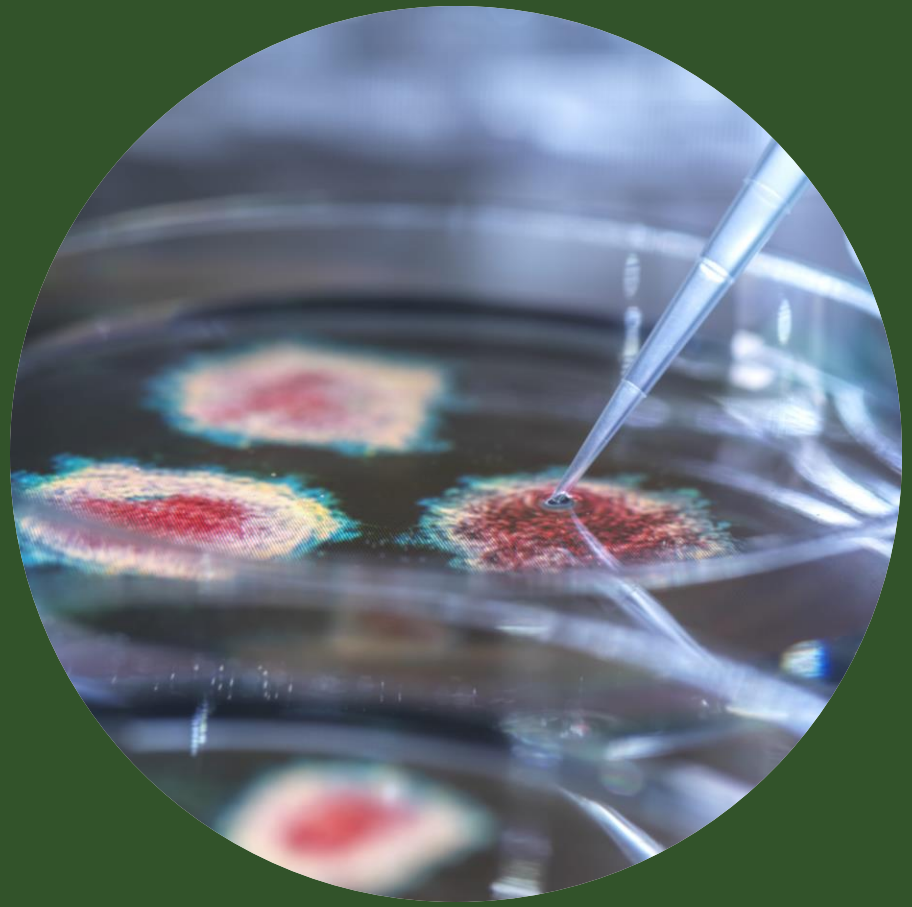


IDSA Clinician Call

Dec 22, 2025

- Began in 2020 as a forum for information sharing for frontline clinicians during the COVID-19 pandemic.

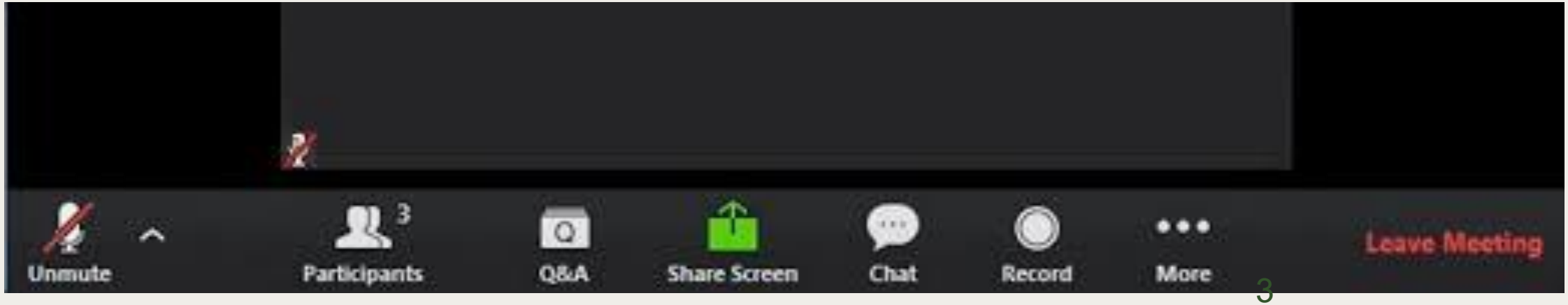
- This webinar is being recorded and can be found online at www.idsociety.org/cliniciancalls.

IDSA Clinician Call:
Applying the IDSA Respiratory Virus Vaccination Guidelines for Immunocompromised Patients

Topic	Presenter
1. Welcome & Introductions	**Dana Wollins, DrPH** *Senior Vice President, Strategy, IDSA*
2. Introduction & Overview of the IDSA Respiratory Virus Vaccination Guidelines	**Lindsey R. Baden, MD** *Vice President of Clinical Research, Brigham and Women's Hospital* *Elizabeth G. and Gary J. Nabel Professor of Medicine, Harvard Medical School*
3. COVID-19 Vaccination Recommendations	**Anoma Nellore, MD** *Associate Professor, NYU Grossman School of Medicine* *Director of Translational Research, Vaccine Center, NYU Langone Health*
4. Influenza Vaccination Recommendations	**Paul Goepfert, MD** *Professor of Medicine, University of Alabama at Birmingham* *Director, Alabama Vaccine Research Clinic*
5. RSV Vaccination Recommendations	**C. Sabrina Tan, MD** *Associate Professor of Internal Medicine-Infectious Diseases* *University of Iowa Carver College of Medicine*
6. Applying the Guidelines in Pediatric Practice	**Tanvi Sharma, MD, MPH** *Clinical Director/Associate Chief, Division of Infectious Diseases; Associate Physician in Pediatrics, Division of Infectious Diseases; Director, Transplant Infectious Disease Service* *Boston Children's Hospital*
7. Putting it All Together: Applying the Vaccination Framework in Daily Practice	**Maricar Malinis, MD** *Associate Professor of Medicine and Surgery; Medical Director, Transplant Infectious Diseases Program; Division of Infectious Diseases* *Vanderbilt University Medical Center*
8. Q&A/Discussion	**All**

Question?
Use the “Q&A” Button

Comment?
Use the “Chat” Button



IDSA Clinician Call:

Applying the IDSA Respiratory Virus Vaccination Guidelines for Immunocompromised Patients

Introduction and Overview

Lindsey R. Baden, MD

Vice President Clinical Research/ Mass General Brigham

Director Infectious Diseases/ Dana-Farber Cancer Institute

Elizabeth G. and Gary J. Nabel Family Professor of Medicine/ Harvard Medical School

Need

- Respiratory virus infections are surging in the US
  - Especially SARS-CoV-2, Influenza, and RSV

- Patients with weakened immune systems are particularly vulnerable to more severe infection and associated complications

- Data driven prevention strategies are needed

SPECIAL ARTICLE

Updated Evidence for Covid-19, RSV, and Influenza Vaccines for 2025–2026

J. Scott,[1] M.S. Abers,[2] H.K. Marwah,[3] N.C. McCann,[4] E.A. Meyerowitz,[2] A. Richterman,[5] D.F. Fleming,[6] E.J. Holmes,[6] L.E. Moat,[6] S.G. Redepenning,[6] E.A. Smith,[6] C.J. Stoddart,[6] M.E. Sundaram,[7] A.K. Ulrich,[6] C. Alba,[8] C.J. Anderson,[6] M.K. Arpey,[6] E. Borre,[9] J. Ladines-Lim,[5] A.J. Mehr,[6] K. Rich,[9] C. Watts,[5] N.E. Basta,[10] J. Jarolimova,[11] R.P. Walensky,[12] and C.M. Dugdale[13]

