."

One big issue involves determining which patients who present to the ED are good candidates for the ACH approach. Cullinan explains potential candidates include patients with a range of diagnoses, such as COPD, bronchitis, heart failure, deep vein thrombosis, pancreatitis, and pneumonia. In general, the program is designed for "sick but stable" patients. However, these need to be patients who meet the criteria for

hospital admission. "There are two models in how we get these patients [in the ED]; a push and a pull is how we look at it," Cullinan says.

For example, under the pull model, the ACH medical team is monitoring all patients in the ED constantly to determine if any meet the criteria. When a potential candidate is identified from the ED tracking board, the ACH team will contact the emergency provider.

Conversely, under the push model, the emergency provider may identify a potential candidate. If so, the provider will initiate discussions with the ACH medical team. "The criteria can be met from their staff looking at our patients or our staff," Cullinan notes.

Identifying potential candidates for the program mostly is the responsibility of the ACH medical team. This likely will be the case until emergency physicians are more accustomed to the program. In fact, for now, an ACH representative is on site in the ED, and takes the lead on introducing the program to potential candidates.

The emergency provider will see the patient and explain that he or she needs to be admitted. The provider also will explain to the patient that someone from the ACH program is going to be speaking with them. Furthermore, the ACH program is presented as optional, which allows the patient to choose the program or pick a traditional inpatient admission.

EXECUTIVE SUMMARY

Emergency providers can provide hospital-level acute care to patients at home under Advanced Care at Home, a new program from the Mayo Clinic that leverages technology and in-person services. The approach has been introduced in Jacksonville, FL, and Eau Claire, WI.

- A signature feature of the new model is that care for patients at both the Wisconsin and Florida sites is driven out of a command center located on the Jacksonville campus.
- The program is focused on two groups: inpatients who can be discharged earlier, thereby reducing their length of stay, and patients who present to the ED and meet inpatient criteria, but can be safely cared for in their homes.
- Patients admitted to the program do not need ICU-level care or advanced-level diagnostics or procedures.
- Patient stays in the program tend to be prolonged, but providers aim to conserve resources by preventing the need for admission to a skilled nursing facility or a repeat hospital admission.

Remove Barriers

While emergency providers always are consulted about potential ACH admissions, it is critical they are not asked to wade through any new processes or steps if a patient elects to receive their hospital-level care at home. "There is a discussion [between the ACH representative and the emergency provider], but I can tell you from the emergency provider standpoint it isn't any more work to go this route. It is actually probably less," Cullinan says. "It is as easy a practice as it is to admit a patient to the hospital, and I think that is the key thing. If you make the process more difficult, it is not going to happen."

When patients identified for ACH agree to this option, they are discharged from the ED, ending their workup in that setting. At this point, an ACH team takes over the patient's care. This team will arrange for an ambulance ride home and subsequent care. Paulson describes the patients admitted thus far to the ACH program from either the inpatient setting or the ED as requiring inpatient hospitalization, but not needing ICU-level care or advanced-level diagnostics or procedures. For instance, a patient with heart failure may need continued IV diuretics, or a patient may need IV antibiotics for their pneumonia or cellulitis. "Those are patients who can be safely cared for in the home," Paulson says.

Each ACH patient is equipped with a home kit that includes a blood pressure cuff, scale, and pulse oximetry monitor. "All of those things are Bluetooth-enabled ... so that we can get those vital signs pretty instantaneously," Paulson says.

However, Paulson stresses the program also relies heavily on providers going into the home, such as nurses, community paramedics, and advanced practice providers. "We can use the technology, but we also have people at the bedside if needed to help facilitate some of those very delicate times when we need a hands-on approach," she says.

During the acute phase of a patient's admission to ACH, a nurse practitioner or physician assistant will visit the home on days one and three, although additional visits can be arranged as needed. "The nurses round virtually just as they would in the hospital, but they do that through the technology," Paulson explains. "If our patients

are requiring IV medications, then our command center will help to determine whether they require a nurse for that, or perhaps a community paramedic."

Make Use of Extra Time

One particularly innovative aspect of the ACH model is each episode of care is prolonged. "We have the luxury of time. Our length of stay tends to be on the 30-day average rather than the four or five days a patient would typically spend in the hospital," Paulson says.

