

## MEMORANDUM

To: Laura Herrera, MD, MPH  
From: Liz Ryan  
Re: Reporting Influenza Vaccination of Healthcare Workers  
Date: August 6, 2008

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### I. Legal Authority:

The Baltimore City Health Commissioner has the authority to regulate disease spreading activity. Section 2-104 of the Baltimore City Health Code tasks the Commissioner with “the . . . prevention of disease . . . affecting public health” as well as “establishing and implementing policies . . . preventing physical . . . illnesses.” In addition, Section 2-105 requires the Commissioner “to investigate and report all cases of communicable disease and take immediate action to stop their spread.” A “communicable disease” is defined in Section 4-401 as “any contagious, infectious, or communicable disease or condition that the Commissioner specifies by rule or regulation . . . .” Pursuant to Section 4-404, when a communicable disease is identified, “the Commissioner may take all possible action to prevent the disease from spreading.” Influenza is clearly a communicable disease because it “spread[s] from person to person.”<sup>1</sup> Moreover, the transmission of influenza between healthcare workers and patients presents a public health threat that influenza vaccination can combat.<sup>2</sup> Generally, Section 2-106 grants the Commissioner the power to “adopt and enforce rules and regulations” necessary for the fulfillment of his responsibilities.

### II. Maryland Influenza Vaccination Laws and Regulations:

Maryland laws and regulations addressing influenza vaccination of hospital and related institution<sup>3</sup> workers mandate that the institutions document both immunization

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<sup>1</sup> See CDC. Prevention and Control of Influenza: Recommendations of the Advisory Committee on Immunization Practices (ACIP), MMWR 2007;56 (No. RR-6): 4, available at <http://www.cdc.gov/MMWR/PDF/rr/rr5606.pdf>.

<sup>2</sup> See CDC. Influenza Vaccination of Health-Care Personnel: Recommendations of the Healthcare Infection Control Practices Advisory Committee (HICPAC) and the Advisory Committee on Immunization Practices (ACIP). MMWR 2006;55 (No. RR-2): 1-2, available at <http://www.cdc.gov/mmwr/pdf/rr/rr5502.pdf>.

<sup>3</sup> A “related institution” is defined in Section 19-301(o)(1) of the Annotated Code of Maryland Health-General Article as:

“an organized institution, environment, or home that . . . (i) [m]aintains conditions or facilities and equipment to provide domiciliary, personal, or nursing care for 2 or more unrelated individuals who are dependent on the administrator, operator, or proprietor for nursing care or the subsistence of daily living in a safe, sanitary, and healthful environment; and (ii) [a]dmits or retains individuals for overnight care.”

and refusal of vaccine. Section 18-404(f)(1)(ii) of the Annotated Code of Maryland Health-General Article requires “[e]ach related institution [to] document the annual immunization against influenza virus received by each employee in the employee’s personnel file.”<sup>4</sup> In addition, under Section 18-404(f)(2), “[i]f a . . . employee refuses to be immunized . . . , the related institution shall document the refusal and the reason for refusal.” Pursuant to Sections 10.07.02.21-1 and 10.07.02.21-3 of The Code of Maryland Regulations, comprehensive and extended care facilities “shall document refusals and . . . conduct surveillance of nonimmune employees during the recognized influenza season” and “maintain documentation of the discussion between the facility and . . . volunteer[s] concerning influenza vaccine.”<sup>5</sup> Likewise, under COMAR 10.07.01.34, governing acute general and special hospitals, the “[r]easons for refusal of the influenza vaccine by an employee shall be documented by the infection control or employee health program.”<sup>6</sup>

To participate in the State’s “2007 Maryland Healthcare Workers Influenza Initiative,” facilities are required to report healthcare worker vaccination rates.<sup>7</sup> The flu initiative, open to a broad range of healthcare providers, “aims to raise influenza vaccination rates among health care workers by providing resources to support facility-wide employee influenza vaccination campaigns and rewarding immunization excellence in healthcare facilities.”<sup>8</sup> “Participants . . . have access to educational and promotional resources to support their efforts to increase influenza rates of their staff” with grants valued up to one thousand dollars available.<sup>9</sup> “Registered partners” of the initiative must

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Under Section 19-301(o)(2), a “[r]elated institution does not include a nursing facility or visiting nurse service that is conducted only by or for adherents of a bona fide church or religious organization, in accordance with tenets and practices that include reliance on treatment by spiritual means alone for healing.”

<sup>4</sup> Section 18-404 sets actual vaccination requirements as well as documentation requirements.

