CALIFORNIA IMMUNIZATION COALITION

December Education Hour Questions and Answers

1. **Please talk about the ethics of a presumptive approach and the increased desire for patients to have informed consent and in depth dialogue to inform their decisions.**

The presumptive approach is really about how one STARTS the conversation. It is not meant to gloss over details for those that desire them but rather make your recommendation match medical standards of care – that vaccines are strongly recommended for everyone (in the appropriate population). It is a way to present an initial subtle message to parents that you are expecting them to agree to vaccination. It can be helpful for those parents who are basically supportive of vaccination and just need reassurance. Importantly, it also helps minimize that you will be inadvertently say something that INCREASES parents' concerns about vaccines. However, it is just the start of the conversation. If a parent has questions of course you will go on to answer them, ideally using an evidence-based approach such as motivational interviewing and appropriately debunking any myths. I think of this similar to what you might do if you were recommending an albuterol treatment in clinic for a patient that is having an asthma exacerbation – you think the treatment is medically necessary and you strongly recommend it. You do not go into informed consent for the treatment, nor typically do you ask parents their feelings about this approach – you strongly recommend it and then get it done. But, of course, if parents DO want to go over risks and benefits of the treatment or have a longer conversation about it, you would do so.

2. **Do you have suggestions fir approaching COVID vaccine hesitant HCWs, esp. nurses and doctors when 1:1 is not available e.g., group communication?**

This is a tricky one as the vaccine does not have the typical history of development nor the long observation period for side effects that other vaccine does. So in some ways concern is justified because we don't have the same certainty or evidence about this vaccine as we do with other vaccines. Thus, I believe it is critically important to make the distinction between those who are vaccine accepting but have reservations about this vaccine in particular (what I think of as "healthy skepticism") versus those that have unjustified, myth-based, erroneous concerns about the vaccine. For the first group the most powerful tool is to stay abreast of the latest science about the vaccines, as it is changing rapidly. New information can potentially quell concerns that "healthy skeptics" may have. For those in the latter category, I would use MI techniques and myth debunking as the same psychological processes are likely going on as with other vaccines.

3. **Can you discuss evidence-based techniques for populations where we see health disparities? For example, African-Americans have lower rates of vaccinations.**

This is an understudied area. We are just now beginning to discover what "works" for vaccine communication in general but few studies have looked at how this may need to be altered to address barriers within specific communities. It is clear that vaccination decisions and beliefs are largely influenced by the community and culture in which one lives. So future research will need to be done to understand how this influences vaccine communication. I think we can conclude that whatever techniques are being used they should be tailored, as much as possible, to the individual's characteristics or circumstances. But at this point we don't have a lot of information on exactly HOW to do that.

4. **Hi, want to clarify, COVID trials may be smaller sizes, but results can be combined if separate trials are using the same technology (MRNA, for example**).

This is a generalization related to the methods used to make vaccines. The two vaccines that are going to be available first in the US both use mRNA technology which is a newer technology for vaccines. Any time a new way of making a product is used, there is concern that the "method" used to make the product may have some inherent limitations (for example when killed virus vaccines were first introduced people were worried it would still make patients sick. This was a concern related to the method of making the vaccine not the specific vaccine product). The fact that both mRNA vaccine trials did not demonstrate any safety concerns is reassuring that the new technology of mRNA-based vaccines is safe. Of course, post-licensure surveillance will still be needed to assess if there are any rarer side effects.