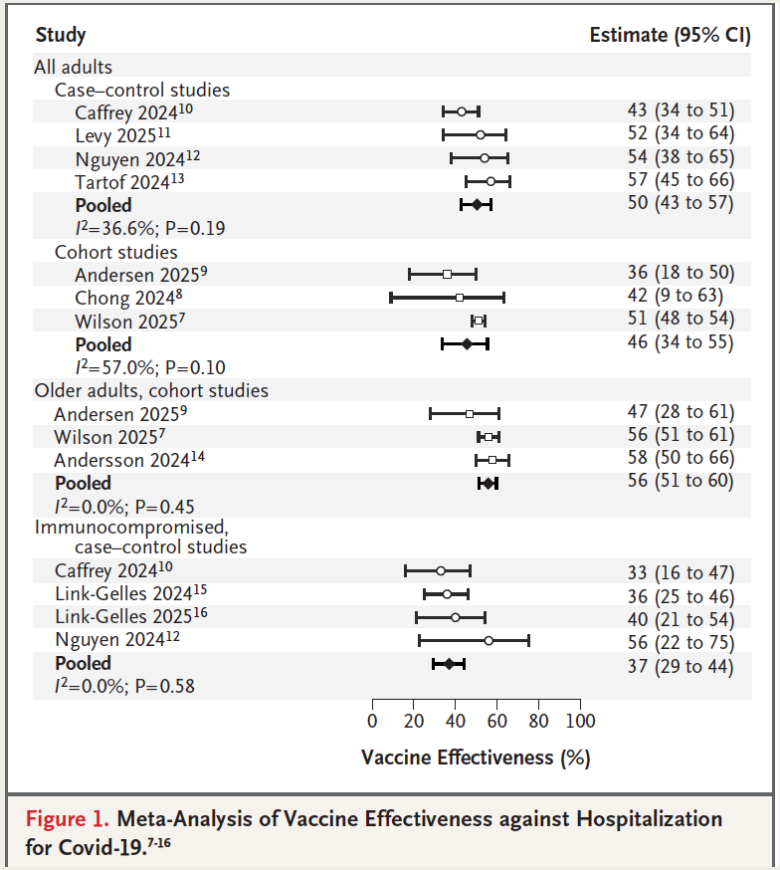


Figure 1. Meta-Analysis of Vaccine Effectiveness against Hospitalization for Covid-19.[7-16]

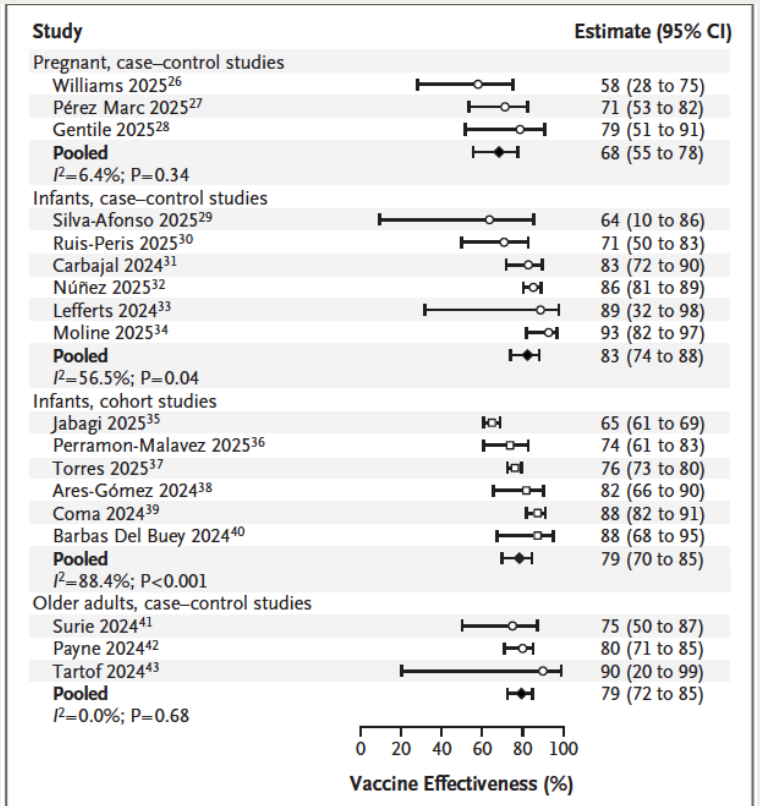


Figure 2. Meta-Analysis of Vaccine Effectiveness against Hospitalization for RSV.[26-43]

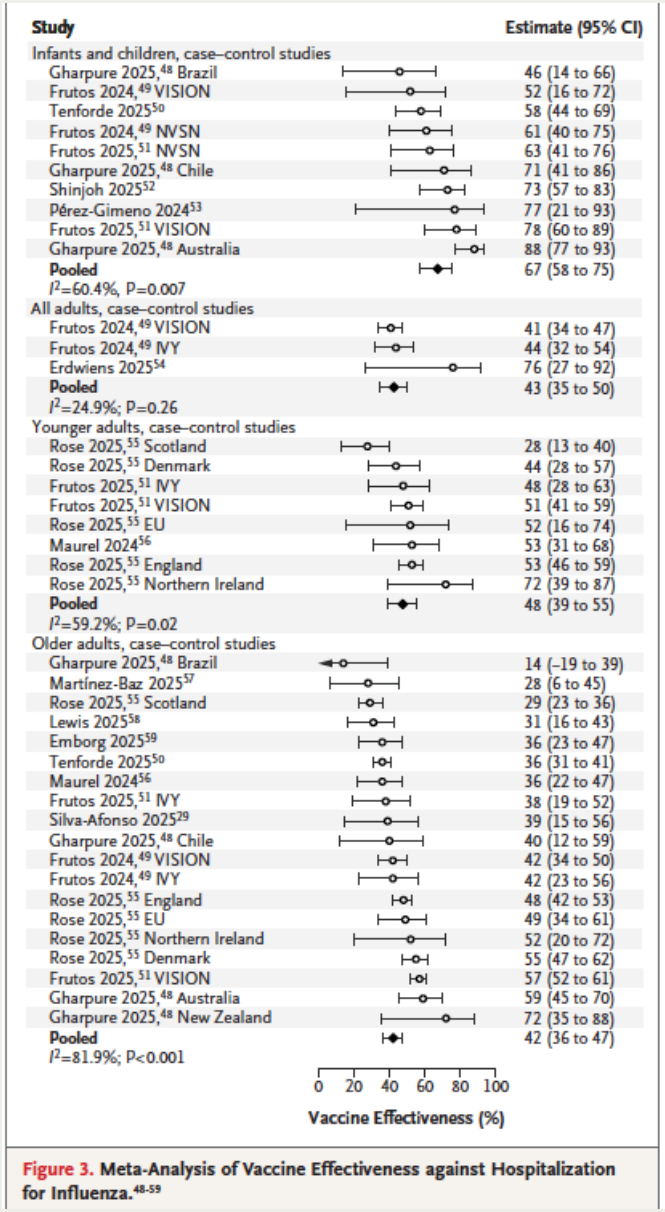


Figure 3. Meta-Analysis of Vaccine Effectiveness against Hospitalization for Influenza.[48-59]

NEJM 29Oct 2025

GRADE

Approach and implications to rating the quality of evidence and strength of recommendations using this methodology

