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# Healthcare Worker Immunization



**Why You Need to be Vaccinated**

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Children's Hospital Colorado

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## Objectives

- Describe in detail what immunizations are recommended for Healthcare workers and why.
- Discuss ways one can use immunizations in outbreak settings.
- Discuss a process to develop a mandatory influenza vaccination program and strategies for mass vaccination clinics.
- Discuss how Colorado was able to make influenza vaccination mandatory for all healthcare workers.

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## Definition of Healthcare Worker

- All paid and unpaid person working in health-care settings who have the potential for exposure to patients and/or infectious materials including:
  - Body substances
  - Contaminated medical supplies and equipment environmental surfaces, or contaminated air.
- Might include (but not limited to):
  - Physicians,
  - nurses
  - nursing assistants, therapists
  - technicians
  - emergency medical service personnel
  - dental personnel,
  - pharmacists, laboratory personnel,
  - autopsy personnel,
  - students and trainees,



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## + Definition of Healthcare Worker

■ Personnel not directly involved in patient care but potentially exposed to infectious agent that can be transmitted to and from health-care personnel and patients

- Clerical
- Dietary
- Housekeeping
- Laundry
- Security
- Maintenance
- Administrative
- Billing
- Volunteers




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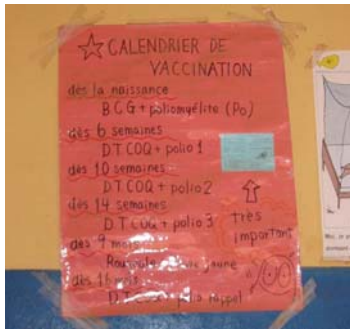
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## + A Simple Immunization Schedule




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## + ACIP Adult Immunization Schedule

VACCINE ▼	AGE GROUP ▶	19-21 years	22-26 years	27-49 years	50-59 years	60-64 years	≥65 years
Influenza <sup>a</sup> *		1 dose annually					
Tetanus, diphtheria, pertussis (Td/Tdap) <sup>b</sup>		Substituting 1 dose of Tdap for Td booster; then boost with Td every 10 years					
Varicella <sup>a</sup> *		2 doses					
Human papillomavirus (HPV) <sup>c</sup> Female		3 doses					
Human papillomavirus (HPV) <sup>c</sup> Male		3 doses					
Zoster <sup>d</sup> **		1 dose					
Mumps, measles, rubella (MMR) <sup>e</sup> †*		1 or 2 doses		1 or 2 doses		1 or 2 doses	
Pneumococcal polysaccharide <sup>f</sup> †*				1 or 2 doses		1 dose	
Meningococcal <sup>g</sup> **		1 or more doses					
Hepatitis A <sup>h</sup> †*		2 doses					
Hepatitis B <sup>i</sup> †*		3 doses					

\*Covered by the Vaccine Injury Compensation Program

■ For all persons in this category who meet the age requirements and who lack documentation of vaccination or have no evidence of previous infection

■ Recommended if some other risk factor is present (e.g., on the basis of medical, occupational, lifestyle, or other indications)

■ †Age recommended for adults if contact with <12 month old child. Either Td or Tdap can be used if no infant contact

□ No recommendation

Centers for Disease Control and Prevention. Recommended adult immunization schedule—United States, 2012. MMWR 2012;61(4).

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## + Immunizations for HCWs



- Hepatitis B
- Measles, Mumps, Rubella (MMR)
- Tetanus and diphtheria (toxoids) and acellular pertussis (Tdap)
- Varicella vaccine
- Quadrivalent meningococcal conjugate vaccine
- Influenza Vaccination

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## + Serologic Testing

- Pre-vaccination antibody screening before immunization for an employee who does not have adequate presumptive evidence of immunity is not necessary unless the medical facility considers it cost effective.
- If have evidence of adequate immunization → no serologic testing needed.
- Incomplete or missing documentation → serologic testing

Centers for Disease Control and Prevention. Immunization of Health-Care Personnel—United States, 2011. MMWR 2011;60(7).

