Dear Dr. Jeff:

Our state has recently begun mandatory data collection regarding the rate of employee vaccination against influenza virus. Of course, we already submit data to CMS regarding vaccination of our residents. We have struggled to get adequate rates for fiscal seniors, but remarkably few of our staff are willing to consent to the injection, often citing previous bad experiences or fear of needles or weird conspiracy theories from the internet. So far, there are no penalties except public shaming for low rates, but many in the nursing home industry expect penalties to follow. Do you have any suggestions as to how we could improve our statistics?

Dr. Jeff responds:

Few issues in long-term care seem as straightforward yet wind up as troublesome as influenza vaccination. There is no difference of opinion among experts in geriatrics or experts in infectious diseases: annual vaccination against influenza virus is indicated for all nursing home residents and employees. Either by virtue of age, or chronic disease, or institutional setting, essentially every nursing home resident meets the criteria for vaccination; all our staff are appropriate for vaccination due to their role as health care providers or close contacts of those who are at high risk.

The influenza vaccine is endorsed by the Centers for Disease Control and Prevention (CDC) and the Association of Professionals in Infection Control (APIC) and is reimbursable through virtually all insurance plans. Most facilities will provide the vaccine without charge to employees who are not covered for it and often provide it for volunteers who spend significant amounts of time with residents. Because the cost of the vaccine is minimal and the medical savings produced are large, managed care companies routinely encourage using the influenza vaccine for institutionalized residents, and they often work with local health departments or generate their own programs to encourage their members in the community to receive the vaccine before the start of flu season.

The primary barrier to near-universal vaccination against influenza is its essentially voluntary nature. The decision to accept or refuse vaccination is considered to be an individual medical decision made through the traditional informed consent process, regardless of whether the process actually involves signing consent forms. The presumption is that each potential vaccine recipient assesses the risks and benefits of receiving the vaccine and makes an autonomous decision. For residents who lack the capacity to make medical decisions, this decision is made by the health care proxy or some legally authorized surrogate decision maker.

Employees are assumed to have decisional capacity and thus can make individual decisions, regardless of any encouragement that might be provided by public health officials or the facility itself. Because the unvaccinated state is not a cause of immediate discomfort, many choose to defer vaccination to avoid short-term discomfort and decide to “take their chances.” Thus, when influenza actually becomes an epidemic, communities have experienced a deluge of desperate applicants for the vaccine — which unfortunately requires several weeks to become effective — or for expensive antiviral medications that can provide temporary protection. Others simply assume that, as essentially healthy young individuals, an episode of influenza will simply represent a brief period of discomfort.

During the 2017–2018 flu season, 47.6% of health care workers where no employer mandates existed reported that they had received the vaccine. Rates were significantly lower for those working primarily in long-term care. This might be seen as comparable to management of hypertension when those with elevated blood pressure may be bombarded on all sides to take medication for pressure control but still retain the right to ignore all this good advice. The CDC estimates that only 54% of the 75 million Americans with hypertension have achieved satisfactory control. Except for the effects on their loved ones and on overall medical expenditures, a medical decision made by a neighbor or coworker regarding hypertension control has little impact on others. However, the effectiveness of vaccination campaigns is measured not only by their impact on the individual immunity levels achieved by the vaccinated but also by the overall immune status of the community. The creation of general immune status, so-called herd immunity, protects the nonimmunized and those with marginal immune status from exposures or local epidemics. Herd immunity is typically achieved when 90% to 95% of the relevant population have been vaccinated.

Individual cases may still occur, as when a visitor with transmissible influenza virus visits and infects a resident who has not been vaccinated or has achieved incomplete protection, but, if routine infection control measures are followed, a unit-wide or facility-wide outbreak will not occur. “Personal choice” decisions become public health concerns.

Employee decisions regarding vaccination are rarely reasoned evaluations of risks and benefits. An organized and vicious campaign of science-denial and fear mongering has invaded the Internet. Multiple websites containing misinformation and skewed data are readily available on the web. Given the known triumphs of vaccination in the elimination of smallpox and polio, these vaccine-deniers often disguise themselves as supporters of “safe” vaccines while raising false concerns regarding current

Vaccines Should Not Be a Sticking Point

Dear Dr. Jeff:

Whether the process actually involves signing consent forms, the presumption is that each potential vaccine recipient assesses the risks and benefits of receiving the vaccine and makes an autonomous decision. For residents who The current president of the United States has expressed doubts regarding vaccine safety. Amazingly, these crazy rumors mixed with a small quantity of false science gained such potency that the British Veterinary Society had to issue a statement to fight off anti-rabies-vaccine campaigners by reminding British pet owners that dogs don’t get autism. Most of the fears raised on these sites relate to the supposed risk of vaccination of innocent babies with these toxic biologic preparations, including the unproven risk that thimerosal (a mercury-containing preservative used in some vaccines but not most influenza vaccines) might have neurotoxicity. However, most of the websites that I reviewed include all known vaccines on their potentially risky list and do not distinguish between childhood and adult vaccination.

