



UW TASP
tele-antimicrobial stewardship program

echo

September 10th, 2024

- Announcements: None
- John Lynch: *(Flu)Vaccines – Getting them to your HCW*
- Guideline Redcap Survey
- Facility Question
- If time allows...rapid fire journal club

Why Vaccinate HCWs?

- Infection
- Transmission
- Disease progression/severe disease
- Death

Vaccinations for HCWs

- Routine vaccines for a person's age
- Influenza vaccine
- COVID-19 vaccine
- Hepatitis B vaccine
- Extra: hepatitis A vaccine, meningococcus vaccine
- Mpox vaccine?

Vaccine	19–26 years	27–49 years	50–64 years	≥65 years
COVID-19	1 or more doses of updated (2023–2024 Formula) vaccine (See Notes)			
Influenza inactivated (IIV4) or Influenza recombinant (RIV4)	1 dose annually			
Influenza live, attenuated (LAIV4)	1 dose annually			
Respiratory Syncytial Virus (RSV)	Seasonal administration during pregnancy. See Notes.			≥60 years
Tetanus, diphtheria, pertussis (Tdap or Td)	1 dose Tdap each pregnancy; 1 dose Td/Tdap for wound management (see notes)			
	1 dose Tdap, then Td or Tdap booster every 10 years			
Measles, mumps, rubella (MMR)	1 or 2 doses depending on indication (if born in 1957 or later)			For healthcare personnel, see notes
Varicella (VAR)	2 doses (if born in 1980 or later)	2 doses		
Zoster recombinant (RZV)	2 doses for immunocompromising conditions (see notes)		2 doses	
Human papillomavirus (HPV)	2 or 3 doses depending on age at initial vaccination or condition	27 through 45 years		
Pneumococcal (PCV15, PCV20, PPSV23)				See Notes
				See Notes
Hepatitis A (HepA)	2, 3, or 4 doses depending on vaccine			
Hepatitis B (HepB)	2, 3, or 4 doses depending on vaccine or condition			
Meningococcal A, C, W, Y (MenACWY)	1 or 2 doses depending on indication, see notes for booster recommendations			
Meningococcal B (MenB)	19 through 23 years	2 or 3 doses depending on vaccine and indication, see notes for booster recommendations		
Haemophilus influenzae type b (Hib)	1 or 3 doses depending on indication			
Mpox				

Recommended vaccination for adults who meet age requirement, lack documentation of vaccination, or lack evidence of immunity

Recommended vaccination for adults with an additional risk factor or another indication

Recommended vaccination based on shared clinical decision-making

No recommendation/Not applicable

VACCINE	Pregnancy	Immunocompromised (excluding HIV infection)	HIV infection CD4 percentage and count		Men who have sex with men	Asplenia, complement deficiency	Heart or lung disease	Kidney failure, End-stage renal disease or on dialysis	Chronic liver disease; alcoholism ^a	Diabetes	Healthcare Personnel ^b		
			<15% or <200mm ³	≥15% and ≥200mm ³									
COVID-19	See Notes												
IIV4 or RIV4	1 dose annually												
LAIV4						1 dose annually if age 19–49 years		1 dose annually if age 19–49 years					
RSV	Seasonal administration. See Notes	See Notes					See Notes						
Tdap or Td	Tdap: 1 dose each pregnancy	1 dose Tdap, then Td or Tdap booster every 10 years											
MMR	*												
VAR	*	See Notes											
RZV		See Notes											
HPV	*	3 dose series if indicated											
Pneumococcal													
HepA													
Hep B	See Notes								Age ≥ 60 years				
MenACWY													
MenB													
Hib		HSCT: 3 doses ^c					Asplenia: 1 dose						
Mpox	See Notes	See Notes										See Notes	

Recommended for all adults who lack documentation of vaccination, OR lack evidence of immunity

Not recommended for all adults, but recommended for some adults based on either age OR increased risk for or severe outcomes from disease

Recommended based on shared clinical decision-making

Recommended for all adults, and additional doses may be necessary based on medical condition or other indications. See Notes.

