How to Develop a COVID-19 Employee Vaccination Policy

A 7-step process can help employers decide whether to mandate vaccinations

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Employers grappling with the issue of whether to require their workers to be vaccinated against COVID-19 as well as other infectious diseases may benefit from the process that Houston Methodist, an academic medical center comprising eight hospitals in Houston, used to make that decision.

On March 31, 2021, we mandated that our 26,000 employees, with some exceptions, be vaccinated, making ours the first U.S. hospital system to do so (https://www.usatoday.com/in-depth/news/investigations/2021/06/17/vaccine-requirement-houston-hospital-could-spark-nationwide-trend/7709591002/). Soon after, the mandate was extended to 7,500 private-practice physicians with privileges to care for patients at our hospitals.

Prior to our mandate, 84 percent of Houston Methodist employees had been vaccinated against COVID-19. After the mandate took effect on June 7, we reached 100 percent compliance among those without a reason to be excused; 285 employees and 108 credentialed private-practice staff received exemptions, and 332 were granted deferrals (2 percent combined).

After instituting this policy, we were sued by 117 employees who claimed that we could not require immunization as a prerequisite for employment. A federal judge summarily dismissed (https://www.npr.org/2021/06/13/1006065385/a-judge-has-thrown-out-a-lawsuit-brought-by-hospital-workers-over-a-vaccine-mand) the lawsuit. He rejected the arguments that the vaccines were experimental and caused harm and said, "It is a choice made to keep staff, patients, and their families safer."

With our policy having stood this legal test, we believe that other employers can use our process for developing a vaccination policy of their own. It consists of seven steps.

1. Establish an ethical framework and hierarchy.

To guide us while making our policies, we defined a "pyramid of responsibility," with patients and their families at the top, followed by our employees, and the Houston community forming the base. This framework was developed through a scientific and ethical review of COVID-19 vaccine research, which established our institutional responsibility under the precepts (https://web.stanford.edu/class/siw198q/websites/reprotech/New%20Ways%20of%20Making%20Babies/EthicVoc.htm) of beneficence (a procedure should only be performed with intent of doing good for the patient) and non-maleficence (a procedure should not harm the patient or others in society).

In developing our vaccination policy, we applied these concepts to prioritize the health and safety of all of those under our responsibility, with a focus on avoiding preventable harm. With this expanded approach, we understood patients coming to Houston Methodist expected, and are entitled to, a safe environment for their medical care. Similarly, employees deserve a workplace that actively avoids preventable harms.

We also evaluated how a potential vaccination mandate for our workers would affect vaccine availability for the Houston community. Houston Methodist is a designated State of Texas COVID-19 vaccine hub. This status gave us access to large volumes of vaccines but also conferred on us the responsibility to ensure that vaccines are distributed equitably throughout the community. Distributive justice (https://plato.stanford.edu/entries/justice-distributive/) requires that a vaccination mandate not be implemented until such time that it will not create vaccine shortages for the community. Thus, Houston Methodist could not ethically mandate the vaccine for employees until the vaccine supply could meet that demand.

Finally, we considered how a vaccination mandate would affect our employees' right to autonomy—their right to make their own decisions without interference from others. In the construct that prioritizes beneficence and non-maleficence, an individual's right to autonomy ends when his or her actions would harm others. We decided that death from COVID-19, was an irreversible harm, and minimizing nosocomial infections—those occurring within 48 hours of hospital admission, three days of discharge, or 30 days of an operation—were critically important tasks and an additional institutional responsibility.

Evaluating potential vaccination policies under this framework, Houston Methodist determined that a vaccination mandate was the best way to ensure that our employees did not pose harm to patients, other employees, or the Houston community. In building this policy, respect for employee confidentiality and the principle of proportionality (https://www.collinsdictionary.com/us/dictionary/english/proportionality) (an action should not be more severe than is necessary) were further considered.