<sup>5</sup> COMAR 10.07.02.21 has actual vaccination requirements as well as documentation requirements.

<sup>6</sup> COMAR 10.07.01.34 provides that acute general and special hospitals “shall have an active hospital-wide program for the prevention, control, and investigation of communicable diseases and infections” and “[i]mmunizations for influenza shall be offered to staff and licensed independent practitioners” in addition to outlining documentation requirements.

<sup>7</sup> See [http://edcp.org/html/hcw\\_initiative.html](http://edcp.org/html/hcw_initiative.html). The 2007 Maryland Supplement to Campaigns to Increase Influenza Vaccinations Among Healthcare Workers highlights the initiative and includes all relevant resources: [http://edcp.org/influenza/pdf/Maryland\\_HCW\\_Initiative\\_Toolkit.pdf](http://edcp.org/influenza/pdf/Maryland_HCW_Initiative_Toolkit.pdf).

<sup>8</sup> See [http://edcp.org/html/hcw\\_initiative.html](http://edcp.org/html/hcw_initiative.html). The following healthcare providers are encouraged to participate:

“[f]acilities, organizations, and community providers of healthcare with an interest in increasing influenza vaccination rates among their employees to protect them from getting the flu and passing it on . . . including, but not limited to: hospitals, local health departments, skilled nursing facilities, private physicians’ offices, senior housing, adult day care services, continuing care retirement communities, [and] any provider of health care services and or staff who serve persons at risk from complications of influenza.” *Id.*

<sup>9</sup> *Id.*

“report . . . healthcare worker vaccination rates at the end of the 2007-2008 Flu Prevention Season.”<sup>10</sup>

### III. Baltimore City May Adopt an Influenza Vaccination Reporting Requirement:

Baltimore City regulations mandating the reporting of influenza vaccination data for healthcare workers would not conflict with State law. In Maryland, when a conflict exists between State and local laws that regulate the same activity, the local law is preempted by the State law.<sup>11</sup> “Supplemental local regulation” is permitted, however, where State law does not “express[ly] deny the right to act by local authority.”<sup>12</sup> Accordingly, the Maryland Court of Appeals has determined that a Baltimore City ordinance with higher penalties for the sale and use of cocaine than State law (*Rossberg v. State*<sup>13</sup>) and a Baltimore City law establishing a minimum wage greater than State law (*Mayor and City Council of Baltimore v. Sitnick*<sup>14</sup>) did not present conflicts.<sup>15</sup>

In addition, “[i]f the local law is in furtherance of the public general law’s function, then the local law is valid . . . .”<sup>16</sup> For example, in *Mayor and City Council of Baltimore v. Hart*,<sup>17</sup> the Baltimore Police Commissioner adopted a General Order regarding emergency vehicle safety standards, a subject already addressed by State law.<sup>18</sup> The General Order explained that “[t]he City of Baltimore is a highly congested urban area which necessitates driving motor vehicles in a safe manner.”<sup>19</sup> Consequently, the Maryland Court of Appeals reasoned that the General Order did not conflict with a State law designed to promote safety because it simply called for a more stringent safety standard.<sup>20</sup> The Court thus found that without an express provision in the Maryland Code revealing that the General Assembly sought to retain all power over emergency vehicle

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<sup>10</sup> *Id.*

<sup>11</sup> *Worton Creek Marina v. Clagett*, 381 Md. 499, 512 (2004).

<sup>12</sup> *Mayor and City Council of Baltimore v. Hart*, 395 Md. 394, 406-08 (2006) (quoting *Mayor and City Council of Baltimore v. Sitnick*, 254 Md. 303 (1969)).

<sup>13</sup> 111 Md. 394 (1909).

<sup>14</sup> 254 Md. 303 (1969).

<sup>15</sup> *Hart*, 395 Md. at 407-08.

<sup>16</sup> *Id.* at 408-09.

<sup>17</sup> 395 Md. 394 (2006).

<sup>18</sup> *Id.* at 409.

<sup>19</sup> *Id.*

<sup>20</sup> *Id.*

operation, “the City Council of Baltimore through its delegation of power to the Baltimore City Police Commissioner, may supplement such regulations.”<sup>21</sup>

There is no Maryland law or regulation governing the reporting of healthcare worker influenza vaccinations. The State only requires related institutions and hospitals to document their efforts. Also, the City regulations would further the public health, the reason the State enacted laws and regulations requiring documentation of whether certain healthcare workers have received influenza vaccinations. Moreover, State law addresses hospital and related institution employees, not all those engaged in providing healthcare. The State legislature has, therefore, clearly not expressed an intent to occupy the field of influenza vaccination of healthcare employees. Thus, just as stricter local laws on the use and sale of cocaine, minimum wage, and emergency vehicle safety did not conflict with State law, stricter influenza vaccination reporting requirements in Baltimore City than mandated by State law should be valid.