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## + Hepatitis B

- Why Hepatitis B?
  - First recommended for HCWs in 1982 estimated 10,000 infections occurred among persons employed in a medical or dental field
  - 2004- 304 infections
- Risk of Hepatitis B
  - Dependant on the frequency of percutaneous and mucosal exposures to blood or body fluids containing Hepatitis B virus (HBV).
  - New trainees

Centers for Disease Control and Prevention. Immunization of Health-Care Personnel—United States, 2011. MMWR 2011;60(7).

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## + Hepatitis B- Risk in HCWs

- High**
  - Blood
  - Serum
  - Wound Exudates
- Medium**
  - Semen
  - Vaginal fluid
  - Saliva
- Low**
  - Urine
  - Feces
  - Sweat
  - Tears
  - Breastmilk

- HBV risk varies depending on e-antigen (HBeAg- a marker for high HBV replication and viral load)
  - If e- antigen (+) risk up to 30%
  - If e- antigen (-) risk 1-6%
- Compared to other bloodborne pathogens
  - HCV risk is 1.8% (range 0-7%)
  - HIV risk is 0.3% (range 0.2-5%)

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## + Hepatitis B and OSHA

- In 1991 CFR 1910.1030 issued mandating hepatitis B vaccine be made available at the employer's expense to all healthcare workers who are exposed occupationally to blood or other potentially infectious materials
- Post exposure prophylaxis defers to ACIP recommendations
- Mandated language for Hepatitis B vaccination

• Part Number:	1910
• Part Title:	Occupational Safety and Health Standards
• Subpart:	Z
• Subpart Title:	Toxic and Hazardous Substances
• Standard Number:	1910.1030 App A
• Title:	Hepatitis B Vaccine Declaration (Mandatory)

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself. However, I decline hepatitis B vaccination at this time. I understand that by declining the vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

[36 FR 6404, Dec. 06, 1971, as amended at 37 FR 12717, April 13, 1972; 37 FR 26226, July 1, 1972; 61 FR 5307, Feb. 13, 1996]

[http://www.osha.gov/pls/oshaweb/owadisp.show\\_document?p\\_table=STANDARDS&p\\_id=10062](http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=10062)

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## + Hepatitis B Primary Schedule

- 2 doses 4 weeks apart; 3<sup>rd</sup> dose 5 months after second.
- Vaccine schedule does not have to be restarted if the second or third dose is delayed.
- If serologic testing is done to determine response to vaccination- should be done 1-2 months after vaccination.
- Contraindications:
  - Previous anaphylactic reaction to common baker's yeast.
  - Hypersensitivity to vaccine component or previous reaction.
  - Pregnancy is not a contraindication.

Centers for Disease Control and Prevention. Immunization of Health-Care Personnel—United States, 2011. MMWR 2011;60(7).

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# + Hepatitis B –serology reminders

How do I interpret some of the common hepatitis B panel results?

Table 2

Tests	Results	Interpretation	Vaccinate?
HBsAg anti-HBc anti-HBs	negative	susceptible	vaccinate if indicated
	negative		
	negative		
HBsAg anti-HBc anti-HBs	negative	immune due to vaccination	no vaccination necessary
	positive with $\geq 10$ IU/mL*		
HBsAg anti-HBc anti-HBs	negative	immune due to natural infection	no vaccination necessary
	positive		
HBsAg anti-HBc IgM anti-HBc anti-HBs	positive	acutely infected	no vaccination necessary
	positive		
	negative		
HBsAg anti-HBc IgM anti-HBc anti-HBs	positive	chronically infected	no vaccination necessary (may need treatment)
	positive		
	negative		
HBsAg anti-HBc anti-HBs	negative	four interpretations possible†	use clinical judgment
	negative		

\* Postvaccination testing, when it is recommended, should be performed 1-2 months after the last dose of vaccine. Infants born to HBsAg-positive mothers should be tested for HBsAg and anti-HBc after completion of at least 3 doses of a standard hepatitis B vaccination series, at age 9-18 months (generally at the next well child visit).

