2026–2027 influenza, RSV and SARS-CoV-2 immunization recommendations

FOR NON-PREGNANT IMMUNOCOMPETENT ADULTS AND HEALTH CARE PERSONNEL

Scope
This guidance covers non-pregnant, immunocompetent adults ≥19 years and health care personnel (HCP). For other populations, see guidance from:

- **American Academy of Pediatrics** (individuals ≤18 years)
- **Infectious Diseases Society of America** (immunosuppressed individuals)
- **American College of Obstetricians & Gynecologists** (pregnant individuals)

Schedule
Recommendations in this document are anchored to the **AAFP Adult Immunization Schedule.** Where AAFP guidance differs from other bodies, the AAFP recommendation governs.

Summary of clinical recommendations[1]

- **All adults ≥19 years should receive an annual influenza vaccine and an updated COVID-19 vaccine.**
- **Adults ≥65 years should preferentially receive an enhanced influenza vaccine** (high dose, adjuvanted, recombinant or mRNA) when available—but should not have vaccination delayed in order to obtain one.
- **Adults ≥65 years should receive two doses of the updated COVID-19 vaccine each season,** the first at month 0 and the second 6 months later.
- **Adults ≥75 years and adults 50–74 years who are at an increased risk should receive a single dose of the respiratory syncytial virus (RSV) vaccine.**
- **HCP should receive an annual influenza and updated COVID-19 vaccination,** given their repeated occupational exposure and contact with patients at high risk of severe disease.

Key points for vaccine implementation and acceptance

- **Recommend vaccines confidently and early:** Use a presumptive recommendation ("You are due for your flu and updated COVID-19 vaccines today."), followed by brief shared decision-making. A strong clinician recommendation is among the most reliable predictors of adult vaccine acceptance.[2]
- **Offer coadministration:** The influenza, COVID-19 and RSV vaccines (when indicated) can be given at the same office visit with no minimum interval and may be coadministered with other routine vaccines such as tetanus and pneumococcal vaccines.[3,4]
- **Use every encounter as a vaccine opportunity:** Previsit planning, standing orders and EHR prompts keep vaccination from being deferred.[2]
- **Maintain continuity when vaccines are given elsewhere:** Ensure timely documentation back into the EHR/immunization information system (IIS).
- **Access the most up-to-date schedule and vaccine information at AAFP.org:** Recommendations and product details may change during the season; the AAFP vaccine hub carries the current recommendation version.

Background: Why respiratory immunization matters this season

Fall and winter respiratory season brings sharply elevated risk from three vaccine-preventable viruses: influenza, RSV and SARS-CoV-2. In a Danish nationwide cohort of adults, RSV and influenza each accounted for substantial hospitalizations, with the risk concentrated in older adults and those with

chronic cardiopulmonary disease—confirming that RSV burden in adults is comparable in magnitude to influenza rather than incidental to it.[5] U.S. surveillance through the Respiratory Virus Hospitalization Surveillance Network (RESP-NET) tracks all three viruses and consistently identifies adults ≥65 years as the group at greatest risk for hospitalization and death.[6]

Older adults are not the only affected group, however. Younger adults with chronic conditions such as diabetes, obesity, chronic lung disease and cardiovascular disease also experience substantial respiratory-related hospitalization, and healthy younger adults contribute to community transmission.[5,7] The recommendations in this document address all adults ≥19 years, not only those at highest risk.

Uptake remains well below where it needs to be, including in the highest-risk group. For the 2024-2025 influenza season, only 41.9% of adults ≥18 years—and 64% of adults ≥65 years—received an influenza vaccine.[8] As of January 2026, 16.1% of adults had received a 2025-2026 COVID-19 vaccine and 43.9% received a 2025-2026 influenza vaccine.[9] RSV uptake among eligible older adults was similarly incomplete: 40.9% of adults ≥75 years and 30.9% of adults 50-74 years with high-risk conditions reported ever receiving an RSV vaccine as of February 2026.

Immunization remains the most effective single intervention to reduce severe respiratory illness.[10] The sections below provide current AAFP recommendations, product guidance and practical workflows for delivering vaccines efficiently in primary care.

Influenza vaccination in non-pregnant immunocompetent adults ≥19 years

AAFP recommendations[1]

- All adults ≥19 years should receive an annual influenza vaccine.
- HCP should receive an annual influenza vaccine.
- For adults ≥65 years, the AAFP **supports preferential use of a high dose, adjuvanted, recombinant or mRNA** over standard-dose unadjuvanted products.

