LEADERSHIP COUNCIL
RECORD OF DECISION EXCERPT
June 18, 2010

1.0 Provincial Approach to Staff Immunizations

Howard Waldner introduced a potential issue related to STIIP and immunization programs.

Action/Decision:

- *Item to be scheduled for further discussion pending research into the issue.*

NOTE: No other material provided for this item.

LEADERSHIP COUNCIL
RECORD OF DECISION EXCERPT
September 16, 2011

1.0 Health Employers Association of BC

1.1 Immunization Update

Update on the introduction of mandatory influenza vaccinations for clinical staff.

Action/Decision:

- *Provincial Health Officer to provide a recommendation and plan for next year.*

Agenda Item Briefing Document
Immunization Update

Purpose: Decision

Issue: Introduction of mandatory influenza vaccination for clinical staff in high risk acute care areas.

Background:

- Influenza is a serious contagious disease spread by droplet transmission through close contact with an infected individual.
- Influenza in vulnerable groups especially the elderly, the very young and the immunosuppressed, is associated with significant morbidity and mortality. It is a major contributor to hospitalizations in winter.
- In addition to causing deaths from acute influenza illness and secondary bacterial pneumonia, influenza has been associated with increased mortality from ischaemic heart disease, cerebrovascular disease, and diabetes.
- Influenza-related complications in older adults include profound disability and serious decrements in functional status. Pneumonia and influenza are among the top three leading causes of catastrophic disability. These patients do not return home after hospitalization but require long term care.
- Influenza vaccine is safe and effective.
- The evidence that vaccinating doctors and nurses protects patients from infection, morbidity and death is well established. Infected individuals are highly contagious and transmit influenza for 24 hours before they are symptomatic, hence, only staff vaccination protects vulnerable patients and fellow healthcare workers (HCW).
- Other infection control measures such as rapid identification of ill patients, handwashing etiquette, restrictions on work and visiting, and the use of antivirals all help but vaccination remains the cornerstone of efforts to control influenza transmission.
- Each year HCW are encouraged to get vaccinated for the protection of themselves, their families and their patients.
- A range of enhancements have been tried. These include bringing the vaccine carts to the wards, extensive publicity via mail-outs, posters webcasts and badges, and a range of inducements such as daily iPods and raffles of Caribbean trips. Despite all this coverage of key clinical staff has remained well under 50% in many settings.
- **Voluntary vaccination strategies have failed and the low rates pose a danger to vulnerable patients.**
- Over the last few years a number of facilities in the United States (US), and some whole jurisdictions (eg New York State and the recent Texas Senate legislation) have mandated vaccination for all HCW or for those in key contact roles. Employees can opt out of receiving shots for certain medical or religious reasons, but then have to follow procedures like wearing masks to protect patients from possible exposure through the winter period.
- The resultant HCW vaccination coverage rates have been around 95% or higher.
- A recent "Lancet" editorial (attached) strongly supported the US approach principally on the ethical imperative to do better.

Agenda Item Briefing Document
Immunization Update

- There are a number of ethical principles behind mandation of vaccination. These include the duty to put patients' interests first, the obligation to do no harm, and, the requirement to protect those who cannot protect themselves.
- The Society for Healthcare Epidemiology of America strongly recommends mandatory vaccination stating in its policy, " .. influenza vaccination of HCW is a core patient and HCW safety practice with which noncompliance should not be tolerated." The policy is also supported by the Infectious Diseases Society of America and the Association of Professionals in Infection Control and Epidemiology.
- The case for introducing influenza vaccination as a condition of service for acute care staff in close contact with the most vulnerable individuals in particular settings such as Long Term Care Facilities (LTCF), and areas of immunosuppression including oncology, intensive care, dialysis, and HIV wards is supported by the strongest data. However, this "geographically targeted approach has the following problems:
    - Not all high risk individuals are in these areas. Many are also found in medical and surgical wards or in Emergency rooms awaiting admission;
    - Requiring vaccination of only some staff is inequitable;
    - Requiring vaccination of only some staff risks lessening the importance of this for those in "less-high risk areas" who are also recommended to be vaccinated; and,
    - The benefits of herd immunity are lost if only some staff are required to be vaccinated.
- As in the US, employees opting out of receiving shots for medical or religious reasons would be required to wear masks.
- This policy has the support of the Chief Medical Health Officer in all five Health Authorities as an appropriate public health measure.
- The current vaccine purchase arrangements in British Columbia would stretch to the extra HCW doses without any additional provincial purchase.