This period includes both a patient's acute phase and what Paulson refers to as the restorative phase.

"This ... gives us time to help with strengthening, patient education, and with ensuring that the patient has become completely independent in their care, or as independent as they can be," she says.

Throughout an ACH episode a patient's primary care provider (PCP) is encouraged to be involved. Toward the end of the episode, ACH care managers will set up an appointment with the PCP before discharge.

"That gives the PCP a warm handoff so that [he or she] understands what has happened during the stay," Paulson says. "If the PCP feels comfortable, then we arrange for discharge [from ACH]. If there are things that still need to be worked on, then we can hold on to the patient a little longer."

With such long episodes of care in the ACH program, how does the program conserve resources?

"The patients who benefit most from this model are patients who are older, they are deconditioned, and they would ordinarily end up in a skilled nursing facility following their acute inpatient hospitalization," Paulson explains. "That is where we can save money, if we can prevent a skilled nursing facility admission or if we can prevent a readmission."

Paulson reiterates that patients in the ACH program have more time to recover while they are monitored closely for their care needs. "A lot of patients need that time," she says.

For example, Paulson notes that discharge from an inpatient hospitalization typically is a rushed time. Even though providers try to make sure patients receive all the education and follow-up appointments they need, many just feel overwhelmed.

> THE PROGRAM SAVES MONEY BY PREVENTING READMISSIONS OR ADMISSIONS TO SKILLED NURSING FACILITIES.

"With this program, instead of giving patients a handout on what reducing their salt intake looks like, we can work with them," Paulson notes. "They invite us into their home, sometimes through video and sometimes in person, but we can work with them." During in-person visits, a clinician might inspect a patient's refrigerator or pantry to make sure someone with heart failure understands which foods he or she should avoid. "Through that educational period, we hope that readmissions to the hospital can be avoided," Paulson says.

Paulson acknowledges that at this point, admission to the ACH program is limited to patients with certain types of insurance. "We are working with individual payers to try to create bundled agreements," she says.

While not all payers are on board with this approach yet, ACH is available to a large population of patients within an accountable care organization in the region. The health system is continually working to add additional payers to the mix so that more patients can access it.

Take It Slow

In the first three months of the ACH implementation in Wisconsin, roughly 18 patients were enrolled. "We have been intentionally slow because we learn a lot with every admission," Paulson observes. "There are a lot of things we can work on to make things better for the next patient."

While there are not enough data to report on outcomes or financial returns, the program has made some progress. "Patients have been overwhelmingly supportive of the model. They are really happy that they are not in the hospital and that they are not in a nursing home," Paulson shares. "Our first three patients cried because they were so happy they didn't have to be in the hospital and were able to go home."

ACH's first patient was a man who had been hospitalized 10 times in the previous 12 months for exacerbations of heart failure and COPD.

"When he got home and I was on a video visit with him, his two dogs, Skittles and Roosevelt, were by his side. He had a big smile on his face. He was just so happy to be in his home environment, able to sleep in his own bed, and have his family visit," Paulson reports.

The second patient enrolled had undergone surgery to his spine and needed a prolonged period of IV antibiotics.

"He was a gentleman who had been in the hospital a few times before and had become delirious. This hospitalization was no exception," Paulson notes. "He had his surgery, did really well with that, but became delirious."

The patient's medical team looked at all the angles and found no other source of the delirium.

"This was someone who we identified could be safely cared for in the home. We talked with his surgeon as well as his family, and they were very excited about him going home."

Otherwise, the patient probably would have spent a few more days in the hospital before transferring to a facility 40 miles away. The family did not want to go through that. "When the patient got home, within a few hours his delirium resolved. It was just stunning," Paulson recalls. "He and his wife were over the moon about the program."

In the early days of the ACH program, the focus was on identifying hospitalized patients who could return home early, thereby shortening their LOS. Now, there is a growing focus on the acute substitution group — patients who are identified in the ED as meeting criteria for an inpatient admission, but can be safely cared for at home.

"We have had two patients so far from the ED that have been admitted [to the ACH program] with COPD, both of them in their 70s," Cullinan says. Further, she notes both patients and emergency providers seem comfortable with the option.

