



Immunize Weekly Summary: October 15, 2026 Seasonal Vaccination and the Health Care Workforce

- Society for Healthcare Epidemiology of America (SHEA) Perspectives
- Post-Acute and Long-Term Medical Care Association (PALT-med) Immunization Recommendations and Resources
- Vaccines and Vaccine Hesitancy in the Workplace: American College of Occupational & Environmental Medicine (ACOEM)

SHEA Perspectives – Lynne Jones Batshon, Director, Policy & Practice, SHEA

Lynne Jones Batshon summarized SHEA's perspectives on immunization policies.

SHEA's members include researchers, clinicians, pharmacists, infection preventionists, public health professionals, and health care leaders working in hospitals, health care systems, long-term care (LTC) facilities, academic institutions, and public health agencies. SHEA supports:

- broad adherence to routine immunization recommendations;
- evidence-based vaccination requirements in health care settings;
- limited exemptions to documented medical contraindications; and
- policies that help protect patients and health care personnel (HCP) from vaccine-preventable diseases.

People working in health care environments regularly care for patients at higher risk of respiratory infections, making prevention especially important. Health care organizations and public health agencies have a duty to reduce preventable risks wherever possible, especially for those with limited ability to protect themselves. At the same time, preventing illness helps reduce strain on health care systems, preserve resources, and maintain access to care for those who need it most. Thus, efforts to reduce transmission can help create safer environments for patients, residents, families, caregivers, and HCP alike.

In the current landscape, questions have surfaced related to trust, risk perception, communication, access, workplace culture, and vaccine. These issues must be better understood to create solutions to protect health. Effective communication starts with acknowledging questions and concerns. It requires transparency about what we know, what

we don't know, and how recommendations are developed. And it depends on trusted messengers who have built relationships within their communities and organizations. SHEA is committed to listening, engaging respectfully, and working alongside partners across health care, public health, occupational health, and patient advocacy communities.

QUESTIONS & ANSWERS

Q: Is the SHEA position statement from March 2026, "[Vaccines for Healthcare Personnel: A Core Safety Measure](#)," the most recent position statement from SHEA?
[Note, the statement does reside behind the journal's firewall.]

Lynne Batshon (SHEA): Yes, that is our most recent policy statement. We're trying to figure out how to navigate the current unanticipated, dramatic change in the immunization policy landscape. We do want to be careful about how we proceed and any changes we might make to that statement. Everything seems to be in flux right now, especially since ACIP [the Advisory Committee on Immunization Practices] is the subject of litigation. But yes.

PALT-med Immunization Recommendations and Resources – Elizabeth Sobczyk, MSW, MPH, Chief Operating Officer, PALT-med

Elizabeth Sobczyk, MSW, MPH, highlighted recent PALT-med resources available to all.

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Recommendations

For the 2026–27 respiratory virus season, PALT-med recommends one dose of COVID-19 vaccine for LTC facility staff and residents. Discussion is underway about the value of a second dose for immunocompromised residents. PALT-med is adding routine influenza and respiratory syncytial virus (RSV) vaccinations to its recommendations for this season.

Results from the Moving Needles Project

A 5-year Centers for Disease Control and Prevention (CDC) cooperative agreement yielded the following publications:

- [New COVID-19 Vaccine Cost and Access Barriers Add Challenges to Immunizing Post-Acute and Long-Term Care Staff](#) [Note that this document is behind the journal's paywall.]
- [Developing and Implementing an Intervention to Increase Immunization Coverage Among Frontline Long-Term Care Staff](#)
- [Lessons Learned From an Immunization Quality Improvement Project Focused on Residents Living in Long-Term Care Settings, United States, 2022 to 2024](#)
- Lessons Learned From an Immunization Quality Improvement Project Focused on Staff Working in Long-Term Care Settings (in press)

Facility-Based Resources

The following resources are available on the [Moving Needles website](#):

- Implementation guide including lessons learned from the 5-year CDC project, process suggestions, a standing order template, sample scripts, planning calendar, tracking spreadsheet for rates, and a billing guide, all free and customizable
- Online courses on talking about RSV vaccines and vaccines in the pipeline and a course on immunization essentials for LTC facility staff
- Clinician fact sheets on RSV disease and talking to staff about vaccines in the pipeline
- Handouts, videos, and in-service slides for staff
- Handouts for families

