No. 23-35014

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

MONTANA MEDICAL ASSOCIATION; FIVE VALLEYS UROLOGY, PLLC; PROVIDENCE HEALTH & SERVICES – MONTANA; WESTERN MONTANA CLINIC, PC; PAT APPLEBY; MARK CARPENTER; DIANA JO PAGE; WALLACE L. PAGE; CHEYENNE SMITH,

Plaintiffs - Appellees,

MONTANA NURSES ASSOCIATION,

Intervenor-Plaintiff – Appellee,

v.

AUSTIN KNUDSEN, Montana Attorney General; LAURIE ESAU, Montana Commissioner of Labor and Industry,

Defendants – Appellants.

On Appeal from the Missoula Division of the
United State District Court, District of Montana
No. 9:21-cv-00108-DWM
Hon. Donald W. Molloy

APPELLEES' SUPPLEMENTAL EXCERPTS OF RECORD INDEX VOLUME

Justin K. Cole
Kathryn S. Mahe
GARLINGTON, LOHN & ROBINSON, PLLP
350 Ryman Street • P.O. Box 7909
Missoula, MT 59807-7909
Phone (406) 523-2500
Fax (406) 523-2595
jkcole@garlington.com
ksmahe@garlington.com
Attorneys for Plaintiffs - Appellees

Raph Graybill
GRAYBILL LAW FIRM, PC
300 4th Street North
Great Falls, MT 59403
Phone: (406) 452-8566
rgraybill@silverstatelaw.net
Attorney for Plaintiff-Intervenor - Appellee

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Justin K. Cole
Kathryn S. Mahe
GARLINGTON, LOHN & ROBINSON, PLLP
350 Ryman Street • P.O. Box 7909
Missoula, MT 59807-7909
Phone (406) 523-2500
Fax (406) 523-2595
jkcole@garlington.com
ksmahe@garlington.com
Attorneys for Plaintiffs - Appellees

Raph Graybill
GRAYBILL LAW FIRM, PC
300 4th Street North
Great Falls, MT 59403
Phone: (406) 452-8566
rgraybill@silverstatelaw.net
Attorney for Plaintiff-Intervenor - Appellee

JoAnn Jett Corson
Registered Diplomate Reporter
Certified Realtime Reporter
P. O. Box 8006
Missoula, Montana 59807-8006
406/829-7123 office
joann_corson@mtd.uscourts.gov

United States Court Reporter

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MONTANA
MISSOULA DIVISION

MONTANA MEDICAL ASSOCIATION et al., Plaintiffs, and MONTANA NURSES ASSOCIATION, Plaintiff-Intervenor, vs. AUSTIN KNUDSEN, Montana Attorney General; and LAURIE ESAU, Montana Commissioner of Labor and Industry, Defendants.	No. CV 21-108-M-DWM **VOLUME 1 OF 3** **TRANSCRIPT OF BENCH TRIAL**

BEFORE THE HONORABLE DONALD W. MOLLOY
UNITED STATES DISTRICT COURT JUDGE
FOR THE DISTRICT OF MONTANA

Russell Smith United States Courthouse
201 East Broadway
Missoula, Montana 59802
Monday, October 24, 2022
08:58:39 to 16:53:43

Proceedings recorded by machine shorthand
Transcript produced by computer-assisted transcription

THE COURT: So, Mr. Mead, what do you want to be heard on? If it was not produced, there was no opportunity to follow the pretrial order.

MR. MEAD: So specific to 221, Your Honor, that's a Food and Drug Administration news release. It's a government document. And so, you know, it's our position that because it is a government document, it --

THE COURT: Well, you can offer it when it's appropriate, the same with 204, and -- yeah.

MR. MEAD: All right.

THE COURT: When we get to it, offer it, and, if there's an objection, we'll deal with it.

MR. MEAD: (Nodded head affirmatively.)

THE COURT: All right.

So, opening on behalf of the Montana Medical Association et al.

Ms. Mahe. You have a total of 15 minutes with you and Mr. Graybill.

MS. MAHE: Your Honor, we will let Mr. Graybill make our joint opening statement.

THE COURT: Mr. Graybill.

MR. GRAYBILL: May it please the Court, Raph Graybill on behalf of the plaintiffs and the plaintiff-intervenor.

This is an unusual trial. Doctors and nurses

representing defendants Attorney General Austin Knudsen and Commissioner Laurie Esau.

At the outset here, it needs to be clear what's on trial. It's not public health. It's not vaccines. It's whether the State can choose to protect its citizens from discrimination based on their medical choices.

We agree with the plaintiffs: All the facts that Your Honor needs to know to reach that legal question, they're in the record. The State has an unquestioned police power to protect its citizens who are the target of discrimination, and it is the State's choice, not private entities, to exercise that authority.

As we've gone through discovery, what the plaintiffs have argued has changed slightly. Now one of their key arguments is that they need to know the actual vaccination status of their coworkers or of their employees in order to protect themselves and patients.

What you're going to see in evidence is that they already have that knowledge. You'll see the vaccination plans for some of the institutional plaintiffs. You'll see that they keep vaccination records on file. They have the information they complain HB 702 denies them.

When we go to the Americans with Disabilities Act, you're not gonna see any documented reasonable accommodation request. You'll hear from all sides that ADA requests have to

immunity?
A Yes, I think we can agree on that.
Q Could you also call it recovered immunity?
A Yes.
Q And, for example, if somebody had been vaccinated for a specific disease and then contracted that disease and recovered, would it be fair to call that hybrid immunity?
A That's good.
Q So the multiple studies that you reference in paragraph 12, are those studies those that are referenced specifically in paragraphs 13, 14, and 15?
A No. A general statement like that first sentence goes back in history to cowpox and smallpox, so we -- that's not specific to anything COVID.
Q Okay.
A And I would point out that depending on the disease that you're talking about, particularly in the realm of vaccine-preventable diseases caused by viruses, some, some families of viruses, some individual viruses are much more stable, and, therefore, immunity is much longer lasting. And some virus families, most particularly influenza, for instance, and the family of coronaviruses, have short-lived natural immunity because of mutations that continue to happen.
Q In other words, the duration of immunity to a specific disease depends on that specific disease and other

individualized factors; is that fair?
A Yeah, factors such as societal response to the disease and so on.
Q And to follow up on that, that note regarding societal response, would you be referring to, for example, lockdowns?
A Well, I think if we look at COVID, we can see that a variety of things have been done. The most effective strategy has been vaccination. But masking, as we see here today, social isolation or social management, distance management, hand sanitizer, there are all kinds of things we do. Vaccination is always the most important.
Q I just want to make sure it's clear. When you refer to "societal response," that includes vaccination, lockdowns, masking, social distancing, other forms of personal protective equipment; is that accurate?
A Right. Among others, yes.
Q In the third sentence in paragraph 12, you state, "The problem remains that immune response is variable after natural infection." Do you see that?
A Yes, indeed.
Q Okay. And is that also a generalized statement not specific to any disease?
A No. It's not generalizable, as I mentioned before. Some virus families, some individual viruses, are much more mutable. They mutate more readily, and that increases their

BY MR. RUSSELL:

Q Okay. I'm going to direct you to paragraph 20 of your report on page 10.

Just let me know when you're there.

A Yeah. It's a long paragraph. Go ahead.

Q I'm just gonna see if I can get some clarification on your statement here. In the middle of that paragraph, or, I guess, closer to the top, you say, "Given the lack of vaccine availability in large parts of the world, vaccine hesitancy where vaccine ability exists, and outright opposition to vaccination (exemplified by House Bill 702)" -- I guess I'll rephrase that question.

Can you point me to anywhere in Montana House Bill 702 that you believe promotes vaccine hesitancy?

A The medical profession as a whole, which is -- as a whole has submitted repeatedly documents in support of widespread vaccination and even mandatory vaccination. All the major medical societies, it's been uniform. There are individuals who disagree, but there are no societies, medical major -- whether it's the Academy of Pediatrics, pediatricians; whether it's ACOG, which is the American College of Obstetrics and Gynecology; whether it's the national organization for family medicine or internal medicine. The agreement is a hundred percent that these vaccines are critically important and should be -- this is in reference to COVID, but, of course, we

already have -- or at least I should say we still, at this point in time, have mandatory vaccines for children, which I believe are the next target in this backwards campaign, but that's my personal opinion, political, and perhaps I shouldn't go there.

In any case, medicine is unified in supporting vaccination. And when a state legislature determines that they will contradict the advice of physicians and physician organizations, that disrespect is contagious, to use a word that we are talking about so much.

Q There's a lot there I have to follow up on.

But was your answer to my previous question no?

A Repeat your previous question, please.

Q Okay. Can you point me to anywhere in Montana House Bill 702 that encourages outright opposition to vaccination?

A I think the act in itself does. There's nothing specific within it that states that as a goal. I think that is, whether intended or unintended, I think that is the consequence of this act.

Q Would it be fair to say that that's your interpretation of House Bill 702?

A Absolutely.

Q Okay. So you stated something about agreement regarding COVID vaccine is 100 percent. Is that accurate?

A No, it's not a hundred percent in individuals. It's a

that it has succeeded in defeating the vaccination. I don't think the vaccines have weakened; it's that Omicron has outsmarted them as did Beta and Delta and all the other iterations in between.

Q In other words, the vaccine that is currently available and being used and mandated in some cases is not specifically targeted to the current strain in circulation; is that accurate?

A Well, at the time of this writing, that would be accurate. Of course, now we have the bivalent vaccine that's under trial with Pfizer and got an Emergency Use Authorization just, what, a few weeks ago.

Q But none of that is included in your expert report?

A No, because, again, Omicron tricked us. COVID tricked us.

Q Okay. And I think you reinforced that statement in paragraph 21. It says, "However, breakthrough infections in people who are vaccinated can occur." That's consistent with what you just said, right?

A That's part of what I was talking about.

Q Turning to page 11 of your report, at the very bottom, you state, "Vaccination has been and remains our most effective tool to prevent both the spread and the severity of disease." Do you see that?

A Yeah. Not so much for heart disease or diabetes, to be

sure. It's a little vague. But for infectious disease caused by vaccine-preventable organisms, absolutely.

Q So that's a broad statement applicable to vaccine-preventable diseases?

A Yeah. The statement is too broad, out of context of vaccine-preventable diseases.

Q In other words, that statement does not apply specifically to COVID or, even more specifically, to Omicron, right?

A No, that's not right.

Q Okay.

A It doesn't apply to appendicitis, and it doesn't apply to osteoarthritis, but it applies to bacterial and virologic infectious disease for which vaccines have been invented.

Q And to follow up with that term, "vaccine-preventable disease," can we accurately call a COVID vaccine -- or, sorry. Strike that.

Can we accurately call COVID a vaccine-preventable disease if the vaccine for that disease doesn't actually prevent that disease?

A Yes.

Q In other words, the vaccine can fail to prevent the disease, but we're still gonna call it a vaccine-preventable disease?

A Correct. And the reason for that is that there is no

A From the regulatory standpoint, no. Not yet.
Q Okay. And by the "regulatory standpoint," you mean the law, generally?
A Right. I think the answer is yes. I think the changes have come from the side of what you call vaccine hesitancy, which means there's support for the idea of eliminating requirement.
Q I'm gonna turn to page 12 of your report at paragraph 23. In the second part of that sentence, you state that "vaccination remains a critically important form of infectious disease prevention, particularly in healthcare settings."

When you say "particularly in healthcare settings," do you mean vaccination of healthcare workers?
A Well, of course. Healthcare workers who are unvaccinated -- you get sick from healthcare patients who have COVID, so it's not just healthcare workers.

But, yes, if you have 30 babies in a newborn intensive care unit and you bring in pertussis, you'll kill every damn one of those kids, right? Which is why adults should have boosters that include pertussis. It's simple to understand.

If you have a -- well, we'll put it in my experience. We, among other things, had a study with monoclonal antibody infusions for treatment of COVID. We have an infusion center at the hospital. The infusion center at the hospital is where

chemotherapy drugs for cancer patients are given. We were not allowed to -- did not want to administer monoclonal antibodies to people with COVID in the same room as immunocompromised individuals. It has an effect on function in the hospital, on healthcare in the hospital, and there was no prohibition in law against that.

In fact, House Bill 702 would make it impossible to ask that, to determine that, to enforce that only vaccinated people would administer chemotherapy and monoclonal antibodies. And yet the basic, common-sense test would say that's a place you shouldn't put people at risk. They're already enough at risk. And House Bill 702 makes it impossible to protect those patients.

Q And, again, that conclusion is based on your own interpretation of House Bill 702, accurate? Is that accurate?

A And my interpretation of the state of medicine in the era of COVID, absolutely. That's my interpretation.

Q And regarding the statements you just made about vaccinated healthcare workers, are you referring specifically to those healthcare workers who are vaccinated for COVID or a number of other diseases?

A This is all COVID-centric. So I would expand that; an obvious example is pertussis vaccination. I wouldn't allow a nurse who is not vaccinated against -- or any respiratory therapist or lab tech just drawing blood or anybody in a NICU

who hadn't been vaccinated for pertussis. It makes perfect sense to have that exclusion.

Q And that reminds me of the statement you made that pertussis would kill every single kid there. Do you remember that?

A Those are generally premature and certainly extremely ill, tenuous survivors in that room, and a respiratory infection would be lethal. And pertussis spreads very readily in that environment. So, yeah, I've had NICU nurses tell me that.

Q Do you cite any studies, data, reports, et cetera, in your expert report to support that contention?

A Actually, I'm not aware of any cases where the population of a NICU was wiped out by pertussis, no.

Q Okay.

A I suspect that there have been, but I'm not aware of any.

Q Okay. And to go back to the statements you made about unvaccinated healthcare workers, you're referring to those who have not been vaccinated for COVID, right?

A Again, this begins with COVID because this discussion began with COVID. So, yes, but it's not the only -- I wouldn't worry about tetanus vaccine in a NICU nurse, but --

Q Okay.

A -- I'd certainly worry --

Q So I'm just gonna stick to COVID specifically.

Q And on that point, do you think everyone should be afraid of COVID?
A I do. "Afraid" may be not the best word. "Diligently protective" against COVID would be what I would propose.
Q And those diligent protective measures against COVID, would those specific measures depend on the individual in question?
A Yes and no. Yes, because the higher risk an individual has, the more they should be vaccinated and perhaps socially isolate and the other less effective measures. No, because I think everybody can get COVID, and, more to the point, everybody who can get COVID can spread COVID.
Q Would you agree that not everybody is afraid of COVID?
A I absolutely agree with that.
Q Would you agree that, among those who are afraid of COVID, that the perceived risk is greater than the actual risk?
A No.
Q Would that depend on individual factors?
A Absolutely.
Q So I think this much is clear from your report, but tell me if this is accurate: You think the best medical practices necessarily include vaccine requirements for all healthcare workers. Is that accurate?
A Yes.

Q And when I say "all healthcare workers," does that include IT staff, for example?
A No.
Q Okay.
A Patient-facing healthcare workers.
Q And with respect to those vaccine requirements, I think you would say that would include COVID, right?
A Correct.
Q Would that include MMR?
A Correct.
Q Would that include DTaP?
A Yes.
Q Would it include polio?
A Yes.
Q Would it include Hib?
A Yes. Not for adults, of course, but for children.
Q Do you know of any children healthcare workers, patient-facing healthcare workers?
A So that means that I could have said no, but --
Q Okay. I just wanted to clarify.
How about varicella?
A Yes.
Q Hepatitis A?
A Yes.
Q Hepatitis B?

A Yes.
Q Pneumococcal?
A Yes.
Q Influenza?
A Yes.
Q Rotavirus?
A Yes.
Q Are there any vaccines that you would not include?
A Oral polio vaccine. Okay. Injectable, yes. Oral polio vaccine, no.

Yellow fever for people who aren't in an endemic area, yes.

And what's interesting is I also do immigration physicals, and the U.S. government requires vaccinations, including full COVID vaccination, which is sadly defined as one Johnson & Johnson or two mRNA vaccines even though the J&J is not terribly effective. But the U.S. government requires that of immigrants. And, of course, our military people are familiar with being required to have vaccines that laypeople are not. So we have that precedent already as a national policy.

Q Would an example of the military vaccine that you're referring to be anthrax?
A I think they get that. I'm not a military provider, so I can't quote you the list of all the vaccines they get. I know

A That is the best assumption to make.
Q And maybe I misheard you earlier, but didn't you attribute that to vaccine hesitancy?
A Yes. The subculture that is the predominant population in the area this occurred is firmly anti-vaccine. It's a religious subculture. The press have been -- the press, the various people who report it -- have been very shy about being specific about that, but the assumptions are almost certainly valid.
Q Going back to the comment regarding yellow fever vaccine, you wouldn't recommend it for anyone not going to a yellow fever endemic area; is that accurate?
A That's correct.
Q Okay. In other words, that depends on the individual circumstances for that particular vaccine?
A Yes. If I were in an endemic area, then it would be on my list of must-do.
Q Okay. So we just went through that whole long list -- I'm not going to repeat it -- of all the vaccines that you would require for patient-facing healthcare workers. Do you recall that?
A Yes. And I would, I would say that almost all of those are mandatory childhood vaccines, or most are still, at the time we talk, allowed to be mandatory childhood vaccines.
Q If a medical facility did not require one or more of

those vaccines, does this violate the standard of care, in your view?

A In my view, yes. It violates, also, in my view, the basic fundamental sort of founding dogma of medicine which goes back to Hippocrates a couple thousand years ago.

Q Are you aware of any other view which would find that that is not a violation of the standard of care, to not require one or more of those vaccines?

A Not a standard of care, not -- could you rephrase the question?

Q That was a bad question.

A It had another double negative.

Q Right.

So you said in your view it would be a violation of the standard of care to not require those vaccines, right?

A That's my view.

Q Okay. Are there other views of which you are aware that that is not the case, that that is not a violation of the standard of care?

A Are there people who disagree with me? Is that the question?

Q To start, sure.

A Yes, there are certainly people who disagree.

Q Are you aware of any organizations, medical organizations, boards, anything of that nature that have an

prevent organ rejection, I have to frequently see medical providers. I have to continue to take medications. Those have to be monitored to see if they need to be adjusted.

I have health implications. I had damage to my eyesight because of high doses of prednisone to save my life. Edema, where fluid builds up when your kidneys shut down, damaged all the nerves in the lower half of my leg. I can't feel the front half of my feet. I had to kind of learn to walk again, and I'm much, much more susceptible to infections.

Q And when you say "infections," are you more susceptible to contracting infectious diseases?

A Yes.

Q Do vaccines work for you?

A Initially, I thought so. I mean, there was no information when the vaccines first came out that indicated that immunocompromised people weren't protected. And so it wasn't until one of my medical providers said, "Hey, you really need to get a test to see if you even developed any antibodies," that I found out that after my second full dose of vaccine, I had not developed any.

And it was, you know, sometime after that that the federal government approved boosters for immunocompromised people, which were actually, for me, a third full dose. I retested and finally did develop some antibodies but a very small quantity. Not protective.

And to this date, I have had three doses -- or six doses of vaccine which do continue to produce some level of antibodies, and I've also had three different applications of monoclonal antibodies since my immune system is compromised and I'm not, I'm not capable of developing antibodies very well to protect myself.

Q And you're talking about the COVID vaccine, correct?

A COVID vaccine, but other vaccines as well are impacted by this.

Q Due to your health condition, should you avoid contact with unvaccinated people?

A Yes. Certainly pre-vaccine, I was living at my lake cabin, up 40 miles outside of town. Very isolated. Restricted myself to a very small group of people that I knew were careful, wore masks, tried everything they could do to prevent infecting me.

Once there was a vaccine, you know, I took those, but it was some time before I had any kind of effective protection from those. I wore masks. I washed my hands. I used sanitizers. I ordered my groceries online so they would bring them to my vehicle. I stopped doing all of the things in public that I used to do.

Q And does your ongoing health condition require you to seek frequent medical care?

A Yes, from multiple medical providers.

Q Are those medical appointments optional for you?
A They are not.
Q Can you go to all of those medical appointments virtually?
A I cannot do that. All of them require blood work or EKGs or various other hands-on assessments. The eye doctor has to use special instruments to look inside my eye for the damage that resulted from heavy doses of prednisone. So they can't be virtual. They can't perform the function they need to. A dermatologist, for example, has to see my skin. Has to take pictures and compare them to previous things they thought might be of concern.
Q Do you receive some of those medical services from hospitals?
A Yes, from Providence and also Western Montana Clinic.
Q So you also get some of those services through physicians' offices --
A Yes.
Q -- like Western Montana Clinic?
A Yes, yes.
Q You mentioned going out less. Did you forego any medical care as a result of your increased risk of exposure?
A Initially. Pre-vaccine, nobody was seeing anybody. It was chaos. I had been required to make return trips to Seattle, to Virginia Mason Hospital, on a yearly basis, and

top of everything else that's going on surrounding this pandemic.

BY MS. MAHE:

Q Are you a higher risk of harm from infectious diseases due to your health condition?

A Yeah. I mean, this particular disease, COVID, could have severely impacted my heart, my lungs, my kidneys, things that I've already had compromised by chronic kidney disease. And so my kidney -- I have one functioning kidney. If that was damaged by COVID or some other disease, I'm not likely, at 67 years of age, to get another transplant anytime soon. I was lucky enough to have a live donor. That's the only reason I got one so quickly. Otherwise, I'd still be waiting for a kidney.

MS. MAHE: I have no further questions at this time.

THE COURT: Mr. Mead, cross-examination?

MR. MEAD: Thank you.

CROSS-EXAMINATION

BY MR. MEAD:

Q Mr. Carpenter, just a couple questions for you.

When you received your transplant in 2017, did you ask your staff if they were vaccinated?

A No, I did not, as it was my assumption at that time that that was a requirement of being a healthcare provider.

Q And we'll say prior to COVID-19, did you ever inquire

were months of having just the state law, 702, in place, people felt that they had the right to not talk about their immunization status, which, you know, the law gave them. And so then you had opposing national and -- or federal, I suppose you would say, and state law. And under that circumstance, we had a higher exemption rate. So that's what I was making reference to.

Q Okay. And if my memory serves me correctly, that amounted to approximately 200 people; is that accurate?

A Yes. The staff is 2,000, so 10 percent would be 200.

Q And all 200 of those employees were accommodated? They weren't fired, right?

A Yes.

Q Does the fact that you were able to accommodate all those employees, in your opinion, decrease the safety of your -- of Bozeman Health?

A Well, the important thing is the transparency. See, what the law doesn't provide, in my opinion, is transparency. We don't know, with the law, because there is this barrier, you know, between knowledge of vaccination status.

You know, there's lots of other issues. You know, you don't know whether the vaccines were immunogenic; you know, producing immune response. All that kind of stuff. But just looking at vaccine -- having received the vaccines or not, you know, that's important information.

So, you know, what we decided was to -- if we were in a situation where the patients were critical, they were in the ICU or they were in the cancer clinics or something like that, that we could remove those people that were unvaccinated from those situations and put them into a place where they were dealing with patients who were less likely to be immunocompromised. It wasn't a perfect kind of situation, but it was the best we could do.

The other thing was masking, you know, and the other thing was requiring periodic testing for COVID. So those were things that we felt would be an important way of ensuring safety under the circumstances.

Q Is it fair to say that you were able to both accommodate the exemptions and ensure the health and safety of your institution in that case?

A Well, I think we tried to do it best we could, given the situation.

Q Are you aware of any data or any evidence to indicate that those accommodations that were made at Bozeman Health led to a decrease in overall patient health?

A No, I don't. I'm not aware that they did that.

Q And you mentioned masking. Is masking still a requirement at Bozeman Health?

A Yes.

Q Is that for everyone?

A Yes.

So the question was if someone was unvaccinated, whether they would be required to wear a different kind of mask that would, you know, provide a greater seal, for example. That kind of thing. So -- and, you know, and I think we're also quite aware, you know, some of these things would kind of reveal who was unvaccinated; if they're wearing different masks or whether they're, you know, having to change jobs, et cetera. And so, you know, I think we were cognizant of those kinds of issues as well.

Q You mentioned periodic testing. Are you still doing that at Bozeman Health?

A I do not believe so.

Q Do you know why?

A No.

Q Briefly going back to your conclusion in paragraph 24 stating that the -- the exemptions being approximately twice as high as the national average which in part is caused by the opposing state mandates, then were there other reasons that you concluded caused the -- that caused the elevated exemption rate aside from House Bill 702?

A I'm not aware of it.

Q Would you agree with the general statement that a patient's risk factors depend on the individualized situation of that patient?

That's on page 29.

In the first sentence there, you say, "Vaccination and immunity status are important to know," right?

A Yes.

Q Okay. Does that mean that it's unsafe to assume that those who don't disclose their status are unvaccinated?

A Well, why have an indirect way of doing things? That's what my objection is. If you're unvaccinated, then say you're unvaccinated, you know, and then not because you're gonna get punished for it but because, you know, we're trying to do the right thing for our patients in our institution or in our doctors' clinic or whatever, and so we want to know who is vaccinated and who is not. We don't want to have to guess. It's silly to guess when the information is known for sure.

Q So I take it your answer is that it is not unsafe to assume that those people who do not disclose their status are unvaccinated?

THE COURT: Well, you're doing this constantly. You're rephrasing what the answer is. I understand what he said. You don't need to rephrase it. Move on.

MR. RUSSELL: Got it.

BY MR. RUSSELL:

Q Paragraph 57 of your report. You state that "it should be clear that vaccinated persons are not as likely to become infected with Covid-19 as the unvaccinated." And, again, I

opportunity before they become immunosuppressed to immunize them against hepatitis B, for example, or other diseases that they might acquire during their period of immunosuppression.

THE COURT: So how is that different than accommodating somebody that is vaccinated or unvaccinated that works in the hospital as a nurse or a tech or whatever?

THE WITNESS: I think it's the idea of providing the safest environment. We can't control the patients. We need to see the patients, regardless. You know, that's, that's what we do. We're a hospital. We see patients. You know, we can't say to the patients that they can't come. If they, if they have an illness or a reason to see us, we need to see them.

That's different than our staff. Our staff we have control over, and we feel that the best way that we can offer care to our patients is to have our staff as safe as possible by immunizing them against circulating diseases, whether that be influenza or COVID or, you know, what-have-you.

THE COURT: All right. Thank you.

We'll take a recess for, oh, 20 minutes. We'll be back in at a quarter after.

You can step down, Doctor. Thank you.

We'll be in recess.

(Recess taken from 14:53:35 to 15:18:43.)

(Open court.)

successfully prevent disease even if one particular part of that layer is not a hundred percent effective.

Q Okay. And part of that checklist in preparing for invasive procedures, is that checking to see if all healthcare staff are vaccinated? And you can separate pre- and post-702 --

A Yes.

Q -- if there was a difference.

A So we don't need to check preinvasive procedures because we know that all of our staff are vaccinated because we require that or have required that for them to be credentialed. Obviously that, you know, might change, but to this point we don't have to individually recheck that because they are checked on hire.

Q Okay. And when you say they're "checked on hire," does that mean that they have to submit proof of vaccination or proof of immunity?

A So I serve on the credentials committee for medical staff, and so for physicians and allied health professionals -- so physician assistants and nurse practitioners who are hired -- there are vaccines that we must submit either a record of or proof that we already have immunity to that disease.

Q And so currently at Community, do those records of immunization or vaccination, are they still in those

A So the precaution that you're referring to is the fact that we wear an N95 mask, or is it the fact that we keep a room closed off and use negative pressure?
Q That you keep the room closed off and use negative pressure.
A So regardless -- and you're asking about the patient's vaccine status or the caregiver's?
Q Well, so in your report, you say that rooms in which someone with measles has been sitting, the room has to be closed off. So that person who has measles, is their vaccination status relevant --
A Yes.
Q -- to closing off the room?
A So measles is an incredibly protective vaccine. I personally have never seen a vaccinated person with measles, but, regardless, if someone is sick with measles, they have the potential to transmit it. So in the patient case, this would be a precaution that we would have to take.

For caregivers, however, our guidelines are currently that someone who does not have measles immunity should not take care of a patient with measles, and those come from the CDC.
Q So in paragraph 22, you use the term "actual knowledge," and I'm wondering if you can just describe for me what you mean by that.

accurate?
A I'm using the definition that we would use that is provided for the specific vaccines that are recommended by ACIP, the Advisory Committee on Immunization Practices, for healthcare providers, and I use that definition of "healthcare settings."
Q Is that a CDC definition?
A I don't know if it's specifically a CDC definition. Again, I can read them to you. Also -- what is it? The healthcare immunization -- oh, I forget the name of it -- also is another committee that would -- the hospital Infection Control Practice Advisory Committee, and others, that have signed off on this, these recommendations.
Q In your experience in Montana, is it common for healthcare settings to allow medical exemptions for vaccination requirements?
A Medical exemptions?
Q (Nodded head affirmatively.)
A My understanding is yes.
Q And in your experience in Montana, is it common for healthcare settings to allow for religious exemptions for vaccination requirements?
A Again, this is an individual decision by each of the different healthcare settings, so I couldn't answer for each specific one, if they decide that or not.

Q In your experience in Montana, is it common for healthcare settings to recommend but not require vaccinations?
A There's many different vaccinations that are out there, so I don't think it would be a pan across the board, but, yes, I think there's situations where they would recommend and not require, and there might be other situations where they're working with very high-risk individuals that they might require the vaccine in order to be in those types of settings.
Q Can you think of any specific example where that would be required?
A I mean, I can't give you a specific, what each hospital or place decides, but if I was -- personally, a NICU, I would want to make sure that everybody that's going in there has had their pertussis vaccination because it's high risk to neonates. So I would want to make sure that they're, what we call, cocooned; everybody around them are vaccinated and that we wouldn't be transmitting the disease.

If I was working in oncology or places where people are immunosuppressed, I would want to make sure that people have been vaccinated against diseases that could be transmitted via respiratory or other kinds of things, so measles, varicella, that can be extremely dangerous for them and for some people that are severely immunocompromised might not be able to be vaccinated with some of these vaccines. So those would be all sorts of different ways.

I would want a surgeon or somebody who is working closely in blood products and in closed areas to be vaccinated against hepatitis B.

At the state, we also, you know, in the laboratory, we ask our laboratory workers to be vaccinated against hepatitis B.

Q When you say you "ask" them to, is that a recommendation or a requirement?

A At this point in time, I am not specifically over the laboratory and I actually have left the state, but we would -- I don't know of anybody that didn't get the hepatitis B vaccine, but I wouldn't have a specific answer on that because I don't look over those records.

Q Do you recall in your experience, while you were there, whether that was a recommendation or a requirement?

A I don't -- I would assume it was a recommendation. I don't know if there is anybody who chose not to, but we had the data, had the information on them.

Q Have you ever worked in a healthcare setting in Montana in which vaccinations were recommended but not required in any other situation that we didn't already cover?

A In Montana, I've only worked in the Blackfeet Indian Reservation, and it was such a long time ago I can't tell you right offhand. I suspect that I was -- they asked for my vaccine records in certain areas like hepatitis B, but I

couldn't answer for you a hundred percent.
Q In any event, that sounds like it was well before the COVID pandemic.
A Yes. This was in the '90s.
Q And turning back to the ACIP's recommended vaccinations, is it your opinion that those should be required in healthcare settings?
A It's my opinion that the healthcare settings need to be able to require them if need be. So when you look at the ACIP recommendations, it's not like they put every vaccine. They've taken the vaccines where they know it is higher risk within that -- in a healthcare setting. So there's seven vaccines, and I would add in COVID now because it was written before COVID. Those are places where it's very high risk. I would want the hospital or the clinic or the dialysis center to be able to make those decisions, knowing their own risk-benefits in those communities and the type of patients that they're taking care of.
Q Does your expert report submitted in this case express any opinion as to the efficacy of any specific vaccine in preventing disease transmission?
A I don't believe I went into specifics of efficacy or -- yeah.
Q That would include COVID-19 vaccines, right?
A Say that again.

Q That would include COVID-19 vaccines?
A Correct.
Q Is it true, in your opinion, that individuals vaccinated against COVID-19 may be asymptomatic carriers of COVID?
A Are you asking if -- can you restate the question?
Q Would you agree that individuals may be asymptomatic carriers of COVID if they're vaccinated against COVID-19?
A People can get COVID still with having the vaccine, and, yes, they may be asymptomatic or they might have symptoms.
Q So I believe in your expert report you state that acquiring an infectious disease is a recognized hazard in working in medical field and healthcare settings; is that accurate?
A Correct.
Q And by "recognized hazard," what do you mean by that?
A Well, we know that you go into the medical field, and, again, it's a diverse field, so it depends on what areas that you're in. But you have increased risk for certain infectious disease, diseases. We put in many different modalities to try to minimize those risks.
Q Is that true regardless of that particular individual's vaccination status?
A Do we put in interventions, you mean? Prevention? Oftentimes we'll use what they call like the control of hierarchy to look at ways to prevent infections, or a lot of

other things, too, but in the sense of infections. And so we put in a lot of different ways to try to minimize that risk, because nothing, as I state in my testimony, is a hundred percent.

Oftentimes, the example I usually give is a Swiss cheese approach. You have one little slice. There's holes in it, and things can get through. If you have a block of Swiss cheese, you don't have the holes, and so you decrease the risk.

Certain things are -- certain interventions are stronger than others, but it depends on the virus or the bacteria or the protozoa or whatever you're talking about. It depends on the host, and it depends on the environment.

Q And with respect to those measures, you mentioned that controlled hierarchy, I think you called it?

A Yeah. Hierarchy of control.

Q Yeah, I'm sorry. Hierarchy of control.

A Um-hmm.

Q Are there any measures in that hierarchy of control that are determined based on an individual's vaccination status?

A Well, it's a hierarchy. It's kind of to look at different things. But when you look at the hierarchy of control, it's basically an inverted pyramid. At the very bottom, one would be PPE. You know, that's one way of doing it.

As you go up, the elimination of the hazard would be the best thing to do. Now vaccines aren't a hundred percent, and they differ on the different types of vaccines, but that would be one way of doing that.

Others would be administrative controls that you might do, so requiring vaccines or other things of that sort.

Another step up can be the environment, so what do you do to protect in that environment?

That might be the different types of precautions that you put in, including vaccinations.

Q So back to the recognized hazard. Did recognized hazards -- well, sorry. Scratch that.

The recognized hazards that you referred to existed prior to COVID-19 with the exception of COVID-19, of course; is that accurate?

A Of these, yeah. I'm going off of the ACIP guidelines, again, which looks at these seven, which shows that there's a higher risk within a hospital setting or within a healthcare setting than in the general public, and that's why these are recommended vaccines.

Q Prior to the CMS COVID vaccination rule, are you aware of any CMS regulation mandating healthcare workers to get vaccinated?

A I am not. I know that there is a quality measure on looking at flu vaccinations. But, again, I am not involved in

put forth significant resources to prevent the spread of diseases within their facilities through types of occupational health services." What, what does this effort entail?

A Well, this is just as I was talking about before. It depends on the disease. It depends on the environment, what community you're talking about.

You know, I'm not gonna have somebody that's not gone through sterilization going into an OR and taking care of patients.

If I was on a transplant unit or a burn unit, people -- we'd want to make sure that they're not sick at the time, that they have -- they're masked up appropriately, wearing the appropriate protective equipment.

And there might be other things. One could be knowing their vaccination status if they're going into places where the patient is very -- at very high risk.

And then there's aspects of, like I said, you know, a negative-pressure room that you may use or leaving equipment in the room and not taking it from room to room, making sure people coming in and out are washing their hands, putting on the appropriate PPE.

Q At the end of paragraph 11, you refer to "unique infectious diseases requires more specific prevention measures." Are you referring to any specific infectious diseases in that paragraph?

A Yeah. It's kind of as I talked about before. Blood-borne precautions I'm going to put on for somebody that has hepatitis or HIV or some of these other things. Droplet precautions are things that you would put on for somebody that might have measles -- excuse me, might have mumps. Airborne precautions for measles or varicella.

So there's all sorts of different ones that, depending on the disease and the transmissibility of that disease and the population that you're working with, you would have different measures that you might do.

Q In paragraph 10, you refer to people who are employed in healthcare settings who could be vulnerable or at higher risk. Are you referring to any specific individuals or groups of individuals?

A Well, within the healthcare setting, we have -- just like the general population, there's all sorts of different people. So people can be maybe immunocompromised, or they could be pregnant and have higher risk to bad outcomes if they were to acquire rubella or to acquire varicella, chickenpox, during that time.

Q And when you say "higher risk," are you relying on any specific studies or data, et cetera, other than your general experience in forming that opinion?

A That, that healthcare workers are -- so what I'm saying in this sense is that in the healthcare sense, they're at

higher risk because the diseases are there. People who have measles are likely to show up at a healthcare setting, so they have higher exposure and higher risk, if that's what you're asking.

Q But you're not referring to or relying on any specific data or reports in that conclusion, are you?

A Well, in this report here, and there's multiple studies out there, but there's cases of that. There's cases in Arizona of measles being transmitted from a hospital worker to a person in the emergency room who ended up in the intensive care unit. There's, there's examples of this, yes.

Q In paragraph 12, you state that there are situations where it's essential to treat employees differently in the conditions of their employment based on their vaccination status; is that accurate?

A Correct.

Q And are there any such conditions of employment that you're referring to that are not contained in your report?

A I would have to go through my report, but I'm sure there is more than -- I gave an example of something such as if somebody wasn't vaccinated against -- I believe. I'll have to even look at this. But I think I used the measles example in that sense. If somebody was not vaccinated against measles, we wouldn't want to put them into the room of a patient that had suspected or known measles.

There would be other cases in that sense, too, with different diseases that we could go through. Somebody who is not vaccinated, I won't want to put them -- or have immunity, whether it's through natural means, to varicella. I wouldn't want them, especially if they were pregnant or immunocompromised.

Q In paragraph 18 of your report, you refer to House Bill 702 and state that it doesn't allow employees in -- healthcare settings to treat employees differently based on their vaccination status. Do you see that?

A "Based on my experience"? That one?

"I understand the House Bill 702 does not allow healthcare settings to treat employees differently based on their vaccination status"? Yeah.

Q Right, right.

Are you relying on any information, studies, data, et cetera, aside from your experience and your own interpretation of House Bill 702 in coming to that conclusion?

A So I'll answer that twofold. One is, yes, that's from my reading of the bill and my understanding of it. The thought process that went through my mind from a public health side, not only from a clinical side but from a public health side, is how we do an outbreak investigation. And during an outbreak investigation, just like you would do with a patient, we look at risk to try to make our decisions of what we're

doing next in trying to control an outbreak.

The goal, anytime there's an outbreak, especially of something that's a rare disease like this, is to try to control it, or highly infectious like measles, is to control it earlier. If you kind of think of a snowball, you want to get it when it's really small, not when it's gotten out of hand and moved into the community. So you move very quickly. And we would use that data on certain diseases. Knowing, knowing their status, vaccine status, would be important and help us move much quicker.

Q Would, assuming somebody's status as being unvaccinated, if they did not disclose their status, would that hinder such an outbreak investigation?

A I think it could, depending on the disease. I could think of scenarios where I would be worried about it. It would also, I think, cause disruption to the hospital. So if you look at something like mumps, if somebody is not vaccinated, they would be told to be out of work for 25 days and not be there; for measles, 21 days.

So those things may make a difference as far as if they are vaccinated or not vaccinated. And if I have to assume that they're not, we would ask them to be moved out of patient care, so that could cause some stress on the hospital situation.

It would also make a difference clinically on how we

might want to respond to a patient. So for some of these diseases, you can -- you might give immunoglobulins to decrease the risk of actually getting the disease.

So if somebody got an accidental needle stick, we would want -- and there's known source of -- or unknown or source of hepatitis B, we would want to know if that person is immunized. We'd actually even want to know the quantity of their response to that immunization, if they've been tested after they were fully immunized, to make sure they had 10 international units or higher of antibodies. We might give them immunoglobulins to try and protect them.

A patient with varicella who is not vaccinated, we may give immunoglobulins.

Mumps is usually a two-vaccine status. During an outbreak, you can consider giving a third vaccine.

We also know, with some of these vaccines, people might have only one in the series, so they might have only gotten one of the measles vaccines. Might be because of age and when they came through the process or not going in. We would want to get them the second vaccine at that time.

Q And in your report, you reference a situation where you would treat employees differently based on vaccination status. Would that include not allowing them to interact with immunocompromised patients, treating them differently, in your use of that term?

provider's vaccination status or they also need to require vaccination?

A I don't think you can put a blanket statement down for every different situation. I think that opportunity and that understanding needs to happen at the clinical level. Again, there's different risks, so it might be very different as far as what vaccines they want to be absolutely sure their employees have or don't have in those situations. So, you know, that, I'd leave up to the different groups and them doing their own risk.

From a public health standpoint and doing an outbreak investigation or any of those other things, knowing the status of the vaccination of these employees is really pertinent for us to be able to move quickly on these type of outbreaks. And so as is recommended in the guidelines, they say that, you know, that you should make sure of the people's vaccination status, of these vaccines that we talk about through ACIP, prior to employment. And they say -- they recommend that you kind of look at that at least once every year so you can kind of go through those things. It also gives a time that you can sit down and talk to the individuals and make sure you can answer their questions.

But, again, in an outbreak situation, I would want to know individual status because it would make a difference on how we might treat individual patients, and then it also has

an effect on us trying to think about how we're trying to control the outbreak to not go any further.

Q In situations where a healthcare setting would need to require a vaccination, in your opinion, could medical and/or religious exemptions be granted?

A In a medical situation, absolutely. And in a religious, that's a decision by the individual institution. They may decide that, even though, with a medical, still hire and work with that individual, but there might be certain situations that they would ask them not to be in.

Q In your experience, do hospitals grant admittance privileges to providers employed at other healthcare settings?

A Yes.

Q In that situation, can hospitals rely on a representation to a provider -- or that a provider is vaccinated, or do they need to require proof?

A So from the guidelines, again, what we say is we want a presumptive immunity. And so for different ones, there's different levels. But for the most part, they're fairly consistent. It might be that they are -- they have known vaccination. They can show that they've gotten the vaccinations for that. It may be that they have known immunity through blood test or that it has been doctor confirmed or healthcare provider confirmed that they had that disease.

(Discussion off the record at counsel table.)

BY MR. RUSSELL:

Q One last question.

Would you agree that states are not required to adopt ACIP recommendations?

