Law and the Public's Health

This *Law and the Public's Health* column examines the current state of the law governing immunization of the health-care workforce, with a particular focus on state law developments.

Sara Rosenbaum, JD
The George Washington University School of Public Health and Health Services
Department of Health Policy, Washington, DC

USING STATE LAWS TO VACCINATE THE HEALTH-CARE WORKFORCE

Alexandra M. Stewart, JD

Mandatory influenza vaccination of health-care workers (HCWs) has been widely studied and debated. State legislators are beginning to use their authority to enact laws requiring HCW vaccination as an infection-control measure. This installment of *Law and the Public's Health* reviews the role of state law in promoting influenza vaccine uptake among the health-care workforce.

BACKGROUND

Influenza outbreaks in health-care settings, attributed to the unvaccinated workforce, have been well described and documented.[1] During an average influenza season, 23% of HCWs are infected with the influenza virus, show mild symptoms, and continue to work despite being infectious.[2] Those with serological evidence of infection do not consistently recall their illness and may continue to work while infectious.[3] These outbreaks have contributed to patient complications or death and increased economic costs to the health-care system.[4,5] Between 3% and 50% of exposed patients can be infected, resulting in median mortality that ranges from 16% in a general ward to 33%–60% in a transplant setting.[3]

Since 1981, the Centers for Disease Control and Prevention (CDC) has recommended that all HCWs receive an annual influenza vaccination.[6] Additionally, Healthy People objectives have set a coverage rate goal of 90% by 2020.[7]

VOLUNTARY STRATEGIES TO INCREASE VACCINATION AMONG HCWs

To encourage increased influenza vaccination among HCWs, health-care facilities have employed educational and promotional campaigns,[8–10] increased access to the vaccine,[11–15] allowed workers to submit declination statements,[16–18] and implemented combination programs that use several complementary approaches to increase uptake.[10,19,20]

Despite attempts to encourage voluntary vaccination, coverage rates between 2004 and 2008 were approximately 40%,[21–29] while rates during the 2009–2011 influenza seasons increased to approximately 64%.[30] However, overall take-up rates among this population remain below the 90% goal.

HCWs have several reasons for refusing the vaccine. Among the most frequently cited are fear of adverse effects, the belief that the vaccine can cause influenza, and the belief that the risk for contracting the disease is low. Some HCWs believe that the vaccine will not prevent influenza, while others continue to express a fear of needles.[31,32] Because coverage rates remain low and vaccine myths persist, additional measures are required to ensure that HCWs are vaccinated, patients are protected, and national coverage goals are achieved.

MANDATORY INFLUENZA VACCINATION POLICIES IN HEALTH-CARE FACILITIES

In September 2004, Virginia Mason Hospital in Seattle, Washington, became the first facility to implement a mandatory seasonal influenza vaccination policy for its workforce. Today, approximately 300 facilities throughout the country have implemented similar measures (Personal communication, Dr. Mark Grabowsky, Deputy Director, National Vaccine Program Office, August 2011).[33] Mandatory programs have proven successful, and facilities have realized a record uptake among HCWs, with several health systems reaching up to 99.3% coverage.[34–38]

However, policies developed at the facility level are necessarily limited in scope. With approximately 600,000 health-care-related employers in the U.S., the use of mandatory policies in 300 facilities is insufficient. It is more efficient to implement mandatory programs at the state level.[39]

STATE LAW AND INFLUENZA VACCINATION OF HCWs

Similar to childcare and school entry vaccination requirements, state laws convert influenza vaccination recommendations for HCWs into legal obligations. As of June 2011, 19 states (Alabama, Arkansas, California, Illinois, Kentucky, Maine, Maryland, Massachusetts, New Hampshire, New York, North Carolina, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, and Virginia) and the District of Columbia have enacted laws that require health-care employers to develop and implement influenza vaccination programs for identified categories of HCWs.

A comprehensive law incorporates six essential components of a mandatory HCW influenza vaccination program, including (*1*) a broad definition of the affected HCW, (*2*) a broad definition of the affected employer, (*3*) identification of employer obligations, (*4*) identification of HCW obligations, (*5*) an identified exemption policy, and (*6*) an identified standard of care.

Defining the affected HCW

People who have either direct or indirect exposure to patients can transmit the influenza virus. Consequently, a comprehensive law should incorporate a broad definition of HCWs. Those required to receive the vaccine should include paid or unpaid employees, staff, contractors, clinicians, volunteers, students, trainees, clergy, home health-care providers, dietary and housekeeping staff, and others whose occupational activities involve direct or indirect contact with patients or contaminated material in health-care, home health-care, or clinical laboratory settings.

However, not all 20 jurisdictions have adopted a broad definition of HCWs. For example, if a state references only "employees," other individuals who have direct or indirect contact with patients will not be required to comply with the mandate. This limitation may affect the total number of HCWs who will have ensured access to the vaccine.

Defining the affected employer

A comprehensive mandatory vaccination law should include a broad range of settings in which mandatory programs must be established. These settings may include acute care hospitals, nursing homes, skilled nursing facilities, physician's offices, urgent care centers, outpatient clinics, home health care, emergency medical services, schools, rehabilitation centers, chronic care facilities, long-term care facilities, assisted-living facilities, specialty care assisted-living facilities, comprehensive care facilities, extended care facilities, and adult day care facilities.