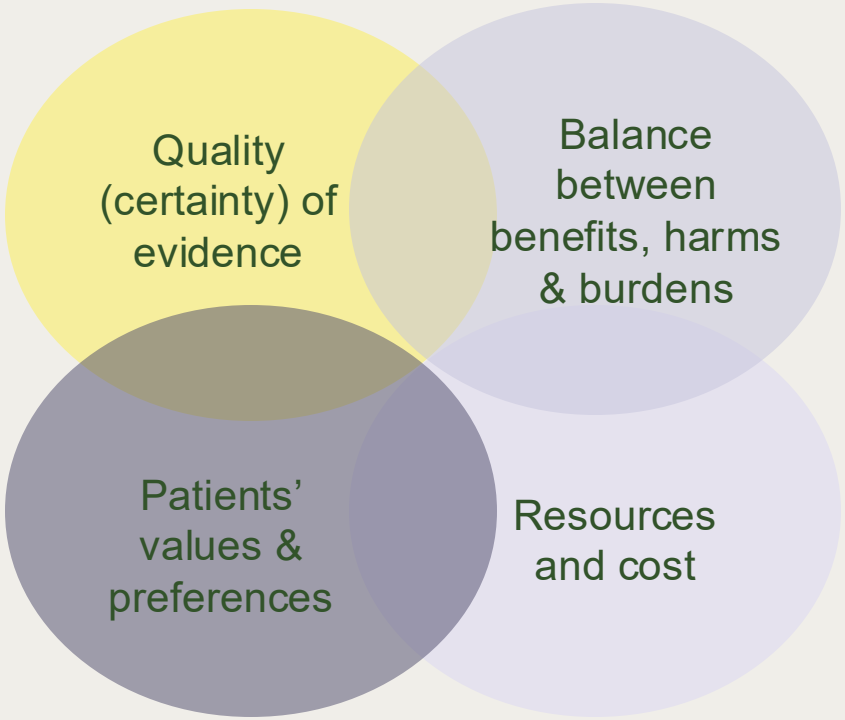
1. Rating the quality of the evidence

1. Establish initial level of confidence		2. Consider lowering or raising level of confidence		3. Final level of confidence rating
Study design	*Initial confidence in an estimate of effect*	*Reasons for considering lowering or raising confidence*		*Confidence in an estimate of effect across those considerations*
		↓ Lower if	↑ Higher if*	
Randomized trials →	High confidence	Risk of Bias Inconsistency Indirectness Imprecision Publication bias	Large effect Dose response All plausible confounding & bias • would reduce a demonstrated effect **or** • would suggest a spurious effect if no effect was observed	High ⊕⊕⊕⊕
				Moderate ⊕⊕⊕◯
Observational studies →	Low confidence			Low ⊕⊕◯◯
				Very low ⊕◯◯◯

GRADE

Approach and implications to rating the quality of evidence and strength of recommendations using this methodology

2. Determinants of the Strength of Recommendation



3. Implication of the Strength of Recommendation

Strong

- Population: Most people in this situation would want the recommended course of action and only a small proportion would not
- Health care workers: Most people should receive the recommended course of action
- Policy makers: The recommendation can be adapted as a policy in most situations

Weak

- Population: The majority of people in this situation would want the recommended course of action, but many would not
- Health care workers: Be prepared to help people to make a decision that is consistent with their own values/decision aids and shared decision making
- Policy makers: There is a need for substantial debate and involvement of stakeholders

Guideline Panel Chair

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Harvard Medical School

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COVID-19 Vaccination Guidelines

Anoma Nellore, MD

Associate Professor, NYU Grossman School of Medicine

Director of Translational Research, Vaccine Center, NYU Langone Health

COVID-19 Vaccine Effectiveness

- COVID-19 vaccine effectiveness: 33-56%
  - Reduction in critical illness
    - VE 40% 95% CI 26-51
    - Moderate certainty of evidence
  - Reduced COVID-19 mortality
    - VE 61% 95% CI 36-77
    - Low certainty of evidence
  - Reduced COVID-19 ED/urgent care
    - Inpatient VE 34% 95% CI 22-45%
    - Outpatient VE 40% 95% CI 19-55%
    - Moderate certainty evidence

COVID-19 Vaccine Adverse Events

- Myocarditis (low certainty evidence)
  - Observed risk lower in vaccinated versus unvaccinated group
  - Imprecise estimate due to rarity of event
- Exacerbations of underlying condition
  - Do not increase
  - One report of increased MS lesions of unclear clinical significance (very low certainty evidence)

COVID-19 Vaccine Recommendation

In adults and children with compromised immunity*, the IDSA guideline panel recommends administering age-appropriate 2025-2026 COVID-19 vaccinations (*strong recommendation, moderate certainty of evidence*).

- FDA approved 2025-2026 COVID-19 vaccine should be given as soon as possible
  - Second dose may extend protection
- Never vaccinated or incompletely vaccinated should refer to published guidelines
- Household members should be vaccinated
- It is appropriate to receive COVID, influenza and RSV vaccines together

COVID-19 Vaccine Implementation Considerations

- Timing
- Shared decision making, ongoing risk assessment and tailored vaccine strategies
- Rapid access to anti-virals are important adjuncts
- Patients may self-attest to immunocompromised status for vaccine eligibility.

Group	Suggested timing of 2025-2026 COVID-19 vaccine*, **
Solid organ transplant	• At least 2 weeks pre-SOT; or ≥3 months post-SOT
Hematologic malignancy	• Optimal timing includes ≥2 weeks before starting treatment and ≥ 3 months after last infusion ○ For B-cell depletion, consider ≥3-6 months after last infusion • If optimal timing not feasible, administer during treatment (blunted immune response likely)
HCT/CAR-T	• Optimal timing includes ≥3 months after transplant or CAR-T treatment ○ For B-cell depletion, consider ≥3-6 months after last infusion • If optimal timing not feasible, administer during treatment (blunted immune response likely)
Solid tumor chemotherapy	• At least 2 weeks before starting therapy; during/after is acceptable
Primary Immuno-deficiency	• Align with IVIG/SCIG or clinic access
Autoimmune immunosuppression	• Optimal timing includes ≥2 weeks before starting treatment and ≥ 3 months after last infusion ○ For B-cell depletion, consider ≥3-6 months after last infusion • If optimal timing not feasible, administer during treatment (blunted immune response likely)
HIV	• Align with preventive routine care

COVID-19 Vaccine Research Priorities

- Defining correlates of protection and immunogenicity thresholds
- Longitudinal studies of vaccine durability
- Comparative effectiveness studies by vaccine platform
- Timing of vaccination and/or vaccine intervals
- Real-world effectiveness
- Enhanced safety data
- Role for temporary modification of immunosuppression
- Equity in access

Influenza Vaccination Guidelines: Practical Application & Nuance

Paul Goepfert, MD

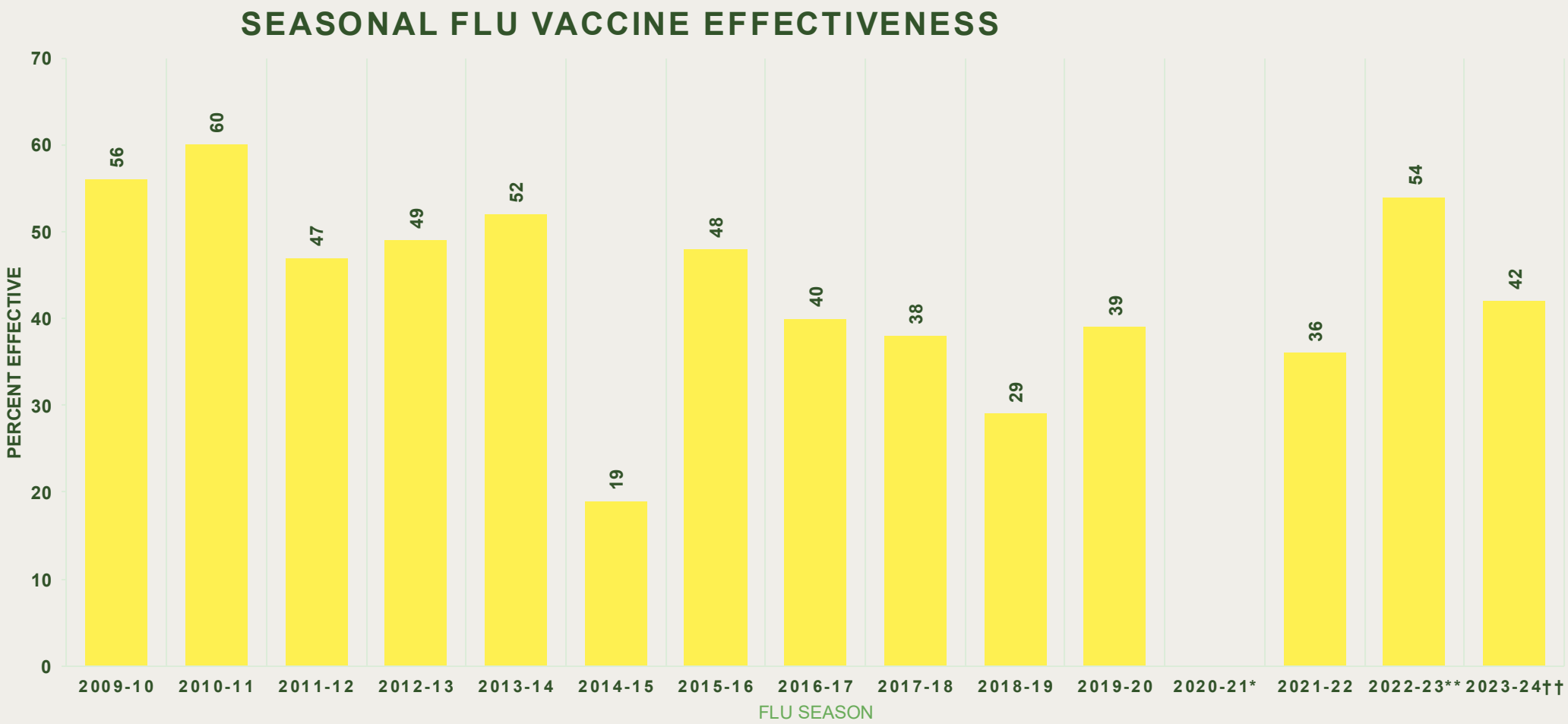
Professor of Medicine, University of Alabama at Birmingham