A The ACIP recommendations are not something that the states would adopt or not adopt in usual situations.

MR. RUSSELL: Okay. No further questions.

THE COURT: All right.

Is there any redirect?

MR. GRAYBILL: Yes, Your Honor.

THE COURT: All right.

Mr. Graybill.

REDIRECT EXAMINATION

BY MR. GRAYBILL:

Q Good afternoon, Dr. Holzman.

A Hello.

Q Does whether you are male or female affect your transmission risk?

A No, not that I know of.

Q Does your immunity status affect your transmission risk?

A It could, yes.

Q Why is knowing a provider's actual immunity status, as opposed to presuming it, important?

A Again, it's, in the different situations, it would be

different areas, but I think I used the example of measles before. Knowing if somebody is vaccinated or not vaccinated for the individual might make a difference of giving immunoglobulins or, again, offering the vaccines, or to even make sure that they've had the full series. We've had outbreaks where people have had only one of the two shots, so you want to make sure that everybody is fully vaccinated, and you need to move quickly in those situations. So knowing that right away is important.

I can give other examples, too, if you'd like.

Q Let's talk -- you mentioned the ACIP guidelines several times.

A Um-hmm.

Q That's the Advisory Committee on Immunization Practices?

A Correct, and there's a specific one for healthcare providers.

MR. GRAYBILL: Davina, could you pull Exhibit 109 and publish it?

MS. TOLLE: (Complied with request.)

BY MR. GRAYBILL:

Q So is this what you're talking about when you talk about the ACIP recommendations?

A Correct.

Q And can you see this up there?

A I have my own copy.

Q You have your own copy?
A Yeah.
MR. GRAYBILL: Okay.
Can we go to page 15 of Exhibit 109?
MS. TOLLE: (Complied with request.)
BY MR. GRAYBILL:
Q Do you see where it says "Varicella Control Strategies" at the top?
A Okay. Varicella. "Postexposure Management"? Is that which one you're . . .
Q Do you see where it says "Varicella Control Strategies" --
A Oh, okay.
Q -- and then it says "Patient Care"?
A Yeah. Let me find it on mine here, here, too. I'll switch glasses and go with this. Sorry.
Q If you have the big exhibit binder, you can just go to Tab 109, page 15. Or do you have a screen you can see it on?
A Yeah, I can see it on the screen.
Q Do you see where it says "Patient Care"?
A Yep.
Q Can you read the first sentence there?
A "Only [healthcare providers] with evidence of immunity to varicella should care for patients who have confirmed or suspected varicella or [herpes zoster]."

Do you want me to continue reading or --

Q That's fine.

A Okay.

Q In your opinion, is that what you're talking about when you talk about treating healthcare workers differently based on their immunity status?

A Yes.

Q And do these recommendations contain similar recommendations about differential treatment for other diseases besides what we have here, which is varicella?

A Yes.

MR. GRAYBILL: Okay. We can take that exhibit down.

MS. TOLLE: (Complied with request.)

BY MR. GRAYBILL:

Q You were asked by counsel about your knowledge of various state requirements based on your experience as state medical officer. Do you remember that discussion?

A Yes.

Q And I think I recall you said you didn't really work on the CMS side of things? Reimbursement?

A Right. I'm not working on the day-to-day qualifications of Medicaid.

Q Was infectious disease a focus of yours?

A Infectious disease, definitely, from the public health side. Yes.

MS. TOLLE: (Complied with request.)

BY MR. GRAYBILL:

Q Is this what you were talking about?

A Yeah. And, again, it's for all hazards.

Q So if somebody says, "Who cares if you're vaccinated? Just wear a mask." Where does that fit on this hierarchy?

A So that's a lower, least effective. Again, it puts in more opportunities for human error and other aspects to happen that might decrease their effectiveness. Again, it depends on the disease and the issue that you're talking about, but they tend to put PPE at the bottom. It's still important, but it's not as strong as getting rid of the disease completely, eliminating it.

Q Where would you put an employer's ability to know actual immunity status or require immunizations with appropriate exemptions on this triangle?

A You know, I think it can fall in different areas, and it probably depends a little bit on what the vaccine is, as we've talked about before. Some vaccines are much more effective at eliminating people even getting the disease, where other ones, the effectiveness is not as strong for possibly elimination of disease. But it definitely plays in the aspect of administrative controls and making effects there, and you could talk about it possibly in engineering controls.

Sometimes when we think about engineering controls, we

think about issues where you don't have to make the decision at the time; you know, decrease the chance for human error and stuff of that sort. So you kind of have that baseline protection.

Q Let's take the measles vaccine. Where would you put that on this in the context of a measles outbreak?

A Again, I think you could put it in different categories. I think, you know, being as precise as I want to say, I can't say it absolutely eliminates it, but it decreases the chance quite, quite considerably because it's a very good vaccine. Definitely plays a huge part in engineering controls and definitely in the administrative controls.

Q What do you say to the person who says, "Don't worry about the measles vaccine, whether I'm vaccinated or not. I'll wear a mask"?

A Well, masks -- again, I'm gonna encourage people not to wear just a mask. I would have them wear an N95 mask that's hopefully fitted specifically for them, so that's a step higher in risk because that is a very transmittable virus. It's also a virus that has -- it can aerosolize and be in the air, can even be in the room after you leave for a certain amount of time. I think they recommend two hours, but I'd have to look that up specifically.

Q What role would a vaccination play in abating that risk?

A Well, it's gonna decrease your chance immensely of ever

even getting the virus or getting infected if you walked into that room or some of your other, kind of using that Swiss cheese approach again, some of the other aspects did not work as well.

Q Final question: As a matter of public health, and drawing on your experience and expertise, should that decision be made by individual healthcare settings or by the government?

A I think this is where, again, you're looking at individual settings, because the ACIP has already said these are higher risk diseases in a healthcare setting. But within the healthcare setting, there's places that are much higher and others that might be lower, and also looking at everybody that works within the healthcare setting. So you can talk about a custodial person and what their risk would be versus a nurse or a doctor working in a NICU or working in a cancer ward.

So they -- a healthcare system can kind of make their decisions on looking at risk and benefit and deciding where they absolutely don't want somebody or where they might be able to feel a little bit more comfortable that they could make some accommodations because the risk is lower.

Q Truly last question: If the government comes in and says, "You don't get to use vaccines or knowledge of vaccination status as a tool," what does that do for workplace

and patient safety?

MR. RUSSELL: Objection, Your Honor. 403.

THE COURT: Overruled.

THE WITNESS: I think it -- I feel that it increases risk for both patients, for co-workers, and, at times, it can be for the community at large, considering we all live in a community that's around there. So those would be my concerns with this going.

Now the other thing I would add to it is we know, with vaccinations, the people that tend not to vaccinate tend to congregate together, which decreases our ability that herd immunity may work in certain situations. And I do get concerned that we may even see people deciding to work in Montana because they don't need to be vaccinated, and that could even increase our risk here.

MR. GRAYBILL: No further questions.

THE COURT: All right.

Mr. Russell, did you have any questions you wanted to recross on with the sole limitation to the history of control issue that was brought up?

MR. RUSSELL: Yes. Very briefly, Your Honor.

THE COURT: Okay. You may, but you're constrained to just that. And if you want them to bring it up, they'll bring it up.

MR. RUSSELL: Yes, Your Honor.

JoAnn Jett Corson
Registered Diplomate Reporter
Certified Realtime Reporter
P. O. Box 8006
Missoula, Montana 59807-8006
406/829-7123 office
joann_corson@mtd.uscourts.gov

United States Court Reporter

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MONTANA
MISSOULA DIVISION

MONTANA MEDICAL ASSOCIATION et al., Plaintiffs, and MONTANA NURSES ASSOCIATION, Plaintiff-Intervenor, vs. AUSTIN KNUDSEN, Montana Attorney General; and LAURIE ESAU, Montana Commissioner of Labor and Industry, Defendants.	No. CV 21-108-M-DWM **VOLUME 2 OF 3** **TRANSCRIPT OF BENCH TRIAL**

BEFORE THE HONORABLE DONALD W. MOLLOY
UNITED STATES DISTRICT COURT JUDGE
FOR THE DISTRICT OF MONTANA

Russell Smith United States Courthouse
201 East Broadway
Missoula, Montana 59802
Tuesday, October 25, 2022
08:45:25 to 15:06:48

Proceedings recorded by machine shorthand
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THE WITNESS: Wallace L. Page.
THE COURT: And how do you spell your last name, Mr. Page?
THE WITNESS: P-a-g-e.
THE COURT: And what city do you live in?
THE WITNESS: Kalispell, Montana.
THE COURT: And what do you do for a profession or occupation?
THE WITNESS: I am retired, 80 years old. And I worked in forestry and hydrology.
THE COURT: All right.
Mr. Cole.
MR. COLE: Good morning, Wally.
THE COURT: No first names, please.
THE WITNESS: Good morning.
WHEREUPON,

MR. WALLACE L. PAGE,

called for examination by counsel for plaintiffs via video teleconference, after having been first duly sworn to testify the truth, the whole truth, and nothing but the truth, testified as follows:

DIRECT EXAMINATION

BY MR. COLE:

Q Mr. Page, you're currently battling cancer; is that correct?

A Correct.
Q And are you currently undergoing chemotherapy treatment for that cancer?
A Yes.
Q Mr. Page, where do you receive your chemotherapy treatments?
A I'm sorry. Could you repeat?
Q Where do you receive your chemotherapy treatments?
A At Logan Health in Kalispell.
Q And that's a hospital in Kalispell?
A Yes.
Q And do you require frequent medical appointments and visits to undergo this treatment for your cancer?
A Yes.
Q About how frequently do you go in for treatments?
A It's variable, but at its peak it was like three or four times a week to go for some kind of a testing or blood draw or infusion work for my cancer treatment.
Q And do these appointments require you to physically go in to the hospital?
A Yes.
Q And can you skip these treatments, Mr. Page, or are these required?
A They're required according to my treatment plan.
Q Do you also see an oncologist?

A I'm 80 years old.
Q And you are a breast cancer survivor; is that right?
A Yes.
Q And when were you first diagnosed with cancer?
A In October of 2019.
Q And can you describe to us the types of treatment you underwent to treat that cancer?
A Well, I had surgery, and I did have multiple surgeries. I ended up having five surgeries, and then I had chemo treatment and then radiation therapy.
Q And so if you were diagnosed in late 2019, were you undergoing chemotherapy treatments during the pandemic?
A Yes.
Q And did you receive radiation after the chemotherapy?
A Yes. I had to wait some time before -- while my body healed before I could actually do the radiation, but, yes.
Q And where did you receive these chemotherapy and radiation treatments?
A I had the chemotherapy in Missoula, Montana at St. Patrick's Hospital, and I had radiation therapy in Kalispell at Logan Health Center.
Q And did you also see an oncologist?
A Yes, I did.
Q And do you have a primary care provider you see in a physician clinic?

A Yes.
Q When you were undergoing this treatment, the chemotherapy and the radiation, did that compromise your immune system?
A Yes, it did.
Q Did it make you more susceptible to getting sick with an infectious disease?
A Yes. That's one of the warnings that the doctors gave me, that that -- I would be compromised and be more susceptible.
Q And can you just describe to us, when you were undergoing this chemo and radiation, how it affected your body and your everyday life, energy? Things of that nature.
A Yeah. The surgeries were just a really long process, and when I was finally able to start chemotherapy, I was already weakened at that point. And so then with the chemotherapy and the compromised immune system, my family was really concerned. And so Wally and I -- that's my husband and I -- were really isolated at that time, and I was tired. And I never did get really sick like nausea and whatnot from the chemo, but I just got extremely tired, and my immune system got pretty low. The white counts dropped, and my blood pressure got really low.
Q Can you explain to us the extra precautions you and your family have taken, just given this increased risk of infection?
A Well, we're a fairly large family, and we do everything

together. We're sports fans. We go to all of our grandchildren and children's activities and their concerts and, you know, whatnot. And that came to a screeching halt. We just could not participate in that any longer. And forgoing holidays together and whatnot. We would, you know, get together maybe with one or two of the family and be masked and whatnot, but we just had to pull away from that. And my kids even came by the house and would stand out in the lawn and talk through the screen door to us just so we could see each other, because we got lonely.

Q Have you avoided folks who aren't vaccinated?

A We have tried to as much as possible, you know. Just -- we -- when we have visitors, we've asked them, especially while we were still going through chemo, when I was going through chemo and now when Wally is going through chemo, that we ask them before they come into our home if they're vaccinated. And if they're not, we, we just visit them from outside. Just cannot have them in an enclosed area with us.

Q Within the last year, have you put off or avoided seeking medical care you otherwise would seek based on this increased risk of infection?

A Yes.

Q Can you explain some of those circumstances?

A Well, the main one I can think of is -- that happened this summer over the 4th of July. I have asthma, and we were

watching fireworks out over the lake and went back into the house, and the minute we stepped into the house, I had an asthma attack. And it was pretty severe.

Anyway, I was finally able to get it under control with the use of our rescue inhaler that I keep on me all the time. And my daughter and my husband wanted me to go to the ER. The asthma attack was severe enough that it just -- when we got in the car and started driving back to town, I fell -- I don't know whether I fell asleep or I passed out, but I just was out.

And then I recovered from that, and they still were insisting that I go on to the hospital, and I said, you know, "I'm not gonna do that. Wally is really compromised at this point." And his counts were so low that we -- I just didn't feel I could go to the ER. And so we went home, and I'm fine. I made it through the night, so.

Q Have you put off any other elective-type treatments, surgeries, things of that nature, due to this increased risk?

A Yes. I have osteoarthritis in my knees, and I have one knee that has been giving me problems for well over a year, and I have put off seeking, you know, continued care on that or any type of surgery or whatever the doctors recommend at this point because it's just not a safe thing to do at this time.

Q Switching gears, do you know whether any of your medical

THE COURT: Would you please state your full name for the record?

THE WITNESS: My name is Meghan Morris.

THE COURT: And, Ms. Morris, what city do you live in?

THE WITNESS: I live in Stevensville.

THE COURT: And what do you do for a profession or occupation?

THE WITNESS: I serve as the CEO for Western Montana Clinic.

THE COURT: All right.

Mr. Cole.

WHEREUPON,

MEGHAN MORRIS, R.N.,

called for examination by counsel for plaintiffs, after having been first duly sworn to testify the truth, the whole truth, and nothing but the truth, testified as follows:

DIRECT EXAMINATION

BY MR. COLE:

Q What is Western Montana Clinic, and what does it do?

A Western Montana Clinic is a multi-specialty physician group. We've been in existence for a hundred years, and we serve patients in eight different specialties as well as an infusion center and a laboratory.

Q And do you operate as a private physician office?

A We do.
Q Do you hold a separate facility licensure?
A We do not.
Q And are you required to hold a separate facility licensure to provide the services you do to the Missoula community?
A We do not.
Q Can you describe where your various clinics are located in Missoula?
A Sure. We operate three clinical locations. One is at the Broadway Building adjacent to Providence St. Patrick Hospital, one is on the Community Medical Center campus on Fort Missoula Road, and one is at the Southgate Mall.
Q And your Broadway Building location, is it in the same physical building as Providence Hospital?
A Yes.
Q Can you describe to us the number of employees and medical providers you have at Western Montana Clinic?
A We have 200 employees, and we have 38 physicians and 11 advanced practice providers, which are nurse practitioners or physician assistants.
Q And do you employ nurses?
A Yes, we do.
Q Are any of your physicians members of the Montana Medical Association?

A Yes, they are.
Q Do you employ any employees who are immunocompromised?
A Yes, we do.
Q You mentioned briefly but can you describe a little more the breadth of services you offer to patients?
A Yes. We have eight different specialties, and they range from birth to death. We have pediatricians and pediatrician subspecialties in GI and cardiology. We have a rheumatology department. We have an urgent care center. We have an OB-GYN department, family medicine, and dermatology.
Q And do you have any pediatric cardiology or specialty pediatric services you offer?
A The GI and cardiology.
Q And how many patients do you see on average per day throughout your various departments?
A We see about 400 patients per day.
Q I want to focus a little on the rheumatology department. Can you explain to us what is rheumatology?
A Rheumatology is just a department that treats rheumatologic conditions, and those are various.
Q And can you describe the types of patients that the rheumatology department sees?
A They are often immunocompromised patients based on their condition.
Q And what kind of therapies do your rheumatologists

provide these patients?
A Many, many of them attend our infusion center as part of their therapy and part of their regular physician care.
Q And do they prescribe immunosuppressing therapies and medications?
A Yes.
Q And do those further compromise the patient's immune system?
A Yes.
Q Can you describe the importance of infection control and vaccination status in a rheumatology department?
A Yes. And the interesting thing about Western Montana Clinic is because we have such varied specialties, we really need to be able to respond differently in each of our departments. And rheumatology and the infusion center are located adjacent to each other, and we take precautions in terms of how we space patients, how we clean those rooms, what our providers are wearing in terms of PPE, their vaccination status, all of those things, to make sure that patients are safe while they're being seen there.
Q Let's talk about the pediatrics department. Can you just describe what type of services you provide and types of patients you see in the pediatric department?
A So pediatrics generally focuses on birth to age 18. We will see some patients older than age 18, but most of them age

out and move into primary care settings. We do well checks to sick checks. So it's for all of those.

Q And do your pediatricians administer vaccinations to children?

A Yes, they do.

Q Can you explain the importance of vaccination to a pediatric department when you're the primary giver of vaccination?

A Well, the Western Montana Clinic pediatrics department has long been a believer and strong supporter in full vaccination for all children and their patients.

Q In your primary care and family medicine -- and you talked about this, sort of birth to very elderly is who you treat -- just to sort of be clear, you treat patients of all ages, right?

A We treat patients of all ages. And by nature of having multi-specialty clinics, you are going to intersect with patients who are receiving multiple modalities of healthcare from many different facilities, may have many different conditions that overlap and be seen as for one specific thing or for overall primary care.

Q You mentioned you'll see patients from other facilities. Can you describe what you mean?

A Well, patients in our departments might be coming from an assisted living facility or a nursing home. They may be

coming just from their home because they're a healthy individual. We might be the conduit for them to be admitted to a hospital stay. We might be seeing them in follow-up after they've been discharged from the hospital. So there's a wide array of intersection of patients that have been in many different facilities and many different healthcare.

Q And you mentioned treating patients from nursing homes and assisted living facilities. Can your providers also treat patients from long-term care settings?

A Absolutely.

Q And can your providers go provide care in a nursing home, for example?

A They can. It is not a super-common event, but we do have providers that occasionally will do a home visit, visit a patient in an assisted living facility or a nursing home.

Q And do you treat immunocompromised patients?

A Yes, we do.

Q Do you treat patients with disabilities?

A Yes, we do.

Q Do you treat patients with infectious diseases?

A Yes, we do.

Q And when your providers treat a patient with an infectious disease on an in-person visit, is that provider then exposed to that disease?

A Yes, they are.

Q What's -- can you -- let me ask it this way.

Does Western Montana Clinic take steps to avoid transmission of disease in your clinics?

A Of course. And that is a big answer.

You know, we do basic things from cleaning to understanding the kinds of patients that are coming in and escorting them to rooms more quickly or less quickly. We have divided waiting rooms for sick and well patients. We will sometimes have telephone encounters or screen patients prior to them entering a facility so that we can help them have the safest place for their care for our employees and providers as well as for the patient. You know, we do all kinds of measures.

Q And does a provider's immunity status play a role in infection prevention?

A It certainly can.

Q Can you explain how?

A Well, certainly in some of our departments more than others, during COVID in particular, we've had a heightened awareness to that. And our urgent care center has been, you know, a very center place for sick patients to go and be treated for COVID, as well as rheumatology. Those patients have a natural expectation for immunity and vaccination and be coming to a safe place for their treatment. But this really applies to all of our departments because, you know, we

expect, ourselves, to maintain the safest environment we can for every patient entering our facilities.

Q And can you provide all of the services you provide to your patients through telemedicine, noncontact?

A No.

Q Are any of your physicians on the medical staffs of the Missoula hospitals?

A Yes. Some of our physicians, by nature of their specialty and their practice, need to have privileges or affiliate privileges with the hospitals.

Q And those physicians who have a hospital-based practice, are they required to be on the medical staffs of those hospitals?

A Yes, they are.

Q And if the medical staffs of those hospitals have certain requirements, do those physicians need to meet those requirements?

A They would.

Q Including immunization and vaccination requirements?

A That's correct.

Q What types of services do your physicians provide in a hospital setting?

A The pediatricians will occasionally, and have in the past, rounded on newborns and see sick patients in the hospital setting. Pediatric specialties, GI and cardiology,

often intersect with patients in the hospital setting, and then we have an OB-GYN department which naturally practices doing surgery and deliveries in the hospital setting.

Q Will your physicians treat patients in an intensive care unit?

A If the patient from their cadre of patients was in the intensive care, they may intersect with them in that setting, yes.

Q And will your pediatricians treat patients in the NICU?

A They could intersect there. There are hospitalists and intensivists that oversee directly those patients, but our physicians might be involved in that care.

Q Has Western Montana Clinic, prior to implementation of House Bill 702, required vaccination or otherwise tracked vaccination status of its providers and staff?

A Primarily we have done this in the flu realm with flu vaccine, and we're about to embark on flu season, and so it's been very important in our facilities to understand flu vaccination status and take measures if people were not vaccinated and flu prevalence became high.

Q And do you expect your providers to be vaccinated?

A We do.

Q And if they -- is there a process by which they can decline to get a flu vaccine?

A So we offered a declination form in the past. After

House Bill 702, we stopped offering that declination form as we didn't feel like we could inquire to that information.

Q So prior to House Bill 702, did you require either that your providers be vaccinated or disclose that they are not vaccinated through the declination form?

A Yes. And there's a very particular reason for having that baseline of knowledge so that when flu prevalence becomes high in the community, we can react to that very swiftly and know where those individuals who were not vaccinated for flu were so that we could protect patients in the facility.

Q And, again, prior to House Bill 702, did you treat employees differently based on their vaccination status?

A For flu, we would make changes, if needed, when that prevalence became high, to either their work location -- we've all been wearing masks now for several years, but we used to ask someone to mask if they were not vaccinated so that we could make sure that they were not directly exposed to patients.

Q So, then, during the COVID pandemic but, again, prior to House Bill 702, when the vaccines, the COVID vaccine, was being rolled out, was there a time where you treated your staff or your providers differently based on their vaccination status as to COVID?

A So COVID has been a really interesting evolution, and, you know, day by day, week by week, month by month, we were

making as many adaptations as we could. And so when vaccine became available, we had many, many staff and many, many providers who were clamoring for that, but it was only available in a limited way at that time.

As we got more and more people vaccinated and the shifts in COVID happened, we considered loosening PPE requirements, all-day mask wearing in some of our clinics, but then it would surge again and we would go back.

But it was a factor we were considering, about how we would adapt in our exam rooms based on whether someone was vaccinated or not.

Q So you would loosen PPE requirements for those that were vaccinated?

A We could have.

Q But you would still require the unvaccinated staff member to wear that extra PPE?

A At a certain period of time, we were considering that.

Q Let's switch gears to a different disease.

Has Missoula experienced a pertussis outbreak in the last several years?

A I'm aware -- I think 2019 is the most recent that I'm aware of.

Q Can you just briefly describe what happened in Missoula with this pertussis outbreak?

A I don't know the specifics of the outbreak in the city,

segregate vaccinated or unvaccinated people?
A We made attempts to segregate sick and well patients.
Q But you didn't consider any of the patients sick or well based on a vaccination status; is that accurate?
A I think that's accurate. I just -- if I understand your question correctly, vaccination status is generally discussed in the exam room setting and in the physician or provider/patient interaction setting, not in a waiting room or facility entry setting.
Q And I understand that you do -- Western Montana Clinic shares some physical space with Providence Health?
A We do. We are co-located on the Broadway Building campus.
Q In that Broadway campus, do you have the same guidelines as Providence with respect to segregation of sick or healthy patients?
A So when we, when we share the campus, we work really hard to be good colleagues to each other, good neighbors, good coexistence there, but we don't have exactly the same policies. We work together to be very consistent with what patients experience when they walk into a building.
For instance, on the fourth floor of the Broadway Building, there is a Providence practice and a Western Montana Clinic practice, and so we work very hard to have that be a consistent experience for the patients, but they have their

policies and we have our guidelines and procedures.
Q In ensuring that your patients and their patients have a consistent experience, as you just described, you have communications with Providence to facilitate that, right?
A We do.
MR. RUSSELL: Could you bring up Exhibit 225, please?
MS. HAGEN: (Complied with request.)
BY MR. RUSSELL:
Q Ms. Morris, do you recognize this document?
A Yes. I'm reading, but I do recognize it. It's an email.
(Pause.)
(Discussion off the record at counsel table.)
BY MR. RUSSELL:
Q This reflects an email from you, correct? Or this is an email from you?
A It is an email from me, and I will -- if you scroll back to the top, I want to point out that it's from March 13 of 2020, if I read that date right.
MR. RUSSELL: Can you scroll down a little more?
MS. HAGEN: (Complied with request.)
BY MR. RUSSELL:
Q This email was in response to an email from an individual with Providence, raising the concerns about the consistent experience that you referenced, correct?

working, and see if we could reassign them or require masking or some other way to prevent flu spread in our facility.

BY MR. RUSSELL:

Q Prior to House Bill 702, did Western Montana Clinic actively track its employees' vaccination status for MMR?

A Not for MMR.

MR. RUSSELL: No further questions.

THE COURT: Any redirect?

MR. COLE: Yes, Your Honor.

REDIRECT EXAMINATION

BY MR. COLE:

Q On the topic of requiring or mandating vaccines, regardless of the definition of what constitutes a requirement, can you explain the importance of knowing actual status, actual knowledge, and how you use that knowledge?

A Yeah. The flu vaccine is a good example, but I think in all of these circumstances we want the ability to be very nimble, very fast, if there were to be a pertussis outbreak, if there were to be very, very high flu spread prevalence, if there were to be any particular kind of COVID surge. Knowing that baseline of information about who is vaccinated or not to put into that full factorial analysis allows us to give that information to our physician governance. They would consider that, and then we can be very quick in adapting to how we can protect the other employees and the patients entering the

facilities.

Q You were asked about the declination form.

And, Davina, can you please pull up Exhibit 210 again?

MS. TOLLE: (Complied with request.)

MR. COLE: And can you highlight that box at the top that says "Employee Must"?

MS. TOLLE: (Complied with request.)

BY MR. COLE:

Q Was it a requirement, regardless of whether you required a certain given reason, was it a requirement that an employee sign this form if they weren't going to receive the vaccine?

A That's correct.

MR. COLE: And you can take that pop out.

MS. TOLLE: (Complied with request.)

MR. COLE: Can you highlight the last bullet before the description of the reason?

MS. TOLLE: (Complied with request.)

MR. COLE: Yep.

BY MR. COLE:

Q Can you just explain why you provide this particular bullet and the other bullets before someone signs a declination form?

A Well, in particular, you know, flu has kind of been not necessarily forgotten about, but this one is speaking to flu. These are very serious diseases that do cause serious illness

and death in individuals every year, and so we wanted to convey that within our form just as another opportunity to educate our employees about the importance of getting the vaccination and, in this case, flu.

MR. COLE: And you can take that down.

MS. TOLLE: (Complied with request.)

BY MR. COLE:

Q You were asked about an email dated March 2020. Was that prior to the rollout of the COVID vaccines?

A Absolutely.

Q And you were asked about whether you had received any written accommodation requests, and you said no.

A Yes.

Q Do you take verbal requests just as seriously?

A We take all requests for accommodations and all employee and patient concerns, whether they're written down or verbal, very seriously.

MR. COLE: I have no further questions.

THE COURT: I have a couple questions for you.

I may have missed it, but would you tell me what is your education and at what institutions following your graduation from high school?

THE WITNESS: So I am a registered nurse. I have a bachelor's of science in nursing from Montana State University, and I became that in 1997. I am also -- I have a

juris doctor from the University of Montana here, and I became an attorney in 2002. And I have a master's of business administration, and I forget the year that I obtained that, but it was after, I believe, 2008.

THE COURT: So tell me, then, if you would, your work history. R.N. graduate, did you work as a nurse?

THE WITNESS: I did. I worked as a nurse. I worked as a nurse's aide, if you want to go that far back, in a nursing home, Riverside Healthcare Center, and that's what inspired me to become a nurse.

And then I worked as a nurse after my graduation from 1997 until -- I worked through my education getting my law degree, and I have worked periodically in healthcare even after that. I returned to healthcare administration after having practiced locally at a firm here for a couple of years.

THE COURT: All right. Thank you. You can step down.

Would you call your next witness?

MR. GRAYBILL: Your Honor, we intend to call Vicky Byrd. Sounds like it will be about an hour with cross, so we could do our break right now if you'd like, or else I will call her right now.

THE COURT: Well, if it's going to take an hour, we'll take a 15-minute recess before you call your next witness.

We'll be in recess for 15 minutes.

(Recess taken from 10:10:48 to 10:28:32.)

(Open court.)

THE COURT: Please be seated.

Mr. Graybill, will you call your next witness, please?

MR. GRAYBILL: We call Vicky Byrd.

THE COURT: All right, ma'am. If you'd come step up in front of the clerk here, raise your right hand, and be sworn?

(Oath administered to the witness.)

THE COURT: Have a seat right over here, if you would.

THE WITNESS: (Complied with request.)

THE COURT: If you're comfortable, you can remove your mask. For the record, would you please state what your full name is?

THE WITNESS: Vicky Rae Byrd.

THE COURT: And, Ms. Byrd, what is your profession or occupation?

THE WITNESS: I am a registered nurse and the CEO of the Montana Nurses Association.

THE COURT: All right. And what city do you live in?

THE WITNESS: I live in East Helena.

THE COURT: Mr. Graybill.

WHEREUPON,

VICKY RAE BYRD, R.N.,

called for examination by counsel for plaintiff-intervenor, after having been first duly sworn to testify the truth, the whole truth, and nothing but the truth, testified as follows:

DIRECT EXAMINATION

BY MR. GRAYBILL:

Q Ms. Byrd, how long have you been a nurse?

A I've been a nurse now going on 34 years.

Q What do you have to do to hold yourself out as a registered nurse in Montana?

A We have to be licensed as a registered nurse, and that includes some regulations, getting continuing education to maintain your licensure.

Q Did you go to school for it?

A I did.

Q Have you served as a nurse in the United States military?

A I did.

Q Can you tell us about that?

A Yeah. In 1988, I was commissioned as an officer for the Army Nurse Corps and received my pediatric training there. Served in Fort Sam Houston for my basic training and then was stationed in Aurora, Colorado at Fort Fitzsimmons.

Q Where did you work as a nurse after the Army?

A I worked at St. Peter's Hospital in Helena, Montana.
Q What kind of work did you do there as a nurse?
A I was a pediatric nurse, pediatric oncology, adult oncology. I also floated to other floors if they needed help like medical ICU, ER, but my main focus was oncology, specializing in pediatrics.
Q What job as a nurse did you have right before becoming CEO of the nurses' association?
A Right before I became CEO, I was an oncology certified pediatric nurse in the cancer treatment center. It's an outpatient clinic but it was hospital-based.
Q Where was that?
A St. Peter's Hospital.
Q Were you required to be vaccinated in that role?
A Yes.
Q For what?
A Well, through school, we had to have the usual that everybody is used to: the MMR and the Tdap. And then in the '90s, I believe, then hepatitis B became a required vaccination, so we all got vaccinated with that. And then yearly, in the cancer center especially, we would have to get the flu vaccine if it wasn't medically contraindicated.
Q Did you have to show proof of your immunity status or vaccination status to work as an oncology nurse?
A Yes.

Q Was that important?
A Yeah. It's super-important because our patient load there, the majority of them are very immunocompromised. And so they -- our patients should not have to worry if the staff that's caring for them is immunized or not, and then that protects them and it protects us.
Q Could you describe for the Court: What is the Montana Nurses Association?
A It's a professional association for the professional nurse in Montana, which includes registered nurses and advanced practice registered nurses.
Q How many nurses are in Montana?
A The last I checked with the Board of Nursing, there was a little over 18,000 registered nurses in Montana.
Q And what is -- how is an advanced practice registered nurse different?
A An advanced practice registered nurse has, of course, advanced education, and then they become -- they are a registered nurse and then, in addition, get an additional certification to be an advanced practice registered nurse.
There's four different categories. The most that people are aware of are a nurse practitioner. And in Montana, luckily, and, you know, very proud of this, they have full practice authority with prescriptive authority, so they can actually be a provider of specialty or primary care.

Q Does that mean they can run their own practice?
A Absolutely.
Q Is the nurses' association also a labor union?
A It is.
Q Can you describe that work?
A Yeah. That work is your labor arm, and it advocates for workplace safety, other working conditions, wages, hours, and, yeah, workplace environment.
Q How many dues-paying members do you have?
A It fluctuates, and we have well over 2,700 but we're almost ready to hit the 3,000 mark so we're super-excited about that.
Q What does the CEO of the nurses' association do?
A Well, I, I have that position, and we do a little bit of everything. So we help with legislation with health policy. We are the liaison through outreach, maybe working with other healthcare partners like the medical association, the hospital association, other -- school nurse association; the student nurses, of course. In addition, oversee the labor program, oversee the professional development program that we provide through our association, all the way down to I mow the lawn and fix the plumbing at the office. So that's what I do.
Q Are you in contact with individual nurses throughout Montana?
A Yeah, every day.

If you would go to page 2?

MS. TOLLE: (Complied with request.)

BY MR. GRAYBILL:

Q All right. Take a look at this paragraph (indicating). Could you read that little bullet for me?

A Yep. "Supremacy or Authority of this mandate? It does supersede all [Montana] laws, including [House Bill] 702."

Q Was that your position at the time?

A At that time, yes.

Q Is that your position now?

A Yes.

MR. GRAYBILL: We can pull down 220.

MS. TOLLE: (Complied with request.)

BY MR. GRAYBILL:

Q Finally, I want to ask you: You were asked some questions about, you know, are nursing homes generally treating sicker people than, I don't know, a sports medicine clinic or a pediatrician's clinic. Do you remember those questions?

A Yes.

Q Are patients in the ICU high-risk patients?

A Yes.

Q Is that in a hospital?

A In a hospital, yes.

Q Patients in the NICU, high risk?

A Yes.
Q Do you remember Mr. Page who testified earlier today, the person being treated for cancer?
A Yes.
Q Is he a high-risk patient?
A Yes, he is.
Q Is he a high-risk patient if he goes to an outpatient foot clinic?
A Yes, he is.
Q Is he a high-risk patient at a primary care physician's office?
A Yes, he is.
Q Is he a high-risk patient anywhere he goes?
A Yes, he is.
Q Do you have a duty to protect him, as a healthcare worker, anywhere he goes where you see him?
A Yes. We have a duty wherever we practice healthcare to protect our patients.
Q And you have a duty to protect your coworkers who may have similar issues, like the coworker you mentioned who is currently being treated for cancer?
A Correct.

MR. GRAYBILL: No further questions.

THE COURT: All right. Thank you.

You can step down.

A We have roughly 2,700 employees in western Montana.
Q Does Providence employ physicians?
A We do.
Q What about nurses?
A We do.
Q What about advanced practice providers?
A We do.
Q And do you also employ nonprovider employees?
A We do. We have a number of nonclinical and other clinical specialties that we employ.
Q How does Providence refer to their employees?
A We use the term "caregiver" for all of our employees.
Q And why do you use that term?
A Well, all of our employees in some way or another are taking care of patients, whether it's working in the laundry and providing the -- you know, cleaning their linen or serving meals. So all employees are considered caregivers.
Q We talked about your hospital and your critical access hospital and assisted living facility. Do your employees also provide care and treatment in a clinic setting?
A Can you restate the question? Are you talking specifically in Polson?
Q Sure.
A Sure. Our employees provide care in a clinical setting; that is sure, for certain. And in the case of Polson, we have

employees that serve in both capacities at the hospital and at the assisted living facility.

Q Can all of the services that Providence provides in Montana be accomplished through telehealth?

A Certainly not. Telehealth is certainly limited in nature. We provide, obviously, high-end surgical care and a number of other things. Telehealth is limited in its ability. It certainly is a nice tool to have, and a number of visits are held via telehealth services, especially during the pandemic, but it's not a replacement for face-to-face serving of a community.

Q Let's talk a little bit about your facilities in Polson. You mentioned St. Joseph Medical Center. Are there physician clinics within that physical facility?

A Yes, there are.

Q And does St. Joseph Medical Center, which is the critical access hospital, does it share staff with the assisted living facility?

A There are staff that are shared. Certainly we have our environmental service workers, who are housekeepers, that work in both facilities to clean those facilities. We have -- the food staff are shared as well, as well as if there are nursing shortages or CNA, certified nursing assistant, shortages at the assisted living facility, we have folks from the hospital that will take rounds there. We have security staff that

patrol both camp- -- both facilities. So, yes, there are, and there are doctors that will do some limited rounding at the assisted living facility as well.

Q And does St. Joseph Medical Center treat patients from the assisting living facility?

A Not in the facility itself. Those patients will be brought down to the hospital.

Q But the same patient would be treated at the assisted living facility and may go --

A That's correct.

Q -- to the hospital?

We have to be a little careful not to talk over each other.

A Sorry.

Q That's okay.

A Sorry.

Q I want to talk a little bit about St. Joseph's policies.

Davina, can you pull up Exhibit 121?

MS. TOLLE: (Complied with request.)

BY MS. MAHE:

Q Kirk, have you -- can you see that document in front of you?

A I can.

Q Are you familiar with this document?

A I am.

Q And what is this document?
A This is a checklist. It's screening requirements for students and agency workers as well as vendors or contractors at the facility.
MS. MAHE: And can you, Davina, turn to page 3, please?
MS. TOLLE: (Complied with request.)
BY MS. MAHE:
Q What is this document?
A It's the new caregiver health screening policy.
Q And you're familiar with this policy?
A I am.
MS. MAHE: We move the admission of Exhibit 121.
THE COURT: Any objection?
MR. MEAD: One moment, Your Honor.
MS. MAHE: There was no objection on the list.
THE COURT: I don't have it on my list.
If there was no objection, then it is admitted without objection.
BY MS. MAHE:
Q And staying on this page 3, is this the policy that St. Joseph has for new employees?
A It is.
Q And does that require proof of any vaccination?
A It does. They're listed there. It requires for

tuberculosis screening; the measles, mumps, and rubella vaccination; chickenpox; hepatitis B; Tdap; and also talks about the annual influenza vaccine.

Q It mentions titers in there. What are those?

A Titers is a test for a concentration of antibodies, so a certain disease that could prove immunity to a disease.

Q Does this policy require either vaccination or proof of immunity status?

A It does.

Q Let's talk about St. Patrick's Hospital in Missoula. Does St. Patrick's Hospital share its physical location with other healthcare entities?

A It does. Within the same physical plant, we have our own physician offices as well as we have -- the Western Montana Clinic is in the same physical location. They share -- they rent space out of the Broadway Building. And just until recently, also the Missoula Surgical Association was part of the -- had rented space on our campus.

Q And are you familiar with St. Patrick's policies?

A I am.

MS. MAHE: Davina, if you'll pull up Exhibit 125?

MS. TOLLE: (Complied with request.)

BY MS. MAHE:

Q Mr. Bodlovic, what is that document?

A This is, again, a preemployment health screening policy;

guidelines for the employee that might be exposed or have a confirmed diagnosis of an infectious disease.

Q And does that policy also describe how you should handle post-disease exposure --

A It does.

Q -- to particular diseases?

A Yes. For example, with mumps, it can -- it will speak specifically about sort of the number of days that the employee would be off work.

Q And would the number of days that an employee who is exposed to mumps be off work depend on their vaccination status?

A It can, yes.

Q Is there any other examples where post-exposure would require different treatment based upon vaccination status?

A Yeah. I think it refers to a confirmed diagnosis or nonimmune status, which I think would infer vaccination status. So varicella is another example.

Q And some of those diseases, would you also require them to have a titer drawn?

A They would, yes, have a titer drawn, again, to determine the concentration of antibodies. That's correct.

Q Prior to Montana Code Annotated 49-2-312, which is House Bill 702, did Providence require proof of immunization for providers to obtain med staff privileges?

A Sure. It requires, and I may miss some here, but it's got the MMR, so mumps, measles, and rubella; Tdap; influenza; hep B; varicella. And I apologize if I missed any there.

MS. MAHE: Davina, if you can scroll down a little bit to Sections 4, 5, and 6 there?

MS. TOLLE: (Complied with request.)

BY MS. MAHE:

Q Does it also require -- well, let's look at -- sorry. Let's look at No. 5. What does this policy require related to influenza?

A Sure. Influenza is not -- is a strongly recommended vaccination that occurs yearly. But as our policy states, there is the ability for a caregiver to submit a declination to the influenza vaccine --

Q And --

A -- and -- oh.

Q Oh, sorry.

A I was just going to follow up and say that if they decline that vaccine, then they are subject to masking requirements throughout the flu season in patient care areas.

Q And does this policy require that they provide a declination?

A It does.

Q Let's talk about 6.

And, Davina, if you'll close out of this so that we can

get the full 6 that's on both pages there?

MS. TOLLE: (Complied with request.)

BY MS. MAHE:

Q What does this portion of the policy provide?

A This, again, on the medical staff policy, refers to the tetanus vaccination. And, interestingly, it does say "strongly recommended," and I can see how that might be a little bit confusing, but clearly it's in reference to a new employer getting an updated tetanus shot regardless of their last dose, so I would say that assumes that they've had a previous dose. And just because of the waning effect of a tetanus shot, as I understand it, it's a recommendation by the med staff that they get that updated upon their starting with privileges at the hospital.

Q So does this refer to boosters, then?

A That's what it appears to me, is that it relates to boosters of their tetanus.

Q And why is that important?

A Well, I think, as it says below, in terms of the patients that they're dealing with, it's important because they're dealing with patients that are at risk.

MS. MAHE: You can take that down, Davina. Thank you.

MS. TOLLE: (Complied with request.)

///

BY MS. MAHE:

Q Approximately how many patients does Providence in Montana see in a month?

A Sure. In a month, we see about 30,000 visits to our hospitals and about another 30,000 visits to our hospital -- or to our clinics.

Q And does that include patients seen across all of the settings that we spoke about today?

A It does, yeah.

Q Does St. Patrick's Hospital treat elderly patients?