In fact, no patient has declined the option thus far. The emergency providers' program acceptance can be attributed in part to multiple simulation sessions. This helped staff understand how patients would be identified and admitted to the ACH program. "The multiple sessions helped with different providers," Cullinan says. "We talked about it, too, with those providers who weren't actually available at the time [of these sessions]. But even if they weren't part of a simulation session, this is very easy ... because there are not a lot of extra things to do."

Including the ED in the early planning sessions and asking ACH administrators to strongly advocate for the program have been significant keys to the smooth implementation of this option in the emergency setting. In addition, Cullinan sees opportunities to further strengthen the program once the surge in COVID-19 patients eases.

"We have case managers in the ED who were pulled at one point to do more work in the hospital," she says. "But I think once we can get them back in the ED, they will be advocates, and they can help us look for [potential] ACH patients." ■

Nurse-Driven Screening Protocol Seeks Flu Vaccine for Every Eligible Child in ED

For good reason, EDs tend to resist taking on added responsibilities beyond the scope of emergency medicine. Their plates are full already, particularly with a serious pandemic that is straining resources and commanding the full attention of frontline clinicians. However, long before COVID-19, the ED at Children's Wisconsin in Milwaukee saw an opportunity to address the low influenza vaccination rates in children. "Within the state of Wisconsin, the vaccination rates in children are ... close to 38% or 40%. We see disparities in vaccinations where minorities and uninsured or underinsured [children] are less likely to get the vaccine," says, **Shannon Baumer-Mouradian**, MD, BS, a pediatric emergency physician at Children's

Wisconsin. Everything from lack of transportation and misinformation to difficulty scheduling a time affect vaccination rates. However, Baumer-Mouradian explains an innovative nurse at Children's Wisconsin saw the ED was uniquely positioned to break down some of these barriers, and came up with the idea of offering the flu vaccination to every pediatric patient who presents.

From here, developers fine-tuned a screening protocol aimed at making the process as easy as possible without disrupting flow. Now in its third year of implementation, the ED has steadily improved its performance in vaccinating kids. In fact, developers are looking to leverage the protocol further, perhaps for the COVID-19 vaccine when it becomes available to children, along with other important pediatric shots.

Once it became clear the ED could raise the pediatric vaccination rate, a multidisciplinary committee was established to figure how to implement such an intervention in the most seamless and efficient way possible. Baumer-Mouradian was part of this panel, but she notes it also included representatives from nursing, medical school faculty, and pharmacy, along with an electronic medical record (EMR) analyst.

"What we developed were adaptations to the EMR to make it easy for nurses to screen every patient who came to the ED, and ask them if they have had all of their vaccines," Baumer-Mouradian explains.

Follow-up questions focused on whether patients had received their flu vaccine for the current year. If not, staff asked patients whether they would consent to receive the vaccine during the ED encounter. "The literature actually shows that a strong recommendation from a provider or a nurse goes a long way with a family," Baumer-Mouradian explains. Before, nurses might have asked a plain question like "Would you like the flu vaccine?" Now, nurses say something along the lines of "We recommend you obtain the vaccine this season for the health of your child." Subtle changes like these have paid dividends.

For instance, during the 2017-18 flu season, before the screening protocol, only 75 children who presented to the Children's Wisconsin ED received the flu vaccine. After implementation, in the 2018-19 flu season, more than 1,300 vaccines were given to children in the ED. "That was 9% of the unvaccinated population that presented to our ED," Baumer-Mouradian shares.[1]

Since that first year, developers have tweaked the protocol, leading to additional improvements. "During this last season [2019-20], we vaccinated almost 3,200 children in our ED, and about half of these children were minorities," Baumer-Mouradian reports.

Further, she states more than three-quarters of these children were uninsured or underinsured, qualifying them for a federally funded program that provides the vaccines at no charge. "The ED vaccine initiative is really filling a neat void in the need for promoting vaccines in children," Baumer-Mouradian adds.

It is never easy to add steps to the ED's busy workflow. The nuts and bolts of precisely how this intervention would be added were critical. For instance, Baumer-Mouradian explains developers decided against asking about flu vaccination during triage, where the primary focus is to identify whether a child is sick.

"We ask these questions when the patient gets to a room. They are part of a normal nursing workflow where we ask a series of questions for every child," she explains. Also, the specific questions pertaining to flu vaccine are only asked during the period when the shot is available and typically provided through the season.

