HOSPITAL EMPLOYEE HEALTH

THE PRACTICAL GUIDE TO KEEPING HEALTHCARE WORKERS HEALTHY

INSIDE

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Ensure Flu Vaccine Policies, Exemptions Are Clear, Equitable

Hospital pays $74k to settle religious exemption vaccine dispute

By Gary Evans, Medical Writer

After a bad flu season last year, experts are emphasizing the importance of vaccinating healthcare workers as the 2019-2020 season begins. Employee health professionals were rolling out their flu immunization programs as this report was filed.

"It's that time of year, and we are starting our annual campaign," says **Lydia Crutchfield**, MA, BSN, RN, director of employee health at Atrium Health in Charlotte, NC, and president of the Association of Occupational Health Professionals in Healthcare (AOHP).

"The ultimate goal is to protect the patient, your co-workers, as well as yourself and your family," she tells *Hospital Employee Health*. "That ends up protecting the community."

> "THE ULTIMATE GOAL IS TO PROTECT THE PATIENT, YOUR CO-WORKERS, AS WELL AS YOURSELF AND YOUR FAMILY. THAT ENDS UP PROTECTING THE COMMUNITY."

Influenza virus is mutable and unpredictable — thus, the adage in public health that "if you've seen one flu season, you've seen one flu season."

Likewise, conventional wisdom holds that the bottom-line measure of vaccine efficacy is keeping people out of the hospital and the morgue. **William Schaffner**, MD, professor of preventive medicine at Vanderbilt University, drove this point home recently at the annual flu season press conference at the National Foundation for Infectious Diseases (NFID) in Washington, DC.

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"It's critical that we emphasize the importance of partial protection," he said. "We need to remember that even if you get influenza after having received the vaccine, you are likely to benefit by having a less severe and shorter illness. More important, you are less likely to suffer the complications, including pneumonia, hospitalization, and dying. This part of the story has not been sufficiently told."

In a separate interview with *HEH*, Schaffer says the seasonal flu vaccine for 2019-2020 contains strains well matched to circulating virus. "Given the viral strains that were circulating in the Southern Hemisphere — our summer, their winter — we've got a pretty good match," he says. "We need as good a match as we can get for maximum protection. We start out knowing that influenza is an imperfect vaccine. It is good, but not perfect."

Varying Efficacy

The CDC estimates vaccine efficacy over the last 15 flu seasons as low as 10% in 2004-2005 to a high of 60% in 2010-2011.[1] The 2018-2019 vaccine was 29% effective overall after a strain of H3N2 influenza A emerged that was a mismatch with the vaccine.

"The beginning of the flu season was dominated by H1N1 viruses, where we had a pretty good match," Schaffner says. "Then, all of a sudden, the latter half of the season was dominated by H3N2 viruses. We had a double barrel flu season, and that contributed to its being long. The match was not as good with the H3N2; it never is. That is unfortunate because H3N2 usually causes more severe disease."

To get the best H3N2 match possible this season, public health officials delayed adding that component to the vaccine from February until March this year. The delay allowed identification of a distinct strain of H3N2 that was growing in the United States. "H3N2 viruses have presented an increasing challenge for vaccine virus selection due to frequent changes in the viruses and difficulties in generating optimal candidate vaccine viruses for use in manufacturing," the CDC stated in explaining the delay.[2]

The H3N2 vaccine component in this season's vaccine is A/Kansas/14/2017. The CDC also added a new H1N1 strain, A/Brisbane/02/2018. Both B/Victoria and B/Yamagata virus components from the 2018-2019 flu vaccine remain the same for the 2019-2020 flu vaccine.