A We certainly do, yes.

Q Immunocompromised patients?

A Yes.

Q Patients with disabilities?

A That is correct.

Q What about St. Joseph Medical Center?

A They see the same set of patients, that's correct.

Q And what about St. Joseph's Assisted Living Center?

A An assisted living facility is really a housing setting for elderly --

Q But are there --

A -- post-acute care, but it's the same. It is primarily an elderly population.

Q There are other types of patients there, too?

A I would say there's an elderly population and it's not --

so if you want to clarify your question on other types of patients?

Q Sure. The assisted living facility could also have somebody who has been -- who is younger that has been in a motorcycle accident, for example?

A That's a possibility, sure.

Q And does the assisted living facility have patients who are immunocompromised?

A Certainly.

Q And patients with disabilities?

A Correct.

Q I want to talk a little bit about swing beds in hospitals. Can you explain to me what those are?

A Sure. Medicare allows for critical access hospitals to have what they call a swing bed. And really it's a bed that allows for skilled nursing facility-like care to be provided in the hospital, and it's actually paid for by Medicare inpatient insurance.

Q Is it true inpatient care?

A Not in that setting. It truly is sort of a skilled nursing facility-type care that's provided in those beds.

Q So would the patients be similar to those in nursing homes?

A Certainly.

Q And is it true that those patients are typically waiting

to be transferred to a nursing home?

A That certainly is the case, yes. That's the intent, especially in some of those smaller communities where those beds may not be available. That is one of the uses for the swing bed.

Q How long can a patient stay in a swing bed?

A You know, I don't know the exact length of stay for a patient in a swing bed, but it certainly extends -- so any critical access hospital, there are length-of-stay requirements for how long a patient can stay in an inpatient bed. That does not apply to a swing bed, so they can stay in there for certainly much longer than a typical stay in a hospital.

Q Are you aware of any patients that have remained in those swing beds for more than six months?

A So specifically at St. Joe's, I am not.

I can tell you at St. Patrick Hospital, where we do not have swing bed status, we have had patients in our hospital for longer than a year, waiting for dis- -- availability to discharge or a proper discharge setting that would accept those patients. They probably did not need our acute level of care.

Q So explain that to me a little bit. They're not called swing beds in hospitals?

A At St. Patrick Hospital, which is a PPS hospital, so it's

not a critical access hospital, we don't have swing beds. That doesn't mean we're not taking care of folks that could otherwise be in an assisted living facility or a skilled nursing home if there were beds available.

Q And you have patients there that are waiting to be discharged to one of those facilities?

A Every day. Every day we have what we would call long length-of-stay patients, probably 25 to 40. And, of those, probably 18 to 25 are in those beds because they're -- only because there are discharge barriers, meaning that there is not a place for them to go safely with a safe discharge plan.

Q And, I'm sorry; how long did you say that they can stay there?

A They could be there -- we've had patients in those facil- -- in our St. Patrick Hospital for well over a year. That's -- so that's probably not typical, but they have been, and we have folks that are in there for many months, and that is very typical.

Q Do you have providers that treat patients in skilled nursing facilities?

A We do. We do pro- -- we do employ some SNFists, so -- and those SNFists, those skilled nursing facility -- they work in skilled nursing facilities. They're long-term care providers, and they actually provide medical directorship and do rounds in the Missoula area skilled nursing homes.

Q And are you saying "SNFist"?
A "SNFist," yeah. Sorry. It's S-N-F-i-s-t, SNFist.
Q Does a hospital provide a higher level of care than an assisted living facility?
A Certainly.
Q Is infectious disease prevention critical to Providence?
A It certainly is. Actually it is -- one of the conditions of participation for Medicare is an infectious disease control, and so certainly it's important to us.
Q Would you describe St. Patrick Hospital as a congregate setting?
A St. Patrick Hospital is a congregate setting. So clearly our patients are separated as best as possible. We have care settings where patients are together, whether that's in our behavioral health setting where there are congregate settings for group activity, that sort of thing. So for the patients, it's not quite the same, maybe, as an assisted living facility, but clearly we have patients that are in group activity and group therapy together.

And then, of course, we have nurses and other care workers that are working in nursing pods in a very close proximity, so a lot of folks in very close space. And then as you might imagine, in OR suites there are a number of folks in contained areas, so.

Q Does Providence treat individuals that have infectious

diseases?
A We do.
Q Does Providence treat individuals with pertussis?
A Certainly.
Q Rubella?
A Yes.
Q Mumps?
A Yes.
Q Measles?
A Yes.
Q Varicella?
A Yes.
Q Monkeypox?
A We do have the first confirmed case of monkeypox at the hospital, yes; in Montana, I should clarify.
Q And are Providence employees exposed to those individuals?
A To the extent that they're caring for those patients on a daily basis, yes, they are exposed to those patients.
Q Does St. Patrick's have a special unit within its ICU?
A We do. We have our isolation unit that is specific to our ability to provide care for the Rocky Mountain Labs down in Hamilton who are obviously dealing with things like the potential for significantly infectious disease or infectious diseases such as, you know, Ebola or smallpox.

Q So are Providence employees prepared to treat patients with smallpox?
A They are in the event that something goes wrong in the facility, that's correct.
Q And what about Ebola?
A Yes, that's correct.
Q Is that a common thing for a hospital to have?
A I think we're one of four in the United States.
Q I want to turn a little bit to talk to you about patients and patient requests.

Has Providence had any patient requests to be treated by only vaccinated staff?
A We have.
Q Can you tell me about those?
A We've had certainly some patients that have reached out to us regarding the status and asking if we could man- -- or could veri- -- set a certain -- sorry about that -- actually verify that they would only be cared for by patient -- or by caregivers that were vaccinated.
Q Do you recall the specific scenario where that occurred?
A We had a couple scenarios. One was a patient that was asked -- they actually had stopped by administration and just asked if they could -- if we could be certain that the patients -- or that the caregivers that saw them would be vaccinated. That was, I think, in Feb- -- that specific

instance, I think, was in February or earlier this year.
Q And how did you respond to that?
A Well, the response really was that, you know, that would have been just after the -- around the time of the CMS mandate going into play. So at that time, certainly, we were just starting the process by which the vaccination was required and/or the exemption process had been followed appropriately.
Our response was that it's obviously very important to us that patients are cared for in a setting that will protect them, but -- and that we have a very high vaccination rate, but that some caregivers could have provided the proper exemption and not have to be -- and not have been vaccinated.
Q Do you recall an incident prior to that involving a patient of the International Heart Institute?
A Yeah. We had one specific example of that, and I think, in that case, the patient actually asked the caregiver their vaccination status. And so the question, of course, at that time came from the manager of that employee. And, actually, in that case, the caregiver offered up that they weren't vaccinated and that they could try to accommodate the patient with somebody that had been vaccinated.
And then there was a request at that time, I think, actually from the physician, asking if -- about how he could guarantee for his patients that the caregivers were vaccinated. Of course, that was pre the injunction from CMS,

so, again, we had a really high vaccination rate, but we couldn't guarantee this -- the vaccination status of all our employees at that time.

Q Have there been other examples as well?

A There are. And I don't have any documents that say that, but certainly we've had folks that have asked the question around vaccination status of our caregivers.

Q The two specific examples that we talked about, were those documented?

A Via email, that's correct. And one --

MR. MEAD: Objection, Your Honor.

THE COURT: What's the objection?

MR. MEAD: Rule 37.

Sorry. Objection based on Rule 37. These documents were not produced to us.

THE COURT: Were they produced?

MS. MAHE: They were, and they're marked as Exhibits 103 and 104 on our exhibit list.

THE WITNESS: Is it all right if I grab a drink of water here?

MS. MAHE: Sure.

THE WITNESS: Are these for the taking?

THE REPORTER: (Nodded head affirmatively.)

THE COURT: One second.

MR. MEAD: In that case, Your Honor, we'll renew the

objection that's listed on our sheet as hearsay.

MS. MAHE: I haven't moved to admit them, Your Honor, and didn't plan on it.

THE COURT: Well, if you're gonna have him testify about it, you better move to admit them.

MS. MAHE: All, all I asked him was if it was documented. That was all. We are moving on.

BY MS. MAHE:

Q Does Providence employ any individuals who have indicated that they have disabilities?

A Certainly.

Q Are any of those employees -- have they indicated that they are immunocompromised?

A Yes.

Q And has Providence had any employees request accommodations based upon the vaccination status of other staff?

A Yes, we have.

Q Can you tell me a little bit about that?

A We had one employee for sure that, because of the fact that we couldn't guarantee that everybody would be vaccinated or would be vaccinated because of the exemption process, that actually decided to leave our employment.

Q Are there other examples?

A We have -- I don't have any top-of-mind examples, but I

know we've just anecdotally -- certainly we've had folks ask about status of the co- -- their coworkers.

Q Are you familiar with OSHA, the Occupational Safety and Health Act?

A Yes.

Q Are you familiar with the OSHA Healthcare Emergency Temporary Standard that was adopted related to healthcare providers specific to COVID-19?

A Yes, I am.

Q And did Providence attempt to comply with that standard?

A We have throughout, yes.

Q Do you know whether Providence is still complying with that standard?

A We are. As I recall, the last update to that that I remember seeing was in December of '21.

Q And what was that update?

A Again, speaking about at that time, certainly speaking about the impact of the variants at that time. And, of course, it got -- earlier this year, we still were seeing significant inpatient volumes of COVID patients. So -- but in general the ETS was about protecting healthcare workers and doing everything they could to standardize those protocols to create a safe work environment.

Q Switching gears again, are you familiar with the Centers for Medicare & Medicaid Services? Generally familiar with

that?
A Yes.
Q And if I say CMS, you understand --
A Yes.
Q -- what I'm talking about?
We have to be careful, again, to not talk over one another.
Are there regulations that Providence has to follow to participate in the Medicare and Medicaid programs?
A There are.
Q Are those the conditions of participation?
A That is correct.
Q What are those?
A Again, that's a list of standards that, to be able to participate and receive reimbursement from CMS, that a healthcare facility, a hospital, must adhere to.
Q Do those standards have health and safety standards?
A They do.
Q Do some of those regulations relate to infection control?
A Yes, they do.
Q Is Providence required to comply with the CMS COVID-19 vaccine mandate?
A We are.
Q Has Providence developed a policy to comply with that mandate?

A We have.
Q And does Providence require all of its employees to be vaccinated or have an exemption -- sorry, vaccinated for the COVID-19 disease or have an exemption in order to continue working?
A Yes, that's correct.
Q Does Providence follow the guidance from the Centers for Disease Control?
A We do.
Q And Providence treats patients covered by Medicare and Medicaid?
A Yes, we do.
Q Is St. Patrick's Hospital required to comply with the conditions of participation?
A St. Patrick Hospital is required to comply with the conditions of participation, that's correct.
Q What about St. Joseph Medical Center?
A Correct.
Q What about St. Joseph's assisted living facility?
A The assisting living facility is in an area that is surveyed by the Joint Commission, and for the most part it is a population, though, that receives Medicaid funding, and so from that standpoint, yes, they need to maintain those same standards.
Q But for the assisted living facility, is there any

facility-based reimbursement under the conditions of participation?

A I'm gonna say that I don't -- can't say for a hundred percent certain here, but they do receive Medicaid funding, so from that standpoint they would be subject to following those requirements.

Q And what happens if one of your facilities that is subject to the conditions of participation is deficient?

A We are at risk for losing our funding from CMS.

Q How much of St. Patrick Hospital's reimbursement comes from CMS?

A For St. Patrick Hospital specifically, over 50 percent of our reimbursement is from CMS, so either through Medicare or Medicaid.

Q And how much of St. Joseph Medical Center's reimbursement comes from CMS?

A For St. Joseph Medical Center, it's over 60 percent.

Q How is reimbursement different than overall revenue reported on a 990?

A When I'm talking about reimbursement, I'm talking about specifically patient revenues. The 990 could reflect nonpatient revenues.

Q What do you mean by "nonpatient revenues"?

A Certainly. Well, as a simple example, we referenced earlier the Western Montana Clinic or other rental

arrangements that Providence might have would be a single example.

Q Would Providence be able to continue their current operations if they lost the ability to participate in Medicare and Medicaid?

A Certainly we could not provide the same care that we provide today. So just as an example, in September of this month, our Medicare and Medicaid reimbursement for St. Patrick Hospital will exceed about $16 million, or half of our funding. Our payroll in western Montana for our 2,700 employees this past month was over $16 million. So without that funding, there is no way we could continue to employ and take care of the community the way that we do.

Q Would loss of that funding impact patient care?

A Most definitely.

Q Has Providence had any claims brought against it alleging a violation of Montana Code Annotated 49-2-312 or House Bill 702?

A Yes. There are five of those allegations or human rights claims.

MS. MAHE: No further questions.

THE COURT: Mr. Mead, how long do you anticipate?

MR. MEAD: More than ten minutes, Your Honor, if we want to break for lunch.

THE COURT: Okay. We'll break for lunch and take a

45-minute break. And just for your information, we're gonna knock off today at 4:30.

So we'll be in recess until 12:30.

(Recess taken from 11:49:31 to 12:29:52.)

(Open court.)

THE COURT: Please be seated.

Have the witness re-take the stand.

THE WITNESS: (Complied with request.)

THE COURT: Mr. Mead, you're up.

CROSS-EXAMINATION

BY MR. MEAD:

Q Good afternoon, Mr. Bodlovic. And am I pronouncing your last name correctly?

A That's correct.

Q Okay.

In direct, you talked about regulations from the Centers for Medicare and Medicaid related to COVID-19, and I want to make sure I'm understanding that you're referring to the CMS vaccination rule, correct?

A Yes. As part of the conditions of participation, that's correct.

Q Yeah. There's also a separate COVID-19 rule that's also a condition of participation for facilities to develop an infection control plan, correct?

A Could you restate the question?

Q Sure.

THE COURT: So you're gonna have to pull that mic closer, if you wouldn't mind.

THE WITNESS: (Complied with request.)

BY MR. MEAD:

Q So there are two CMS COVID-19 regulations: the CMS vaccine mandate and then the separate regulation requiring facilities to create a COVID-19 plan.

A Correct. That's correct.

Q Okay. And in direct, were you only referencing the CMS vaccine mandate?

A I was referencing the overall condition of participation for infec- -- for preventing infectious -- spread of infectious disease as well as the COVID-19 plan, but not the COVID, development of a COVID plan.

Q Okay. And does the development of that COVID-19 plan, not the vaccine mandate but the development of the COVID-19 plan, does that require vaccination of staff?

A The initial plan came out prior to the availability of vaccinations, and I can't say that I'm familiar with, enough, with that plan to read into what it says about vaccinations.

Q It's reasonable, though, to assume that if it came out prior to vaccines being available that it doesn't require vaccines?

A Certainly.

Q Okay. So I want to pull up Exhibit 119 that was also referenced during direct. And just as a refresher, this is Providence's immunization requirements for physicians and allied health professionals, correct?

A It is the medical staff policy at Providence, yes, for immunization requirements for physicians and allied health professionals.

MR. MEAD: Okay. So if we can turn to page 2?

MS. HAGEN: (Complied with request.)

BY MR. MEAD:

Q Does the vac- -- does the immunization policy in paragraph 1 there under "Procedure Details," does that give you knowledge of the medical staff's immunization for hepatitis B?

A It says that, "Each provider must provide documentation of Hepatitis B immunization series, a titer . . . or sign a statement of declination."

Q And so do you have knowledge of their hepatitis B immunization under this policy?

A We would have knowledge that they've met the requirements of the policy.

Q I mean, it is a yes or no answer.

Does this, does this policy give you knowledge of their immunization status for hepatitis B?

A Not if they decline. Not if they submitted a written

declination.
Q Okay. And is that the same for MMR under Section 2?
THE WITNESS: Can you scan to the next page?
MS. HAGEN: (Complied with request.)
THE WITNESS: I don't know -- I'm just looking for a piece about written declination. It does say that they must sign a declination if they are unable to be vaccinated.
BY MR. MEAD:
Q So you would have knowledge of their immunization status for MMR?
A Yes. According to this policy, we would know if they would have submitted a declination or be vaccinated.
THE COURT: Well, clear that up. If they file a declination, do you know what their vaccination status is?
THE WITNESS: Not necessarily, no.
BY MR. MEAD:
Q And so for No. 4 for varicella, does this policy give you the actual knowledge of whether the medical provider is immune or not?
A Again, it does offer the ability to sign a declination, which, again, I'll have to go back to how I answered the question the first time. We know that they've met the policy. They've signed a declination or they've provided immunity records.
Q Okay. And just because I want to make sure how I

understand this policy interacts with the conditions of participation, do the CMS conditions of participation require you to have actual knowledge?

A For these specific vaccinations, the policy -- the conditions of participation talk broadly about infectious disease control. And to that, we follow, in implementing those infectious disease -- control of infectious disease in our organizations, that we follow industry standard --

Q Okay.

A -- which, then, I would default to our policies that talk about vaccination requirements as part of that, following that standard.

Q And I believe this has been ruled on by the Court, but I want to be very clear. This policy was in effect prior to HB 702, correct?

A That is correct.

Q And then just very quickly going to paragraph 5, do you have knowledge of whether an employee has received their seasonal influenza shot under this policy?

A Again, we will know if they received vaccination or if they've submitted a written declination.

Q Okay. And this policy is currently in effect, correct?

A That's correct.

Q I also think I heard on direct that you said that Providence has been subject to roughly five HB 702-related

complaints; is that correct?
A Correct. We have five filed HRBs.
Q And were any of those filed complaints related to this policy?
A They were specific to the vaccination -- COVID vaccination mandate.
Q Okay. So they were not related to this policy which does not mention COVID-19, I believe.
A I think at the end of this policy -- and I could -- do you want to scroll down? I just want to confirm that's not in here.
MS. HAGEN: (Complied with request.)
THE WITNESS: This one may not have been updated for the COVID component.
BY MR. MEAD:
Q There is, there is a paragraph on page 2 that mentions COVID and the policy that we're not gonna contest right now --
A Okay.
Q -- so thank you.
So now I want to -- well, first, we've talked about the COVID-19 vaccine requirement from CMS. Are you aware of any previous vaccine requirement issued by CMS as a condition of participation?
A I'll repeat that we have followed conditions of participation around maintaining an environment safe from

infectious disease. So the specific, it doesn't specifically talk about vaccination requirements in those conditions of participation -- or it does talk about maintaining that environment and using industry practice and standards to do so.

Q And prior to the OSHA Emergency Temporary Standard, OSHA had never previously required vaccines; is that correct?

A To my knowledge, that's the same, and our policies will reflect that. That, again, the screening policies that we've looked at, again, reference maintaining a safe environment and refer to OSHA standards, the CDC, and CMS's standards.

Q Okay. On direct, I think I heard you mention the Joint Commission and CMS surveys; is that right?

A That's correct.

Q What is the Joint Commission?

A The Joint Commission is a body approved by CMS to do -- that will do their surveys and provide accreditation.

Q And Providence contracts with the Joint Commission to do those surveys, correct?

A That's correct.

Q And the Joint Commission conducted such a survey in June of this year; is that right?

A That's correct.

MR. MEAD: Okay. So I want to pull up Exhibit 222, which is on the defendants' may-call list, and offer it.

THE COURT: Is there any objection?

MS. MAHE: No objection.

THE COURT: Exhibit 222 is received without objection.

BY MR. MEAD:

Q When you have a chance to look through this, is this a copy of the Joint Commission survey that was done at Providence?

A That's correct.

Q And to your knowledge, did the Joint Commission find any deficiencies related to staff vaccination status at Providence?

A There aren't specific references to deficiencies on vaccination status. If you were to go through this entire document, you would see the listing of all the conditions of participation, including the infectious disease section.

Q And in that infectious disease section, to your knowledge, do any of the citations in here relate to staff vaccination status?

A Not specific to vaccination status, that's correct.

Q And do any of the citations relate to Providence having a lack of knowledge of its staff's vaccination status?

A I don't believe so.

Q And you had a discussion on direct about the various facilities Providence operates in Montana.

A Correct.
Q In your role, are you aware of general patient outcomes for COVID-19 across those settings?
A So in my role, we have, for the last two years, had our COVID incident command established, and so certainly we looked at the impact of COVID on our patient population. I don't know that I can sit here and speak to specifics about patients and overall conditions, but certainly I have a familiarity with.
Q In your experience, are there disproportionate outcomes among elderly populations? I should say disproportionately negative outcomes for elderly populations?
A We have had a number of patients that were impacted by COVID certainly of all ages. The larger share were of elderly populations. It's just in general. It's a general statement on my part.
MR. MEAD: Okay. So I want to pull up Exhibit 200, and this is the notice from the Federal Register for "Medicare and Medicaid Programs; COVID-19 Vaccine Requirements for Long-Term Care Facilities and Intermediate Care Facilities for Individuals With Intellectual Disabilities Residents, Clients, and Staff" that is dated May 13, 2021, and we would like to move it into evidence.
THE COURT: All right. Well, it was listed.
Is there any objection?

MS. MAHE: No objection.

THE COURT: Exhibit 200 is admitted without objection.

MR. MEAD: And if we can pull up, if you see that highlighted paragraph down there on page 1?

MS. HAGEN: (Complied with request.)

BY MR. MEAD:

Q Do you see at the bottom where it says, "Nursing home residents are less than 1 percent of the American population, but have historically accounted for over one-third of all COVID-19 deaths"?

A I do see it.

Q Does that track with your experience for COVID-19 outcomes in Providence facilities?

MS. MAHE: Objection. Foundation.

THE COURT: Overruled.

THE WITNESS: So, again, we, as Providence, see a significant number of patients on a given -- on every month, and a number of those during the last couple years had the COVID diagnosis. I don't have the specific numbers, but I guess they would align with these national averages. I don't think there's any reason to believe that a population in Missoula and western Montana is different than the national averages.

MR. MEAD: Okay. No further questions, Your Honor.

THE COURT: Ms. Mahe, any redirect?

MS. MAHE: Yes, Your Honor.

REDIRECT EXAMINATION

BY MS. MAHE:

Q Mr. Bodlovic, you were asked some questions on cross about the conditions of participation. Do you recall that?

A I do.

Q And I was a little confused about the infectious disease prevention conditions of participation. Can you explain that to me?

A Certainly. To the best of my ability, there are conditions of participation that require our facilities to create a safe environment, free from hospital-acquired infections and to reduce the transmission of infectious disease and to use industry standard to do so.

Q And is that separate from the specific COVID-19-related regulations?

A It is.

MS. MAHE: Would you please bring up Exhibit 119?

MS. TOLLE: (Complied with request.)

BY MS. MAHE:

Q You were asked some questions about this policy.

And, Davina, if you can scroll down to pages 2 and 3?

MS. TOLLE: (Complied with request.)

///

BY MS. MAHE:

Q You were asked some questions about the declination requirement. Do you recall that testimony?

A I do.

MS. MAHE: Davina, if you'll scroll down just a little bit further?

MS. TOLLE: (Complied with request.)

MS. MAHE: Davina, will you highlight 4(a), please?

MS. TOLLE: (Complied with request.)

BY MS. MAHE:

Q Does that policy require only nonimmune individuals to fill out the declination?

A It does say, "Non-immune individuals who are unable to be vaccinated due to health reasons must sign a declination."

Q So in those cases where you might not know their vaccination status, do you know their immunity status?

A This would indicate that we -- this would indicate that. That's correct.

Q And why is that information important?

A Well, the written declination piece in general is interesting to me on a med staff policy because if we refer to all-caregiver policy, it limits the places where they can work. So it's interesting that it's even in there, certainly.

But clearly it's important to us because we want to make sure we've got a safe environment for the patients that we

serve, and part of that is making sure that we have vaccinated staff that are able to care for our patients.

Q Is that knowledge critical to infection prevention and control?

A It is.

MS. MAHE: No further questions.

THE COURT: All right. Thank you. You can step down.

Would you call your next witness, please?

MS. MAHE: Plaintiffs call Marieke Beck.

THE COURT: All right. If you would step forward, ma'am, all the way up in front of the courtroom here to the clerk? And, once you're there, raise your right hand, if you would, please.

(Oath administered to the witness.)

THE COURT: Have a seat over here, please.

THE WITNESS: (Complied with request.)

THE COURT: You can remove your mask if you're comfortable. If you want to keep it on, that's fine, too.

For the record, would you please state your full name?

THE WITNESS: Marieke Beck.

THE COURT: And, Ms. Beck, what is your current profession or occupation?

THE WITNESS: I am the bureau chief for Montana's

Human Rights Bureau.

THE COURT: All right. And what city do you live in?

THE WITNESS: Helena, Montana.

THE COURT: All right.

Counsel, Ms. Mahe.

WHEREUPON,

MS. MARIEKE BECK,

called for examination by counsel for plaintiffs, after having been first duly sworn to testify the truth, the whole truth, and nothing but the truth, testified as follows:

DIRECT EXAMINATION

BY MS. MAHE:

Q Ms. Beck, you're testifying on behalf of the Montana Human Rights Bureau, correct?

A Correct.

Q And you understand, when I refer to the HRB, that I'm talking about the Montana Human Rights Bureau?

A Correct.

Q You're an employee of the Human Rights Bureau, right?

A Yes. I'm the bureau chief.

Q And you've held that position for almost 11 years?

A Correct. 2011.

Q You were counsel for the HRB prior to that, true?

A Correct. Counsel for the Department of Labor and

Industry, serving primarily the Human Rights Bureau.
Q Would it be fair to say that you've been with the Human Rights Bureau for approximately 20 years?
A Correct.
Q You probably know more about the Human Rights Bureau than anyone?
A I hope somebody who has been doing it for 20 years knows a lot about it.
Q The HRB is an agency within the Department of Labor and Industry, correct?
A Correct.
Q And it's the agency that's tasked with enforcing the Montana Human Rights Act, true?
A Correct.
Q The HRB is the enforcement arm of the Department of Labor and Industry related to the Montana Human Rights Act, right?
A Correct.
Q And Montana Code Annotated 49-2-312, which is also referred to as House Bill 702, that's part of the Montana Human Rights Act, right?
A Yes.
Q And complaints related to violations of that statute are filed with the Human Rights Bureau, true?
A Yes.
Q During the investigatory process, the Human Rights Bureau

applies Montana Code Annotated 49-2-312 to the facts of a complaint to determine whether reasonable cause exists to believe that discrimination has occurred, right?

A Correct. Under 49-2-504, yes.

Q And HRB is currently enforcing 49-2-312, correct?

A For complaints that aren't subject to an injunction, yes.

Q Right. So for complaints that aren't subject to this Court's current injunction, true?

A Correct.

Q And if the Human Rights Bureau issues a for-cause finding, then the case would proceed to conciliation, right?

A Correct.

Q And conciliation is the period of time where the parties can try and resolve the matter, right?

A Yes. We offer mediation throughout after a complaint gets filed, but after there is a cause finding, it goes into conciliation.

Q And after that for-cause finding, the parties cannot resolve the matter without involving the Human Rights Bureau, right?

A Underneath 49-2-504, we have an obligation to seek redress. We have to try and fix the discrimination that's found during an investigation.

Q And just to be clear, so that means the parties cannot resolve the matter without involving the Human Rights Bureau?

A Correct.
Q And that's based, I think you mentioned, on the obligation to seek redress, right?
A Correct.
Q And any agreement reached after a for-cause finding would necessarily involve you to the extent that the Human Rights Bureau is going to ask for targeted equitable relief, right?
A Correct. Also known as affirmative relief, yes.
Q Right.
And the HRB in that process attempts to resolve the complaint with conditions that eliminate the discriminatory practice found, right?
A Yes.
Q And targeted equitable relief could involve requiring a respondent to make policy changes?
A What it could require is that we seek the entity that was found cause to do whatever it is to make the situation right again. It could be policy changes. It could be training. It could be posters.
Q It could be asking them to perform a climate survey, right?
A Correct.
Q And then it could be requiring them to implement a plan to fix the deficiencies noted in that survey?
A Yes.

Q Okay. And after a for-cause finding, the department has -- or must order the party to refrain from engaging in future discriminatory practices, right?
A Yes. That's a stock portion of our agreement.
Q And the Human Rights Bureau can also prescribe conditions on a respondent's future conduct, correct?
A To the extent that we say, "Don't do that again," correct.
Q And to the extent that you would enforce the targeted equitable relief within the conciliation agreement, right?
A We have enforcement authority underneath the statute.
Q And you can require any reasonable measure to correct the discriminatory practice and rectify the harm, right?
A Yes.
Q And you can require the person found to have violated the Montana Human Rights Act to report on the manner with which they're complying with the conciliation agreement, true?
A Yes. We're obligated to follow up on our agreements.
Q And if one of your orders is not obeyed, you could petition the district court to enforce the order, right?
A Correct.
Q And the Human Rights Bureau can sue a party in district court to enforce a conciliation agreement?
A Correct. It's 49-2-506 or 508. I can't remember in this moment.

Q And there have been four conciliation agreements entered into -- or at least four -- related to 49-2-312, right?
A In this moment, that is my best recollection. I had hoped to do a bit more review, but, yes, it's my best recollection it's four.
Q And there was targeted equitable relief required by the Human Rights Bureau in those conciliation agreements?
A There would be, correct.
Q And the Human Rights Bureau is monitoring compliance with those agreements?
A Correct.
Q And there have been at least 25 for-cause findings related to violations of 49-2-312, right?
A There may be more than 25. At least 25.
Q And some of those have been against healthcare entities?
A Correct.
Q Some have been against hospitals?
A Correct.
Q Let's talk about some of those.
Davina, will you pull up Exhibit 75?
MS. TOLLE: (Complied with request.)
BY MS. MAHE:
Q Marieke, have you seen this document before?
A (No response.)
Q Can you see it okay?

A She's a little blurry, but I can do this.
Q There probably is a hard copy of it up there as well.
A No, part of it is just the -- just a little light, but it's okay.
Q Okay. Is this a final investigative report related to an alleged violation of 49-2-312?
A Yes.
Q Are you familiar with this report?
THE COURT: Here (handing).
THE WITNESS: Yes.
MS. MAHE: We move admission of Exhibit 75.
THE COURT: Any objection?
MR. RUSSELL: No objection.
THE COURT: Exhibit 75 is received without objection.
BY MS. MAHE:
Q Is Exhibit 75 -- it's a finding for cause related to a violation of 49-2-312, correct?
A Correct.
Q Which means the bureau found there was reasonable cause to believe that that statute had been violated, true?
A Yes.
Q And this situation involved a flight paramedic, right?
A Correct.
Q And in this situation, the flight paramedic had alleged

that he was discriminated against because he was required to be vaccinated with the influenza vaccine, right?
A Correct.
Q And the investigator found that there was cause to believe that discrimination occurred based upon a requirement to have the flu vaccine, yes?
A Correct.
Q And the adverse action in this particular matter was the requirement to vaccinate, true?
A Correct.
Q And that was without any corresponding employment adverse action, correct?
A Correct. The bureau accepted complaints based on the requirement to vaccinate.
MS. MAHE: Davina, if you'll pull up Exhibit 76?
MS. TOLLE: (Complied with request.)
BY MS. MAHE:
Q Ms. Beck, have you seen this document before?
A Yes.
Q And this is a final investigative report related to 49-2-312, right?
A Yes.
Q Are you familiar with this final investigative report?
A Yes.
MS. MAHE: We move the admission of Exhibit 76.

THE COURT: Any objection, Mr. Russell?

MR. RUSSELL: Your Honor, the only objection would be to the extent that it seeks to bind the defendants to the position stated in the report. Otherwise, no.

THE COURT: I know, but that's actually a legal objection. I just asked if you had an objection. You said no, so it's admitted without objection.

BY MS. MAHE:

Q And in Exhibit 76, the charging party had alleged that she had been denied in-person access to a retreat for cancer survivors, correct?

A Correct.

Q And this retreat for cancer survivors required those attending in person to be vaccinated, right?

A Yes.

Q And this was in about mid-2021, true?

A Yes.

Q And in this case, the retreat was offering an option for those who were not vaccinated to appear remotely, correct?

A Correct.

Q Yet the investigator found that limiting in-person attendance to only those vaccinated for COVID was a violation of the Montana Human Rights Act, right?

A Correct.

Q And the Human Rights Bureau found this despite

acknowledging that the respondent "was clearly addressing difficult and necessary health and safety issues amidst unprecedented circumstances created by the COVID-19 pandemic," true?

A Correct. We don't have any sort of finding as to whether or not in-person versus a Zoom is the same, so, again, the public accommodation provision says you can't segregate.

Q And in this scenario, requiring a non-vaccinated person to appear remotely constituted reasonable cause to believe discrimination had occurred, correct?

A Correct.

Q The Human Rights Bureau treats healthcare facilities differently than other environments when applying 49-2-312, correct?

A As required by the statute.

Q And that's based upon the exception found at 49-2-312(3)(b)?

A Yes.

Q And the Human Rights Bureau does not include offices of private physicians as being included within that definition of "health care facility," correct?

A No, because the definition doesn't include it.

MS. MAHE: Davina, will you please pull up Exhibit 77?

MS. TOLLE: (Complied with request.)

BY MS. MAHE:

Q Marieke, have you seen these documents before?

A Yes.

Q Are these final investigative reports related to -- all relating to the same respondent?

A Yes.

Q And the respondent in this case was a prison, right?

A Correct.

MS. MAHE: We move admission of Exhibit 77.

THE COURT: Any objection?

MR. RUSSELL: No objection.

THE COURT: It's received without objection.

BY MS. MAHE:

Q Ms. Beck, you participated in helping prepare these final investigative reports, correct?

A Yes, I did.

Q And these investigative reports are related to complaints filed by nine inmates alleging violations of 49-2-312, true?

A Correct.

Q Looking at that first final investigative report -- if we turn to page 12, Davina? You can highlight that first paragraph.

MS. TOLLE: (Complied with request.)

BY MS. MAHE:

Q The investigator in this case stated that 49-2-312 treats

healthcare facilities different than other environments, right?

A Yes.

Q And the investigator then went on to evaluate the definition of "health care facility" and determined -- to determine whether that exception applied, correct?

A Yes, they did.

Q Okay. And there was an argument in this case that if the exception applied, it should only apply to the prison's infirmary, correct?

A Correct. The inmates argued it was contained in the infirmary. The exception was limited to the infirmary.

Q However, the Human Rights Bureau interpreted the definition of "health care facility" as very broad, right?

A Correct. After talking to witnesses, it became clear that the services were offered throughout the campus.

Q And the investigator ended up finding that the entire state prison facility was a healthcare facility under the exception in 49-2-312(3)(b), true?

A Correct.

Q And then you went on to analyze, after finding that that exception was there, determining whether reasonable accommodation measures were taken under that exception, correct?

A Reasonable accommodation measures, correct.

MS. MAHE: Davina, if you'll turn to page 13? You can highlight the third full paragraph down.

MS. TOLLE: (Complied with request.)

BY MS. MAHE:

Q You noted that, "A reasonable accommodation is some form of assistance provided to a person with a disability that allows that person to perform in a position or perhaps enjoy a governmental service," correct?

A Right.

Q And then you go on to state, "In this new statute the term 'reasonable accommodation measures' appears unrelated to this definition" of a reasonable accommodation, correct?

A Correct.

Q And then HRB goes on to state that, "The term reasonable accommodation measures are not intended to attach to a person with a disability," correct?

A Right. There's not been a determination as to whether or not somebody has a disability and so, again, it doesn't appear to be related, so it seems like a separate provision.

Q And because you found that the prison was an excepted healthcare facility and that that exception had been satisfied, you found that there was no reasonable cause to believe that the prison had violated 49-2-312, correct?

A After it satisfied both Sub (1) and Sub (2) of the statute.

Q You found that they did not violate 49-2-312?
A Correct.
MS. MAHE: You can put that down.
MS. TOLLE: (Complied with request.)
BY MS. MAHE:
Q The Human Rights Bureau treats nursing homes, assisted living facilities, and long-term care facilities different than other environments when analyzing 42-312, correct?
A They could come under the 313 provision.
Q Right.
Davina, will you please pull up Exhibit 80?
MS. TOLLE: (Complied with request.)
BY MS. MAHE:
Q Ms. Beck, are you familiar with this document?
A Yes.
Q And is this a final investigative report related to an alleged violation of 49-2-312?
A Yes.
MS. MAHE: We move admission of Exhibit 80.
THE COURT: Any objection?
MR. RUSSELL: No objection.
THE COURT: It's received without objection.
BY MS. MAHE:
Q And in this case, the respondent was arguing that it was a long-term care facility, correct?

A Correct.
Q And it argued that it was exempted from 49-2-312 based upon the exemption in 49-2-313 for exempted facilities, right?
A Right.
Q And this argument was premised on the fact that it was a long-term care facility and that the CDC recommends vaccination against COVID-19 for all healthcare personnel, true?
A That was the argument that was being raised, the defense that was being raised.
Q And the investigator found that the respondent did not violate 49-2-312, right?
A We found that the charging party was unable to establish the prima facie for the disparate treatment.
Q And are you looking at the last page of that?
A Correct.

MS. MAHE: Davina, will you pull that up?

MS. TOLLE: (Complied with request.)

BY MS. MAHE:
Q And that was because the charging party did not dispute the fact that the respondent was an exempted facility under 313, correct?
A Correct.
Q And so, then, that exemption applied in this case, true?
A In this, in this case, correct.

Q And, therefore, there was no reasonable cause to believe discrimination had occurred?
A Right. We found no cause.
THE REPORTER: I'm sorry. "We found no cause"?
THE WITNESS: We found no cause.
THE REPORTER: Thank you.
BY MS. MAHE:
Q Let's talk about a little bit -- let me start over.
Let's talk a little bit about the Americans with Disabilities Act. Do you understand when I talk about that if I call it the ADA?
A Yes.
Q Okay. The HRB is the deferral agency for Title I of the ADA, correct?
A Correct.
Q And so in that role, the Human Rights Bureau investigates complaints of alleged violations of Title I of the ADA, true?
A Yes.
Q And it issues a for-cause or no-reasonable-cause finding related to those allegations, right?
A Correct.
Q And in situations where there is a claim under the ADA Title I, the HRB makes a determination as to --
(Sneeze audible from gallery.)
MS. MAHE: What? Sorry.

THE WITNESS: No, there was a sneeze.

MS. MAHE: Oh, okay.

THE WITNESS: Bless you.

MS. MAHE: Sorry.

BY MS. MAHE:

Q And in those situations, the HRB would make a determination as to whether or not someone is disabled under the act, correct?

A Assuming that's relevant to the analysis, yes.

Q And in that analysis, the HRB is looking at whether they have an impairment that substantially impacts a major life activity, right?

A Correct.

Q The HRB would most likely consider cancer to be a disabling condition, true?

A It's a major bodily function, and one of the limitations is normal cell growth, so cancer is (inaudible).

THE REPORTER: I'm sorry. I'm sorry. Start again. "It's a major"?

THE WITNESS: It's a major bodily function. Cell growth is a major bodily function, and so abnormal cell growth is typically considered -- cancer is typically considered a disability.

(Discussion off the record between the witness and the court reporter re: microphone.)

MS. MAHE: You can maybe pull it to you, too. I don't know.

BY MS. MAHE:

Q The Equal Employment Opportunity Commission puts out guidance for its Fair Employment Practices Agencies, right?

A Correct, for everyone.

Q And the HRB is a Fair Employment Practices agency for the EEOC, right?

A Yes.

Q And the EEOC has put out specific guidance related to COVID-19, true?

A True.

MS. MAHE: Will you please pull up Exhibit 74, Davina?

MS. TOLLE: (Complied with request.)

BY MS. MAHE:

Q This document has been preadmitted, but you're familiar with this document, Ms. Beck?

A Yes.

Q Actually, I think this is your copy of this document.

If you -- will you please turn to page 30? And can you highlight the bottom part of the paragraph with the bold statement?

MS. TOLLE: (Complied with request.)

///

BY MS. MAHE:

Q In this guidance, the EEOC states that, "A determination of direct threat also would include whether the employee is up to date on vaccinations," correct?

A Correct.

Q And so this states that vaccinations matter when you're performing a direct-threat analysis under the ADA, true?

A I don't quite have these memorized, so give me one moment.

(Pause.)

BY MS. MAHE:

Q And to be clear, I'm talking about this particular sentence that we just looked at.

A Correct. The EEOC guidance says a determination of direct threat would include consideration of a person's vaccination status.

MS. MAHE: Davina, will you pull up page 49?

MS. TOLLE: (Complied with request.)

MS. MAHE: And we're gonna be looking at question K.11 which kind of spans pages 49 and 50.

BY MS. MAHE:

Q And in this guidance, the EEOC says that, "When an employee asks for a reasonable accommodation, whether the employee is fully vaccinated or not, the employer should engage in an interactive process to determine if there is a

disability-related need for reasonable accommodation," correct?

A Yes, that's what the guidance says.

Q And this question is related to an employee who is fully vaccinated for COVID-19 requesting "accommodation for an underlying disability because of a continuing concern that the employee faces a heightened risk of severe illness from a COVID-19 infection," correct?

A Correct.

Q And then at the bottom there, it says, "For example, some individuals who are immunocompromised might still need reasonable accommodations because their conditions may mean that the vaccines may not offer them the same measure of protection as other vaccinated individuals," correct?

A That's what it says, correct.

Q And, "If there is a disability-related need for accommodation, an employer must explore potential reasonable accommodations that may be provided absent undue hardship," true?

A That's what it says.

Q The question of whether an employer must grant accommodations to individuals who are disabled can be related to vaccine status, right?

A Can you ask that again, please?

Q Sure.

The question of whether an employer must grant accommodations to individuals with disabilities can be related to vaccine status, right?

A Can that be a part of the equation? Correct. It will depend, of course, on the fact pattern.

Q And in analyzing a failure-to-accommodate claim under the ADA, the Human Rights Bureau always looks at what the employee's requested accommodation is, right?

A Right. That's part of the analysis.

Q The HRB has put out some guidance related to 49-2-312, right?

A Correct. On our website, we have frequently asked questions.

Q And HRB also put out a video related to vaccination discrimination?

A Right. We have training on our website.

Q And that video is accurate, correct?

A Correct.

Q And the Human Rights Bureau has indicated that requiring individuals who are unvaccinated or failed to provide proof of vaccination to wear a mask is discrimination, correct?

A Now say that again.

Q Sure.

