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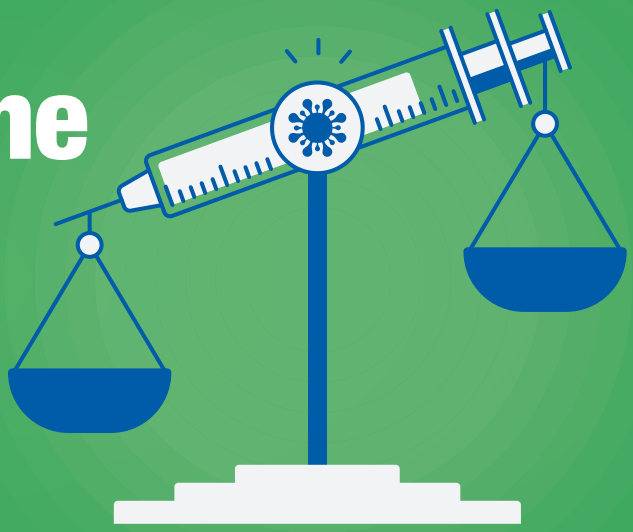
Overcoming Vaccine Hesitancy is a Team Sport



Donna Furlong

My father frequently tells the story of a time when, as a boy, he went to visit a friend in an iron lung. I do not know the fate of the boy and I am not sure he remembers either, we never quite get to that part of the story. What I do know is how that image still brings him to tears today, more than 60 years later. He often expresses to me his frustration and astonishment at people who choose not to vaccinate, whether skipping one vaccine or many, he simply cannot comprehend the choice. Many of us in the health care industry have the same difficulty understanding this choice. My father and these like-minded health care workers have something in common, an understanding from firsthand knowledge, through study or stories, the devastation caused by vaccine preventable diseases. Perhaps many even assuming that the same is true for all health care workers, but it is not. Vaccine hesitancy is a complex topic which requires context for understanding.

The concept of being anti-vaccine or vaccine hesitant is not new. In 1853, 80,000 people marched through the streets of Leicester, England, carrying banners of opposition, a child's coffin, and an effigy of Edward Jenner (creator of the smallpox vaccine) after the government mandated smallpox vaccines (Isaacs, 2019). Today, vaccine hesitancy is considered to be one of the top 10 greatest threats to global health situated among such concerns as pandemic influenzas, climate change, and high threat pathogens like Ebola or COVID-19 (Isaacs, 2019).

One of the greatest achievements in relatively modern medicine, vaccines are a victim of their own success. Vaccines prevent 2-3 million deaths annually (Ather & Sherin, 2019) and most vaccines are 90%-95% effective in preventing disease when given in the manner and dosages prescribed by the Centers for Disease Prevention and Control (CDC) (Natbony & Genies, 2019). This means many of the younger generation of providers have only read about diseases like diphtheria, polio, and chicken pox in textbooks. More recently, there have been outbreaks of measles and whooping cough so providers could see the effects rather than just read about them. Providers and parents have not witnessed or experienced the pain and suffering these diseases bring and the only knowledge or personal experience they might have is second- or third-hand from survivors who made it through the disease.

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Many settings. Multiple roles. One unifying specialty.

Better Together: Belonging to a Professional Organization

Kathleen Martinez

I am tired. I bet you are, too.

The last 24 months have placed enormous strain on all of us. Not only have we weathered a global pandemic, but we have dealt with the unimagined consequences of this tragedy. We have faced political division, polarized communities, separation from family members, personal risks because of PPE shortages, and staffing shortages. Sometimes it is difficult to see the value and impact of our daily work.

It's times like this that I remind myself I am a member of a noble profession. My influence is not limited to the day-to-day activities of my job, but is much deeper, wider, and more impactful. Professions, by definition, have a contract with society whereby they are granted self-regulation in exchange for sharing the many benefits of their specialized knowledge. We can influence health and equity across a broader community. This means we are all obligated to interpret, evaluate, and explain the work we do, and to understand how it benefits society. We also have the right and responsibility to oversee the education and training required for individuals to enter the profession and advance within it.

I am sure you are aware of the many resources available on the American Academy of Ambulatory Care Nursing (AAACN) website: Scope and Standards for ambulatory care, telehealth, and care coordination and transition management (CCTM®); and *Core Curriculums* for Ambulatory Care and CCTM. There are also educational resource directories, conceptual frameworks, business case templates, position papers, transition to practice guides, and toolkits. These resources are created, reviewed, and maintained by members of AAACN. They are used to establish job descriptions, quality and safety criteria, orientation and residency programs, training, and continuing education. I always get a thrill when I read a scholarly paper that references our position papers or standards of practice, or when a media story highlights an ambulatory care leader associated with AAACN. Our newest resource, the Ambulatory Care Nurse Executive Toolkit, was created by influential ambulatory care nurse executives with the specific purpose of supporting AAACN members on their professional journey as leaders.

One of the benefits of belonging to a professional organization is the chance to take part in developing these standards and guidelines that guide our practice. AAACN frequently sends out a 'Call for Volunteers' highlighting opportunities to engage in practice recommendations and guideline creation and review. Through participation in committees and task forces, creation of position papers, oversight committees, serving on the Board, and engagement in discussion boards, members can have considerable influence on the development and direction of our profession. The next time you see a 'Call for Volunteers,' consider responding so your voice and expertise can contribute to the body of knowledge that defines ambulatory care nursing.

An easy way to get involved is through the AAACN Annual Conference. The conference offers continuing education credits, opportunities to hear how peers in other locations are managing similar issues and concerns, and a chance to develop new friends and professional connections. This year's conference in Las Vegas,

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Prevalence and Determinants of Violence in Ambulatory Care via the Telephone

Cara Spencer, Rachel Musenero, and June Fouse

Key Words: Workplace violence, ambulatory care, telephone triage, continuing nursing education, verbal abuse, verbal violence, verbal violence via telephone, aggression, reactive-expressive, passive aggressive, contributing factors, management techniques.

Approximately 75% of all workplace violence events occur in health care, which is higher than construction, retail, and manufacturing combined (Occupational Health and Safety Administration [OSHA], 2015). Recognized as a serious barrier to providing patient care, The Joint Commission (TJC) (2018) released Sentinel Event Alert #59 to address physical and verbal violence as it undermines a culture of safety. Although violence is commonly referred to as physical or emotional, TJC acknowledges verbal abuse as a form of violence (2018).