High-risk groups

Older adults (≥65 years)

Adults ≥65 years are at substantially higher risk for influenza-related hospitalization and death.[11] For this group, the **AAFP recommends preferential use of a high-dose, adjuvanted, recombinant or mRNA influenza vaccine** when available.[1] This is consistent with longstanding Advisory Committee on Immunization Practices (ACIP) guidance and with the 2025 American College of Physicians (ACP) practice points, which likewise favor an enhanced (i.e., high-dose) product for adults ≥65 years.[12,13]

Evidence context: The preferential recommendation rests on consistent immunogenicity and effectiveness advantages for enhanced products, but the trial evidence on severe outcomes is not uniform, and clinicians should understand the nuance:

- In the **GALFLU** trial, a pragmatic, registry-based randomized trial of 103,169 community-dwelling adults 65-79 years in Galicia, Spain, a high-dose vaccine reduced the composite of influenza or pneumonia hospitalization relative to standard dose (relative vaccine effectiveness, 23.7%; 95% CI, 6.6-37.7), with a consistent effect on influenza hospitalization specifically (relative vaccine effectiveness, 31.8%; 95% CI, 5.0-51.3). Serious adverse events were similar between groups.[14]
- In **DANFLU-2,** a pragmatic, randomized trial of 332,438 Danish adults ≥65 years, the primary endpoint was neutral; per the trial's prespecified design, no hypothesis testing was performed for cardiovascular secondary and exploratory endpoints.[15]

Taken together, these data support **a preferential—not exclusive—**recommendation. The absolute benefit of an enhanced product is modest, and **no eligible patient should go unvaccinated because a preferred product is unavailable.** Vaccinating with any age-appropriate product is substantially better than deferring vaccination.[16]

Options for adults ≥65 years include[17-21]:

- **Fluzone® high dose (HD-IIV3):** Four times the antigen of a standard dose.
- **Fluad® adjuvanted (aIIV3):** Contains MF59 adjuvant to elicit a stronger immune response.
- **Flublok® recombinant (RIV3):** Egg-free; higher antigen concentration.
- **mFlusiva® (mRNA):** Egg-free; first flu vaccine using messenger RNA (mRNA) technology, the same technology as the COVID-19 vaccines.

Moderna's mFlusiva (mRNA-1010) was approved by the U.S. Food and Drug Administration (FDA) in August 2026 and is available for the 2026-2027 season.[20,21] For adults ≥65 years, mRNA-1010 is included among the **preferentially recommended enhanced products** (alongside high-dose, adjuvanted and recombinant vaccines). For adults in the younger FDA-approved age group **(50-64 years),** it is an **additional age-appropriate option** without preferential status.

Adults with chronic conditions
Chronic disease is an independent risk factor for serious influenza complications, including hospitalization and death.[22] High-risk conditions include asthma and chronic lung disease (e.g., COPD, cystic fibrosis); neurologic and neurodevelopmental conditions; blood disorders (e.g., sickle cell disease); diabetes mellitus; heart disease and stroke history; kidney and liver disorders; severe obesity (i.e., body mass index [BMI] ≥40); and immunocompromising conditions or therapies, including cancer and cancer treatment. Clinicians should prioritize annual vaccination, encourage early evaluation when influenza is suspected and initiate antiviral treatment promptly when indicated.

Health care personnel
Unvaccinated HCP are at increased risk of occupational influenza acquisition, resulting in symptomatic illness and absenteeism during peak season.[23] A systematic review and meta-analysis of influenza vaccination in health workers found lower rates of laboratory-confirmed influenza and reduced absenteeism among vaccinated personnel. Likewise, higher HCP vaccination coverage in long-term care settings has been associated with reduced patient influenza-like illness and lower all-cause patient mortality, supporting HCP vaccination as a patient-safety intervention, as well as an occupational one.[24]

Timing
For most adults, aim for **September-October** vaccination, continuing throughout the season while influenza viruses are circulating.[25] For adults ≥65 years, avoid vaccination in July-August unless later vaccination may not be feasible, given evidence of waning protection over the course of the respiratory season. Earlier vaccination may be reasonable when influenza is already circulating at elevated levels in the community. Do not delay vaccination while waiting for a preferred product to become available.

Product selection
For most adults, any age-appropriate licensed influenza vaccine is acceptable. Adults ≥65 years should preferentially receive a high-dose, adjuvanted, recombinant or mRNA product when available.[17-19] People with egg allergies—regardless of the severity of their previous reaction—can receive any age-appropriate influenza vaccine, including egg-based products, with no additional safety precautions beyond those recommended for any vaccine.[1] Product-specific contraindications and precautions (e.g., a history of severe allergic reaction to a prior dose or vaccine component) apply as listed in each product's labeling and in the AAFP schedule; clinicians should screen for these before administration.

Adults who prefer to avoid injections may opt for the live attenuated influenza vaccine (FluMist®), approved for non-pregnant individuals 2-49 years without relevant contraindications.[26] FluMist is now also approved for **self-administration** by adults 18-49 years, or caregiver administration for recipients 2-17 years and can be ordered and administered at home.

Thimerosal: A June 2025 ACIP vote to recommend only thimerosal-free influenza formulations was paused by a federal court stay in March 2026, and is not, as a formal recommendation, in effect.[27] Thimerosal, when present historically, appeared only in multidose vials, and large studies have found no evidence of harm from those quantities.[28] **Do not delay vaccination over thimerosal concerns.**

All U.S. seasonal influenza vaccines are trivalent (IIV3/ccIIV3/RIV3/LAIV3/mRNA) and have been developed to target the A(H1N1)pdm09, A(H3N2) and B/Victoria-lineage virus.[29] The B/Yamagata lineage was removed beginning with the 2024-2025 season because it has not been detected in global surveillance since March 2020.[30] Product names and "-4" designations from prior seasons (IIV4, RIV4) no longer apply.