Precaution: Might be indicated if benefit of protection outweighs risk of adverse reaction

Contraindicated or not recommended
^aVaccinate after pregnancy, if indicated

No Guidance/ Not Applicable

Influenza Vaccination




The World Health Organization and other national and international agencies strongly recommend that all healthcare workers (HCWs) receive an annual influenza vaccination to minimize flu-generated morbidity and mortality among professionals, prevent potential nosocomial outbreaks, and limit absenteeism and consequent disruption of medical services [1–3]. Although flu immunization is the most effective public health intervention to mitigate and prevent seasonal influenza [3], influenza causes up to 650,000 deaths per year worldwide [4] and vaccination rates among HCWs remains largely suboptimal [5–7]. Encouraging flu vaccination uptake among HCWs seems even more relevant and urgent as the world navigates through the COVID-19 pandemic [8].


Review


Nudges or mandates? The ethics of mandatory flu vaccination

Alex Dubov ^{a, b}  , Connie Phung ^c 

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<https://doi.org/10.1016/j.vaccine.2015.03.048> 

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Highlights

- Influenza vaccination mandates are very effective but controversial.
- Those opposing mandates believe it is unethical to remove one's choice about own health.
- Behavioral economics offers choice-preserving strategies to increase vaccination.
- These strategies incentivize vaccinations and help better align intentions with actions.

Influenza Vaccination

A review of studies looking at reasons for declination of influenza vaccination may identify several groups of incompliant healthcare workers: *unaware*, *unbelieving*, *unmotivated*, and *unconcerned*. The *unaware* group tends to consider themselves at a low risk of infection and consequently not as a high priority group to receive vaccinations. Their sense of good health and associated perception of risk as well as minimization of the risk of influenza for patients guides their decisions to decline vaccinations.

The *unbelieving* group doesn't agree with recommendations to be vaccinated as they don't believe in the effectiveness of vaccines.

Influenza Vaccination

The *unmotivated* group cites their fear of side-effects and long-term complications, their fear of needles, and their general dislike of medication as the reason they forego vaccination

Finally, the *unconcerned* group convey the sense that vaccination stations are not readily available and the process of vaccination is inconvenient especially for nurses working off shifts [15].

Cognitive Biases and Nudges

Table 1. Cognitive biases involved in vaccination decision-making and potential nudges that may alleviate their effect.

Cognitive bias	Definition	Effect on vaccination decisions	Potential nudges
Omission bias	The tendency to prefer a potentially harmful inaction (omission) to a potentially less harmful act	Higher risk of catching a disease is preferable to suffering from vaccine side effects. Willingness to suffer longer from symptoms of a disease rather than the side effects of a vaccine	Pre-commitment devices (writing down date and time of the vaccination appointment)
Ambiguity aversion	The tendency to prefer a known risk (continue without treatment) to unknown risk (a confusing treatment)	Foregoing vaccination when the safety information appears to be inconsistent	Social norms
Present bias	The tendency to place more weight on costs and benefits today, and less weight on those realized in the future	The inconveniences of vaccination experienced in the present outweigh the benefits of future protection	Financial incentives, tax incentives

Table 1. Cognitive biases involved in vaccination decision-making and potential nudges that may alleviate their effect.

Cognitive	Definition	Effect on vaccination decisions	Potential nudges
Availability bias	The tendency to judge occurrence of side effects as likely or frequent if it is easy to imagine or recall	The more vivid information about vaccine side-effects clouds the factual information about vaccine benefits	Vaccination message framing
Optimism bias	The tendency to be more optimistic about a particular health risk, believing it is greater for other people than for themselves	Chances of getting a disease are higher for other people than for oneself, therefore no felt urgency to vaccinate	Pre-commitment devices (writing down date and time of the vaccination appointment)
Naturalness bias	The tendency to prefer natural products or substances even when they are identical or worse than synthetic alternatives	Declination of synthetic treatments and belief in the natural immunity of the body	Emotional prompting
Protected values	Values absolutely held and not amenable to tradeoffs	Vaccinations are wrong	Nudges may backfire

Influenza Vaccination

When one decides to become a healthcare provider, he or she automatically decides to make certain sacrifices and assume some personal risks that come with this profession. Just as firefighters are not free to choose whether they will attend at a particularly bad fire or police officers have to patrol dangerous areas, healthcare professionals may not be free to decide about the negligible level of personal risk that comes with vaccination but offers protection to their patients.

UW Medicine HCW Flu Vaccine Campaign



UW Medicine Influenza Prevention Program 2024

UW Medicine is providing influenza vaccine free of charge to our healthcare workers and volunteers beginning on **Monday, September 23th, 2024.**

The most effective way to prevent influenza from spreading in our workplace, homes and communities is to get vaccinated. Per UW Medicine Policy, you must be compliant with the Influenza Vaccination Program by **November 15, 2024.**

Compliance is defined as one of the following:

1. You have gotten the flu vaccine at one of our Employee Health Clinics.

Flu vaccination is offered on a walk in basis for employees, volunteers and students working in our facilities at any of our hospital-based employee health clinics. Flu vaccination is also offered on your unit or in your clinic – please see your department leader if you are unsure who your team's flu vaccination champion is.

