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INSIDE

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Help Physicians, Nurses Overcome Fear of Seeking Assistance for Stress Relief

Stress has long been a serious problem for physicians and nurses, but the added burden of COVID-19 is bringing attention to a particular challenge: All too often, clinicians are reluctant to seek the support of their employee assistance programs (EAPs) and other mental health resources available to them.

A primary reason they avoid seeking help is that they fear they will face negative repercussions at work, even losing their jobs, according to recent research.[1]

A survey conducted by the American College of Emergency Physicians (ACEP) revealed 45% of emergency physicians do not feel comfortable seeking mental health treatment. Most emergency physicians (87%) said they have felt more stress since the start of the COVID-19 pandemic, citing a lack of personal protective equipment (PPE) and other resources as key reasons.

"These new data add real urgency to the need for emergency physicians, policymakers, and clinical leaders to work together to change our approach to mental health. Every healthcare professional, especially those on the frontlines of the pandemic, should be able to address their mental health without fear of judgment or consequences," **Mark Rosenberg**, DO, MBA, FACEP, president of ACEP, said in a statement.[2]

ACEP reports physicians avoid seeking help because they fear being asked about mental health treatment at some future point in their careers. Specifically, the poll revealed stigma in the workplace (73%) and fear of professional reprisal (57%) as the top reasons for avoiding mental healthcare. Additionally, many state medical boards require disclosure of mental health problems on physician licensing applications, although there appears to be ongoing debates and evolution about these policies.[3,4]

In the early stage of the pandemic, an emergency physician serving as

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medical director at a New York City hospital committed suicide. Her family cited the stress of treating COVID-19 patients as a primary cause. In the same week, a paramedic in New York City also killed himself; the family cited COVID-19 stress.

(Editor's Note: ACEP eulogized Lorna Breen, MD, FACEP, on April 27, 2020: http://bit.ly/2YyTkPt. EMT John Mondello took his own life on April 24, 2020. Learn more about him here: http://bit.ly/3ddwBMO.)

High Stress, Reluctant for Help

It is important to separate the mental health resource from the place of employment, says **Charles Rothberg**, MD, chair of the Physician Wellness and Resilience Committee at the Medical Society of the State of New York (MSSNY).

"Physicians in general are in one of the high-stress professions, like law enforcement and the military. Like both of those professions, there is a culture where physicians don't seek help because of certain cultural and professional hurdles," Rothberg says. "Layered on that is the stress related to COVID-19. That stress is extraordinary."

Medical students and residents suffer the same stress. The additional burden of feeling like they are not ready for the COVID-19 pandemic exacerbates the problem.

"When you combine that with the social isolation, particularly for people like residents who have traveled to a new city and don't have the support of local family and friends, all of that disrupts a person's natural ability to cope," Rothberg says.

In July 2020, the MSSNY launched a program to assist physicians, residents, and medical students who may be contemplating suicide. The week the MSSNY P2P started, three physicians reached out requesting support.

The program can offer independent support that may appeal to physicians who do not want to reach out to their own institution for help.

"The idea of peer-to-peer is that it is a nonjudgmental, nonthreatening, noninstitutional encounter that calms people, reassures them, validates their thoughts and feelings, and supports people by telling them that what they are feeling is normal and not extraordinary," Rothberg says. "Or, if it's not normal, they provide resources to pursue a remedy."

There are similar peer-to-peer programs that are institutionally driven, Rothberg notes, but the MSSNY program is not tied to

NY PHYSICIANS PEER SUPPORT FOR STRESS

The Medical Society of the State of New York (MSSNY) offers peer-to-peer support for any New York state physician, resident, or medical student.

- Email P2P@mssny.org and request to speak with a peer supporter.
- Call (844) P2P-PEER and request to speak with a peer supporter. The line is answered Monday through Friday, 8:30 a.m. to 5 p.m. After 5 p.m., an answering service will take contact information for follow-up.

any healthcare institutions. The program ensures the peer supporters do not have an employee-employer relationship or supervisory control over the person seeking support, Rothberg notes.

The goal of the program is to assist physicians before their stress reaches a critical point and affects their performance at work or leads to related issues like substance abuse. Those seeking help are matched confidentially with a peer physician through email and a toll-free phone number. The program matches the physician in need with a peer in similar professional standing, but not necessarily in the same geographical area. For confidentiality, physicians seeking help do not want to talk with someone in their immediate community. *(Learn more in the sidebar on page 14.)*

Firewall Between Help and Employer

Some hospital systems have expressed interest in adopting an approach like the MSSNY program as part of existing EAPs. However, Rothberg urges caution to leaders considering this path.