Currently available influenza vaccine products (U.S., 2026-2027)[1,20,31]

Product (manufacturer)	Vaccine type/platform	FDA-approved indication	Practice notes
Fluarix® (GlaxoSmithKline)	Standard-dose IIV3 (egg-based)	≥6 months	Intramuscular (IM); age-appropriate for most persons
FluLaval® (GlaxoSmithKline)	Standard-dose IIV3 (egg-based)	≥6 months	IM; age-appropriate for most persons
Fluzone (Sanofi)	Standard-dose IIV3 (egg-based)	≥6 months	IM; age-appropriate for most persons
Flucelvax® (Seqirus)	Cell culture-based IIV3 (ccIIV3)	≥6 months	IM; cell-based manufacturing; age-appropriate for most persons
Flublok (Sanofi)	Recombinant IIV3 (RIV3)	≥9 years	**AAFP-preferred for adults ≥65 years when available;** Age indication was lowered from ≥18 years to ≥9 years effective the 2025-2026 season.
Fluad (Seqirus)	Adjuvanted IIV3 (aIIV3)	≥65 years	**AAFP-preferred for adults ≥65 years when available.**
Fluzone® high dose (Sanofi)	High-dose IIV3 (HD-IIV3)	≥65 years	**AAFP-preferred for adults ≥65 years when available.**
FluMist (AstraZeneca)	Live attenuated (LAIV3; intranasal)	2-49 years	Non-pregnant persons without contraindications; not for adults ≥50 years. Approved for self-administration (18-49 years) or caregiver administration (recipients 2-17 years).
mFlusiva (Moderna)	mRNA	≥50 years	**AAFP preferred for adults ≥65 years when available;** first flu vaccine using COVID-19 vaccine's mRNA technology.

Product table reflects the AAFP Adult Immunization Schedule.

2026-2027 strain composition[29]

The FDA's Vaccines and Related Biological Products Advisory Committee (VRBPAC) met March 12, 2026, and recommended the following compositions (the current recommendation and rationale are posted on the FDA VRBPAC website):

- **Egg-based vaccines:** A/Missouri/11/2025 (H1N1)pdm09-like; A/Darwin/1454/2025 (H3N2)-like; B/Tokyo/EIS13-175/2025 (Victoria lineage)-like
- **Cell- or recombinant-based vaccines:** A/Missouri/11/2025 (H1N1)pdm09-like; A/Darwin/1415/2025 (H3N2)-like; B/Pennsylvania/14/2025 (Victoria lineage)-like

COVID-19 vaccination in non-pregnant immunocompetent adults ≥19 years

AAFP recommendations[1]

All adults ≥19 years should receive an updated COVID-19 vaccine, with particular emphasis on:

- Adults ≥65 years
- Adults at increased risk for severe COVID-19
- Adults who have never received a COVID-19 vaccine

HCP should receive an updated COVID-19 vaccine.

2026-2027 vaccine composition

VRBPAC met **May 28, 2026,** and recommended that the 2026-2027 COVID-19 vaccine composition include the **JN.1-lineage XFG variant** as the preferred SARS-CoV-2 variant for an updated monovalent vaccine.[32,33] The committee voted 8-0 in favor, with one abstention. Based on the totality of the evidence, the FDA subsequently advised manufacturers that COVID-19 vaccines for use in the United States beginning in fall 2026 should be a **monovalent JN.1-lineage XFG variant vaccine.**

Both influenza and SARS-CoV-2 undergo continual antigenic change, so their vaccines are periodically updated to better match circulating strains—a key reason annual or updated vaccination is needed rather than a single lifetime series.[34] XFG remains within the JN.1 lineage targeted by the 2025-2026 formula (which preferentially used the LP.8.1 strain).[35] This continuity matters when counseling patients. Effectiveness estimates generated during the 2025-2026 season derive from a JN.1-lineage vaccine against JN.1-descendant circulation and so remain informative for the 2026-2027 product rather than being superseded by it.

High-risk groups

Adults at an increased risk for severe COVID-19

The risk for severe COVID-19 rises sharply with advancing age, particularly for individuals ≥65 years.[36] Additional high-risk conditions include individuals with moderate-to-severe immunocompromised conditions; chronic kidney disease; chronic lung disease (e.g., COPD, interstitial lung disease); diabetes mellitus (i.e., type 1 or 2); obesity; cardiovascular disease; cancer; neurologic conditions (e.g., dementia); and individuals who currently smoke or formerly smoked. Risk increases with multiple comorbidities and when patients are not up to date on vaccination (i.e., they have not received an updated COVID-19 vaccine during the current respiratory season).[37]

Health care personnel

HCP have frequent, close contact with patients and face repeated occupational exposure to SARS-CoV-2. While current vaccines offer less protection against mild infection with evolving variants, effectiveness evaluations consistently demonstrate meaningful protection against severe outcomes. Interim estimates for the 2025-2026 JN.1-lineage vaccine demonstrated protection against medically attended COVID-19 among immunocompetent adults,[35] and estimates for the 2024-2025 formulation demonstrated protection against severe COVID-19 requiring hospitalization or critical care.[37] Protection against severe outcomes persisted through long-term follow up in a target trial emulation of the 2024-2025 KP.2 vaccines, although effectiveness against infection waned.[38] Together, these support vaccination as a key strategy to reduce HCP morbidity and protect high-risk staff.