System-Based Resources

- [Two papers](#) on electronic health record (EHR) and immunization information systems interoperability
- Resources on the [challenges of vaccinating staff in LTC facilities](#)
- [Frontline staff survey results](#) revealing that many have questions about efficacy that could be addressed with education
- [Billing guide](#) that addresses the unique considerations of LTC facilities

QUESTIONS & ANSWERS

Q: There is a general reduction in vaccination of all health care providers, and so specifically, the question is: what were the root causes? In last week's presentation, Carla Black of the CDC noted the dramatic decline in coverage among the LTC facility nursing aide population. So the question is, what seems to be the cause?

Lynne Batshon (SHEA): My answer is easy: I don't know. I only know what we hear anecdotally from members, and that was supported by the presentation Dr. Black gave last week, so I look forward to the publication of that manuscript when it comes out. Having said that, what we're hearing from members anecdotally is that, because of political pressure coming not just from the federal government but from certain state governments, it becomes more difficult to track the vaccination status of HCP. There are some states that are actually preventing employers, including health care employers, from asking about, for example, COVID-19 vaccination status.

The other, more common issue I hear about is really in the LTC space. Not for lack of trying or effort, but the turnover rate among staff in nursing homes and assisted living is so high that it becomes difficult to track when and where staff actually get their vaccines, and to confirm that [vaccination]. So it's more of a surveillance and recordkeeping issue, and less about resistance to getting the vaccine. Now, having said that, it does appear that some of the folks who are declining vaccine are declining for reasons other than logistics. They're hesitant or perhaps have received some information that is discouraging, so we're trying to figure that out.

Elizabeth Sobczyk (PALT-med): Yeah, I completely agree. There's both a logistics component and a hesitancy component to address. For a while we had the LTC vaccination program that was able to provide COVID-19 vaccine on site for staff, and the pharmacies had some exemptions as well, so it was just much easier for a short period of time to get vaccinated at your facility, and that no longer exists.

As I noted, we have a higher uninsured population in the LTC space, so when you don't have a safety net program providing that vaccine, it's certainly challenging. And with high turnover, as Lynne mentioned, a lot of facilities do one clinic to get everybody vaccinated. You might not hit all of your staff shifts, you might not hit people who were out that day, and when you have high turnover rates, a one-time [clinic] might not carry you through a full season for all of your staff on site. So, I think all of those contribute to the logistical side of things.

We've also seen cases where LTC staff were mandated to get the COVID vaccine, and some facilities mandated flu along with that. So, we think there's a little bit of pushback now, saying, "I didn't get the choice then, and I am making the choice now not to get it." That's not the entirety of the population, and it might not even be the majority, but it's a theme that has come up repeatedly. So I think there are both of those pieces going on.

Amy Behrman (ACOEM): I'm going to echo Lynne and Elizabeth and say: I don't know. I think logistics play a significant role, and growing personal hesitancy plays a huge role. But I'm going to add that I think the root causes are heterogeneous. I think they are local in many cases. And I think they reflect the fact that we think of ourselves as somehow separate from the general population in terms of our knowledge, attitudes, and politics, but we're not. Health care workers are people; they are subject to the same community trends and pressures and nudges that everybody else is, and I think that's a large part of what we're seeing.

Q: In the [PALT-med] pilot study, did you come across any successful examples of staff immunization being integrated into hospital-acquired infection [reduction] efforts, along with strategies that support this approach in LTC facilities? And if so, can you share the details?

Elizabeth Sobczyk (PALT-med): We actually did not see a lot of that. I know across CDC and other spaces we've tried linking the two—antimicrobial resistance efforts and things like that—but there are separate measures for vaccination in LTC, and the efforts tend to be separate. The challenges are logistical: you've got to get consent for vaccinations, you've got to get the clinic scheduled, and things like that. We do talk about some of those pieces in our in-service for staff, but we didn't see a lot of facilities trying to integrate it into other pieces. It seemed to be a pretty distinct component. So, I think it's worth incorporating into education with staff, but the execution efforts seem to be fairly distinct from what we saw in the pilots.