The HRB has indicated that requiring individuals who are unvaccinated or failed to provide proof of vaccination,

requiring those individuals to wear a mask and not others is discrimination, correct?
A It could be a violation.
Q And the video actually says it's discrimination, true?
A Well, I think the video talks and is couched in terms of these are the cases that have wandered through our administrative process to date, and this is where we found cause. Is that what you're asking?
Q Sure. So HRB has found cause in that situation, then?
A We have, depending on the facts of that case.
Q And the HRB has also indicated that it is discriminatory to require an unvaccinated employee to submit to regular testing for COVID-19 and refrain from business travel, right?
A In, in that particular case, yes.
Q And the HRB has also found that an employer providing a dollar-an-hour raise and four hours of paid leave upon showing proof of vaccination was so substantial to be coercive, correct?
A Correct. That was a cause finding.
Q Right. And so, therefore, because it was so substantial to be coercive, it was discriminatory?
A Correct. That's how we're interpreting the incentive.
Q And under 49-2-312, it's the HRB's position that a person has no obligation to respond to a request about vaccination status, correct?

A No.
Q Well, that was a double negative, so is it the --
A Go ahead. I mean, a person doesn't have to respond to an inquiry about vaccination status. It is not -- right at the beginning, we got a flood of calls regarding the fact that folks felt that the law said that asking about vaccination status was a violation.
Q And asking, itself, isn't a violation, correct?
A It is not a violation.
Q But the person doesn't have to answer.
A Correct.
Q And they can't be treated differently based upon their failure to answer?
A Correct.
Q You mentioned that the Human Rights Bureau puts out some frequently asked questions related to 49-2-312, right?
A Yes.
Q And those frequently asked questions are on your website?
A Yes.
Q And the first round of those questions was put out in July of 2021, right?
A Yes.
Q And you were involved in helping create those responses to those particular questions, right?
A Correct.

in front of you.

This has been preadmitted.

Have you seen this before?

A Most likely, yes.

Q Are you having difficulty reading it?

A Yeah. Yes, I believe I've seen it before.

Q Okay. Sorry. That was a little confusing.

Yes, you're having difficulty reading it?

A I, I can read it.

Q Okay. And this is a printout of one of the frequently asked questions on the Department of Labor's website, correct?

A Correct.

Q And it looks like that updated date is January 24, 2022. So this is one of the ones that Mr. Elizandro created, correct?

A Correct.

Q Okay. And that FAQ states, "A public accommodation cannot require you to wear a mask on their premises or present evidence of a negative COVID-19 test if you are unvaccinated or choose not to share your vaccination status," correct?

A Correct.

Q And that's the HRB's position related to employers as well, true?

A Correct.

Q And if we look at that bottom question there that's also

machine, separating the white blood cells out. Those white blood cells are then sent to a facility outside of San Diego, California where the PROVENGE medication is instilled into the white blood cells. The white blood cells have a finite amount of time they can live outside of the body, so that medication-instilled white blood cells are then sent back to our office where the patient comes back in and, through the same process the blood is drawn out, the fortified white blood cells are attached back into the blood and then put back into the patient's body to help their body fight the cancer.

Q Are there other services provided in-office as well?

A Yes. We perform another procedure called the MonaLisa Touch, which is a procedure for our female patients who are experiencing the conditions of atrophic vaginitis, designed to restore collagen and allow their body to return to the normal function for lubrication and prevent bleeding and cracking.

Q Can all of the procedures or services offered by Five Valleys be performed through telehealth?

A No.

Q How many employees does Five Valleys Urology have?

A Currently, we have 34. It generally ranges between about 32 and 40. Somewhere in that range.

Q And how many providers are there?

A We have eight medical providers. Five are medical doctors. Two are physician assistants, both certified, and

one is a certified family nurse practitioner.
Q Does Five Valleys Urology require its providers to have hospital privileges as a condition of employment?
A We do.
Q Do you know if those hospitals require proof of vaccination as a condition for privileges?
A They do.
Q And how do you know that?
A It's part of the credentialing process. We receive credentialing packets and applications that spell out all of the requirements to receive privileges in the facilities, and submitting proof of immunization is one of those requirements.
Q And gathering that proof of immunization, is that part of what you do in your role?
A It can be. I generally assist the providers the first time that they apply for privileges. Much of the privileging process has changed over the last several years to be online and digital, so after the initial appointment, the provider themselves can either conduct their reappointment process or can ask me to assist them.
Q Approximately how many patients does Five Valleys Urology see in a month?
A We see a little over 1,400 patients a month. Our annual volume is generally somewhere between 15,000 and 18,000.
Q Does Five Valleys Urology treat elderly patients?

A We do.
Q Do you treat immunocompromised patients?
A We do.
Q Do you treat patients with disabilities?
A We do.
Q Have any of those patients requested to be treated only by vaccinated staff?
A As I mentioned in my deposition, I do not have the specific names of those individuals, although I know that it occurred.
Q Do your providers also treat patients of hospitals?
A Yes.
Q Do they treat patients from nursing homes?
A Yes.
Q Long-term care facilities?
A Yes.
Q Assisted living facilities?
A Yes. As a general statement, we treat patients from time of birth to end of life, and we are the only urology provider in Missoula County.
Q I want to turn to your employees a little bit.
Have any Five Valleys employees indicated that they are disabled?
A (No response.)
Q That was a really poorly worded question. Can I try

again?
A (No response.)
Q Has Five Valleys employed individuals who have indicated that they have a disability?
A In the past we have, yes.
Q And have any of those disabilities related to an increased risk of harm from contracting a vaccine-preventable disease?
A Yes.
Q Have you had any immunocompromised employees request accommodation?
A We have.
Q And have any of those employees requested an accommodation based upon the vaccination status of your other staff?
A Yes.
Q Without giving me their identifying information, can you tell me about those?
A Sure. We had an employee who both themselves and their daughter were immunocompromised and had chronic conditions. That employee requested a leave of absence.
Q And any other instances?
A We had another individual with a chronic condition who requested isolation.
Q And was that individual a direct patient-care provider?

A Which individual? I'm sorry.
Q Sorry. The isolation.
A No, it was not a direct patient-care provider.
Q Let's start with the employee where you granted the leave of absence. Why were you able to grant her a leave of absence?
A When the pandemic took off and the federal government started making some policies and trying to respond, one of the programs that they put in place allowed for employers to grant paid leave of absences to individuals, and there was a credit, payroll tax credit, for that, and that allowed us to do that.
Q And was that the specific accommodation requested by that employee?
A It was.
Q And if she hadn't requested leave, would you have been able to accommodate her?
A For that particular employee, no, we would not. She was a direct patient-care provider.
Q How long of a leave did you provide her?
A I don't recall the exact length of time. I believe it was somewhere between three and four months.
Q And why was she able to return?
A She was able to return because both she and her daughter received the COVID vaccination.
Q Moving back to the individual that you isolated, why were

you -- how were you able to accommodate her?
A Our office does have individual office spaces with closed doors in them. Those spaces were originally used by our providers. We were able to put that employee into one of those spaces, allowing her to be isolated with the door closed.
Q Is that an accommodation that you could give to an individual who was involved in direct patient care?
A No, that is not.
Q During the pandemic, was there a period of time where you were requiring additional screening requirements for unvaccinated individuals?
A Yes.
Q Can you explain that to me a little bit?
A We were following CDC guidelines, and, during this time, our employees, regardless of their vaccination status, were required to mask. And individuals who indicated that they did not have the COVID vaccination were required to provide us with temperature and symptom checks in the morning before they reported to their workstations.
Q And did you stop that policy at some point?
A We did.
Q And why?
A CDC guidelines changed earlier this year, and we went to a mask-optional situation, and we stopped taking symptom

temperature checks.
Q Does Five Valleys Urology comply with CDC recommendations?
A We do.
Q Does Five Valleys Urology have an OSHA manual?
A Yes, we do.
Q And why do you have that manual?
A We are required to not only have the OSHA manual but comply with OSHA guidelines.
MS. MAHE: Davina, will you pull up Exhibit 118?
MS. TOLLE: (Complied with request.)
MS. MAHE: This document has already been preadmitted.
BY MS. MAHE:
Q Is this the Five Valleys Urology OSHA manual?
A It is.
MS. MAHE: Davina, will you turn to page 9, please? Will you blow up the second bullet point under "When a New Employee is Hired"?
MS. TOLLE: (Complied with request.)
BY MS. MAHE:
Q Does this policy manual reflect Five Valleys' policy related to OSHA compliance?
A Yes.
Q And is this, "When a New Employee is Hired" section, is

Centers for Disease Control and Prevention
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Morbidity and Mortality Weekly Report (*MMWR*)

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Immunization of Health-Care Personnel: Recommendations of the Advisory Committee on Immunization Practices (ACIP)

Recommendations and Reports
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Prepared by

Abigail Shefer, MD1

William Atkinson, MD1

Carole Friedman, DO1*

David T. Kuhar, MD2

Gina Mootrey, DO1

Stephanie R. Bialek, MD1

Amanda Cohn, MD1

Anthony Fiore, MD3

Lisa Grohskopf, MD1

Jennifer L. Liang, DVM1

Suchita A. Lorick, DO1

Mona Marin, MD1

Eric Mintz, MD2

Trudy V. Murphy, MD4

Anna Newton, MPH2

Amy Parker Fiebelkorn, MSN, MPH1

Jane Seward, MBBS1

Gregory Wallace, MD1

1*National Center for Immunization and Respiratory Diseases*

2*National Center for Emerging and Zoonotic Infectious Diseases*

3*Center for Global Health*

4*National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention*

**Deceased.*

The material in this report originated in the National Center for Immunization and Respiratory Diseases, Anne Schuchat, MD, Director.

Corresponding preparer: Abigail Shefer, MD, National Center for Immunization and Respiratory Diseases, 1600 Clifton Rd., MS A-19, Atlanta, GA 30333. Telephone: 404-639-8233; Fax: 404-417-0791; E-mail: ams7@cdc.gov.

Summary

This report updates the previously published summary of recommendations for vaccinating health-care personnel (HCP) in the United States (CDC. Immunization of health-care workers: recommendations of the Advisory Committee on Immunization Practices [ACIP] and the Hospital Infection Control Practices Advisory Committee [HICPAC]. MMWR 1997;46[No. RR-18]). This report was reviewed by and includes input from the Healthcare (formerly Hospital) Infection Control Practices Advisory Committee. These updated recommendations can assist hospital administrators, infection-control practitioners, employee health clinicians, and HCP in optimizing infection prevention and control programs. The recommendations for vaccinating HCP are presented by disease in two categories: 1) those diseases for which vaccination or documentation of immunity is recommended because of risks to HCP in their work settings for acquiring disease or transmitting to patients and 2) those for which vaccination might be indicated in certain circumstances. Background information for each vaccine-preventable disease and specific recommendations for use of each vaccine are presented. Certain infection-control measures that relate to vaccination also are included in this report. In addition, ACIP recommendations for the remaining vaccines that are recommended for certain or all adults are summarized, as are considerations for catch-up and travel vaccinations and for work restrictions. This report summarizes all current ACIP recommendations for vaccination of HCP and does not contain any new recommendations or policies.

The recommendations provided in this report apply, but are not limited, to HCP in acute-care hospitals; long-term--care facilities (e.g., nursing homes and skilled nursing facilities); physician's offices; rehabilitation centers; urgent care centers, and outpatient clinics as well as to persons who provide home health care and emergency medical services.

Introduction

This report updates the previously published summary of recommendations of the Advisory Committee on Immunization Practices (ACIP) and the Healthcare (formerly Hospital) Infection Control Practices Advisory Committee (HICPAC) for vaccinating health-care personnel (HCP) in the United States (*1*). The report, which was reviewed by and includes input from HICPAC, summarizes all current ACIP recommendations for vaccination of HCP and does not contain any new recommendations or policies that have not been published previously. These recommendations can assist hospital administrators, infection-control practitioners, employee health clinicians, and HCP in optimizing infection prevention and control programs.

HCP are defined as all paid and unpaid persons working in health-care settings who have the potential for exposure to patients and/or to infectious materials, including body substances, contaminated medical supplies and equipment, contaminated environmental surfaces, or contaminated air. HCP might include (but are not limited to) physicians, nurses, nursing assistants, therapists, technicians, emergency medical service personnel, dental personnel, pharmacists, laboratory personnel, autopsy personnel, students and trainees, contractual staff not employed by the health-care facility, and persons (e.g., clerical, dietary, housekeeping, laundry, security, maintenance, administrative, billing, and volunteers) not directly involved in patient care but potentially exposed to infectious agents that can be transmitted to and from HCP and patients (*2*).

Because of their contact with patients or infective material from patients, many HCP are at risk for exposure to (and possible transmission of) vaccine-preventable diseases. Employers and HCP have a shared responsibility to prevent occupationally acquired infections and avoid causing harm to patients by taking reasonable precautions to prevent transmission of vaccine-preventable diseases. Vaccination programs are therefore an essential part of infection prevention and control for HCP. Optimal use of recommended vaccines helps maintain immunity and safeguard HCP from infection, thereby helping protect patients from becoming infected; pertinent ACIP statements on various individual vaccines and diseases have been published (Table 1). Nationwide, ongoing implementation of these vaccine recommendations through well-managed vaccination programs could substantially reduce both the number of susceptible HCP in any setting in which they interact with patients and their risks for transmitting vaccine-preventable diseases to patients, other HCP, and other contacts (*3*).

HICPAC and CDC have recommended that secure, preferably computerized, systems should be used to manage vaccination records for HCP so records can be retrieved easily as needed (*3*). Each record should reflect immunity status for indicated vaccine-preventable diseases (i.e., documented disease, vaccination history, or serology results) as well as vaccinations administered during employment and any documented episodes of adverse events after vaccination (*4*). For each vaccine, the record should include date of vaccine administration (including for those vaccines that might have been received prior to employment), vaccine manufacturer and lot number, edition and distribution date of the language-appropriate Vaccine Information Statement (VIS) provided to the vaccinee at the time of vaccination, and the name, address, and title of the person administering the vaccine (*4*). Accurate vaccination records can help to rapidly identify susceptible HCP (i.e., those with no history of vaccination or lack of documentation of immunity) during an outbreak situation and can help reduce costs and disruptions to health-care operations (*5--7*). HCP should be provided a copy of their vaccination records and encouraged to keep it with their personal health records so they can readily be made available to future employers.

HICPAC has encouraged any facility or organization that provides direct patient care to formulate a comprehensive vaccination policy for all HCP (*3*). The American Hospital Association has endorsed the concept of vaccination programs for both hospital personnel and patients (*8*). To ensure that all HCP are up to date with respect to recommended vaccines, facilities should review HCP vaccination and immunity status at the time of hire and on a regular basis (i.e., at least annually) with consideration of offering needed vaccines, if necessary, in conjunction with routine annual disease-prevention measures (e.g., influenza vaccination or tuberculin testing). These recommendations (Tables 2 and 3) should be considered during policy development. Several states and health-care facilities have established requirements relating to assessment of vaccination status and/or administration of one or more vaccines for HCP (*9,10*). Disease-specific outbreak control measures are described in this report and elsewhere (*3,11,12*). All HCP should adhere to all other recommended infection-control guidelines, whether or not they are individually determined to have immunity to a vaccine-preventable disease.

Methods

In 2008, the ACIP Immunization of Health-Care Personnel Work Group (the Work Group) was formed as a subgroup of the ACIP Adult Immunization Work Group to update the previously published recommendations for immunization of HCP. The Work Group comprised professionals from academic medicine (pediatrics, family medicine, internal medicine, occupational and environmental medicine, and infectious disease); federal and state public health professionals; and liaisons from the Society for Healthcare Epidemiology of America and HICPAC. The Work Group met monthly, developed an outline for the report, worked closely with subject matter experts at CDC (who developed, revised, and updated sections of the report), and provided subsequent critical review of the draft documents. The approach of the Work Group was to summarize previously published ACIP recommendations and not to make new recommendations or policies; a comprehensive list of publications containing the various vaccine-specific recommendations is provided (Table 1). In February 2011, the updated report was presented to ACIP, which voted to approve it.

The recommendations for vaccination of HCP are presented below by disease in two categories: 1) those diseases for which routine vaccination or documentation of immunity is recommended for HCP because of risks to HCP in their work settings and, should HCP become infected, to the patients they serve and 2) those diseases for which vaccination of HCP might be indicated in certain circumstances. Vaccines recommended in the first category are hepatitis B, seasonal influenza, measles, mumps, and rubella, pertussis, and varicella vaccines. Vaccines in the second category are meningococcal, typhoid, and polio vaccines. Except for influenza, all of the diseases prevented by these vaccines are notifiable at the national level (*13*). Main changes from the 1997 ACIP recommendations have been summarized (Box).

Diseases for Which Vaccination Is Recommended

On the basis of documented nosocomial transmission, HCP are considered to be at substantial risk for acquiring or transmitting hepatitis B, influenza, measles, mumps, rubella, pertussis, and varicella. Current recommendations for vaccination are provided below.

Hepatitis B

Background

Epidemiology and Risk Factors

Hepatitis B is an infection caused by the hepatitis B virus (HBV), which is transmitted through percutaneous (i.e., breaks in the skin) or mucosal (i.e., direct contact with mucous membranes) exposure to infectious blood or body fluids. The virus is highly infectious; for nonimmune persons, disease transmission from a needlestick exposure is up to 100 times more likely for exposure to hepatitis B e antigen (HBeAg)--positive blood than to HIV-positive blood (*14*). HBV infection is a well recognized occupational risk for U.S. HCP and globally. The risk for HBV is associated with degree of contact with blood in the work place and with the hepatitis B e-antigen status of the source persons (*15*). The virus is also environmentally stable, remaining infectious on environmental surfaces for at least 7 days (*16*).

In 2009 in the United States, 3,371 cases of acute HBV infection were reported nationally, and an estimated 38,000 new cases of HBV infection occurred after accounting for underreporting and underdiagnosis (*17*). Of 4,519 persons reported with acute HBV infection in 2007, approximately 40% were hospitalized and 1.5% died (*18*). HBV can lead to chronic infection, which can result in cirrhosis of the liver, liver failure, liver cancer, and death. An estimated 800,000--1.4 million persons in the United States are living with chronic HBV infection; these persons serve as the main reservoir for continued HBV transmission (*19*).

Vaccines to prevent hepatitis B became available in the United States in 1981; a decade later, a national strategy to eliminate HBV infection was implemented, and the routine vaccination of children was recommended (*20*). During 1990--2009, the rate of new HBV infections declined approximately 84%, from 8.5 to 1.1 cases per 100,000 population (*17*); the decline was greatest (98%) among persons aged <19 years, for whom recommendations for routine infant and adolescent vaccination have been applied. Although hepatitis B vaccine coverage is high in infants, children, and adolescents (91.8% in infants aged 19--35 months and 91.6% in adolescents aged 13--17 years) (*21*,*22*), coverage remains lower (41.8% in 2009) for certain adult populations, including those with behavioral risks for HBV infection (e.g., men who have sex with men and persons who use injection drugs) (*23*).

Hepatitis B in Health-Care Settings

During 1982, when hepatitis B vaccine was first recommended for HCP, an estimated 10,000 infections occurred among persons employed in a medical or dental field. By 2004, the number of HBV infections among HCP had decreased to an estimated 304 infections, largely resulting from the implementation of routine preexposure vaccination and improved infection-control precautions (*24--26*).

The risk for acquiring HBV infection from occupational exposures is dependent on the frequency of percutaneous and mucosal exposures to blood or body fluids (e.g., semen, saliva, and wound exudates) containing HBV, particularly fluids containing HBeAg (a marker for high HBV replication and viral load) (*27--31*). The risk is higher during the professional training period and can vary throughout a person's career (*1*). Depending on the tasks performed, health-care or public safety personnel might be at risk for HBV exposure; in addition, personnel providing care and assistance to persons in outpatient settings and those residing in long-term--care facilities (e.g., assisted living) might be at risk for acquiring or facilitating transmission of HBV infection when they perform procedures that expose them to blood (e.g., assisted blood-glucose monitoring and wound care) (*32--34*).

A Federal Standard issued in December 1991 under the Occupational Safety and Health Act mandates that hepatitis B vaccine be made available at the employer's expense to all health-care personnel who are exposed occupationally to blood or other potentially infectious materials (*35*). The Federal Standard defines occupational exposure as reasonably anticipated skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials that might result from the performance of an employee's duties (*35*). Occupational Safety and Health Administration (OSHA) vaccination practice requirements (e.g., preexposure and postexposure antibody testing) are based on current ACIP recommendations. OSHA regulations might have accelerated the use of hepatitis B vaccine in HCP (*36*).

Data from a national, cross-sectional survey demonstrated that during 2002--2003, an estimated 75% of HCP had received the 3-dose hepatitis B vaccination series (*37*). Since 2002, rates of 1-dose and 3-dose vaccination coverage have remained stable. Data obtained through the National Health Interview Survey (NHIS) in 2009 demonstrated a ≥1-dose coverage rate of 75%--77% and a ≥3-dose rate of 67%--68% among HCP aged 18--49 years (*23*). Similarly, data obtained through the National Immunization Survey--Adult (NIS-Adult) in 2007 demonstrated a ≥3-dose coverage of 62% among HCP aged 18--64 years (*38*). The Healthy People 2020 goal (objective no. IID-15.3) of a hepatitis B vaccination coverage rate of 90% among HCP (*39*) has not been achieved.

Vaccine Effectiveness, Duration of Immunity, and Vaccine Safety

Vaccine Effectiveness

The 3-dose vaccine series administered intramuscularly at 0, 1, and 6 months produces a protective antibody response in approximately 30%--55% of healthy adults aged ≤40 years after the first dose, 75% after the second dose, and >90% after the third dose (*40--42*). After age 40 years, <90% of persons vaccinated with 3 doses have a protective antibody response, and by age 60 years, protective levels of antibody develop in approximately 75% of vaccinated persons (*43*). Smoking, obesity, genetic factors, and immune suppression also are associated with diminished immune response to hepatitis B vaccination (*43--46*).

Duration of Immunity

Protection against symptomatic and chronic HBV infection has been documented to persist for ≥22 years in vaccine responders (*47*). Immunocompetent persons who achieve hepatitis B surface antibody (anti-HBs) concentrations of ≥10 mIU/mL after preexposure vaccination have protection against both acute disease and chronic infection. Anti-HBs levels decline over time. Regardless, responders continue to be protected, and the majority of responders will show an anamnestic response to vaccine challenge (*47--51*). Declines might be somewhat faster among persons vaccinated as infants rather than as older children, adolescents, or adults and among those administered recombinant vaccine instead of plasma vaccine (which has not been commercially available in the United States since the late 1980s). Although immunogenicity is lower among immunocompromised persons, those who achieve and maintain a protective antibody response before exposure to HBV have a high level of protection from infection (*52*).

Among persons who do not respond to a primary 3-dose vaccine series (i.e., those in whom anti-HBs concentrations of ≥10 mIU/mL were not achieved), 25%--50% respond to an additional vaccine dose, and 44%--100% respond to a 3-dose revaccination series using standard or high dosage vaccine (*43*,*53--58*). Persons who have measurable but low (i.e., 1--9 mIU/mL) levels of anti-HBs after the initial series have better response to revaccination than persons who have no anti-HBs (*49*,*53*,*54*). Persons who do not have protective levels of anti-HBs 1--2 months after revaccination either are infected with HBV or can be considered primary nonresponders; for the latter group, genetic factors might be associated with nonresponse to hepatitis B vaccination (*54*,*58*,*59*). ACIP does not recommend more than two vaccine series in nonresponders (*52*).

Vaccine Safety

Hepatitis B vaccines have been demonstrated to be safe when administered to infants, children, adolescents, and adults (*52*,*60*,*61*). Although rare cases of arthritis or alopecia have been associated temporally with hepatitis B vaccination, recent data do not support a causal relationship between hepatitis B vaccine and either arthritis or alopecia (*61--63*). During 1982--2004, an estimated 70 million adolescents and adults and 50 million infants and children in the United States received ≥1 dose of hepatitis B vaccine (*52*). The most frequently reported side effects in persons receiving hepatitis B vaccine are pain at the injection site (3%--29%) and temperature of >99.9°F (>37.7°C) (1%--6%) (*64--67*). However, in placebo-controlled studies, these side effects were reported no more frequently among persons receiving hepatitis B vaccine than among persons receiving placebo (*40*,*41*,*64--67*). Revaccination is not associated with an increase in adverse events.

Hepatitis B vaccination is contraindicated for persons with a history of hypersensitivity to yeast or any vaccine component (*4*,*64--66*). Persons with a history of serious adverse events (e.g., anaphylaxis) after receipt of hepatitis B vaccine should not receive additional doses. As with other vaccines, vaccination of persons with moderate or severe acute illness, with or without fever, should be deferred until illness resolves (*4*). Vaccination is not contraindicated in persons with a history of multiple sclerosis, Guillain-Barré Syndrome, autoimmune disease (e.g., systemic lupus erythematosis and rheumatoid arthritis), or other chronic diseases. Pregnancy is not a contraindication to vaccination; limited data suggest that developing fetuses are not at risk for adverse events when hepatitis B vaccine is administered to pregnant women (*4*,*68*). Available vaccines contain noninfectious hepatitis B surface antigen (HBsAg) and do not pose any risk for infection to the fetus.

Recommendations

Two single-antigen hepatitis B vaccines, Recombivax HB (Merck & Co., Inc., Whitehouse Station, New Jersey) and Engerix-B (GlaxoSmithKline Biologicals, Rixensart, Belgium) and one combination hepatitis A and hepatitis B vaccine, Twinrix (GlaxoSmithKline Biologicals), are available in the United States. Primary vaccination consists of ≥3 intramuscular doses of hepatitis B vaccine or of the combined hepatitis A and hepatitis B vaccine. The hepatitis vaccine series does not need to be restarted if the second or third dose is delayed. Detailed vaccination recommendations are available in previously published

guidelines (52). Vaccine schedules are available at http://www.cdc.gov/vaccines/recs/schedules/adult-schedule.htm#HCWs. In adults, hepatitis B vaccine always should be administered into the deltoid muscle. Longer needles (up to 1.5 inches in length) might be required for obese adults (4).

Preexposure

Unvaccinated and Incompletely Vaccinated HCP and Trainees: Pre- and Postvaccination Serologic Testing

- Prevaccination serologic testing for previous infection is not indicated for the majority of persons being vaccinated because of occupational risk unless the hospital or health-care organization considers such testing cost-effective (3,52,69--72). However, such testing is indicated for HCP and is cost-effective in certain high-risk populations (see HCP and Trainees at Additional Risk), regardless of vaccination status (71,73).
- All unvaccinated persons whose work- and training-related activities involve reasonably anticipated risk for exposure to blood or other infectious body fluids (e.g., HCP, long-term--care facility staff, and public safety workers) should be vaccinated with the complete, ≥3-dose hepatitis B vaccine series.
- Persons with an incomplete series are not considered protected and should complete the ≥3-dose series.
- Because higher risk has been reported during the professional training period, the vaccination series should be completed before trainees have contact with blood; vaccination should be offered in schools of medicine, dentistry, nursing, laboratory technology, and other allied health professions.
- To determine the need for revaccination and to guide postexposure prophylaxis, postvaccination serologic testing should be performed for all HCP at high risk for occupational percutaneous or mucosal exposure to blood or body fluids. Postvaccination serologic testing is performed 1--2 months after administration of the last dose of the vaccine series using a method that allows detection of the protective concentration of anti-HBs (≥10 mIU/mL). Persons determined to have anti-HBs concentrations of ≥10 mIU/mL after receipt of the primary vaccine series are considered immune, and the result should be documented. Immunocompetent persons have long-term protection and do not need further periodic testing to assess anti-HBs levels. Postvaccination testing for persons at low risk for mucosal or percutaneous exposure to blood or body fluids (e.g., public safety workers and HCP without direct patient contact) likely is not cost effective (52); however, persons who do not undergo postvaccination testing should be counseled to seek immediate testing if exposed.
- Persons determined to have anti-HBs concentrations of <10 mIU/mL soon after receipt of the primary vaccine series should be revaccinated. For these persons, administration of a second complete 3-dose series on an appropriate schedule, followed by anti-HBs testing 1--2 months after the third dose, usually is more practical than conducting serologic testing after each additional dose of vaccine.
- Persons who do not have a protective concentration of anti-HBs (≥10 mIU/mL) after revaccination (i.e., after receiving a total of 6 doses) should be tested for HBsAg and anti-HBc to determine infection status. Those determined not to be infected but who have anti-HBs <10 mIU/mL (nonresponders) should be considered susceptible to HBV infection and should be counseled about precautions to prevent HBV infection and the need to obtain hepatitis B immune globulin (HBIG) postexposure prophylaxis for any known or likely exposure to HBsAg-positive blood (72). Persons determined to be infected (anti-HBc-positive) and positive for HBsAg should be provided counseling regarding how to prevent HBV transmission to others and referred for further evaluation (e.g., HBV viral load testing), care, treatment, and other services, as appropriate (69--71). Persons who are HBsAg-positive and who perform exposure-prone procedures should seek counsel from a review panel comprised of experts with a balanced perspective (e.g., HCPs' personal physicians and infectious disease specialists) regarding the procedures that they can perform safely. They should not be excluded from work (69). Persons who were infected in the past (anti-HBc-positive but negative for HBsAg) require no vaccination or treatment.

Postexposure

The need for postexposure prophylaxis should be evaluated immediately after HCP experience any percutaneous, ocular, mucous-membrane or nonintact skin exposure to blood or body fluid in the workplace. Decisions to administer postexposure prophylaxis should be based on the HBsAg status of the source and the vaccination history and vaccine-response status of the exposed HCP (Table 4) (72).

Unvaccinated and Incompletely Vaccinated HCP and Trainees

- Unvaccinated or incompletely vaccinated persons who experience a workplace exposure from persons known to be HBsAg-positive should receive 1 dose of hepatitis B immune globulin HBIG (i.e., passive vaccination) as soon as possible after exposure (preferably within 24 hours). The effectiveness of HBIG when administered >7 days after percutaneous or permucosal exposures is unknown (Table 4).
- Hepatitis B vaccine should be administered in the deltoid muscle as soon as possible after exposure; HBIG should be administered at the same time at another injection site. The 3-dose hepatitis B vaccine series should be completed for previously unvaccinated and incompletely vaccinated persons who have needlestick or other percutaneous exposures, regardless of the HBsAg status of the source and whether the status of the source is known. To document protective levels of anti-HBs (≥10mIU/mL), postvaccination testing of persons who received HBIG for postexposure prophylaxis should be performed after anti-HBs from HBIG is no longer detectable (4--6 months after administration).

Vaccinated HCP and Trainees

- Vaccinated HCP with documented immunity (anti-HBs concentrations of ≥10 mIU/mL) require no postexposure prophylaxis, serologic testing, or additional vaccination.
- Vaccinated HCP with documented nonresponse to a 3-dose vaccine series should receive 1 dose of HBIG and a second 3-dose vaccine series if the source is HBsAg-positive or known to be at high risk for carrying hepatitis. If the source is known or determined to be HBsAg- negative, these previously nonresponding HCP should complete the revaccination series and undergo postvaccination testing to ensure that their response status is documented (Table 4). Postvaccination testing of persons who received HBIG for PEP should be performed after anti-HBs from HBIG is no longer detectable (4--6 months after administration).
- Vaccinated HCP with documented nonresponse to two 3-dose vaccine series should receive 2 doses of HBIG, 1 month apart if the source is HBsAg-positive or known to be at high risk for carrying hepatitis; no additional vaccination is necessary. If the source is known or determined to be HBsAg-negative, these previously nonresponding HCP need no additional testing or treatment (Table 4).
- Vaccinated HCP with no documentation of postvaccination serologic response who are exposed to an HBsAg-positive source should have serum obtained for anti-HBs testing immediately. Those determined to have protective levels of antibody (anti-HBs ≥10 mIU/mL) require no additional treatment; those with concentrations <10 mIU/mL should receive 1 dose of HBIG, along with a booster dose of hepatitis B vaccine. To document protective levels of anti-HBs (≥10mIU/mL), postvaccination testing of persons who received HBIG for postexposure prophylaxis should be performed after anti-HBs from HBIG is no longer detectable (4--6 months after administration).
- Vaccinated HCP with no documentation of postvaccination serologic response who are exposed to a source with unknown infection status should be tested for anti-HBs. Those determined to have protective levels of antibody require no additional treatment; those with concentrations <10 mIU/mL should receive a booster dose of hepatitis B vaccine and serologic testing 1--2 months later.
- Vaccinated HCP with no documentation of postvaccination serologic response who are exposed to a source known to be HBsAg-negative require no testing or treatment (Table 4).

HCP and Trainees at Additional Risk

- Regardless of vaccination history, HCP and trainees in certain high-risk populations, including those born in geographic regions with high HBsAg prevalence (≥8%) and intermediate (2%--7%) prevalence (71), unvaccinated U.S-born HCP whose parents were born in regions of high HBsAg prevalence, HIV-positive HCP, HCP who have disclosed having engaged or currently engaging in high-risk substance abuse or sexual behaviors, and HCP who require immunosuppressive therapy or who are on hemodialysis should be tested for HBsAg and anti-HBc/anti-HBs to determine infection status. For those who are unvaccinated, blood should be drawn for testing before the first dose of vaccine is administered, and vaccination should be administered during the same health-care visit. Persons testing negative for hepatitis B infection or immunity should be managed in the same manner as other uninfected HCP. Persons determined to be HBsAg-positive should be provided counseling regarding how to prevent HBV transmission to others and referred for further evaluation (e.g., HBV viral load testing), care, treatment, and other services as appropriate (69--71). Persons who are HBsAg-positive and who perform exposure-prone procedures should seek counsel from a review panel comprised of experts with a balanced perspective (e.g., personal physicians of HCP and infectious disease specialists) regarding the procedures that they can perform safely. They should not be excluded from

work (69). Additional information regarding prevaccination testing for HCP with other hepatitis B risk factors and for pregnant women has been published previously (52,71). HCP receiving hemodialysis should be provided annual anti-HBs testing and should be administered a booster dose of vaccine when anti-HBs levels decline to <10 mIU/mL (52).
- For other immunocompromised HCP (e.g., HIV-infected persons, hematopoietic stem-cell transplant recipients, and persons receiving chemotherapy), the frequency of postvaccination testing and the need for booster doses has not been determined (52).

Other Considerations

- Occupational health programs and others responsible for infection prevention and control should identify all staff whose work-related activities involve exposure to blood or other potentially infectious body fluids in a health-care, laboratory, public safety, or institutional setting (including employees, students, contractors, attending clinicians, emergency medical technicians, paramedics, and volunteers); provide education to staff to encourage vaccination; and implement active follow-up, with reminders to track completion of the vaccine series and postvaccination testing among persons receiving vaccination (72).
- In partnership with state and local health authorities, household, sex, or needle-sharing contacts of HBsAg-positive HCP and trainees should be identified, tested, vaccinated (if indicated), and provided with counseling and referral for needed services, when appropriate.

Influenza

Background

Epidemiology and Risk Factors

Influenza causes an estimated average of >200,000 hospitalizations and 3,000--49,000 deaths annually in the United States (*74--76*). The majority of influenza-related severe illnesses and deaths occur among persons with chronic medical conditions, infants and young children, seniors, and pregnant women (*74--78*). Reducing the risk for influenza among persons at higher risk for complications is a major focus of influenza prevention strategies (*77*).

Influenza Transmission in Health-Care Settings

HCP are exposed to patients with influenza in the workplace and are thus at risk of occupationally acquired influenza and of transmitting influenza to patients and other HCP. In a cross-sectional survey of hospital house staff (physicians in training), 37% reported influenza-like illness during September--April, and 9% reported more than one respiratory illness. Length of illness varied (range: 1--10 days; mean: 7 days), as did days of work missed (range: 0--10 days; mean: 0.7 days) (*79*). Infected HCP who continue to work while ill might transmit influenza to patients, many of whom are at increased risk for severe outcomes from influenza. HCP are therefore recommended for routine annual influenza vaccination (*77*).

Few randomized trials of the effect that influenza vaccination has on illness in HCP have been conducted. In one randomized trial of 427 HCP, influenza vaccination of HCP failed to decrease episodes of respiratory infection or duration of illness but was associated with a 28% decrease in absenteeism (from 1.4 days to 1.0 day) attributable to respiratory infections (*80*). No laboratory confirmation of influenza was obtained in this study. In another randomized trial among HCP, vaccination was associated with a significantly lower rate of serological evidence of influenza infection, with a vaccine efficacy rate of 88% for influenza A and 89% for influenza B ($p<0.05$) (*81*); however, no significant differences were noted in days of febrile respiratory illness or absenteeism.

Influenza can cause outbreaks of severe respiratory illness among hospitalized persons and long-term-care residents (*82--90*). Influenza outbreaks in hospitals (*86--88*) and long-term--care facilities (*91*) have been associated with low vaccination rates among HCP. One nonrandomized study demonstrated an increase in HCW vaccination rates and decrease in nosocomially acquired, laboratory-confirmed influenza in a hospital after a mobile cart--based HCP vaccination program was introduced (*86*). Several randomized controlled studies of the impact of HCP vaccination on morbidity and mortality in long-term care facilities have been performed (*92--95*). These studies have demonstrated substantial decreases in all-cause mortality (*92--95*) and influenza-like illness (*92,94,95*). However, studies which examine and demonstrate efficacy in preventing more specific outcomes (e.g., laboratory-confirmed influenza illness and mortality) are lacking. Recent systematic reviews suggest that vaccination of HCP in settings in which patients also were vaccinated provided significant reductions in deaths among elderly patients from all causes and deaths from pneumonia, but also note that additional randomized controlled trials are warranted (*96,97*), as are examination of more specific outcomes.

Preventing influenza among HCP who might serve as sources of influenza virus transmission provides additional protection to patients at risk for influenza complications. Vaccination of HCP can specifically benefit patients who cannot receive vaccination (e.g., infants aged <6 months or those with severe allergic reactions to prior influenza vaccination), patients who respond poorly to vaccination (e.g., persons aged ≥85 years and immune-compromised persons), and persons for whom antiviral treatment is not available (e.g., persons with medical contraindications). Although annual vaccination has long been recommended for HCP and is a high priority for reducing morbidity associated with influenza in health-care settings (*98--100*), national survey data have demonstrated that the vaccination coverage level during the 2008--09 season was 52.9% (*101*).

Considerations Regarding Influenza Vaccination of HCP

Barriers to HCP aceptance of influenza vaccination have included fear of vaccine side effects (particularly influenza-like symptoms), insufficient time or inconvenience, perceived ineffectiveness of the vaccine, perceived low likelihood of contracting influenza, avoidance of medications, and fear of needles (*79,102--109*). Factors demonstrated to increase vaccine acceptance include a desire for self-protection, previous receipt of influenza vaccine, a desire to protect patients, and perceived effectiveness of vaccine (*79,105,106,109--112*). Strategies that have demonstrated improvement in HCP vaccination rates have included campaigns to emphasize the benefits of HCP vaccination for staff and patients, vaccination of senior medical staff or opinion leaders, removing administrative barriers (e.g., costs), providing vaccine in locations and at times easily accessible by HCP, and monitoring and reporting HCP influenza vaccination rates (*99,113--120*). Intranasally administered live attenuated influenza vaccine (LAIV) is an option for healthy, nonpregnant adults aged <50 years who dislike needles.

The practice of obtaining signed declinations from HCP offered influenza vaccination has been adopted by some institutions but has not yet been demonstrated to exceed coverage rates of >70%--80% (*99,115,121--123*). Institutions that require declination statements from HCP who refuse influenza vaccination should educate and counsel these HCP about benefits of the vaccine.

Each health-care facility should develop a comprehensive influenza vaccination strategy that includes targeted education about the disease, including disease risk among HCP and patients, and about the vaccine. In addition, the program should establish easily accessible vaccination sites and inform HCP about their locations and schedule. Facilities that employ HCP should provide influenza vaccine at no cost to personnel (124). The most effective combination of approaches for achieving high influenza vaccination coverage among HCP likely varies by institution. Hospitals and health-care organizations in the United States traditionally have employed an immunization strategy that includes one or more of the following components: education about influenza, easy access to vaccine, incentives to encourage immunization, organized campaigns, institution of declination policies, and legislative and regulatory efforts (e.g., vaccination requirements) (*99, 115, 121--126*).

Beginning January 1, 2007, the Joint Commission on Accreditation of Health-Care Organizations required accredited organizations to offer influenza vaccinations to staff, including volunteers and licensed independent practitioners and to report coverage levels among HCP (*127*). Standards are available for measuring vaccination coverage among HCP as a measure of program performance within a health-care setting (*128*). Beginning January 2013, the Centers for Medicaid Services will require acute care hospitals to report HCP influenza vaccine as part of its hospital inpatient quality reporting program.*

Vaccine Effectiveness, Duration of Immunity, and Vaccine Safety

Effectiveness of influenza vaccines varies from year to year and depends on the age and health status of the person getting the vaccine and the similarity or "match" between the viruses or virus in the vaccine and those in circulation. Vaccine strains are selected for inclusion in the influenza vaccine every year based on international surveillance and scientists' estimations about which types and strains of viruses will circulate in a given year. Annual vaccination is recommended because the predominant circulating influenza viruses typically change from season to season and, because immunity declines over time postvaccination (*ZZ*).

In placebo-controlled studies among adults, the most frequent side effect of vaccination was soreness at the vaccination site (affecting 10%--64% of patients) that lasted <2 days (*129,130*). These injection-site reactions typically were mild and rarely interfered with the recipient's ability to conduct usual daily activities. The main contraindication to influenza vaccination is a history of anaphylactic hypersensitivity to egg or other components of the vaccine. A history of Guillain-Barré Syndrome within 6 weeks following a previous dose of influenza vaccine is considered to be a precaution for use of influenza vaccines (*ZZ*).

Recommendations

Vaccination

Annual influenza vaccination is recommended for all persons aged ≥6 months who have no medical contraindication; therefore, vaccination of all HCP who have no contraindications is recommended. The influenza vaccine is evaluated annually with one or more vaccine strains updated almost every year. In addition, antibody titers decline during the year after vaccination. Thus, annual vaccination with the current season's formulation is recommended. Annual vaccination is appropriate and safe to begin as early in the season as vaccine is available. HCP should be among the groups considered for prioritized receipt of influenza vaccines when vaccine supply is limited.