"There needs to be a firewall. An in-house program, no matter how well intentioned and designed, is not going to work as well as something that is separate from the institution," Rothberg says. "They want to set it up through human resources because it is an employee benefit, but I don't think that any system in house can be as effective as a [external] physician-run program."

Rothberg notes physicians in a peer-to-peer program remain obligated to report impaired physicians and misconduct. If either party learns of misconduct or that substance abuse has affected the other physician's work, that must be reported to the proper authorities.

"This program is not made for someone who is already impaired. A physician who is impaired might be reluctant to seek help for fear of being reported, so we are sensitive to that and have mechanisms to avoid getting into that situation," Rothberg says. "An employer might not feel the same way about that sensitivity."

Employer Tie Creates Problem

The greatest difficulty in treating frontline healthcare workers for their COVID-19-amplified stress is their resources for help are tied so closely to their employers, says **Wilfred G. van Gorp**, PhD, ABPP, who offers neuropsychology testing in New York City and Chicago.

"That is a huge hurdle for healthcare institutions to overcome, especially with doctors," he says. "The very act of acknowledging you have a problem and asking for help could derail your career. It's a quandary that is very problematic for some professions and difficult to overcome."

Van Gorp advocates for strong barriers between the EAP and the employer. Confidentiality must be absolute and promoted effectively to employees and physicians.

"The confidentiality must be explained, guaranteed, and agreed to by hospital administration. Otherwise, no one would avail themselves of this resource," van Gorp says. "This has to be widely endorsed by hospital administration because the repercussions could be quite serious if the employer is not serious about it. You need to be physically distant from the hospital, and available off hours, not on the second floor where everyone sees the chief of surgery going in to the therapist's office."

Nurses Equally Affected

Nurses deal with the same reluctance to seek help for stress, says **Mike Hastings**, MSN, RN, CEN, president of the Emergency Nurses Association (ENA).

"We are the caretakers. Historically, we just don't do a good job of taking care of ourselves," he says. "With COVID, we have seen some hospitals focus more

on wellness issues and pushing out more resources for healthcare workers. Convincing nurses to take full advantage of those resources can still be a challenge." Many nurses fear they might lose their license to practice nursing or lose their employment if they seek mental healthcare, according to **Holly Carpenter**, BSN, RN, senior policy advisor for the Nursing Practice and Work Environment and Innovation departments with the American Nurses Association (ANA).

Hospitals should offer mental health screenings and crisis response protocols, according to Carpenter. She also says mental health treatment should be covered by employee health plans — and that information should remain private. State laws and boards of nursing regulations concerning mental healthcare treatment, substance abuse treatment, disclosure, and possible penalties are not uniform. This prevents nurses from knowing exactly how to proceed if they think they need help.

"Those fears can be a reality if the care was not confidential and there was not a program in place to safely transition them back to work," Carpenter explains. "Patient safety, nurse safety, and the employer obligations all have to be taken into account. It's not as cut and dried as you might think when nurses ask about how this can affect their careers."

ENA has encouraged the use of peer support groups in which nurses can talk about their struggles and find healthy ways to cope.[5]

"It's a good chance for them to realize they are not alone. For nurses, that can be critical. A lot of times, when you only know what's happening in your one institution, there can be a mindset that you're the only one facing these problems," Hastings explains. "When we're able to reach out to others, we realize that the problem is more global than just your own institution. It at least allows you to understand you're not alone in what you're facing. Together, you'll get through this."

Hastings says talking about stress in the workplace regularly can help remove stigma about the subject. "This is something that everyone in our world experiences sometimes," he adds. "It's important to establish that it's OK to talk about it and get help."

"We really want to see the assessment and screening so they don't get to the point of crisis, and then a form of help that doesn't threaten their license, their confidentiality, or their employment," Carpenter says. "Optimal staffing is a big help. It would be great if a nurse could actually take her breaks as scheduled. If you don't have time to eat or go to the bathroom in a 12-hour shift, that's not going to help anybody."