Hospital immunization rates have improved in recent years, driven in part by mandatory policies, education about myths and misinformation, and overall awareness of how vaccines are critical to protect vulnerable patient populations. Hospitals with mandatory requirements immunized 95% of workers in the 2017-2018 flu season, according to a CDC survey.[3] However, the same survey showed that one-third of long-term care workers were not vaccinated. *(See related story, page 125.)*

"It is a patient safety issue," Schaffner says. "That's the principal reason healthcare workers should get immunized. I think it is both a professional and ethical obligation for us to be vaccinated." Vaccination also is critical to ensure healthcare teams can stay on the job and care for a potential upsurge in patients, he says.

As more facilities adopt mandatory vaccination policies, they have to decide whether to allow exemptions. Some require influenza vaccination as condition of employment, while others allow specified exemptions. Medical exemptions may include allergy to vaccine components or a history of Guillain-Barré syndrome.

"We have had a mandatory flu vaccination policy for four years now," Crutchfield says. "We allow medical and religious exemptions here. If someone completes an exemption form, that's perfectly fine and makes them compliant with the program. But when flu season is declared by our epidemiologist, if an [unvaccinated] team member is within six feet of a patient, they are required to wear a mask."

One key to these policies appears to be consistency in making equitable arrangements, as workers denied religious exemptions have successfully sued through the federal Equal Employment Opportunity Commission (EEOC). Memorial Healthcare in Owosso, MI, recently paid $74,418 to settle a lawsuit brought by the EEOC on behalf of a newly hired medical transcriptionist who claimed religious exemption to vaccines.

"Memorial refused to accommodate the sincerely held religious requirement of the transcriptionist, whose Christian beliefs require her to forgo inoculations," the EEOC stated.[4] "The transcriptionist offered to wear a mask during flu season. This was an acceptable alternative under hospital policy for those with medical problems with the flu shot, but Memorial refused to extend it to her. It then rescinded her offer of employment."

Under the consent decree settling the suit, Memorial will permit those with religious objections to wear masks in lieu of receiving a flu vaccine, the EEOC reported. "The hospital also will train managerial staff participating in the accommodation process on the religious accommodation policy," the EEOC stated. "In addition, the transcriptionist will receive $34,418 in back pay, along with $20,000 in compensatory damages and $20,000 in punitive damages."

Considering such cases, healthcare facilities should carefully consider exemption policies and seek legal advice in developing a mandated flu shot program. The EEOC cited the case as a violation of Title VII of the Civil Rights Act of 1964, which requires employers to "provide reasonable accommodations for religious observances and beliefs, absent undue hardship."

"Employees should not have to check their religious beliefs at the workplace door," EEOC attorney **Dale Price** said in a statement. "The transcriptionist's objection could have been easily accommodated by allowing her to use the mask option utilized by other employees. Nevertheless, Memorial's revision of its policy is a welcome change that will provide broader accommodations for applicants and employees."[4]

Reasonable Accommodation

Douglas Opel, MD, assistant professor of pediatrics at the University of Washington School of Medicine in Seattle, outlined legal strategies in a review article on flu vaccine mandates and exemptions.[5]

"In our analysis, we found that hospitals prevailed in lawsuits when they developed ways to accommodate their employee's religious views and still protect patients," he tells *HEH*. It makes sense for hospitals to tailor this accommodation based on where in the hospital employees work, he adds.

"For example, for employees with patient contact, reasonably accommodating them might mean having them wear a mask to prevent them spreading influenza to their patients," Opel says. "But for an employee without patient contact, it might be reasonable to simply require her to stay home if she had symptoms."

In general, avoid the appearance of arbitrary or inconsistent vaccination policies that could be perceived as discriminatory by a healthcare worker seeking an exemption, he recommends.

"Influenza vaccination mandates for healthcare workers represent good policy, but heavy-handed, context-free implementation does not," Opel and colleagues concluded in the paper.

The EEOC's definition of "religion" includes "moral or ethical beliefs as to what is right and wrong which are sincerely held with the strength of traditional religious views." Courts are not bound by the definition, but it is broad enough to create uncertainty about the line between religious and philosophical objections, Opel notes.