Director, Alabama Vaccine Research Clinic

Influenza disease burden among immunocompromised individuals

- **Higher Risk of Severe Outcomes**
  - Immunocompromised individuals have **2–4 times higher risk** complications
  - Increased likelihood of **hospitalization, ICU admission, and mortality**.
- **Hospitalization Rates**
  - H**ospitalization rates of 15–30%** versus ~2–5% in the general population.
  - **Length of stay** is often longer (median 7–14 days vs. 3–5 days).
- **Mortality**
  - Influenza-attributable mortality in immunocompromised adults ranges from **5–15%**.

Effectiveness of Seasonal Flu Vaccines from the 2005 – 2024 Flu Seasons



Source: https://www.cdc.gov/flu/professionals/vaccination/effectiveness-studies.htm **Data from CDC**

Core influenza vaccination recommendations: methods and results

- **Guideline Development**
  - Expert panel review (Aug 2023–Jul 2025) using GRADE (Grading of Recommendations Assessment, Development and Evaluation) approach.
  - Focus: Comparative effectiveness & safety data.
- **Evidence Summary**
  - **Direct evidence:** 32% reduction in influenza-related hospitalization in immunocompromised patients.
  - **Indirect evidence:** Older adult data supports reduced ICU admission & mortality.
  - **Safety:** No increased risk of Guillain–Barré syndrome or serious adverse events.

Core influenza vaccination recommendations

- **Age-appropriate 2025-2026 Influenza vaccinations is strongly recommended in adults and children with compromised immunity**
- **Moderate certainty of evidence due to limited studies in immunocompromised (IC) individuals**
  - Repeat vaccination on an annual basis
  - High dose or adjuvanted influenza vaccines provide more robust immune response,
  - Close contacts of IC patients should be up to date with Influenza vaccination

Practical considerations around vaccine selection

- **2025–2026 Flu Vaccine Composition**
  - **Trivalent vaccines (most common) will include:**
    - Influenza A (H1N1)
    - Influenza A (H3N2)
    - Influenza B (Victoria lineage)
- **Available Vaccine Types**
  - **Standard-dose inactivated vaccines** (egg-based and cell-based)
  - **High-dose and adjuvanted vaccines** for adults ≥65 years
  - **Live attenuated nasal spray** for eligible non-immunocompromised individuals*
  - **Recombinant vaccines** (egg-free option)

*close contacts of severely immunosuppressed individuals
(e.g., recent HCT recipients or GVHD, severe combined immunodeficiency)

Practical considerations around vaccine timing

- **Solid Organ Transplant**
  - ≥2 weeks before transplant (SOT) OR ≥1 month after SOT
- **Hematologic Malignancy**
  - ≥2 weeks before starting treatment AND >3 months after last infusion
- **HCT / CAR-T**
  - ≥3 months after transplant or CAR-T treatment
- **Solid Tumor Chemotherapy**
  - Ideally ≥2 weeks before starting therapy
  - During or after therapy is acceptable
- **Primary Immunodeficiency**
  - Align with IVIG/SCIG schedule or clinic access
- **Autoimmune Immunosuppression**
  - ≥2 weeks before starting treatment AND >3 months after last infusion
- **HIV**
  - Align with routine preventive care

*For B-cell depletion: consider >3–6 months after last infusion
**If optimal timing not feasible, earlier administration is reasonable (blunted response possible)

Integrating influenza vaccination into broader respiratory virus prevention

- **Co-administration of Vaccines**
  - Flu, COVID-19, and RSV vaccines can be given together safely.
  - CDC confirms no waiting period required.
- **Unified Public Health Campaigns**
  - HHS/CMS provide multi-virus outreach materials.
  - CDC offers Respiratory Illness Season Toolkit.
- **Routine Immunization + Hygiene**
  - Vaccination plus hand hygiene, ventilation, and masking recommended.
- **Surveillance & Coverage Monitoring**
  - WHO integrates tracking for flu, RSV, COVID-19.
  - Preparedness frameworks leverage seasonal vaccination systems.
- **Provider Engagement**
  - Strong combined vaccine recommendations boost uptake.
  - Special timing for immunocompromised patients.
- **Convenient Access**
  - Multi-vaccine clinics in workplaces, schools, LTC facilities.

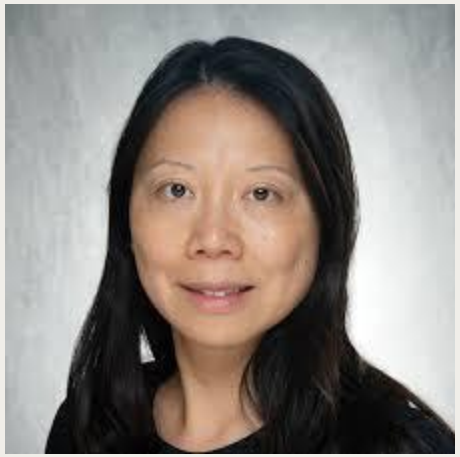
Acknowledgments

- **Morgan Katz, MD, MHS** (The Johns Hopkins University)
- **Daniel Kaul, MD** (University of Michigan Medical School
- **Tanvi Sharma, MD, MPH** (Boston Children's Hospital; Harvard Medical School)
- **Dipleen Kaur** (IDSA)
- **Yngve Falck-Ytter** (Case Western Reserve University)
- **Lindsey Baden, MD** (Brigham and Women's Hospital; Harvard Medical School)