Q: Dr. Black gave a number [for coverage rates for influenza vaccination in LTC HCP] that was in the low 60s. The question is, what could be the proportion of staff in LTC facilities who are vaccinated, given the unique challenges you've cited?

Elizabeth Sobczyk (PALT-med): "What could be" and "what are" are two different things. The recordkeeping is a big problem. With residents, when you see your HCP, you have an EHR tracking that, but you don't have an EHR for staff who are employed. So typically you're talking about a shadow system, an Excel spreadsheet, and [then add in] the high turnover we've already mentioned. Whatever numbers we have likely don't represent the full picture of people who have been vaccinated, because they may have been vaccinated off site and maybe didn't bring in a slip of paper saying, "Yes, I've been vaccinated at such-and-such pharmacy." And it might not reflect somebody sitting there counting during a clinic to make sure the people who said they were coming in did [come in]. So, there are a lot of tracking issues, and I'm not giving a number, which I know this person probably wants.

I think 60–70%—I’d be really happy with 60–70%, to be honest. I’d be really happy with 50%, to be honest. I think it’s a really great start. Once you hit that point, you’re starting to norm more than not norm, which is a big part of the LTC experience, and that is a protective factor for an entire community—not a closed community, but a very defined community.

Q: Does economics motivate staff to get vaccinated? I know it’s not entirely the staff who bring in influenza, but the cost of ameliorating an influenza outbreak in a LTC facility can be significant when you’re thinking about antivirals and lost staff productivity. Is that a motivation for staff members to get vaccinated, or do they not really see that?

Elizabeth Sobczyk (PALT-med): No. We’ve even looked at the incentive piece of it—I know the literature is mixed on the benefit of incentives. We saw facilities that had people donate iPads, cars, all of these things going into a raffle, and those really did not move the needle on vaccination rates. It was really fascinating to me. What we saw was that community-based incentives drove it more than anything—things like “Team Vaccine” T-shirts and jackets, coming together as a community to say, “This is who we are, and this is what we represent.” Those kinds of incentives were more impactful. We had a facility that had \$5 gift cards, and they would call out vaccine trivia over the loudspeaker, and whichever staff member got to the office first with the correct answer got the \$5 gift card. So it was not the big incentives that made a difference; it was really connecting residents and staff and making things about the community rather than about the economic incentive.

Q: How much of a factor is educating and getting consent from family members to get the patients vaccinated?

Elizabeth Sobczyk (PALT-med): That’s definitely something that takes a lot of time and energy and is a big factor. Most people need family consent, or it’s been mandated by the chain or the facility that they have family consent as opposed to allowing assent from the residents themselves. So, in that implementation guide we have a multi-vaccine consent form that we really recommend folks use on admission for residents, in the admissions paperwork. It can be revoked at any time. It’s based on CDC recommendations, but it’s been vetted. We did this with the National Community Pharmacists Association, so it meets their needs as well. I really highly recommend using this multi-vaccine consent form on admission, if your legal counsel will allow it, to address that barrier, so that you can minimize the number of times you have to go to family members to ask for individual vaccine approvals.

Vaccines and Vaccine Hesitancy in the Workplace: Amy J. Behrman, MD, Chief, Occupational Medicine, University of Pennsylvania

Amy J. Behrman, MD, described findings from local experience and international research on vaccine hesitancy among HCP.

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Lessons Learned From Institutional Approaches to Vaccine Uptake

- Promotions, incentives, and prizes had little impact on seasonal influenza vaccine uptake.
- Education targeting the stated reasons for refusal (from declination forms) resulted in a small increase in uptake of seasonal influenza vaccine uptake.
- Employer mandates (a.k.a. conditions or requirements of employment) are effective but some employees strongly object to them.
- Employer recommendations for vaccination are less effective than mandates but more effective than no mandate or recommendation.
- Mitigating barriers to vaccination is very effective, such as providing free vaccines in the workplace.