† May be retesting from acute HBV infection

1. May be distant immune, but the test may not be sensitive enough to detect a very low level of anti-HBs in serum
2. May be distant immune, but the test may not be sensitive enough to detect a very low level of anti-HBs in serum
3. May be susceptible with a false positive anti-HBs
4. May be chronically infected and have an undetectable level of HBsAg present in the serum

Source: [immunize.org/askexperts/experts\\_hepb.asp](http://immunize.org/askexperts/experts_hepb.asp)

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# + To Immunize or Not? - Post Exposure

Table 3: Recommendations for postexposure prophylaxis after percutaneous or mucosal exposure to HBV in an occupational setting

Vaccination and antibody response status of exposed person <sup>1</sup>	Treatment		
	Source is HBsAg positive	Source is HBsAg negative	Source is unknown or not tested
Unvaccinated	HBIG <sup>2</sup> (1 dose) and begin a hepatitis B vaccine series	Begin a hepatitis B vaccine series	Begin a hepatitis B vaccine series
Known responder <sup>3</sup>	No treatment	No treatment	No treatment
Nonresponder <sup>3</sup>			
Not retested <sup>4</sup>	HBIG (1 dose) and begin a vaccine series	Begin a vaccine series	HBIG (1 dose) and begin a vaccine series
After retest <sup>4</sup>	HBIG (2 doses) <sup>5</sup>	No treatment	HBIG (2 doses) <sup>5</sup>
Antibody response unknown	Test for anti-HBc <sup>6</sup> If negative, no treatment If negative, HBIG (1) and vaccine boosters <sup>7</sup>	No treatment	Test for anti-HBc <sup>6</sup> If negative, no treatment If negative, give vaccine boosters and check anti-HBc in 3-6 months

1. Person was a bare hand HBV infection or was given a cut or abrasion which was exposed to HBV or vaccine.

2. Hepatitis B immune globulin (1.0 mL at 0, 7, and 21 days post-exposure).

3. Defined as a person who had a documented positive anti-HBs test after vaccination.

4. For treatment - additional 1 dose series of hepatitis B vaccine administered after the primary series.

5. That dose series is given after exposure and before retest results.

6. Using qualitative test as in a specific lab report.

7. For anti-HBc test.

Source: This table was adapted from "Guidelines for the Management of Occupational Exposures to HBV, HCV, and HIV and Recommendations for Postexposure Prophylaxis," MMWR, vol 60, No. 10, pp 231-237

[http://www.immunize.org/askexperts/experts\\_hepb.asp](http://www.immunize.org/askexperts/experts_hepb.asp)

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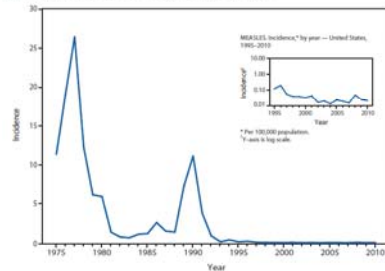
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# + Measles

MEASLES. Incidence,\* by year — United States, 1975–2010



\* Per 100,000 population.  
Measles vaccine was licensed in 1963. Evidence suggests that measles is no longer endemic in the United States.

Centers for Disease Control and Prevention. Summary of Notifiable Diseases—United States, 2011. MMWR 2010;59(S3).

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## + Measles and the Healthcare Setting

- During 2001-2008 a total of 12.5% (one of eight) of measles cases reported to CDC among HCWs occurred in persons born BEFORE 1957; the other seven cases occurred among HCWs born AFTER 1957.
- Medical settings were a primary site of measles transmission during the 1989-91 measles resurgence.
  - Only 3 states have laws mandating that all hospital personnel have proof of measles immunity and did not allow for religious or philosophic exemptions
    - New York
    - Oklahoma
    - Rhode Island

Centers for Disease Control and Prevention. Immunization of Health-Care Personnel—United States, 2011. MMWR 2011;60(7).

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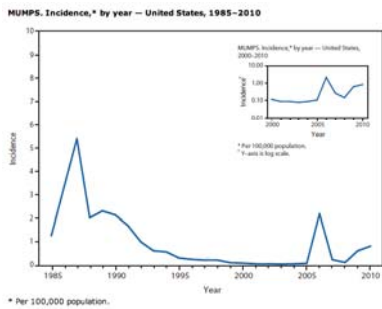
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## + Mumps



Centers for Disease Control and Prevention. Summary of Notifiable Diseases—United States, 2011. MMWR 2010;59(53).