RSV Vaccination Recommendations in Immunocompromised Individuals

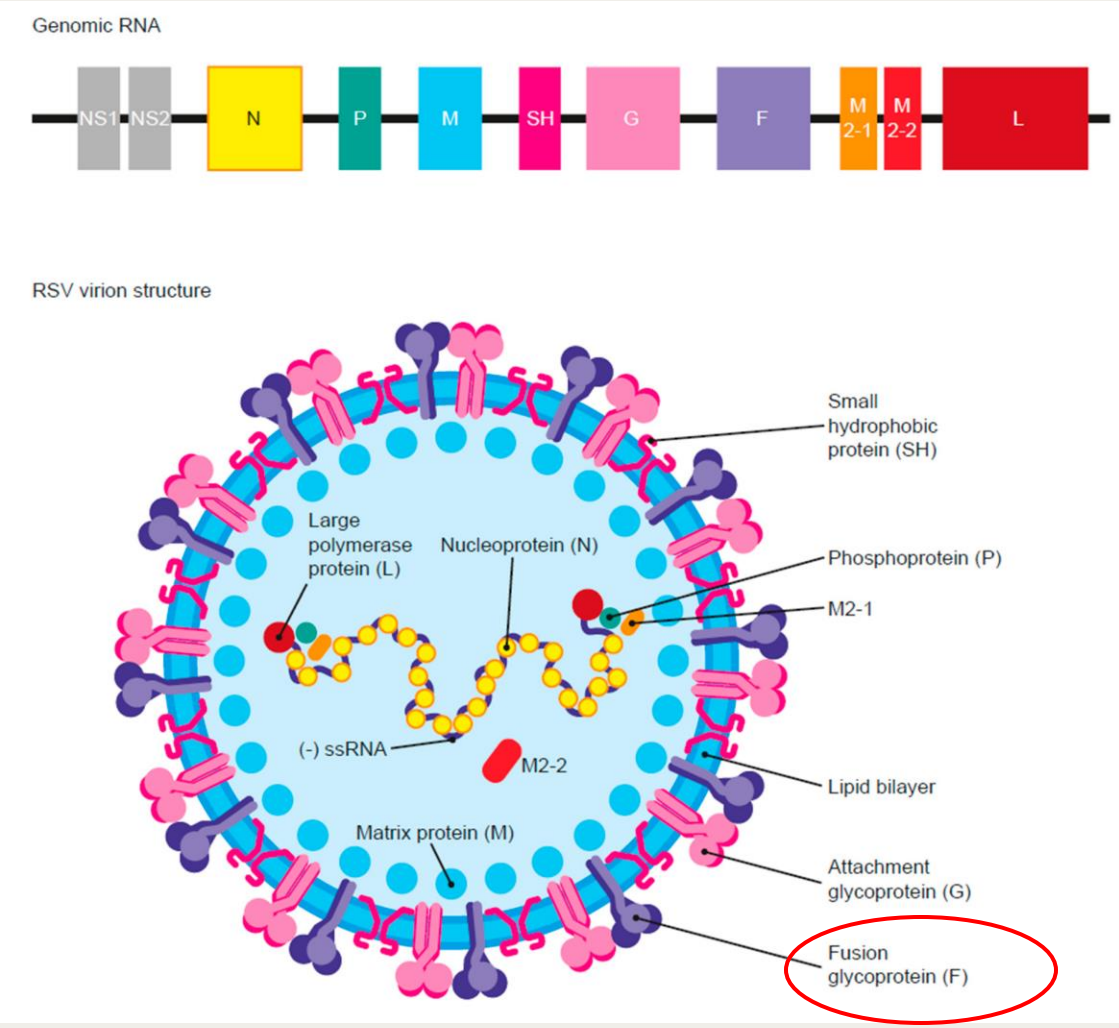
C. Sabrina Tan, MD, MS

Associate Professor of Internal Medicine-Infectious Diseases
University of Iowa Carver College of Medicine



Respiratory Syncytial Virus (RSV)

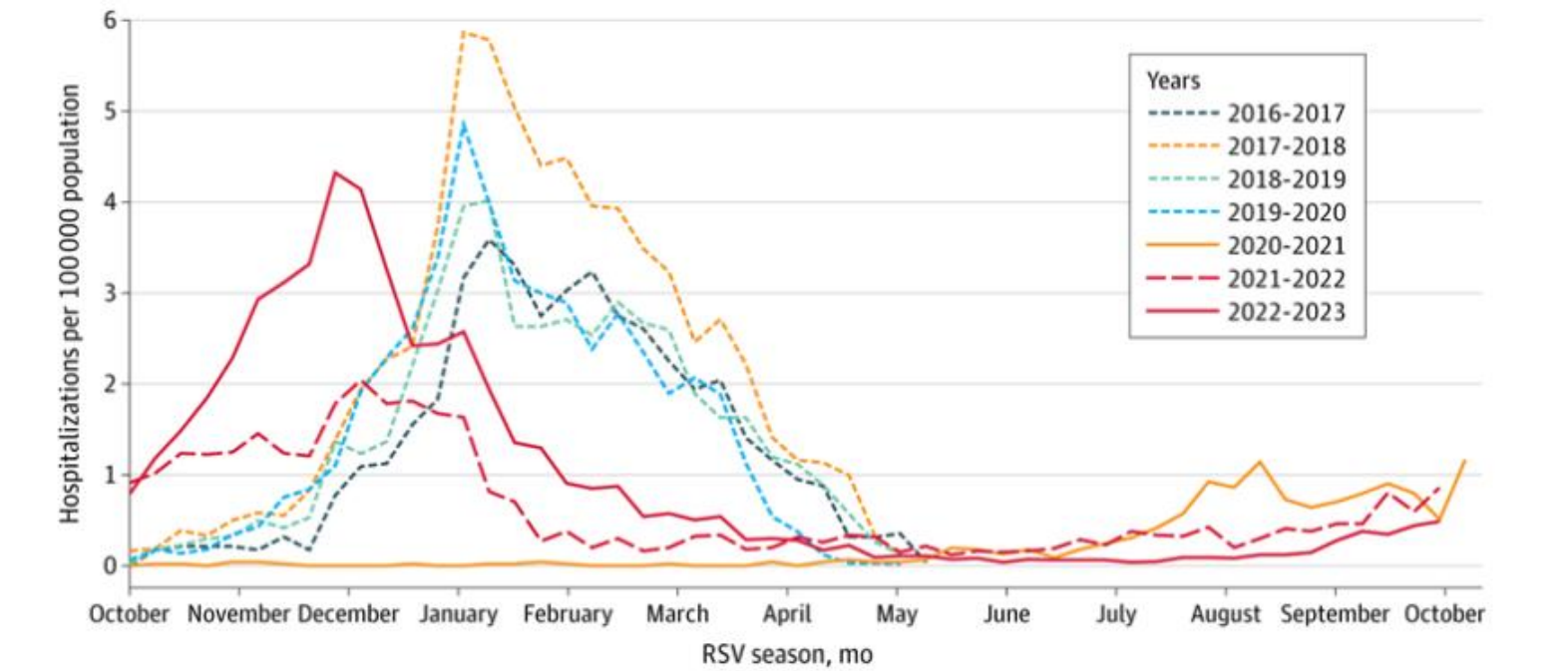
- Virology: Negative-sense, single-stranded RNA virus
- Classification: Pneumoviridae family ->Orthopneumovirus genus
- Transmission: close contact and droplet
- Replication: epithelial lining of nasopharynx and upper respiratory tract
- Disease: bronchiolitis.