Nurses need time and space to decompress after a patient death. Avoid mandatory overtime, and provide resources like float nurses so colleagues can take these breaks. Effective and enforced workplace bullying and violence prevention policies help, too. *(See the story on p. 18 for more suggestions on addressing nurses' mental health.)*

"I'm a nurse working at the ANA office. If we had a death at the ANA, we'd probably all be given time off and have people calling to check in on us. But for most nurses, they have to prepare the body for the morgue and get ready for the next patient," Carpenter says. "They may have known that patient for days, and they need a nice, serene place where they can decompress for five to 15 minutes. Nurses are used to death, but they're not inured to it — nor do we want them to be."

The most important thing is for nurses to know they are not alone, Carpenter adds. Hospitals should offer some type of free, confidential, and easily acceptable mental health screening, she says. The goal is for people to obtain help before the stress leads to a more serious condition.

Many Symptoms of Stress

The symptoms of stress can manifest in many ways, including headaches, lethargy, emotional outbursts, and sleep disorders, says **Jorge Palacios**, MD, clinical researcher at SilverCloud Health, a digital mental health company with offices in Boston, London, and Dublin.

"The more experienced the healthcare workers are, the less likely they are to experience mental health issues related to work. It's the new people who have been on the job for less time that are at higher risk," he says. "Adequate training and support also have been identified in scientific studies as lowering the risk. Healthcare workers who don't feel they have enough training to deal with these situations, and who don't have the support to deal with their own problems, are at greater risk."

On top of everything else, healthcare workers have been anxious about bringing COVID-19 home and transmitting it to loved ones. This leaves workers feeling even more vulnerable. "There is a loss of control, even though they have been trained and know more than most about the virus. They worry about the unknowns, the symptoms and

the mutations, whether the vaccine will work," Palacios says. "That has an effect on mental health."

On the bright side, Palacios says research has indicated some healthcare workers feel an increased sense of meaning and purpose because of the pandemic.[6] Exercise, talk therapy, meditation, yoga, in-person support groups, and online therapy tools all could help healthcare workers cope, according to Palacios.

Physicians or nurses seeking mental healthcare are making themselves vulnerable, not just professionally but on a personal level. Any program seeking to help them must acknowledge that vulnerability and assure users of confidentiality. *(See the story on p. 18 for more advice on how to structure a program.)*

"It's important to understand the needs of your frontline healthcare workers and provide the kind of assistance they need in the form that makes them most comfortable accepting it," Palacios says. "It's not enough to say that you have these resources within the hospital or health system and you should make use of them. If the help is not provided in a way that makes them feel safe, they will not use it."

(Editor's Note: For those in need, contact your state's medical society or medical board to identify resources in your area.) ■

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Structuring a Stress Program for Healthcare Workers

Hospital leaders seeking to provide help to physicians, nurses, and other healthcare workers dealing with the added stress of COVID-19 should keep certain elements in mind, says **Jorge Palacios**, MD, clinical researcher at SilverCloud Health, a digital mental health company.

Palacios says these techniques have been shown to help healthcare employees cope with the increased stress of COVID-19:

• **Exercise.** Physical activity has shown efficacy in reducing the stress brought on by many situations.[1,2] Establishing a workout routine could help frontline healthcare workers through the COVID-19 pandemic.

• **Cognitive reframing.** This is a type of therapy in which the person is encouraged to reframe stressful situations. For example, an employee who is stressed about allegedly "losing freedoms" during quarantine can be encouraged to think of it as "not relinquishing your freedom, but rather doing something noble and necessary like protecting your friends and family."

• **Practicing empathy.** This is about seeing something from someone else's point of view.

This encourages "emotion regulation," which is the ability to take in the experience of others without feeling overwhelmed.

• **Acknowledging a collective form of grief.** Healthcare employees should be allowed to grieve in whatever way feels best for them. That may be crying, laughing at the absurdity of the situation, or feeling annoyed. "Healthcare workers are in it all the time, and the appreciation they may have felt when this was first raging might be dissipating, because we're just all in it now," Palacios says. "You don't have to be the best version of yourself all the time. When people realize that, they can more readily accept help." ■

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ANA Offers Resources for Supporting Nurses' Mental Health

Hospital leaders can draw on many resources to support the mental health of nurses, says **Holly Carpenter**, BSN, RN, senior policy advisor for the American Nurses Association (ANA). Carpenter refers hospital leaders to the ANA position statement on nurses' mental health,[1] which includes these suggestions:

• Healthcare employers should designate a chief wellness officer and actively recruit nurses to fill this position.

