Provider Update Call Q&A

March 2025

There were a lot of great questions during our most recent Provider Update Call. We have collected all the answers and wanted to make sure we shared this information

If you need help accessing or understanding this information, contact ahs.vdhimmunizationprogram@vermont.gov.

Do pharmacies send information to VDH when they give a vaccine?

Everyone in Vermont who received a vaccine by law should be reported in the IMR. If you are finding a case where that is not happening, please reach out to the IMR team for them to follow-up or VITL (support@vitl.net) to see if there is a data reporting error.

Is there a recommendation around redrawing titers if a certain amount of time has passed since last drawn? i.e. an individual had titers showing immunity over 20 years ago. Would those results still hold?

ACIP does not recommend people routinely have titers drawn after MMR vaccination. There are some limitations to the commercial testing sensitivity for determining vaccine-induced immunity. MMR vaccines provide lifelong protection so time since vaccination would not impact testing (but the sensitivity of the testing might). If someone has evidence of immunity from 20 years ago (via titers) that would still be considered valid for acceptable evidence of immunity for routine measles immunization recommendation.

We have been getting many calls from parents about getting their child's 2nd dose of MMR. We typically give the vaccine at 1 year old and again at 4 or 5 years old. Should we be giving the 2nd dose sooner?

(The second dose of MMR or MMRV vaccine is considered valid if given before the child's fourth birthday if there is a minimum of 4 weeks (MMR vaccine) or 3 months (MMRV vaccine) between dose one and dose two. There is nothing in our school documentation that states that the second dose *must* be given after the child's 4th birthday to be counted for school entry.

The community risk for measles in Vermont is currently very low. There is no recommendation to give the second dose early, but you know your patients best and can make that decision. It is important to reiterate to patients that one dose of measles vaccine is 93% effective against measles, two doses are 97% effective against measles.

If we are part of the VAVP program can we give MMR thru VDH program?

Yes, to adults 19-64 years. If you have patients that would be eligible, please order adult intent MMR. For assistance with vaccine ordering, please contact the vaccine ordering specialist you work with.

In case of patients needing proof of vaccination for immigration paperwork, would you recommend titers for MMR and varicella or just give a dose?

Either is appropriate, but there is no harm in giving a MMR vaccination to anyone meeting vaccination eligibility (without contraindications) who may already be immune to one or more of the vaccine viruses. We often find it is cheaper to go ahead and administer a dose (titers are sometimes not covered by insurance).

Can you run through which adults will need a booster? Or provide a link about this. I am still a bit confused.

"Boosters" are not recommended for measles. Adults with evidence of immunity do not need any further vaccines. For adults, the Centers for Disease Control and Prevention (CDC) defines acceptable presumptive evidence of immunity against measles as having one of the following:

- written documentation of adequate vaccination:
- for low-risk adults (most adults): one or more doses of a measles-containing vaccine
- for high-risk adults (college students, healthcare personnel, international travelers, those with HIV infection who are not severely immunosuppressed, and close contacts of individuals with altered immunocompetence): two doses of measles-containing vaccine
- laboratory evidence of immunity
- laboratory confirmation of measles (verbal history of measles does not count)
- birth before 1957

Individuals who are up to date on their measles vaccination are considered to have life-long immunity. It is an extremely effective vaccine with 93% effectiveness with a single dose. The second dose that is routinely recommended for children, adolescents and high risk adults is not considered a 'booster' dose but instead is intended to produce immunity in the small number of people who do not respond to the first dose.

Some individuals who were vaccinated between 1963-1967 may need to be revaccinated. During this time period, there was both a live measles vaccine and an inactivated (killed) measles vaccine available. The killed measles vaccine was removed from the market after it was determined it did not provide adequate protection. Individuals who have documentation that they received the killed measles vaccine or do not have documentation of which measles vaccine they received during that time period need to be revaccinated to be considered up-to-date. There is a flowchart at the bottom of this page that may be helpful.

If a patient is traveling and has no documentation for having measles but were born before 1957 do they need 2 doses of MMR vaccine?

No, individuals born before 1957 are presumed to be immune. People born before 1957 were very likely to have had measles disease as they lived through several years of epidemic measles before the first measles vaccine was available in 1963. Per the Immunization Action Coalition, "Surveys suggest that 95% to 98% of those born before 1957 are immune to measles."

It is not necessary for these individuals to be vaccinated prior to travel as they are considered immune based on their birth year. But, they may be vaccinated if they do not have a contraindication to MMR vaccination.

What if someone gets pneumonia vaccine earlier than the recommended 5 yr spacing between P23 and PCV?

