Take 3 – Practical Practice Pointers© March 2, 2020 Edition

Pediatric Immunizations, Implicit Bias, PeerRx Program

From the ACIP and the CDC

1) Updates on ACIP Recommended Vaccines for Children 2020

At the same time the new adult vaccine schedule is released in February each year, so too is the child schedule. This year's schedule includes relatively minor updates and clarifications of previous recommendations. These include:

Td and Tdap

- As in adults, this recommendation is updated to allow either Td or Tdap for the every-10-year booster AFTER an adolescent Tdap vaccine.
- Furthermore, it is now OK to count a DTaP or Tdap given at 10 years old (but not before) as the required adolescent Tdap. The ideal schedule is still a Tdap at 11-12.

Hepatitis B

- There are certain clinical situations for children that may indicate RE-vaccination for hepatitis B. Infants born to Hepatitis B SAg positive mothers, children on hemodialysis and children with certain immunocompromising conditions may be candidates for revaccination for hepatitis B – mainly if serologic testing indicates lack of immunity after the initial vaccine series.

Meningococcal conjugate vaccines (MenACWY, Menactra or Menveo)

- Children who may have gotten this series before age 11-12 (mainly for immune system compromise) should be routinely revaccinated according to the regular schedule (1st dose at 11-12 years and booster at 16 years).

Meningitis B vaccine

- The MenB vaccine is now recommended for children aged ≥10 years who have complement deficiency, who use complement inhibitors, who are asplenic, and who are determined by public health officials to be high risk in a meningitis outbreak.

Polio vaccine

- Oral poliovirus doses documented simply as "OPV" given before April 1st, 2016 now can count toward the total required polio vaccine doses. This is primarily an issue for assessing vaccine status for immigrants and refugees. Prior to April 1st, 2016, the only vaccine used in international vaccine schedules was the trivalent vaccine. However, if the child was vaccinated in a vaccination *campaign* at any time or internationally after April 1st, 2016 a vaccine documented as OPV cannot be assumed to be the trivalent vaccine (mono- and bi-valent vaccines have been used in campaigns and more recently in schedules), and the child should be vaccinated with the full complement of inactivated polio vaccine (IPV) doses according to the catch-up schedule.

Catch-Up vaccination:

Hib

- There is no need to catch-up unvaccinated or under-vaccinated children who are not at increased risk for Hib infection (immune compromise, asplenia, etc.) after age 5.

Hepatitis A

- Catch-up vaccination for all children aged 2-18 is recommended with a 2-dose Hepatitis A vaccine series.

John's Comments:
I've discussed the highlights, but I recommend reading the notes and their references if your patients fall into one of the categories mentioned. There is more detail to be considered for most of these recommendations. It is nice to have the flexibility in the Tdap/Td dosing – making sure, of course, that we've gotten the recommended adolescent Tdap dose in already. I cannot emphasize enough how useful the catch-up schedule (available with the schedule every year) is for children. It makes a complex and important task a little easier. Additionally, the CDC has published some helpful documents for the new catch-up changes available at the second link below.

References:

- CDC: Birth-18 Years Immunization Schedule 2020. Link
- CDC: Immunization Schedule Changes 2020. Link

From the Literature and an Opportunity for Professional Growth

2) Implicit Bias & the Doctor-Patient Relationship

Disparities based on race and ethnicity persist in access to health care, quality of care received, disease incidence and prevalence, life expectancy, and mortality. Research suggests that clinician's bias plays a role in health care disparities and stigmatization in the health care system. Moreover, the biases we have affect our personal relationships and those with staff and colleagues and the medical education of our learners.

An **implicit bias** is an attitude that often occurs outside of our awareness and influences our understanding, actions, and decisions. **Stigma** is the social devaluation and discrediting that occurs when a concept (e.g. black people, gay people) is positively or negatively associated with a characteristic or stereotype (e.g. athletic, creative). When we express implicit biases in interactions where there is a power differential, such as a medical encounter, we can reinforce harmful stigmas or unintentionally communicate that the clinical space is not safe/nonjudgmental.

Indeed, one study involving 445 providers investigated the association between implicit race bias with provider communication and patient ratings of interpersonal care. Physicians with negative attitudes (i.e. implicit negative bias) about race and adherence were more likely to conduct narrow biomedically focused visits with their patients and, regardless of patient race, dominate the conversation. Further, these physicians were perceived by their patients as having a poor communication style and less likely to involve patients in treatment decisions.

Clinicians, like everyone else, have biases. Yet in our professional role we differ from the general public in that we espouse and strive to adhere to the principles of beneficence, nonmaleficence, autonomy, and justice in our care.

Self-awareness and Stepping Outside Your Comfort Zone:
The first place to start is to become more self-aware of your implicit biases (we all have them). The Implicit Association Test is widely used online tool that measures the strength of associations between concepts (e.g. elderly) and evaluations (e.g. good,

bad) or stereotypes (e.g. slow, wise). The tool measures how quickly you sort items and determines the strength of your implicit bias for various human concepts. See the link in References to take the tests.