[Want to learn more about employers' COVID-19 policies? Join us at the SHRM Annual Conference & Expo 2021 (https://annual21.shrm.org/)*, taking place Sept. 9-12 in Las Vegas and virtually.]*

2. Conduct a risk-benefit analysis compliant with professional standards.

The first step is to conduct a risk-benefit analysis of vaccination versus no vaccination. Critically, this analysis must be performed by subject-matter experts who can accurately assess the situation.

Our risk-benefit analysis asked one question: Do the available vaccines reduce the risk of harm from a COVID-19 infection more than they increase the risk of severe adverse reactions? The vaccines approved under the U.S. Food and Drug Administration's (FDA's) emergency use authorization (https://www.fda.gov/emergency-preparedness-and-response/mcm-legal-regulatory-and-policy-framework/emergency-use-authorization) are highly effective.

The Pfizer/BioNTech, Moderna and Johnson & Johnson vaccines are 95 percent (https://www.nejm.org/doi/full/10.1056/NEJMoa2034577), 94 percent (https://www.nejm.org/doi/full/10.1056/NEJMoa2035389) and 72 percent (https://www.cdc.gov/mmwr/volumes/70/wr/mm7009e4.htm?s_cid=mm7009e4_worization) effective in preventing symptomatic infection, respectively; all reduce hospitalization and mortality to nearly zero. This is on par with, or better than, many familiar FDA-approved vaccines. They have shown effectiveness against the UK (Alpha, or B.1.17), South African (Beta, or B.1.351) (https://www.nejm.org/doi/full/10.1056/NEJMc2104974), Brazilian (Gamma, or P.1) (https://investors.modernatx.com/news-releases/news-release-details/moderna-announces-positive-initial-booster-data-against-sars-cov), California (B1.427 and B1.429) (https://www.nejm.org/doi/full/10.1056/NEJMc2103740?query=featured_home), and related variants.

Beyond their established effectiveness, these vaccines are incredibly safe. More than 2.1 billion doses have been administered around the world under heavy scrutiny from researchers, governments, and watchdog organizations. One real-world study of 627,383 fully vaccinated individuals reported (https://www.thelancet.com/journals/laninf/article/PIIS1473-3099%2821%2900224-3/fulltext) an even lower rate of side effects than seen in the previous clinical trials, with fewer than one in four experiencing symptoms, most commonly headache, fever, and fatigue. Serious adverse events—those that cause or extend hospitalization or result in persistent disability or death—have been rare (https://www.cdc.gov/coronavirus/2019-ncov/vaccines/safety/adverse-events.html).

In contrast, COVID-19 has killed more than 3.9 million people (https://covid19.who.int/), according to the official tally of the World Health Organization (WHO). (Other estimates (https://news.northeastern.edu/2021/05/24/an-accurate-count-of-the-covid-19-death-toll-would-better-prepare-us-for-future-pandemics-heres-why/) are much higher.) Furthermore, as many as one-third (https://www.bmj.com/content/372/bmj.n693) of COVID-19 patients experience significant health problems after they've had the disease; these include (https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-care/post-covid-conditions.html) cardiovascular, pulmonary, renal, dermatologic, neurologic, and autoimmune effects. The available COVID-19 vaccines are orders of magnitude safer than an acute or chronic infection or the quality-of-life impact from post-COVID-19 syndrome.

Members of a vaccinated workforce are far less likely to risk infecting (https://jamanetwork.com/journals/jama/fullarticle/2779853?guestAccessKey=76ecdff9-de67-435b-9202-9f4859e33142&utm_source=silverchair&utm_medium=email&utm_campaign=article_alert-jama&utm_content=olf&utm_term=050621) their customers or each other, thus reducing social and economic harm across the community. A stark reminder of this danger is a nursing home in Kentucky, where an unvaccinated employee caused an outbreak (https://www.cdc.gov/mmwr/volumes/70/wr/mm7017e2.htm) that sickened 20 employees and 26 residents, killing two. Both the employee and the organization are responsible for this loss of life and the irreparable harm to this community. When considering vaccination mandates, it is critical to remember the potential endangerment that is more likely to be caused by unvaccinated employees. Hence, institutions are responsible for creating mitigation strategies.

