



Immunizations Recommendations for Health Care Workers

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Immunizations for Health Care Workers



- Health care workers are at risk for exposure to serious, and sometimes deadly, diseases.
- In addition to protecting employees, ensuring that they are up-to-date with recommended vaccines will:
 - decrease the potential of employee furlough
 - reduce the need and cost for post-exposure prophylaxis of patients/residents/employees
 - help ensure an efficient exposure response
- Good vaccine coverage among health care workers will also protect the health of patients and visitors.



Who are Health Care Workers?

- **Include but not limited to:**

Physicians	Emergency Medical Service Personnel	Autopsy Personnel	Housekeeping
Nurses	Laboratory Personnel	Students and Trainees	Laundry
Therapists	Technicians	Contractual Staff not Employed by the Healthcare Facility	Administrative/Clerical
Pharmacists	Dietary	Maintenance	Billing
Nursing Assistants	Dental Personnel	Security	Volunteers
Other personnel not directly involved in patient care but potentially exposed to infectious agents.			



What vaccines are recommended for HCW?

- **Routine for all HCWs:**
 - Hepatitis B
 - Influenza (annual)
 - MMR
 - Varicella
 - Tdap
- **Risk-based:**
 - Meningococcal (lab exposure, travel)



Varicella (Chickenpox) – Health Care Workers Recommendations

All health care workers (regardless of year born) should have evidence of immunity to varicella.

Vaccine Recommendation:

- 1 dose if previously received 1 dose varicella-containing vaccine
- 2-dose series 4–8 weeks apart if previously did not receive any varicella-containing vaccine, regardless of whether U.S.-born before 1980

Evidence of immunity:

- Documentation of 2 doses varicella-containing vaccine at least 4 weeks apart,
- Diagnosis or verification of history of varicella or herpes zoster by a health care provider,
- Laboratory evidence of immunity or disease

Influenza

- Health care workers should get one dose annually.
- Influenza (flu) among health care workers can result in lost workdays and can spread to other coworkers and to patients who are at higher risk of serious flu complications.
- Flu vaccination of health care workers has been shown to reduce the risk of flu and absenteeism in vaccinated health care workers and reduce the risk of respiratory illness and deaths in nursing home residents.



Tetanus, Diphtheria, Pertussis (Tdap) General Recommendations

Health care workers should follow the same recommendations as the general public.

Routine Recommendation:

- A booster dose of either Td or Tdap should be administered every 10 years throughout life.

Catch-up Recommendation

- Persons aged ≥ 19 years who have not received a dose of Tdap at or after 11 years should receive 1 dose of Tdap followed by a booster every 10 years.
- No minimum interval between doses of tetanus - or diphtheria-containing vaccines

Pre-vaccination serologic testing is not recommended.



Meningococcal Conjugate



- Health care personnel meeting the following requirements should receive a single dose of MenACWY with a booster every five years while they remain at increased risk.
- Health care professionals traveling to work in high-risk areas should receive a single dose of MCV4 before travel if they have never received it or if they received it >5 years previously.
- Clinical microbiologists and research microbiologists who might be exposed routinely to isolates of *N. meningitidis* should receive a single dose of MCV4 and receive a booster dose every 5 years if they remain at increased risk.

Meningococcal B

- Microbiologists routinely exposed to *Neisseria meningitidis* are recommended to receive Meningococcal B vaccine:
 - Give either 2 dose (Bexsero®) or 3 dose (Trumemba®) primary series.
 - Booster dose given 1 year after primary series
 - Revaccinate every 2-3 years if risk remains.

Which health care personnel need serologic testing after receiving a HepB vaccine series?

- All personnel, including trainees, who have a high risk of occupational percutaneous or mucosal exposure to blood or body fluids (for example, personnel with direct patient contact, those at risk of needlestick or sharps injury, laboratory workers who draw, test or handle blood specimens) should have postvaccination testing for antibody to hepatitis B surface antigen (anti-HBs).
- Postvaccination testing should be done 1–2 months after the last dose of vaccine.
- Postvaccination testing for individuals at low risk for mucosal or percutaneous exposure to blood or body fluids (for example, public safety workers and health care personnel without direct patient contact) likely is not cost-effective.

Hepatitis B

All Health care workers (and all adults 19-59), complete a 2 or 3, or 4-dose series:

2-dose series with Heplisav-B®

- 2 doses given at least 4 weeks apart
- Not recommended in pregnancy.

3-dose series with Engerix-B®, PreHevbrio®, or Recombivax HB®

- Routine schedule at 0, 1, and 6 months
- Minimum intervals:
 - Dose 1 to 2: 4 weeks
 - Dose 2 to 3: 8 weeks
 - Dose 1 to 3: 16 weeks
- PreHevbrio® is not recommended in pregnancy.