Timing

Offer updated COVID-19 vaccination as soon as the updated formulation is available, particularly for adults ≥65 years, immunocompromised individuals, HCP and residents of long-term care facilities. SARS-CoV-2 circulates year-round, and protection wanes over time. Do not delay COVID-19 vaccination while waiting for a preferred product.

Two doses for adults ≥65 years: Adults ≥65 years are recommended to receive **two doses of the updated COVID-19 vaccine each season**—the first dose at month 0 and the second dose 6 months later—to counter waning protection.[39] This two-dose schedule also applies to many moderately or severely immunocompromised adults. Confirm current guidance and payer coverage at the time of administration.

Product selection

There is no preferential recommendation among licensed COVID-19 products. For patients who prefer a non-mRNA option, Novavax (Nuvaxovid, protein subunit) is available.[40] All four licensed products now carry a risk-based indication rather than a simple minimum age—see the table and notes below.

Currently available COVID-19 vaccine products (U.S., 2026-2027)[1,40]

Product (manufacturer)	Vaccine type/platform	FDA-approved indication	Practice notes
Spikevax® (Moderna)	mRNA	**≥65 years, OR 6 months to 64 years with ≥1 underlying condition,** conferring high risk for severe COVID-19	Only FDA-approved product for 6 months to 4 years.
Comirnaty® (Pfizer-BioNTech)	mRNA	**≥65 years,** OR **5 to 64 years with ≥1 underlying condition**	Not approved for 6 months to 4 years; the prior emergency use authorization for that age group has been withdrawn.
mNexspike® (Moderna)	mRNA	**≥65 years,** OR **12 to 64 years with ≥1 underlying condition**	Dose volume (0.2 mL) differs from Spikevax (0.5 mL)—do not interchange without checking.
Nuvaxovid™ (Novavax)	Protein subunit (adjuvanted)	**≥65 years,** OR **12 to 64 years with ≥1 underlying condition**	Non-mRNA option for patients who prefer it.

Pediatric indications shown for context only; this guidance focuses on adults ≥19 years.

Important: The AAFP recommendation is broader than the FDA-approved indication. The AAFP recommends COVID-19 vaccination for **all adults ≥19 years.**[1] The FDA-approved indication, however, is narrower. Here, "indication" means the FDA-approved population, not a clinical recommendation—the FDA does not issue vaccination recommendations. Since 2025, every licensed COVID-19 product is approved only for adults ≥65 years or adults <65 years with at least one underlying condition that confers high risk for severe COVID-19.[41] A healthy adult 19-64 years with no qualifying condition therefore falls **outside the FDA-approved indication,** even though the AAFP recommends vaccination for this population too.

What this means in practice: Vaccinating a patient who does not have an underlying high-risk condition is an off-label use of an FDA-approved product, which is within the practice of medicine and is supported by AAFP recommendations. Note that the list of qualifying conditions is broad—including obesity (BMI ≥30), diabetes, cardiovascular disease, chronic lung disease, current or former smoking and physical inactivity—so most adults who wish to be vaccinated will qualify on review. Patients may self-attest to a risk factor; no documentation or attestation form is required.

Practice points: AHIP's (formerly called America's Health Insurance Plans) member health plans have stated they will continue covering all ACIP-recommended immunizations with no cost-sharing through the end of 2027,[42] which should limit out-of-pocket cost for most patients. Still, please confirm coverage locally, as some plans may track the FDA-approved indication. Pharmacy authority to vaccinate is tied to ACIP recommendations in some states, so pharmacy access for patients outside the labeled indication may vary. Where access is uncertain, vaccinate in the office.

RSV vaccination in non-pregnant immunocompetent adults ≥19 years

AAFP recommendations[1]

- Adults ≥75 years: single dose of any age-appropriate FDA-licensed RSV vaccine.
- Adults 50-74 years at increased risk of severe RSV: single dose of any age-appropriate FDA-licensed RSV vaccine.
- HCP: RSV vaccination should be based on individual health and age/risk eligibility, not occupational status alone.

High-risk groups

Adults at an increased risk for severe RSV

High-risk groups include adults ≥75 years; adults 50-74 years with chronic heart or lung disease; adults of any age with weakened immune systems; adults with certain other underlying medical conditions; and adults residing in nursing homes or long-term care facilities.[1,43]

Benefit: A single dose of RSV vaccine substantially reduces RSV-associated lower respiratory tract disease and hospitalization in older adults.[44,45] Effectiveness against RSV-associated outcomes was maintained across two respiratory seasons in a large U.S. cohort,[44] with supporting randomized and observational data in adults ≥60 years.[44,45] RSV vaccination is currently a one-time recommendation; there is insufficient evidence to recommend revaccination at this time.[1]

Health care personnel

HCP may have occupational exposure to RSV in close-contact clinical settings. However, HCP status alone is not an indication for RSV vaccination.[1] RSV vaccine should be offered to HCP who meet the age- or risk-based eligibility criteria above. Current evidence does not support RSV vaccination based on occupational status alone.