The most prevalent form of *workplace violence* is verbal and may be defined as "aggressive or inappropriate language which makes the worker feel threatened, scared, or uncomfortable and includes behaviors such as yelling, name-calling, rude language, or verbal bullying" (Pompeii et al., 2015, p. 1,195). Ranging between loud yelling to more subversive and indirect behaviors, verbal violence is a dynamic problem. In the seminal work by Ramirez & Andreu (2003), aggression can be categorized as either reactive-expressive or passive aggressive; both categories apply to verbal violence. *Reactive-expressive verbal violence* appears as yelling, cursing, or arguing. *Passive aggressive violent behaviors* are more covert, subtle, and not as well defined and relate to the word choices and behaviors. These can include blaming, criticizing, being rude, degrading, and using snide language. Behaviors may include withholding pertinent information, ignoring the nurse, and speaking in a tone of voice which triggers a negative reaction (Avander et al., 2016; Mento et al., 2020; Ramirez & Andreu, 2003).

Verbal violence is often perpetrated by the patient or visitor (Pompeii et al., 2020). Unlike physical violence, which is commonly triggered by a mental issue or metabolic disorder such as drug intoxication, verbal violence is most often perpetrated by patients in a lucid and normal state of consciousness (d'Ettorre et al., 2018). Whereas face-to-face verbal violence triggers are known to be caused by unmet expectations, communication failures, human error, perceived substandard care, and management failures, little is understood about verbal violence via the telephone in the ambulatory care setting (Baig et al., 2018).

The physical distance from the patients may prevent physical forms of workplace violence but may increase the risk of verbal violence. Pompeii and colleagues (2020) found verbal abuse to be the most reported form of workplace violence in outpatient settings with prevalence rates ranging between 42.1%-94.3% annually, depending upon the staff's role. Ambulatory care nurses are especially at risk for verbal violence due to the many roles which require patient contact via the telephone. Depending upon the role within the ambulatory care setting, nurses may spend up to 100% of the day on the phone.

Verbal violence is especially damaging to nurses as it strains mental health and wellbeing while at work. Compared to physical violence, verbal violence is perceived to be more frightening due to the perpetrator's lucidity and intention to cause harm, as well as the personal nature of the attacks toward the staff (Jakobsson et al., 2020). Consequences of the verbal violence may trigger emotions and reactions such as fear, irritation, anger, depression, anxiety, guilt, humiliation, feelings of helplessness, and reduced job satisfaction and performance (d'Ettorre et al., 2018; Pompeii et al., 2020).

Currently, there is a dearth of understanding about verbal violence experienced over the telephone in the health care setting. The purpose of this quality improvement project was to ask ambulatory care nurses to describe verbal violence by callers when conducting patient care over the telephone and provide their perception of the frequency of violence. The project also identified nurse perceptions of verbal violence triggers, how nurses managed or handled verbally violent calls, and determined the impact on the nurse.

Methods

This was a cross-sectional, retrospective, descriptive quality improvement

project conducted in the western United States within an ambulatory care setting of an academic health care system of approximately 700 beds and greater than 100,000 ambulatory care visits per month. An anonymous electronic survey was emailed via organizational listserv addressed to nurses within the administrative definition of ambulatory care areas:

- Clinics.
- Patient care offices.
- Patient call-lines.

The survey, using self-identifying responses, measured several points. First, the nurses' perceived levels of experience and comfort level with phone violence was measured via four-point Likert scales (e.g., highly experienced to not at all experienced and excellent to poor). Additionally, multiple choice questions asked the participant to describe types of verbal violence over the phone, the perceived frequency of events, techniques used to manage the difficult call, perspectives of the contributing factors as to why the caller verbally escalates, and consequences of the call on the nurse. Descriptive statistics of the quantitative results were used to understand violence against nurses via the telephone within ambulatory care.

The options listed in the multiple-choice questions were derived from workplace violence sources within grey literature. Grey literature is defined as information retrieved from governmental, academic, or business sources (e.g., police, airline, and retail sources) (The New York Academy of Medicine, n.d.). Due to the lack of health care related evidence, grey literature specific to telephone workplace violence needed to be utilized. To capture the depth of nursing experiences, multiple-choice questions allowed the participant to choose more than one option from the list.

Additional questions were constructed using information from literature but adjusted to the ambulatory care setting for telephone violence. Questions were created to learn about the nurse's management techniques of violent calls, nurse perceptions of contributing factors, and consequences to the nurse after a violent telephone call (Pompeii et al., 2020). These questions also allowed for multiple choices as needed to match their practice.

Free-text responses were utilized to maximize unique nursing contributions as well as capture health care specific data. These responses were analyzed by the three project team members to identify themes and content. Using Saldana's qualitative process coding structure which captured observable and conceptual actions in the data, this method was appropriate to understand participant actions, interactions, and consequences (Miles et al., 2014).

Results

The survey was sent to all staff within ambulatory care departments: Patient care clinics, ambulatory care pharmacy, patient telephone call-in line staff, ambulatory care leadership, and medical assistants (n = 1,805). Ambulatory care nurses constituted approximately half of the eligible total (n = 938) with a response rate of 14% (n = 132). The participating nurses worked in ambulatory care clinics (n = 100); other nurses worked for the patient call-in line (n = 21), pharmacy (n = 4), and leadership (n = 8). Half of the nurses reported spending at least 50% of their day on the telephone. More than half (55%) had worked in their current role longer than 3 years and nearly 75% of the nurses rated themselves as 'experienced' or 'highly experienced' with verbal violence via the telephone. Almost 80% of the nurses self-reported to be 'good' or 'excellent' at managing or handling verbal violence.

The frequency of telephone verbal violence experienced by ambulatory care nurses was measured using a scale of five increments with 1 week as the denominator. A third of the nurses experienced verbal violence less than once a week (n = 44). The largest segment of nurses (41%) reported verbal violence at a rate of one to four times per week. However, a quarter of the nurses reported verbal violence ranging from five to more than 15 events per week (n = 21). In other words, 25% of ambulatory care nurses experience verbally violent telephone calls ranging from once daily to three times a day (see Table 1).

Verbal Violence Description

The most frequently reported verbally violent behaviors included the reactive-expressive forms which included yelling, cursing, and overtly rude behaviors including threats. The most frequently reported passive aggressive forms of violence were condescending and degrading language. Other forms of passive aggressive violence reported by less than a third of the nurses included racial slurs, personal attacks, and stereotyping comments (see Table 2).

Nurses' free-text responses added further insight as to how verbal violence manifests on the phone and illuminated the covert nature of passive aggressive verbal violence. Additional passive aggressive behaviors reported by participants included "abruptly hang[ing] up", "repeating self over and over, multiple times", "pass[ing] the phone off to another family member or friend, suddenly, … when they are dissatisfied." Nurse participants also reported the caller might demonstrate defiant forms of passive aggression which may appear as "not accepting the answers or recommendations," or "unwilling to cooperate with instructions."