• Nurses and nurse leaders should be trained to recognize signs of mental distress not only in nursing staff but also in patients at elevated risk of mental illness, and make referrals for appropriate, voluntary, confidential assistance.

• Healthcare employers should offer free and confidential mental health screenings to all nurses.

• Healthcare employers should ensure all nurses know their mental healthcare benefits, coverage, and available resources. Confidential crisis hotlines and long-term supports should be available. These resources should be reviewed regularly for adequacy and quality.

• Nurse educators and leaders should emphasize and integrate racial equity approaches at all levels of addressing mental health in nurse practice settings.

• Nurse leaders should work with stakeholders, particularly in the mental health community, to reduce mental health-related stigma in healthcare settings at all levels and in society at large.

Carpenter suggests hospital leaders encourage nurses to visit the ANA website dedicated to preventing nurse suicide.[2] ■

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Hospital Cuts COPD Readmission Rates with Bundle Checklist

The development of a bundle checklist for patients with chronic obstructive pulmonary disease (COPD) has helped a Maryland hospital sharply reduce its readmission rates for these patients. Overall care quality improved for these patients while admitted.

The effort was spurred by a hospitalwide effort to improve processes and identify gaps in care, says **Vanessa Piñeiro**, BA, RRT-NPS, RRT-ACCS, manager of respiratory care services, PFT Lab & EEG, at Adventist HealthCare Shady Grove Medical Center in Rockville, MD.

"Our chronic obstructive pulmonary disease patients were readmitted at a very high rate, sometimes as high as 30%. Of course, the hospital is not reimbursed if you are readmitted for something that was not adequately treated during admission, so that had a big impact on the hospital overall," Piñeiro reports. "We respiratory therapists looked at that and thought there must be ways we can improve those rates."

At that time, the hospital's COPD readmission average rate was 16.09%, an all-time high for the facility. Reimbursement for hospitals in Maryland was determined in part by the state's Health Services Cost Review Commission. COPD readmission rates higher than 10.8% resulted in a penalty.

The penalty, in addition to the other negative effects of readmission, inspired the hospital to set a target goal of 10.7%, and a stretch goal of 10.2%, Piñeiro explains. The hospital would surpass both goals within a year.

Task Force Studies Processes

The hospital established a task force that met monthly to study processes, people, and how the hospital's electronic medical record (EMR) affected readmissions or could be used to reduce them. In addition, respiratory care specialists studied the patient education process at discharge to look for possible improvements.

Others contributing to the project were the medical director of pulmonary services, case management professionals, discharge nurses, hospitalists, and home health nurses. The informatics department assisted with data collection and analysis. "One of the first things we did was to flag the patients who were diagnosed with COPD and who were readmitted. We looked at each case, tried to peel the onion and see why these patients were readmitted to the hospital," Piñeiro says. "We actually did a small case study of about 28 patients and monitored them for readmissions for about three or four months. We ... [tried] to identify gaps in care and potential reasons for readmission."

In some cases, the task force found the patients were readmitted for a comorbidity. Many COPD patients experience comorbidities such as diabetes, high blood pressure, and uncontrolled infections.

"Once we identified why these patients were coming back to the hospital, we tried to identify what we as respiratory therapists can control. We don't treat them for diabetes, but from a respiratory viewpoint we wanted to identify all the points of care that might be improved," Piñeiro says. "There were multiple factors related to the readmissions, but we wanted to see what we could influence as respiratory therapists."

Piñeiro and task force members from several departments used the Lean Six Sigma approach to tackle

the problem, including the DMAIC methodology, which stands for Define (the problem), Measure (the gaps in the problem), Analyze (the problem), Improve (the problem), and Control (how do we maintain the process).

That prompted a wider investigation into how the hospital could address issues such as comorbidities and noncompliance with COPD patients.

For example, some COPD patients continued to smoke. Other patients would feel worse after they returned home, in part because they did not comply with instructions for medication and monitoring. This could lead to a trip to the emergency department.

"From the time they came in the door, we had to educate them on the things that would make their treatment successful and avoid coming back," Piñeiro says. "That meant educating them on their medications, whether they knew what the medications were for and how to use them. A lot of these patients knew what COPD was, but never really understood the medications and why their conditions had to be carefully monitored, even after they went home."