EXECUTIVE SUMMARY

Frustrated with low vaccination rates, the ED at Children's Wisconsin in Milwaukee implemented a screening protocol to offer the flu vaccine to every eligible child who presents for care. Now in its third year, the nurse-driven intervention has proven successful, with leaders working to expand the approach ahead of an expected COVID-19 vaccine.

- Screening questions have been integrated into an already-established electronic medical record workflow that nurses carry out on every patient once they have been taken to a room in the ED.
- Nurses encourage parents to sign off on the shot for eligible children. If families hesitate, a physician can be activated to discuss the issue further.
- Once the patient's provider approves the vaccine, a nurse administers the shot at the point of discharge from the ED.
- During the 2019-20 flu season, the screening protocol was used to successfully vaccinate more than 3,000 children in the ED, about half of whom were minorities who usually vaccinate at a rate lower than the state's already-small percentage rate.

Abigail Kleinschmidt, DNP, CPNP-PC, RN, CPN, a pediatric nurse in the ED at Children's Wisconsin who helped lead the vaccine initiative, attributes much of the program's success to making the process as convenient and seamless as possible for staff.

"Our ED is incredibly busy during flu season and it puts a lot of strain on us as nurses," she says. "We wanted to make sure that we weren't adding a ton to their workflow, so we added the flu vaccine screening to an already-established [EMR] workflow. It is just one extra click where nurses already do initial patient screenings. We embedded not only the suggested scripting, but also the one-step ordering and a pop-up of the inclusion/exclusion criteria."

For instance, the nurse will click a button to indicate whether the child has received his or her flu shot. Then, if the family indicates they would like to vaccinate their child, the nurse will click a button indicating the family's affirmative request. The order goes to the pharmacist and physician to verify. "When the patient is about to go home, the physician has already met [with him or her] and determined the level of their illness," Baumer-Mouradian says. "If the patient is very sick and requires hospitalization, the patient is ineligible for the vaccine."

When a physician determines a child is eligible to receive the shot, he or she can click an approval button.

"That approval goes to the nurse, and the nurse administers the vaccine at the time of discharge," Baumer-Mouradian reports. "It is about five additional minutes to administer the vaccine."

Address Hesitancy

The vaccine initiative team added another intervention to the protocol whereby the physician can weigh in on the issue with families who remain reluctant even after a nurse recommendation.

"If a family says no and declines the flu vaccine ... the nurse is able to click that the patient has not yet been vaccinated, but intentionally needs some more information," Baumer-Mouradian explains.

This added step can be particularly helpful in cases in which the family expresses "red flags" such as a concern the vaccine might cause the flu or might be unsafe. In these cases, the nurse can tag the patient on the tracking board where all the ED patients are listed. "We have an icon there that [indicates vaccine] hesitancy. It is a little question mark," Baumer-Mouradian observes. "The provider is able to recognize those patients ... and go immediately to discuss [the flu vaccine] further."

Within the system, there is a resource that helps providers guide these conversations. "Last year, with that additional effort, there were 140 more vaccines given in cases where initially the families told the nurse 'no, thank you,'" Baumer-Mouradian says. "Upon the provider re-discussing the issue, and focusing on that vaccine hesitancy, we had some improvement."

Since the process began, Children's Wisconsin staff managed to stock the vaccine in the ED. By no longer waiting on shots to arrive from the pharmacy, the department shortened wait times and cut the number of patients who could not or would not hang around to wait for the shot. Kleinschmidt adds that vaccination rates "skyrocketed" thanks to this change.

Kleinschmidt also attributed higher vaccination rates to the fact nurses became more comfortable with the whole process over time. Adding an option for a physician assist has helped even more.

Obtain Buy-In

Considering emergency clinicians tend to resist adding tasks to their already busy workloads, it can be challenging to introduce changes like this. "Traditionally, EDs offer the tetanus vaccine because we see exposures to dirty wounds. There is a lot of literature on the fact that EDs do a great job of offering the tetanus vaccine, but we don't do a great

job of offering any other vaccine," Baumer-Mouradian laments.