Reported Nurse Management Techniques of Verbal Violence

Four management options were overwhelmingly reported by nurses to handle verbally violent calls:

- 'Listen.'
- 'Remain calm.'
- 'Validate the caller's feelings.'
- 'Let the caller vent.'

Other notable management techniques used by the nurse included softening or lowering their voice and setting

Table 1.
Nurse Perception of Frequency of Abusive Calls
(*n* = 132)

Frequency of Abusive Calls	Frequency (%)
Less than 1 per week	44 (33%)
1-4 per week	54 (41%)
5-10 per week	26 (17%)
11-15 per week	4 (3%)
Greater than 15 per week	2 (1%)

Table 2.
Nurse Report of Verbally Abusive Calls
(*n* = 132)

Reactive Expressive Descriptors*	Frequency	Passive Aggressive Descriptors*	Frequency
Argumentative	117	Condescending/talking down	96
Yelling	113	Degrading	95
Cursing	102	Insulting language	92
Loud voice	94	Threatening	90
Interrupting	84	Criticizing	87
		Blaming	85
		Litigation threats	68
		Personal attacks	61
		Name calling	67
		Racial slurs	45

Note: * = May choose all that apply

appropriate patient expectations for language. Other management techniques not listed on the table and reported by less than a third of the nurses included transferring the call to a peer or supervisor, notifying the patient advocate, or notifying the supervisor. None of the nurses reported using 'Yelling back,' or 'Hanging up' on the patient as a technique (see Table 3).

Free-text responses regarding the management or handling of verbally violent calls provided insight into the nurse's professionalism. Comments included: "Be extra cautious to avoid certain things like saying anything that could be misinterpreted as condescending or uncaring," or nurses 'apologized' to the caller which reportedly diffuses tension. Also, safety was a consideration when addressing violence via the telephone: "I notify security if the threat entails coming to the hospital to get what they want." Other nurses reported taking action to guide the direction of the call stating, "If the patient begins to escalate, I will professionally end the conversation if they are being abusive and ask for us to complete the call at a later time." Nurses also expressed empathy for those who act verbally violent. "I get [calls that] are mostly with anxious patients and family members who are having to plan and/or make difficult decisions about care. These people can be emotional or sometimes [may] be crying while talking to me." Another nurse remarked about the difficulties patients face while navigating the health care system, "My heart goes out to our patient[s]". One nurse summarized, "I try to resolve their problem as quickly and efficiently as possible. The patient usually ends up apologizing by the end of the call explaining they were frustrated at whatever. I try to remain understanding, polite, and respectful."

Contributing Factors for Verbal Violence

Nurses were provided with a list of possible contributing factors related to why callers were verbally violent and instructed to choose what they perceived to be the top three causes for their area (see Table 4). Although insurance issues, frequent telephone transfers, lack of knowledge related to health care, and delays in care were common responses, patient and family stress ranked the highest. Eighty percent of nurses perceived patient and family stress as the cause of verbal violence over the telephone.

Free-text responses from nurses regarding contributing factors highlight the health status of the patient as a trigger for verbal violence. Patient or family callers who were overwhelmed by treatment side effects, disease progression, or poor prognoses demonstrated verbal violence. Compounding issues included the age of caregivers and incomplete patient/family teaching about the patient's health status provided additional insight by nurses. This is reflected in one nurse's comment:

> *Age and possible baseline disabilities are not taken into consideration… Some of these patients are also primary caregivers for their spouse or other family members… There is this assumption that patients should be able to navigate the increasingly more complex world of health care on their own… [More education is needed] to help them connect the dots with their plan of care.*

Emotional Consequences of Violence via the Telephone and Self Care Actions

Most nurses reported an emotional impact after a verbally violent call. Whereas 41% (*n* = 55) state they were upset but recovered in time to take the next call, 34% (*n* = 46) reported they felt upset for more than an hour after the event. Moreover, 16% (*n* =21) of the sur-

Table 3.
Nurse Call Reported Management Techniques
(*n* = 132)

Technique Used	Frequency
Listen	127
Remain calm	126
Validate caller's feelings	118
Let caller vent	110
Lower voice	64
Set appropriate expectations for language and behavior	62

Table 4.
Perceived Contributing Factors for Verbal Violence
(*n* = 132)

Factor*	Frequency
Patient and family stress	105
Transferred caller frequently	84
Delays in care	82
Pain	74
Lack of knowledge about health care processes	74
Communication issues	73
Insurance issue Mental health issue Substance abuse	56 (each)

Note: * = May choose three that apply.

veyed nurses reported a verbally violent call upset them for the remainder of the day and after arriving home. Only 6% (*n* = 8) stated being unaffected by verbally violent calls.

Nurses' multiple choice and free-text responses were divided into the three thematic categories: Active recovery, reflection, or passive recovery. Most nurses used active recovery (67%). Active recovery involved acting on behalf of the patient or their own wellbeing. Some actions identified included calling the patient's specialty clinic, venting to a colleague, or simply taking a break. Although part of active recovery, less than half of the nurses reported they would notify a supervisor, and less than 10% stated they would file a report after a verbally violent event. Other nurses (30%) recovered using reflection which included evaluating what was learned from the call or empowered themselves to, "Make the next call the best call of the day." Passive recovery was the least applied by nurses at less than five percent. Passive recovery included doing nothing, remembering the caller's name to avoid talking to them in the future, or disengaging by letting a co-worker take the next few calls.

Discussion

This project illustrated verbal violence via the telephone experienced by ambulatory care nurses was a form of workplace violence. Ambulatory care nurses reported experiencing violent calls with defiant behaviors and inappropriate language including argumentativeness, threats, yelling, cursing, condescending, criticizing, blaming, degrading language, and racial slurs. These descriptors of verbal violence by ambulatory care nurses aligns with OSHA's definition of workplace violence, which exposes workers to harassment, intimidation, and threatening behaviors at the worksite (OSHA, 2015). Nearly two-thirds of ambulatory care nurses experienced these events from once a week up to three times a day, depending upon the role.

The reactive expressive verbal violence, yelling, and cursing were noted to be the most experienced forms of verbal violence. According to Ramirez & Andreu (2003), reactive-expressive verbal violence appears to be more impulsive, unplanned, and in response to feelings of anger, fear, or retaliation. This form of violence may be interpreted as more unintentional and not perceived as particularly frightening or threatening to the nurse (Jakobsson et al., 2020).

