INFLUENZA VACCINATION AS A CONDITION OF EMPLOYMENT AT AN INTEGRATED HEALTH SYSTEM: A SIX-YEAR REVIEW

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PROBLEM
Annual Caregiver influenza vaccination has been demonstrated to reduce rate of transmission from staff to patients. Voluntary participation has failed to achieve CDC targets in most settings. Mandated vaccination programs have raised concerns regarding staff opposition and legal challenges.

BACKGROUND
Influenza remains a significant contributor to morbidity and mortality in the United States, with 8,646 related hospitalizations and 174 pediatric deaths in the 2015-16 flu season. Healthcare workers can be both victims and vectors of influenza. Numerous hospital outbreaks of influenza have been associated with infected caregivers. Influenza vaccination of healthcare workers is believed to be protective for both caregivers and patients. Aurora’s voluntary caregiver influenza vaccination program failed to achieve CDC target goals of 90%, remaining in the 70% range despite free or onsite vaccination and encouragement. In 2011 Aurora, following CDC recommendations, instituted a program requiring annual influenza vaccine as a condition of employment for all caregivers.

OBJECTIVES
To evaluate the safety and efficacy of the influenza vaccination as a requirement of employment program after the initial six years of deployment.
To evaluate caregiver acceptance and satisfaction with the program

METHODS
An interprofessional ‘Flu Team’ meets regularly through the year, establishing vaccine ordering, distribution, communications and protocols.

RESULTS
Vaccination Rates: The influenza program has resulted in >98% vaccination of caregivers each year since its inception.

Exemption Requests:

Medical exemption requests:
- Dropped significantly after the first year
- Most approved requests were due to documented severe systemic reactions to vaccine and thus granted for the duration of employment (83%)
- New requests varied from 72 to 127 per subsequent year
- Approval rates have been >80%-90%, reflecting a conscious decision by the committee to defer to the treating clinician's judgment even in cases where evidence suggests use of the influenza vaccine, e.g. patient using daclizumab for Multiple Sclerosis.

Personal Belief exemption requests:
- Grew from 33 in 2011 to 64 in 2016-17.
- Reasons for the growth of these exemptions included
  1. Broadening of the legal definition to any “strongly held personal beliefs”;
  2. Expansion of the program to include network clinicians, including a number of chiropractors who made up the largest category of caregivers requesting religious exemptions; and
  3. Expansion of the program to include contracted workers who did not necessarily have a healthcare education or orientation.
- Although no explicit religious criteria is required, in the 2016-17 season, 65% of requesters volunteered a specific creed, with 95% of these citing Judeo Christianity (e.g. quoting Old or New Testament verses, referring to ‘Bible’ or ‘Jesus’) with veganism, Islam and Native American spiritual beliefs being noted by 1-2 caregivers each.

Conclusions
Although laborious, implementing an influenza program as a condition of employment is feasible, effective at reaching targeted vaccination rates, and reasonably acceptable by caregivers. Our effort was unable to identify whether compulsory influenza vaccination impacted caregiver absenteeism due to changes in our system coding of absenteeism.

References
3. Adding justice to the clinical and public health ethics arguments for mandatory seasonal influenza vaccination for healthcare workers.Journal of Medical Ethics 2015;41:187