3-dose series with HepA-HepB combination Twinrix®

- Routine schedule at 0, 1, and 6 months
- Minimum intervals:
 - Dose 1 to 2: 4 weeks
 - Dose 2 to 3: 5 months

4-dose series with HepA-HepB combination Twinrix®

- Accelerated schedule at 0, 7, and 21-30 days, followed by a booster dose at 12 months

How often should I test health care personnel after they've received the HepB vaccine series to make sure they're protected?

- For immunocompetent health care personnel, periodic testing or vaccine boosting is not needed.
- Postvaccination testing (anti-HBs) should be done 1–2 months after the last dose of the HepB series. If adequate anti-HBs (at least 10 mIU/mL) is present, nothing more needs to be done.
 - This information should be made available to the employee and recorded in the employee's health record.

What should be done if a healthcare professional's post-vaccination anti-HBs test is negative (less than 10 mIU/mL) 1-2 months after the last dose of vaccine?

There are two options for healthcare professionals who test negative after completing their first HepB series.

- **Option 1:** Give one additional dose of HepB, then retest for anti-HBs.
 - If positive they are considered immune
 - If negative, give the remaining doses in the series and then retest for anti-HBs.
 - If the result is positive, the person should be considered immune.
 - If negative, the person should be tested for HBsAg and total anti-HBc to determine their HBV infection status
- **Option 2:** Repeat the full 2- or 3-dose series (depending on vaccine brand) and test for anti-HBs 1–2 months after the final dose of the repeat series.
 - If positive, they are considered immune.
 - If the test is still negative after a second vaccine series, the person should be tested for HBsAg and total anti-HBc to determine their HBV infection status.

Measles Mumps Rubella (MMR) – health care worker recommendations

All health care workers (regardless of year born) should have evidence of immunity to measles, mumps or rubella.

Vaccine Recommendation:

- 1 dose if previously received 1 MMR vaccine
- 2-dose series 4–8 weeks apart if previously did not receive any doses of MMR.

Evidence of immunity:

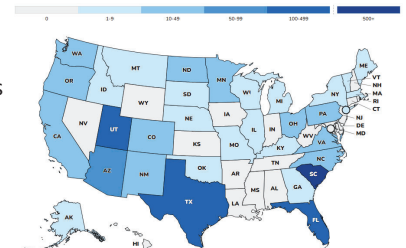
- Documentation of receipt of MMR vaccine,
- Laboratory evidence of immunity or disease

What should be done if a healthcare professional's postvaccination anti-HBs test is negative (less than 10 mIU/mL) 1–2 months after the last dose of vaccine?

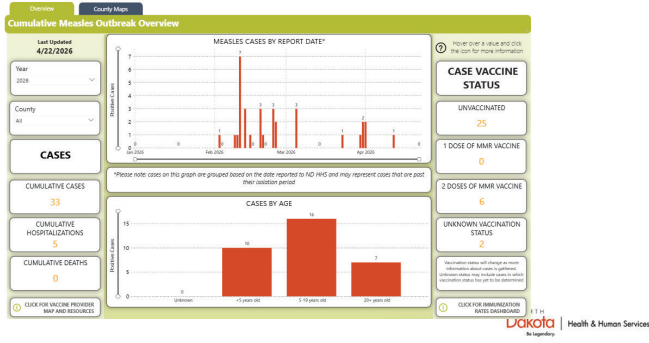
- People who test negative for HBsAg and total anti-HBc should be considered vaccine non-responders and susceptible to HBV infection. They should be counseled about precautions to prevent HBV infection and the need to obtain hepatitis B immune globulin (HBIG) prophylaxis for any known or likely exposure to HBsAg-positive blood.
- Those found to be HBsAg negative but total anti-HBc positive were infected in the past and require no vaccination or treatment.
- If the HBsAg and total anti-HBc tests are positive, the person should receive appropriate counseling for preventing transmission to others as well as referral for ongoing care to a specialist experienced in the medical management of chronic HBV infection.

Measles in the United States in 2026

- As of April 16, 2026, a total of **1,748** measles cases were reported across 33 jurisdictions
 - 6% of cases have been hospitalized
 - 92% unvaccinated or have an unknown status
 - 21% of cases are under 5 years old