In contrast, passive aggressive verbal violence may be more frightening as it could be perceived as an ad hominem (personal) attack (Jakobsson et al., 2020). These personal attacks – in the form of insulting, degrading, criticizing, blaming, or personal threats to cause harm outside of work – are more directed toward the nurse. This may make passive aggressive forms of violence, events perpetrated by patients or visitors with intention, more difficult to cope with than physical violence (Ramirez & Andreu, 2003; Jakobsson et al., 2020). Additionally, the passive aggressive forms of verbal violence include a wider breadth of behaviors/descriptors and appear to occur more frequently when viewed in aggregate. It is unclear if passive aggressive verbal violence has a higher occurrence rate compared to reactive expressive violence from this project.

During a verbally violent call, ambulatory care nurses identified four fundamental techniques to navigate phone verbal violent events. 'Listen,' 'Remain calm,' 'Validate the caller's feelings,' and 'Let the caller vent,' were main techniques used by nearly all the nurses who self-identified as 'good' or 'excellent' at managing verbally violent calls. Additionally, apologizing to the caller was noted to be a specific de-escalation technique used by ambulatory care nurses. These techniques were all targeted more towards the reactive-

expressive forms of verbal violence such as yelling and cursing.

Management of passive aggressive verbal violence may require a different form of de-escalation. Due to the personal condemnation of passive aggressive behaviors such as condescending and degrading language, the management techniques effective for reactive-expressive may not be as effective. Allowing the caller to vent and listen when the caller is using racial slurs may cause more emotional difficulties for the nurse when enduring these types of personal attacks. Brandt (2017) recommends nurses intervene against passive aggressive behaviors by:

1) Holding callers accountable and confronting the violence in a calm and controlled fashion.
2) Not apologizing for comments which allude towards personal attacks which include blaming, condemning, condescending, or sexually or racially implied language.
3) Empowering nurses to take care of themselves after managing a caller who is trying to exert control over situations in which they feel powerless. (Ramirez & Andreu, 2003)

Efficacy of these passive aggressive techniques is unclear and were not measured in the scope of this project.

Triggers or causes of telephone verbal violence were identified by ambulatory care nurses. Patient and family stress and delays in care were the main sources of verbal violence, but it was unclear if other contributing factors, such as insurance difficulties, receiving a terminal diagnosis, or existing mental health issues, were included within the patient and family stress category. Other contributing factors related to health care operations, such as frequent call transfers, communication issues, and lack of knowledge about health care processes, were less often the source of verbal violence.

Triggers for verbal violence in ambulatory care are noted to be different from inpatient face-to-face verbal violence. Pompeii and colleagues (2015) found inpatient face-to-face verbal violence was perpetrated by visitors and associated with dissatisfaction with the patient care being provided, unmet expectations of care, long wait times for care, and scheduling delays. Conversely, outpatient verbal violence triggers mirror the unmet expectations and long wait times and include patient conditions, such as drug use, mental illness, and poverty, as additional contributors (Pompeii, et al. 2020). Thus, inpatient verbal violence appears to be about immediate care expectations and verbal violence in ambulatory care may involve patient specific issues such as new diagnoses, health chronicity, or navigating a complex health care system.

Verbally violent events impact the overall wellbeing of ambulatory care nurses. This project found 94% of nurses were affected by a difficult call to varying degrees. Most nurses were upset for a few moments, only until the next call, while other nurses experienced distress lingering through the remainder of the shift and into the evening at home. Cannovo and colleagues (2019) found similar consequences of violent events which showed negative emotions such as fear, sadness, humiliation, helplessness, disappointment, anger, and annoyance in the recipient. Additionally, the more frequently employees were exposed to verbal violence, long-term psychological consequences may develop leading to dissatisfaction in work, poor work performance, absenteeism, and burnout (Avander et al., 2016; Pompeii, 2020; Schablon et al., 2018).

Project limitations were present and worth noting. First, this was a retrospective self-report survey and subject to memory. As a seminal project about phone verbal violence without health care related evidence, refinement of the topic may be needed. Additionally, this was a voluntary survey with a low response rate. Responding participants may have been those most impacted by verbal violence. Lastly, the survey provided respondents with choices which may have introduced acquiescence bias.

Areas of future study include establishing measurable de-escalation techniques with call management for reactive-expressive as well as passive aggressive verbal violence over the phone. Additionally, understanding productivity consequences of telephone verbal violence on operations would provide insight as to the impact of workplace violence in ambulatory care and needs to include nurses who provide remote patient care via the telephone. Lastly, underreporting of workplace violence in the ambulatory care setting continues to be an identified need to promote workplace safety.

Conclusion

Nurses are the leading victims of workplace violence worldwide – more than other health care professionals (Li et al., 2020). Ambulatory care nurses who experience verbal violence while performing patient care over the telephone are no exception. This project helped define telephone verbal violence and provided understanding regarding the frequency of the events. As nursing practice evolves and remote patient care continues to expand, it is important to recognize verbal violence and telephone verbal violence as forms of workplace violence. Awareness of support services are essential for ambulatory care nurses after workplace violence events including those who work independently or remotely.

Cara Spencer, PhD, RN, FNP-BC, is a Research Nurse Scientist, Professional Development, UCHealth, Aurora, CO. She may be contacted at Cara.Spencer@uchealth.org

Rachel Musenero, BSN, RN, is a Charge Nurse, Neurosciences Clinics, UCHealth, Aurora, CO.

June Fouse, MSN/Ed, RN, NPD-BC, is a Clinical Nurse Educator, Ambulatory Services Professional Development, UCHealth, Aurora, CO.

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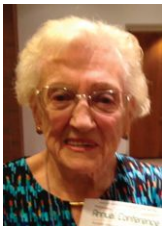
AAACN News

In Memoriam: Kaye McGaw



Kaye McGaw

It is with great sadness we share the news that Kaye McGaw, AAACN's first President, has passed away peacefully at the age of 90. McGaw played a huge role in the establishment of AAACN and was recognized at the 2015 Annual Conference in Palm Springs, CA, for her contribution and dedication to AAACN. She spent most of her working life as director of ambulatory nursing for Kaiser Permanente in Santa Clara, CA. McGaw will be greatly missed.

Join us for Community Live

The Open Forum Community is one of AAACN's most valued benefits as it allows members to share knowledge, ask questions, and network virtually. You asked, we listened! AAACN members can now participate virtually on topics that have received a lot of attention. Based on popular topics trending in the communities, Zoom calls will be set up to further discuss chosen topics. Each call will have a facilitator and moderator.