IOWA

Battles, M.B., Nature Rev. Micro, 2019, Jenkins, V.A., et al, Vaccines 2023

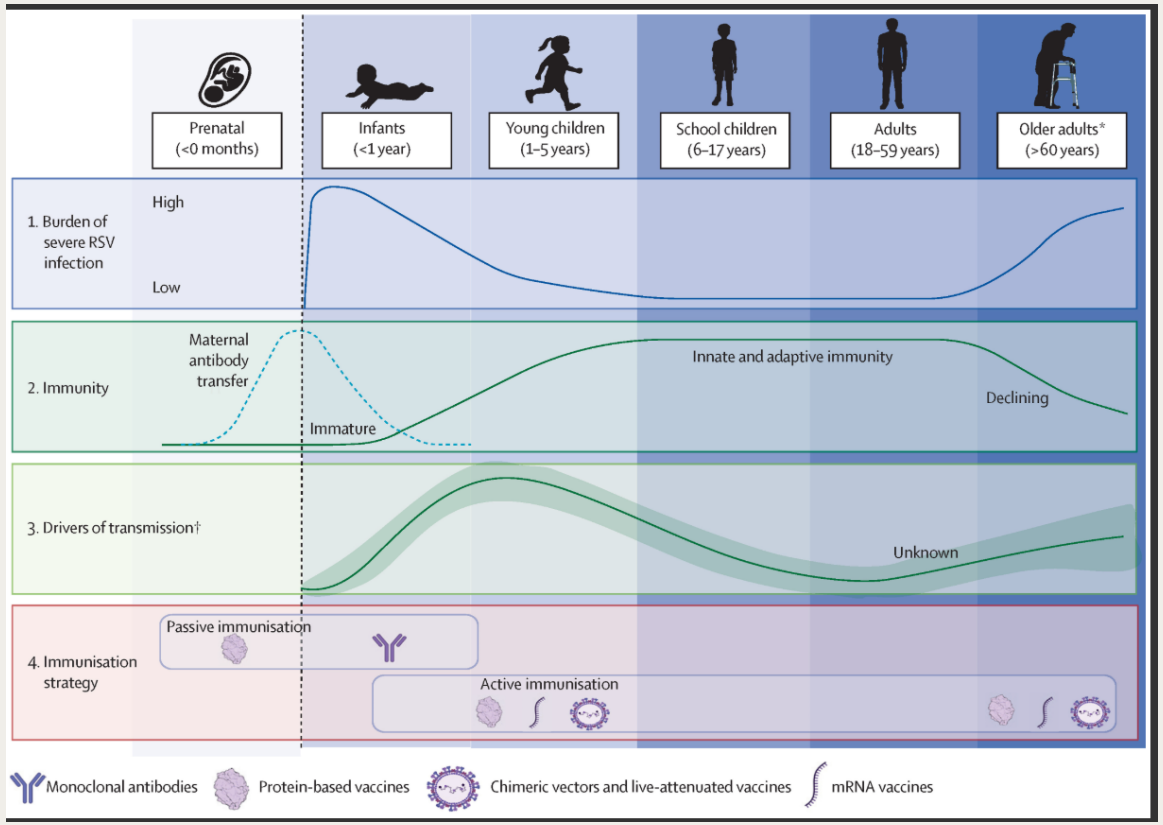
Weekly Adjusted Respiratory Syncytial Virus (RSV)–Associated Hospitalizations per 100 000 Adult Population for the 2016 to 2017 Through 2022 to 2023 Seasons



Season is defined as October to April for 2016 to 2017 through 2019 to 2020 and as October to September for 2020 to 2021 through 2022 to 2023.

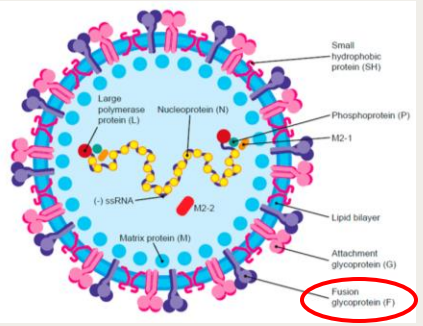
Havers, F.P., et al, JAMA Network Open, 2024

Immunity to RSV declines with age



Terstappen, J., et al, The Lancet Infectious Diseases, 2024

Current FDA approved RSV vaccines



RSV vaccine	Product	Approved indication
RSVPreF3 (Arexy)	RSV F protein + adjuvant (AS01E)	• 60+ years old • 50-59 years old at high risk
RSVPreF (Abrysvo)	RSV F protein	• 60+ years old • 18-59 years old at high risk • Pregnant individual at 32-36 weeks gestational age
mRNA-1345 (mRESVIA)	mRNA of RSV F protein	• 60+ years old • 18-59 years old at high risk

How effective is the RSV vaccine in immunocompromised individuals:

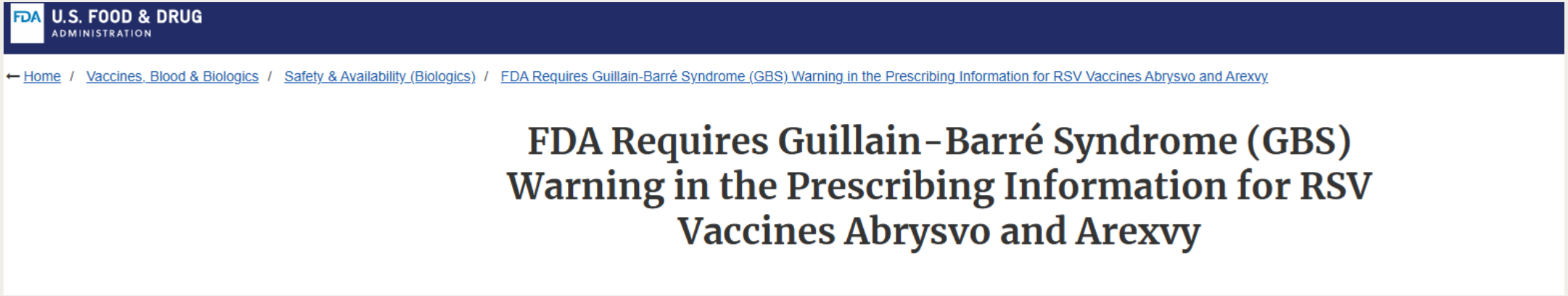
- In immunocompromised population:
  - RSV vaccination was 70% effective against RSV associated hospitalization (pooled estimate from 2 studies, 95% CI: 66-73%)

Payne, A.B., et al, The Lancet 2024; Fry, S.E., et al, JAMA Open Network, 2025

Adverse events

FDA warning labels on Abrysvo and Arexvy:

- increased risk of Guillain-Barre Syndrome (GBS) in the 42 days after vaccination.



https://www.fda.gov/vaccines-blood-biologics/safety-availability-biologics/fda-requires-guillain-barre-syndrome-gbs-warning-prescribing-information-rsv-vaccines-abrysvo-and

Adverse events: comparable risks between vaccinated and unvaccinated groups.

- One self-controlled case series found an increased risk of Guillain-Barre syndrome
  - incidence rate ratio of 2.1 (95% CI: 1.5-2.9)
  - attributing to 11.2 excess cases per 1,000,000 doses.
- Three randomized controlled trials reported no increased risk
  - Comparing to placebo group
  - relative risk of 1.02 (95% CI: 0.96-1.09) for serious adverse events in older adults

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Walsh, E.E., et al, CID 2025, Papi, A., et al, NEJM 2023, Wilson, E., et al, NEJM 2023

Clinical decision with RSV vaccines in immunocompromised patients

- All immunocompromised individuals aged ≥18 years should receive the RSV vaccine.
- For immunocompromised patients <18 years, administration should be guided by shared decision making.
- Majority of the evidence came from the protein subunit vaccines.
- RSV vaccine may be given at the same time as other vaccines.

https://www.idsociety.org/Seasonal-RTI-Vaccinations-in-Immunocompromised-Patients/

Clinical decision with newer RSV vaccines in immunocompromised patients

- Currently, only a single dose is recommended.
- Shared clinical decision-making is essential, allowing flexibility in timing and dosing to accommodate immunosuppressive therapy schedules, travel, and individual risk factors.
- Eligible household members and close contacts should be up to date with RSV vaccination to reduce transmission risk.

https://www.idsociety.org/Seasonal-RTI-Vaccinations-in-Immunocompromised-Patients/

RSV vaccines implementation considerations

- Solid Organ Transplant (SOT):
  - Vaccination is optimally timed ≥2 weeks pre-transplant.
  - Consider administering RSV vaccine as early as 1 month after induction/transplant during RSV season and delaying vaccination up to 6 months if outside RSV season
- Hematopoietic Cell Transplant (HCT)/CAR-T:
  - Vaccination is recommended ≥3 months post-HCT/CAR-T, or ≥6 months after B-cell depleting therapy
- Hematologic Malignancy:
  - Align vaccination with treatment cycles, ideally ≥2 weeks before new immunosuppression

https://www.idsociety.org/Seasonal-RTI-Vaccinations-in-Immunocompromised-Patients/