Decision Requested:

- That Leadership Council agrees to mandate influenza vaccination in LTCF and acute care settings in British Columbia.
- That Leadership Council, recognising the implementation challenge for 2011, appoint a group to lead the development of an implementation model complete with a communication strategy.

Documents Provided:

- Caplan A, The art of medicine: time to mandate influenza vaccination in health-care workers. Lancet . 2001; 378:310-311
- Revised SHEA position paper: Influenza vaccination of Healthcare Personnel. Infection Control and Hospital Epidemiology. 2010;31:(10) 987-995. Available at http://www.jstor.org/stable/10.1086/656558

Presenter/Leadership Council Member Lead:

- Dr Nigel Murray, CEO, Fraser Health Authority
- Michael Marchbank, HEABC

The art of medicine

Time to mandate influenza vaccination in health-care workers

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INFECTION CONTROL AND HOSPITAL EPIDEMIOLOGY OCTOBER 2010, VOL. 31, NO. 10

SHEA POSITION PAPER

Revised SHEA Position Paper: Influenza Vaccination of Healthcare Personnel

Thomas R. Talbot, MD, MPH; Hilary Babcock, MD, MPH; Arthur L. Caplan, PhD; Deborah Cotton, MD, MPH; Lisa L. Maragakis, MD, MPH; Gregory A. Poland, MD; Edward J. Septimus, MD; Michael L. Tapper, MD; David J. Weber, MD, MPH

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LEADERSHIP COUNCIL
RECORD OF DECISION EXCERPT
April 20, 2012

1.0 Influenza Vaccination for Health Care Workers

Dr. Perry Kendall, Paul Van Buynder (FHA), and Michael Marchbank (HEABC) led the discussion on the implementation of influenza vaccinations for all health authority staff. Health authorities agreed to commit to a coordinated effort that included patient safety first.

Action/Decision:

- *Paul Van Buynder (FHA), Perry Kendall and Barb Korabek to lead a team for coordination of the implementation across the health authorities.*

Agenda Item Briefing Document
Influenza Vaccination for Health Care Workers

Purpose: Decision

Issue: Introduction of influenza vaccination as a condition of service for health authority staff.

> "It's the right thing to do."
> "It takes less effort and resources now to achieve 95% than it took to get 45% before."
> "Why wouldn't we do it now?"

Background:

- At Leadership Council in September 2011, the Provincial Health Officer was to asked to provide a recommendation and plan for implementation of influenza vaccination of clinical staff for next year.
- The Fraser Health Chief Medical Health Officer led a team from across Canada to review the case for vaccination of staff, and undertook a review of a large number of organisations in North America where this had occurred. Discussions have taken place among provincial Chief Medical Health Officers and the Human Resources Vice Presidents have been briefed.

Key Findings of the Review

- The following organisations support mandating health care workers influenza vaccination
  - Society for Healthcare Epidemiology of America (SHEA)
  - Infectious Diseases Society of America (IDSA)
  - American Hospital Association (AHA)
  - American College of Physicians (ACP)
  - American Academy of Pediatrics (AAP)
  - National Patient Safety Foundation (NPSF)
  - Department of Defence (DOD)
  - Over 150 organizations in 36 US states
  - Health Officers Council of BC

Summary of Key Drivers for Implementation of the Program

- Health care workers (HCWs) and health care systems have an ethical and moral responsibility to protect vulnerable patients from transmissible diseases.
- Influenza is a significant disease in the community. Influenza has by far the highest rates of mortality among vaccine-preventable diseases in the US, outpacing all other vaccine preventable diseases combined. Hospitalized patients are more vulnerable to influenza than members of the general population.
- Transmission occurs before symptoms are obvious.
- The impact of infection on the frail can lead to failure to return to self care – influenza and pneumonia are the third commonest cause of catastrophic disability whereby elderly require subsequent long term care placement, behind only stroke and cardiac failure.