Timing

Eligible adults may receive the RSV vaccine at any time, but the **optimal window is late summer to early fall,** before RSV activity typically increases in the community.[1] This aligns RSV vaccination with influenza and COVID-19 vaccination outreach and supports "one-stop" respiratory season visits.

Product selection and safety considerations

Available products: Arexvy® (GlaxoSmithKline; AS01E adjuvanted); Abrysvo™ (Pfizer; adjuvant-free); and mResvia® (Moderna; mRNA-based). All three are approved for **all adults ≥60 years,** and all three are now additionally approved for **younger adults at increased risk** for RSV lower respiratory tract disease. No product is preferentially recommended over another.[1]

Currently available RSV vaccine products (U.S., 2026-2027)[1,46-49]

Product (manufacturer)	Vaccine type/platform	FDA-approved indication	Practice notes
Arexvy (GlaxoSmithKline)	Protein subunit (prefusion F) + AS01E adjuvanted	≥60 years (all); 50-59 years at increased risk; ***18-49 years at increased risk (added March 2026)**	Single dose (0.5 mL IM). Not for use in pregnancy (product limitation). Postmarketing observational data prompted a Guillain-Barré syndrome (GBS) warning.
Abrysvo (Pfizer)	Protein subunit (bivalent prefusion F), adjuvant-free	≥60 years (all); 18-59 years at increased risk	Single dose IM. Also indicated for maternal immunization at 32-36 weeks gestational age (separate, non-adult indication). Postmarketing observational data prompted a GBS warning.
mResvia (Moderna)	mRNA (prefusion F), adjuvant-free	≥60 years (all); 18-59 years at increased risk	Single dose (0.5 mL IM).

** See note in the green box on next page regarding age recommendation.*

Safety signals: Post-authorization surveillance identified a potential signal for GBS with RSV vaccines in older adults. Pooled evidence estimates an excess of approximately **18 GBS cases per million doses** for the bivalent prefusion F (RSVpreF) product;[3] the absolute risk is small relative to the benefits in high-risk groups. A separate atrial fibrillation concern arose primarily from trial and postmarketing data for the AS01E-adjuvanted product,[48] and pooled data remain insufficient to quantify any excess risk. This concern should therefore be described as product-specific and not well quantified.

Notably, in a prespecified analysis of the DAN-RSV randomized trial of 131,276 adults ≥60 years, RSVpreF was evaluated against cardiovascular hospitalization outcomes, providing randomized data relevant to cardiovascular safety and benefit.[45] Clinicians should discuss GBS briefly during shared decision-making, particularly with patients who have a prior history of GBS.

The FDA-approved age range is broader than the AAFP recommendation for RSV. In March 2026, the FDA expanded the Arexvy indication to include adults **18-49 years at increased risk** for RSV lower respiratory tract disease.[49] Abrysvo and mResvia are similarly approved down to 18 years for at-risk adults.[47,48] These are **FDA approvals that have not been reviewed by ACIP,** and current CDC/ACIP guidance and AAFP recommendations do not extend routine RSV vaccination below age 50. Clinicians should follow the AAFP age/risk thresholds for routine practice. The younger-adult approvals may be considered on an individual basis but are not part of the routine recommendation.

Applying the age and risk criteria: The AAFP recommendation and the FDA-approved indications align more closely than they may first appear, because every RSV vaccine is labeled for use in adults at increased risk (in addition to all adults ≥60 years).[46-50] Adults 50-74 years with a qualifying high-risk condition therefore fall squarely within the AAFP recommendation to vaccinate—this is a recommendation, not merely a shared decision-making option. For adults 60-74 years without any high-risk condition, vaccination is within the FDA-approved indication (≥60 years) but below the AAFP's risk-based threshold; shared decision-making is appropriate in these instances. For adults 50-59 years without a qualifying condition, the vaccines are neither AAFP-recommended nor are they within the FDA-approved indication.

Practice implementation: Getting vaccines to patients AAFP policy foundation: The AAFP supports universal immunization regardless of socioeconomic or insurance status and recommends that patients receive all indicated vaccines from their usual source of primary care.[51] When vaccines are provided elsewhere, all vaccine-related information should be submitted to the patient's EHR and/or IIS, so the primary care record remains complete and accurate. (AAFP Immunizations policy, October 2023 COD)

Evidence-based strategies
A component network meta-analysis of interventions to increase vaccine uptake found that multicomponent strategies combining patient reminders, clinician prompts and reduced structural barriers outperform single-component approaches, and that education delivered in isolation has limited effect.[2] A systematic review focused specifically on primary care reached concordant conclusions, finding that in-person clinician conversations and recommendations are associated with meaningful increases in adult vaccination uptake, and that counseling is most effective when bundled with workflow supports.[52] The seven strategies below for increasing vaccination reflect that evidence.