However, that is precisely why Baumer-Mouradian views the vaccine initiative at Children's Wisconsin as "exciting, groundbreaking" work. "This was initially started as a nursing initiative, and the nurses give out at least 85% of the vaccines that we administer every year," she says. "The physicians are kind of the second tier."

Further, Baumer-Mouradian stresses that obtaining buy-in to offer the vaccine in the emergency setting is a critical early step to making any such initiative a success. "We did a lot of campaigning and education about why the flu vaccination was really important," she says.

This came prior to the start of the COVID-19 pandemic, so the importance of prioritizing flu vaccinations has only increased since the early days of the vaccine initiative.

Kleinschmidt says the team driving the vaccine initiative focused considerable attention on how administering more shots could help ED staff directly in the ED. "We would hope to have a less chaotic viral season [based on] the more kids we vaccinated, and overall a healthier community," she says.

A somewhat trickier aspect of securing buy-in concerned ensuring that it did not adversely affect patient flow, always a high priority in the ED. "The complicated thing about our ED is that it is an academic center. We have trainees involved at all different levels," Baumer-Mouradian says. She estimates on top of 30 physicians and another 15 advanced practice providers, there might be 10 to 20 residents rotating through the department every month.

> VACCINATING MORE CHILDREN AGAINST THE FLU COULD LEAD TO A LESS CHAOTIC VIRAL SEASON AND AN OVERALL HEALTHIER COMMUNITY.

Leaders sent weekly updates on how well the ED was performing. "I specifically targeted our little red question marks on the patients we knew needed more information," Baumer-Mouradian says. "I gave feedback about that every week."

Further, once the nurses became accustomed to clicking the extra button to inform physicians about reluctant families, Baumer-Mouradian targeted her messaging efforts toward the physicians. "Every week, we would recognize people for not just [administering] the flu vaccine, but also going up to those families who were hesitant and convincing them. We did shout-outs very frequently, and I think that raised morale," she says.

Many providers are worried about their own personal safety, the safety of their families, and caring for all the patients who are presenting with COVID-19. Still, Baumer-Mouradian notes the Children's Wisconsin ED performed at least as well, if not a little better, on administering flu shots in the most recent season than in previous years.

Knowing a COVID-19 vaccine is not far away, Baumer-Mouradian says plans are in the works to expand the screening protocol to six urgent care sites in the region, and then to integrate it across the health system to primary care, specialty clinics, and in the hospital. The goal is to administer nearly 100,000 flu vaccines to children systemwide. ■

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Tips for Successfully Implementing a Flu Vaccination Program

Pediatric ED leaders interested in implementing a screening protocol to boost flu vaccination rates in children should rely on quality improvement principles, advises **Shannon Baumer-Mouradian**, MD, BS, a pediatric emergency physician at Children's Wisconsin in Milwaukee.

When forming a team to lead the effort, include physician and pharmacy representatives as well as nursing leaders and frontline representatives.

"The nursing staff [members], who administer close to 85% of our vaccines, really need to be involved in both the planning and implementation process," Baumer-Mouradian stresses. "You've got to get buy-in from your nursing staff. It means so much more when it comes from colleagues rather than through a top-down approach."

Also, an EMR or IT support person is essential for EDs planning to embed their vaccination screening protocol into the EMR workflow.

Abigail Kleinschmidt, DNP, CPNP-PC, RN, CPN, a pediatric nurse in the ED at Children's Wisconsin, says it is important for leaders to provide education "early and often" to all providers involved with a flu vaccine program like this. This includes weekly emails filled with community-level flu data, along with statistics regarding how many vaccines were administered and the percentage of patients screened. "We use those same emails to help brainstorm and solve any bumps in the road," Kleinschmidt adds. Leaders must find a way to reach all the providers, especially the residents. "We have a lot of residents rotating through often, so it falls on nurses to explain to them how the process [works]," Kleinschmidt says. "Catching them early saves everyone a little headache."

Lastly, be sure to identify flu vaccination champions. The weekly emails at Children's Wisconsin include information about nurses who have ordered the most vaccines. "An effort to promote a little healthy competition and provide recognition," Kleinschmidt says. "Recruit nurses who are passionate about immunizations. That can be a big help toward solidifying teamwork between the nurses and doctors." ■

Poll: Many Emergency Physicians Avoid Mental Health Treatment

Already at high risk of suffering from burnout and PTSD, emergency physicians are straining to care for patients with COVID-19. However, recent evidence suggests many of these providers are reluctant to seek the mental healthcare they need, creating adverse circumstances for themselves, their colleagues, and maybe even their patients.