Agenda Item Briefing Document
Influenza Vaccination for Health Care Workers

- Many studies show that vaccination of HCWs reduces the risk to patients since HCWs are frequently implicated as the source of influenza in health care settings and that patient mortality goes down when healthcare workers receive flu vaccination. (Carman, Haywood, Potter)
- There are particularly good data about the impact of HCW influenza vaccination in long term care on reducing patient mortality and morbidity.
- The data are less strong because of the cost of randomized trials in acute care settings but:
    - Some data exists from ecological studies;
    - Vaccination is known to protect against transmission;
    - A Scottish study showed a quarter of staff had flu in a season and many didn't record it as such and continued to work;
    - Individual case studies exist about transmission in acute care in association with high profile deaths especially in paediatric settings; and
    - Staff do not isolate when ill and can't anyway because of the period of asymptomatic transmission.
- It is a **patient quality and safety** issue akin to hand washing, isolation of infected patients, the use of masks and so on; this policy reinforces our core business.
- We have other mandatory processes already such as requiring immunity to measles, mumps, rubella, requiring TB skin testing, and requiring proper attire in the operating room.
- It is an "excellence of organisation and leading edge "issue. To stay competitive in the US healthcare market, organizations viewed mandatory immunization as a leading edge strategy that sets them apart world-wide. They were proud of their statistics and awards.
- It is increasingly seen in North America as an accreditation issue.
- In addition to being a quality and safety issue it is cost saving. One study in health care setting showed absenteeism related to respiratory disease reduced by 28%. Many studies in other industries showed cost savings with worker vaccination.
- It protects staff and their families as well as patients
- No other method, be it performance linking, marketing, or offering inducements works to raise coverage to acceptable levels. No model of introduction in the variable US settings failed to achieve exceptional coverage.
- It aids capacity for disaster preparedness – annual influenza vaccination of staff can be seen as a drill to be prepared for a disaster event involving communicable disease – being ready to immunize thousands of HCWs quickly during a disaster improved capacity in the US facilities and in some improved technology such as the introduction of hand-held ID badge scanners to improve the ease and speed of vaccination data entry.

<u>Summary of Implementation Issues in US Facilities</u>

- After initial long term introduction challenges in the 'benchmark site at Virginia Mason subsequent roll outs have been very smooth. This has included smaller facilities of only 5,000 workers but also Hospital Corporation of America with almost 200,000 workers.
- The initial court case challenge based on "fitness for duty" was lost. A number of challenges since then based on "introduction for patient care" were won by the health authorities (for example, HCA was sued twice and won both).