RSV vaccines implementation considerations

- Solid Tumor Chemotherapy:
  - Prefer vaccination ≥2 weeks before therapy
- Primary Immunodeficiency:
  - Vaccinate when clinically stable, aligning with IVIG/SCIG schedules or clinic access
- Autoimmune Immunosuppression:
  - Vaccinate
    - ≥2 weeks prior to biologics
    - ≥3 months after therapy
    - ≥6 months after B-cell depletion
- HIV: Vaccinate regardless of CD4 count or viral load

https://www.idsociety.org/Seasonal-RTI-Vaccinations-in-Immunocompromised-Patients/

RSV vaccines implementation considerations in immunocompromised patients

- Defer vaccine during acute illness
- Consider vaccination during high community transmission
- If vaccine is given earlier than the optimal timing, consider re-dose.

https://www.idsociety.org/Seasonal-RTI-Vaccinations-in-Immunocompromised-Patients/

RSV vaccine patient counseling

- RSV can cause severe lower respiratory tract disease
- RSV associated disease is more severe in immunocompromised patients
- Current FDA approved vaccines are safe for use in immunocompromised patients
- RSV vaccines may not be as effective in immunocompromised patients
- RSV vaccine could reduce severity of RSV associated disease

IOWA

Acknowledgements

- RSV subgroup:
  - Shweta Anjan MD, University of Miami
  - Ella Ariza Heredia MD, MD Anderson Cancer Center
  - Tim Minniear MD, University of Tennessee
  - Francisco Magana MD, Ohio State University

- Lindsey Baden MD
- Yngve Falck-Ytter PhD
- Dipleen Kaur (IDSA)

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Boston Children's Hospital
Where the world comes for answers

HARVARD MEDICAL SCHOOL
TEACHING HOSPITAL

Applying the Guidelines in Pediatric Practice

Tanvi Sharma, MD, MPH

Clinical Director and Associate Chief, Division of Infectious Diseases
Director of Infectious Diseases, Pediatric Transplant Center
Program Director, Pediatric Infectious Diseases Fellowship Program
Boston Children's Hospital
Harvard Medical School

Pediatric-Specific Vaccine Considerations

- Protection against COVID-19, influenza, and RSV is essential for prevention of hospitalization and severe complications in immunocompromised children

- A child's immune system continues to mature after birth through early childhood
  - Immunocompromising conditions affect children differently than adults
  - Young children do not have preexisting immunity to many pathogens
  - Vaccine efficacy varies depending on underlying level of immunodeficiency at time of administration

Pediatric-Specific Vaccine Considerations

- Available data as presented in the guidelines indicate that respiratory viral vaccines are safe for administration in immunocompromised individuals, including children

- Limitations exist regarding vaccine use in children
  - Available COVID-19 and influenza vaccines are currently approved for children 6+ months of age
  - RSV vaccine is not currently approved for children
  - Many immunocompromising conditions in children are present in early infancy

Pediatric-Specific Vaccine Considerations

- COVID-19 and influenza protection
  - Administer COVID-19 and influenza vaccines to immunocompromised children beginning at 6 months of age
  - Immunocompromised children, including those under 6 months of age and unable to be vaccinated, are best protected by ensuring that close contacts, household members, and healthcare providers are also fully vaccinated

Pediatric-Specific Vaccine Considerations

- RSV protection
  - Administer RSV vaccine to pregnant patients to enable protection to all young infants
  - Administer RSV-specific monoclonal antibody to newborn infants up to 8 months of age at the start of RSV season
  - Administer RSV-specific monoclonal antibody to high-risk infants up to 20 months of age
    - Immunocompromised infants fall into this group
  - RSV vaccine is currently approved for immunocompromised patients 18+ years of age
    - Consider RSV vaccine in immunocompromised patients <18 years of age with shared decision-making between providers and patients

Evidence Gaps and Implementation Challenges

- Data is limited regarding vaccine efficacy in pediatric patients with immunocompromising conditions unique to childhood
  - Primary immunodeficiencies
  - Congenital cardiac disease, other congenital conditions requiring transplantation in infancy
  - Neonatal oncologic diagnoses
  - Extrapolate from other immunocompromised populations

- Encourage support and uptake of vaccines by parents and broader community; limited ability for children to self-advocate

Putting it All Together:
Using the Vaccination Framework in Daily Practice

Maricar Malinis, MD, FIDSA

Associate Professor of Medicine and Surgery
Medical Director, Transplant Infectious Diseases Program
Division of Infectious Diseases
Vanderbilt University Medical Center

Disclosures

- None

Why this Matters Now

Vaccines are safe and effective

Despite evidence-based guidance, uptake remains suboptimal especially for vulnerable population

Growing complexity of applying them in real world settings

Vaccination Trends:

Reported on Friday, December 19, 2025

- The percent of the population reporting receipt of the 2025—26 COVID-19 vaccine is 7.5% (6.0-9.0) for children and 15.8% (14.9-16.7) for adults age 18+, including 32.1% (30.2-33.9) among adults age 65+.
- The percent of the population reporting receipt of an influenza vaccine is 42.3% (39.9-44.7) for children and 42.2% (40.9-43.5) for adults age 18+, including 63.2% (60.6-65.9) among adults age 65+.
- The percent of adults age ≥75 reporting *ever* receiving an RSV vaccine is 42.0% (39.1-44.9).

CDC.gov

Reality Check

Structural and Access Barriers

Cost and Insurance

Logistics

Healthcare System

Sociocultural barriers

Health Literacy

Social Norms and culture

Language and communication

Attitudinal and Belief Barriers

Safety and Efficacy

Mistrust

Information Deficit

Fear of needles or anxiety about vaccine process

Kolobova et al. Vaccine uptake and barriers to vaccination among at-risk adult populations in the US. Hum Vaccin Immunother. 2022 Nov 30;18(5):2055422

System Barriers

Time constraints during visits

Unclear ownership of vaccination decisions

Fragmented documentation across systems

Applying Framework Across Clinical Scenarios

Primary care / routine visits

- Annual influenza + COVID-19 updates
- Identifying RSV eligibility in older adults

Specialty care (hematology/oncology, transplant, rheumatology)

- Frequent visits = key opportunities

Hospitalization and transitions of care

- Missed opportunities and discharge-based vaccination

Dialysis Center

Immunocompromised patients

- Prioritization, timing, and coordination with specialty teams

Practical Strategies

- Using every encounter as a vaccination touchpoint
  - *Embed vaccine assessment into routine vital sign or intake workflows*
- Team-based vaccination workflows (nursing, pharmacy)
- Collaborative approach with other sub-specialties or pharmacy
- EMR prompts and standing orders
- Proper documentation of vaccine receipt
- Use **simple scripts** to normalize vaccination discussions
- Keep messaging centered on prevention of severe outcomes
- Focus on **“today’s opportunity”** rather than perfect timing
- Co-administration when appropriate to reduce return visits (RSV, COVID-19 and Influenza vaccines)

Talking points

Benefits

- Prevents serious infection while waitlisted
- Prevents serious infection after transplant
- Protects the graft (e.g. Chronic lung allograft dysfunction in lung transplant recipients)
- Reduces risk of complications (e.g superimposed infection, hospitalization)

Addressing patient’s concerns

- Expected adverse events
- Costs

Vaccination and Insurance

Table 1: Summary of Vaccine Coverage Requirements by Payer/Program

Payer/Program	Coverage Requirement Linked to CDC/ACIP?	Date When Requirement First Enacted[3]
Private/Employer-Sponsored Plans	Yes	2010
Medicare Part B	No	Variable by vaccine, starting in 1981
Medicare Part D	Yes	2022
Medicaid/CHIP	Yes	2010 (expansion), 2022 (traditional/CHIP)
Vaccines for Children	Yes	1993
Uninsured Adults	N/A	N/A

Value of Transplant ID

Infectious diseases pre-transplant evaluation improves vaccination rates for liver transplant candidates

Erika May Z. Pineda[1,2] | Michael L. Spinner[1] | Andrea Pallotta[1] | Christine Koval[1] | Jessica Bollinger[1]