A poll conducted in October by the American College of Emergency Physicians (ACEP) and Morning Consult revealed 87% of 862 emergency physicians are more stressed since the start of the pandemic, with 72% reporting they are experiencing more symptoms of burnout.[1] Despite the availability of mental health services, the data show nearly half of emergency physicians are uncomfortable seeking mental health treatment. Seventy-three percent of respondents cited stigma in the workplace, and 57% cited a fear of professional reprisal as the top barriers to seeking mental healthcare. Also, 27% said they avoided seeking mental healthcare out of a concern for their job.

Advocate for Change

In an Oct. 26 media briefing, ACEP President **Mark Rosenberg**, DO, MBA, FACEP, said the results underscore what his group has been hearing from members. "We take care of patients instead of ourselves ... as a result, there is a higher rate of career burnout and PTSD than in any other specialty."

Rosenberg stressed the poll results add urgency to the need for emergency physicians, policymakers, and clinical leaders to work together to change the approach to mental health.

In April 2020, after exhaustively caring for patients with COVID-19 in New York City before contracting the virus herself, emergency physician Lorna Breen, MD, took her own life. Family members attended the Oct. 26 media briefing.

"For the first 49 years and six months of her life, [Lorna] showed no signs of depression or anxiety. That changed after she got

COVID-19 and was an emergency provider in Manhattan," noted **Jennifer Breen Feist**, JD, Breen's sister and co-founder of the Dr. Lorna Breen Heroes' Foundation.[2]

While Dr. Breen did seek mental health treatment, she was worried about the possible negative consequences for her career.

"She was so concerned about the stigma of seeking help and so concerned about how she would be perceived by her peers that it was her main focus. We believe it ultimately was her downfall," Feist said.

Tackle the Barriers

As poll statistics suggest, thousands of frontline providers are suffering in silence, observed **Corey Feist**, JD, MBA, co-founder of the Breen foundation.

"Given the scale of suffering that we are seeing in our hospitals across the country, it is no surprise that many of our emergency physicians feel that they've got to be superhuman at work. We simply need to give them the reassurance as well as the support they need to take care of themselves first and foremost before they take care of patients," he said.

Feist noted that as he and his wife have delved deeper into the topic, they have learned about the adverse consequences of stress and burnout, not just on providers but patients, too. "There is a 200% chance of an increase in patient errors when healthcare providers are burned out. If our healthcare heroes in the ED aren't going to [get help] for themselves, they need to do it for their patients who they were sworn to protect," Corey Feist said. "Physicians across the country are reluctant to reach out for mental health. Jennifer and I strongly believe that this status quo must change."

Feist noted one of the big barriers to culture change in this area concerns the sometimes-invasive questioning of physicians regarding mental healthcare treatment they may have received before. Such questions are part of some state licensing and hospital credentialing processes.

Nurture Peer Support

Rosenberg pledged that ACEP is moving on several fronts to reduce the stigma attached to mental healthcare, including assuaging fears about losing a job.

"We need to have the opportunity to share [these concerns] and maybe get professional help without being afraid of what is going to happen," he said. ACEP offers a wellness resource program for the group's 40,000 members that includes peer support, crisis support, and physician advocacy and wellness resources.[3]

Corey Feist said one of the most effective tools for physicians under stress is talking to colleagues. "Peer support networks are critical to addressing the solution. Even if you don't think you have the skills, you do by virtue of the MD behind your name," he said. "Particularly right now, it just takes hearing each other. Give yourselves permission to talk and listen. It is critical now more than ever."