Two types of influenza vaccines are available. LAIV is administered intranasally and is licensed for use in healthy nonpregnant persons aged 2--49 years. The trivalent inactivated vaccine (TIV) is administered as an intramuscular injection and can be given to any person aged ≥6 months. Both vaccine types contain vaccine virus strains that are selected to stimulate a protective immune response against the wild-type viruses that are thought to be most likely in circulation during the upcoming season. Use of LAIV for HCP who care for patients housed in protective inpatient environments has been a theoretic concern, but transmission of LAIV in health-care settings has not been reported. LAIV can be used for HCP who work in any setting, except those who care for severely immunocompromised hospitalized persons who require care in a protective environment. HCP who themselves have a condition that confers high risk for influenza complications, who are pregnant, or who are aged ≥50 years should not receive LAIV and should be administered TIV instead. An inactivated trivalent vaccine containing 60 mcg of hemagglutinin antigen per influenza vaccine virus strain (Fluzone High-Dose [sanofi pasteur]) is an alternative inactivated vaccine for persons aged ≥65 years. Persons aged ≥65 years may be administered any of the standard-dose TIV preparations or Fluzone High-Dose (*ZZ*). The majority of TIV preparations are administered intramuscularly. An intradermally administered TIV was licensed in May 2011 and is an alternative to other TIV preparations for persons aged 18--64 years (*131*).

Use of Antiviral Drugs for Treating Exposed Persons and Controlling Outbreaks

Use of antiviral drugs for chemoprophylaxis or treatment of influenza is an adjunct to (but not a substitute for) vaccination. Oseltamivir or zanamivir are recommended currently for chemoprophylaxis or treatment of influenza (*132,133*). TIV can be administered to exposed, unvaccinated HCP at the same time as chemoprophylaxis, but LAIV should be avoided because the antiviral medication will prevent viral replication needed to stimulate a vaccine response (*ZZ*). Antivirals are used often among patients during outbreaks in closed settings such as long-term--care facilities but also can be administered to unvaccinated HCP during outbreaks, when an exposure to a person with influenza occurs, or after exposure when vaccination is not thought to be protective against the strain to which a vaccinated HCP was exposed. Chemoprophylaxis consists of 1 dose (of either antiviral drug) daily for 10 days, and treatment consists of 1 dose twice daily for 5 days. In many instances of HCP exposure, watchful waiting and early initiation of treatment if symptoms appear is preferred rather than use of antiviral chemoprophylaxis immediately after exposure. The intensity and duration of the exposure and the underlying health status of the exposed worker are important factors in clinical judgments about whether to provide chemoprophylaxis. If chemoprophylaxis is used, the provider should base choice of the agent on whether the circulating strain or strains of influenza have demonstrated resistance to particular antivirals.

Program Evaluation

- Health-care administrators should include influenza vaccination coverage among HCP as a measure of quality of care (*124*).
- Influenza vaccination rates among HCP within facilities should be regularly measured and reported, and ward-, unit-, and specialty-specific coverage rates should be provided to staff and administration (*124*). Such information might be useful to promote compliance with vaccination policies.

Measles

Background

Epidemiology and Risk Factors

Measles is a highly contagious rash illness that is transmitted by respiratory droplets and airborne spread. Severe complications, which might result in death, include pneumonia and encephalitis. Before the national measles vaccination program was implemented in 1963, almost every person acquired measles before adulthood; an estimated 3--4 million persons in the United States acquired measles each year (*134*). Approximately 500,000 persons were reported to have had measles annually, of whom 500 persons died, 48,000 were hospitalized, and another 1,000 had permanent brain damage from measles encephalitis (*134*).

Through a successful 2-dose measles vaccination program (i.e., a first dose at age 12--15 months and a second dose between ages 4--6 years) (*135*) and better measles control throughout the region of the Americas (*136*), endemic transmission of measles was interrupted in the United States, and measles was declared eliminated from the country in 2000 (*137*). However, measles remains widespread in the majority of countries outside the Western Hemisphere, with an estimated 20 million measles cases occurring worldwide (*138*) and approximately 164,000 related deaths (*139*). Thus, the United States continues to experience international importations that might lead to transmission among U.S. residents and limited outbreaks, especially in unvaccinated populations (*140*--*143*).

During 2001--2008, a total of 557 confirmed measles cases were reported in the United States from 37 states and the District of Columbia (annual median: 56; range: 37 in 2004 to 140 in 2008), representing an annual incidence of less than one case per million population (*144*). Of the 557 reported case-patients, 126 (23%) were hospitalized (annual median: 16; range: 5--29); of these, at least five case-patients were admitted to intensive care. Two deaths were reported, both in 2003 (*144*).

Of the 557 reported case-patients during 2001--2008, a total of 223 (40%) were adults, including 156 (28%) aged 20--39 years and 67 (12%) aged ≥40 years. Of the 438 measles cases among U.S. residents, 285 (65%) cases were considered preventable (i.e., occurred among persons who were eligible for vaccination but were unvaccinated) (*144*). The remaining 153 (35%) cases were considered nonpreventable. Cases were defined as nonpreventable if they occurred among U.S. resident case-patients who had received ≥1 dose of measles-containing vaccine, if patients were vaccinated as recommended if traveling internationally, or if they were not vaccinated but had other evidence of immunity (i.e., were born before 1957 and therefore presumed immune from natural disease in childhood, had laboratory evidence of immunity, or had documentation of physician-diagnosed disease) or for whom vaccination is not recommended.

During 2001--2008, a total of 12.5% (one of eight) of measles cases reported to CDC among HCP occurred in persons born before 1957; the other seven cases occurred among HCP born after 1957.

Measles-mumps-rubella (MMR) vaccination policies have been enforced with variable success in United States health-care facilities over the past decade. Even though medical settings were a primary site of measles transmission during the 1989--1991 measles resurgence (*145,146*), as of September 2011, only three states (New York, Oklahoma, and Rhode Island) had laws mandating that all hospital personnel have proof of measles immunity and did not allow for religious or philosophic exemptions (*147*).

Vaccine coverage in the United States is high; in 2010, a total of 91.5% of children aged 19--35 months had received 1 dose of MMR vaccine (*21*); during 2009--2010, a total of 94.8% of kindergartners had evidence of 2 doses (*148*); and in 2010, a total of 90.5% of adolescents had evidence of 2 doses (*22*). Nationally representative data on MMR vaccine coverage of U.S. HCP are not available.

Measles Transmission and the Costs of Mitigating Measles Exposures in Health-Care Settings

Health-care--associated cases of measles are of public health concern. Because of the severity of measles, infected persons are likely to seek medical care in primary health-care facilities, emergency departments, or hospitals (*141,149,150*). Medical settings played a prominent role in perpetuating outbreaks of measles transmission during the 1989--1991 measles resurgence (*145,146*) and were a primary site of measles transmission in a health-care--associated outbreak in 2008 (*149*). During 2001--2008, a total of 27 reported measles cases were transmitted in U.S. health-care facilities, accounting for 5% of all reported U.S. measles cases.

Because of the greater opportunity for exposure, HCP are at higher risk than the general population for becoming infected with measles. A study conducted in 1996 in medical facilities in a county in Washington state indicated that HCP were 19 times more likely to develop measles than other adults (*151*). During 2001--2008, in the 23 health-care settings in which measles transmission was reported, eight cases occurred among HCP, six (75%) of whom were unvaccinated or had unknown vaccination status. One health-care provider was hospitalized in an intensive care unit for 6 days from severe measles complications (*142*). During a health-care--associated measles outbreak in Arizona in 2008 with 14 cases, six cases were acquired in hospitals, and one was acquired in an outpatient setting. One unvaccinated health-care worker developed measles and infected a hospital emergency room patient who required intensive care following hospital admission for measles (*149*).

High costs also are involved in evaluating and containing exposures and outbreaks in health-care facilities, as well as a substantial disruption of regular hospital routines when control measures are instituted, especially if hospitals do not have readily available data on the measles immunity status of their staff and others included in the facility vaccination program. In 2005 in Indiana, one hospital spent more than $113,000 responding to a measles outbreak (*142*), and in 2008 in Arizona, two hospitals spent $799,136 responding to and containing cases in their facilities (*149*). The Arizona outbreak response required rapid review of measles documentation of 14,844 HCP at seven hospitals and emergency vaccination of approximately 4,500 HCP who lacked documentation of measles immunity. Serologic testing at two hospitals among 1,583 HCP without documented history of vaccination or without documented laboratory evidence of measles immunity revealed that 138 (9%) of these persons lacked measles IgG antibodies (*149*).

Vaccine Effectiveness, Duration of Immunity and Seroprevalence Studies, and Vaccine Safety

Vaccine Effectiveness

MMR vaccine is highly effective in preventing measles with a 1-dose vaccine effectiveness of 95% when administered on or after age 12 months and a 2-dose vaccine effectiveness of 99% (*135*).

Duration of Immunity and Seroprevalence Studies

Two doses of live measles vaccine are considered to provide long-lasting immunity (*135*). Although antibody levels decline following vaccination, a study examining neutralizing antibody levels up to 10 years following the second dose of MMR vaccine in children indicates that antibodies remain above the level considered protective (*152*).

Studies among HCP in the United States during the measles resurgence in the late 1980s through early 1990s demonstrated that 4%--10% of all HCP lacked measles IgG antibodies (*153--156*). During the 2008 Arizona outbreak, of the 1,077 health-care providers born during or after 1957 without documented measles immunity, 121 (11%) were seronegative (*149*). In a study of measles seroprevalence among 469 newly hired HCP at a hospital in North Carolina who were born before 1957, and thus considered immune by age, who could not provide written evidence of immunity to measles, serologic testing indicated that six (1.3%) lacked measles IgG antibodies (*157*). Other serologic studies of hospital-based HCP indicate that 2%--9% of those born before 1957 lacked antibodies to measles (*156,158--160*).

A survey conducted during 1999-- 2004 found a seroprevalence of measles antibodies of 95.9% among persons in the U.S. population aged 6--49 years (*161*). The survey indicated that the lowest prevalence, 92.4%, was among adults born during 1967--1976 (*161*). A 1999 study of U.S. residents aged ≥20 years determined that 93% had antibodies to measles virus (*162*).

Vaccine Safety

Measles vaccine is administered in combination with the mumps and rubella components as the MMR vaccine in the United States. Monovalent measles vaccine rarely has been used in the United States in the past 2 decades and is no longer available. After decades of use, evidence demonstrates that MMR vaccine has an excellent safety profile (*134*).

The majority of documented adverse events occur in children. In rare circumstances, MMR vaccination of adults has been associated with the following adverse events: anaphylaxis (approximately 1.0--3.5 occurrences per million doses administered) (*134*), thrombocytopenia from the measles component or rubella component (a rate of three to four cases for every 100,000 doses) (*134*), and acute arthritis from the rubella component (arthralgia develops among approximately 25% of rubella-susceptible postpubertal females after MMR vaccination, and approximately 10% have acute arthritis-like signs and symptoms) (*135*). When joint symptoms occur, they generally persist for 1 day--3 weeks and rarely recur (*135*). Chronic joint symptoms attributable to the rubella component of the MMR vaccine are reported very rarely, if they occur at all. Evidence does not support an association between MMR vaccination and any of the following: hearing loss, retinopathy, optic neuritis, Guillain-Barré Syndrome, type 1 diabetes, Crohn's disease, or autism (*135,163--169*).

A woman can excrete the rubella vaccine virus in breast milk and transmit the virus to her infant, but the infection remains asymptomatic (*135*). Otherwise, persons who receive MMR or its component vaccines do not transmit measles, rubella, or mumps vaccine viruses (*135*). No transmission of MMR vaccine virus in a health-care setting has been documented.

Recommendations

Vaccination

All persons who work in health-care facilities should have presumptive evidence of immunity to measles. This information should be documented and readily available at the work location. Recently vaccinated HCP do not require any restriction in their work activities.

Presumptive evidence of immunity to measles for persons who work in health-care facilities includes any of the following:

- written documentation of vaccination with 2 doses of live measles or MMR vaccine administered at least 28 days apart,†
- laboratory evidence of immunity,§
- laboratory confirmation of disease, or
- birth before 1957.¶

Prevaccination Testing

Prevaccination antibody screening before MMR vaccination for an employee who does not have adequate presumptive evidence of immunity is not necessary unless the medical facility considers it cost effective (*134,170--172*) although no recent studies have been conducted. For HCP who have 2 documented doses of MMR vaccine or other acceptable evidence of immunity to measles, serologic testing for immunity is not recommended. In the event that a HCP who has 2 documented doses of MMR vaccine is tested serologically and determined to have negative or equivocal measles titer results, it is not recommended that the person receive an additional dose of MMR vaccine. Such persons should be considered to have presumptive evidence of measles immunity. Documented age-appropriate vaccination supersedes the results of subsequent serologic testing. Because rapid vaccination is necessary to halt disease transmission, during outbreaks of measles, serologic screening before vaccination is not recommended.

Use of Vaccine and Immune Globulin for Treating Exposed Persons and Controlling Outbreaks

Following airborne infection--control precautions and implementing other infection-control measures are important to control the spread of measles but might fail to prevent all nosocomial transmission, because transmission to other susceptible persons might occur before illness is recognized. Persons infected with measles are infectious 4 days before rash onset through 4 days after rash onset.

When a person who is suspected of having measles visits a health-care facility, airborne infection--control precautions should be followed stringently. The patient should be asked immediately to wear a medical mask and should be placed in an airborne-infection isolation room (i.e., a negative air-pressure room) as soon as possible. If an airborne-infection isolation room is not available, the patient should be placed in a private room with the door closed and be asked to wear a mask. If possible, only staff with presumptive evidence of immunity should enter the room of a person with suspect or confirmed measles. Regardless of presumptive immunity status, all staff entering the room should use respiratory protection consistent with airborne infection--control precautions (i.e., use of an N95 respirator or a respirator with similar effectiveness in preventing airborne transmission) (*3,150*).

Because of the possibility, albeit low (~1%), of measles vaccine failure in HCP exposed to infected patients (*173*), all HCP should observe airborne precautions in caring for patients with measles. HCP in whom measles occurs should be excluded from work until ≥4 days following rash onset. Contacts with measles-compatible symptoms should be isolated, and appropriate infection-control measures (e.g., rapid vaccination of susceptible contacts) should be implemented to prevent further spread (*174*).

If measles exposures occur in a health-care facility, all contacts should be evaluated immediately for presumptive evidence of measles immunity. HCP without evidence of immunity should be offered the first dose of MMR vaccine and excluded from work from day 5--21 following exposure (*135*). HCP without evidence of immunity who are not vaccinated after exposure should be removed from all patient contact and excluded from the facility from day 5 after their first exposure through day 21 after the last exposure, even if they have received postexposure intramuscular immune globulin of 0.25 mL/kg (40 mg IgG/kg) (*135*). Those with documentation of 1 vaccine dose may remain at work and should receive the second dose.

Case-patient contacts who do not have presumptive evidence of measles immunity should be vaccinated, offered intramuscular immune globulin of 0.25 mL/kg (40 mg IgG/kg), which is the standard dosage for nonimmunocompromised persons (*135*), or quarantined until 21 days after their exposure to the case-patient. Contacts with measles-compatible symptoms should be isolated, and appropriate infection-control measures should be implemented to prevent further spread. If immune globulin is administered to an exposed person, observations should continue for signs and symptoms of measles for 28 days after exposure because immune globulin might prolong the incubation period.

Available data suggest that live virus measles vaccine, if administered within 72 hours of measles exposure, will prevent, or modify disease (*134*). Even if it is too late to provide effective postexposure prophylaxis by administering MMR, the vaccine can provide protection against future exposure to all three infections. Identifying persons who lack evidence of measles immunity during contact investigations provides a good opportunity to offer MMR vaccine to protect against measles as well as mumps and rubella, not only for HCP who are part of an organization's vaccination program, but also for patients and visitors. If an exposed person is already incubating measles, MMR vaccination will not exacerbate symptoms. In these circumstances, persons should be advised that a measles-like illness occurring shortly after vaccination could be attributable either to natural infection or to the vaccine strain. In such circumstances, specimens should be submitted for viral strain identification.

Mumps

Background

Epidemiology and Risk Factors

Mumps is an acute viral infection characterized by fever and inflammation of the salivary glands (usually parotitis) (*175*). The spectrum of illness ranges from subclinical infection (20%--40%) to nonspecific respiratory illness, sialadenitis including classic parotitis, deafness, orchitis, and meningoencephalitis; severity increases with age (*175*). In the prevaccine era, mumps was a common childhood illness, with approximately 186,000 mumps cases reported in the United States per year (*176*). After the introduction of the Jeryl Lynn strain mumps vaccine in 1967 and the implementation of the 1-dose mumps vaccine policy for children in 1977 (*177*), reports of mumps cases in the United States declined 99% (*178*). During 1986--1987, an increase in reported mumps cases occurred, primarily affecting unvaccinated adolescents and young adults. In the late 1980s, sporadic outbreaks continued to occur that affected both unvaccinated and 1-dose vaccinated adolescents and young adults (*178*). In 1989, a second dose of MMR vaccine was recommended nationwide for better measles control among school-aged children (*179*). Historically low rates of mumps followed with only several hundred reported cases per year in the United States during 2000--2005.

In 1998, a national goal to eliminate mumps was set for 2010 (*180*). However, in 2006, a total of 6,584 mumps cases were reported in the United States, the largest U.S. mumps outbreak in nearly 20 years (*181--183*). Whereas overall national mumps incidence was 2.2 per 100,000 population, eight states in the Midwest were the most affected, with 2.5--66.1 cases per 100,000 population (*183*). The highest incidence (31.1 cases per 100,000 population) was among persons aged 18--24 years (e.g., college-aged students), the majority of whom had received 2 doses of mumps-containing vaccine. Of the 4,017 case-patients for whom age and vaccination status were known, 1,786 (44%) were aged ≥25 years (incidence: 7.2 cases per 100,000 persons); of these 1,786 patients, 351 (20%) received at least 2 doses, 444 (25%) received 1 dose, 336 (19%) were unvaccinated, and 655 (37%) had unknown vaccination status.

Since the 2006 resurgence, two additional large U.S. mumps outbreaks have occurred, both during 2009--2010, one among members of a religious community with cases occurring throughout the northeastern United States (*184*) and the other in Guam (*185*); both outbreaks primarily affected children and adolescents in crowded environments who had received 2 doses of vaccine.

Vaccine coverage in the United States is high; in 2010, approximately 91.5% of children aged 19--35 months had received 1 dose of MMR vaccine (*21*); during 2009--2010, a total of 94.8% of kindergartners had evidence of 2 doses (*148*). In 2010, a total of 90.5% of adolescents had evidence of 2 doses (*22*). Nationally representative data on MMR vaccine coverage of U.S. HCP are not available.

Mumps Transmission and the Costs of Mitigating Mumps Exposures in Health-care Settings

Although health-care--associated transmission of mumps is infrequent, it might be underreported because of the high percentage (~20%--40%) of infected persons who might be asymptomatic (*186--189*). In a survey of 9,299 adults in different professions conducted in 1968, before vaccine was used routinely, the rate of mumps acquisition was highest among dentists and HCP, with rates of 18% among dentists and 15% among physicians (37% for pediatricians), compared with 9% among primary and secondary school teachers and 2% among university staff members (*190*).

In the postvaccine era, mumps transmission also has been documented in medical settings (*191--193*). During a Tennessee mumps outbreak during 1986--1987, a total of 17 (12%) of 146 hospitals and three (50%) of six long-term--care facilities reported one or more practices that could contribute to the spread of mumps, including not isolating patients with mumps, assigning susceptible staff to care for patients with mumps, and not immunizing susceptible employees. Health-care--associated transmission resulted in six cases of mumps infections among health-care providers and nine cases of mumps infections among patients (*191*). In Utah in 1994, two health-care providers in a hospital developed mumps after they had contact with an infected patient (*192*). During the 2006 outbreak, one health-care facility in Chicago experienced ongoing mumps transmission lasting 4 weeks (*193*).

During the 2006 multistate U.S. outbreak, 144 (8.5%) of 1,705 adult case-patients in Iowa for whom occupation was known were health-care providers (Iowa Department of Public Health, unpublished data, 2006). Whether transmission occurred from patients, coworkers, or persons in the community is unknown. During the 2009--2010 outbreak in the northeastern region of the United States, seven (0.2%) of the 3,400 case-patients were health-care providers, six of whom likely were infected by patients because they had no other known exposure.

Exposures to mumps in health-care settings also can result in added economic costs because of furlough or reassignment of staff members from patient-care duties or closure of wards (*194*). In 2006, a Kansas hospital spent $98,682 containing a mumps outbreak (*195*). During a mumps outbreak in Chicago in 2006, one health-care facility spent $262,788 controlling the outbreak (*193*).

Vaccine Effectiveness, Duration of Immunity and Seroprevalence Studies, and Vaccine Safety

Vaccine Effectiveness

MMR vaccine has a 1-dose vaccine effectiveness in preventing mumps of 80%--85% (range: 75%--91%) (*175,196--199*) and a 2-dose vaccine effectiveness of 79%--95% (*199--202*). In a study conducted on two Iowa college campuses during the 2006 mumps outbreak among a population that was primarily vaccinated with 2 doses, 2-dose vaccine effectiveness ranged from 79% to 88% (*202*).

Duration of Immunity and Seroprevalence Studies

Mumps antibody levels wane over time following the first or second dose of vaccination (*203,204*), but the correlates of immunity to mumps are poorly understood and the significance of these waning antibody levels is unclear. A study on a university campus in Nebraska in 2006 indicated lower levels of mumps neutralizing antibodies among students who had been vaccinated with a second MMR dose >15 years previously than among those who had been vaccinated 1--5 years previously, but the difference was not statistically significant ($p>0.05$) (*205*). In a 2006 study on a university campus in Kansas, students with mumps were more likely to have received a second dose of MMR vaccine ≥10 years previously than were their roommates without mumps (*206*). However, another 2006 study from an Iowa college campus identified no such association (*202*).

During 1999--2004, national seroprevalence for mumps antibodies for persons aged 6--49 years was 90% (95% confidence interval [CI]: 88.8--91.1) (*207*). In the Nebraska study, 414 (94%) of the 440 participants were seropositive for mumps antibodies (*205*). A study in Kansas in 2006 indicated that 13% of hospital employees lacked antibodies to the mumps virus (*195*). In a recent study on mumps seroprevalence among 381 newly hired health-care personnel at a hospital in North Carolina who were born before 1957 and thus considered immune by age and who could not provide written evidence of immunity to mumps, serologic testing indicated that 14 (3.7%) lacked IgG antibodies to mumps (*157*).

Vaccine Safety

Mumps vaccine is administered in combination with the measles and rubella components as the MMR vaccine in the United States. Monovalent mumps vaccine has rarely been used in the United States in the past 2 decades and is no longer available. After decades of use, evidence demonstrates that MMR vaccine has an excellent safety profile. The most common adverse reactions to the mumps component of the MMR vaccine are parotitis 10--14 days after vaccination and low-grade fever (*175*). On the basis of biologic plausibility, orchitis, arthritis, or sensorineural deafness might rarely follow vaccination (*175*).

The majority of documented adverse events occur in children. In rare circumstances, MMR vaccination of adults has been associated with anaphylaxis (approximately 1.0--3.5 occurrences per million doses administered) (*134*), thrombocytopenia from the measles component or rubella component (rate: three to four cases for every 100,000 doses) (*134*), and acute arthritis from the rubella component (arthralgia develops among approximately 25% of rubella-susceptible postpubertal females after MMR vaccination, and approximately 10% have acute arthritis-like signs and symptoms) (*135*). When joint symptoms occur, they generally persist for 1 day--3 weeks and rarely recur (*135*). Chronic joint symptoms attributable to the rubella component of the MMR vaccine are reported rarely, if they occur at all. Evidence does not support a link between MMR vaccination and hearing loss, retinopathy, optic neuritis, Guillain-Barré Syndrome, type 1 diabetes, Crohn's disease, or autism (*135,163--169*).

A woman can excrete the rubella vaccine virus in breast milk and transmit the virus to her infant, but the infection remains asymptomatic (*135*). Otherwise, persons who receive MMR or its component vaccines do not transmit measles, rubella, or mumps vaccine viruses (*135*). No transmission of MMR vaccine virus in a health-care setting has been documented.

Recommendations

Vaccination

All persons who work in health-care facilities should have presumptive evidence of immunity to mumps. This information should be documented and readily available at the work location. Recently vaccinated HCP do not require any restriction in their work activities.

Presumptive evidence of immunity to mumps for persons who work in health-care facilities includes any of the following:

- written documentation of vaccination with 2 doses of live mumps or MMR vaccine administered at least 28 days apart,**
- laboratory evidence of immunity,††
- laboratory confirmation of disease, or
- birth before 1957.§§

Prevaccination Testing

For HCP who do not have adequate presumptive evidence of mumps immunity, prevaccination antibody screening before MMR vaccination is not necessary (*135,175*). For HCP who have 2 documented doses of MMR vaccine or other acceptable evidence of immunity to mumps, serologic testing for immunity is not recommended. In the event that a health-care provider who has 2 documented doses of MMR vaccine is tested serologically and determined to have negative or equivocal mumps titer results, it is not recommended that the person receive an additional dose of MMR vaccine. Such persons should be considered immune to mumps. Documented age-appropriate vaccination supersedes the results of subsequent serologic testing. Likewise, during outbreaks of mumps, serologic screening before vaccination is not recommended because rapid vaccination is necessary to halt disease transmission.

Controlling Mumps Outbreaks in Health-Care Settings

Placing patients in droplet precautions and implementing other infection-control measures is important to control the spread of mumps but might fail to prevent all nosocomial transmission, because transmission to other susceptible persons might occur before illness is recognized (*208*). When a person suspected of having mumps visits a health-care facility, only HCP with adequate presumptive evidence of immunity should be exposed to the person, and in addition to standard precautions, droplet precautions should be followed. The index case-patient should be isolated, and respiratory precautions (gown and gloves) should be used for patient contact. Negative pressure rooms are not required. The patient should be isolated for 5 days after the onset of parotitis, during which time shedding of virus is likely to occur (*209*).

If mumps exposures occur in a health-care facility, all contacts should be evaluated for evidence of mumps immunity. HCP with no evidence of mumps immunity who are exposed to patients with mumps should be offered the first dose of MMR vaccine as soon as possible, but vaccine can be administered at any interval following exposure; they should be excluded from duty from day 12 after the first unprotected exposure through day 25 after the most recent exposure. HCP with documentation of 1 vaccine dose may remain at work and should receive the second dose. HCP with mumps should be excluded from work for 5 days from the onset of parotitis (*209*).

Antibody response to the mumps component of MMR vaccine generally is believed not to develop soon enough to provide effective prophylaxis after exposure to suspected mumps (*191,210*), but data are insufficient to rule out a prophylactic effect. Nonetheless, the vaccine is not recommended for prophylactic purposes after exposure. However, identifying persons who lack presumptive evidence of mumps immunity during contact investigations provides a good opportunity to offer MMR vaccine to protect against mumps as well as measles and rubella, not only for HCP who are part of an organization's vaccination program, but also for patients and visitors. If an exposed person already is incubating mumps, MMR vaccination will not exacerbate the symptoms. In these circumstances persons should be advised that a mumps-like illness occurring shortly after vaccination is likely to be attributable to natural infection. In such circumstances, specimens should be submitted for viral strain identification to differentiate between vaccine and wild type virus. Immune globulin is not routinely used for postexposure protection from mumps because no evidence exists that it is effective (*135*).

Rubella

Background

Epidemiology and Risk Factors

Rubella (German measles) is a viral disease characterized by rash, low-grade fever, lymphadenopathy, and malaise (*211*). Although rubella is considered a benign disease, transient arthralgia and arthritis are observed commonly in infected adults, particularly among postpubertal females. Chronic arthritis has been reported after rubella infection, but such reports are rare, and evidence of an association is weak (*212*). Other complications that occur infrequently are thrombocytopenia and encephalitis (*211*). Infection is asymptomatic in 25%--50% of cases (*213*). Clinical diagnosis of rubella is unreliable and should not be considered in assessing immune status. Many rash illnesses might mimic rubella infection and many rubella infections are unrecognized. The only reliable evidence of previous rubella infection is the presence of serum rubella IgG antibody (*211*).

Of primary concern are the effects that rubella can have when a pregnant woman becomes infected, especially during the first trimester, which can result in miscarriages, stillbirths, therapeutic abortions, and congenital rubella syndrome (CRS), a constellation of birth defects that often includes blindness, deafness, mental retardation, and congenital heart defects (*211,213*). Postnatal rubella is transmitted through direct or droplet contact from nasopharyngeal secretions. The incubation period ranges from 12 to 23 days (*214,215*). An ill person is most contagious when the rash first appears, but the period of maximal communicability extends from a few days before to 7 days after rash onset (*213*). Rubella is less contagious than measles.

In the prevaccine era, rubella was an endemic disease globally with larger epidemics that occurred; in the United States, rubella epidemics occurred approximately every 7 years (*211*). During the 1964--1965 global rubella epidemic, an estimated 12.5 million cases of rubella occurred in the United States, resulting in approximately 2,000 cases of encephalitis, 11,250 fetal deaths attributable to spontaneous or surgical abortions, 2,100 infants who were stillborn or died soon after birth, and 20,000 infants born with CRS. The economic impact of this epidemic in the United States alone was estimated at $1.5 billion in 1965 dollars ($10 billion in 2010 dollars) (*216*).

After the rubella vaccine was licensed in the United States in 1969, reported rubella cases decreased from 57,686 in 1969 to 12,491 in 1976 (*216*), and CRS cases reported nationwide decreased from 68 in 1970 to 23 in 1976 (*217*). Declines in rubella age-specific incidence occurred in all age groups, including adolescents and adults, but the greatest declines were among children aged <15 years (*216*). During 1977--1978, a resurgence of rubella occurred, primarily among older adolescents and young adults, because the initial vaccination strategy targeted children (*218*). During this resurgence, 62% of reported rubella cases occurred among persons aged >15 years compared with 23% of cases during 1966--1968 (*135*). As a result of the change in the epidemiologic profile of rubella, in 1977, ACIP modified its recommendations to include the vaccination of susceptible postpubertal girls and women. In 1989, a second MMR vaccination dose was recommended in response to large measles outbreaks nationwide (*179*). During 2001--2004, the annual numbers of rubella and CRS cases were extremely low, with 23 reported rubella cases in 2001, a total of 18 in 2002, a total of 7 in 2003, and a total of 9 in 2004 (*219*).

Rubella was declared eliminated from the United States in 2004 (*219,220*). During 2005--2009, a total of 54 cases of rubella were reported; the majority of the cases occurred among persons aged >20 years. Of the reported cases, 23 (43%) were import-associated; only two outbreaks of rubella were reported during this time, and both involved only three cases (CDC, unpublished data, 2009). Since 2005, only four cases of CRS have been reported, with two cases reported in 2009; three (75%) cases were acquired internationally, and the other had an unknown source (CDC, unpublished data, 2009). Rubella importations are expected to continue in the immediate future.

As of September 2011, only three states (i.e., New York, Oklahoma, and Rhode Island) had laws mandating that all hospital personnel have proof of rubella immunity and did not allow for religious or philosophical exemptions (*147*). Additional states had requirements for specific types of facilities or for certain employees within those facilities, but they did not have universal laws mandating proof of rubella immunity for all hospital personnel (*147*).

MMR vaccine coverage in the United States is high; in 2010, an estimated 91.5% of children aged 19--35 months had received 1 dose of MMR vaccine (*21*); during 2009--2010, a total of 94.8% of kindergarteners had evidence of 2 doses (*148*); and in 2010, a total of 90.5% of adolescents had evidence of 2 doses (*22*). Nationally representative data on MMR vaccine coverage of U.S. HCP are not available.

Rubella Transmission and the Costs of Mitigating Rubella Exposures in Health-Care Settings

No documented transmission of rubella to HCP or other hospital staff or patients in U.S. health-care facilities has occurred since elimination was declared. However, in the decades before elimination, rubella transmission was documented in at least 10 U.S. medical settings (*221--231*) and led to outbreaks with

serious consequences, including pregnancy terminations, disruption of hospital routine, absenteeism from work, expensive containment measures, negative publicity, and the threat of litigation (*232*). In these outbreaks, transmission occurred from HCP to susceptible coworkers and patients, as well as from patients to HCP and other patients. No data are available on whether HCP are at increased risk for acquiring rubella compared with other professions.

Vaccine Effectiveness, Duration of Immunity and Seroprevalence Studies, and Vaccine Safety

Vaccine Effectiveness

Vaccine effectiveness of the RA 27/3 rubella vaccine against clinical rubella is 95% (85%--99% CI) and >99% for clinical laboratory confirmed rubella (*211,233*). Antibody responses to rubella as part of MMR vaccine are equal (i.e., >99%) to those seen after the single-antigen RA 27/3 rubella vaccine (*211,234*).

Duration of Immunity and Seroprevalence Studies

In clinical trials, 97%--99% of susceptible persons who received a single dose of the RA 27/3 rubella vaccine when they were aged ≥12 months developed antibody (*211,235,236*). Two studies have demonstrated that vaccine-induced rubella antibodies might wane after 12--15 years (*237,238*); however, rubella surveillance data do not indicate that rubella and CRS are increasing among vaccinated persons.

National seroprevalence for rubella antibodies among persons aged 6--49 years during 1999--2004 was 91% (*239*). During 1986--1990, serologic surveys in one hospital indicated that 5% of HCP (including persons born in 1957 or earlier) did not have detectable rubella antibody (*240*). Earlier studies indicated that up to 14%--19% of U.S. hospital personnel, including young women of childbearing age, lacked detectable rubella antibody (*225,241,242*). In a recent study on rubella seroprevalence among 477 newly hired HCP at a hospital in North Carolina who were born before 1957, and thus considered immune by age, who could not provide written evidence of immunity to rubella, serologic testing revealed that 14 (3.1%) lacked detectable levels of antibody to rubella (*157*).

Because of the potential for contact with pregnant women in any type of health-care facility, all HCP should have documented presumptive evidence of immunity to rubella. History of disease is not considered adequate evidence of immunity.

Vaccine Safety

Rubella vaccine is administered in combination with the measles and mumps components as the MMR vaccine in the United States. Monovalent rubella vaccine has been used rarely in the United States in the past 2 decades and is no longer available. After decades of use, evidence demonstrates that MMR vaccine has an excellent safety profile. The most common adverse reactions to the rubella component of the MMR vaccine are transient rashes, which usually appear 7--10 days after vaccination in approximately 5% of vaccinated persons, or transient lymphadenopathy, fever, sore throat, and headache (*135,211*).

The majority of documented adverse events occur in children. In rare circumstances, MMR vaccination of adults has been associated with the following adverse events: anaphylaxis (approximately 1.0--3.5 occurrences per million doses administered) (*134*), thrombocytopenia from the measles component or rubella component (rate: three to four cases for every 100,000 doses) (*134*), and acute arthritis from the rubella component (arthralgia develops among approximately 25% of rubella-susceptible postpubertal females after MMR vaccination, and approximately 10% have acute arthritis-like signs and symptoms from the rubella component of the vaccine) (*135*). When joint symptoms occur, they generally persist for 1 day--3 weeks and rarely recur (*135*). Chronic joint symptoms attributable to the rubella component of the MMR vaccine are very rarely reported, if they occur at all.

As a result of the theoretic risk to the fetus, women should be counseled to avoid becoming pregnant for 28 days after receipt of a rubella-containing vaccine (*243*). However, receipt of rubella-containing vaccine during pregnancy should not be a reason to consider termination of pregnancy; data from 18 years of following to term 321 known rubella-susceptible women who were vaccinated within 3 months before or 3 months after conception indicated that none of the 324 infants born to these mothers had malformations compatible with congenital rubella syndrome, but five had evidence of subclinical rubella infection (*244*). The estimated risk for serious malformations to fetuses attributable to the mother receiving RA 27/3 vaccine is considered to range from zero to 1.6% (*135,244*).

Evidence does not support a link between MMR vaccination and any of the following: hearing loss, retinopathy, optic neuritis, Guillain-Barré Syndrome, type 1 diabetes, Crohn's disease, or autism (*135,163--169*).

A woman can excrete the rubella vaccine virus in breast milk and transmit the virus to her infant, but the infection remains asymptomatic (*135*). Otherwise, persons who receive MMR or its component vaccines do not transmit measles, rubella, or mumps vaccine viruses (*135*). No transmission of MMR vaccine virus in a health-care setting has been documented.

Recommendations

Vaccination

All persons who work in health-care facilities should have presumptive evidence of immunity to rubella. Adequate rubella vaccination for HCP consists of 1 dose of MMR vaccine. However, because of the 2-dose vaccination requirements for measles and mumps, the use of the combined MMR vaccine will result in the majority of HCP receiving 2 doses of rubella-containing vaccine, which should provide an additional safeguard against primary rubella vaccine failure. Recently vaccinated HCP do not require any restriction in their work activities.

Presumptive evidence of immunity to rubella for persons who work in health-care facilities includes any of the following:

- written documentation of vaccination with 1 dose of live rubella or MMR vaccine,
- laboratory evidence of immunity,¶¶
- laboratory confirmation of rubella infection or disease, or
- birth before 1957*** (except women of childbearing potential who could become pregnant, although pregnancy in this age group would be exceedingly rare†††).

Prevaccination Testing

For HCP who do not have adequate presumptive evidence of rubella immunity, prevaccination antibody screening before MMR vaccination is not necessary unless the medical facility considers it cost effective (*135*). For HCP who have 1 documented dose of MMR vaccine or other acceptable evidence of immunity to rubella, serologic testing for immunity is not recommended. In the event that a health-care provider who has at least 1 documented dose of rubella-containing vaccine is tested serologically and determined to have negative or equivocal rubella titer results, receipt of an additional dose of MMR vaccine for prevention of rubella is not recommended. Such persons should be considered immune to rubella. However, if the provider requires a second dose of measles or mumps vaccine, then a second dose of MMR should be administered. Documented age-appropriate vaccination supersedes the results of subsequent serologic testing. Likewise, during outbreaks of rubella, serologic screening before vaccination is not recommended because rapid vaccination is necessary to halt disease transmission.

Controlling Rubella Outbreaks

To prevent transmission of rubella in health-care settings, patients suspected to have rubella should be placed in private rooms. In addition to standard precautions, droplet precautions should be followed until 7 days after onset of symptoms. Room doors can remain open, and special ventilation is not required.

Any exposed HCP who do not have adequate presumptive evidence of rubella immunity should be excluded from duty beginning 7 days after exposure to rubella and continuing through either 1) 23 days after the most recent exposure or 2) 7 days after rash appears if the provider develops rubella (*213--215*). Exposed HCP who do not have adequate presumptive evidence of immunity who are vaccinated postexposure should be excluded from duty for 23 days after the most recent exposure to rubella because no evidence exists that postexposure vaccination is effective in preventing rubella infection (*244*).

Neither rubella-containing vaccine (*244*) nor immune globulin (IG) (*211,244*) is effective for postexposure prophylaxis of rubella. Although intramuscular administration of 20 mL of immune globulin within 72 hours of rubella exposure might reduce the risk for rubella, it will not eliminate the risk (*135,245*); infants with congenital rubella have been born to women who received IG shortly after exposure (*213*). In addition, administration of IG after exposure to rubella might modify or suppress symptoms and create an unwarranted sense of security with respect to transmission.

If exposure to rubella does not cause infection, postexposure vaccination with MMR vaccine should induce protection against subsequent infection of rubella, as well as measles and mumps. If the exposure results in infection, no evidence indicates that administration of MMR vaccine during the presymptomatic or prodromal stage of illness increases the risk for vaccine-associated adverse events (*213*).

Pertussis

Background

Epidemiology and Risk Factors

Pertussis is a highly contagious bacterial infection. Secondary attack rates among susceptible household contacts exceed 80% (*246,247*). Transmission occurs by direct contact with respiratory secretions or large aerosolized droplets from the respiratory tract of infected persons. The incubation period is generally 7--10 days but can be as long as 21 days. The period of communicability starts with the onset of the catarrhal stage and extends into the paroxysmal stage. Symptoms of early pertussis (catarrhal phase) are indistinguishable from other upper respiratory infections.

Vaccinated adolescents and adults, whose immunity from childhood vaccinations wanes 5--10 years after the most recent dose of vaccine (usually administered at age 4--6 years), are an important source of pertussis infection for susceptible infants. Infants too young to be vaccinated are at greatest risk for severe pertussis, including hospitalization and death. The disease can be transmitted from adults to close contacts, especially unvaccinated children.

Vaccination coverage among infants and children for diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine remains high. In 2010, coverage for children aged 19--35 months who have received ≥4 doses of DTaP/diphtheria and tetanus toxoids and pertussis vaccine (DTP)/diphtheria and tetanus toxoids vaccine (DT) was 84% (*21*). Among children entering kindergarten for the 2009--2010 school year, DTaP coverage was 93% (*148*). Vaccination coverage for tetanus toxoid, reduced diphtheria toxoid and acellular pertussis (Tdap) vaccine was 68.7% among adolescents in 2010 and <7% among adults in 2009 (*22,248*). Tdap vaccination coverage among HCP was 17.0% in 2009 (*248*).

Disease in Health-Care Settings and Impact on Health-Care Personnel and Patients

In hospital settings, transmission of pertussis has occurred from hospital visitors to patients, from HCP to patients, and from patients to HCP (*249--252*). Although of limited size (range: 2--17 patients and 5--13 staff), documented outbreaks were costly and disruptive. In each outbreak, HCP were evaluated for cough illness and required diagnostic testing, prophylactic antibiotics, and exclusion from work.

During outbreaks that occur in hospitals, the risk for contracting pertussis among patients or staff is often difficult to quantify because exposure is not well defined. Serologic studies conducted among hospital staff indicate that exposure to pertussis is much more frequent than suggested by attack rates of clinical disease (*246,249--254*). In one outbreak, seroprevalence of pertussis agglutinating antibodies among HCP correlated with the degree of patient contact and was highest among pediatric house staff (82%) and ward nurses (71%) and lowest among nurses with administrative responsibilities (35%) (*251*).