April's Community Live Zoom call will feature standing protocols. It will include a presentation by Jessica Castner, PhD, RN-BC, FAEN, FAAN, and will be facilitated by AAACN member, Dr. Larry Garrett. Look for the date and time in the Open Forum with a link to join the call!

Module 1 of our new Telephone Triage Course is now available!

American Academy of Ambulatory Care Nursing
Telephone Triage Course

Experience Module 1 for free!

Module 1: *Telephone Triage: What is it? Essentials of Safe Care* is now available to everyone at no cost. The module can be found in the AAACN Online Library. We're offering AAACN members and non-members a free opportunity to experience the format of the course and the valuable education it will offer.

Module 1 provides the foundation for the course and prepares you to defend telephone triage as a professional nursing practice. Key knowledge you will gain from this module:

- **Explain** telephone triage as it relates to professional nursing and telehealth
- **Describe** telephone triage, what it is, and what it is not
- **Identify** critical elements of telephone triage required for safe care delivery
- **Recognize** the impact of misconceptions related to telephone triage process and practices

Visit AAACN's Online Library to access Module 1 at aaacn.org/telephonetriage

From the Eyes of a Nurse:

Self-Care in the Black Community

Andrea Petrovanie-Green

Andrea Petrovanie-Green

Working on the front lines of care in military and ambulatory care settings for almost 30 years has provided me with a unique perspective of self-care for myself and others in the Black community. As a Black woman and an ambulatory care registered nurse, I am acutely aware of the many challenges we face when focusing on our own self-care. My passion for taking care of people and making a difference in the lives I touch has made me appreciate the importance of taking care of myself so I can be physically, mentally, and emotionally present when I care for my patients and their families. That caring in a typical day usually begins with meeting with my staff to ensure they have what they need to do their jobs, providing education for patients and staff on health literacy, wellness, self-management, and goal formation, as well as promoting opportunities for improvement to continue providing safe, high quality, patient-centered care.

It wasn't until a family member had to have her lower leg amputated due to diabetes that I experienced an awakening to focus on myself and my quality of life. I started by setting aside time every morning for a 30-minute wellness routine. I sit in silence for 5 minutes, close my eyes, and breathe. Next, I do 5 minutes of gentle stretching, then 20 minutes of brisk walking. My routine has been a game-changer for me, and I look forward to this time to start my day. Because I have a passion for teaching others and promoting wellness in the community, I now urge others to formulate healthy routines and habits. I now take every opportunity to educate my patients, family, and friends about self-care; emphasizing that it is not selfishness, but essential to personal health. Fortunately, something I've learned during my 30 years of nursing practice is people listen to nurses and trust us implicitly. According to the annual Gallup Poll, nurses have ranked No. 1 as the American public's most trusted professionals for 20 consectutive years (American Nurses Association, 2022).

Such guidance and trust are essential for the Black community. In addition to diabetes, Black men and women are disproportionately affected with chronic diseases such as hypertension, obesity, and cancer. Educating them about risks and lifestyle is critical, so I make it a priority to explain the importance of diet, exercise, and quality sleep. Many individuals in the Black community face financial hardship, lack of health insurance, and have challenges accessing care. Combined with personal and cultural beliefs, and – in some cases – a lack of trust, many don't get the care and education they desperately need.

To foster a healthier community, I encourage people to have achievable goals and projects. I suggest projects like starting a community garden and having friendly competitions for the 'best' one. I encourage parents to walk their children to school, take the stairs, and make exercise a fun family or community event. I also educate them about prioritizing sleep and taking breaks from social media, screens, and TV. Black women have critical roles in our communities, and our voices have been a beacon of hope when caring for loved ones. Our inherent drive to care for others gives us the power to move our communities forward in changing lifestyles and improving health.

For registered nurses, having a plan and starting off with small, realistic goals is the key to success. Strategies can include inviting a nurse colleague to join you in outreach to community leaders and churches, offering to provide free education and information to help promote a healthier community. Teaching by example is powerful, and when others see that you've invested in yourself, they're motivated to do the same. After all, no matter our community, race, or ethnic background, we all share the universal desire to achieve a longer, healthier, and happier life. ●

Andrea Petrovanie-Green, MSN, RN, AMB-BC, is a National Director, American Academy of Ambulatory Care Nursing (AAACN) Board of Directors. She may be contacted at petrovanie@hotmail.com

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Working from Home: Is it a Perk or a Problem?

Kathryn Koehne

Up until early 2020, I traveled throughout the country to present telephone triage seminars. Since then, health care delivery has changed in dramatic ways. Who would have imagined a nanoparticle known as SARS-CoV-2 could change the world? During the pre-pandemic seminars, I asked the participants to share information about where they worked. As hands were raised, individuals stated the locations: Clinics, campus health centers, specialty departments, and so on. As recently as January 2020, it was rare for nurses to report working from home. When it did happen, the participants turned to see who the privileged individual was. Working from home was coveted.

At the onset of the pandemic, ambulatory care nurses were displaced by being sent to inpatient units, placed on furlough, or required to take telephone calls. Telephone triage nurses – who were already working from home – were impacted by increasing volumes of calls, but their work environment did not change. Organizations that previously had a work from home (WFH) program experienced cataclysmic phone volumes, but the nurses were already trained, and the workflows established. The once-coveted opportunity to WFH was now being thrust upon many nurses. Some were already proficient in telephone triage practice and others were assigned this new responsibility with no training. Whether trained or not, many nurses now were handling patient calls from their homes.

The pandemic has existed worldwide for over 2 years and WFH has become a new norm and, for many individuals, a permanent assignment. Many employers view teleworking positively as it reduces operating costs. Likewise, for some employees it has been beneficial personally and professionally. For others, WFH has been disappointing or even distressing. Boell and colleagues (2016) describe research findings regarding the impact of WFH as puzzling and paradoxical. Many studies have conflicting data about the pros and cons of this work option. According to Brunelle and Fortin (2021), employees who WFH have a higher level of job satisfaction when compared to their counterparts working in office settings. In contrast, Ipsen and colleagues (2021) investigated WFH experiences of nearly 6,000 workers in 59 countries, and identified the following disadvantages: Missing colleagues, missing leaving home, and poor physical conditions.

Common Problems and Solutions

Working from home can present unexpected disillusionments. Xiao and colleagues (2021) identified when working remotely, employees experience decreased physical activity, poor quality food intake, and lack of communication with coworkers which leads to a decrease in physical and mental well-being. The following section will present the various negative experiences and proposed solutions based on my years of experience educating and consulting in telehealth nursing.