Recommendations for pneumococcal vaccines often depend on the type of pneumococcal conjugate vaccine administered and which pneumococcal vaccine was administered first (pneumococcal conjugate vaccine or pneumococcal polysaccharide vaccine). In terms of administering a vaccine earlier than recommended, generally, to determine if the dose administered was valid, we consider whether the vaccine administered met the minimum interval between doses. Usually when a dose meets the minimum interval and is considered valid, it is not recommended to readminister.

Additional details on pneumococcal vaccines, including recommended spacing can be found at Summary of Risk-based Pneumococcal Vaccination Recommendations | Pneumococcal | CDC.

For feedback on specific scenarios, please reach out to the Immunization Program at ahs.vdhimmunizationprogram@vermont.gov.

My community is the southwestern corner of Vermont. If kids live in Vermont but see a provider in MA or NY, are they included in the school data? State data?

Yes, if they attend a school in Vermont, they are included in the school data. They would also be included in the aggregated school data at the county and state level. For state-level IMR data, their data may be included if the out of state provider reported it to the IMR, or if the provider entered the dose into the IMR as a historical dose. The IMR includes vaccine data from VT residents receiving vaccinations at Dartmouth-Hitchcock Medical Center in New Hampshire and VT residents receiving vaccinations in New York State.

Just to confirm we would be able to provide MMR to any patient 12 months and older who does not have documentation of vaccination without doing a titer?

That's correct, individuals without evidence of immunity and no contraindications to MMR vaccine can be vaccinated without testing. There is no harm in giving MMR vaccine to a person who may already be immune to one or more of the vaccine viruses. (For using state-supply vaccine, the individual must meet the state eligibility requirements which means birth through 64 years.)

I had a question regarding PPSV23 for our immunocompromised patients and the use of PCV20 instead. We are currently not stocking PCV20 for these compromised patients. Can you give some guidance re: when we should use PPSV23?

The answer is dependent on the patient's age, underlying conditions and history of pneumococcal vaccination. Here are two great resources for outlining pneumococcal vaccination recommendations for adults with immunocompromising conditions and exactly what is recommended based on their past pneumococcal vaccination: one is from CDC and one is from the California Department of Public Health. For guidance on pneumococcal recommendations for children with underlying conditions, see this California Department of Public Health job aid or the CDC website. We have also heard positive feedback from providers about PneumoVax Advisor, the CDC app/website.

Also, it should be noted, ACIP recommends that pneumococcal conjugate vaccine (PCV15, PCV20, PCV21) be administered before PPSV23 for optimal immune response to vaccination. Based on recent changes to ACIP recommendations that were made in October 2024, for adults, if an individual receives an PCV20 or PCV21 vaccine, they are no longer recommended to receive PPSV23. PPSV23 is only recommended to be administered after a dose of PCV15 or if there are no other pneumococcal vaccines available. We would recommend following ACIP recommendations and ensuring you have a pneumococcal conjugate vaccine available (PCV20 or PCV21 are available through the Vermont Vaccine Purchasing Program). For children and adolescents, there are specific circumstances in which PPSV23 is recommended. Please see the following CDC guidance to determine when it is appropriate to administer PPSV23: Summary of Risk-based Pneumococcal Vaccination Recommendations | Pneumococcal | CDC. CDC's PneumoVax Advisor application/website can also be used.

If someone has had a pregnancy and had a positive rubella titer, can we assume that they are immune to measles?

No, although it may seem likely they are immune to measles, per CDC recommendations, evidence of immunity is defined as:

- Written documentation of adequate vaccines for measles, mumps, and rubella
- Laboratory evidence of immunity
- Laboratory confirmation of disease
- Birth before 1957

Titers are vaccine-preventable disease specific, so a positive rubella titer is specific to rubella only, not measles or mumps. It is not correct to assume they are immune to measles based on rubella titers alone.

Is there any concern about running into shortages of the MMR vaccine if everyone tries to get vaccinated at the same time?

No, there is no MMR vaccine shortage, and we are not being limited by CDC in our ordering. Order MMR vaccine as you normally would and if you need assistance contact the vaccine ordering specialist.

Do pharmacies in border states (i.e., NH, MA) report vaccinations to the IMR team? And, are they able to view patient's records through the IMR?

There are some pharmacies bordering Vermont that report immunizations given to Vermonters. As of right now, however, these sites have not been granted access to view records in the Registry.

Additional details on pneumococcal vaccines, including recommended spacing can be found at Summary of Risk-based Pneumococcal Vaccination Recommendations | Pneumococcal | CDC.

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