A model to estimate the cost of vaccinating HCP and the net return from preventing nosocomial pertussis was constructed using probabilistic methods and a hypothetical cohort of 1,000 HCP with direct patient contact followed for 10 years (*255*). Baseline assumptions, determined from data in the literature, included incidence of pertussis in HCP, ratio of identified exposures per HCP case, symptomatic percentage of seroconfirmed pertussis infections in HCP, cost of infection-control measures per exposed person, vaccine efficacy, vaccine coverage, employment turnover rate, adverse events, and cost of vaccine (*255*). In a 10-year period, the cost of infection control would be $388,000 without Tdap vaccination of HCP compared with $69,000 with such a program (*255*). Introduction of a vaccination program would result in a net savings as high as $535,000 and a benefit-cost ratio of 2.38 (i.e., for every dollar spent on the vaccination program, the hospital would save $2.38 on control measures) (*255*).

Vaccine Effectiveness, Duration of Immunity, and Vaccine Safety

A prelicensure immunogenicity and safety study in adolescents and adults of a vaccine containing acellular pertussis estimated vaccine efficacy to be 92% (*256*). Recent postlicensure studies of Tdap demonstrate vaccine effectiveness at 78% and 66% (*257,258*). Duration of immunity from vaccination has yet to be evaluated. Data from pre- and postlicensure studies support the safety of Tdap in adolescents and adults (*259--263*).

Since the 2005 Tdap recommendations for HCP, one study tried to determine if postexposure prophylaxis following pertussis exposure was necessary for Tdap-vaccinated HCP (*264*). During the study period, 116 exposures occurred among 94 HCP. Pertussis infection occurred in 2% of those who received postexposure prophylaxis compared with 10% of those who did not, suggesting a possible benefit of postexposure prophylaxis among Tdap-vaccinated HCP (*264*). Because Tdap coverage is suboptimal among HCP, and the duration of protection afforded by Tdap is unknown, vaccination status does not change the approach to evaluate the need for postexposure prophylaxis in exposed HCP. Postexposure prophylaxis is necessary for HCP in contact with persons at risk for severe disease. Other HCP either should receive postexposure prophylaxis or be monitored for 21 days after pertussis exposure and treated at the onset of signs and symptoms of pertussis. Recommended postexposure prophylaxis antibiotics for HCP exposed to pertussis include azithromycin, clarithroymycin, or erythromycin. HCP are not at greater risk for diphtheria or tetanus than the general population.

Recommendations

Vaccination

Regardless of age, HCP should receive a single dose of Tdap as soon as feasible if they have not previously received Tdap and regardless of the time since their most recent Td vaccination. Vaccinating HCP with Tdap will protect them against pertussis and is expected to reduce transmission to patients, other HCP, household members, and persons in the community. Tdap is not licensed for multiple administrations; therefore, after receipt of Tdap, HCP should receive Td for future booster vaccination against tetanus and diphtheria. Hospitals and ambulatory-care facilities should provide Tdap for HCP and use approaches that maximize vaccination rates (e.g., education about the benefits of vaccination, convenient access, and the provision of Tdap at no charge).

Prevaccination Testing

Prevaccination serologic testing is not recommended.

Demonstrating Immunity

Immunity cannot be demonstrated through serologic testing because serologic correlates of protection are not well established.

Controlling Pertussis Outbreaks in Health-Care Settings

Prevention of pertussis transmission in health-care settings involves diagnosis and early treatment of clinical cases, droplet isolation of infectious patients who are hospitalized, exclusion from work of HCP who are infectious, and postexposure prophylaxis. Early diagnosis of pertussis, before secondary transmission occurs, is difficult because the disease is highly communicable during the catarrhal stage, when symptoms are still nonspecific. Pertussis should be considered in the differential diagnoses for any patient with an acute cough illness with severe or prolonged paroxysmal cough, particularly if characterized by posttussive vomiting, whoop, or apnea. Nasopharyngeal specimens should be taken, if possible, from the posterior nasopharynx with a calcium alginate or Dacron swab for cultures and/or polymerase chain reaction (PCR) assay.

Health-care facilities should maximize efforts to prevent transmission of *Bordetella pertussis*. Precautions to prevent respiratory droplet transmission or spread by close or direct contact should be employed in the care of patients admitted to hospital with suspected or confirmed pertussis (*265*). These precautions should remain in effect until patients are improved clinically and have completed at least 5 days of appropriate antimicrobial therapy. HCP in whom symptoms (i.e., unexplained rhinitis or acute cough) develop after known pertussis exposure might be at risk for transmitting pertussis and should be excluded from work until 5 days after the start of appropriate therapy (*3*).

Data on the need for postexposure prophylaxis in Tdap-vaccinated HCP are inconclusive (*264*). Certain vaccinated HCP are still at risk for *B. pertussis*. Tdap might not preclude the need for postexposure prophylaxis. Postexposure antimicrobial prophylaxis is recommended for all HCP who have unprotected exposure to pertussis and are likely to expose a patient at risk for severe pertussis (e.g., hospitalized neonates and pregnant women). Other HCP should either receive postexposure antimicrobial prophylaxis or be monitored daily for 21 days after pertussis exposure and treated at the onset of signs and symptoms of pertussis.

Varicella

Background

Epidemiology and Risk Factors

Varicella is a highly infectious disease caused by primary infection with varicella-zoster virus (VZV). VZV is transmitted from person to person by direct contact, inhalation of aerosols from vesicular fluid of skin lesions of varicella or herpes zoster (HZ), a localized, generally painful vesicular rash commonly called shingles, or infected respiratory tract secretions that also might be aerosolized (*266*). The average incubation period is 14--16 days after exposure to rash (range: 10--21 days). Infected persons are contagious an estimated 1--2 days before rash onset until all lesions are crusted, typically 4--7 days after rash onset (*266*). Varicella secondary attack rates can reach 90% among susceptible contacts. Typically, primary infection with VZV results in lifetime immunity. VZV remains dormant in sensory-nerve ganglia and can reactivate at a later time, causing HZ. Before the U.S. childhood varicella vaccination program began in 1995, approximately 90% of varicella disease occurred among children aged <15 years (*266*). During 1997--2009, national varicella vaccine coverage among children aged 19--35 months increased from 27% to 90%, leading to dramatic declines of >85% in varicella incidence, hospitalizations, and deaths (*267--269*). The decline in disease incidence was greatest among children for whom vaccination was recommended; however, declines occurred in every age group including infants too young to be vaccinated and adults, indicating reduced communitywide transmission of VZV.

Current incidence of varicella among adults is low (<0.1/1,000 population), and adult cases represent <10% of all reported varicella cases (*270*). National seroprevalence data from 1999--2004 demonstrated that, in the early vaccine era, adults continued to have high immunity to varicella (*271*). In this study, 98% of persons aged 20--49 years had VZV-specific IgG antibodies. However, with declining likelihood of exposure to VZV, children and adolescents who did not receive 2 doses of varicella vaccine could remain susceptible to VZV infection as they age into adulthood, when varicella can be more severe.

The clinical presentation of varicella has changed since the implementation of the varicella vaccination program, with more than half of varicella cases reported in 2008 occurring among persons who were vaccinated previously, the majority of them children. Varicella disease in vaccinated children (breakthrough varicella) usually has a modified or atypical presentation; the rash is typically mild, with <50 lesions that are more likely to be predominantly maculopapular than vesicular (*266*). Fever is less common, and the duration of illness is shorter. Nevertheless, breakthrough varicella is infectious. One study indicated that vaccinated children with varicella with <50 lesions were only one third as infectious as unvaccinated children whereas those with ≥50 lesions were as infectious as unvaccinated children (*272*). Because the majority of adults are immune and few need vaccination, fewer breakthrough cases have been reported among adults than among children, and breakthrough varicella in adults has tended to be milder than varicella in unvaccinated adults (*273,274*).

The epidemiology of varicella in tropical and subtropical regions differs from that in the United States. In these regions, a higher proportion of VZV infections are acquired later in life. Persons emigrating from these regions might be more likely to be susceptible to varicella compared to U.S.-born persons and, therefore, are at a higher risk for developing varicella if unvaccinated and exposed (*275,276*).

Disease in Health-Care Settings and Impact on Health-Care Personnel and Patients

Although relatively rare in the United States since introduction of varicella vaccine, nosocomial transmission of VZV is well recognized and can be life-threatening to certain patients (*277--289*). In addition to hospital settings, nosocomial VZV transmission has been reported in long-term--care facilities and a hospital-associated residential facility (*290,291*). Sources of nosocomial exposure that have resulted in transmission include patients, HCP, and visitors with either varicella or HZ. Both localized and disseminated HZ in immunocompetent as well as immunocompromised patients have been identified as sources of nosocomial transmission of VZV. Localized HZ has been demonstrated to be much less infectious than varicella; disseminated HZ is considered to be as infectious as varicella (*266*). Nosocomial transmission has been attributed to delays in the diagnosis or reporting of varicella or HZ and in failures to implement control measures promptly. In hospitals and other health-care settings, airborne transmission of VZV from patients with either varicella or HZ has resulted in varicella in HCP and patients who had no direct contact with the index case-patient (*284--288,291*). Although all susceptible patients in health-care settings are at risk for severe varicella disease with complications, certain patients without evidence of immunity are at increased risk: pregnant women, premature infants born to susceptible mothers, infants born at <28 weeks' gestation or who weigh ≤1,000 grams regardless of maternal immune status, and immunocompromised persons of all ages (including persons who are undergoing immunosuppressive therapy, have malignant disease, or are immunodeficient).

VZV exposures among patients and HCP can be disruptive to patient care, time-consuming, and costly even when they do not result in VZV transmission (*281,282,292*). Studies of VZV exposure in health-care settings have documented that a single provider with unrecognized varicella can result in the exposure of >30 patients and >30 employees (*292*). Identification of susceptible patients and staff, medical management of susceptible exposed patients at risk for complications of varicella, and furloughing of susceptible exposed HCP are time-consuming and costly (*281,282*).

With the overall reduction in varicella disease attributable to the success of the vaccination program, the risk for exposure to VZV from varicella cases in health-care settings is likely declining. In addition, an increasing proportion of varicella cases occur in vaccinated persons who are less contagious. Diagnosis

of varicella has become increasingly challenging as a growing proportion of cases occur in vaccinated persons in whom disease is mild, and HCP encounter patients with varicella less frequently. Although not currently routinely recommended for the diagnosis and management of varicella, laboratory testing of suspected varicella cases is likely to become increasingly useful in health-care settings, especially as the positive predictive value of clinical diagnosis declines.

Vaccine Effectiveness, Duration of Immunity, and Vaccine Safety

Vaccine Effectiveness

Formal studies to evaluate vaccine efficacy or effectiveness have not been performed among adults. Studies of varicella vaccine effectiveness performed among children indicated good performance of 1 dose for prevention of all varicella (80%--85%) and >95% effectiveness for prevention of moderate and severe disease (*266*,*293*). Studies have indicated that a second dose among children produces an improved humoral and cellular immune response that correlates with improved protection against disease (*266*,*294*).

Varicella vaccine effectiveness is expected to be lower in adults than in children. Adolescents and adults require 2 doses to achieve seroconversion rates similar to those seen in children after 1 dose (*266*). A study of adults who received 2 doses of varicella vaccine 4 or 8 weeks apart and were exposed subsequently to varicella in the household estimated an 80% reduction in the expected number of cases (*295*).

Duration of Immunity

Serologic correlates of protection against varicella using commercially available assays have not been established for adults (*266*). In clinical studies, detectable antibody levels have persisted for at least 5 years in 97% of adolescents and adults who were administered 2 doses of varicella vaccine 4--8 weeks apart, but boosts in antibody levels were observed following exposures to varicella, which could account for the long-term persistence of antibodies after vaccination in these studies (*295*). Studies have demonstrated that whereas 25%--31% of adult vaccine recipients who seroconverted lost detectable antibodies 1--11 years after vaccination (*273*,*296*), vaccine-induced VZV-specific T-cell proliferation (marker for cell-mediated immunity [CMI]) was maintained in 94% of adults 1 and 5 years postvaccination (*297*). Disease was mild in vaccinated persons who developed varicella after exposure to VZV, even among vaccinees who did not seroconvert or who lost detectable antibody (*273*,*274*). Severity of illness and attack rates among vaccinated adults did not increase over time. These studies suggest that VZV-specific CMI affords protection to vaccinated adults, even in the absence of detectable antibody response.

Vaccine Safety

The varicella vaccine has an excellent safety profile. In clinical trials, the most common adverse events among adolescents and adults were injection-site complaints (24.4% after the first dose and 32.5% after the second dose) (*266*,*295*). Varicella-like rash at the injection site occurred in 3% of vaccine recipients after the first dose and in 1% after the second. A nonlocalized rash occurred in 5.5% of vaccine recipients after the first dose and in 0.9% after the second, with a median number of lesions of five, at a peak of 7--21 and 0--23 days postvaccination, respectively (*295*). Data on serious adverse events among adults after varicella vaccination are limited, but the proportion of serious adverse events among all adverse events reported to the Vaccine Adverse Events Reporting System during 1995--2005 was low (5%) among both children and adults (*298*). Serious adverse events reported among children included pneumonia, hepatitis, HZ (some hospitalized), meningitis with HZ, ataxia, encephalitis, thrombocytopenic purpura. Not all adverse events reported after varicella vaccination have been laboratory confirmed to be attributable to the vaccine strain VZV (*266*,*298*).

Risk for transmission of vaccine virus was assessed in placebo recipients who were siblings of vaccinated children and among healthy siblings of vaccinated leukemic children (*266*). The findings suggest that transmission of varicella vaccine virus from healthy persons to susceptible contacts is very rare. The risk might be increased in vaccinees in whom a varicella-like rash develops after vaccination. However, this risk is also low. The benefits of vaccinating HCP without evidence of immunity outweigh this extremely low potential risk. Since implementation of the varicella vaccine program, transmission of vaccine virus has been documented from eight persons (all of whom had a rash after vaccination) resulting in nine secondary infections among household and long-term--care facility contacts (*299*). No transmission has been documented from vaccinated HCP.

Recommendations

Vaccination

Health-care institutions should ensure that all HCP have evidence of immunity to varicella. This information should be documented and readily available at the work location. HCP without evidence of immunity to varicella should receive 2 doses of varicella vaccine administered 4--8 weeks apart. If >8 weeks elapse after the first dose, the second dose may be administered without restarting the schedule. Recently vaccinated HCP do not require any restriction in their work activities; however, HCP who develop a vaccine-related rash after vaccination should avoid contact with persons without evidence of immunity to varicella who are at risk for severe disease and complications until all lesions resolve (i.e., are crusted over) or, if they develop lesions that do not crust (macules and papules only), until no new lesions appear within a 24-hour period.

Evidence of immunity for HCP includes any of the following (*266*):

- written documentation of vaccination with 2 doses of varicella vaccine,
- laboratory evidence of immunity§§§ or laboratory confirmation of disease,
- diagnosis or verification of a history of varicella disease by a health-care provider,¶¶¶ or
- diagnosis or verification of a history of HZ by a health-care provider.

In health-care settings, serologic screening before vaccination of personnel without evidence of immunity is likely to be cost effective. Key factors determining cost-effectiveness include sensitivity and specificity of serologic tests, the nosocomial transmission rate, seroprevalence of VZV antibody in the personnel population, and policies for managing vaccine recipients developing postvaccination rash or who are exposed subsequently to VZV. Institutions may elect to test all unvaccinated HCP, regardless of disease history, because a small proportion of persons with a positive history of disease might be susceptible. For the purpose of screening HCP, a less sensitive and more specific commercial ELISA should be considered. The latex agglutination test can produce false-positive results, and HCP who remained unvaccinated because of false test results subsequently contracted varicella (*289*).

Routine testing for varicella immunity after 2 doses of vaccine is not recommended. Available commercial assays are not sensitive enough to detect antibody after vaccination in all instances. Sensitive tests that are not generally available have indicated that 92%--99% of adults develop antibodies after the second dose (*266*). Seroconversion does not always result in full protection against disease and, given the role of CMI for providing long-term protection, absence of antibodies does not necessarily mean susceptibility. Documented receipt of 2 doses of varicella vaccine supersedes results of subsequent serologic testing.

Health-care institutions should establish protocols and recommendations for screening and vaccinating HCP and for management of HCP after exposures in the work place. Institutions also should consider precautions for HCP in whom rash occurs after vaccination, although they should also consider the possibility of wild-type disease in HCP with recent exposure to varicella or HZ.

A vaccine to prevent HZ is available and recommended for all persons aged ≥60 years without contraindications to vaccination. HZ vaccine is not indicated for HCP for the prevention of nosocomial transmission, but HCP aged ≥60 years may receive the vaccine on the basis of the general recommendation for HZ vaccination, to reduce their individual risk for HZ.

Varicella Control Strategies

Appropriate measures should be implemented to manage cases and control outbreaks (*300*).

Patient Care

Only HCP with evidence of immunity to varicella should care for patients who have confirmed or suspected varicella or HZ. Airborne precautions (i.e., negative air-flow rooms) and contact precautions should be employed for all patients with varicella or disseminated HZ and for immunocompromised patients with localized HZ until disseminated infection is ruled out. These precautions should be kept in place until lesions are dry and crusted. If negative air-flow rooms are not available, patients should be isolated in closed rooms and should not have contact with persons without evidence of immunity to varicella. For immunocompetent persons with localized HZ, standard precautions and complete covering of the lesions are recommended.

Postexposure Management of HCP and Patients

Exposure to VZV is defined as close contact with an infectious person, such as close indoor contact (e.g., in the same room) or face-to-face contact. Experts differ regarding the duration of contact; some suggest 5 minutes, and others up to 1 hour; all agree that it does not include transitory contact (*301*).

All exposed, susceptible patients and HCP should be identified using the criteria for evidence of immunity. An additional criterion of evidence of immunity only for patients who are not immunocompromised or pregnant is birth in the United States before 1980. Postexposure prophylaxis with vaccination or varicella-zoster immunoglobulin, depending on immune status, of exposed HCP and patients without evidence of immunity is recommended (*266*).

HCP who have received 2 doses of vaccine and who are exposed to VZV (varicella, disseminated HZ, and uncovered lesions of a localized HZ) should be monitored daily during days 8--21 after exposure for fever, skin lesions, and systemic symptoms suggestive of varicella. HCP can be monitored directly by occupational health program or infection-control practitioners or instructed to report fever, headache, or other constitutional symptoms and any atypical skin lesions immediately. HCP should be excluded from a work facility immediately if symptoms occur. HCP who have received 1 dose of vaccine and who are exposed to VZV (varicella, disseminated HZ, and uncovered lesions of a localized HZ) (in the community or health-care setting/workplace) should receive the second dose within 3--5 days after exposure to rash (provided 4 weeks have elapsed after the first dose). After vaccination, management is similar to that of 2-dose vaccine recipients. Those who did not receive a second dose or who received the second dose >5 days after exposure should be excluded from work for 8--21 days after exposure.

Unvaccinated HCP who have no other evidence of immunity who are exposed to VZV (varicella, disseminated HZ, and uncovered lesions of a localized HZ) are potentially infective from days 8--21 after exposure and should be furloughed during this period. They should receive postexposure vaccination as soon as possible. Vaccination within 3--5 days of exposure to rash might modify the disease if infection occurred. Vaccination >5 days postexposure is still indicated because it induces protection against subsequent exposures (if the current exposure did not cause infection). For HCP at risk for severe disease for whom varicella vaccination is contraindicated (e.g., pregnant or immunocomprosed HCP), varicella-zoster immune globulin after exposure is recommended. The varicella-zoster immune globulin product currently used in the United States, VariZIG (Cangene Corporation, Winnipeg, Canada), is available under an Investigational New Drug Application Expanded Access protocol; a sample release form is available at http://www.fda.gov/downloads/BiologicsBloodVaccines/SafetyAvailability/UCM176031.pdf. Varicella-zoster immune globulin might prolong the incubation period by a week, thus extending the time during which personnel should not work from 21 to 28 days. In case of an outbreak, HCP without evidence of immunity who have contraindications to vaccination should be excluded from the outbreak setting through 21 days after rash onset of the last identified case-patient because of the risk for severe disease in these groups. If the VZV exposure was to localized HZ with covered lesions, no work restrictions are needed if the exposed HCP had previously received at least 1 dose of vaccine or received the first dose within 3--5 days postexposure. A second dose should be administered at the appropriate interval. HCP should be monitored daily during days 8--21 after exposure for fever, skin lesions, and systemic symptoms suggestive of varicella and excluded from a work facility if symptoms occur. If at least 1 dose was not received, restriction from patient contact is recommended.

Diseases for Which Vaccination Might Be Indicated in Certain Circumstances

Health-care facilities and other organizations should consider including in their vaccination programs vaccines to prevent meningococcal disease, typhoid fever, and polio for HCP who have certain health conditions or who work in laboratories or regions outside the United States where the risk for work-related exposure exists.

Meningococcal Disease

Background

Epidemiology and Risk Factors

Meningococcal disease is rare among adults in the United States and incidence has decreased to historic lows; during 1998--2007 the average annual incidence of meningococcal disease was 0.28 (range: 0.26--0.31) cases per 100,000 population among persons aged 25--64 years (*302*).

Routine vaccination with meningococcal conjugate vaccine is recommended by ACIP for adolescents aged 11--18 years, with the primary dose at age 11--12 years and the booster dose at age 16 years. In 2010, coverage with meningococcal conjugate vaccine among persons aged 13--17 years was 62.7% (*22*).

Nosocomial transmission of *Neisseria meningitidis* is rare, but HCP have become infected after direct contact with respiratory secretions of infected persons (e.g., managing of an airway during resuscitation) and in a laboratory setting. HCP can decrease the risk for infection by adhering to precautions to prevent exposure to respiratory droplets (*303,304*) and by taking antimicrobial chemoprophylaxis if exposed directly to respiratory secretions.

Vaccine Effectiveness, Duration of Immunity, and Vaccine Safety

Two quadrivalent (A, C, W-135, Y) conjugate meningococcal vaccines (MCV4) are licensed for persons aged through 55 years (*305,306*). Both protect against two of the three serogroups that cause the majority of meningococcal disease in the United States and against 75% of disease among adults. Available data indicate that the majority of persons do not have enough circulating functional antibody to be protected ≥5 years after a single dose of MCV4. Both vaccines had similar safety profiles in clinical trials. Quadrivalent (A, C, W-135, Y) meningococcal polysaccharide vaccine (MPSV4) is available for use in persons aged >55 years. No vaccine for serogroup B meningococcal disease is licensed in the United States.

Recommendations

Vaccination

MCV4 is not recommended routinely for all HCP.

HCP Recommended to Receive Vaccine to Prevent Meningococcal Disease

A 2-dose vaccine series is recommended for HCP with known asplenia or persistent complement component deficiencies, because these conditions increase the risk for meningococcal disease. HCP traveling to countries in which meningococcal disease is hyperendemic or epidemic also are at increased risk for

infection and should receive vaccine. Those with known asplenia or persistent complement component deficiencies should receive a 2-dose vaccine series. All other HCP traveling to work to 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. meningitides* should receive a single dose of MCV4 and receive a booster dose every 5 years if they remain at increased risk. Health-care personnel aged >55 years who have any of the above risk factors for meningococcal disease should be vaccinated with MPSV4 (*305*).

HCP Who May Elect to Receive Vaccine to Prevent Meningococcal Disease

HCP with known HIV infection are likely at increased risk for meningococcal disease and may elect vaccination. If these HCP are vaccinated, they should receive a 2-dose vaccine series (*307*).

Booster Doses

HCP who receive the 2-dose MCV4 vaccine series and/or remain in a group at increased risk should receive a booster dose every 5 years (*306*).

Postexposure Management of Exposed HCP

Postexposure prophylaxis is advised for all persons who have had intensive, unprotected contact (i.e., without wearing a mask) with infected patients (e.g., via mouth-to-mouth resuscitation, endotracheal intubation, or endotracheal tube management), including HCP who have been vaccinated with either the conjugate or polysaccharide vaccine (*3*).

Antimicrobial prophylaxis can eradicate carriage of *N. meningitidis* and prevent infections in persons who have unprotected exposure to patients with meningococcal infections (*305*). Rifampin, ciprofloxacin, and ceftriaxone are effective in eradicating nasopharyngeal carriage of *N. meningitidis*. In areas of the United States where ciprofloxacin-resistant strains of *N. meningitidis* have been detected (as of August 30, 2011, only parts of Minnesota and North Dakota), ciprofloxacin should not be used for chemoprophylaxis (*308*). Azithromycin can be used as an alternative. Ceftriaxone can be used during pregnancy. Postexposure prophylaxis should be administered within 24 hours of exposure when feasible; postexposure prophylaxis administered >14 days after exposure is of limited or no value (*305*). HCP not otherwise indicated for vaccination may be recommended to be vaccinated with meningococcal vaccine in the setting of a community or institutional outbreak of meningococcal disease caused by a serogroup contained in the vaccine.

Typhoid Fever

Background

Epidemiology and Risk Factors

The incidence of typhoid fever declined steadily in the United States during 1900--1960 and has since remained low. During 1999--2006, on average, 237 cases were reported annually to the National Typhoid and Paratyphoid Fever Surveillance System (*309*). The median age of patients was 22 years and 54% were male; 79% reported foreign travel during the 30 days before onset of symptoms. Among international travelers, the risk for *Salmonella* Typhi infection appears to be highest for those who visit friends and relatives in countries in which typhoid fever is endemic and for those who visit (even for a short time) the most highly endemic areas (e.g., the Indian subcontinent) (*310*).

Increasing resistance to fluoroquinolones such as ciprofloxacin, which are used to treat multidrug-resistant. *S.* Typhi, has been seen particularly among travelers to south and southeast Asia (*311*). Isolates with decreased susceptibility to ciprofloxacin (DCS) do not qualify as resistant according to current Clinical and Laboratory Standards Institute criteria but are associated with poorer clinical outcomes (*311,312*). Resistance to nalidixic acid, a quinolone, is a marker for DCS and increased from 19% in 1999 to 59% in 2008 (*313*). Nine isolates resistant to ciprofloxacin also were seen during this time period (*313*).

Although overall *S.* Typhi infections have declined in the United States, increased incidence and antimicrobial resistance including resistance to fluoroquinolones have been seen for paratyphoid fever caused by Paratyphi A (*314*). No vaccines that protect against Paratyphi A infection are available.

Transmission and Exposure in Health-Care Settings

During 1985--1994, seven cases of laboratory-acquired typhoid fever were reported among persons working in microbiology laboratories, only one of whom had been vaccinated (*315*). Additionally, *S.* Typhi might be transmitted nosocomially via the hands of infected persons (*315*).

Vaccine Effectiveness, Duration of Immunity, and Vaccine Safety

Two typhoid vaccines are distributed in the United States: oral live-attenuated Ty21a vaccine (one enteric-coated capsule taken on alternate days for a total of four capsules) and the capsular polysaccharide parenteral vaccine (1 0.5 mL intramuscular dose). Both vaccines protect 50%--80% of recipients. To maintain immunity, booster doses of the oral vaccine are required every 5 years, and booster doses of the injected vaccine are required every 2 years. Complication rates are low for both types of *S.* Typhi vaccines. During 1994--1999, serious adverse events requiring hospitalization occurred in an estimated 0.47 to 1.3 per 100,000 doses, and no deaths occurred (*310*). However, live-attenuated Ty21a vaccine should not be used among immunocompromised persons, including those infected with HIV (*316*). Theoretic concerns have been raised about the immunogenicity of live, attenuated Ty21a vaccine in persons concurrently receiving antimicrobials (including antimalarial chemoprophylaxis), viral vaccines, or immune globulin (*317*). A third type of vaccine, a parenteral heat-inactivated vaccine associated with higher reactogenicity, was discontinued in 2000 (*310,318*).

Recommendations

Vaccination

Microbiologists and others who work frequently with *S.* Typhi should be vaccinated with either of the two licensed and available vaccines. Booster vaccinations should be administered on schedule according to the manufacturers' recommendations.

Controlling the Spread of Typhoid Fever

Personal hygiene, particularly hand hygiene before and after all patient contacts, will minimize risk for transmitting enteric pathogens to patients. However, HCP who contract an acute diarrheal illness accompanied by fever, cramps, or bloody stools are likely to excrete substantial numbers of infective organisms in their feces. Excluding these HCP from care of patients until the illness has been evaluated and treated can prevent transmission (*3*).

Poliomyelitis

Background

Epidemiology and Risk Factors

In the United States, the last indigenously acquired cases of poliomyelitis caused by wild poliovirus occurred in 1979, and the Americas were certified to be free of indigenous wild poliovirus in 1994 (*319,320*). With the complete transition from use of oral poliovirus vaccine (OPV) to inactivated poliovirus vaccine (IPV) in 2000, vaccine-associated paralytic poliomyelitis (VAPP) attributable to OPV also has been eliminated (*321,322*), so the risk for exposure to any live poliovirus in the United States is limited. However, global eradication of poliomyelitis has not yet occurred, so reintroductions of poliovirus into the United

States are possible. Two cases of paralytic polio from vaccine-derived poliovirus have occurred since 2000 (one imported case in 2005 and one case in an immunodeficient person in 2008), and evidence of limited circulating vaccine-derived poliovirus in an undervaccinated community was documented in 2005 (*323--325*).

Transmission and Exposure in Health-Care Settings

Poliovirus can be recovered from infected persons, including from pharyngeal specimens, feces, urine, and (rarely) cerebrospinal fluid. HCP and laboratory workers might be exposed if they come into close contact with infected persons (e.g., travelers returning from areas where polio is endemic) or with specimens that contain poliovirus.

Vaccine Effectiveness, Duration of Immunity, and Vaccine Safety

Both IPV and OPV are highly immunogenic and effective when administered according to their schedules. In studies conducted in the United States, 3 doses of IPV resulted in 100% serocoversion for types 2 and 3 poliovirus and 96%--100% for type 1 (*326*). Immunity is prolonged and might be lifelong. IPV is well tolerated, and no serious adverse events have been associated with its use. IPV is an inactivated vaccine and does not cause VAPP. IPV is contraindicated in persons with a history of hypersensitivity to any component of the vaccine, including 2-phenoxyethanol, formaldehyde, neomycin, streptomycin, and polymyxin B. OPV is no longer available in the United States.

Recommendations

Vaccination

Because the majority of adults born in the United States are likely immune to polio as a result of vaccination during childhood, poliovirus vaccine is not routinely recommended for persons aged ≥18 years. The childhood recommendation for poliovirus vaccine consists of 4 doses at ages 2, 4, and 6--18 months and 4--6 years.

However, vaccination is recommended for HCP who are at greater risk for exposure to polioviruses than the general population, including laboratory workers who handle specimens that might contain polioviruses and HCP who have close contact with patients who might be excreting wild polioviruses, including HCP who travel to work in areas where polioviruses are circulating.

Unvaccinated HCP should receive a 3-dose series of IPV, with dose 2 administered 4--8 weeks after dose 1, and dose 3 administered 6--12 months after dose 2. HCP who have previously completed a routine series of poliovirus vaccine and who are at increased risk can receive a lifetime booster dose of IPV if they remain at increased risk for exposure. Available data do not indicate the need for more than a single lifetime booster dose with IPV for adults.

Controlling the Spread of Poliovirus

Standard precautions always should be practiced when handling biologic specimens. Suspect cases require an immediate investigation including collection of appropriate laboratory specimens and control measures. All suspect or confirmed cases should be reported immediately to the local or state health department.

Other Vaccines Recommended for Adults

Certain vaccines are recommended for adults based on age or other individual risk factors but not because of occupational exposure (*327*). Vaccine-specific ACIP recommendations should be consulted for details on schedules, indications, contraindications, and precautions for these vaccines.

- **Pneumococcal polysaccharide vaccine (PPSV).** PPSV is recommended for healthy persons aged ≥65 years. PPSV is also recommended for persons aged <65 years with certain underlying medical conditions, including anatomic or functional asplenia, immunocompromise (including HIV infection), chronic lung, heart or kidney disease, and diabetes.
- **Tetanus and diphtheria toxoids (Td).** All adults should have documentation of having received an age-appropriate series of Td-containing vaccine and a routine booster dose every 10 years. Persons without documentation of having received a Td series should receive a 3-dose series. The first dose of the series should be administered as Tdap (see Pertussis).
- **Human papillomavirus (HPV) vaccine.** Either quadrivalent HPV vaccine (Gardasil) or bivalent HPV vaccine (Cervarix) is recommended for females at age 11 or 12 years with catch-up vaccination recommended through age 26 years. Quadrivalent HPV vaccine (Gardasil) may be administered to males aged 9--26 years.
- **Zoster vaccine.** Zoster vaccine contains the same live attenuated varicella zoster virus as varicella vaccine but at a higher concentration (approximately 14 times more vaccine virus per dose). Zoster vaccine is recommended for the prevention of HZ (shingles) in persons aged ≥60 years. Transmission of vaccine virus from the recipient to a contact has not been reported. Consequently, limiting or restricting work activities for persons who recently received zoster vaccine is not necessary.
- **Hepatitis A vaccine.** HCP have not been demonstrated to be at increased risk for hepatitis A virus infection because of occupational exposure, including persons exposed to sewage. Hepatitis A vaccine is recommended for person with chronic liver disease, international travelers, and certain other groups at increased risk for exposure to hepatitis A.

Catch-Up and Travel Vaccination

Catch-Up Programs

Managers of health-care facilities should implement catch-up vaccination programs for HCP who already are employed, in addition to developing policies for achieving high vaccination coverage among newly hired HCP. HCP vaccination records could be reviewed annually during the influenza vaccination season or concurrent with annual TB testing. This strategy could help prevent outbreaks of vaccine-preventable diseases. Because education, especially when combined with other interventions such as reminder/recall systems and low or no out-of-pocket costs, enhances the success of many vaccination programs, informational materials should be available to assist in answering questions from HCP regarding the diseases, vaccines, and toxoids as well as the program or policy being implemented (*120*,*328*). Conducting educational workshops or seminars several weeks before the initiation of a catch-up vaccination program might promote acceptance of program goals.

Travel

Hospital personnel and other HCP who perform research or health-care work in foreign countries might be at increased risk for acquiring certain diseases that can be prevented by vaccines recommended in the United States (e.g., hepatitis B, influenza, MMR, Tdap, poliovirus, varicella, and meningococcal vaccines) and travel-related vaccines (e.g., hepatitis A, Japanese encephalitis, rabies, typhoid, or yellow fever vaccines) (*329*). Elevated risks for acquiring these diseases might stem from exposure to patients in health-care settings (e.g., poliomyelitis and meningococcal disease) but also might arise from circumstances unrelated to patient care (e.g., high endemicity of hepatitis A or exposure to arthropod-vector diseases [e.g., yellow fever]). All HCP should seek the advice of a health-care provider familiar with travel medicine at least 4--6 weeks before travel to ensure that they are up to date on routine vaccinations and that they receive vaccinations recommended for their destination (*329*). Although bacille Calmette-Guérin vaccination is not recommended routinely in the United States, HCP should discuss potential beneficial and other consequences of this vaccination with their health-care provider.

Work Restrictions

Work restrictions for susceptible HCP (i.e., no history of vaccination or documented lack of immunity) exposed to or infected with certain vaccine-preventable diseases can range from restricting individual HCP from patient contact to complete exclusion from duty (Table 5). A furloughed employee should be considered in the same category as an employee excluded from the facility. Specific recommendations concerning work restrictions in these circumstances have been published previously (*3,11*).

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* US Department of Health and Human Services. Medicare program; hospital inpatient prospective payment systems for acute care hospitals and the long-term care hospital prospective payment system and FY2012 rates; hospitals' FTE resident caps for graduate medical education payment; final rules. Federal Register 2011;76:51631--3.

† The first dose of measles-containing vaccine should be administered on or after the first birthday; the second dose should be administered no earlier than 28 days after the first dose.

§ Measles immunoglobulin (IgG) in the serum; equivocal results should be considered negative.

¶ The majority of persons born before 1957 are likely to have been infected naturally and may be presumed immune, depending on current state or local requirements. For unvaccinated personnel born before 1957 who lack laboratory evidence of measles immunity or laboratory confirmation of disease, health-care facilities should consider vaccinating personnel with 2 doses of MMR vaccine at the appropriate interval. For unvaccinated personnel born before 1957 who lack laboratory evidence of measles immunity or laboratory confirmation of disease, health-care facilities should recommend 2 doses of MMR vaccine during an outbreak of measles.

** The first dose of mumps-containing vaccine should be administered on or after the first birthday; the second dose should be administered no earlier than 28 days after the first dose.

†† Mumps immunoglobulin (IgG) in the serum; equivocal results should be considered negative.

§§ The majority of persons born before 1957 are likely to have been infected naturally between birth and 1977, the year that mumps vaccination was recommended for routine use, and may be presumed immune, even if they have not had clinically recognizable mumps disease. (This might vary depending on current state or local requirements.) For unvaccinated personnel born before 1957 who lack laboratory evidence of mumps immunity or laboratory confirmation of disease, health-care facilities should consider vaccinating personnel with 2 doses of MMR vaccine at the appropriate interval; for unvaccinated personnel born before 1957 who lack laboratory evidence of mumps immunity or laboratory confirmation of disease, health-care facilities should recommend 2 doses of MMR vaccine during an outbreak of mumps.

¶¶ Rubella immunoglobulin (IgG) in the serum; equivocal results should be considered negative.

*** Depending on current state or local requirements, for unvaccinated personnel born before 1957 who lack laboratory evidence of rubella immunity or laboratory confirmation of infection or disease, health-care facilities should consider vaccinating personnel with one dose of MMR vaccine; for unvaccinated personnel born before 1957 who lack laboratory evidence of rubella immunity or laboratory confirmation of infection or disease, health-care facilities should recommend 1 dose of MMR vaccine during an outbreak of rubella.

††† Because rubella can occur in some persons born before 1957 and because congenital rubella and congenital rubella syndrome can occur in the offspring of women infected with rubella virus during pregnancy, birth before 1957 is not acceptable evidence of rubella immunity for women who could become pregnant.

§§§ Commercial assays can be used to assess disease-induced immunity, but they often lack sensitivity to detect vaccine-induced immunity (i.e., they might yield false-negative results).

¶¶¶ Verification of history or diagnosis of typical disease can be provided by any health-care provider (e.g., a school or occupational clinic nurse, nurse practitioner, physician assistant, or physician). For persons reporting a history of, or reporting with, atypical or mild cases, assessment by a physician or their designee is recommended, and one of the following should be sought: 1) an epidemiologic link to a typical varicella case or to a laboratory-confirmed case or 2) evidence of laboratory confirmation if it was performed at the time of acute disease. When such documentation is lacking, persons should not be considered as having a valid history of disease because other diseases might mimic mild atypical varicella.

BOX. Summary of main changes* from 1997 Advisory Committee on Immunization Practices/Hospital (now Healthcare) Infection Control Practices Advisory Committee recommendations for immunization of health-care personnel (HCP)

Hepatitis B

- HCP and trainees in certain populations at high risk for chronic hepatitis B (e.g., those born in countries with high and intermediate endemicity) should be tested for HBsAg and anti-HBc/anti-HBs to determine infection status.

Influenza

- Emphasis that all HCP, not just those with direct patient care duties, should receive an annual influenza vaccination
- Comprehensive programs to increase vaccine coverage among HCP are needed; influenza vaccination rates among HCP within facilities should be measured and reported regularly.

Measles, mumps, and rubella (MMR)

- History of disease is no longer considered adequate presumptive evidence of measles or mumps immunity for HCP; laboratory confirmation of disease was added as acceptable presumptive evidence of immunity. History of disease has never been considered adequate evidence of immunity for rubella.
- The footnotes have been changed regarding the recommendations for personnel born before 1957 in routine and outbreak contexts. Specifically, guidance is provided for 2 doses of MMR for measles and mumps protection and 1 dose of MMR for rubella protection.

Pertussis

- HCP, regardless of age, should receive a single dose of Tdap as soon as feasible if they have not previously received Tdap.
- The minimal interval was removed, and Tdap can now be administered regardless of interval since the last tetanus or diphtheria-containing vaccine.
- Hospitals and ambulatory-care facilities should provide Tdap for HCP and use approaches that maximize vaccination rates.

Varicella

Criteria for evidence of immunity to varicella were established. For HCP they include

- written documentation with 2 doses of vaccine,
- laboratory evidence of immunity or laboratory confirmation of disease,
- diagnosis of history of varicella disease by health-care provider, or diagnosis of history of herpes zoster by health-care provider.

Meningococcal

- HCP with anatomic or functional asplenia or persistent complement component deficiencies should now receive a 2-dose series of meningococcal conjugate vaccine. HCP with HIV infection who are vaccinated should also receive a 2 dose series.
- Those HCP who remain in groups at high risk are recommended to be revaccinated every 5 years.

Abbreviations: HBsAg = Hepatitis B surface antigen; anti-HBc = hepatitis B core antibody; anti-HBs = hepatitis B surface antibody; Tdap = tetanus toxoid, reduced diptheria toxoid and acellular pertussis vaccine; HIV = human immunodeficiency virus.

* Updated recommendations made since publication of the 1997 summary of recommendations (CDC Immunization of health-care workers: recommendations of the Advisory Committee on Immunization Practices [ACIP] and the Hospital Infection Control Practices Advisory Committee [HICPAC]. MMWR 1997;46[No. RR-18]).

TABLE 1. Recommendations for immunization practices and use of immunobiologics applicable to disease prevention among health-care personnel* --- Advisory Committee on Immunization Practices (ACIP), June 9, 1989--August 26, 2011

Subject	Publication in *MMWR*
General recommendations on immunization	2011;60(No. RR-2)
Diphtheria, tetanus, and pertussis	1991;40(No. RR-10) 1997;46(No. RR-7)
Hepatitis B	1991;40;(No. RR-8)† 1991;40(No. RR-13)

	2001;50(No. RR-11)†
	2006;55(No. RR-16)
	2008;57(No. RR-8)†
Influenza§	2010;59(No. RR-8)
	2011;60:1128--32
Measles, mumps, rubella (MMR)	1998;47(No. RR-8)
Meningococcal disease and outbreaks	2005;54(No. RR-7)
	2011;60:72--6
Mumps (see also MMR and Measles)	1989;38:388--92, 397--400
	2006;55:629--630
	2006;55(No. RR-3)
Pertussis, acellular (see also Diphtheria, tetanus, and pertussis)	2006;55(No. RR-17)
	2008;57(No. RR-4)
	2011;60:13--15
Poliomyelitis	2000;49(No. RR-5)
	2009;58:829--30
Rubella (see also MMR, Measles, and Mumps)	2001;50:1117
Typhoid	1994;43(No. RR-14)
Varicella	2007;56(No. RR-4)

* Persons who provide health care to patients or work in institutions that provide patient care (e.g., physicians, nurses, emergency medical personnel, dental professionals and students, medical and nursing students, laboratory technicians, hospital volunteers, and administrative and support staff in health-care institutions). **Source:** U.S. Department of Health and Human Services. Definition of health-care personnel (HCP). Available at http://www.hhs.gov/ask/initiatives/vacctoolkit/definition.html .