Lack of Teamwork

According to Şentürk and colleagues (2021), "workplace loneliness occurs when interpersonal relationships that individuals expect in the workplace and the actual relationships are different, and individuals' inability to compensate for this difference" (p. 47). Nurses are at risk for workplace loneliness when providing care remotely. A core concept in nursing practice is presence. Yesilot (2016) discusses physical, psychological, and clinical presence. The authors emphasize many of the nurse's primary functions require physical closeness. In telephone triage practice, nurses are separated from patients by distance and, without connections with co-workers, the sense of isolation can be more intense.

To address the diminished sense of belonging and cohesion, it may be beneficial to schedule employees to rotate working at home and in the department/setting. Holding monthly online meetings and requiring screens to be turned on will allow employees to see and get to know their co-workers. Assigning group projects and bringing the entire team together one to two times per year for annual education will allow for team building.

Decreased Physical Activity

Nurses who manage patients via telephone are less active than nurses who provide in-person care. And when working remotely, there is potentially even less physical movement. Fukushima and colleagues (2021) confirmed teleworkers were less physically active and had prolonged periods of sedentary behavior during work time than those who worked in an organizational environment. Lack of physical activity may impact a person's mood (National Institutes of Health, 2019). In addition, Park and colleagues (2020) explain being sedentary – at work or home – increases risk for many chronic conditions and all-cause mortality.

According to the Anxiety & Depression Association of America

(2021), consistent participation in exercise may decrease tension, elevate and stabilize various moods, and improve sleep and self-esteem. Stamatakis and colleagues (2019) found 20-40 minutes of physical activity eliminates most health risks associated with sitting. Movement can be easily implemented by standing up in between calls, taking brief walks during breaks, and keeping a set of hand weights nearby to use intermittently throughout the workday.

Unhealthy Workspaces

When organizations have a well-designed telework program, workstations are set up with a thoughtful plan. Employees who were sent home urgently at the beginning of the pandemic had no time to set up ergonomic workstations. According to Seva and colleagues (2021), spaces in homes, furniture design, acoustics, temperature/humidity, or lighting may not be suitable for prolonged hours of work and can lead to eye strain, fatigue, respiratory issues, hearing impairment, and musculoskeletal issues.

Reducing repetitive movements and improving the ergonomic design of workstations can reduce the impacts of physical overuse and stress. This can be accomplished by requesting a workstation assessment from employers. Employees who work from home must also be mindful of posture while using the computer. Being at home may encourage using comfortable furniture which reduces good posture. It is also important to engage in micro-stretches to eliminate musculoskeletal strains.

Distant Leadership

When employees engage in WFH, there are rare in-person connections with clinical managers, directors, and mentors. Access to next level leaders is crucial for professional growth and support. Formal and informal check-ins and observations allow leaders to evaluate work performance. Nurse managers have significant influence on performance across measures of safety, quality, and patient experience, as well as indicators of nurse engagement such as nurse job satisfaction and retention (Press Ganey, 2017). More importantly, when nursing staff work externally, it is beneficial for nurse leaders to extend their presence to wherever their staff are providing care. Although it may take significant effort, it is essential leaders are familiar with the needs, interests, and abilities of each employee. Engaging in effective communication by asking questions and providing timely feedback is essential.

Conclusion

For many ambulatory care nurses, engaging in telephone triage and care management from their homes is an ideal work arrangement, but for others it can lessen a sense of belonging and decrease physical and psychological health. Nurses and leaders must be aware of the impact of WFH and collaborate to create a model that promotes teamwork and wellbeing which, in turn, will result in safe and quality patient care. ●

Kathryn Koehne, DNP, RN-BC, C-TNP, is Director of Nursing and Operations, Crescent Cove, Minneapolis, MN; Consultant and Presenter, Telephone Triage Consulting, Inc.; and Adjunct Faculty, Viterbo University, La Crosse, WI. She may be contacted at kmkoehne1418@gmail.com

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Overcoming Vaccine Hesitancy is a Team Sport

continued from page 1

For medical professionals with little firsthand experience seeing the effects of many of these diseases, it can be difficult to endorse a pro-vaccine stance. Providers need to be taught how the benefits outweigh the risks of vaccine so they can present a confident and strong recommendation for vaccines when talking with patients and parents. While providers might understand the benefits of vaccines, many of them do not have time during a visit and will sometimes steer away from conversations that seem political or time consuming, or are difficult conversations to have with patients. Providers are not the only ones who have difficulty knowing how to discuss these topics with patients and families. Everyone in the medical office, from those who have first contact with the patient such as greeters or the front desk staff, to the medical assistants (MAs) and nurses, struggle with finding the right words to help patients and families navigate this complex topic. The entire staff needs to understand how to have these conversations and be comfortable with them.

In 2014, the New England Journal of Medicine conducted a study where they discovered that only 30% of patients trusted "medical leadership" but in the same study 70% of patients felt their physicians had high integrity and could be trusted (Natbony & Genies, 2019). This is a subtle distinction. It says that the CDC, the World Health Organization (WHO), and other medical leaders can advise that vaccines are good and diseases are bad, but if a patient's providers and frontline medical staff do not echo the same message, patients and families will not trust the guidance of vaccine schedules and the like. In a similar study, it was illustrated that the most common reason for parents with children under seven to change their minds about vaccines was due to health care provider advice (McGregor & Goldman, 2021). Another study found parental intention to vaccinate was due to the trust with the provider to do "what is in the best interest of the public" (McGregor & Goldman, 2021, p. 340).

Conversations about the benefits of vaccines do not have to solely lie with the provider. Each team member can make an impact and build on the relationship being developed with the patient. This unified message not only improves the likelihood that the patient will take vaccines, but it could increase overall patient compliance with all health care recommendations given by the provider. Teams can be the key to helping overcome vaccine concerns. Unfortunately, communicating a unified message is not as simple as scripting language for staff and providers; the idea of vaccine hesitancy is much more faceted then just saying the 'right words.'

A troubling issue surrounding vaccines is the current political rhetoric which has created controversy and division about the benefits of vaccines in general. Society is increasingly focused on the power of one and consistently missing the idea that one can be made stronger by community (Achor, 2018). Sage Steele, an ESPN analyst, was recently quoted saying that she felt defeated after getting the COVID-19 vaccine because it was mandated by her employer to keep her job (Fieldstadt, 2021). In Arizona on July 15, 2021, Governor Doug Ducey issued an executive order banning higher education institutions in the state from requiring masks on campus. Arizona's legislative body also signed into law a bill that prohibited mask mandates for students and teachers in public schools, effectively hampering schools' ability to provide additional measures to stop the spread of COVID-19. The law led school districts to file suit against the state and eventually led a Superior Court judge to rule the House bill was unconstitutional (Billeaud & Christie, 2021). All this turmoil means health care teams not only have to work to overcome the misinformation in the media and individual fears surrounding vaccines, but they must also combat political ideals that pit individualism and a need to protect personal rights against the ideal of caring for our communities.