The task force created a COPD bundle, addressing issues such as the signs and symptoms of infection, education, inhaler management, and smoking cessation. A new patient education plan was integrated into the EMR. "It was a huge undertaking to revise the education process, and that took about six months," Piñeiro says. "But immediately after we implemented that education, we saw a dramatic drop in readmissions."

Many Touchpoints for Patients

A significant revelation for the task force was understanding how many touchpoints were involved with a COPD patient. A single patient might be treated by a physician for diabetes, an infection specialist, a respiratory therapist, and others.

"None of us were really collaborating. We all worked in our own little silos," Piñeiro says. "The patient heard different things from different providers, and that left the patient overwhelmed and a little lost."

To help clinicians implement the COPD bundle, the task force created a "swim lane" process map that shows the various roles involved with the bundle so each clinician could clearly see what he or she was responsible for completing with the patient.

The Shady Grove facility also collaborated with an Adventist team that was working systemwide to improve aftercare for COPD patients at home, helping ensure the education provided to COPD patients in the hospital was consistent with and reinforced by the education provided at home.

Sharp Reduction in Readmissions

After the plan was implemented, the COPD readmission rate decreased from an average rate of 16.09% in 2017 to an average rate of 14.62% in early 2018. By June 2018, the rate was down to 9.54%, surpassing the hospital's stretch goal.

Those results have been sustained since then, and the COPD task force still meets monthly. New staff are onboarded to the bundle, and Shady Grove is working with other Adventist hospitals interested in adopting the same approach.

"We've been under 10% for two and half years. We have never gone back up to 30%," Piñeiro says. "The task force and all the others involved in the care of these patients feel like we've made a real difference for them. When a patient does come back now, we are very interested in looking back at their experience and trying to see if there was a gap in care that could have prevented that readmission."

Piñeiro says she and her fellow task force members did not realize the enormity of the problem until they were deep into the analysis of COPD readmissions.

"That's when we realized we needed collaborations with the nurses, discharge nurses, home health, so many people," she says. "If you think you can do this by yourself and you don't need anybody, you're very mistaken. When you're implementing an idea, it's very important that you have all the stakeholders at the table to share their input. You have to consider

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how all of these different people affect the patient's experience before you try to implement change."

She recalls one example involving patient education about COPD. The task force originally developed a three-page patient education document, but then others pointed out that patients are unlikely to read such lengthy material. It was revised to a one-page document that included the most important information.

"You have to be willing to ask for help and be vulnerable, to say you're trying to do something but it's not working out," Piñeiro says. "As respiratory therapists, we can focus so much on our part of the patient care that we don't realize there are others we can reach out to who have the same goal of improving the quality of care. It takes a village." ■

SOURCE

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Hospital Reduces Episiotomies with Transparency on Peer Rates

Texas Children's Hospital in Houston is reporting continued success with a program that reduced the rate of episiotomies from 9.11% of births to 3.44%. The hospital used a five-step approach that focused on publicizing the rate of episiotomies and encouraging physicians to improve their individual rates. The hospital's experience is an example of how some quality improvement efforts may take time to implement, but can produce long-lasting results.

Episiotomies have been targeted for reduction by the American College of Obstetricians and Gynecologists.[1] In 2015, the Leapfrog Group set a target rate of 5% or lower for these procedures. A 2018 report by Castlight and Leapfrog on maternity care revealed the average rate of episiotomies at hospitals was 7.8% in 2017.[2]

"While routine episiotomies were common for many years — ostensibly to prevent tears during delivery — recent studies have found that more selective use of this procedure may result in 30% fewer women experiencing severe perineal/vaginal trauma — including tears, pelvic floor defects, and loss of bladder or bowel control," the report authors wrote.[2]

Texas Children's effort to reduce episiotomies started as far back as 2012 when its Pavilion for Women opened. Hospital leaders saw the opening of the pavilion as an opportunity to improve quality of care for women, with episiotomies a primary target for reform, says **Manisha Gandhi**, MD, maternal fetal medicine clinic chief. At that time, Leapfrog called for a episiotomy rate of 12% or lower. Texas Children's was at 9%. Nonetheless, leaders wanted to cut the rate further.

"We knew we could tell people to stop doing episiotomies because there was an increased risk with episiotomies. We had to devise a way to do it so that physicians could feel they were reducing unnecessary episiotomies but still had the ability to do the procedure when necessary," Gandhi says.