In Maryland, because related institutions and hospitals must document influenza vaccinations of healthcare workers, reporting the information to guide decision-making on how to improve vaccination rates is the next logical step. For example, Arkansas,<sup>22</sup> New Hampshire,<sup>23</sup> New York,<sup>24</sup> Rhode Island,<sup>25</sup> and Utah<sup>26</sup> all mandate the reporting of

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<sup>21</sup> *Id.* at 409-10.

<sup>22</sup> ARK. CODE ANN. § 20-10-1304(b)(3) (2008) (“Each nursing home facility in this state shall . . . [d]ocument and report annually immunizations against . . . [i]nfluenza virus for . . . full-time and part-time employees . . .”).

<sup>23</sup> N.H. REV. STAT. ANN. § 151:33 (II)(b)(3) (2007) (“Hospitals shall also initially identify, track, and report process measures including . . . [c]overage rates of influenza vaccination for health care personnel . . .”).

<sup>24</sup> See New York State Department of Health Statutory Advisory, DAL #00-10: [http://www.health.state.ny.us/nysdoh/infection/ltc\\_act/advisory.htm](http://www.health.state.ny.us/nysdoh/infection/ltc_act/advisory.htm) (“The Law requires facilities to document their immunization efforts. It also requires the Department of Health to report to the Governor and Legislature on outbreaks and hospitalizations. To that end, each facility must . . . [s]ubmit the Influenza . . . Immunization and Outbreak Data Report by May 1st of each year.”). See also New York State Department of Health Influenza Immunization Data Report: <http://www.health.state.ny.us/forms/doh-4193.pdf> and Optional Worksheet for Recording Influenza Immunization Status of Employees: <http://www.health.state.ny.us/nysdoh/infection/docs/worksheet2.pdf>.

<sup>25</sup> R.I. CODE R. §14-000-028.6.3 (2008) (“The health care facility shall develop an active surveillance program to track and record influenza vaccination levels among health care workers, including vaccinations obtained outside of the formal health care facility program. Each health care facility shall be responsible for documenting and reporting to the Center for Epidemiology at the Department annually (by July 1st of each year commencing on July 1, 2008): 1) the number of health care workers who are eligible for said vaccination; 2) the number of health care workers who accept said vaccination; and 3) for those who declined, the reason(s) for such declination. Such reporting shall occur according to procedures and format outlined by the Center for Epidemiology.”). See also R.I. GEN. LAWS § 23-17.19-7(c) (2007) (“Three years from July 13, 2000, the department shall report to the General Assembly on the number of outbreaks in facilities each year due to influenza virus . . . The number of hospitalizations of facility residents each year due to influenza virus . . . and complications . . . must be reported as well.”).

<sup>26</sup> UTAH ADMIN. CODE r.386-705-3 (2) (2007) (“Each hospital and each long term care facility shall report

healthcare worker immunization data. In addition, Utah requires hospitals and long term care facilities to “attest to the implementation and effectiveness of its health care infection prevention program and its systems for reporting . . . once every three years.”<sup>27</sup> Utah also penalizes failure to report healthcare worker influenza vaccination rates.<sup>28</sup>

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its influenza vaccination rates for its healthcare workers.”). UTAH ADMIN. CODE r.386-705-25 (2007) (“(1) Reports of influenza vaccination rates shall include the number of health care workers and the number of those workers who are documented to have received an influenza vaccine for the current influenza season. Influenza vaccination rates may be measured by complete enumeration of all health care workers in the facility during the season and the number of them who were vaccinated during that season or may be estimated by a cross-sectional assessment. (2) Each hospital and licensed long term care facility shall report its influenza vaccination rates for the current influenza season by January 31.”).

<sup>27</sup> UTAH ADMIN. CODE r.386-705-100 (2007).

<sup>28</sup> UTAH ADMIN. CODE r.386-705-101 (2007) (“An entity that violates any provision of this rule may be assessed a civil money penalty not to exceed the sum of \$5,000 or be punished for violation of a class B misdemeanor for the first violation and for any subsequent similar violation within two years for violation of a class A misdemeanor as provided in Section 26-23-6.”).