Agenda Item Briefing Document
Influenza Vaccination for Health Care Workers

- After long term consultation lead up at Virginia Mason and extensive discussions about stakeholder involvement and consultations, every model since then, irrespective of lead in process has worked. Some facilities planned for a year before introduction, one introduced it out of the blue half way through a flu season. Some had vaccinate or be fired, some had vaccinate or wear a mask, some had wear a mask or vaccinate; all achieved over 95%. Those with more restrictive declinations achieved over 99% but at some implementation cost.
- All facilities had an all-in approach. While many confined it to facilities with patients, for example, associated research institutions were often exempt, where patients were present the policy applied to all clinical and non-clinical. Good for the patients, good for you, good for your family and the community. Any pain in sorting out declinations, dealing with those who wished to make a point, dealing with union issues were concentrated in the first year and after that it ran smoothly. The message was don't progressively introduce over time, for example, LTCF then high risk etc .this prolongs the difficulty, reduces herd immunity, is inequitable and is not supported by the science.
- Organizational policy should be applied equally to **all** – anyone whose work takes them into a healthcare facility, staff, physicians, volunteers, students, contractors.
- As a patient safety issue requiring vaccine is more defensible legally than mandatory masking as the strength of evidence is better.
- While all US models examined worked there were some consistent drivers:
    - Marketing the patient safety in messaging and ignoring the savings – the right thing to do not the way to save some money.
    - Having it as a Senior Leader Priority - every organization told us it must come from the top down – Senior Leaders must set staff influenza immunization as an organizational priority – a core competence for all managers and staff.
    - Every organization had developed strategies and practices to share responsibility across the organization to get everyone immunized. Most organizations had very few occupational health nursing resources – their role was to coordinate rather than give thousands of immunizations themselves.
    - Core Job Requirement – condition of employment rather than a fitness for duty program.
    - Multi-disciplinary Planning Committee – chaired by a Senior Leader; meetings all year; members include clinical operations including chief nursing officer, occupational health, infection control, IT, communications and marketing, pharmacy, human resources, and internal medicine.
    - **Most had minimal start up costs** by having a decentralised vaccine administration - Flu Captains / Peer Nurse Immunizers – RNs across the organization who would be responsible for immunizing coworkers. Adopt-A-Dept for those without an RN.
    - Proof of Immunization / Attestation Form – documenting vaccinations by external providers.
    - Toolkits for Flu Captains.
    - Continue to provide information– online training for all (10 mins).
    - Pre-registration online for immunization (online consent completed).

- Online Infection Control training module for all physicians – combine influenza information with BBF, hand hygiene, violence prevention, respirator fit testing, etc.
- Intranet visual campaign.
- Managers responsible to speak to unvaccinated staff.
- Masking requirement of unvaccinated monitored and enforced by managers.
- Masking period established by Senior Leadership for non-vaccinated; for example, December 1-March 31.
- Masking required by non-vaccinated when within six feet of a person rather than a patient. This does not apply at meal times in cafeterias in facilities studied.
- Centralized Adverse Event reporting (Occupational Health).
- Robust electronic database with regular drill-down reports to managers and senior leaders.
- Maximum 30-day campaign.
- Bar-code scanning of ID badges and vials – direct data entry.
- Flu Hotline / Consult a Nurse.

Rationale for Masks for Unvaccinated Workers

- Masks can serve as a method of source control of infected HCW who may have had no symptoms.
- Masks may protect unvaccinated HCW from as yet unrecognised infected patients or visitors with influenza.
- Masks in conjunction with hand hygiene shown to have reduced rates of influenza like illness in residents of college dormitories and households. (JID, 2010;210:491-8, Ann Intern Med 2009;151:437-446)
- Masks can filter influenza virus to undetectable levels when measured by real time PCR at a distance of 20 cm from an infected patient. (CID2009;49:275-7)

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Agenda Item Briefing Document
Influenza Vaccination for Health Care Workers

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Decision Requested:

- That Leadership Council agrees to the introduction of influenza vaccination as a condition of service for health authority staff in long term care facilities and acute care settings in BC. Staff refusing to vaccinate or unable to do so for medical or religious reasons would be required to wear a mask during winter.
- That health authority CEOs agree to the formation of an implementation committee to standardise messaging and assist with documentation and resources. This committee should include Workplace health, public health, human resources, infection control and communications staff. In view of the collation of resources from external sources undertaken by Fraser Health, Fraser Health be requested to coordinate this work.

Documents Provided:

- PowerPoint Presentation

Presenters:

- Dr. Paul Van Buynder, Chief Medical Health Officer, Fraser Health
- Mr Michael Marchbank, HEABC
- Dr Perry Kendall, Provincial Health Officer

Leadership Council Member Lead:

- Dr. Nigel Murray

Influenza vaccination as a condition of service for Health authority staff.