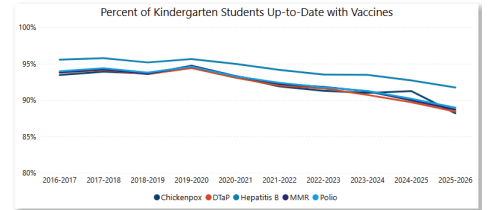


Measles in North Dakota

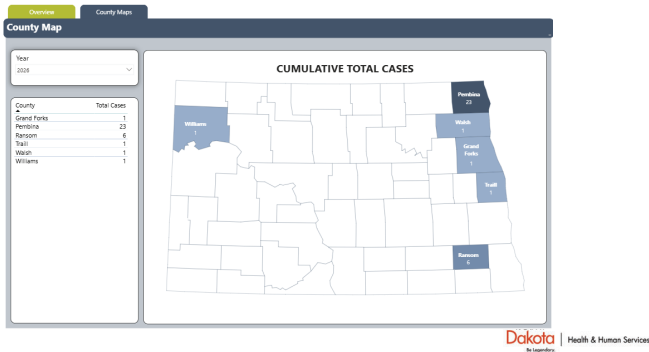


Kindergarten Immunization Rates and Trends 2025-2026

Vaccine	Coverage Rate
MMR	88.7%
DTaP	88.4%
Polio	89.0%
Hepatitis B	91.8%
Varicella	88.2%

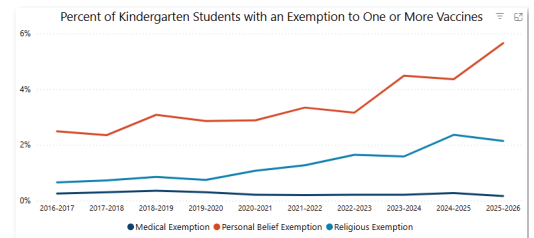


Measles in North Dakota



Kindergarten Immunization Rates and Trends 2025-2026

Exemption	Rate
Medical	0.2%
Personal Belief	5.7%
Religious	2.1%



Measles Scenario

Patient Encounter — Primary Care Visit (2 Days Before Rash)

- Patient presented with fever, cough, and conjunctivitis symptoms
- Sat in waiting room for approximately 20 minutes
- Diagnosed with strep throat; measles was not suspected
- Approximately 10 staff were present that day.
- 20 other patients were present in the waiting room while patient was there.
- An additional 10 patients were present in the 2 hours after the patient left.
- The clinic had **no documented measles, mumps, or rubella records** for staff



Patient Encounter — Emergency Department Visit (Rash Present)

- Patient returned with classic measles rash and was preliminarily diagnosed with measles infection
- Patient was placed in airborne isolation immediately due to emergency department protocols
- Patient escorted out a side entrance after testing was completed
- The ED maintained a policy requiring HCW immunity verification, allowing faster exposure risk assessment

Measles Considerations for Healthcare Providers

Make sure all staff are appropriately vaccinated against measles.

Use airborne precautions and appropriate PPE.

Use a negative pressure room if available for confirmed or suspected measles patients.

Only vaccinated individuals should enter the room with the patient.

Staff who are immune-suppressed should avoid being around confirmed or suspected measles patients (i.e., pregnancy, medication, etc.).

Sanitize any rooms or space that a suspect or confirmed measles case has been and do not use the room for a minimum of **TWO HOURS** after its use.

Measles Scenario - Aftermath

Primary Care – No MMR records

- **Exposure Investigation Challenges**
 - No measles, mumps, or rubella immunity records for staff
 - Required manual outreach to determine susceptibility
 - Waiting room patients and staff were both considered exposure contacts
- **Operational Impact**
 - Several healthcare workers recommended exclusion during the 5–21 day monitoring window recommended by the Centers for Disease Control and Prevention
 - Staffing shortages occurred unexpectedly
 - Clinic appointments were delayed or rescheduled

Emergency Department – MMR records on hand

- **Preparedness Advantages**
 - HCW measles immunity status was already documented
 - Susceptible staff could be rapidly identified
 - Exposure risk assessment was completed quickly
- **Operational Impact**
 - Fewer workforce disruptions
 - Faster containment decision-making
 - More efficient communication with public health partners

Measles Considerations for Healthcare Providers

Screen all patients for measles and possible measles exposure at intake. If patients have symptoms of measles (febrile rash) and/or recent travel abroad, **room the patient as soon as possible after check-in.**

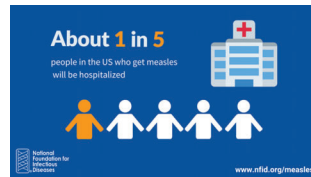
Make sure staff are fit-tested for N-95 masks and have them available for staff working directly with confirmed or suspected measles cases. Because it is airborne, a regular surgical mask will not fully protect a person from contracting or passing along measles.

Patients and other individuals should wear surgical masks, since N-95 masks will be of limited use without a prior fit test.

Consider alternative testing options, such as drive-up testing or testing patients outdoors or in their vehicle when weather allows.

Measles Prevention Activities

- Conduct reminder/recall for patients who are behind on the MMR vaccine.
- Host convenient vaccination clinics to get patients up to date.
- Start preparing now for the possibility of measles cases. Update policies and make sure staff know what to look for and what to do with a possible measles case.



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THANK YOU!

PLEASE email any questions to VACCINE@ND.GOV with any questions

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