In the paper, Opel cited a case involving an employee who sued after being denied a vaccination exemption on the basis of strongly held beliefs in a vegan diet. The hospital filed to dismiss the suit, but agreed to settle after a court ruled it would allow the plaintiff "to try to show that veganism constituted a religious belief."

"Though the belief need not be theistic, it must relate to ultimate questions, not just vaccines," Opel and colleagues wrote. "At a minimum, hospitals should feel fairly confident in rejecting mere anxieties

about vaccine safety. Providing a religious-belief definition in vaccination policies and explaining what does and doesn't qualify should also help reduce misguided requests and lawsuits."

Some hospitals require signoff by clergy regarding a religious exemption, although there have been legal challenges in some of these cases.

"This raises the metaphysical question of 'What is a religion?'" Schaffner says. "My understanding is that, other than Christian Science, there is no tradition of vaccine avoidance in any of the major religious traditions in the United States. These religious traditions and doctrines were established long before vaccines were developed."

Amy Behrman, MD, FACP, FACOEM, director of occupational medicine at the Hospital of the University of Pennsylvania in Philadelphia, concurs. "My own opinion is that religious exemptions are rarely justified by scripture," she says.

While emphasizing that he is a doctor and not a lawyer, Schaffner notes the contrast between religious exemptions in healthcare and the requirements for children to be vaccinated for childhood diseases to attend schools. This issue has come to the fore in recent years due to outbreaks of measles. "When it comes to school vaccination requirements, there are several states now that have eliminated religious exemptions," he says. "I'm just a lay person, but I don't quite understand the distinction here."

The issue is complicated on several levels, including the fact that the flu vaccine changes every year and has varying levels of efficacy. Regarding the religious exemption issue, it also is fair to reiterate the moral imperative of protecting frail patients.

"I am perfectly comfortable managing medical exemptions and certainly think it is crucial to be as evidence-based as possible," Behrman says. "Religious exemptions are much more challenging."

There is considerable work involved in exemption reviews to ensure they are performed fairly and to ensure that any administrative policies like wearing a mask are enforced.

"There is a huge amount of work — shout-out to human resources, who need to actually operationalize the administrative policies to make the program work," Behrman says. "Effective mandates should take you close to 100% [flu vaccination rates]. In our institution, we have just over a 98% vaccination rate every year with about a 1.5% exemption rate."

Mandatory flu vaccination policies vary, going from work reassignment for the non-immunized, formal declination forms, masking, and immunization simply as a condition of employment.

"My own reading of the literature, primarily in acute care, is that any requirement is a huge and powerful tool for improving immunization rates, and in my view, normalizing them," Behrman says. "We should normalize the concept of healthcare worker vaccination while acknowledging that there is a spectrum of immunization requirements." ■

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Flu Vaccination Rates in Long-Term Care Workers Improving

Improving healthcare worker flu vaccination in long-term care settings remains a challenge, but there are signs of improvement as more facilities are seeking "honor roll" status aimed at reaching higher immunization rates, says **Amy Behrman**, MD, FACP, FACOEM.

"There has been a leap forward in terms of the number of [long-term care] institutions providing proof that they belong on the honor roll," explains Behrman, co-chair of the Influenza Working Group (IWG) of the National Adult Immunization and Influenza Summit (NAIIS), and director of occupational medicine at the Hospital of the University of Pennsylvania. "I have every confidence that we are going to see the number improved enormously over the next few weeks."

The IWG partnered with the Immunization Action Coalition (IAC) to encourage joining the immunization honor roll for healthcare facilities and flu vaccine. "To be included in this honor roll, your organization's mandate must require influenza vaccination for employees and must include serious measures to prevent transmission of influenza from unvaccinated workers to patients," according to the IAC.[1] "Such measures might include a mask requirement, reassignment to non-patient care duties, or dismissal of the employee."

