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Navigating Evolving Influenza Vaccine Guidance

Announcer:

You're listening to *VacciNation* on ReachMD. This episode is sponsored by CSL Seqirus. Here's your host, Dr. Charles Turck.

Dr. Turck:

This is *VacciNation* on ReachMD, and I'm Dr. Charles Turck. Joining me to discuss how clinicians can make confident, evidence-based influenza vaccination recommendations amid evolving guidance are Drs. Rachael Lee and Flor Muñoz.

Dr. Lee is a Professor of Medicine in the Division of Infectious Diseases at the University of Alabama Heersink School of Medicine, where she's also the Chief Healthcare Epidemiologist. Dr. Lee, welcome to the program.

Dr. Lee:

Thank you for having me.

Dr. Turck:

And Dr. Muñoz is an Associate Professor of Pediatrics, Infectious Diseases, and Molecular Virology and Microbiology at Baylor College of Medicine and Texas Children's Hospital in Houston. Dr. Muñoz, thanks for being here today.

Dr. Muñoz:

Thank you. Glad to be here.

Dr. Turck:

So let's start with you, Dr. Lee. Clinicians are accustomed to seeing flu vaccination recommendations change over time, but differences across federal agencies, state guidance, and specialty societies can make those updates more challenging to interpret. From your perspective, how does that variability affect the way clinicians interpret and apply recommendations in everyday practice?

Dr. Lee:

I think a big effect of variability is that clinicians now have to distinguish between a change in underlying science versus a change in how a particular organization has translated that science into policy. Those aren't always the same thing.

So a good example is, with influenza vaccination, several different decisions can be embedded in what looks like one recommendation: who should be vaccinated, when they should be vaccinated, which formulation is preferred, whether a recommendation is routine or based on shared decision-making, and how that guidance affects coverage or institutional policy.

And so organizations may agree on the core evidence, but may have somewhat different judgments about implementation, feasibility, equity, etc. So a change in policy language really doesn't necessarily mean that the underlying biology or evidence has changed, but it does make the work of the clinician much, much harder.

So in daily practice, variability causes real friction, and patients can really pick up on that. Maybe a clinician doesn't know whether a difference represents a genuine scientific disagreement, a population-specific recommendation, or simply just guidance issued at different times. And I think the greater concern of that uncertainty is that it really weakens the clinician's recommendation.

Rather than you saying, "Hey, I recommend an influenza vaccine because of your age and medical history," the clinician may say, "There are several opinions, so it's really up to you." And so that sounds neutral, but it really puts a large onus on the patient to make that decision, and that can be confusing for them.

Dr. Turck:

And turning to you now, Dr. Muñoz, when recommendations from various sources don't fully align, how do you interpret those differences and decide which guidance is most appropriate to apply in clinical practice?

Dr. Muñoz:

Yes, I think that the concern that we have as healthcare providers and clinicians is that we used to rely on a source of guidance and recommendations that had a process in place, that has been evidence-based, and that has been supported, not just by a single group of experts, for example, but actually several professional organizations backing up recommendations. And when we don't have that process and that stable guidance, as we would see, it creates confusion, and it certainly creates a problem for clinicians.

And so the way that I approach the current confusion is really to go back and look at where this guidance is coming from, what the process is that is guiding this information, and how these recommendations are put together. Oftentimes, when there are changes, for example, with influenza vaccine, we expect changes every year in the guidance, but this is because there are known changes that would occur. For example, the influenza vaccine needs to be updated every year, so we know that the strains in the vaccine could be different every year. That is completely expected. Or maybe there is a new vaccine that becomes available, or there is actually a different age group that can be included in the vaccination recommendations—all of this based on clinical studies or data that supports these changes.

I think that what we have seen now is that some of the discrepancies are not necessarily supported by that evidence that has been newly generated. And therefore, what I would adhere to is really the guidance from our professional organizations and our professional societies, which are staying with that process in mind.

Dr. Turck:

Coming back to you now, Dr. Lee—when guidance does not fully align, clinicians may be concerned about whether their recommendation reflects present standards of care and institutional policies or exposes them to potential liability. Without getting into legal advice, how have you seen those concerns influence clinical decision-making?

Dr. Lee:

You know, more than likely, those concerns make clinicians more conservative in their recommendations. They may defer any sort of vaccination discussion until they get guidance from some other groups. Some may just follow the very narrowest guidance and really not get into those areas of uncertainty.

I think hesitation is understandable. A clinician is not really working from guidelines in the abstract. They're dealing with a patient that's directly in front of them that has real questions. And they're also kind of working through everything that Dr. Muñoz was talking about: state rules, institutional policies, vaccine availability, formulary decisions, and, on top of that, the comorbidities of the patient directly in front of them.

I would say that the safest response to conflicting guidance is not clinical paralysis. It's just transparent, evidence-based, well-documented process. I think institutions can really help their clinicians and help with that guidance, and that we really shouldn't leave every individual clinician to independently referee a national organization's guidance during a fifteen-minute visit. We have to help where we can.

Dr. Turck:

For those just tuning in, you're listening to *VacciNation* on ReachMD. I'm Dr. Charles Turck, and I'm speaking with Drs. Rachael Lee and Flor Muñoz about navigating evolving flu vaccination guidelines in clinical practice.

So, Dr. Lee, even after a clinician has worked through the available guidance and makes a recommendation, the patient may still arrive with questions or conflicting information from other sources. Knowing that, how do you communicate the evidence and reasoning behind your recommendation in a way that addresses the patient's concerns and supports an informed vaccination decision?