There are five different predictors of vaccine hesitancy:

1) Risk conceptualization.
2) Mistrust of pharmaceutical companies.
3) How vaccines are scheduled.
4) How the vaccines might overwhelm the immune system.
5) The risk of vaccinating. (Bradley & Elder, 2020)

Risk conceptualization is the idea that vaccines present a bigger threat to the individual then the actual disease. This concept partly comes from the idea that so many people today have not had the experience of seeing someone suffer with vaccine preventable diseases and if they do know someone that had measles or chicken pox, generally they survived with very few, if any, long-term effects. The COVID-19 vaccine might have been an opportunity to turn that tide for all vaccines. Many people know a relatively healthy person who contracted COVID-19. Maybe that person died or maybe they continue to suffer with long-term health problems because of COVID-19. Unfortunately, the COVID-19 vaccine story seems to be lost in politics. Despite a CDC study released in July 2021 which revealed that persons living in Los Angeles County who were unvaccinated were 29.2% more likely to be hospitalized with COVID-19 than fully vaccinated individuals, people continue to fight against getting the vaccine (Griffin et al., 2021). Meanwhile, at the writing of this article in Fall of 2021, the epidemic spikes again, leaving health care workers feeling the strain of compassion fatigue.

The second predictor of vaccine hesitancy is the mistrust of pharmaceutical companies. The prevailing thought being that pharmaceutical companies are benefiting from those who are suffering and often cannot afford the high cost of medications. It is hard to deny medicines are expensive and pharmaceutical companies have made lots of money over the years, but there is a cost to illness as well. For example, measles was declared eradicated from the United States in 2000. This eradication declaration did not indicate measles

was no longer occurring in the United States, it indicated none of the cases in the United States were 'home grown;' they could all be traced to places beyond U.S. borders. Approximately 1,900 cases of measles occurred in the United States between 2014 and 2019. The cost of containment of these 1,900 cases was $140,000 per case and the cost to stop the spread of the disease $266 million (The American Journal of Managed Care, 2020).

The third predictor of vaccine hesitancy is the CDC schedule, which has been a parental concern for years. The idea that there are so many more vaccines now than in the '70s and '80s is true, but vaccines also cover about twice the diseases today and have fewer antigens. *Antigens* are defined as bacteria or viruses in the body that trigger the production of antibodies by the immune system (CDC, 2020). Antigens in vaccines are altered so they cannot cause the disease to replicate within the body, but they still look enough like the disease to trigger the body's immune system to react. This means the immune system not only makes antibodies in the moment but creates memory cells so that when the body sees the actual disease later in life it already knows what to do to defeat the disease (CDC, 2020).

In the 1900's, there was a single vaccine which contained approximately 200 antigens. In 1960, five vaccines existed to fight five different diseases and they included approximately 3,217 antigens. By the 1980s, there were seven vaccines and technology had kept the number of antigens at 3,041. By 2000, we could prevent 11 diseases through 11 vaccines that only utilized about 125 antigens (Offit et al., 2002). Technology has brought us so far that we now are able to prevent many more diseases with fewer antigens than we had in the first vaccine in the 1900s (Offit et al., 2002).

The next predictor of vaccine hesitancy is that the number of vaccines given will overwhelm a child's immune system. As previously illustrated, even if all 11 vaccines were given at the same time, the number of antigens introduced to the body would be much smaller than germs encountered when a child leaves the safety and protection of the womb and is exposed to daily life. A German study found that babies vaccinated per the schedule in the first 3 months of life not only had fewer vaccine-related illnesses, but also had fewer illnesses beyond those specifically prevented by vaccines, such as colds or strep throat, than non-vaccinated babies (Offit et al., 2002).

Many parents feel the risk of vaccinating is greater than the risk of the disease and the immunity gained from experiencing the disease is better. While no medical treatment or procedure is without risk, the risk of harm caused by vaccine is incredibly small. The following examples are a comparison of risk:

- One to two persons in 1 million who receive vaccines may have a severe allergic reaction (Office of Infectious Disease and HIV/AIDS Policy, 2021).
- One person in 500,000 are struck by lightning annually, and 32% of these strikes occur indoors (CDC, 2013).
- One person in 138,849 people die from lightning strikes (National Safety Council, 2020).
- 1.8 persons in 100,000 people die from influenza (CDC, 2022).
- About one person in 37,500 people are bitten by venomous snakes each year (Johnson, 2020)
- One person in seven dies of cancer (National Safety Council, 2020).

These statistics are meant to put into perspective the risk of vaccines compared to other causes of injury or death. Other examples of benefit versus risk are the flu and human papilloma (HPV) vaccines. While the flu vaccine is not generally as efficacious in its prevention of contracting the flu, it is remarkably effective at lessening the effects of the disease and reducing the risk of mortality (CDC, 2021). The relatively new HPV vaccine is incredibly effective against the risk of developing cancers caused by HPV especially when given at 11 to 12 years of age as directed by the CDC (National Cancer Institute, 2021).

Talking to patients about vaccines requires the entire team to understand how their words can help or hinder overcoming patient vaccine hesitancy. For example, standing in the lobby of a practice one morning a parent was overheard telling a staff member at the check-in desk that they were here for an appointment and the parent said that she knew the doctor was going to 'bug her' about giving the flu vaccine to her child. What an opportune moment for that staff member to impart some great wisdom to the parent! The staff member looked up from her computer and said, "They are bugging me about getting mine, too. It is mandatory here, but I am waiting until the last possible second to get it because I hate vaccines." In talking with the staff member later, it was discovered that she was not against getting the flu vaccine or any vaccine; like many, she just dreaded the needle but that may not have been the message conveyed to the parent.

The words used by each staff member influence patients/families and how they view the care and medical advice given. Nursing leadership must find a way to help each team member know what to say when patients are hesitant about care and must be aware of how some words might unintentionally cause hesitation or doubt. Learning to utilize the confidence placed on health care workers by the public is key, but it means organizations need to impart knowledge about all care – including vaccines – to each member of the team. Even the most innocent comment from a staff member could set back efforts to building a trusting relationship with patients and families. Start by listening to each member of the team, providers, nurses, medical assistants, and support staff. How do they feel about vaccines? What makes them uncomfortable about vaccines? Where is additional training needed? Providers are a wealth of knowledge but, when it comes to

vaccines, they are not always the experts and may wish they had an outlet to ask questions to improve their knowledge. One provider, when asked about the HPV vaccine, said it was not needed for all patients; when queried further, the provider indicated only girls needed the vaccine and even then, the vaccine was so new they hesitated to recommend it. If the provider had been given the most up to date information, he may have felt more confident in recommending the vaccine and able to support the families in making an informed decision.