† This report provides guidance from CDC and is not an ACIP statement.

§ Each year influenza vaccine recommendations are reviewed and amended to reflect updated information concerning influenza activity in the United States for the preceding influenza season and to provide information on the vaccine available for the upcoming influenza season. These recommendations are published periodically in *MMWR*. The most current published recommendations should be consulted (available at http://www.cdc.gov/vaccines/pubs/acip-list.htm).

TABLE 2. Immunizing agents and immunization schedules for health-care personnel (HCP)*

Generic name	Primary schedule and booster(s)	Indications	Major precautions and contraindications	Special considerations
Immunizing agents recommended for all HCP				
Hepatitis B (HB) recombinant vaccine	2 doses 4 weeks apart; third dose 5 months after second; booster doses not necessary; all doses should be administered IM in the deltoid	Preexposure: HCP at risk for exposure to blood or body fluids; postexposure (see Table 4)	On the basis of limited data, no risk for adverse effects to developing fetuses is apparent. Pregnancy should not be considered a contraindication to vaccination of women. Previous anaphylactic reaction to common baker's yeast is a contraindication to vaccination.	The vaccine produces neither therapeutic nor adverse effects in HBV-infected persons. Prevaccination serologic screening is not indicated for persons being vaccinated because of occupational risk but might be indicated for HCP in certain high-risk populations. HCP at high risk for occupational† contact with blood or body fluids should be tested 1--2 months after vaccination to determine serologic response.
Hepatitis B immune globulin (HBIG)	0.06 mL/kg IM as soon as possible after exposure, if indicated	Postexposure prophylaxis (see Table 4)	See package insert§	
Influenza vaccine (TIV and LAIV)	Annual vaccination with current seasonal vaccine. TIV is available in IM and ID formulations. LAIV is administered intranasally.	All HCP	History of severe (e.g., anaphylactic) hypersensitivity to eggs; prior severe allergic reaction to influenza vaccine	No evidence exists of risk to mother of fetus when the vaccine is administered to a pregnant woman with an underlying high-risk condition. Influenza vaccination is recommended for women who are or will be pregnant during influenza season because of increased risk for hospitalization and death. LAIV is recommended only for healthy, non--pregnant persons aged 2--49 years. Intradermal vaccine is indicated for persons aged 18--64 years. HCP who care for

				severely immunosuppressed persons who require a protective environment should receive TIV rather than LAIV.
Measles live--virus vaccine	2 doses SC; ≥28 days apart	Vaccination should be recommended for all HCP who lack presumptive evidence of immunity;¶ vaccination should be considered for those born before 1957.	Pregnancy; immunocompromised persons,** including HIV-infected persons who have evidence of severe immunosuppression; anaphylaxis to gelatin or gelatin-containing products; anaphylaxis to neomycin; and recent administration of immune globulin.	HCP vaccinated during 1963--1967 with a killed measles vaccine alone, killed vaccine followed by live vaccine, or a vaccine of unknown type should be revaccinated with 2 doses of live measles virus vaccine.
Mumps live--virus vaccine	2 doses SC; ≥28 days apart	Vaccination should be recommended for all HCP who lack presumptive evidence of immunity.†† Vaccination should be considered for those born before 1957.	Pregnancy; immunocompromised persons,** including HIV-infected persons who have evidence of severe immunosuppression; anaphylaxis to gelatin or gelatin-containing products; anaphylaxis to neomycin	HCP vaccinated before 1979 with either killed mumps vaccine or mumps vaccine of unknown type should consider revaccination with 2 doses of MMR vaccine.
Rubella live-virus vaccine	1 dose SC; (However, due to the 2-dose requirements for measles and mumps vaccines, the use of MMR vaccine will result in most HCP receiving 2 doses of rubella-containing vaccine.)	Vaccination should be recommended for all HCP who lack presumptive evidence of immunity.§§	Pregnancy; immunocompromised persons** including HIV--infected persons who have evidence of severe immunosuppression; anaphylaxis to gelatin or gelatin--containing products; anaphylaxis to neomycin	The risk for rubella vaccine--associated malformations in the offspring of women pregnant when vaccinated or who become pregnant within 1 month after vaccination is negligible.¶¶ Such women should be counseled regarding the theoretical basis of concern for the fetus.

TABLE 2. (*Continued*) Immunizing agents and immunization schedules for health-care personnel (HCP)*

Generic name	Primary schedule and booster(s)	Indications	Major precautions and contraindications	Special considerations
Tetanus and diphtheria (toxoids) and acellular pertussis (Tdap)	1 dose IM as soon as feasible if Tdap not already received and regardless of interval from last Td. After receipt of Tdap, receive Td for routine booster every 10 years.	All HCP, regardless of age.	History of serious allergic reaction (i.e., anaphylaxis) to any component of Tdap. Because of the importance of tetanus vaccination, persons with history of anaphylaxis to components in Tdap or Td should be referred to an allergist to determine whether they have a specific allergy to tetanus toxoid and can safely receive tetanus toxoid (TT) vaccine. Persons with history of encephalopathy (e.g., coma or prolonged seizures) not attributable to an identifiable cause within 7 days of administration of a vaccine with pertussis components should receive Td instead of Tdap.	Tetanus prophylaxis in wound management if not yet received Tdap***
Varicella vaccine (varicella zoster virus live-virus vaccine)	2 doses SC 4--8 weeks apart if aged ≥13 years.	All HCP who do not have evidence of immunity defined as: written documentation of vaccination with 2 doses of varicella vaccine: laboratory evidence of immunity††† or laboratory confirmation of disease; diagnosis or verification of a history of varicella disease by a health-care provider,§§§ or diagnosis or verification of a history of herpes zoster by a health-care provider.	Pregnancy; immunocompromised persons;** history of anaphylactic reaction after receipt of gelatin or neomycin. Varicella vaccination may be considered for HIV-infected adolescents and adults with CD4+ T-lymphocyte count >200 cells/uL. Avoid salicylate use for 6 weeks after vaccination.	Because 71%--93% of adults without a history of varicella are immune, serologic testing before vaccination is likely to be cost-effective.

Varicella-zoster immune globulin	125U/10 kg IM (minimum dose: 125U; maximum dose: 625U)	Persons without evidence of immunity who have contraindications for varicella vaccination and who are at risk for severe disease and complications¶¶¶ known or likely to be susceptible who have direct, nontransient exposure to an infectious hospital staff worker or patient		Serologic testing may help in assessing whether to administer varicella--zoster immune globulin. If use of varicella--zoster immune globulin prevents varicella disease, patient should be vaccinated subsequently. The varicella--zoster immune globulin product currently used in the United States (VariZIG) (Cangene Corp. Winnipeg Canada) can be obtained 24 hours a day from the sole authorized U.S. distributor (FFF Enterprises, Temecula, California) at 1-800-843-7477 or http://www.fffenterprises.com .

Other immunobiologics that might be indicated in certain circumstances for HCP

Quadrivalent meningococcal conjugate vaccine (tetravalent (A,C,Y,W) for HCP ages 19--54 years, Quadrivalent meningococcal polysaccharide vaccine for HCP age >55 years	1 dose; booster dose in 5 years if person remains at increased risk	Clinical and research microbiologists who might routinely be exposed to isolates of *Neisseria meningitidis*	The safety of the vaccine in pregnant women has not been evaluated; it should not be administered during pregnancy unless the risk for infection is high.	

TABLE 2. (*Continued*) Immunizing agents and immunization schedules for health-care personnel (HCP)*

Generic name	Primary schedule and booster(s)	Indications	Major precautions and contraindications	Special considerations
Typhoid vaccine IM, and oral	IM vaccine: 1 dose, booster every 2 years. Oral vaccine: 4 doses on alternate days. Manufacturer recommends revaccination with the entire 4-dose series every 5 years.	Workers in microbiology laboratories who frequently work with *Salmonella* typhi.	Severe local or systemic reaction to a previous dose. Ty21a (oral) vaccine should not be administered to immunocompromised persons** or to persons receiving antimicrobial agents.	Vaccination should not be considered an alternative to the use of proper procedures when handling specimens and cultures in the laboratory.
Inactivated poliovirus vaccine (IPV)	For unvaccinated adults, 2 doses should be administered at intervals of 4--8 weeks; a third dose should be administered 6--12 months after the second dose.	Vaccination is recommended for adults at increased risk for exposure to polioviruses including health-care personnel who have close contact with patients who might be excreting polioviruses. Adults who have previously received a complete course of poliovirus vaccine may receive one lifetime booster if they remain at increased risk for exposure.	Hypersensitivity or anaphylactic reactions to IPV or antibiotics contained in IPV. IPV contains trace amounts of streptomycin, polymyxin B, and neomycin.	

Abbreviations: IM = intramuscular; HBV = hepatitis B virus; HBsAg = hepatitis B surface antigen; SC = subcutaneous; HIV = human immunodeficiency virus; MMR = measles, mumps, rubella vaccine; TB = tuberculosis; HAV = hepatitis A virus; IgA = immune globulin A; ID = intradermal; TIV = trivalent inactivated split-virus vaccines; LAIV = live attenuated influenza vaccine; BCG = bacille Calmette-Guérin; OPV = oral poliovirus vaccine.

* Persons who provide health care to patients or work in institutions that provide patient care (e. g., physicians, nurses, emergency medical personnel, dental professionals and students, medical and nursing students, laboratory technicians, hospital volunteers, and administrative and support staff in health-care institutions). **Source:** U.S. Department of Health and Human Services. Definition of health-care personnel (HCP). Available at http://www.hhs.gov/ask/initiatives/vacctoolkit/definition.html .

† Health-care personnel and public safety workers at high risk for continued percutaneous or mucosal exposure to blood or body fluids include acupuncturists, dentists, dental hygienists, emergency medical technicians, first responders, laboratory technologists/technicians, nurses, nurse practitioners, phlebotomists, physicians, physician assistants, and students entering these professions. **Source:** CDC. A comprehensive immunization strategy to eliminate transmission of hepatitis B virus infection in the United States: recommendations of the Advisory Committee on Immunization Practices. Part II: immunization of adults. MMWR 2006;55(No. RR-16).

§ The package insert should be consulted to weigh the risks and benefits of giving HBIG to persons with IgA deficiency, or to persons who have had an anaphylactic reaction to an IgG containing biologic product.

¶ Written documentation of vaccination with 2 doses of live measles or MMR vaccine administered ≥28 days apart, or laboratory evidence of measles immunity, or laboratory confirmation of measles disease, or birth before 1957.

** Persons immunocompromised because of immune deficiency diseases, HIV infection (who should primarily not receive BCG, OPV, and yellow fever vaccines), leukemia, lymphoma or generalized malignancy or immunosuppressed as a result of therapy with corticosteroids, alkylating drugs, antimetabolites, or radiation.

†† Written documentation of vaccination with 2 doses of live mumps or MMR vaccine administered ≥28 days apart, or laboratory evidence of mumps immunity, or laboratory confirmation of mumps disease, or birth before 1957.

§§ Written documentation of vaccination with 1 dose of live rubella or MMR vaccine, or laboratory evidence of immunity, or laboratory confirmation of rubella infection or disease, or birth before 1957, except women of childbearing potential who could become pregnant; though pregnancy in this age group would be exceedingly rare.

¶¶ **Source:** CDC. Revised ACIP recommendation for avoiding pregnancy after receiving a rubella-containing vaccine. MMWR 2001;50:1117.

*** **Source:** CDC. Update on adult immunization: recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 1991:40(No. RR-12).

††† Commercial assays can be used to assess disease--induced immunity, but they often lack sensitivity to detect vaccine-induced immunity (i.e., they might yield false-negative results).

§§§ Verification of history or diagnosis of typical disease can be provided by any health-care provider (e.g., school or occupational clinic nurse, nurse practitioner, physician assistant, or physician). For persons reporting a history of, or reporting with, atypical or mild cases, assessment by a physician or their designee is recommended, and one of the following should be sought: 1) an epidemiologic link to a typical varicella case or to a laboratory--confirmed case or 2) evidence of laboratory confirmation if it was performed at the time of acute disease. When such documentation is lacking, persons should not be considered as having a valid history of disease because other diseases might mimic mild atypical varicella.

¶¶¶ For example, immunocompromised patients or pregnant women.

TABLE 3. Summary of recommendations for immunization of health-care personnel* (HCP) with special certain conditions --- Advisory Committee on Immunization Practices, United States, 2011

Vaccine	Pregnancy	HIV infection	Severe immunosuppression†	Asplenia	Renal failure	Diabetes	Alcoholism and alcoholic cirrhosis
Hepatitis B	R	R	R	R	R	R	R
Influenza	R§	R	R	R	R	R	R
Measles, mumps, rubella	C	R¶	C	R	R	R	R
Meningococcus	UI	UI	UI	R**	UI	UI	UI
IPV ††	UI	UI	UI	UI	UI	UI	UI
Pertussis, tetanus, diphtheria	R	R	R	R	R	R	R
Typhoid, inactivated Vi§§	UI	UI	UI	UI	UI	UI	UI
Typhoid, Ty21a	UI	C	C	UI	UI	UI	UI
Varicella	C	UI¶¶	C	R	R	R	R

Abbreviations: R = recommended; C = contraindicated; UI = use if indicated; IPV = inactivated poliovirus vaccine.

* Persons who provide health care to patients or work in institutions that provide patient care (e. g., physicians, nurses, emergency medical personnel, dental professionals and students, medical and nursing students, laboratory technicians, hospital volunteers, and administrative and support staff in health-care institutions). **Source:** U.S. Department of Health and Human Services. Definition of health-care personnel (HCP). Available at http://www.hhs.gov/ask/initiatives/vacctoolkit/definition.html .

† Severe immunosuppression can be caused by congenital immunodeficiency, leukemia, lymphoma, generalized malignancy or therapy with alkylating agents, antimetabolites, ionizing radiation, or large amounts of corticosteroids.

§ Women who are or will be pregnant during the influenza season.

¶ Contraindicated in HIV-infected persons who have evidence of severe immunosuppression.

** Recommendation is based on the person's underlying condition rather than occupation.

†† Vaccination is recommended for unvaccinated HCP who have close contact with patients who may be excreting wild polioviruses. HCP who have had a primary series of oral poliovirus vaccine (OPV) or IPV who are directly involved with the provision of care to patients who may be excreting poliovirus may receive another dose of either IPV or OPV. Any suspected case of poliomyelitis should be investigated immediately. If evidence suggests transmission of poliovirus, control measures to contain further transmission should be instituted immediately.

§§ Capsular polysaccharide parenteral vaccine.

¶¶ Varicella vaccine may be considered for HIV-infected adults without evidence of immunity and with CD4 T-lymphocyte count ≥200 cells/Ul.

TABLE 4. Recommended postexposure prophylaxis for percutaneous or permucosal exposure to hepatitis B virus --- Advisory Committee on Immunization Practices, United States

Vaccination and antibody response status of exposed person	Treatment		
	Source HBsAg-positive	Source HBsAg-negative	Source not tested or status unknown
Unvaccinated	HBIG x 1; initiate HB vaccine	Initiate HB vaccine	Initiate HB vaccine series

	series	series	
Previously vaccinated			
Known responder	No treatment	No treatment	No treatment
Known nonresponder			
After 3 doses	HBIG x 1 and initiate revaccination	No treatment	If known high-risk source, treat as if source were HBsAg-positive
After 6 doses	HBIG x 2 (separated by 1 month)	No treatment	If known high-risk source, treat as if source were HBsAg-positive
Antibody response unknown	Test exposed person for anti-HBs If adequate,* no treatment If inadequate,* HBIG x 1 and vaccine booster	No treatment	Test exposed person for anti-HBs If adequate,* no treatment If inadequate,* initiate revaccination

Abbreviations: HBsAg = Hepatitis B surface antigen; HBIG = hepatitis B immune globulin; anti-HBs = antibody to hepatitis B surface antigen; HB = hepatitis B.

Source: Adapted from CDC. A comprehensive immunization strategy to eliminate transmission of hepatitis B virus infection in the United States: recommendations of the Advisory Committee on Immunization Practices (ACIP). Part II: immunization of adults. MMWR 2006;55(No. RR-16).

* A seroprotective (adequate) level of anti-HBs after completion of a vaccination series is defined as anti-HBs ≥10 mIU/mL; a response < 10 mIU/mL is inadequate and is not a reliable indicator of protection.

TABLE 5. Advisory Committee on Immunization Practices work restrictions for health-care personnel* (HCP) exposed to or infected with certain vaccine-preventable diseases and conditions

Disease/Condition	Work restriction	Duration
Hepatitis B		
HCP positive for HBsAg (e.g., acute or chronic hepatitis B infection):		
HCP who do not perform exposure-prone invasive procedures	No restriction unless linked epidemiologically to transmission of hepatitis B virus infection	Standard precautions always should be observed
HCP who perform exposure-prone invasive procedures	These HCP should not perform exposure-prone invasive procedures until they have sought counsel from an expert review panel, which should review and recommend the procedures the worker can perform, taking into account the specific procedure as well as the skill and technique of the worker	Per recommendation of expert panel
Upper respiratory infections		
HCP in contact with persons at high risk for complications of influenza†	Exclude from duty	Until afebrile ≥24 hours (without the use of fever-reducing medicines such as acetaminophen). Those with ongoing respiratory symptoms should be considered for evaluation by occupational health to determine appropriateness of contact with patients. If returning to care for patients in a protective environment (e.g., hematopoietic stem cell transplant patients), consider for temporary reassignment or exclusion from work for 7 days from symptom onset or until the resolution of symptoms, whichever is longer. Those who develop acute respiratory symptoms without fever should be considered for evaluation by occupational health to determine appropriateness of contact with patients and can be allowed to work unless caring for patients in a protective environment; these personnel should be considered for temporary reassignment or exclusion from work for 7 days from symptom onset or until the resolution of all noncough symptoms, whichever is longer. If symptoms such as cough and sneezing are still present, HCP should wear a facemask during patient care activities. The importance of performing frequent hand hygiene (especially before and after each patient contact) should be reinforced.
Measles		
Active	Exclude from duty	4 days after rash appears
Postexposure (HCP without presumptive	Exclude from duty	5 days after first exposure through 21 days after last exposure and/or 4 days after the rash appears

evidence of measles immunity)		
Mumps		
Active	Exclude from duty	5 days after onset of parotitis
Postexposure (HCP without presumptive evidence of mumps immunity)	Exclude from duty	12 days after first exposure through 25 days after last exposure or 5 days after onset of parotitis
Pertussis		
Active	Exclude from duty	Beginning of catarrhal stage through third week after onset of paroxysms or until 5 days after start of effective antimicrobial therapy
Postexposure		
Symptomatic personnel	Exclude from duty	5 days after start of effective antimicrobial therapy
Asymptomatic personnel -- HCP likely to expose a patient at risk for severe pertussis§	No restriction from duty; on antimicrobial prophylactic therapy	
Asymptomatic personnel -- other HCP	No restriction from duty; can receive postexposure prophylaxis *or* be monitored for 21 days after pertussis exposure and treated at the onset of signs and symptoms of pertussis	

TABLE 5. (*Continued*) Advisory Committee on Immunization Practices work restrictions for health-care personnel* (HCP) exposed to or infected with certain vaccine-preventable diseases and conditions

Disease/Condition	Work restriction	Duration
Rubella		
Active	Exclude from duty	7 days after the rash appears
Postexposure (personnel without evidence of rubella immunity)	Exclude from duty	7 days after first exposure through 23 days after last exposure and/or 7 days after rash appears
Varicella		
Active	Exclude from duty	Until all lesions dry and crust. If only lesions that do not crust (i.e., macules and papules), until no new lesions appear within a 24-hour period
Postexposure (HCP without evidence of varicella immunity)	Exclude from duty unless receipt of the second dose within 3-5 days after exposure	8th day after 1st exposure through 21st day (28th day if varicella-zoster immune globulin administered) after the last exposure; if varicella occurs, until all lesions dry and crust or, if only lesions that do not crust (i.e., macules and papules), until no new lesions appear within a 24-hour period
Herpes zoster		
Localized in immunocompetent person	Cover lesions; restrict from care of high-risk patients¶	Until all lesions dry and crust
Disseminated or localized in immunocompromised person until disseminated infection is ruled out	Exclude from duty	Until all lesions dry and crust
Postexposure (HCP without evidence of varicella immunity)		
Disseminated zoster or localized zoster with uncontained/uncovered lesions	Exclude from duty unless receipt of the second dose of varicella vaccine within 3--5 days after exposure	8th day after 1st exposure through 21st day (28th day if varicella-zoster immune globulin administered) after the last exposure; if varicella occurs, until all lesions dry and crust or, if only lesions that do not crust (i.e., macules and papules), until no new lesions appear within a 24-hour period
Localized zoster with contained/covered lesions	For HCP with at least 1dose of varicella vaccine, no work restrictions. For HCP	8th day after 1st exposure through 21st day (28th day if varicella-zoster immune globulin administered) after the last exposure; if varicella occurs, until all lesions dry

with no doses of varicella vaccine, restrict from patient contact	and crust or, if only lesions that do not crust (i.e., macules and papules), until no new lesions appear within a 24-hour period

Abbreviation: HBsAg = hepatitis B surface antigen.

Sources: Adapted from CDC. Recommendations for preventing transmission of human immunodeficiency virus and hepatitis B virus to patients during exposure-prone invasive procedures. MMWR 1991;40(No. RR-8); CDC. Guideline for isolation precautions in hospitals: recommendations of the Hospital Infection Control Practices Advisory Committee (HICPAC) and the National Center for Infectious Diseases. Infect Control Hosp Epidemiol 1996;17:53--80; Williams WW. CDC guideline for infection control in hospital personnel. Infect Control 1983;4(Suppl):326--49; CDC. Immunization of health-care workers: recommendations of the Advisory Committee on Immunization Practices (ACIP) and the Hospital Infection Control Practices Advisory Committee (HICPAC). MMWR 1997;46(No. RR-18).

* Persons who provide health care to patients or work in institutions that provide patient care (e. g., physicians, nurses, emergency medical personnel, dental professionals and students, medical and nursing students, laboratory technicians, hospital volunteers, and administrative and support staff in health-care institutions). **Source:** U.S. Department of Health and Human Services. Definition of health-care personnel (HCP). Available at http://www.hhs.gov/ask/initiatives/vacctoolkit/definition.html .

† Includes children aged <5 years, adults aged ≥65 years, pregnant women, American Indians/Alaska Natives, persons aged <19 years who are receiving long-term aspirin therapy, and persons with certain high-risk medical conditions (i.e., asthma, neurologic and neurodevelopmental conditions, chronic lung disease, heart disease, blood disorders, endocrine disorders, kidney disorders, liver disorders, metabolic disorders, weakened immune system due to disease or medication, and morbid obesity).

§ Includes hospitalized neonates and pregnant women.

¶ Includes patients who are susceptible to varicella and at increased risk for complications of varicella (i.e., neonates, pregnant women, and immunocompromised persons of any age).

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Immunization of Health-Care Personnel Work Group

Abigail Shefer, MD, National Center for Immunization and Respiratory Diseases, William Atkinson, MD, National Center for Immunization and Respiratory Diseases, Jane Seward, MBBS, National Center for Immunization and Respiratory Diseases, Elizabeth Bolyard, MPH, National Center for Emerging Zoonotic Infectious Diseases, David Kuhar, MD, National Center for Emerging Zoonotic Infectious Diseases, Suchita Lorick, MD, National Center for Immunization and Respiratory Diseases, Gina Mootrey, DO, National Center for Immunization and Respiratory Diseases, CDC, Atlanta; Joseph Perz, DrPH, National Center for Emerging Zoonotic Infectious Diseases, CDC, Atlanta, Georgia; Paul Cieslak, MD, Public Health Division, Oregon Health Authority, Portland, Oregon; Kristen Ehresmann, MPH, Minnesota Department of Health, St Paul, Minnesota; Alexis Elward, MD, Washington University School of Medicine, St Louis, Missouri; Harry Keyserling, MD, Emory University School of Medicine, Atlanta, Georgia; ACIP liaison representatives: Jean Haulman, MD, University of Washington, Seattle, Washington; Mark Russi, MD, American College of Occupational and Environmental Medicine, New Haven, Connecticut; David Weber, MD, University of North Carolina, Chapel Hill, North Carolina.

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Type and Duration of Precautions Recommended for Selected Infections and Conditions[1]

Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007)

Appendix A Updates [September 2018]

Changes: Updates and clarifications made to the table in Appendix A: Type and Duration of Precautions Recommended for Selected Infections and Conditions.

A B C D E F G H I J K L M N O P Q R S T U V W Y Z

A

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Abscess Draining, major	Contact + Standard	Duration of illness	Until drainage stops or can be contained by dressing.
Abscess Draining, minor or limited	Standard	n/a	If dressing covers and contains drainage.
Acquired human immunodeficiency syndrome (HIV)	Standard	n/a	Postexposure chemoprophylaxis for some blood exposures [866].
Actinomycosis	Standard	n/a	Not transmitted from person to person.
Adenovirus infection (see agent-specific guidance under Gastroenteritis, Conjunctivitis, Pneumonia)	n/a	n/a	n/a
Amebiasis	Standard	n/a	Person-to-person transmission is rare. Transmission in settings for the mentally challenged and in a family group has been reported [1045]. Use care when handling diapered infants and mentally challenged persons [1046].
Anthrax	Standard	n/a	Infected patients do not generally pose a transmission risk.

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Anthrax Cutaneous	Standard	n/a	Transmission through non-intact skin contact with draining lesions possible, therefore use Contact Precautions if large amount of uncontained drainage. Handwashing with soap and water preferable to use of waterless alcohol-based antiseptics since alcohol does not have sporicidal activity [983].
Anthrax Pulmonary	Standard	n/a	Not transmitted from person to person.
Anthrax Environmental: aerosolizable spore-containing powder or other substance	n/a	Until environment completely decontaminated	Until decontamination of environment complete [203]. Wear respirator (N95 mask or PAPRs), protective clothing; decontaminate persons with powder on them (Notice to Readers: Occupational Health Guidelines for Remediation Workers at Bacillus anthracis-Contaminated Sites — United States, 2001–2002 accessed September 2018). **Hand hygiene:** Handwashing for 30-60 seconds with soap and water or 2% chlorhexidine gluconate after spore contact (alcohol handrubs inactive against spores [983].) **Postexposure prophylaxis following environmental exposure:** 60 days of antimicrobials (either doxycycline, ciprofloxacin, or levofloxacin) and postexposure vaccine under IND.
Antibiotic-associated colitis (see *Clostridium difficile*)	n/a	n/a	n/a
Arthropod-borne • viral encephalitides (eastern, western, Venezuelan equine encephalomyelitis; St Louis, California encephalitis; West Nile Virus) and • viral fevers (dengue, yellow fever, Colorado tick fever)	Standard	n/a	Not transmitted from person to person except rarely by transfusion, and for West Nile virus by organ transplant, breastmilk or transplacentally [530, 1047]. Install screens in windows and doors in endemic areas. Use DEET-containing mosquito repellants and clothing to cover extremities.
Ascariasis	Standard	n/a	Not transmitted from person to person.
Aspergillosis	Standard	n/a	Contact Precautions and Airborne if massive soft tissue infection with copious drainage and repeated irrigations required [154].
Avian influenza (see influenza, avian below)	n/a	n/a	n/a

B

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Babesiosis	Standard	n/a	Not transmitted from person to person, except rarely by transfusion.
Blastomycosis, North American, cutaneous or pulmonary	Standard	n/a	Not transmitted from person to person.
Botulism	Standard	n/a	Not transmitted from person to person.
Bronchiolitis (see Respiratory Infections in infants and young children)	Contact + Standard	Duration of illness	Use mask according to Standard Precautions.
Brucellosis (undulant, Malta, Mediterranean fever)	Standard	n/a	Not transmitted from person to person, except rarely via banked spermatozoa and sexual contact [1048, 1049]. Provide antimicrobial prophylaxis following laboratory exposure [1050].

C

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Campylobacter gastroenteritis (see Gastroenteritis)	n/a	n/a	n/a
Candidiasis, all forms including mucocutaneous	Standard	n/a	n/a
Cat-scratch fever (benign inoculation lymphoreticulosis)	Standard	n/a	Not transmitted from person to person.
Cellulitis	Standard	n/a	n/a
Chancroid (soft chancre) (*H. ducreyi*)	Standard	n/a	Transmitted sexually from person to person.
Chickenpox (see Varicella)	n/a	n/a	n/a
Chlamydia trachomatis Conjunctivitis	Standard	n/a	n/a

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Chlamydia trachomatis Genital (lymphogranuloma venereum)	Standard	n/a	n/a
Chlamydia trachomatis Pneumonia (infants ≤3 mos. of age)	Standard	n/a	n/a
Chlamydia pneumoniae	Standard	n/a	Outbreaks in institutionalized populations reported, rarely [1051, 1052].
Cholera (see Gastroenteritis)	n/a	n/a	n/a
Closed-cavity infection Open drain in place; limited or minor drainage	Standard	n/a	Contact Precautions if there is copious uncontained drainage.
Closed-cavity infection No drain or closed drainage system in place	Standard	n/a	n/a
Clostridium botulinum	Standard	n/a	Not transmitted from person to person.
Clostridium difficile (see Gastroenteritis, *C. difficile*)	Contact + Standard	Duration of illness	n/a
Clostridium perfringens Food poisoning	Standard	n/a	Not transmitted from person to person.
Clostridium perfringens Gas gangrene	Standard	n/a	Transmission from person to person rare; 1 outbreak in a surgical setting reported [1053]. Use Contact Precautions if wound drainage is extensive.
Coccidioidomycosis (valley fever) Draining lesions	Standard	n/a	Not transmitted from person to person except under extraordinary circumstances, because the infectious arthroconidial form of *Coccidioides immitis* is not produced in humans [1054].

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Coccidioidomycosis (valley fever) Pneumonia	Standard	n/a	Not transmitted from person to person except under extraordinary circumstances, (e.g., inhalation of aerosolized tissue phase endospores during necropsy, transplantation of infected lung) because the infectious arthroconidial form of *Coccidioides immitis* is not produced in humans [1054, 1055].
Colorado tick fever	Standard	n/a	Not transmitted from person to person.
Congenital rubella	Contact + Standard	Until 1 yr of age	Standard Precautions if nasopharyngeal and urine cultures repeatedly negative after 3 mos. of age.
Conjunctivitis Acute bacterial	Standard	n/a	n/a
Conjunctivitis Acute bacterial *Chlamydia*	Standard	n/a	n/a
Conjunctivitis Acute bacterial Gonococcal	Standard	n/a	n/a
Conjunctivitis Acute viral (acute hemorrhagic)	Contact + Standard	Duration of illness	Adenovirus most common; enterovirus 70 [1056], Coxsackie virus A24 [1057] also associated with community outbreaks. Highly contagious; outbreaks in eye clinics, pediatric and neonatal settings, institutional settings reported. Eye clinics should follow Standard Precautions when handling patients with conjunctivitis. Routine use of infection control measures in the handling of instruments and equipment will prevent the occurrence of outbreaks in this and other settings. [460, 461, 814, 1058-1060].
Corona virus associated with SARS (SARS-CoV) (see Severe Acute Respiratory Syndrome)	n/a	n/a	n/a
Coxsackie virus disease (see enteroviral infection)	n/a	n/a	n/a
Creutzfeldt-Jakob disease (CJD, vCJD)	Standard	n/a	Use disposable instruments or special sterilization/disinfection for surfaces, objects contaminated with neural tissue if CJD or vCJD suspected and has not been R/O; No special burial procedures. [1061]
Croup (see Respiratory Infections in infants and young children)	n/a	n/a	n/a

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Crimean-Congo Fever (see Viral Hemorrhagic Fever)	Standard	n/a	n/a
Cryptococcosis	Standard	n/a	Not transmitted from person to person, except rarely via tissue and corneal transplant. [1062, 1063]
Cryptosporidiosis (see Gastroenteritis)	n/a	n/a	n/a
Cysticercosis	Standard	n/a	Not transmitted from person to person.
Cytomegalovirus infection, including in neonates and immunosuppressed patients	Standard	n/a	No additional precautions for pregnant HCWs.

D

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Decubitus ulcer (see Pressure Ulcer)	n/a	n/a	n/a
Dengue fever	Standard	n/a	Not transmitted from person to person.
Diarrhea, acute-infective etiology suspected (see Gastroenteritis)	n/a	n/a	n/a
Diphtheria Cutaneous	Contact + Standard	Until off antimicrobial treatment and culture-negative	Until 2 cultures taken 24 hours apart negative.
Diphtheria Pharyngeal	Droplet + Standard	Until off antimicrobial treatment and culture-negative	Until 2 cultures taken 24 hours apart negative.

E

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Ebola virus (see Viral Hemorrhagic Fevers)	n/a	n/a	**Ebola Virus Disease for Healthcare Workers [2014]** ⚠**Update:** Recommendations for healthcare workers can be found at Ebola For Clinicians. (accessed September 2018).

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Echinococcosis (hydatidosis)	Standard	n/a	Not transmitted from person to person.
Echovirus (see Enteroviral Infection)	n/a	n/a	n/a
Encephalitis or encephalomyelitis (see specific etiologic agents)	n/a	n/a	n/a
Endometritis (endomyometritis)	Standard	n/a	n/a
Enterobiasis (pinworm disease, oxyuriasis)	Standard	n/a	n/a
Enterococcus species (see Multidrug-Resistant Organisms if epidemiologically significant or vancomycin-resistant)	n/a	n/a	n/a
Enterocolitis, *C. difficile* (see Gastroenteritis, *C. difficile*)	n/a	n/a	n/a
Enteroviral infections (i.e., Group A and B Coxsackie viruses and Echo viruses) (excludes polio virus)	Standard	n/a	Use Contact Precautions for diapered or incontinent children for duration of illness and to control institutional outbreaks.
Epiglottitis, due to *Haemophilus influenzae* type b	Droplet + Standard	Until 24 hours after initiation of effective therapy	See specific disease agents for epiglottitis due to other etiologies.
Epstein-Barr virus infection, including infectious mononucleosis	Standard	n/a	n/a
Erythema infectiosum (also see Parvovirus B19)	n/a	n/a	n/a
Escherichia coli gastroenteritis (see Gastroenteritis)	n/a	n/a	n/a

F

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Food poisoning Botulism	Standard	n/a	Not transmitted from person to person.
Food poisoning C. *perfringens* or *welchii*	Standard	n/a	Not transmitted from person to person.
Food poisoning Staphylococcal	Standard	n/a	Not transmitted from person to person.

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Furunculosis, staphylococcal	Standard	n/a	Contact if drainage not controlled. Follow institutional policies if MRSA.
Furunculosis, staphylococcal Infants and young children	Contact + Standard	Duration of illness (with wound lesions, until wounds stop draining)	n/a

G

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Gangrene (gas gangrene)	Standard	n/a	Not transmitted from person to person.
Gastroenteritis	Standard	n/a	Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks for gastroenteritis caused by all of the agents below.
Gastroenteritis Adenovirus	Standard	n/a	Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks.
Gastroenteritis *Campylobacter* species	Standard	n/a	Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks.
Gastroenteritis Cholera (*Vibrio cholerae*)	Standard	n/a	Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks.
Gastroenteritis *C. difficile*	Contact + Standard	Duration of illness	Discontinue antibiotics if appropriate. Do not share electronic thermometers; [853, 854] ensure consistent environmental cleaning and disinfection. Hypochlorite solutions may be required for cleaning if transmission continues [847]. Handwashing with soap and water preferred because of the absence of sporicidal activity of alcohol in waterless antiseptic handrubs [983].
Gastroenteritis *Cryptosporidium species*	Standard	n/a	Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks.
Gastroenteritis *E. coli* Enteropathogenic O157:H7 and other Shiga toxin-producing strains	Standard	n/a	Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks.

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Gastroenteritis *E. coli* Other species	Standard	n/a	Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks.
Gastroenteritis *Giardia lamblia*	Standard	n/a	Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks.
Gastroenteritis Noroviruses	⚠ **Update:** Contact + Standard	n/a	Use Contact Precautions for a minimum of 48 hours after the resolution of symptoms or to control institutional outbreaks. Persons who clean areas heavily contaminated with feces or vomitus may benefit from wearing masks since virus can be aerosolized from these body substances [142, 147 148]; ensure consistent environmental cleaning and disinfection with focus on restrooms even when apparently unsoiled [273, 1064]. Hypochlorite solutions may be required when there is continued transmission [290-292]. Alcohol is less active, but there is no evidence that alcohol antiseptic handrubs are not effective for hand decontamination [294]. Cohorting of affected patients to separate airspaces and toilet facilities may help interrupt transmission during outbreaks. **Gastroenteritis, Noroviruses Precaution Update [April 2019]** ⚠**Update:** The Type of Precaution was updated from "Standard" to "Contact + Standard" to align with Guideline for the Prevention and Control of Norovirus Gastroenteritis Outbreaks in Healthcare Settings (2011).
Gastroenteritis Rotavirus	Contact + Standard	Duration of illness	Ensure consistent environmental cleaning and disinfection and frequent removal of soiled diapers. Prolonged shedding may occur in both immunocompetent and immunocompromised children and the elderly [932, 933].
Gastroenteritis *Salmonella* species (including *S. typhi*)	Standard	n/a	Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks.
Gastroenteritis *Shigella* species (Bacillary dysentery)	Standard	n/a	Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks.
Gastroenteritis *Vibrio parahaemolyticus*	Standard	n/a	Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks.
Gastroenteritis Viral (if not covered elsewhere)	Standard	n/a	Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks.

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Gastroenteritis *Yersinia enterocolitica*	Standard	n/a	Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks.
German measles (see Rubella; see Congenital Rubella)	n/a	n/a	n/a
Giardiasis (see Gastroenteritis)	n/a	n/a	n/a
Gonococcal ophthalmia neonatorum (gonorrheal ophthalmia, acute conjunctivitis of newborn)	Standard	n/a	n/a
Gonorrhea	Standard	n/a	n/a
Granuloma inguinale (Donovanosis, granuloma venereum)	Standard	n/a	n/a
Guillain-Barré syndrome	Standard	n/a	Not an infectious condition.

H

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Haemophilus influenzae (see disease-specific recommendations)	n/a	n/a	n/a
Hand, foot, and mouth disease (see Enteroviral Infection)	n/a	n/a	n/a
Hansen's Disease (see Leprosy)	n/a	n/a	n/a
Hantavirus pulmonary syndrome	Standard	n/a	Not transmitted from person to person.
Helicobacter pylori	Standard	n/a	n/a

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Hepatitis, viral Type A	Standard	n/a	Provide hepatitis A vaccine postexposure as recommended. [1065]
Hepatitis, viral Type A-Diapered or incontinent patients	Contact + Standard	n/a	Maintain Contact Precautions in infants and children <3 years of age for duration of hospitalization; for children 3-14 yrs. of age for 2 weeks after onset of symptoms; >14 yrs. of age for 1 week after onset of symptoms [833, 1066, 1067].
Hepatitis, viral Type B-HBsAg positive; acute or chronic	Standard	n/a	See specific recommendations for care of patients in hemodialysis centers. [778]
Hepatitis, viral Type C and other unspecified non-A, non-B	Standard	n/a	See specific recommendations for care of patients in hemodialysis centers. [778]
Hepatitis, viral Type D (seen only with hepatitis B)	Standard	n/a	n/a
Hepatitis, viral Type E	Standard	n/a	Use Contact Precautions for diapered or incontinent individuals for the duration of illness. [1068]
Hepatitis, viral Type G	Standard	n/a	n/a
Herpangina (see Enteroviral Infection)	n/a	n/a	n/a
Hookworm	Standard	n/a	n/a
Herpes simplex (*Herpesvirus hominis*) Encephalitis	Standard	n/a	n/a
Herpes simplex (Herpesvirus hominis) Mucocutaneous, disseminated or primary, severe	Contact + Standard	Until lesions dry and crusted	n/a
Herpes simplex (Herpesvirus hominis) Mucocutaneous, recurrent (skin, oral, genital)	Standard	n/a	n/a

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Herpes simplex (Herpesvirus hominis) Neonatal	Contact + Standard	Until lesions dry and crusted	Also, for asymptomatic, exposed infants delivered vaginally or by C-section and if mother has active infection and membranes have been ruptured for more than 4 to 6 hours until infant surface cultures obtained at 24-36 hours of age negative after 48 hours incubation. [1069, 1070]
Herpes zoster (varicella-zoster) (shingles) Disseminated disease in any patient Localized disease in immunocompromised patient until disseminated infection ruled out	Airborne + Contact + Standard	Duration of illness	Susceptible HCWs should not enter room if immune caregivers are available; no recommendation for protection of immune HCWs; no recommendation for type of protection (i.e. surgical mask or respirator) for susceptible HCWs.
Herpes zoster (varicella-zoster) (shingles) Localized in patient with intact immune system with lesions that can be contained/covered	Standard	Until lesions dry and crusted	Susceptible HCWs should not provide direct patient care when other immune caregivers are available.
Histoplasmosis	Standard	n/a	Not transmitted from person to person.
Human immunodeficiency virus (HIV)	Standard	n/a	Postexposure chemoprophylaxis for some blood exposures [866].
Human metapneumovirus	Contact + Standard	Duration of illness	HAI reported [1071], but route of transmission not established [823]. Assumed to be Contact transmission as for RSV since the viruses are closely related and have similar clinical manifestations and epidemiology. Wear masks according to Standard Precautions.