The next step is to become more aware with patients, learners, and staff and intentionally utilize patient-centered communication skills. Try these over the next week:

1. Acknowledge when you communicated in a manner that others may perceive as judgmental or stigmatizing. By taking responsibility for your behavior and its impact on people, you are demonstrating respect for that individual and reminding them of their self-worth. Practice out loud: *"I realized that when I said [did] X it may have come across as judgmental, and I apologize."*
2. Adopt a nonjudgmental curious attitude and tone of voice by ask the person for feedback and to educate you: *"How could I help you feel more safe or welcome when you're in my clinic?"* or *"I have not worked with many transgender patients, so please feel comfortable in alerting me if I say or do something that can be perceived as hurtful or stigmatizing."*
3. Learn patient-centered communication skills such as agenda-setting, balancing open and close ended questions; exploring familial and cultural context, elements of collaborative decision-making and goal setting. Providers who use these communication strategies tend to be more efficient in their patient encounters and patients are more adherent and more likely to report that their needs were met. (see 3rd Reference)

Mark's Comments:
I would encourage everyone to take one of the Implicit Association Tests. My own results have been quite eye-opening for me and have definitely raised my awareness as to what were previously my own "unconscious" biases. Many thanks to Laura Daniels, PhD, our residency faculty Behavioralist and Associate Program Director, for taking the lead on writing this Pointer.

References:

- Project Implicit – Implicit Association Test: Link for Test
- Cooper LA, et al. The associations of clinicians' implicit attitudes about race with visit communication and patient ratings of care. Am J Pub Heal 2012102(5), 979–987. Article
- Epstein RM and Street RL. The values and value of patient-centered care. Ann Fam Med (2011) 9 (2): 100-103. Article

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From the "4th Aim": Promoting Professional Connection

3) Time to Thrive! Join the PeerRx Movement

Thriving … joyful … flourishing ... fulfilled! What's the word that describes you when you're at your best? Stop and picture yourself there. What if it was not only possible but essential for you to spend much more of your professional life in that place?

We know that the practice of medicine is filled with both rewards and challenges. One of the results of the many challenges has been the unprecedented number of physicians and other healthcare team members experiencing professional distress, which has many manifestations, including burnout, depression, compassion fatigue, apathy, decision fatigue, relational dysfunction, and moral distress or injury.

The increased complexity, regulation, and pace of medical practice has also led to a greater sense among physicians that they are professionally and socially isolated from their colleagues and alone in their struggles. Indeed, the MedScape National Physician

Burnout Report 2020 indicated that almost half of all physicians across generations respond to feelings of professional distress by isolating themselves from others, even as we know that professional connection is our lifeblood.

Mark's Comments:
It is for the reasons noted above that PeerRxMed™ (PeerRx or PRx for short) was created, built upon the premise that "No One Cares Alone™." PeerRx is a free, peer-to-peer program for physicians and others working in health care designed to provide support, connection, encouragement, resources, and skill-building in order to help participants advance along the Burnout to Thriving Index (Burnout —> Surviving —> Fine —> Well —> Thriving) toward optimal well-being, however you would define that state for yourself.

The foundation of the PeerRxMed™ program is PeerRx90, also known as PRx90™, which is structured to support paired clinicians through a "buddy system" and provide a platform to facilitate encouragement, accountability, and mutual support/growth. Such a system has precedent in the United States Armed Forces ("wingmen" in the Air Force, "battle buddies" in the Army, "shipmates" in the Navy), the Boy Scouts of America, the Girl Scouts of the USA, and the YMCA swimming programs. The time has come for you to Strive to Thrive and join the PeerRx Movement.

First identify a Buddy: Before you can get started, you'll need to find one partner or "buddy" to go through the PeerRx process with. Though over time you may connect with other PeerRx pairs, it is recommended that you only have one partner for the PRx90 portion of the program.

There is no set way to choose a PeerRx Partner. It is recommended that your partner be either someone you already know well, or someone you would like to get to know better. Someone who has similar professional values and goals will likely work out better. There is no reason they must to be of the same medical specialty, age, or gender. As in all things, your discernment will be vital.

Though some "peer mentoring" may result from your relationship, this is not intended to be a mentoring program, so if your prospective partner is of a different age or professional stage, having an understanding of intent will be important.

Once you have a sense of who you might invite to be your PeerRx partner, approach them and share the details of the program (**including the website link below**) as well as your desire to partner with them in this process. An e-mail, phone call, or personal invitation will likely be the most effective way to engage them in dialogue and gauge their interest. And then get started! I look forward to traveling this journey with many of you!

References:

- PeerRxMed Program Website and Sign-up: www.peerrxmed.com
- Kane L. Medscape National Physician Burnout and Suicide Report 2020. Link

Feel free to forward Take 3 to your colleagues. Glad to add them to the distribution list.

Mark and John

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