While other healthcare sectors have made progress on flu immunizations, workers in long-term care reported only a 67% vaccination rate in a CDC survey.[2]

"Long-term facilities lag far behind the vaccination rates in healthcare personnel in all other settings, despite the fact that their patients are at highest risk of complications and death," Behrman says. "In my opinion, the evidence supporting vaccinating healthcare personnel to protect patients is actually the strongest in long-term care."

Long-term care residents are vulnerable to flu outbreaks, as they may attain only marginal immunity if vaccinated. The virus spreads easily in communal settings. "They tend to have a much higher staff turnover. In general, their staff have much more physical contact on an ongoing basis as they help residents and patients with activities of daily living," she says. "It is a vulnerable and challenging workplace."

Behrman cites 2017-2018 flu season data in making her case for employee immunization. In one example, Kentucky reported 124 confirmed flu outbreaks in long-term care facilities that season.[3]

The lagging immunization rates reflect, in part, high staff turnover in these settings, as well as an education gap on the safety of the vaccine that has been largely closed in acute care. For example, a 2015 study revealed that 40% of long-term care staff disagreed with the statement: "Vaccine does not cause influenza."[4]

The evidence is fairly compelling if ignorance and fear can be overcome. Influenza outbreaks in long-term care have been associated with low vaccination rates among staff.[5] Conversely, studies have demonstrated decreases in all-cause mortality in facilities where many staffers are vaccinated.[6]

Overall, 24 states offer some form of flu shot provision for long-term care workers, with varying levels of requirements and exemptions, the CDC reports.[7] The NAIIS is comprised of multiple public and private organizations, including the CDC, the IAC, and the National Vaccine Program Office. Behrman's IWG committee is pursuing a 2018-2019 goal to improve staff flu vaccination coverage in long-term care.

"We have tried to create tools and promote an incentive that is relatively user friendly," says Behrman, who also updated the effort recently in Baltimore at the annual meeting of the Association of Occupational Health Professionals in Healthcare.

As part of this initiative, the IWG developed a guidance document for long-term care administrators who are considering requiring staff flu vaccination.[8] "Implementation of a mandatory influenza vaccination policy for healthcare personnel is not required by the federal government," the IWG document states. "However, there is compelling evidence that healthcare organizations that implement influenza vaccination requirements successfully increase vaccination coverage of their healthcare personnel, and that such increases are associated with reduced staff and patient morbidity and mortality."

The guidelines also cite a recommendation by the Society for Post-Acute and Long-Term Care Medicine, which recommends mandatory flu vaccination policies and masking of those who are not immunized.

"We feel that there is a lot of room to bring the insight, guidance, and tools in acute care to long-term

care settings," says Behrman. "That is acknowledging that the leadership and staff of long-term care facilities have many challenges that are easier to deal with in acute care."

Large healthcare systems in acute care and other settings are "basically making this a norm," she says. Can employee flu vaccination culture change be achieved in long-term care settings?

"I think the answer to that is definitely yes," she says. "We would like them to achieve the Healthy People 2020 goal of 90% vaccination, which will be difficult." ■

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Presenteeism Common in Long-Term Care

Results of a study[1] using active surveillance for acute respiratory infection (ARI) over a five-month period revealed that 89% of sick staff in a long-term care facility still reported to work. The facility established policies against such presenteeism, but they may need to be revised to minimize the pressure on staff not to miss work, the authors noted.

"This finding suggests that facilities should consider strengthening communication and enforcement of work restriction policies and should ensure that they are feasible," the authors concluded.

The investigators conducted active surveillance over a five-month period, taking nasal and throat swabs whenever symptoms were reported by staff members and residents at a long-term care facility. Overall, 76 healthcare workers were enrolled, including 21 nurses. In addition, 105 patients/residents were enrolled. The findings include 13 patients and 24 healthcare personnel (HCP) who reported respiratory symptoms during the period. Overall, 18 healthcare workers met the study definition for ARI.