Pre-transplant vaccination

- 77% for influenza vaccine

Vaccine 36 (2018) 5112–5115

Contents lists available at ScienceDirect

Vaccine

journal homepage: www.elsevier.com/locate/vaccine

Short communication

Infectious diseases consult improves vaccination adherence in kidney transplant candidates

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Table 3
Vaccination rates and associated immunity in dialysis and ID evaluated patients.

				n/total (%)		
	Dialysis	Non-dialysis	P value	ID Evaluation	No ID Evaluation	P value
Influenza	155/317 (49)	33/76 (43)	0.39	18/27 (67)	170/366 (46)	0.04
Pneumococcal						
PPSV-23 OR PCV-13	262/317 (83)	42/76 (55)	<0.01	25/27 (92)	279/366 (76)	0.05
PPSV-23 AND PCV-13 (complete)	21/317 (7)	4/76 (5)	0.80	9/27 (33)	16/366 (4)	<0.01
Hepatitis B						
At least one Hepatitis B administration	244/317 (77)	42/76 (55)	<0.01	25/27 (92)	261/366 (71)	0.02
Hepatitis B immunity[a]	205/317 (65)	28/76 (37)	<0.01	21/27 (78)	212/366 (58)	0.043
Hepatitis B immunity without vaccine documentation	39/205 (19)	14/28 (50)	<0.01	4/21 (19)	49/212 (23)	0.79
Varicella						
Varicella	311/317 (98)	69/76 (91)	0.01	26/27 (96)	354/366 (97)	0.61
Varicella immunity[b]	309/317 (97)	69/76 (91)	0.01	26/27(96)	352/366(96)	1.00
Zoster[c]	23/95 (24)	4/18 (22)	1.00	6/10 (60)	21/103 (20)	0.01
MMR	46/317 (14)	14/76 (18)	0.40	8/27 (30)	52/366 (14)	0.04
Td in the past 10 years	98/317 (31)	21/76 (28)	0.58	21/27 (78)	98/366 (27)	<0.01
Human papillomavirus (HPV)[d]						
HPV	1/12 (8)	0/2 (0)	1.00	0/2 (0)	1/12 (8)	1.00
Complete HPV series	0/12 (0)	0/2 (0)	1.00	0/2 (0)	0/12 (0)	1.00

Value of Transplant ID

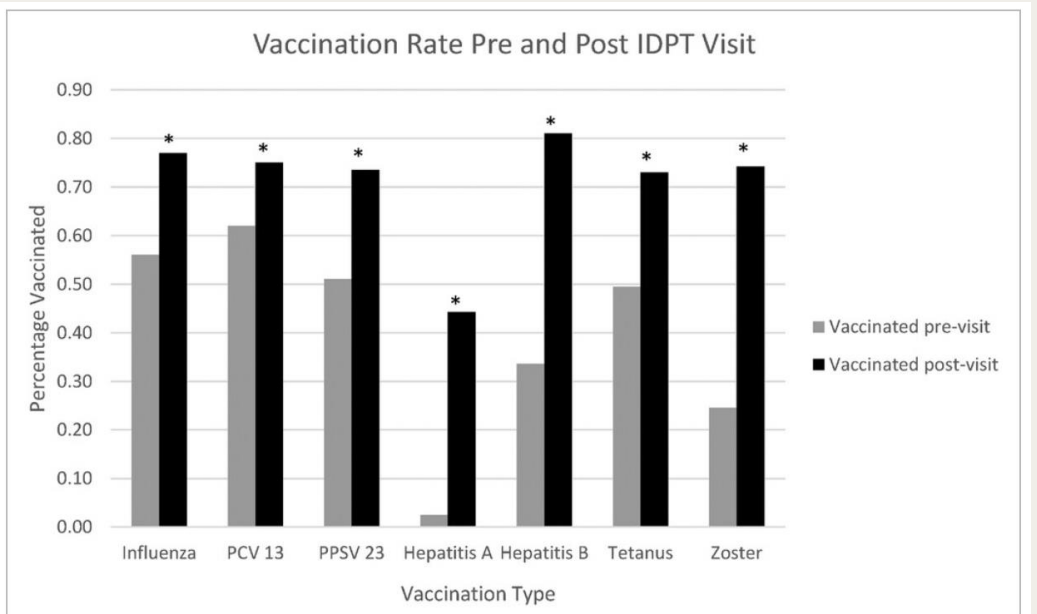
Transplant Infectious Disease

WILEY

ORIGINAL ARTICLE

Improving Vaccination Rates in Adult Solid Organ Transplant Candidates: Impact of an Infectious Diseases Pretransplant Clinic

Zachary Hanna[1] | Navina Birk[1] | Joud Jarrah[1] | Tommy Parraga[1] | Jonathan Williams[1] | Jennifer McCorquodale[1] | Eloy E. Ordaya[1] | Odaliz Abreu-LanFranco[1] | Ramon Del Busto[1] | Mei Lu[2] | Mayur Ramesh[1] | George Alangaden[1]

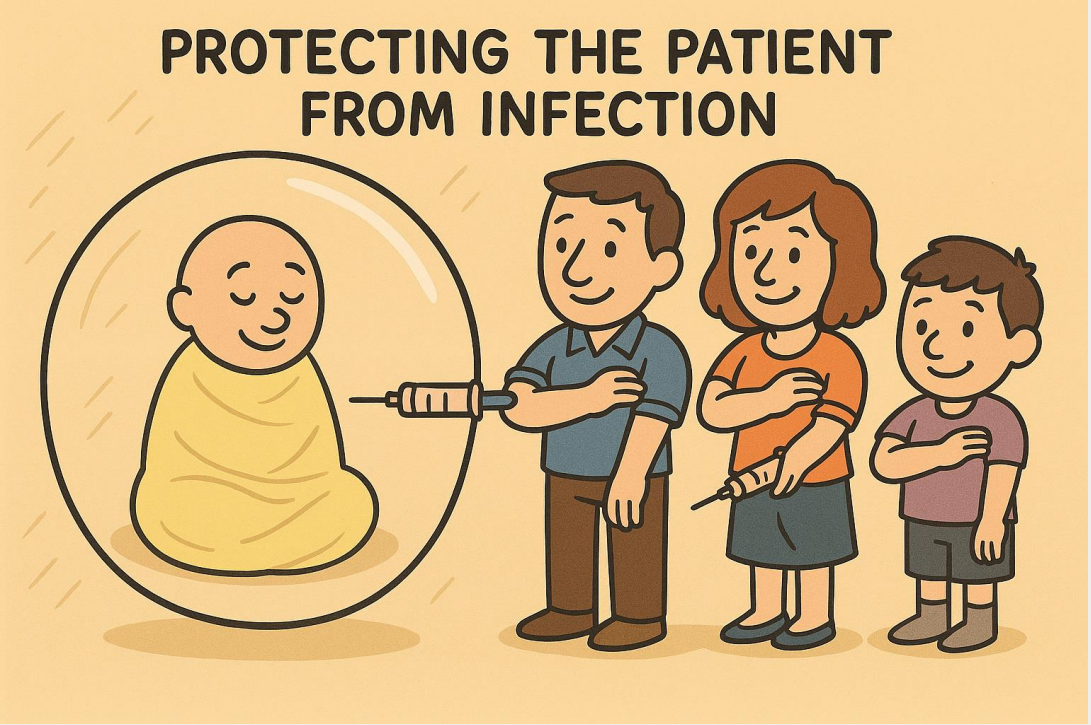


* p value <.01

All patients (n = 200) were eligible for vaccination with Influenza, PCV13/PPSV23 (Pneumococcal conjugate and polysaccharide), and Tdap/Td (Tetanus, Diphtheria, with/without acellular pertussis vaccines). Number of eligible patients based on age or serostatus: HepA (Hepatitis A) 122; HepB (Hepatitis B) 116; ZVL/ZVR (Zoster virus live/zoster virus recombinant): 151.

Cocoon of Protection

- Household /caregiver vaccination
- Healthcare worker vaccination
- Infection Prevention Practices



Thank you!

Q&A/Discussion

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