1. Make every visit a vaccine visit
Use previsit planning to identify vaccines due before scheduled appointments and use rooming workflows—standing prompts for a medical assistant/registered nurse to check the status and provide pending orders—so that vaccination is assessed at acute, chronic care and preventive visits.[2] Incorporating an "any visit" approach to vaccination is the single most impactful structural change a practice can make to improve immunization coverage.

2. Standing orders and expanded vaccinators
Implement standing orders (consistent with state scope-of-practice laws) to allow trained staff—nurses and pharmacists (where permitted)—to assess eligibility and administer indicated vaccines without a same-day clinician order.[2]

3. Strong recommendations and motivational counseling
A strong, presumptive clinician recommendation ("You are due for your flu and updated COVID-19 vaccines today.") is among the strongest predictors of adult vaccine acceptance.[53] When patients express a lack of confidence in the effectiveness of vaccines, try using motivational interviewing techniques to explore concerns without delaying protection.[2] Shared clinical decision-making can help adults weigh the benefits and risks in light of their own circumstances; clinicians may still offer a clear recommendation informed by clinical judgment.[54]

4. Reminder/recall and measurement
Use IIS- or EHR-enabled reminder/recall (i.e., text, phone, mail, patient portal) for patients who are due or overdue, and pair outreach with clinician assessment and feedback to identify gaps and sustain improvement over time.[2]

5. Coadministration
When adults are eligible for multiple respiratory vaccines, offer coadministration (i.e., influenza plus COVID-19 vaccination, along with RSV [when indicated]) at the same office visit to reduce return trips.[3] Respiratory vaccines may also be coadministered with other routine vaccines such as tetanus, shingles and pneumococcal vaccines. Evidence synthesis identified 17 studies of COVID-19 and influenza coadministration showing immunogenicity and safety comparable to sequential administration; five randomized trials supporting RSV and influenza coadministration in adults ≥65 years; and acceptable immunogenicity and safety for triple coadministration. Real-world safety surveillance of influenza, COVID-19 and RSV coadministration in older adults did not identify new safety signals.[4] Counsel patients that mild, short-lived reactogenicity (i.e., fatigue, myalgias) may be similar to or modestly more common than with single-vaccine administration and use different injection sites when possible.[3]

6. Immunization systems and documentation
Document all administered vaccines in the EHR and submit them to the IIS promptly to maintain consolidated vaccination histories and support automated dose forecasting. Query the IIS at the point of care to confirm what a patient has already received—particularly important for adults ≥65 years on a two-dose COVID-19 schedule and for patients who receive vaccines across multiple settings. If your clinic cannot administer all indicated vaccines, establish bidirectional referral pathways with pharmacies or occupational health facilities and ensure doses given elsewhere are documented in the EHR/IIS, so the primary care record stays complete and accurate.

7. Anticipatory guidance
Use brief, proactive counseling to normalize vaccination expectations before the visit (e.g., scheduling outreach messages, rooming scripts and previsit planning) and to set up same-day vaccination when patients arrive. As a standalone strategy, education has limited evidence. It is most effective when bundled with workflow supports such as reminders, standing orders and convenient access.[2]

Conclusion

Protecting patients from respiratory illness this season means combining timely vaccination against influenza, COVID-19 and RSV (when indicated) with practical workflows that prevent missed opportunities. Offering vaccines at every visit, using reminder/recall systems and standing orders, and maintaining accurate records across care settings are the highest-yield actions available to primary care practices.[2] Strong, clear clinician recommendations—paired with shared decision-making where appropriate—remain the most reliable bridge between vaccine availability and patient protection.[54]