"None of the patients with ARIs reported contact with a sick visitor during the previous five days," the authors reported. "However, 44% of HCP with ARIs reported a sick household member prior to illness. Of the 18 HCP with an ARI, five (28%) reported having taken sick days and 16 (89%) reported working while ill, including four HCP who had also used sick days."

Self-reporting symptoms was a limitation of the study, with the authors conceding that healthcare workers "may have been particularly reluctant to report respiratory symptoms if they had come to work while ill."

In contrast to many long-term settings, the facility created a mandatory flu immunization program for workers. One worker had influenza but the most commonly identified pathogen was rhinovirus. Many had infections of unknown etiology. No patients had influenza. The study did not show direct transmission of respiratory viruses between patients and staff, but the level of presenteeism presented that risk. ■

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Burnout: The Signs of Onset, Methods of Prevention

A new book is surprisingly specific about a general problem

Burnout is a systemic problem in healthcare and a test of resilience for the individual worker. In a new book[1] on a problem that has become epidemic, a physician draws on his own experience with burnout and interviews those who are susceptible to the condition or are surprisingly resilient.

Hospital Employee Health spoke with book author **Rajeev Kurapati**, MD, MBA, a clinician at St. Elizabeth Healthcare in Edgewood, KY, in the following interview, which has been edited for length and clarity.

HEH: Why did you decide to take this approach in your book? Is it something that has worked for you personally or has demonstrated efficacy in others?

Kurapati: A combination of both. I'm a hospitalist and I do critical care. I've been doing this for over a decade. I have noticed in myself some of the signs of burnout, before I termed it "burnout." That term for this condition or state of mind is actually not quite accurate. It is very difficult to find a suitable word or term for that. Burnout [implies that] the individual is weak, incompetent, and unable to deal with the stress the medical profession is imposing on him or her. The word "burnout" almost signifies an individual weakness. Some of the medical doctors detest that and they don't like the word. They have come up with different names for it. One that kind of describes what it is like is "job-related distress." Some call it a "system-induced" distress. But if it is an institutional problem, it is almost like it is not my problem. It is difficult to define along the spectrum between the individual and the system because it is both. The medical industrial complex has created so many rules, regulations, policies, and job requirements that take away the passion and joy of medicine. The individual can succumb to this. But the solution has to be from both a system and individual standpoint.

HEH: Can you describe your personal experience with feelings of burnout or job-related distress?

Kurapati: I started picking up some of these signs in myself. For instance, after about five or six hours working on a given day, I would get really irritable. I see about 20 to 25 patients a day, and by the evening I was irritable. My mind says "Enough — I can't deal with this anymore." Maybe I promised my children I would do something with them, but it is difficult to keep those promises to your family members and friends. Medical professionals are overachievers. We feel like we are invincible and can do anything. This is how we see ourselves when we go through medical school. We see ourselves with superhuman capacity.

Sometimes you have to push the pause button, slow down, and ask yourself "What is going on?" That is exactly what I did. I went to the Mayo Clinic and interviewed some of the burnout specialists and some of the doctors going through job-related distress. I also interviewed doctors who are resilient, who are doing very well despite the stressors that the job imposes upon them. I started journaling and researching how pervasive this problem is. I found I was not the only one. It's personal, but I have seen these signs in my colleagues and the people I interviewed.

HEH: Your book includes some specific approaches to a problem that often is generalized. For example, to self-assess burnout, you recommend people ask themselves three questions: Do you feel burdened by your next work task? Do work tasks seem to lack purpose? Do you have a persistent feeling of aversion toward the people around you? Can you elaborate on these three areas?

Kurapati: If you cannot stand other people, it means you are depersonalized. In the medical profession, connection is important. If you say, "I cannot deal with people," then something is really wrong. It is not necessarily something wrong with you, but you have to figure out why this is happening. Are you depersonalized, emotionally exhausted, or poorly functioning despite adequate training? Those questions target three areas, but you don't have to have all three. If you answer yes to one of the questions, you are probably in the early phases of burnout. You don't want to wait until you are completely exhausted. If you answer yes for one, it is time to do something about it.