Dr. Lee:

With my patients, I begin with a clear recommendation rather than opening up with a huge data dump. So, for example, I may say, "We're getting close to flu season. I recommend that you receive an influenza vaccine because it lowers your risk of getting sick, and more importantly, it lowers the risk of severe illness and hospitalization." And then from there, I ask if the patient is willing to receive the vaccine, and if they are, then that makes it simple for me.

But if they aren't, I lean into their concerns. I ask open-ended questions, which is really important to understand where the hesitation is coming. Conflicting information may not be the problem for them. It may be a concern about effectiveness or side effects, for instance, "I get the flu from the flu shot," or ingredients, or changing recommendations. It could be any one of those. Until I know which concern is driving the question, giving more facts beforehand may actually cause confusion in the patient, or maybe they then get more questions.

I also really try to be open and honest about uncertainty. We know influenza vaccine effectiveness varies by season and by age and immune status. But imperfect effectiveness is not the same as no benefit, so I really lean into that.

And then finally, I personalize the recommendation. This is where our relationships as a clinician with our patients really thrive and shine. So for an older adult, a patient who's pregnant, someone with COPD, or someone who's immunocompromised, I really want to try to make those nuanced associations about why the benefit may be bigger for them in getting a flu vaccine.

Dr. Turck:

Dr. Muñoz, influenza vaccination decisions in pediatrics often involve a parent or a caregiver as well as the child or adolescent. So how do you tailor the conversation to address the parent's concerns, involve the young person when appropriate, and still provide a clear, confident vaccination recommendation?

Dr. Muñoz:

So pediatrics is certainly a different perspective, and I think it's different types of challenges. I think for the very young children, we have a tremendous responsibility in pediatrics to make sure that we inform the parents—many times new parents, first-time parents—about the pathways towards achieving good health and preventing diseases in their children.

When it comes to babies, parents are usually concerned about the number of vaccines they're getting already, the number of visits they have to go to, side effects, and other concerns that might come from different sources. Some of them are perceived, some of them might be unsubstantiated concerns that people might see, unfortunately, now in social media and from different sources.

So there's a lot of little nuance there that goes into talking to parents. And why is it different from adults? We still want all children to be protected during the wintertime and to have the vaccines that they need. We provide reassurance about the fact, again, these are vaccines are well-tolerated, and they can be given with other vaccines that are given in pediatrics. There's no problem getting it, even if it's at the same time. I know there are concerns about components of the vaccine causing side effects, and I have to say, most—probably all—of the vaccines we use in pediatrics right now are single-dose, preservative-free vaccines. And so that part in and of itself, which comes up often, is something they should not worry about.

And I think that the issue of adolescents—just to touch on that briefly—is a little bit different because here we're talking about opportunities, because adolescents do get busy. They go to college. They're doing other things in life. And so, at this point, they become more responsible for their own health, and making sure that they also receive the information that we provide to the parents so they can make these decisions is also very important.

I like to talk to parents about the fact that a simple case of flu going through a sports team or at the time of important exams or important activities—it could be a musical event, a ballet dance, something that children and adolescents are heavily involved in—can result in a lot of interruption and a lot of other effects, and that's something that could've been completely preventable. And so we do have these tools, and it's important for parents to know that not getting the flu also has a lot of benefits in the daily life of their children.

Dr. Turck:

Now, before we wrap up, I'd like to ask both of you one more question. Dr. Muñoz, starting with you, what's the practical decision-making approach you'd encourage clinicians to use this flu season if and when guideline recommendations differ so that they can continue making individualized evidence-based vaccination recommendations with confidence?

Dr. Muñoz:

I think the practical approach is to know that influenza vaccine is one of the many recommended vaccines that we utilize in practice. The recommendations are there for a reason, and the reason is because we know influenza is not good. Influenza is a terrible disease at any age once you get it. You remember when you had the flu. And we have safe and effective vaccines to prevent them.

So I would basically offer my approach, which would be to make sure that we offer this vaccine to everyone six months of age and older, because it is something that we all care about—both parents and providers, and in our case, adults themselves. We want to be healthy, and this is one way to maintain our health.

Dr. Turck:

And Dr. Lee, same question to you. What key message would you like to leave with clinicians going into this year's flu season?

Dr. Lee:

Yeah, I think it's important for us to be honest about uncertainty, but don't communicate uncertainty when the science remains clear. We know vaccination remains our principal preventive tool.

Also, don't feel like a failure if you don't convince that patient in one meeting that they should get vaccinated. I have many stories,

particularly during COVID, where I started at one place with a patient, and at each subsequent visit continued to ask if they had questions about the vaccine. I addressed their hesitancy head-on every time, and I was able to do that because they trusted me in the care of other issues.

I really am stuck with one of my patients who, after receiving that vaccine, said he was going to take everything that I taught him and help his family members. I think that's important. It's very humbling as a clinician to be able to say, "Look, I've been able to make a difference in one person's life who's then going to be the person that can help those other people that maybe I cannot reach."

Dr. Turck:

Such great points to consider as we come to the end of our discussion. And I want to thank my guests, Drs. Rachael Lee and Flor Muñoz, for sharing practical approaches to interpreting flu vaccination guidance in clinical practice. Dr. Lee, Dr. Muñoz, it was great having you both on the program.

Dr. Lee:

Thank you.

Dr. Muñoz:

Thank you so much for having us.

Announcer:

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