3. Ensure that policies for religious and medical exemptions are consistent with public health recommendations and state and local laws.

At Houston Methodist, the multidisciplinary committee that reviews requests for COVID-19 vaccination exemptions and deferments is the same one that annually reviews requests to be exempted from our influenza vaccination mandate.

Our vaccination mandate includes thoughtful policies that accommodate employees and credentialed staff with medical conditions or sincerely held religious beliefs inconsistent with vaccination. In addition, pregnant women were granted deferrals since pregnancy was an exclusion criterion in the initial cohort of individuals who participated in the early vaccination trials. The data collected since the emergency use authorization indicates the COVID-19 vaccine is safe in pregnant women. Furthermore, the American College of Obstetricians and Gynecologists

recommends (https://www.acog.org/clinical/clinical-guidance/practice-advisory/articles/2020/12/covid-19-vaccination-considerations-for-obstetric-gynecologic-care) the vaccine for pregnant women. Based on these expert opinions and because pregnant women are more likely to experience severe disease, we highly encouraged pregnant women to get vaccinated.

It is also important that vaccination policies are aligned with state and local laws. Texas, for example, requires (https://www.texmed.org/immunizationrequirements/) employers to grant exemptions on religious and medical grounds.

But to ensure the safety of everyone in our hospital, those granted permanent or temporary exemptions must undergo COVID-19 testing every two weeks and wear face shields as well as the various kinds of face masks (e.g., N95s and surgical masks) that all personnel in the hospital are required to use.

4. Provide a robust educational campaign.

Educate individuals throughout the organization on the risk and benefits of vaccination versus non-vaccination. Transparently explain the process you employed to create your policy. Make an extra effort to listen to the concerns of employees who are hesitant to be vaccinated and address their concerns. Education has multifold advantages over compulsion.

Houston Methodist developed a targeted messaging campaign that consisted of emails and open town halls, where subject-matter experts explained the risk-benefit analysis to workers. We made sure that there were platforms where everyone could ask questions; in addition to the town halls, they included email channels to various leaders and functions and internet chat portals. Critically, we ensured that these platforms were accessible to people who were working on different shifts and who had varying levels of knowledge about the vaccines or vaccination. And we made the information available in multiple languages.

5. Combat misinformation.

Houston Methodist worked throughout the pandemic to counteract misinformation. In town halls and emails, we continually shared updated scientific information and proactively identified and corrected misinformation. Feedback showed that employees greatly appreciated this transparent communication.

6. Lead by example.

Before asking non-management workers to comply with the mandate, it is crucial for them to see that managers were compliant with this policy. At Houston Methodist, the deadline for executives and other managers to be fully vaccinated was approximately two months prior to the one for all workers.

7. Monitor the vaccination rates.

By measuring vaccine rates over time and sharing the impact of vaccination policies, you can demonstrate that the policy is equitably applied and is an institutional priority. Health care workers are more likely to voluntarily receive vaccines and comply with vaccine policies (https://www.sciencedirect.com/science/article/abs/pii/S0195670116302523) when they observe others complying with the institutional policies.

Our previous experience with vaccination mandates illustrates this. In 2009, we initiated an annual influenza vaccination mandate that followed this same process. All of our staff has been compliant with it, and it has not adversely affected attitudes: Employee engagement scores have remained above the 97th percentile for years.

Some may wonder whether our mandatory vaccination policy asks too much of our employees and whether a similar approach would ask too much of their own. Our view is the top priority should be to keep employees, customers, and our community safe. Organizations must strive to eliminate any avoidable harm, which clearly includes avoiding the transmission of infectious and deadly diseases.

At Houston Methodist, if we were not striving for these goals, we would not be adhering to our organizational values—integrity, compassion, respect, accountability, and excellence (I CARE). We suspect that many other organizations would also find their values are strongly aligned with a vaccination mandate.

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