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## + Mumps and the Healthcare Setting

- Tennessee mumps outbreak 1986-87: transmission to 6 HCWs
- Utah 1994, 2 HCWs developed mumps after contact with infected patient.
- 2006 multistate US outbreak: 144 (8.5%) of 1,705 adult case-patients in Iowa for whom occupation was known were health-care providers.
- 2009-10 outbreak: seven of 3,400 case patients were health-care providers (6 of whom likely were infected by patients – no know other exposure).

Centers for Disease Control and Prevention. Immunization of Health-Care Personnel—United States, 2011. MMWR 2011;60(7).

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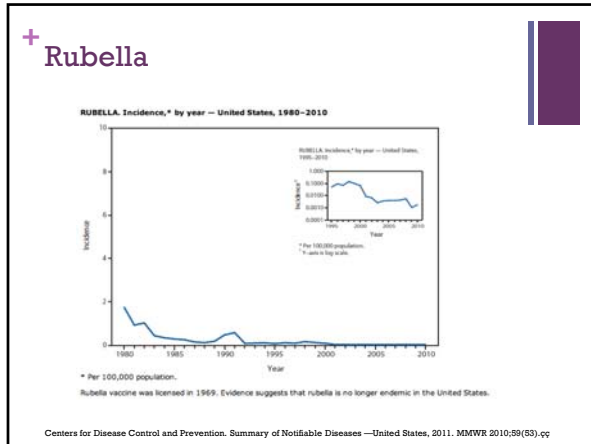
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### + Rubella and the Healthcare Setting

- Rubella was declared eliminated from the United States in 2004.
- No documented transmission of rubella to HCW or other hospital staff or patients in US healthcare facilities has occurred since elimination was declared.

Centers for Disease Control and Prevention. Immunization of Health-Care Personnel—United States, 2011. MMWR 2011;60(7).

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### + MMR Vaccination in HCWs

- Vaccination should be recommended for all HCW who lack presumptive evidence of immunity
  - Documentation of 2 doses of MMR vaccine administered  $\geq 28$  days apart
  - Laboratory evidence of measles, mumps, rubella immunity
  - Laboratory confirmation of measles disease
  - Birth before 1957
- Birth before 1957  $\rightarrow$  consider vaccinating personnel with 2 doses of MMR vaccine at the appropriate interval.

Centers for Disease Control and Prevention. Immunization of Health-Care Personnel—United States, 2011. MMWR 2011;60(7).

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### + Serologic testing for Measles, Mumps, and Rubella

- HCW who do not have adequate presumptive evidence of immunity → antibody screening not necessary unless cost effective.
- If have 2 documented MMR- no serology needed.
- If have 2 documented MMR and is serologically tested- measles and mumps results are negative or equivocal = not recommended to give additional dose of MMR.
- Documented age-appropriate vaccination supersedes the results of subsequent serologic testing.
- If HCW has 1 documented dose of rubella containing vaccine and determined to have negative or equivocal rubella titer results – receipt of an additional dose of MMR for prevention of rubella is not recommended.

Centers for Disease Control and Prevention. Immunization of Health-Care Personnel—United States, 2011. MMWR 2011;60(7).

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### + Controlling Measles and Mumps in Health-Care Setting

- Engineering controls:
  - Isolation of patient:
    - Measles (airborne precautions)
    - Mumps (droplet precautions)
    - Rubella (droplet precautions)
- Measles outbreak- elimination of HCWs
  - All contacts evaluated for presumptive evidence of measles immunity
  - HCW without immunity should be offered first dose of MMR vaccine and excluded from work from day 5-21 following exposure.
  - HCW without immunity and not vaccinated after exposure should be excluded from the facility from day 5 after 1<sup>st</sup> exposure through 21 days after the last exposure.
  - Those with 1 dose of vaccine may remain at work and receive second dose.

Centers for Disease Control and Prevention. Immunization of Health-Care Personnel—United States, 2011. MMWR 2011;60(7).

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### + Controlling Measles and Mumps in Health-Care Setting (continued)

- Mumps outbreak- elimination of HCWs
  - All contacts should be evaluated for evidence of mumps immunity
  - HCW with no evidence of mumps immunity and exposed should be offered 1<sup>st</sup> dose of MMR.
  - Excluded from duty from day 12 after the first unprotected exposure through day 25 after the most recent exposure.
  - HCW with 1 dose of MMR vaccine may remain at work and should remain at work and receive 2<sup>nd</sup> dose.
  - HCW with mumps should be excluded from work for 5 days from the onset of parotitis.