The HPV-4 vaccine was originally only given to girls because two of the initially covered strains (16 and 18) prevented 70% of cervical cancers. So, while men in 2006 could certainly spread the virus to women, it was most effective to give it to females (National Cancer Institute, 2021). The HPV vaccine now covers nine strains of the virus which cause genital warts, anal cancers, penile cancers, oral pharyngeal cancers, and cervical cancers. Since the HPV virus is spread by both females and males during sexual intercourse or intimate contact, the current vaccine can prevent HPV from causing cancers which affect both sexes (National Cancer Institute, 2021). Additionally, oral pharyngeal cancers are increasing at an alarming rate; so fast in fact that many dentists are now encouraging patients to get the HPV vaccine from their primary care providers (Demopoulous et al., 2017).

All staff need to be aware of the possible side effects of any vaccine. For example, understanding that fainting is a possible side effect for the HPV vaccine means patients should never be vaccinated standing up and staff should take precautions to protect the patient from a fall during and just after vaccination. As is common practice with all vaccines, teams should observe the recommended 15-minute waiting period following vaccination to ensure the patient will not have other side effects (National Cancer Institute, 2021). With 80 million Americans infected with at least one strain of HPV, and another 14 million contracting the virus each year, it is obvious the benefits of the HPV vaccine greatly outweigh any potential risks (The American Journal of Managed Care, 2020).

Once it is understood how staff feel about vaccines, leaders can begin an open dialog and provide training that will help staff and providers with their own hesitations which will also better equip staff and providers when relating to patients/families. For example, what if the conversation with the parent about the flu vaccine had gone more like this?

Parent: *We are here for our annual check up and I just know the doctor is going to bug me about my child getting the flu vaccine.*

Staff: *I completely understand, but the staff here are so wonderful. Let them know your questions and concerns. They will be happy to talk with you more about it.*

The staff member is not making a recommendation but is empathizing with the parent and encouraging them to ask questions. Additionally, if the staff member is vaccine hesitant, this response allows the staff member to support the practice and the parent without lying about their own beliefs. This staff member should immediately message the staff/provider that there is concern about the vaccine. By doing this, the parent will feel all staff are on the same page and it gives the provider an easy way to open the conversation with the parent already feeling heard and supported.

In talking with patients/families about vaccine hesitancy, it is imperative staff do not answer questions patients/families have not asked. A parent talking with a medical assistant indicated they were concerned about the HPV vaccine. The medical assistant immediately turned and said getting the HPV vaccine does not mean the doctor thinks your child is having sex. Based on the conversation that ensued, the parent had not even considered this aspect; her original concern was that she knew it was not required by the school, so she was not sure that it was necessary. Now the provider had two issues to overcome in the conversation.

Not every interaction will result in overcoming vaccine hesitancy, but it is important teams continue to have these conversations with patients/families. Those who refuse even a single vaccine should be supported and educated without judgement. Staff should appreciate the patient's position on vaccination and let the patient know they can continue the conversation at the next appointment. These patients/families should also sign a refusal form to acknowledge they understand the risks of declining vaccines at each visit. Finally, staff should build the expectation for the next appointment by letting patients/families know what vaccines will be due at their next visit, even if they are the same ones the patient/family just declined. Do not forget about flu vaccines. If the care of the patient does not require another appointment during flu vaccine season, make sure to remind them that they will want to make an appointment for that vaccine as well. If possible, this could be a vaccine only visit completed by a medical assistant or nurse with a pre-written or standing order from the provider. By building that expectation and the necessary follow up into plans of care, the patient/family is prepared for the next visit and the expectation is set.

Overcoming vaccine hesitancy starts with listening to staff and providers and understanding where they might need support and education. Teams must also provide every member of the team with language to help them discuss concerns with patients/families in a way that is honest and appropriate to their level of training and position in the practice. Then, and only then, can staff listen to the needs of patients and families and attempt to address their concerns. ●

Donna Furlong, MSN, RN, NEA-BC, is a Senior Director of Clinical Services and registered nurse, Banner Medical Group, Phoenix, AZ. She may be contacted at Donna.Furlong@bannerhealth.com

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From the President

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taking place May 17-21, will be a hybrid model, offering in-person attendance as well as a virtual option. I hope to see many of you there, to learn from your experience and expertise, and engage in discussions of this amazing profession we share. If you are not able to attend in person, consider the virtual option.

Thank you for being a light in this dark time. Thank you for showing up every day with kindness and compassion. Thank you for responding to fear with information, to frustration with patience, and to uncertainty with hope. Never forget your kindness can change a life. ●

Kathleen Martinez, MSN, RN, CPN, is an Infection Preventionist, Children's Hospital Colorado, Aurora, CO. She may be contacted at aaacn@aaacn.org

American Academy of Ambulatory Care Nursing
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AAACN is a welcoming, unifying community for registered nurses in all ambulatory care settings. Our mission is to advance the art and science of ambulatory care nursing.

connect with us

Join your ambulatory care nursing colleagues in-person in Las Vegas or online to connect, learn together, and network at the Annual Conference May 17-21, 2022.

HIGHLIGHTS:

Leveraging Partnerships: Academic and Ambulatory Care Practice Models for the Future

L. Jessie Jones-Bell, MSN Ed, RN, PHN; Laurel More, MS, RN, NPD-BC, CPN, with a panel of others, will explore how the *Best Practice Guidelines for Academic and Practice Partnerships in Ambulatory and Community Settings* will enhance education and preparation of ambulatory care nurses.

Opening Keynote: *Ambulatory Care: Walking the Talk*

Dr. Beverly Malone, President and CEO of the National League for Nursing, will share valuable information in advancing the science of nursing education through promoting greater collaboration among stakeholders, increasing diversity, and advancing excellence in care for patients.

Town Hall

Featuring Dr. Susan B. Hassmiller, who served as the senior scholar in residence and adviser to the president on nursing at the National Academy of Medicine. The Town Hall will explore:

- Key takeaways from the report
- How the recommendations are aligned with ambulatory care nursing
- How AAACN nurses and their organizations can advance the report recommendations

The session facilitators, Kris Grayem and Kathy Mertens, AAACN past presidents, along with Dr. Hasmiller, will then highlight selected exemplar submissions from organizations across the country and field questions from attendees.

**Separate fee applies, and this preconference session is in-person only.*