Feist also encouraged clinicians to advocate for resources in their own healthcare settings. "Recognize that you play a key role in helping to change the culture and in taking care of each other," he said. "Speaking to each other about this stigma and ... your needs is going to lift an incredible weight off of everyone's shoulders so that [people] don't have to hide in the shadows anymore." ■

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Analysis: Nurses at High Risk of Contracting COVID-19

As the COVID-19 pandemic lingers, the CDC recently warned nurses are at significant risk of contracting the disease.[1]

Investigators reported 6% of adult patients hospitalized with the virus from March until May 2020 were healthcare workers. Of these, 36% were nurses or nursing assistants. Further, 28% of the hospitalized healthcare workers required admission to ICUs, 16% needed mechanical ventilation, and 4% died. The analysis highlights the enhanced vulnerability of patients with underlying health conditions. Close to three-quarters of healthcare workers hospitalized with the

virus were obese, a factor that puts patients at higher risk of death. Further, the CDC reported most hospitalized healthcare workers in the analysis were women (71.9%), and they tended to be older, with a median age of 49 years.

While investigators could not pin down where the healthcare worker participants contracted the virus, the majority had provided direct care to patients. Thus, investigators concluded nurses who serve in frontline roles face a heightened risk of contracting COVID-19 because of their close patient contact and extended, ongoing exposure to those potentially infected with the virus.

The analysis authors emphasized the need for rigorous infection control practices in healthcare settings as well as mitigation efforts aimed at reducing transmission of the virus in the community. ■

REFERENCE

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AMA Prepares for COVID-19 Vaccine with Coding Updates

The American Medical Association (AMA) recently revealed updates to the Current Procedural Terminology (CPT), helping the U.S. healthcare industry lay the administrative groundwork for an eventual COVID-19 vaccine.[1]

There are codes unique to two possible vaccines and other unique codes concerning administration of those vaccines. All the updates have been released now so healthcare leaders can update electronic systems; prepare to allocate vaccines properly; and track, report, and analyze related data. The codes will become effective if/when the FDA either approves a vaccine or issues an emergency use authorization (EUA) for one.

"An effective national immunization program is key to bringing the coronavirus pandemic to an end," AMA President **Susan R. Bailey**, MD, said in a statement.[2] "Correlating each coronavirus vaccine with its own unique CPT code provides analytical advantages to help track, allocate, and optimize resources as an immunization program ramps up in the United States."

Although the FDA has not issued an EUA for a COVID-19 vaccine yet, there is a feeling that momentum is building toward a breakthrough. For its part, the federal government has created Operation Warp Speed to provide funding for vaccine research and speed the process.[3] Although the political pressure from the Trump White House is intense, large manufacturers are trying not to rush the process. Executives from nine companies have publicly committed to thorough testing to ensure proper safety.[4]

> THE CODES WILL BECOME EFFECTIVE IF THE FDA APPROVES A VACCINE OR ISSUES AN EMERGENCY USE AUTHORIZATION FOR ONE.

For more Relias Media coverage of the COVID-19 pandemic, please visit: https://bit.ly/3nv89vE. ■

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COMING IN FUTURE MONTHS

- COVID-19 vaccination plans for frontline clinicians
- Questions about potentially excessive urine testing in the ED
- Screening for STIs in the ED
- Streamlining the interhospital transfer process

CME/CE INSTRUCTIONS

To earn credit for this activity, please follow these instructions:

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CME/CE QUESTIONS

1. **The Mayo Clinic's Advanced Care at Home program is focused on two groups of patients, the "reduced length-of-stay" group and the:**
   a. "reduced hospital visits" group.
   b. "mental health support" group.
   c. "rehabilitation services" group.
   d. "acute substitution" group.

2. **Despite the availability of mental health services, a poll revealed what proportion of emergency physicians surveyed are not comfortable seeking such treatment?**
   a. Nearly half
   b. One-quarter
   c. Three-quarters
   d. One-third

3. **Cognizant of the high importance of patient flow in the ED, how long does it take clinicians involved with implementation of the flu vaccine initiative at Children's Wisconsin to administer the shot?**
   a. Two additional minutes
   b. Five additional minutes
   c. Eight additional minutes
   d. 10 additional minutes

4. **What do clinicians need "early and often" when it comes to a vaccine initiative like the one at Children's Wisconsin?**
   a. Hands-on assistance
   b. Leadership rounding
   c. Education
   d. Initiative-focused bonuses

CME/CE OBJECTIVES

After completing this activity, participants will be able to:

1. Apply new information about various approaches to ED management;
2. Discuss how developments in the regulatory arena apply to the ED setting;
3. Implement managerial procedures suggested by your peers in the publication.