Location (map):	HARBORVIEW MEDICAL CENTER MAIN HOSPITAL (1EC-21)	UW MEDICAL CENTER MONTLAKE (BB-306)	UW MEDICAL CENTER NORTHWEST (MAB-107)
Hours of Operation:	Monday-Friday 0630-1630 Extended Hours: (9/23/24-10/5/24) Monday-Friday 0600-1800 Saturday 1100-2100	Monday-Friday 0715-1600	Monday-Friday 0715-1600
Phone:	206-744-3081	206-598-7971	206-668-1625

*See "Flu Vaccine Pop-ups" schedule for additional options.

2. You have gotten the flu vaccine elsewhere OR You have completed the declination process.

Tell us when and where you got it by submitting your vaccine information OR complete declination here:

Vaccine Attestation

Vaccine Attestation

UW Medicine

2023-2024 UW Medicine Influenza and COVID-19 Vaccination Campaign



John B. Lynch

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Employee ID:

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I am declining a vaccine OR notifying Employee Health that I received a vaccine elsewhere for:

Vaccine(s) You Are Attesting

- ☐ Covid-19
- ☐ Flu
- ☐ Both

NEXT

RESET

Original Investigation | Public Health

State COVID-19 Vaccine Mandates and Uptake Among Health Care Workers in the US

Yin Wang, MA; Charles Stoecker, PhD; Kevin Callison, PhD; Julie H. Hernandez, PhD

Abstract

IMPORTANCE Seventeen states introduced COVID-19 vaccine mandates for health care workers (HCWs) in mid-2021. Prior research on the effect of these mandates was centered on the nursing home sector, and more evidence is needed for their effect on the entire HCW population.

OBJECTIVE To examine the association between state COVID-19 vaccine mandates for HCWs and vaccine uptake in this population.

DESIGN, SETTING, AND PARTICIPANTS This repeated cross-sectional study included biweekly, individual-level data for adults aged 25 to 64 years who were working or volunteering in health care settings obtained from the Household Pulse Survey between May 26 and October 11, 2021. Analyses were conducted between November 2022 and October 2023.

EXPOSURE Announcement of a state COVID-19 vaccine mandate for HCWs.

MAIN OUTCOMES AND MEASURES An indicator for whether a sampled HCW ever received a COVID-19 vaccine and an indicator for whether an HCW completed or intended to complete the primary COVID-19 vaccination series. Event study analyses using staggered difference-in-differences methods compared vaccine uptake among HCWs in mandate and nonmandate states before and after each mandate announcement. The sample was further stratified by the availability of regular COVID-19 testing in place of a vaccination (ie, a test-out option) and by the ages of HCWs (25-49 or 50-64 years) to examine heterogeneous associations.

RESULTS The study sample included 31 142 HCWs (mean [SD] age, 45.5 [10.6] years; 72.1% female) from 45 states, 16 of which introduced COVID-19 vaccine mandates for HCWs. Results indicated a mandate-associated 3.46-percentage point (pp) (95% CI, 0.29-6.63 pp; $P = .03$) increase in the proportion of HCWs ever vaccinated against COVID-19 and a 3.64-pp (95% CI, 0.72-6.57 pp; $P = .02$) increase in the proportion that completed or intended to complete the primary vaccination series 2 weeks after mandate announcement from baseline proportions of 87.98% and 86.12%, respectively. In the stratified analyses, positive associations were only detected in mandate states with no test-out option and among HCWs aged 25 to 49 years, which suggested vaccination increases of 3.32% to 7.09% compared with baseline proportions.

CONCLUSIONS AND RELEVANCE This repeated cross-sectional study found that state COVID-19 vaccine mandates for HCWs were associated with increased vaccine uptake among HCWs, especially among younger HCWs and those in states with no test-out option. These findings suggest the potential for vaccine mandates to further promote vaccinations in an already highly vaccinated HCW population, especially when no test-out option is in place.

for health care workers
entered on the nursing
HW population.

mandates for HCWs and

study included biweekly,
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October 11, 2021. Analyses

Ws.