HEH: You note that some people seem to be naturally resilient, while for many of us it is an acquired skill.

Kurapati: Resilience is, by definition, the ability to bounce back in the face of adversity. How quickly are you able to bounce back? If you are not able to bounce back,

why not? Some people can take on change and still function really well. Those are the type of people, if you observe them, whose egos are not so strong. They go with the flow, saying, "This works for everybody, so let me change," instead of, "This doesn't work for me, so I am not going to change." They change themselves for the welfare and the greater good of others. It helps the patients and the organization. For some people, this is innate, although there is breaking point to everything. At that point, they have to have the wisdom to say, "This is out of control, and I'm going to work someplace else." But resilience is an acquired skill for most of us. People who see the big picture become more resilient. Again, we are talking about personal resilience here, but organization resilience also is important.

HEH: Can you comment further on this concept of "shadow work," which you say can be daunting if you do not acknowledge it?

Kurapati: We have all been told if you love your job, you never really work a single day. The statement doesn't work anymore. No matter how much you love your job, there are aspects that are not pleasant. For example, my passion as a doctor is two things. One is intellectual reasoning. I am faced with a problem when a patient comes to me. My brain kicks into intellectual mode and starts doing the detective work. How do I diagnose this problem? What tests should I order? The other part is the connection with the patient. If I make a good connection with the patient and I am able to intellectually use my skills that I learned in medical school, that completes the picture. That is what excites me in my job.

But the job doesn't stop there. I have to fill out the charts and paperwork. I am accountable to insurance companies and the institution where I work. This is the "shadow work." These are the necessary compromises I have to make to be in this profession. When I went to med school, I didn't expect that one-third of my life would be spent doing chart work. I didn't expect I would take chart work home. But all of these things are necessary and you have to acknowledge it. It is not what I am passionate about, but it is something I have to deal with.

Find creative solutions and list them. Say a new requirement is put in place by policymakers. Find a way to deal with it that is most efficient and that works for you. List solutions to your shadow work and find one that works for you.

HEH: Can you speak a little bit to this idea of "bringing order to the content of your mind?"

Kurapati: Most people run away from spending time with themselves. You look for some distraction to your mind. The usual attitude is that it is a scary place and you don't want to go there. But it is the content of your mind that determines the kind of person you are. It is the narrator of your story; it tells you what kind of life you are living. If the content of your mind is disorganized or you don't have control over it, you have lost it. People who are successful — and I don't mean wealth, but people who have contentment in their life — are happy with what they have and find passion in what they do. These people have mastered the content of their mind.

The best way to examine this is to take a walk with no distractions. Observe the dialogue that goes on in your mind. That will tell you what kind of life you are living. Are you constantly complaining and playing the victim? Listen to the inner dialogue that goes on in your mind. If your mind is saying, "Despite the ups and downs, I am content with my life," then you are in reasonable control of the content of your mind. But if the dialogue says you are unable to deal with the stresses of your life, you have to reorganize the content of your mind. The way you do that is start with what is important in your life, what you are passionate about, and work toward that.

HEH: After someone begins to recognize and tries to prevent burnout, you recommend a follow-up self-assessment. This includes determining how frequently you feel emotionally upset, the intensity of those feelings, and your resilience in overcoming the experience and returning to a steady state.

Kurapati: No matter what techniques, strategies, and interventions that you do, you need to know if they are working. This is more or less a performance evaluation of the changes that you made. How frequently are you getting disturbed? Imagine you are calm and in a state of equilibrium, then life throws you a curve ball. You may be faced with adversity and change. Your mind gets comfortable in a certain stream of workflow. When a change happens, your mind sees that as a threat. It sees it as adversity. In that emotional state, how frequently are you getting disturbed or losing your cool? How intensely are you reacting to this adversity? Are you reacting to the point where you are becoming depersonalized and dysfunctional? Or, are you able to manage it and still function well? Intensity is important. No matter how hard the adversity is, [the key] is how you react to it.