References

1. American Academy of Family Physicians (AAFP). Adults 19 and older immunization schedule. Accessed August 7, 2026. www.aafp.org/clinical-insights/immunizations-and-vaccines/immunizations-schedules-resources/adult-immunization-schedules
2. Davies SR, Davies AL, Higgins JPT, et al. Effectiveness of interventions to increase vaccine uptake: component network meta-analysis. *BMJ.* 2026;393:e087578.
3. Scott J, Abers MS, Marwah HK, et al. Updated evidence for Covid-19, RSV, and influenza vaccines for 2025-2026. *N Engl J Med.* 2025;393(22):2221-2242.
4. Parker CE, Hause AM, Marquez P, et al. Trends in the administration of COVID-19 vaccines with other vaccines in the United States reported to V-safe during December 14, 2020—May 19, 2023. *Hum Vaccin Immunother.* 2024;20(1):2361946.
5. Fonseca MJ, Bratković S, Pedersen M, et al. Burden of respiratory syncytial virus and influenza in adults – a Danish nationwide cohort study. *Clin Microbiol Infect.* 2026;32(6):1006-1014.
6. CDC. Respiratory Virus Hospitalization Surveillance Network (RESP-NET). RESP-NET interactive dashboard. 2025-2026 season. Accessed August 7, 2026. www.cdc.gov/resp-net/dashboard/index.html
7. Goldberg R. Chronic conditions linked to severe outcomes in younger adults with influenza. Pulmonary Advisor. January 5, 2024. Accessed August 7, 2026. www.pulmonologyadvisor.com/news/younger-adults-with-chronic-conditions-have-severe-influenza-outcomes/
8. CDC. Flu vaccination coverage, United States, 2024-25 influenza season. FluVaxView. January 8, 2026. Accessed August 7, 2026. www.cdc.gov/fluvaxview/coverage-by-season/2024-2025.html
9. CDC. Vaccination uptake, intent, and confidence. RespVaxView. February 20, 2026. Accessed August 7, 2026. www.cdc.gov/respvaxview/dashboards/vaccination-behavioral-social-drivers.html
10. CDC. Respiratory Illness Season Toolkit. February 27, 2026. Accessed August 7, 2026. www.cdc.gov/respiratory-viruses/php/toolkit/index.html
11. CDC. Flu and people 65 years and older. Influenza (Flu). September 5, 2024. Accessed August 7, 2026. www.cdc.gov/flu/highrisk/65over.htm
12. Hsiao A, Leong T, Fireman B, et al. Adjuvanted vs high-dose influenza vaccines in older US adults. *JAMA Netw Open*. 2026;9(5):e2610120.
13. Qaseem A, Wilt TJ, Harrod CS, et al. Influenza vaccines for 2025-2026 in adults who are not pregnant or immunocompromised: rapid practice points from the American College of Physicians. *Ann Intern Med.* 2026;179(1):110-117.
14. Pardo-Seco J, Rodríguez-Tenreiro-Sánchez C, Giné-Vázquez I, et al. High-dose influenza vaccine to reduce hospitalizations. *N Engl J Med.* 2025;393(23):2303-2312.
15. Johansen ND, Modin D, Loiacono MM, et al. High-dose vs standard-dose influenza vaccine and cardiovascular outcomes in older adults: a prespecified secondary analysis of the DANFLU-2 randomized clinical trial. *JAMA Cardiol.* 2025;10(11):1186-1194.
16. CDC. Timing and spacing of immunobiologics. Vaccines & Immunizations. July 24, 2024. Accessed August 7, 2026. www.cdc.gov/vaccines/hcp/imz-best-practices/timing-spacing-immunobiologics.html