Data Gathered for Baseline

The hospital established guidelines for the use of episiotomies and began collecting monthly data on the procedure for benchmarking. Those rates were not made public or provided to physicians. In 2014, monthly rates were revealed at monthly staff meetings, and leaders encouraged fewer procedures. In 2015 and 2016, as data reporting continued in monthly meetings, leaders emphasized Leapfrog's 5% target. In 2016 and 2017, the hospital began providing each physician with his or her individual episiotomy rate each month, with a comparison to the department rate.

"If a department was 7% and you were at 9%, the idea was that you should look at why you're doing more of these and whether that's justified," Gandhi says. "If your individual rate is lower than the department rate, there could be a discussion about what you are doing differently and what others might learn from your experience."

From 2017 and continuing today, Texas Children's reports quarterly on the individual episiotomy rates of all physicians, allowing for peer-to-peer comparisons.

Hawthorne Effect in Play

Individual rates began to decline after clinicians saw how their rates

compared to the department average. Gandhi says this is an example of the "Hawthorne effect," in which subjects change their behavior for the better when they know they are under observation. The natural competitive spirit of physicians also plays a role.

"We all compare ourselves to each other. We all very much want to meet the standard of care. Providing individual data and comparing it to what your peers are doing can be very powerful," Gandhi says. "It's a nice complement to system changes when you have people committed to doing it as a group. You're giving them information as individuals, but it really leads to a response as a group."

The hospital's cumulative episiotomy rate fell to 3.44% by November 2017. Today, that rate holds steady. Administrators continue issuing quarterly reports about episiotomies so peers may continue comparing their numbers. Gandhi argues this is necessary because, under the Hawthorne effect theory, subjects may revert to previous negative behavior if they believe no one is regularly watching them perform the new, desired method anymore.

(Editor's Note: There has been much speculation about the integrity of the data and methodologies used in the experiment conducted in the 1920s and 1930s that led to the term "Hawthorne effect," first coined in the 1950s. In the decades since, many investigators have suggested alternative theories and called for more research.[3])

Data Collection, Analysis Team Required

The biggest challenge for a hospital interested in replicating this success could be the heavy demand for statistical analysis, according to Gandhi. Texas Children's employs a strong team of data specialists.

"If a hospital has to do this on its own without a strong data infrastructure of a health system to back them up, I could see data collection and interpretation being the challenge," Gandhi cautions.

The long-term success of the effort is at least partly attributable to how leaders moved deliberately, carrying out the improvement plan in multiple phases over several years.

"Any time you're making big changes — and if there is no acute rush to change it immediately — you'll see more success with an approach that gives people time to learn about the issue, understand the concerns, understand where the recommendations are coming from, and give people time to get to it," Gandhi says. "We're continuing with the reports because it is clear that if you're getting feedback on your performance, you are more likely to change your practice and work to maintain an acceptable rate." ■

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SOURCE

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HHS Says Not All Guidance Enforceable

The Department of Health and Human Services (HHS) recently issued a rule making clear that not all "guidance" from the agency creates obligations on hospitals and other healthcare organizations.[1]

The new rule clarifies that some guidance from the agency is just that — only guidance, not a binding requirement. The agency wanted to clarify that "HHS guidance documents do not impose obligations on regulated parties that are not already reflected in statutes or regulations," HHS said in a statement accompanying the rule.[2]

"For too long, federal agencies have succumbed to the temptation to create law without notice and comment or public participation," HHS Chief of Staff **Brian Harrison** said.[2] "Our Good Guidance Practices regulation empowers and protects those we regulate by requiring increased transparency and raising the standards for issuing significant guidance." ■

REFERENCES

1. HHS.gov. HHS final rule for Executive Order 13891. https://bit.ly/3nZBLSu
2. HHS.gov. HHS finalizes Good Guidance Practices rule and issues advisory opinion regarding compliance with notice-and-comment obligations. Dec. 3, 2020. http://bit.ly/3mVs8CR

State Support Could Improve HPV Vaccination Rates

Investigators researched three programs to guide lawmakers on this public health issue

School-located vaccination programs, centralized reminder systems, and quality improvement (QI) visits with primary care physicians are three state-level outreach tactics lawmakers could use to improve HPV vaccination rates, according to the results of a recently published analysis.[1]

