patient dialysis would lead to any meaningful misclassification of a dialysis unit’s anemia management practice. We disagree with Zhang et al that our findings are inconsistent with a report that the dialysis chain using the smallest doses of ESAs also had the lowest mortality rates.1 Our model suggests that centers using ESAs the most aggressively across all hematocrit categories would have increased mortality rates relative to the most conservative centers. Therefore, our results are quite compatible with the cited report.

We agree with Dr Auerbach that IV iron is a useful aspect of anemia management. However, we note that a study of 10 169 hemodialysis patients found an 11% increased risk of all-cause mortality and a 12% increased risk of hospitalization in patients prescribed more than 10 vials of iron over a 6-month period compared with patients prescribed no iron.2 That study cites 5 abstracts reporting associations between iron exposure and adverse events, including all-cause mortality and infection-related outcomes. It is likely true that most of the risk of anaphylaxis comes with use of high-molecular-weight iron dextran, but many other important aspects of IV iron use are not well understood. There is a lack of evidence on the comparative effectiveness and safety of different iron dosing strategies (including bolus vs maintenance dosing) and of the different iron complexes, which have different pharmacokinetic properties.

Changes in reimbursement coupled with evidence suggesting that frequent use of iron may increase hemoglobin in patients who do not respond well to ESAs3 are likely to lead to increasing use of IV iron for anemia management in hemodialysis patients. This makes it increasingly important to continue studying IV iron to identify agents and dosing protocols that maximize its considerable benefits while minimizing possible harms and unnecessary use.

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27%-39%) in the opt-in condition (P = .003), a 36% relative increase. Six participants (3 in each group) were vaccinated after randomization but before initial e-mails were sent.

This difference was mediated by participant appointment status: only 18 opt-out participants (6%) canceled appointments, and only 50 opt-in participants (21%) made appointments. Consequently, opt-out participants were much more likely than opt-in participants to have an appointment (92% [95% CI, 89%-96%] vs 21% [95% CI, 16%-26%]; P < .001). Participants with an appointment were more likely than those without to get a flu shot, although not necessarily at the appointment time (Figure). 148 of 271 participants (55%: 95% CI, 49%-61%) vs 40 of 207 participants (19%: 95% CI, 14%-25%) (P < .001). Statistically controlling for appointment status eliminated the default effect (Sobel test = 7.64, P < .001).

Comment. Both opt-in and opt-out conditions allow decision makers to select the option they want, but the opt-out condition increased the probability of a flu shot appointment, which in turn increased the likelihood of getting vaccinated. The study was limited to a university workplace sample, and vaccination records were limited to vaccinations received at the occupational health department. Nevertheless, the results suggest that automatic scheduling of flu shot appointments may be an effective way to increase vaccination rates.

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