The final one is recovery. When faced with change and adversity, are you able to recover and bring yourself back to a state of equilibrium? This is where you need to calm your mind. Rather than saying, "I am a victim of this change," say, "I am going to use this change to make my life enriching." You must find solutions to get around it, and turn it in a way that actually works for you. If it doesn't work for you and you are in distress, then you have to make the hard decision whether this is the right thing to continue. ■

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Infectious Disease Groups Demand Border Patrol Administer Flu Shots to Detainees

'You could not design a more ideal circumstance for transmission'

Employee health professionals know all too well that confined, crowded conditions for unvaccinated people during influenza season increases the change of an outbreak.

Leading clinicians and public health officials are strongly questioning the U.S. Customs and Border Patrol's (CBP) decision not to vaccinate migrants in detention facilities against flu and other infections. The CBP should at the very least immunize employees so they do not bring the virus in to detainees or acquire it, says **Amy Behrman**, MD, FACP, FACOEM, director of occupational medicine at the Hospital of the University of Pennsylvania in Philadelphia.

"It is unethical and dangerous for the people outside the facilities as well as being completely wrong and immoral for the people inside," she tells *Hospital Employee Health*. "Absolutely they should immunize the employees for their own and their families' protection, and to protect the individuals in the facilities."

Close Confinement Causes Easy Transmission

Closely confining people who may be weak and malnourished from an arduous journey sets the stage for an outbreak if flu or other infectious agents are introduced by a new arrival or a facility employee.

"You could not design a more ideal circumstance for the transmission of respiratory viruses and intestinal pathogens because of the close, sustained person-to-person contact they have within an enclosed environment," says **William Schaffner**, MD, a leading vaccine expert and professor of preventive medicine at Vanderbilt University.

A letter[1] submitted to Congress by clinicians at Harvard University and Johns Hopkins hospital said autopsy results show that three children have died in U.S. custody in part because of influenza since December 2018.

"These children were aged two, six, and 16," the clinician letter states. "These tragic deaths appear to represent more than half of child deaths in the last year in these immigration facilities, and to reflect a rate of influenza deaths substantially higher than that in the general population."

In addition to influenza, the CDC recently reported that from Sept.1, 2018, to Aug. 22, 2019, there were 898 confirmed and probable cases of mumps in detained migrants.[2]

The CBP has issued a widely quoted statement that "due to the short-term nature of CBP holding and the complexities of operating vaccination programs, neither CBP nor its medical contractors

administer vaccinations to those in our custody."

There is some speculation that medical care and vaccinations may occur at a later stage of the immigration process, but that could not be confirmed as this report was filed. "They are not thinking in terms of the individual," Schaffner says. "They are thinking administratively and bureaucratically. We know that immunity develops over 10 days to two weeks, so some of these children who are less than eight years old would require two doses of vaccine separated by a month."

With flu season approaching, time is of the essence. "All of this is more poignant and pointed because we have had not only the illnesses described, but they have had children who have died of influenza," he says. "What could be more motivating for them to initiate protection against influenza at the earliest possible moment?"

Indeed, the issue raises a moral and ethical imperative for providers and caregivers. "CBP actually keeps some people much longer than two or three days. If they are not committed to providing medical evaluations and preventive health services, that's terribly unfortunate," Schaffer says. "We as a society have, because of these policies, assumed responsibility for these individuals. They are now our responsibility."

Several major infectious disease groups also issued a joint statement calling the inaction on immunizations "a violation of the most basic principles of public health and human rights."[3] The statement was issued by the presidents of the Infectious Disease Society of America, the Society for Healthcare Epidemiology of America, the Pediatric Infectious Diseases Society, the HIV Medicine Association, and the American Society of Tropical Medicine and Hygiene.