Centers for Disease Control and Prevention. Immunization of Health-Care Personnel—United States, 2011. MMWR 2011;60(7).

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## + Controlling Measles and Mumps in Health-Care Setting (continued)

- Rubella Outbreak- Elimination of HCWs
  - If not immune- excluded from duty beginning 7 days after exposure to rubella and continuing through either:
    - 23 days after the most recent exposure
    - 7 days after rash appears if the provider develops rubella.
  - Exposed HCW who do not have adequate presumptive evidence of immunity who are vaccinated post exposure should be excluded from duty fro 23 days after the most recent exposure.
  - No evidence exists that postexposure vaccination is effective in preventing rubella infection.

Centers for Disease Control and Prevention. Immunization of Health-Care Personnel—United States, 2011. MMWR 2011;60(7).

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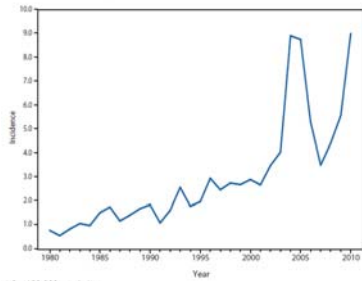
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## + Pertussis

PERTUSSIS. Incidence,\* by year — United States, 1980–2010



\* Per 100,000 population.  
Centers for Disease Control and Prevention. Summary of Notifiable Diseases—United States, 2011. MMWR 2010;58(S3):pp

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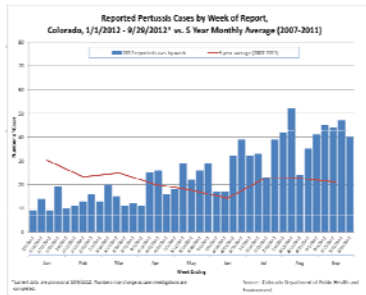
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## + Pertussis in Colorado



Reported data are preliminary. \* Per 100,000 population. Source: Colorado Department of Public Health and Environment.

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## + Pertussis and HCWs



### Hospital-Acquired Pertussis Among Newborns --- Texas, 2004

On July 15, 2004, staff members at a children's hospital in Texas noted that six infants with pertussis diagnosed by clinical symptoms and confirmed by polymerase chain reaction testing had all been born during June 4–16 at the same area general hospital. The infants had symptoms consistent with pertussis, including cough, congestion, cyanosis, stridor, and/or inspiratory crackles associated with hyperinflated lungs.

- Transmission has occurred from hospital visitors to patients
- HCWs to patients
- Patients to HCWs
- Texas 2004: HCW was at work with symptoms of pertussis and was tested positive. Cared for 113 infants 11 of which later developed pertussis.

Centers for Disease Control and Prevention. Hospital-Acquired Pertussis Among Newborns. MMWR 2008;57(22)

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## + Pertussis Vaccination Recommendations

- Regardless of age, HCW should receive a single dose of Tdap as soon as feasible if have not already received Tdap.
- Tdap is not licensed for multiple administrations → after Tdap continue with Td.
- ACIP in 2011 - if don't know when last Td, vaccinate regardless when last Td was given
- Immunity cannot be demonstrated through serologic testing.

Centers for Disease Control and Prevention. Immunization of Health-Care Personnel—United States, 2011. MMWR 2011;60(7).

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## + Pertussis in Outbreak Settings

- Engineering Controls
  - Isolate patient (droplet)
- HCWs with symptoms or positive for pertussis should be excluded from work until 5 days after the start of appropriate therapy.
- Postexposure antimicrobial prophylaxis is recommended for all HCWs who have unprotected exposure to pertussis regardless of vaccination status.

Centers for Disease Control and Prevention. Immunization of Health-Care Personnel—United States, 2011. MMWR 2011;60(7).

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## + Varicella and HCWs

- With the increase in childhood varicella immunization, HCW exposure is declining.
- Studies of VZV exposure in health-care setting have documented that a single provider with unrecognized varicella can result in the exposure of >30 patients and >30 employees.