HPV causes more than 30,000 cancer cases in the United States annually, but more than 90% of those cases could be prevented with the HPV vaccine.[2] However, just 51% of Americans age 13 to 17 years are up to date on all their shots; 68% percent have received just one dose.[3]

State-level policy on HPV vaccination is heavily fragmented. Forty-eight states, the District of Columbia, and Puerto Rico allow pharmacists to provide the vaccine. But only a few states, like New Hampshire and Illinois, have enacted legislation that allows eligible patients to receive the vaccine for free. Just five states require this vaccine for school attendance.[4]

"With limited and shrinking budgets for state-based government programs in preventive care and increasing centralization of primary care in cost-conscious healthcare systems, it is important to identify not just effective but high-value [tactics] for improving HPV vaccine uptake," the authors of the recent study wrote.

Investigators created a simulation model of HPV transmission and progression for a theoretical population of 5 million people. The simulation considered 50 years of outcomes if there were no interventions or QI visits, school-based vaccine programs, or a centralized reminder system. Each intervention was cost-effective to some degree. The QI option seemed to be most effective if budgets were tight; the school-based program appeared to be most successful. When scaled to the rest of the U.S. population, the authors estimated these interventions could prevent between 3,000 and 14,000 cancer cases.

"Three interventions for increasing HPV vaccine coverage were cost-effective and offered substantial health benefits," the authors concluded. "Policymakers seeking to increase HPV vaccination should, at minimum, dedicate additional funding for QI visits, which are consistently effective at low cost and may additionally consider more resource-intensive interventions (reminder and recall or school-located vaccination)."

The National HPV Vaccination Roundtable, a group formed by the American Cancer Society and which receives funding from the Centers for Disease Control and Prevention, created a toolkit to help nurses improve HPV vaccination rates where they work.[5] ■

REFERENCES

1. Spencer JC, Brewer NT, Trogdon JG, et al. Cost-effectiveness of interventions to increase HPV vaccine uptake. *Pediatrics* 2020;146:e20200395.
2. Senkomago V, Henley SJ, Thomas CC, et al. Human papillomavirus-attributable cancers — United States, 2012-2016. *MMWR Morb Mortal Wkly Rep* 2019;68:724-728.
3. Walker TY, Elam-Evans LD, Yankey D, et al. National, regional, state, and selected local area vaccination coverage among adolescents aged 13-17 years — United States, 2018. *MMWR Morb Mortal Wkly Rep* 2019;68:718-723.
4. National Conference of State Legislatures. HPV vaccine: State legislation and regulation. http://bit.ly/2L4bUtU
5. Stone A. Nurses lead charge for HPV prevention. ONS Voice. Feb. 24, 2020. http://bit.ly/3aR4Ewh

CE OBJECTIVES

After completing this activity, participants will be able to:

1. Identify a particular clinical, legal, or educational issue related to quality improvement and performance outcomes;

2. Describe how clinical, legal, or educational issues related to quality improvement and performance outcomes affect nurses, healthcare workers, hospitals, or the healthcare industry in general;

3. Cite solutions to the problems associated with quality improvement and performance outcomes based on guidelines from relevant authorities and/or independent recommendations from clinicians at individual institutions.

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CE QUESTIONS

1. **What is one way to help physicians who are trying to manage stress?**

   a. Separate the mental health resource from the place of employment.
   b. The mental health resource should be specific to the physician's specialty.
   c. The help should be provided by someone in the same immediate community.
   d. The help should be provided in a group setting.

2. **Why do nurses avoid seeking mental healthcare?**

   a. Their employers do not offer mental health services as an employee benefit.
   b. Many nurses fear they will lose their license or employment if they seek help.
   c. They do not have time away from work and home responsibilities to seek care.
   d. Many nurses do not believe in the effectiveness of mental health services.

3. **To reduce COPD readmissions at Adventist HealthCare Shady Grove Medical Center, what was one major part of the strategy?**

   a. Strengthening criteria for determining appropriate discharge
   b. Expanding the use of home healthcare
   c. Improving patient education about COPD and discharge compliance
   d. Changing the definition of a readmission to include only COPD complaints

4. **What led to the successful reduction in the rate of episiotomies at Texas Children's Hospital?**

   a. Promoting change over several years rather than all at once
   b. Tying physician compensation to meeting the target rates
   c. Educating expectant mothers on why episiotomies should be avoided
   d. Providing adequate research material to physicians