"The CBP's decision to withhold vaccinations against seasonal influenza from migrants in border detention facilities … runs directly counter to the imperative that no individual should be harmed as a result of being detained, and that the community standard of medical care be available to persons in the custody of the U.S. government," the joint statement read.

Since 2010, the CDC has recommended universal flu vaccination for those age six months and older. "In conditions of overcrowding, poor sanitation, and emotional stress involving vulnerable populations such as pregnant women and young children, choosing not to follow the CDC recommendations is particularly egregious," according to the statement. ■

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MERS Shows 16% Mortality Rate in Healthcare Workers

Case review in Middle East underscores occupational threat

Middle East Respiratory Syndrome (MERS) coronavirus threatened emergence in the United States in May 2014, when two healthcare workers became symptomatic after working in Saudi Arabian hospitals.

The emerging infection was identified and stopped, but healthcare workers in Saudi Arabia and the surrounding region still are acquiring MERS — sometimes fatally.

A recently published analysis[1] of reported MERS cases between December 2016 and January 2019 revealed that 26% of 403 cases in the region were healthcare workers. The case fatality rate was a disturbing 16% among healthcare workers, compared to 34% among patients. Only 1.9% of the healthcare workers infected had comorbidities compared to 71% in other MERS cases over the period.

"Healthcare workers constitute a high-risk group owing to continued exposure at healthcare settings," the authors warned. "It is important to screen exposed healthcare workers prior to allowing them to resume medical duties, and multiple samples

may be needed. In addition, there is a need for continued vigilance and identification of suspected cases."

Early Detection, Treatment Vital

The review period included a large outbreak in Saudi Arabia in 2017 involving three hospitals, with healthcare workers acquiring the virus from admitted patients. "All healthcare facilities should adopt strategies for early detection and isolation of patients suspected to have MERS infection," the authors reported.

Most healthcare workers who acquire MERS experience mild or asymptomatic infections. However, there have been cases of asymptomatic workers transmitting MERS to their colleagues.

In addition to Saudi Arabia, MERS cases were reported from Lebanon, Malaysia, Oman, Qatar, and United Arab Emirates. Although most likely of bat origin, the coronavirus has established an animal reservoir in camels in the region. Camel exposures, primarily consuming camel milk, were reported in 64% of the community MERS cases.

The first MERS cases emerged in 2012, and the link to dromedary camels now is well established. The camel is deeply entrenched the Saudi culture, which has thus far resisted the kind of large cull of animal reservoirs performed for emerging infections like SARS and H5N1 avian flu. ■

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1. Al-Tawfiq, Memish ZA. Middle East respiratory syndrome coronavirus in the last two years: Health care workers still at risk. *American Jrl Infect Control* 2019;47:1167-1170.

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CE QUESTIONS

1. **Which did William Schaffner, MD, professor of preventive medicine at Vanderbilt University, say is critical to emphasize about flu vaccine?**

   a. Nasal spray and needleless immunizations
   b. Common side effects go away within 36 hours
   c. The importance of partial protection
   d. Protection against pneumococcus

2. **Lydia Crutchfield, MA, BSN, RN, said her facility's flu immunization policy requires exempt unvaccinated employees to wear a mask:**

   a. if they show respiratory illness symptoms.
   b. if they work in a unit with immune-compromised patients.
   c. if they run a fever.
   d. if they are within six feet of a patient.

3. **According to the CDC, hospitals with mandatory requirements immunized what percentage of workers in the 2017-2018 flu season?**

   a. 85%
   b. 90%
   c. 95%
   d. 98.5%

4. **Rajeev Kurapati, MD, MBA, said if you start feeling you cannot stand people at work, you are likely experiencing:**

   a. depersonalization.
   b. emotional exhaustion.
   c. chronic fatigue.
   d. system-induced distress.

COMING IN FUTURE MONTHS

- NIOSH moving to quieter powered air purifying respirator
- Managing worker colonization with multidrug-resistant organisms
- Joint Commission stance and standards on drug diversion
- Workplace health teams: All for one and one for all?

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