Haiduvven-Griffiths D, Peckro H. Varicella in hospital personnel: a challenge for the infection control practitioner. Am J Infect Control 1987; 15:207-11

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## + Varicella Vaccination Recommendations

- Written documentation of vaccination with 2 doses of varicella vaccine.
- Laboratory evidence of immunity or laboratory confirmation of disease.
- Diagnosis or verification of a history of varicella disease by a health-care provider
- Diagnosis or verification of a history of HZ by a healthcare provider.

Centers for Disease Control and Prevention. Immunization of Health-Care Personnel—United States, 2011. MMWR 2011;60(7).

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## + How do you verify history?



- Verification of history or diagnosis of typical disease can be provided by:
  - Any health-care provider (e.g. school or occupational clinic nurse, NP, PA, or physician).
- When History is reported you should seek:
  - Epidemiologic link to a typical varicella case or to a laboratory-confirmed case
  - Evidence of laboratory confirmation if it was performed at the time of acute disease.
- If documentation is lacking not a valid history

Centers for Disease Control and Prevention. Immunization of Health-Care Personnel—United States, 2011. MMWR 2011;60(7).

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## + Varicella in Outbreak Settings

- Engineering controls:
  - Isolate patient (airborne)
- Postexposure Management
  - All exposed susceptible HCWs should be identified using the criteria for immunity.
  - If have received 2 doses of vaccine, monitor for s/sx for 8-12 days.
  - If have received 1 dose of vaccine, should receive 2<sup>nd</sup> dose within 3-5 days after exposure to rask.
  - Unvaccinated HCWs who have no other evidence of immunity are potentially infective from days 8-21 after exposure and should be excluded from work. Should receive post exposure vaccination as soon as possible.

Centers for Disease Control and Prevention. Immunization of Health-Care Personnel—United States, 2011. MMWR 2011;60(7).

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## + A Shout out for Meningococcal Disease



- Hospital transmission is rare but HCWs have become infected after direct contact with respiratory secretions of infected persons and in laboratory settings.
- Main Rule of Thumb- use precautions.
- MCV4 is not recommended routinely for all HCWs → should be given to laboratory workers that handle specimens (*N. meningitides*).
  - Should receive a single dose of MCV4
  - Booster dose every 5 years if they remain at increased risk.

Centers for Disease Control and Prevention. Immunization of Health-Care Personnel—United States, 2011. MMWR 2011;60(7).

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## + Influenza Vaccination



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## + Influenza Vaccination: Everybody is doing it

- January 2007: Joint Commission on Accreditation of Health-Care Organizations (JACHO)- required accredited organizations to offer influenza vaccinations to staff and report levels.
- ACIP in 2010: Recommended Universal Coverage
- 2010- present several medical organizations have submitted support for influenza vaccination and HCWs.
  - [www.immunize.org/honor-roll](http://www.immunize.org/honor-roll)
- January 2013, CMS will require acute care hospitals to report HCW influenza immunization rates.

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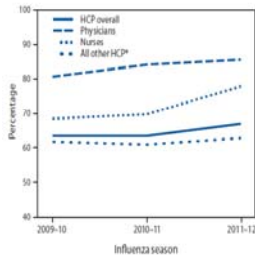
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## + Influenza Immunization and HCWs

FIGURE 1. Percentage of health-care personnel (HCP) who received influenza vaccination, by occupation – Internet panel surveys, United States, 2009–10, 2010–11, and 2011–12 influenza seasons



CDC. Influenza vaccination coverage among health-care personnel—United States, 2010–11 influenza season. MMWR 2011;60:1073–7.

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## + HCW Influenza Vaccination by the Numbers

- 85.6% of physicians
- 77.9% nurses
- 62.8% other HCW
- In hospital setting 76.9% vaccinated
- In physician's office 67.7% vaccinated
- In long term care facility 52.4% vaccinated
- If in hospital where vaccination required 95.2% vaccinated
- If in hospital where not required 68.2% vaccinated

CDC. Influenza vaccination coverage among health-care personnel—United States, 2010–11 influenza season. MMWR 2011;60:1073–7.