17. CDC. Fluzone high-dose seasonal influenza vaccine. Influenza (Flu). June 11, 2026. Accessed August 7, 2026. www.cdc.gov/flu/vaccine-types/flu-zone.html
18. CDC. Adjuvanted flu vaccine. Influenza (Flu). January 6, 2026. Accessed August 7, 2026. www.cdc.gov/flu/vaccine-types/adjuvant.html
19. CDC. Recombinant influenza (flu) vaccine. Influenza (Flu). June 16, 2026. Accessed August 7, 2026. www.cdc.gov/flu/vaccine-types/flublok-vaccine.html
20. U.S. FDA. mFlusiva. Package insert. August 2026. Accessed August 7, 2026. www.fda.gov/media/194120/download
21. BioPharm International. Moderna's mFlusiva approval validates mRNA platform beyond COVID-19: what it means for biopharmaceutical manufacturing. August 6, 2026. Accessed August 7, 2026. www.biopharminternational.com/view/moderna-mflusiva-approval-validates-mrna-platform-beyond-covid-19-what-it-means-for-biopharmaceutical-manufacturing
22. CDC. People at increased risk for flu complications. September 11, 2024. Accessed August 7, 2026. www.cdc.gov/flu/highrisk/index.htm
23. Li T, Qi X, Li Q, et al. A systematic review and meta-analysis of seasonal influenza vaccination of health workers. *Vaccines (Basel).* 2021;9(10):1104.
24. Ahmed F, Lindley MC, Allred N, et al. Effect of influenza vaccination of healthcare personnel on morbidity and mortality among patients: systematic review and grading of evidence. *Clin Infect Dis.* 2014;58(1):50-57.
25. CDC. ACIP recommendations summary. Influenza (Flu). June 10, 2026. Accessed August 7, 2026. www.cdc.gov/flu/hcp/vax-summary/acip-recommendations.html
26. AstraZeneca. FluMist approved for self-administration in the US [press release]. September 20, 2024. Accessed July 28, 2026. www.astrazeneca.com/media-centre/press-releases/2024/flumist-approved-for-self-administration-in-the-us.html
27. Gallagher A. Ongoing AAP, HHS legal battle will determine future health care action. Drug Topics. June 4, 2026. Accessed August 7, 2026. www.drugtopics.com/view/ongoing-aap-hhs-legal-battle-will-determine-future-health-care-action
28. CDC. Thimerosal and vaccines. October 28, 2025. Accessed August 7, 2026. www.cdc.gov/vaccine-safety/about/thimerosal.html
29. U.S. FDA. Influenza vaccine composition for the 2026-2027 U.S. influenza season. March 13, 2026. Accessed August 7, 2026. www.fda.gov/vaccines-blood-biologics/vaccines/influenza-vaccine-composition-2026-2027-us-influenza-season
30. U.S. FDA. Use of trivalent influenza vaccines for the 2024-2025 U.S. influenza season. March 5, 2024. Accessed August 7, 2025. www.fda.gov/vaccines-blood-biologics/lot-release/use-trivalent-influenza-vaccines-2024-2025-us-influenza-season
31. CDC. Seasonal influenza vaccine dosage & administration. Influenza (Flu). May 12, 2026. Accessed August 7, 2026. www.cdc.gov/flu/hcp/vax-summary/vaccine-dosage-admin.html
32. U.S. FDA. COVID-19 vaccines (2026-2027 formula) for use in the United States beginning in fall 2026. May 29, 2026. Accessed August 7, 2026.
33. Splete H. FDA advisors favor dominant US strain, XFG, for next COVID vaccine. May 29, 2026. Accessed August 7, 2026. www.medscape.com/viewarticle/fda-advisors-favor-dominant-us-strain-xfg-next-covid-vaccine-2026a1000i01
34. Thompson MG, Cowling BJ. How repeated influenza vaccination effects might apply to COVID-19 vaccines. *Lancet Respir Med.* 2022;10(7):636-638.
35. Wiegand RE, Chickery S, Yang DH, et al. Interim estimated effectiveness of 2025-2026 COVID-19 vaccines in adults using a test-negative design. *JAMA Netw Open.* 2026;9(6):e2625152.
36. CDC. People with certain medical conditions and COVID-19 risk factors. Covid. June 11, 2025. Accessed August 7, 2026. www.cdc.gov/covid/risk-factors/index.html
37. Ma KC, Webber A, Lauring AS, et al. Estimated effectiveness of 2024-2025 COVID-19 vaccination against severe COVID-19. *JAMA Netw Open.* 2026;9(2):e2557415.
38. Ioannou GN, Berry K, Yan L, et al. Effectiveness of the 2024-025 KP.2 COVID-19 vaccines in the United States during long-term follow-up. *Nat Commun.* 2026;17(1):1043.
39. Roper LE, Godfrey M, Link-Gelles R, et al. Use of additional doses of 2024-2025 COVID-19 vaccine for adults aged ≥65 years and persons aged ≥6 months with moderate or severe immunocompromise: recommendations of the Advisory Committee on Immunization Practices – United States, 2024. *MMWR Morb Mortal Wkly Rep.* 2024;73(49):1118-1123.
40. U.S. FDA. Vaccines licensed for use in the United States. March 9, 2026. Accessed August 7, 2026. www.fda.gov/vaccines-blood-biologics/vaccines/vaccines-licensed-use-united-states
41. Stein R. The latest COVID vaccines come with new FDA limits. August 27, 2025. Accessed August 7, 2026. www.npr.org/sections/shots-health-news/2025/08/27/nx-s1-5515503/fda-covid-vaccines-restricted
42. AHIP. AHIP statement on vaccine coverage. Updated May 2026. Accessed July 28, 2026. www.ahip.org/news/press-releases/ahip-statement-on-vaccine-coverage
43. CDC. RSV vaccine guidance for adults. Respiratory syncytial virus infection (RSV). February 24, 2026. Accessed August 7, 2026. www.cdc.gov/rsv/hcp/vaccine-clinical-guidance/adults.html
44. Bajema KL, Bui DP, Yan L, et al. Durability of respiratory syncytial virus vaccine effectiveness among US veterans. *JAMA Intern Med.* 2026;186(1):78-88.
45. Lassen MCH, Johansen ND, Christensen SH, et al. Bivalent RSV prefusion F protein-based vaccine for preventing cardiovascular hospitalizations in older adults: a prespecified analysis of the DAN-RSV trial. *JAMA.* 2025;334(16):1431-1441.
46. U.S. FDA. GSK's Arexvy. Package insert. July 2026. Accessed August 7, 2026. www.fda.gov/media/167805/download
47. U.S. FDA. Pfizer's Abrysvo. Package insert. December 2025. Accessed August 7, 2026. www.fda.gov/media/168889/download
48. U.S. FDA. Moderna's mResvia. Package insert. June 2025. Accessed August 7, 2025. https://www.fda.gov/media/179005/download
49. Reuters. GSK gets US FDA approval for expanded use of RSV vaccine. March 13, 2026. Accessed August 7, 2026. www.reuters.com/business/healthcare-pharmaceuticals/gsk-gets-us-fda-approval-expanded-use-rsv-vaccine-2026-03-13/
50. Ferguson M, Schwarz TF, Nunez SA, et al. Immune persistence and safety of the AS01E-adjuvanted respiratory syncytial virus prefusion F protein-based vaccine in adults 50-59 years of age, including at-increased-risk adults: a randomized controlled trial. *Hum Vaccin Immunother.* 2025;21(1):2579335.
51. AAFP. Immunizations. AAFP policy. Accessed August 7, 2026. www.aafp.org/about/policies/immunizations
52. Wheeler SG, Beste LA, Overland MK, Wander PL. Interventions in primary care to increase uptake of adult vaccines: a systematic review. *J Public Health* (Oxf). 2025;47(2):222-231.
53. Wolf J. New AAFP resources strengthen adult immunization conversations. AAFP Blog. August 3, 2026. Accessed August 7, 2026. www.aafp.org/about/blog/new-aafp-resources-strengthen-adult-immunization-conversations
54. Elwyn G, Gulbrandsen P, Leavitt H, et al. Shared decision-making. A primer for clinicians. *J Gen Intern Med.* 2025;40(16):3889-3899.

HOPS260718305