Given the strong elements of suspicion in our society of expertise, scientific research, and often knowledge and education in general, the recommendations of the CDC and unanimity of expert recommendation regarding influenza vaccination are sometimes treated as one side in a “controversy” regarding vaccine safety. Although it is doubtful that many of our employees actually search the Internet to visit these sites or even read the supermarket checkout line magazine articles these celebrities have fostered, much less familiarized themselves with the evidence supporting recommended vaccination practices, there is certainly awareness that some difference of opinion appears to exist. This awareness fuels vaccination “hesitancy,” the term used in the literature to describe the reluctance to proceed with recommended vaccines. Particularly when vaccination involves a sharpened needle (the inhaled vaccine has been questioned and is not suitable for those over 50 but may be making a comeback), hesitancy typically leads to avoidance.

All 50 states and the District of Columbia have legislatively mandated vaccination policies regarding childhood illnesses, although the list of mandated vaccinations varies somewhat. A small number of states, including New York, have mandated the influenza vaccine for health care workers during flu season. Most or all of these mandates have exemptions for medical contraindications or religious objections. However, the only true contraindication to influenza vaccination is a relatively rare documented allergy to the vaccine itself (egg-free preparations are now available, so egg allergy is no longer a medical justification to avoid vaccination). Many consider that a small list of other conditions, such as certain immunodeficiency conditions or a history of Guillain-Barre syndrome, merit discussion with one’s primary care physician and possible medical exemption. Religious exemptions are also extremely

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unusual — every major faith group supports vaccination programs. Although a small number of Old Order Amish oppose vaccination, the majority of Amish and other Anabaptist sects accept vaccines. Some “Orthodox Protestant” groups from the Netherlands and a few subgroups of Hasidic Jews have opposed vaccination as well, but these are all tiny segments of the population, and they seldom choose positions in health care for employment.

Some state and local regulations or employer policies also permit (or mandate) the use of protective masks during flu season as an alternative to vaccination. The mask must be worn whenever the employee is in resident care areas or other portions of the facility where residents might be present. The masks must be surgical masks suitable for maintaining droplet precaution (not Halloween masks to frighten off the virus) to address the biological reality that even asymptomatic employees can shed influenza virus. Because the masks are intended to protect the patients, they need not be individually fitted N95 respirators and are not personal protective equipment. Because they are typically warm, uncomfortable, and may interfere with simple actions such as obtaining a drink of water or communicating with facial expressions, most employees are reluctant to use them. Also, when only a small number of individuals are wearing surgical masks, they tend to stigmatize the wearer as a potential disease carrier. Overall, the cost to the employer of surgical masks used for months during the potential flu season and changed at least daily is usually higher than a single dose of vaccine.

The primary barrier to near-universal vaccination against influenza is its essentially voluntary nature.

The solution to low vaccination rates among health care workers is simply making vaccination mandatory. A recent JAMA Network study found that for U.S. hospitals surveyed, mandatory vaccination policies increased from 37% in 2013 to 61% in 2017 (JAMA Netw Open 2018;1:e180143), which suggests that the tide is turning. It is time for a similar policy change for long-term care, in both nursing facilities and assisted living facilities. In 2018, the board of the Society for Post-Acute and Long-Term Care (AMDA) formally adopted a policy supporting mandatory vaccination of health care workers. This was based on ample evidence that such programs work, are protective of our residents, and incidentally reduce employee illness-related absences.

The Society joined many partners in the Immunization Action Coalition, including the American Academy of Family Physicians, American College of Physicians, American Academy of Pediatrics, American Hospital Association, Veterans Health Administration of the Department of Veterans Affairs, and a wide variety of public health, infectious disease, and infection control specialists.

Open and public support by facility leadership — including particularly the director of nursing and the medical director — convenient available vaccines, and pizza parties for the units or departments with high vaccination rates are all great, but all these combined will not achieve the vaccination rates that will truly protect your residents. Other policies, such as requiring unvaccinated individuals to wear a mask at all times in the proximity of patients, might offer additional protection. But only a mandatory vaccination policy will allow your facility to join the Immunization Action Coalition Honor Roll and to fulfill the ethical obligation of beneficence, doing the right thing for our residents.

Dr. Nichols is president of the New York Medical Directors Association and a member of the Caring for the Ages Editorial Advisory Board. Read this and other columns at www.caringfortheages.com under “Columns.”