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**+ Mandatory Influenza Vaccination Programs**

**Influenza Vaccination Rates**

Year	Vaccination Rate (%)
2002	38.0%
2003	50.0%
2004	29.0%
2005	87.0%
2006	86.0%
2007	89.7%
2008	89.0%
2009	89.0%

Rakita RM et al Infect Control Hosp Epidemiol

Slide from Dr. Chris Nevin-Woods; Pueblo PH Director and member of NVAC

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**+ Influenza Vaccination Recommendations**

- Annual vaccination of all HCWs with either TIV or LAIV.
- Use of LAIV for HCWs who work with patients in a protective environment= theoretical concern
  - Transmission of LAIV in health-care settings have not been reported.

Centers for Disease Control and Prevention. Immunization of Health-Care Personnel—United States, 2011. MMWR 2011;60(7).

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**+ Influenza in Outbreak Settings**

- Engineering Controls
  - Isolate patients (droplet)
  - Limit visitors during respiratory season
- Use of antiviral drugs for chemoprophylaxis or treatment of influenza is not a substitute for vaccination.
- TIV can be administered to exposed, unvaccinated HCWs at the same time as chemoprophylaxis but LAIV should be avoided.

Centers for Disease Control and Prevention. Immunization of Health-Care Personnel—United States, 2011. MMWR 2011;60(7).

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### + Mandatory Influenza Vaccination: Experience of Children's Hospital Colorado

- Largest Pediatric Hospital in Colorado
- Affiliated with University of Colorado Hospital
- Approximately 4,500 staff
- 10,000 employees and non-employees
- First year of mandatory vaccination program immunization rate of 99.7% among employees
- Offer Medical and Religious Declinations



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### + Many Hands- Must Haves

- Backing and support from administration/ HR
  - Use evidence based practice to support immunization activity
- Policy must be detailed on who, what, when, and where
  - Consequences for non-vaccination
  - Who is included- definition of HCW
  - How will vaccinations be given
  - Deadlines for immunization
- Make vaccination process EASY
  - Influenza Captains
  - PR campaigns
  - Mass vaccination clinics- can use this with bioterrorism planning

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### + Meeting Documentation Challenges

- Have a system of tracking who has been vaccinated and who hasn't.
- Intranet documentation database
  - Online VIS statements, consent forms
  - Online compliance reports available to all managers
  - Influenza captains have access to enter information
- Vaccinated elsewhere
  - Need to get other hospitals on board with similar vaccination programs.

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**+ Colorado Board of Health Rule** 46

- Approved February 15, 2012
- Developed with extensive stakeholder input
- Applies to all facilities licensed by CDPHE
  - Hospitals, Long Term Care Facilities, Ambulatory Surgical Centers
  - Other facilities: Assisted Living, Home Health, Dialysis
- Does NOT apply to healthcare entities that are NOT licensed by CDPHE such as outpatient physician clinics, doctor's offices, dental offices, and chiropractor's offices

Slide from Dr. Rachel Herlihy, Immunization Program Director, CDPHE

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**+ Rule Intent**

- To promote patient safety by protecting vulnerable patients from influenza
- To encourage healthcare entities that are already appropriately implementing strategies to prevent influenza to continue to do so
- To assist those entities that can improve
- To prompt entities to adopt more effective policies to prevent influenza.

Slide from Dr. Rachel Herlihy, Immunization Program Director, CDPHE

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**+ Requirement of the Rule**

- Reporting
  - All healthcare entities licensed by CDPHE must keep track of the number of its employees that are vaccinated against seasonal influenza and
  - Annually report that number to CDPHE
  - There is no exemption from the annual reporting requirement of the rule
- Policy implementation
  - There are different policy requirements for different types of healthcare entities
  - The rule allows for an exemption from the policy requirements if certain vaccination targets are met

Slide from Dr. Rachel Herlihy, Immunization Program Director, CDPHE

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## + Phased –in Approach

- Vaccination Targets
  - 60 percent of all employees vaccinated by December 31, 2012.
  - 75 percent of all employees vaccinated by December 31, 2013
  - 90 percent of all employees vaccinated by December 31, 2014 and every year thereafter
- If target is met, facility is exempt from policy implementation requirement for the next year

Slide from Dr. Rachel Herlihy, Immunization Program Director, CDPHE

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- Presentation : Influenza Vaccination of Healthcare workersHCP/IVS-NVAC 2012 given by Dr. Chris Nevin-Woods, and Dr. Rachel Herlihy

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