"It's the right thing to do."
"Why wouldn't we do it now?"

Leadership Council
April 20th 2012

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Overview

- The scope of the problem
- Impact of and reason for vaccination
- Alternatives to "mandation"
- Review of US sites – lessons learned
- Overview of Policy
  - Benefits
  - Cost
- Leadership Council Proposal

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The Scope of the problem

- Health care workers and health care systems have an ethical and moral responsibility to protect vulnerable patients from transmissible diseases.
- Influenza has by far the highest rates of mortality among vaccine-preventable diseases.
- Hospitalized patients are more vulnerable to influenza than members of the general population.
- Transmission occurs before symptoms are obvious

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The Scope of the problem

- The impact of infection on the frail can lead to failure to return to self care – the 3rd commonest cause of catastrophic disability behind only stroke and CCF.

- Vaccination of healthcare workers reduces the risk to patients - frequently implicated as the source of influenza in healthcare settings and patient mortality and morbidity goes down when HCWs are vaccinated.

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In acute care??

- The data are less strong because of the cost of randomized trials in acute care settings but
  - Data exists from ecological studies
  - Vaccination is known to protect against transmission
  - A Scottish study showed a quarter of staff had flu in a season and many didn't record it as such and continued to work
  - Individual case studies exist about transmission in acute care in association with high profile deaths especially in pediatric settings
  - Staff do not isolate when ill and can't anyway because of the period of asymptomatic transmission.

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Key Drivers Behind Program

- It is a **patient quality and safety** issue akin to handwashing, isolation of infected patients, the use of masks and so on .. this policy reinforces our core business
- We have other mandatory processes already such as requiring immunity to measles, mumps, rubella, requiring TB skin testing, and requiring proper attire in the OR.
- It is an "excellence of organisation and leading edge "issue.

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Key Drivers Behind Program

- It is increasingly seen in North America as an accreditation issue
- In addition to being a quality and safety issue **it is cost saving**. One study in health care setting showed absenteeism related to respiratory disease reduced by 28%. Many studies in other industries showed cost savings with worker vaccination
- It protects staff and their families as well as patients
- It aids capacity for disaster preparedness – annual influenza vaccination of staff can be seen as a drill to be prepared for a disaster event involving communicable disease

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Review of US sites – lessons learned

- After introduction challenges in the 'benchmark site at Virginia Mason subsequent roll outs have been smooth. This has included facilities of 5000 – 200,000 workers.
- The initial court case challenge based on "fitness for duty" was lost. Challenges since then based on "introduction for patient care" won by the health authorities. Eg HCA sued twice and won both.
- Every US model since VM has worked, irrespective of lead in process. One facility introduced it out of the blue half way through a flu season. Some had vaccinate or be fired, some had vaccinate or wear a mask, some had wear a mask or vaccinate...all achieved over 95%. Those with more restrictive declinations achieved over 99% but at some implementation cost.

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Review of US sites – lessons learned

- All facilities had an all-in approach. Where patients were present the policy applied anyone whose work takes them into a healthcare facility, staff, physicians, volunteers, students, contractors
- Good for the patients, good for you, good for your family and the community.
- Any pain in sorting out declinations, dealing with those who wished to make a point, dealing with union issues were in the first year and after that it ran smoothly.
- The message was **don't progressively introduce** over time eg LTCF then high risk etc .this prolongs the difficulty, reduces herd immunity, is inequitable and is not supported by the science.