While state laws define the health-care employers governed by the law, several states do not incorporate all categories of employers that manage HCWs. If a law fails to define employers broadly, opportunities to vaccinate HCWs affiliated with excluded organizations will be limited.

Defining employer obligations

A comprehensive mandatory vaccination law should outline employer activities that have proven to be effective at increasing vaccine uptake among HCWs. Laws should require employers to provide the vaccine, specify the appropriate timing of the vaccination, educate HCWs about the program and the vaccine, ensure that HCWs are not required to pay for the vaccination, document the immunization status of HCWs, report vaccination rates to appropriate public health authorities, and manage HCW noncompliance.

Operating a program with well-defined employer duties will ensure that workers will not miss an opportunity to be vaccinated due to misinformation about the vaccine, inconvenient administration locations and times, or an inability to pay for the service. Proper recordkeeping will also ensure that the employer is aware of all workers who have not complied with the requirement so that proper action may be taken to reduce disease transmission.

Those states that require employers to provide free vaccination to HCWs rarely address how an employer should manage the cost of vaccine purchase, administration, and recordkeeping requirements. Employers may find it difficult or impossible to implement a mandatory vaccination program without receiving financial support from public or private sources.

In general, states do not explicitly authorize employers to apply progressive discipline to HCWs who do not comply with the vaccination requirement. Without clearly defined sanctions, the effectiveness of the vaccination requirements is undermined, and employers may be unable to adequately enforce the policy.

Defining an exemption policy

Establishing an exemption policy is one of the most frequently debated components of a mandatory HCW influenza vaccination program. Most states permit HCWs to decline the vaccination for one or more of five reasons: (*1*) medical contraindication, (*2*) religious belief, (*3*) philosophical belief, (*4*) declination statement, or (*5*) inadequate vaccine supply.

States that permit HCWs to easily exercise nonmedical exemptions may inadvertently incentivize

using exemptions over the seemingly more complicated process of obtaining an influenza vaccine. Therefore, legislators should permit exemptions only for HCWs who present a licensed health-care provider's written statement indicating the HCW has a condition contraindicated for immunization.

However, despite concerns regarding easily accessible opt-outs, most states permit HCWs to refuse the vaccination by signing a declination statement that indicates the receipt or refusal of the vaccination after receiving education, by showing the existence of a medical contraindication, by declaring that the vaccination conflicts with a religious belief, or when public health officials determine that a shortage of vaccine requires program suspension.

Defining HCW obligations

A comprehensive, mandatory vaccination law should explicitly outline expected duties so that all affected HCWs will understand how to comply with the law. The law should require HCWs to obtain an influenza vaccination either at work or from a provider of their choice, and present documentation to the employer that will certify either the receipt of vaccination or an approved exemption.

Most states require HCWs to present their employer with a Certificate of Immunization from the provider who administered the vaccine. However, states rarely expressly permit HCWs to receive the vaccination from a provider of his or her choice. The lack of clarity regarding provider choice may discourage HCWs from seeking the influenza vaccine.

Adopting an appropriate standard of care

The Healthcare Infection Control Practices Advisory Committee (HICPAC) and the Advisory Committee on Immunization Practices (ACIP) are federal advisory committees that issue immunization recommendations. The HICPAC and ACIP jointly recommend that all HCWs should be vaccinated annually against influenza. They also encourage all health-care facilities to provide the vaccine to HCWs using evidence-based approaches.[40] The recommendations are recognized as the principal nationwide practice standard.[41,42] Therefore, states should consider adopting the ACIP standard when developing a comprehensive mandatory vaccination law.

Most state laws that identify standards for influenza immunization have adopted the ACIP standard. Other states reference the recommendations of the federal Occupational Safety and Health Administration or state commissioners of health.

IMPLICATIONS FOR PUBLIC HEALTH POLICY AND PRACTICE

The current policy environment suggests that states are prepared to expand immunization requirements for HCWs. The existing legal framework, grounded in ethical and professional principles, supports compulsory vaccination when it serves the public's health. As demonstrated in school and childcare entry requirements and mandates of other vaccines for HCWs, state laws, if fully implemented, will prove effective in increasing uptake of influenza vaccine among HCWs.

Twenty jurisdictions have already addressed the need to increase HCW vaccination through the enactment of mandatory policies. While the laws differ in how they incorporate the six elements of a comprehensive mandatory HCW influenza policy, they represent policy makers' best efforts to reduce hospital-acquired infections.

While revising or drafting state laws, policy makers might consider initiatives that (*1*) require every health-care employer operating in the state to participate in mandatory immunization, (*2*) identify strategies to help health-care employers purchase and distribute influenza vaccine to HCWs, (*3*) draft exemption policies that permit HCWs to opt out only for a medical contraindication, and (*4*) draft clear policies and procedures to address appropriate sanctions for noncompliant HCWs.

Alexandra Stewart is an Assistant Professor at the George Washington University Medical Center School of Public Health and Health Services in Washington, D.C.

Address correspondence to: Alexandra M. Stewart, JD, George Washington University, Department of Health Policy, 2021 K St. NW, Ste. 800, Washington, DC 20006; tel. 202-994-4141; e-mail <stewarta@gwu.edu>.

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