Survey and Literature Findings on HCP and Vaccine Hesitancy

- Resistance, fear, and exemption requests appear to be increasing. There are concerns that vaccine-hesitant HCP are less likely to follow evidence-based guidelines for patient care and more likely to live in communities with low vaccination rates (according to ACOEM survey findings).
- Vaccine uptake among [European HCPs](#) varies by HCP type and by region, and concerns include vaccine safety and lack of information.
- Vaccine hesitancy is [multifactorial](#) and not necessarily related to vaccine availability.
- There is a need to [build trust](#), employ HCP-specific communication strategies, and address logistic barriers of time and cost.
- [A review](#) spanning 50 years of research suggests interventions be targeted to HCP roles and contexts.
- One of the few [studies](#) of interventions to reduce vaccine hesitancy pointed out that education was critical to the success of employer mandates.
- Efforts to increase [measles vaccination](#) among HCP had limited effect and highlighted that adult vaccine hesitancy potentially affects all workplaces.
- A [30-year review](#) found that multi-component interventions are more effective than mono-component ones and suggested “soft” policy interventions may be more effective in some contexts.
- Since 2021, exemption rates have been increasing across nine Philadelphia medical centers, despite no changes in policy, leadership, or staff demographics, and religious exemptions now account for the majority of exemptions (from unpublished data).

ACOEM Deliverables

- 2026 ACOEM Position Statement: [Building a Healthier Workforce](#): The Value of Employer Sponsored Vaccination Programs in the Workplace focuses primarily on economic benefits and includes recommendations for employers in any setting.
- Update to [Guidance for Occupational Health Services in Medical Centers](#) (2019) is in press.

QUESTIONS & ANSWERS

Q: In some places with policy, we've been using the term "condition of employment" versus "mandate." The question is whether "mandate" turns people off and hardens resistance.

Amy Behrman (ACOEM): Oh, I absolutely think it does—and sorry, I was using “mandate” as shorthand. I think “employer requirement” and “employer policy” are a far better way to go.

Elizabeth Sobczyk (PALT-med): Yes, I do think anything “mandated” at this point is a much harder sell. There still is a sense of desire to protect others, but anything that triggers a person’s brain to say “they’re not giving me a choice” is really hard to overcome right now.

Lynne Batshon (SHEA): Yeah, just building on that, we also limit our terminology to “condition of employment,” and we also allow the employee to establish that they have immunity. So, we don’t require or mandate that a vaccine be taken, but if that employee can show otherwise that they are immune from a vaccine-preventable disease, then that would meet the condition of employment.

Amy Behrman (ACOEM): Strongly agree. The more choices you can give people, the better. The more agency they have in the process, the better.

Q: Regarding the increased 60% religious exemption: how is it determined that the identified religion is legitimate? I think Dr. Paul Offit has said that there’s only truly one religion that disqualifies immunization.

Amy Behrman (ACOEM): I’m certainly not a theologian, and I’m thankfully not involved in reviewing the religious exemption requests, but we do wrestle with this often. I think there are different state regulations and institutional legal risk tolerances that tend to guide that, and those are evolving in a direction that makes it more lenient, or easier, to obtain those exemptions. I don’t know if that helps.

Q: My understanding from the American Nurses Association is that immunization is really not taught in nursing school. They have a lot of topics they must teach, and immunization is not one of those. So, when nurses come into your facilities, Amy—or what are the recommendations for you, Elizabeth—to do some of that initial education about vaccines that many early-career professionals just probably didn’t get?

Amy Behrman (ACOEM): Unfortunately, I think what you just said applies to physician training as well as nurse training, and honestly advanced practice provider training. That is an issue.

Q: In general, what you see is that the more education people have had based on occupation, the higher the vaccination rates. The American Pharmacists Association has a wonderful required immunization program, and their vaccination rates generally mirror those of physicians. But we see declining rates among different levels of nursing education. So I was just wondering if you have recommendations or programs that try to get early-career professionals up to speed on immunizations.

Amy Behrman (ACOEM): I’ll just say one sentence, speaking both for ACOEM and for Penn Medicine: there’s been a lot of energy put into getting readable, accessible educational materials out, but that is not the same as assigning them and making sure people actually absorb them.

Elizabeth Sobczyk (PALT-med): Just to harken back to Amy’s prior comments: the health care professionals in these settings are part of their broader communities. They’re not just health care professionals. You can provide in-service training and things like that to bring

them up to speed from the health care professional side, but from the personal beliefs side, they're very much coming from the communities they come from—which is highly variable depending on where your health system is. But I think that single component is incredibly important to recognize as we develop any kind of training program. It's not just for health care professionals; it's for people coming from communities that bring a lot of hesitations with them.