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Policy

- That Leadership Council agrees to the introduction of influenza vaccination as a condition of service for Health Authority staff in care settings in British Columbia. Staff refusing to vaccinate or unable to do so for medical or religious reasons would be required to wear a mask during winter

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Rationale for masks for unvaccinated workers

- As a patient safety issue requiring vaccine is more defensible legally than mandatory masking as the strength of evidence is better.
- Masks can serve as a method of source control of infected HCW who may have had no symptoms
- Masks may protect unvaccinated HCW from as yet unrecognised infected patients or visitors with flu
- Masks in conjunction with hand hygiene shown to have reduced rates of influenza like illness in residents of college dormitories and households
- Masks can filter virus to undetectable levels when measured by RT-PCR 20 cm from an infected patient
-

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Policy Messaging

- Marketing the patient safety in messaging and ignoring the savings – the right thing to do not the way to save some money
- Having it as a Senior Leader Priority - Every US organization told us it must come from the top down – Must be an organizational priority – a core competence for all managers and staff.
- Every organization developed strategies & practices to share responsibility. Most had very few OH nursing resources – their role was to coordinate rather than give thousands of immunizations themselves.
- Core Job Requirement – condition of employment rather than a fitness for duty program

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- Core Job Requirement – condition of employment rather than a fitness for duty program

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Implementation

- Multi-disciplinary Planning Committee – chaired by a Senior Leader; meetings all year; members include clinical operations, occupational health, infection control, IT, communications & marketing, pharmacy, human resources, and internal medicine.
- **Most had minimal start up costs** by having a decentralised vaccine administration - Flu Captains / Peer Nurse Immunizers – RNs across the organization who would be responsible for immunizing coworkers. Adopt-A-Dept for those without an RN

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Costs

- Only significant where vaccinate or be dismissed applied and then only first year or two. Related to medical declination reviews mainly. Occasional use of casuals to vaccinate.
- All suggested that absenteeism benefits outweighed costs but no messaging about this
- Costs of masks small – change when wet not every two hours – soft approach as proposed for BC averaged 95% coverage in US and this increased in subsequent years – made their point and moved on

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Costs

- After first year it was routine and just happened.

- "It takes less effort and resources now to achieve 95% than it took to get 45% before."

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Pages 39 through 40 redacted for the following reasons:
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Implementation Planning Group

- Second arm of LC proposal
  - Need to standardise messaging and assist with documentation and resources. This committee should include Workplace health, public health, human resources, infection control and communications staff. In view of the collation of resources from external sources undertaken by Fraser Health, Fraser could be requested to coordinate this work but for ownership need
    - Provincial Project Executive Sponsor, Sponsor, Initiative Manager, Project Manager, and Health Authority project leads.

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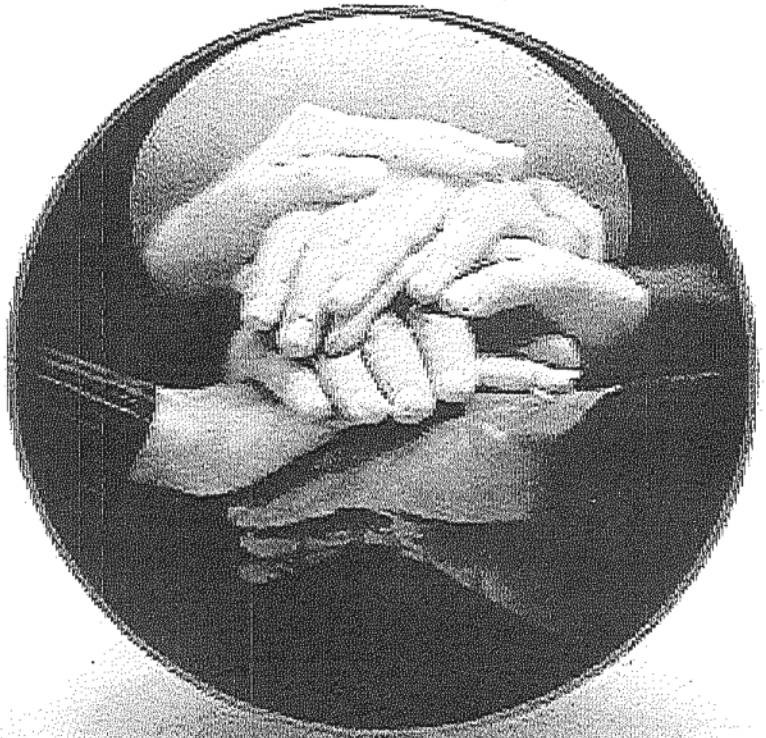

"Coming together is a beginning. Keeping together is progress. Working together is success. "

~ Henry Ford

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LEADERSHIP COUNCIL
RECORD OF DECISION EXCERPT
June 15, 2012

1. **Mandatory Staff Influenza Immunization**
   Full implementation versus a phased approach to this mandatory program was discussed.

   Action/Decision:

   - *Nigel Murray undertook to explore potential options to address or mitigate implementation concerns; this issue will be brought forward to the July 20 Leadership Council meeting for decision.*
   - *Michael Marchbank will undertake some due diligence on certain implementation aspects.*
   - *Dr. Perry Kendall will provide a written update, for the July 20 Leadership Council meeting, on whether special flu vaccinations in long-term care facilities may be required again this year.*

NOTE: No other material provided for this item.

2. Mandatory Staff Influenza Vaccination

M. Marchbank led a discussion respecting the implementation of the provincial HCW vaccination. Not Responsive

Not Responsive

Action/ Decision:

- *Leadership Council approved the implementation of the policy.*
- *Implementation materials will be sent to the CEOs within the next 10 days, including suggested messaging for their distribution to staff after the unions have been notified; M. Marchbank to advise when this has occurred. The timing of communications to the unions, health authorities' staff, and BC Medical Association will be coordinated by HEABC, the Ministry of Health and the CEOs.*

Agenda Item Briefing Document
Mandatory Staff Influenza Vaccination

Purpose: Decision

Issue: Introduction of mandatory influenza vaccination for staff in patient care areas.

Background:

- In April Leadership Council:
  - Agreed to make influenza vaccination a condition of service for staff in patient care areas in British Columbia.
  - Recognising the implementation challenge agreed to appoint a group to lead the development of an implementation model complete with a communication strategy.
- An update on progress was requested in June as well as a review on whether a staged implementation was desirable.

Update:

1. **Progress to date:**
   - The implementation and communications development is going well. The following resources are to be made available this month as soon as the announcement is made and resources can be shared. A key communications link in each health authority has been identified.

     1. Policy on influenza as a condition of service
     2. Mask Policy
     3. Q&A document
     4. Template letters to all organisations from Health Authority CEOs
     5. Peer nurse immunizer kits
     6. Managers kits
     7. Peer nurse immunizer training program
     8. Stickers to identify those vaccinated

   - Additionally Fraser has filmed videos of support with CEO, physician, ICU nurse and CMHO all featured and the scripts are available to other health authorities.
   - In addition to the peer nurse immunize program other capacity building initiatives are under way including an extension of pharmacist training in Northern Areas. The province via Laura Neufeld in Communications are working on other releases.

2. **Desirability of a Staged Implementation:**
   - The case for introducing influenza vaccination as a condition of service for health care staff only in close contact with the most vulnerable individuals in particular settings such as long term care facilities, and areas of immunosuppression including oncology, intensive care, dialysis, and HIV wards has been preferred by some of those consulted. However, this "geographically" targeted approach has the following problems:
     - Not all high risk individuals are in these areas. Many are also found in medical and surgical wards or in Emergency rooms awaiting admission.
     - Requiring vaccination of only some staff is inequitable.

- Requiring vaccination of only some staff risks lessening the importance of this for those in "less-high risk areas" who are also recommended to be vaccinated.
- The benefits of herd immunity are lost if only some staff are required to be vaccinated.
- The lessons from the United States were clear on the undesirability of this. Inevitably, some people, in the first year, wanted to make a statement about not agreeing with this. By the second year resistance disappeared and it became the norm. Staged implementation over many years would "multiply the pain".

Decision Requested:

- That Leadership Council reaffirms the decision to implement the policy, expedites public messaging and commits to support enforcement of the policy.

Presenter/Leadership Council Member Lead:

- Dr Nigel Murray