I

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Impetigo	Contact + Standard	Until 24 hours after initiation of effective therapy	n/a

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Infectious mononucleosis	Standard	n/a	n/a
Influenza Human (seasonal influenza)	n/a	n/a	See Prevention Strategies for Seasonal Influenza in Healthcare Settings (accessed September 2018). [Current version of this document may differ from original.] for current seasonal influenza guidance.
Influenza Avian (e.g., H5N1, H7, H9 strains)	n/a	n/a	See [This link is no longer active: www.cdc.gov/flu/avian/professional/infect-control.htm. Similar information may be found at Interim Guidance for Infection Control Within Healthcare Settings When Caring for Confirmed Cases, Probable Cases, and Cases Under Investigation for Infection with Novel Influenza A Viruses Associated with Severe Disease (accessed September 2018).] for current avian influenza guidance.
Influenza Pandemic Influenza (also a human influenza virus)	Droplet + Standard	n/a	See [This link is no longer active: http://www.pandemicflu.gov. Similar information may be found at Interim Guidance for Infection Control Within Healthcare Settings When Caring for Confirmed Cases, Probable Cases, and Cases Under Investigation for Infection with Novel Influenza A Viruses Associated with Severe Disease (accessed September 2018).] for current pandemic influenza guidance.

K

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Kawasaki syndrome	Standard	n/a	Not an infectious condition.

L

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Lassa fever (see Viral Hemorrhagic Fevers)	n/a	n/a	n/a
Legionnaires' disease	Standard	n/a	Not transmitted from person to person.
Leprosy	Standard	n/a	n/a
Leptospirosis	Standard	n/a	Not transmitted from person to person.

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Lice Head (pediculosis)	Contact + Standard	Until 24 hours after initiation of effective therapy	See [This link is no longer active: https://www.cdc.gov/ncidod/dpd/parasites/lice/default.htm. Similar information may be found at CDC's Parasites – Lice (accessed September 2018).]
Lice Body	Standard	n/a	Transmitted person-to-person through infested clothing. Wear gown and gloves when removing clothing; bag and wash clothes according to CDC guidance Parasites – Lice (accessed September 2018).
Lice Pubic	Standard	n/a	Transmitted person-to-person through sexual contact. See CDC's Parasites – Lice (accessed September 2018).
Listeriosis (listeria monocytogenes)	Standard	n/a	Person-to-person transmission rare; cross-transmission in neonatal settings reported. [1072-1075]
Lyme disease	Standard	n/a	Not transmitted from person to person.
Lymphocytic choriomeningitis	Standard	n/a	Not transmitted from person to person.
Lymphogranuloma venereum	Standard	n/a	n/a

M

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Malaria	Standard	n/a	Not transmitted from person to person, except through transfusion rarely and through a failure to follow Standard Precautions during patient care. [1076-1079] Install screens in windows and doors in endemic areas. Use DEET- containing mosquito repellants and clothing to cover extremities.
Marburg virus disease (see Viral Hemorrhagic Fevers)	n/a	n/a	n/a

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Measles (rubeola)	Airborne + Standard	4 days after onset of rash; duration of illness in immune compromised	**Interim Measles Infection Control [July 2019]** ⚠ See Interim Infection Prevention and Control Recommendations for Measles in Healthcare Settings Susceptible healthcare personnel (HCP) should not enter room if immune care providers are available; regardless of presumptive evidence of immunity, HCP should use respiratory protection that is at least as protective as a fit-tested, NIOSH-certified N95 respirator upon entry into the patient's room or care area. For exposed susceptibles, postexposure vaccine within 72 hours or immune globulin within 6 days when available [17, 1032, 1034]. Place exposed susceptible patients on Airborne Precautions and exclude susceptible healthcare personnel.
Melioidosis, all forms	Standard	n/a	Not transmitted from person to person.
Meningitis Aseptic (nonbacterial or viral; also see Enteroviral infections)	Standard	n/a	Contact for infants and young children.
Meningitis Bacterial, gram-negative enteric, in neonates	Standard	n/a	n/a
Meningitis Fungal	Standard	n/a	n/a
Meningitis *Haemophilus Influenzae*, type b known or suspected	Droplet + Standard	Until 24 hours after initiation of effective therapy	n/a
Meningitis *Listeria monocytogenes* (See Listeriosis)	Standard	n/a	n/a
Meningitis *Neisseria meningitidis* (meningococcal) known or suspected	Droplet + Standard	Until 24 hours after initiation of effective therapy	See Meningococcal Disease below.
Meningitis *Streptococcus pneumoniae*	Standard	n/a	n/a

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Meningitis *M. tuberculosis*	Standard	n/a	Concurrent, active pulmonary disease or draining cutaneous lesions may necessitate addition of Contact and/or Airborne. For children, Airborne Precautions until active tuberculosis ruled out in visiting family members (see Tuberculosis below). [42]
Meningitis Other diagnosed bacterial	Standard	n/a	n/a
Meningococcal disease: sepsis, pneumonia, Meningitis	Droplet + Standard	Until 24 hours after initiation of effective therapy	Postexposure chemoprophylaxis for household contacts, HCWs exposed to respiratory secretions; postexposure vaccine only to control outbreaks. [15, 17]
Molluscum contagiosum	Standard	n/a	n/a
Monkeypox			See CDC's Monkeypox website (accessed May 2022) for information on infection prevention and control.
Mucormycosis	Standard	n/a	n/a
Multidrug-resistant organisms (MDROs), infection or colonization (e.g., MRSA, VRE, VISA/VRSA, ESBLs, resistant *S. pneumoniae*)	Contact + Standard	n/a	MDROs judged by the infection control program, based on local, state, regional, or national recommendations, to be of clinical and epidemiologic significance. Contact Precautions recommended in settings with evidence of ongoing transmission, acute care settings with increased risk for transmission or wounds that cannot be contained by dressings. See recommendations for management options in Management of Multidrug-Resistant Organisms In Healthcare Settings, 2006 [870]. Contact state health department for guidance regarding new or emerging MDRO.
Mumps (infectious parotitis)	Droplet + Standard	Until 5 days after the onset of swelling	**Mumps [October 2017]** ⚠ **Update:** The Healthcare Infection Control Practices Advisory Committee (HICPAC) voted to change the recommendation of isolation for persons with mumps from 9 days to 5 days based on this 2008 MMWR reportUpdated Recommendations for Isolation of Persons with Mumps (accessed September 2018). After onset of swelling; susceptible HCWs should not provide care if immune caregivers are available. **The below note has been superseded by the above recommendation update** Note: (Recent assessment of outbreaks in healthy 18-24 year olds has indicated that salivary viral shedding occurred early in the course of illness and that 5 days of isolation after onset of parotitis may be appropriate in community settings; however the implications for healthcare personnel and high-risk patient populations remain to be clarified.)

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Mycobacteria, nontuberculosis (atypical)	n/a	Not transmitted person-to-person.	n/a
Mycobacteria, nontuberculosis (atypical)	Pulmonary	Standard	n/a
Mycobacteria, nontuberculosis (atypical)	Wound	Standard	n/a
Mycoplasma pneumonia	Droplet + Standard	Duration of Illness	n/a

N

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Necrotizing enterocolitis	Standard	n/a	Contact Precautions when cases clustered temporally [1080-1083].
Nocardiosis, draining lesions, or other presentations	Standard	n/a	Not transmitted person-to-person.
Norovirus (see Gastroenteritis)	n/a	n/a	n/a
Norwalk agent Gastroenteritis (see Gastroenteritis)	n/a	n/a	n/a

O

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Orf	Standard	n/a	n/a

P

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Parainfluenza virus infection, respiratory in infants and young children	Contact + Standard	Duration of illness	Viral shedding may be prolonged in immunosuppressed patients [1009, 1010]. Reliability of antigen testing to determine when to remove patients with prolonged hospitalizations from Contact Precautions uncertain.
Parvovirus B19 (Erythema infectiosum)	Droplet + Standard	n/a	Maintain precautions for duration of hospitalization when chronic disease occurs in an immunocompromised patient. For patients with transient aplastic crisis or red-cell crisis, maintain precautions for 7 days. Duration of precautions for immunosuppressed patients with persistently positive PCR not defined, but transmission has occurred [929].
Pediculosis (lice)	Contact + Standard	Until 24 hours after initiation of effective therapy after treatment	n/a
Pertussis (whooping cough)	Droplet + Standard	Until 5 days after initiation of effective antibiotic therapy	Single patient room preferred. Cohorting an option. Postexposure chemoprophylaxis for household contacts and HCWs with prolonged exposure to respiratory secretions [863]. Recommendations for Tdap vaccine in adults under development. **Tdap Vaccine Recommendations [2018]** ⚠**Update:** Current recommendations can be found at Tdap / Td ACIP Vaccine Recommendations (accessed September 2018).
Pinworm infection (Enterobiasis)	Standard	n/a	n/a
Plague (*Yersinia pestis*) Bubonic	Standard	n/a	n/a
Plague (*Yersinia pestis*) Pneumonic	Droplet + Standard	Until 48 hours after initiation of effective antibiotic therapy	Antimicrobial prophylaxis for exposed HCW [207].
Pneumonia Adenovirus	Droplet + Contact + Standard	Duration of illness	Outbreaks in pediatric and institutional settings reported [376, 1084-1086]. In immunocompromised hosts, extend duration of Droplet and Contact Precautions due to prolonged shedding of virus. [931]

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Pneumonia Bacterial not listed elsewhere (including gram-negative bacterial)	Standard	n/a	n/a
Pneumonia *B. cepacia* in patients with CF, including respiratory tract colonization	Contact + Standard	Unknown	Avoid exposure to other persons with CF; private room preferred. Criteria for D/C precautions not established. See CF Foundation guideline. [20]
Pneumonia *B. cepacia* in patients without CF (see Multidrug-Resistant Organisms)	n/a	n/a	n/a
Pneumonia *Chlamydia*	Standard	n/a	n/a
Pneumonia Fungal	Standard	n/a	n/a
Pneumonia *Haemophilus influenzae*, type b Adults	Standard	n/a	n/a
Pneumonia *Haemophilus influenzae*, type b Infants and children	Droplet + Standard	Until 24 hours after initiation of effective therapy	n/a
Pneumonia *Legionella spp.*	Standard	n/a	n/a
Pneumonia . Meningococcal	Droplet + Standard	Until 24 hours after initiation of effective therapy	See Meningococcal Disease above.

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Pneumonia Multidrug-resistant bacterial (see Multidrug-Resistant Organisms)	n/a	n/a	n/a
Pneumonia *Mycoplasma* (primary atypical Pneumonia)	Droplet + Standard	Duration of illness	n/a
Pneumonia Pneumococcal pneumonia	Standard	n/a	Use Droplet Precautions if evidence of transmission within a patient care unit or facility. [196-198, 1087]
Pneumonia *Pneumocystis jiroveci* (*Pneumocystis carinii*)	Standard	n/a	Avoid placement in the same room with an immunocompromised patient.
Pneumonia *Staphylococcus aureus*	Standard	n/a	For MRSA, see MDROs.
Pneumonia *Streptococcus*, group A Adults	Droplet + Standard	Until 24 hours after initiation of effective therapy	See Streptococcal Disease (group A *Streptococcus*) below Contact Precautions if skin lesions present.
Pneumonia *Streptococcus*, group A Infants and young children	Droplet + Standard	Until 24 hours after initiation of effective therapy	Contact Precautions if skin lesions present.
Pneumonia Varicella-Zoster (See Varicella-Zoster)	n/a	n/a	n/a
Pneumonia Viral Adults	Standard	n/a	n/a

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Pneumonia Viral Infants and young children (see Respiratory Infectious Disease, acute, or specific viral agent)	n/a	n/a	n/a
Poliomyelitis	Contact + Standard	Duration of illness	n/a
Pressure ulcer (decubitus ulcer, pressure sore) infected Major	Contact + Standard	Duration of illness	Until drainage stops or can be contained by dressing.
Pressure ulcer (decubitus ulcer, pressure sore) infected Minor or limited	Standard	n/a	If dressing covers and contains drainage.
Prion disease (See Creutzfeld-Jacob Disease)	n/a	n/a	n/a
Psittacosis (ornithosis) (*Chlamydia psittaci*)	Standard	n/a	Not transmitted from person to person.

Q

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Q fever	Standard	n/a	n/a

R

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Rabies	Standard	n/a	Person to person transmission rare; transmission via corneal, tissue and organ transplants has been reported [539, 1088]. If patient has bitten another individual or saliva has contaminated an open wound or mucous membrane, wash exposed area thoroughly and administer postexposure prophylaxis. [1089]
Rat-bite fever (*Streptobacillus moniliformis* disease, *Spirillum minus* disease)	Standard	n/a	Not transmitted from person to person.
Relapsing fever	Standard	n/a	Not transmitted from person to person.
Resistant bacterial infection or colonization (see Multidrug-Resistant Organisms)	n/a	n/a	n/a
Respiratory infectious disease, acute (if not covered elsewhere) Adults	Standard	n/a	n/a
Respiratory infectious disease, acute (if not covered elsewhere) Infants and young children	Contact + Standard	Duration of illness	Also see syndromes or conditions listed in Table 2.
Respiratory syncytial virus infection, in infants, young children and immunocompromised adults	Contact + Standard	Duration of illness	Wear mask according to Standard Precautions [24] CB [116, 117]. In immunocompromised patients, extend the duration of Contact Precautions due to prolonged shedding [928]. Reliability of antigen testing to determine when to remove patients with prolonged hospitalizations from Contact Precautions uncertain.
Reye's syndrome	Standard	n/a	Not an infectious condition.
Rheumatic fever	Standard	n/a	Not an infectious condition.
Rhinovirus	Droplet + Standard	Duration of illness	Droplet most important route of transmission [104 1090]. Outbreaks have occurred in NICUs and LTCFs [413, 1091, 1092]. Add Contact Precautions if copious moist secretions and close contact likely to occur (e.g., young infants) [111, 833].
Rickettsial fevers, tickborne (Rocky Mountain spotted fever, tickborne Typhus fever)	Standard	n/a	Not transmitted from person to person except through transfusion, rarely.

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Rickettsialpox (vesicular rickettsiosis)	Standard	n/a	Not transmitted from person to person.
Ringworm (dermatophytosis, dermatomycosis, tinea)	Standard	n/a	Rarely, outbreaks have occurred in healthcare settings, (e.g., NICU [1093], rehabilitation hospital [1094]. Use Contact Precautions for outbreak.
Rocky Mountain spotted fever	Standard	n/a	Not transmitted from person to person except through transfusion, rarely.
Roseola infantum (exanthem subitum; caused by HHV-6)	Standard	n/a	n/a
Rotavirus infection (see Gastroenteritis)	n/a	n/a	n/a
Rubella (German measles) (also see Congenital Rubella)	Droplet + Standard	Until 7 days after onset of rash	Susceptible HCWs should not enter room if immune caregivers are available. No recommendation for wearing face protection (e.g., a surgical mask) if immune. Pregnant women who are not immune should not care for these patients [17, 33]. Administer vaccine within 3 days of exposure to non-pregnant susceptible individuals. Place exposed susceptible patients on Droplet Precautions; exclude susceptible healthcare personnel from duty from day 5 after first exposure to day 21 after last exposure, regardless of postexposure vaccine.
Rubeola (see Measles)	n/a	n/a	n/a

S

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Salmonellosis (see Gastroenteritis)	n/a	n/a	n/a
Scabies	Contact + Standard	Until 24 hours after initiation of effective therapy	n/a
Scalded skin syndrome, staphylococcal	Contact + Standard	Duration of illness	See Staphylococcal Disease, scalded skin syndrome below.
Schistosomiasis (bilharziasis)	Standard	n/a	n/a

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Severe acute respiratory syndrome (SARS)	Airborne + Droplet + Contact + Standard	Duration of illness plus 10 days after resolution of fever, provided respiratory symptoms are absent or improving	Airborne preferred; Droplet if AIIR unavailable. N95 or higher respiratory protection; surgical mask if N95 unavailable; eye protection (goggles, face shield); aerosol-generating procedures and "supershedders" highest risk for transmission via small droplet nuclei and large droplets [93, 94, 96]. Vigilant environmental disinfection (see [This link is no longer active: www.cdc.gov/ncidod/sars. Similar information may be found at CDC Severe Acute Respiratory Syndrome (SARS) (accessed September 2018).])
Shigellosis (see Gastroenteritis)	n/a	n/a	n/a
Smallpox (variola; see Vaccinia for management of vaccinated persons)	Airborne + Contact + Standard	Duration of illness	Until all scabs have crusted and separated (3-4 weeks). Non-vaccinated HCWs should not provide care when immune HCWs are available; N95 or higher respiratory protection for susceptible and successfully vaccinated individuals; postexposure vaccine within 4 days of exposure protective [108, 129, 1038-1040].
Sporotrichosis	Standard	n/a	n/a
Spirillum minor disease (rat-bite fever)	Standard	n/a	Not transmitted from person to person.
Staphylococcal disease (*S. aureus*) Skin, wound, or burn Major	Contact + Standard	Duration of illness	Until drainage stops or can be contained by dressing.
Staphylococcal disease (*S. aureus*) Skin, wound, or burn Minor or limited	Standard	n/a	If dressing covers and contains drainage adequately.
Staphylococcal disease (*S. aureus*) Enterocolitis	Standard	n/a	Use Contact Precautions for diapered or incontinent children for duration of illness.
Staphylococcal disease (*S. aureus*) Multidrug-resistant (see Multidrug-Resistant Organisms)	n/a	n/a	n/a

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Staphylococcal disease (*S. aureus*) Pneumonia	Standard	n/a	n/a
Staphylococcal disease (*S. aureus*) Scalded skin syndrome	Contact + Standard	Duration of illness	Consider healthcare personnel as potential source of nursery, NICU outbreak [1095].
Staphylococcal disease (*S. aureus*) Toxic shock syndrome	Standard	n/a	n/a
Streptobacillus moniliformis disease (rat-bite fever)	Standard	n/a	Not transmitted from person to person.
Streptococcal disease (group A *Streptococcus*) Skin, wound, or burn Major	Contact + Droplet + Standard	Until 24 hours after initiation of effective therapy	Until drainage stops or can be contained by dressing.
Streptococcal disease (group A *Streptococcus*) Skin, wound, or burn Minor or limited	Standard	n/a	If dressing covers and contains drainage.
Streptococcal disease (group A *Streptococcus*) Endometritis (puerperal sepsis)	Standard	n/a	n/a
Streptococcal disease (group A *Streptococcus*) Pharyngitis in infants and young children	Droplet + Standard	Until 24 hours after initiation of effective therapy	n/a
Streptococcal disease (group A *Streptococcus*) Pneumonia	Droplet + Standard	Until 24 hours after initiation of effective therapy	n/a

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Streptococcal disease (group A *Streptococcus*) Scarlet fever in infants and young children	Droplet + Standard	Until 24 hours after initiation of effective therapy	n/a
Streptococcal disease (group A *Streptococcus*) Serious invasive disease	Droplet + Standard	Until 24 hours after initiation of effective therapy	Outbreaks of serious invasive disease have occurred secondary to transmission among patients and healthcare personnel [162, 972, 1096-1098]. Contact Precautions for draining wound as above; follow recommendations for antimicrobial prophylaxis in selected conditions [160].
Streptococcal disease (group B *Streptococcus*), neonatal	Standard	n/a	n/a
Streptococcal disease (not group A or B) unless covered elsewhere Multidrug-resistant (see Multidrug-Resistant Organisms)	n/a	n/a	n/a
Strongyloidiasis	Standard	n/a	n/a
Syphilis Latent (tertiary) and seropositivity without lesions	Standard	n/a	n/a
Syphilis Skin and mucous membrane, including congenital, primary, Secondary	Standard	n/a	n/a

T

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Tapeworm disease *Hymenolepis nana*	Standard	n/a	Not transmitted from person to person.
Tapeworm disease *Taenia solium* (pork)	Standard	n/a	n/a
Tapeworm disease Other	Standard	n/a	n/a
Tetanus	Standard	n/a	Not transmitted from person to person.
Tinea (e.g., dermatophytosis, dermatomycosis, ringworm)	Standard	n/a	Rare episodes of person-to-person transmission.
Toxoplasmosis	Standard	n/a	Transmission from person to person is rare; vertical transmission from mother to child, transmission through organs and blood transfusion rare.
Toxic shock syndrome (staphylococcal disease, streptococcal disease)	Standard	n/a	Droplet Precautions for the first 24 hours after implementation of antibiotic therapy if Group A *Streptococcus* is a likely etiology.
Trachoma, acute	Standard	n/a	n/a
Transmissible spongiform encephalopathy (see Creutzfeld-Jacob disease, CJD, vCJD)	n/a	n/a	n/a
Trench mouth (Vincent's angina)	Standard	n/a	n/a
Trichinosis	Standard	n/a	n/a
Trichomoniasis	Standard	n/a	n/a
Trichuriasis (whipworm disease)	Standard	n/a	n/a
Tuberculosis (*M. tuberculosis*) Extrapulmonary, draining lesion	Airborne + Contact + Standard	n/a	Discontinue precautions only when patient is improving clinically, and drainage has ceased or there are 3 consecutive negative cultures of continued drainage [1025, 1026]. Examine for evidence of active pulmonary tuberculosis.

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Tuberculosis (*M. tuberculosis*) Extrapulmonary, no draining lesion, Meningitis	Standard	n/a	Examine for evidence of pulmonary tuberculosis. For infants and children, use Airborne until active pulmonary tuberculosis in visiting family members ruled out. [42]
Tuberculosis (*M. tuberculosis*) Pulmonary or laryngeal disease, confirmed	Airborne + Standard	n/a	Discontinue precautions only when patient on effective therapy is improving clinically and has 3 consecutive sputum smears negative for acid-fast bacilli collected on separate days (MMWR 2005; 54: RR-17 Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings, 2005) (accessed September 2018) [12].
Tuberculosis (*M. tuberculosis*) Pulmonary or laryngeal disease, suspected	Airborne + Standard	n/a	Discontinue precautions only when the likelihood of infectious TB disease is deemed negligible, and either 1. there is another diagnosis that explains the clinical syndrome, or 2. the results of 3 sputum smears for AFB are negative. Each of the 3 sputum specimens should be collected 8 -24 hours apart, and at least 1 should be an early morning specimen.
Tuberculosis (*M. tuberculosis*) Skin-test positive with no evidence of current active disease	Standard	n/a	n/a
Tularemia Draining lesion	Standard	n/a	Not transmitted from person to person.
Tularemia Pulmonary	Standard	n/a	Not transmitted from person to person.
Typhoid (*Salmonella typhi*) fever (see Gastroenteritis)	n/a	n/a	n/a
Typhus Rickettsia prowazekii (Epidemic or Louse-borne Typhus)	Standard	n/a	Transmitted from person to person through close personal or clothing contact.
Typhus *Rickettsia typhi*	Standard	n/a	Not transmitted from person to person.

U

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Urinary tract infection (including pyelonephritis), with or without urinary catheter	Standard	n/a	n/a

V

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Vaccinia	n/a	n/a	Only vaccinated HCWs have contact with active vaccination sites and care for persons with adverse vaccinia events; if unvaccinated, only HCWs without contraindications to vaccine may provide care.
Vaccinia Vaccination site care (including autoinoculated areas)	Standard	n/a	Vaccination recommended for vaccinators; for newly vaccinated HCWs: semi-permeable dressing over gauze until scab separates, with dressing change as fluid accumulates, ~3-5 days; gloves, hand hygiene for dressing change; vaccinated HCW or HCW without contraindication to vaccine for dressing changes. [205, 221, 225].
Vaccinia (adverse events following vaccination) Eczema vaccinatum	Contact + Standard	Until lesions dry and crusted, scabs separated	For contact with virus-containing lesions and exudative material.
Vaccinia (adverse events following vaccination) Fetal vaccinia	Contact + Standard	Until lesions dry and crusted, scabs separated	For contact with virus-containing lesions and exudative material.
Vaccinia (adverse events following vaccination) Generalized vaccinia	Contact + Standard	Until lesions dry and crusted, scabs separated	For contact with virus-containing lesions and exudative material.
Vaccinia (adverse events following vaccination) Progressive vaccinia	Contact + Standard	Until lesions dry and crusted, scabs separated	For contact with virus-containing lesions and exudative material.

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Vaccinia (adverse events following vaccination) Postvaccinia encephalitis	Standard	n/a	n/a
Vaccinia (adverse events following vaccination) Blepharitis or conjunctivitis	Contact + Standard	n/a	Use Contact Precautions if there is copious drainage.
Vaccinia (adverse events following vaccination) Iritis or keratitis	Standard	n/a	n/a
Vaccinia (adverse events following vaccination) Vaccinia-associated erythema multiforme (Stevens Johnson Syndrome)	Standard	n/a	Not an infectious condition.
Vaccinia (adverse events following vaccination) Secondary bacterial infection (e.g., *S. aureus*, group A beta hemolytic *Streptococcus*)	Standard + Contact	n/a	Follow organism-specific (strep, staph most frequent) recommendations and consider magnitude of drainage.

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Varicella Zoster	Airborne + Contact + Standard	Until lesions dry and crusted	Susceptible HCWs should not enter room if immune caregivers are available; no recommendation for face protection of immune HCWs; no recommendation for type of protection (i.e., surgical mask or respirator) for susceptible HCWs. In immunocompromised host with varicella pneumonia, prolong duration of precautions for duration of illness. **Varicella Post-exposure Prophylaxis Update [April 2019]** ⚠ **Update:** Postexposure prophylaxis: provide postexposure vaccine ASAP but within 120 hours; for susceptible exposed persons for whom vaccine is contraindicated (immunocompromised persons, pregnant women, newborns whose mother's varicella onset is <5 days before delivery or within 48 hours after delivery) provide varicella zoster immune globulin as soon as possible after exposure and within 10 days. Use Airborne for exposed susceptible persons and exclude exposed susceptible healthcare workers beginning 8 days after first exposure until 21 days after last exposure or 28 if received varicella zoster immune globulin, regardless of postexposure vaccination. [1036]
Variola (see Smallpox)	n/a	n/a	n/a
Vibrio parahaemolyticus (see Gastroenteritis)	n/a	n/a	n/a
Vincent's angina (trench mouth)	Standard	n/a	n/a
Viral hemorrhagic fevers due to Lassa, Ebola, Marburg, Crimean-Congo fever viruses	Droplet + Contact + Standard	Duration of illness	**Ebola Virus Disease for Healthcare Workers [2014]** ⚠ **Update:** Recommendations for healthcare workers can be found at Ebola For Clinicians. (accessed September 2018). Single-patient room preferred. Emphasize: 1. use of sharps safety devices and safe work practices, 2. hand hygiene; 3. barrier protection against blood and body fluids upon entry into room (single gloves and fluid-resistant or impermeable gown, face/eye protection with masks, goggles or face shields); and 4. appropriate waste handling. Use N95 or higher respirators when performing aerosol-generating procedures. Largest viral load in final stages of illness when hemorrhage may occur; additional PPE, including double gloves, leg and shoe coverings may be used, especially in resource-limited settings where options for cleaning and laundry are limited. Notify public health officials immediately if Ebola is suspected [212, 314, 740, 772]. Also see Table 3C for Ebola as a bioterrorism agent.

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Viral respiratory diseases (not covered elsewhere) Adults	Standard	n/a	n/a
Viral respiratory diseases (not covered elsewhere) Infants and young children (see Respiratory infectious disease, acute)	n/a	n/a	n/a

W

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Whooping cough (see Pertussis)	n/a	n/a	n/a
Wound infections Major	Contact + Standard	Duration of illness	Until drainage stops or can be contained by dressing.
Wound infections Minor or limited	Standard	n/a	If dressing covers and contains drainage.

Y

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Yersinia enterocolitica Gastroenteritis (see Gastroenteritis)	n/a	n/a	n/a

Z

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Zoster (varicella-zoster) (see Herpes Zoster)	n/a	n/a	n/a
Zygomycosis (phycomycosis, mucormycosis)	Standard	n/a	Not transmitted person-to-person.

Page last reviewed: July 22, 2019

CDC Centers for Disease Control and Prevention

Vaccine Information for Adults

Recommended Vaccines for Healthcare Workers

COVID-19 Vaccination

COVID-19 Vaccines for Healthcare Personnel

Healthcare workers (HCWs) are at risk for exposure to serious, and sometimes deadly, diseases. If you work directly with patients or handle material that could spread infection, you should get appropriate vaccines to reduce the chance that you will get or spread vaccine-preventable diseases. Protect yourself, your patients, and your family members. Make sure you are up-to-date with recommended vaccines.

Healthcare workers include physicians, nurses, emergency medical personnel, dental professionals and students, medical and nursing students, laboratory technicians, pharmacists, hospital volunteers, and administrative staff.

Vaccines	Recommendations in brief
Hepatitis B	If you don't have documented evidence of a complete hepB vaccine series, or if you don't have a blood test that shows you are immune to hepatitis B (i.e., no serologic evidence of immunity or prior vaccination) then you should • Get a 3-dose series of Recombivax HB or Engerix-B (dose #1 now, #2 in 1 month, #3 approximately 5 months after #2) or a 2-dose series of Heplisav-B, with the doses separated by at least 4 weeks. • Get an anti-HBs serologic test 1-2 months after the final dose. See Prevention of Hepatitis B Virus Infection in the United States: Recommendations of the ACIP.
Flu (Influenza)	Get 1 dose of influenza vaccine annually.
MMR (Measles, Mumps, & Rubella)	If you were born in 1957 or later and have not had the MMR vaccine, or if you don't have a blood test that shows you are immune to measles or mumps (i.e., no serologic evidence of immunity or prior vaccination), get 2 doses of MMR (1 dose now and the 2nd dose at least 28 days later). If you were born in 1957 or later and have not had the MMR vaccine, or if you don't have a blood test that shows you are immune to rubella, only 1 dose of MMR is recommended. However, you may end up receiving 2 doses, because the rubella component is in the combination vaccine with measles and mumps.For HCWs born before 1957, see the MMR ACIP vaccine recommendations.
Varicella (Chickenpox)	If you have not had chickenpox (varicella), if you haven't had varicella vaccine, or if you don't have a blood test that shows you are immune to varicella (i.e., no serologic evidence of immunity or prior vaccination) get 2 doses of varicella vaccine, 4 weeks apart.
Tdap (Tetanus, Diphtheria, Pertussis)	Get a one-time dose of Tdap as soon as possible if you have not received Tdap previously (regardless of when previous dose of Td was received). Get either a Td or Tdap booster shot every 10 years thereafter. Pregnant HCWs need to get a dose of Tdap during each pregnancy.
Meningococcal	Microbiologists who are routinely exposed to *Neisseria meningitidis* should get meningococcal conjugate vaccine and serogroup B meningococcal vaccine.

To learn more about these diseases and the benefits and potential risks associated with the vaccines, read the Vaccine Information Statements (VIS).

Published Recommendations



- Immunization of HCW: Recommendations of ACIP. *MMWR*. 2011;60(RR07):1-45.
- General Best Practice Guidelines for Immunization.
- ACIP Immunization Recommendations by specific disease

State Immunization Laws

- State Immunization Laws for Healthcare Workers and Patients
  Summarizes state immunization laws for healthcare workers, correctional inmates/residents, hospital inpatients, and developmentally disabled facility residents; search for information on vaccine administration, assessment, and Hepatitis B reporting.

Resources for More Information

- HCW resources from Immunization Action Coalition
- Flu: Protect Your Patients. Protect Yourself
  Toolkit features a variety of helpful resource materials for healthcare institutions to implement or expand their healthcare worker immunization programs (from the Association for Professionals in Infection Control and Epidemiology (APIC).
- Increasing Flu Vaccination Rates among Healthcare Workers
  Position statements from professional organizations, mandatory influenza vaccination policies, and many helpful resources from the National Influenza Vaccine Summit's website.

Resources for Those Vaccinating HCWs

- Healthcare Personnel Vaccination Recommendations [1 page]
  One-page reference sheet detailing the vaccines and conditions for vaccinating HCWs.
- HCW web button
  Place this web button on your website so HCWs can quickly access this page to see what vaccines they need.
- Healthcare personnel resources from Immunization Action Coalition
  - "Ask the Experts" **MMR** and HCW Questions and Answers
    Answers to "If HCW develops rash after vaccinated, is he or she infectious?", "What is the recommendation?"
  - "Ask the Experts" **Flu** and HCW Questions and Answers
    Answers to "Which HCWs need the vaccine?", "Can NICU staff receive vaccine without compromising their neonates?" and more.
  - "Ask the Experts" **Hepatitis B** and HCW Questions and Answers
    Answers to "If HCW had one dose only 4 months ago, should series be restarted?", "Is it safe for HCWs to be vaccinated during pregnancy?" and more.
- Flu Vaccination of Healthcare Personnel

Page last reviewed: May 2, 2016

AN ACT PROHIBITING DISCRIMINATION BASED ON A PERSON'S VACCINATION STATUS OR POSSESSION OF AN IMMUNITY PASSPORT; PROVIDING AN EXCEPTION AND AN EXEMPTION; PROVIDING AN APPROPRIATION; AND PROVIDING EFFECTIVE DATES.

WHEREAS, as stated in section 50-16-502, MCA, the Legislature finds that "health care information is personal and sensitive information that if improperly used or released may do significant harm to a patient's interests in privacy and health care or other interests"; and

WHEREAS, the Montana Supreme Court in State v. Nelson, 283 Mont. 231, 941 P.2d 441 (1997), concluded that "medical records fall within the zone of privacy protected by Article II, section 10, of the Montana Constitution" and "are quintessentially private and deserve the utmost constitutional protection".

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Discrimination based on vaccination status or possession of immunity passport prohibited -- definitions. (1) Except as provided in subsection (2), it is an unlawful discriminatory practice for:

(a) a person or a governmental entity to refuse, withhold from, or deny to a person any local or state services, goods, facilities, advantages, privileges, licensing, educational opportunities, health care access, or employment opportunities based on the person's vaccination status or whether the person has an immunity passport;

(b) an employer to refuse employment to a person, to bar a person from employment, or to discriminate against a person in compensation or in a term, condition, or privilege of employment based on the person's vaccination status or whether the person has an immunity passport; or

(c) a public accommodation to exclude, limit, segregate, refuse to serve, or otherwise discriminate against a person based on the person's vaccination status or whether the person has an immunity passport.

(2) This section does not apply to vaccination requirements set forth for schools pursuant to Title 20, chapter 5, part 4, or day-care facilities pursuant to Title 52, chapter 2, part 7.

(3) (a) A person, governmental entity, or an employer does not unlawfully discriminate under this section if they recommend that an employee receive a vaccine.

(b) A health care facility, as defined in 50-5-101, does not unlawfully discriminate under this section if it complies with both of the following:

(i) asks an employee to volunteer the employee's vaccination or immunization status for the purpose of determining whether the health care facility should implement reasonable accommodation measures to protect the safety and health of employees, patients, visitors, and other persons from communicable diseases. A health care facility may consider an employee to be nonvaccinated or nonimmune if the employee declines to provide the employee's vaccination or immunization status to the health care facility for purposes of determining whether reasonable accommodation measures should be implemented.

(ii) implements reasonable accommodation measures for employees, patients, visitors, and other persons who are not vaccinated or not immune to protect the safety and health of employees, patients, visitors, and other persons from communicable diseases.

(4) An individual may not be required to receive any vaccine whose use is allowed under an emergency use authorization or any vaccine undergoing safety trials.

(5) As used in this section, the following definitions apply:

(a) "Immunity passport" means a document, digital record, or software application indicating that a person is immune to a disease, either through vaccination or infection and recovery.

(b) "Vaccination status" means an indication of whether a person has received one or more doses of a vaccine.

Section 2. Exemption. A licensed nursing home, long-term care facility, or assisted living facility is exempt from compliance with [section 1] during any period of time that compliance with [section 1] would result in a violation of regulations or guidance issued by the centers for medicare and medicaid services or the centers for disease control and prevention.

Section 3. Appropriation. There is appropriated $200 from the general fund to the department of labor and industry for the biennium beginning July 1, 2021, for the purposes of:

(1) notifying local boards of health of the requirements of [section 1] and requiring local boards of health to prominently display notice of the requirements of [section 1] on the home page of their website, if available, for at least 6 months after [the effective date of this act]; and

(2) requiring the department of public health and human services to prominently display notice of the requirements of [section 1] on the home page of the department's website for at least 6 months after [the effective date of this act].

Section 4. Codification instruction. [Sections 1 and 2] are intended to be codified as an integral part of Title 49, chapter 2, part 3, and the provisions of Title 49, chapter 2, part 3, apply to [sections 1 and 2].

Section 5. Severability. If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

Section 6. Effective date. (1) Except as provided in subsection (2), [this act] is effective on passage and approval.

(2) [Section 3] is effective July 1, 2021.

- END -

I hereby certify that the within bill,

HB 702, originated in the House.

_____

Chief Clerk of the House

_____

Speaker of the House

Signed this _____day

of_____, 2021.

_____

President of the Senate

Signed this _____day
of_____, 2021.

HOUSE BILL NO. 702

INTRODUCED BY J. CARLSON, D. SKEES, J. READ, D. LENZ, W. GALT, S. BERGLEE, J. HINKLE, M. NOLAND, V. RICCI, B. TSCHIDA, S. GUNDERSON, M. REGIER, L. SHELDON-GALLOWAY, J. TREBAS, D. BARTEL, C. KNUDSEN, B. USHER, J. PATELIS, S. VINTON, M. HOPKINS, F. FLEMING, J. FULLER, R. KNUDSEN, J. KASSMIER, T. MOORE, B. LER, B. PHALEN, F. NAVE, L. BREWSTER, B. MITCHELL, A. REGIER, S. KERNS, S. GALLOWAY, S. GIST, E. HILL, J. SCHILLINGER, K. SEEKINS-CROWE, M. STROMSWOLD, J. GILLETTE, C. HINKLE, M. BINKLEY, R. MARSHALL

AN ACT PROHIBITING DISCRIMINATION BASED ON A PERSON'S VACCINATION STATUS OR POSSESSION OF AN IMMUNITY PASSPORT; PROVIDING AN EXCEPTION AND AN EXEMPTION; PROVIDING AN APPROPRIATION; AND PROVIDING EFFECTIVE DATES.

MONTANA DEPARTMENT OF LABOR & INDUSTRY
EMPLOYMENT RELATIONS DIVISION
HUMAN RIGHTS BUREAU

[redacted], Charging Party, vs. [redacted], Respondent.	Final Investigative Report HRB Case No. 0210440

Recommendation: Based on my investigation, I find **no reasonable cause** to believe unlawful discrimination occurred as alleged in Charging Party's complaint.

I. ISSUE PRESENTED

Did [redacted] discriminate against [redacted] on the basis of vaccination status in violation of the Montana Human Rights Act (Title 49, Chapter 2, MCA), by threatening her with termination of employment if she chose not to receive the COVID-19 vaccination?

II. SUMMARY OF THE INVESTIGATION

This report constitutes a summary of the investigation conducted in this case. Content of this report is limited to witnesses, documents, and other evidence relevant to the analysis of the issue presented. The case file may contain additional evidence not included in this report.

A. Charging Party's Position Statement:

[redacted] self-drafted a complaint based on vaccination status and submitted that complaint to the Human Rights Bureau (Bureau) on May 25, 2021. After submitting her complaint, the Bureau only received one more communication from [redacted] (an email dated August 19, 2021). In that email, [redacted] indicated she no longer wished to pursue her claim. The Bureau then provided Wrenfrow with a Request for Withdrawal form, but [redacted] failed to return the form and did not respond to any subsequent communications from the Bureau.

The body of [redacted] complaint, in its entirety, consisted of the following:

> [redacted] stated on March 31 that all [redacted] Employees would be mandated to be vaccinated by July 1, then on May 6 It was stated that only Senior Service Employees were required to be vaccinated by July 1. This was also stated again on May 19 and again on May 24. On March 14 I was told that If we were not vaccinated by July 1 that we would not get terminated, however it would be a voluntary Quit due to failure to follow policy. [sic all]

EXHIBIT 80
30(b)(6) Designee
Mon, Aug 22, 2022
Reported by:
Mary Sullivan, RMR, CRR

DEFS 000983

B. Respondent's Position Statement:

[redacted] denies it discriminated against [redacted].

As [redacted] vaccination policy was evolving as the law changed, and at all times remained compliant. To be clear, although [redacted] initially planned to require vaccination of all employees, once Montana law precluded this option, [redacted] altered its plan. As the plan was altered, it was communicated to all employees, including Charging Party. Once HB 702 passed, [redacted] altered its vaccination requirement to comply. It limited mandatory vaccinations only to senior services employees, in accordance with the exemption set forth in HB 702, since the CDC has recommended all health care workers be vaccinated.

In addition, employees at [redacted], like Charging Party, were also aware [redacted] was following a no lay off policy. In other words, not a single individual was laid off during the pandemic who wanted to continue working and performed in accord with [redacted] policies and procedures. More significantly, individuals working in senior services who chose not to get vaccinated have been moved to alternate positions.

C. Charging Party's Rebuttal:

On August 19, 2021, [redacted] sent the following email to the Bureau:

> I would like to start out by addressing the comment that if we chose not to get vaccinated we would be moved to alternate positions. I was at no time offered an alternate position nor was I ever spoken to about choices. As far as them saying that I was planning on getting vaccinated until [redacted] required it is false. I stated that I was considering it until they were forcing it in order to keep my job. I however did get vaccinated due to the fact that June 30th we would no longer be able to work in Senior Services if we were not fully vaccinated so yes I did get vaccinated to keep my job so as not to lose my house, my car, and be unable to pay my bills. My complaint is that they are mandating a vaccine that is still not FDA-approved and I feel it is my choice to not get a vaccination that is not approved. I will withdraw my complaint however I felt it important to get some of the facts straight, there was no communication to me whatsoever that I could transfer or change to a different location in order to not get vaccinated and if I chose to move elsewhere I would have to take a pay cut as our wage as a CNA is more in Senior Living than the hospital. When I did receive my vaccination I did sign the paper stating that I was getting the vaccine under duress because I could not afford to lose my job.
>
> Thank you for your time in this matter. I am unhappy that I was forced to get a vaccine that is not approved and is experimental in order to keep my current position that I love. I love working with the elderly in rehabilitation and want to keep working at a job I love. I unfortunately disagree with the covid vaccine mandate but chose to follow their rules to keep my position.

D. **Documents:**

- Centers for Disease Control and Prevention, COVID-19 Vaccines for Healthcare Personnel, updated May 27, 2021, reads, in part, as follows:

> Healthcare personnel continue to be on the front line of the nation's fight against COVID-19. By providing critical care to those who are or might be infected with the virus that causes COVID-19, some healthcare personnel are at increased risk of infection from COVID-19. All healthcare personnel are recommended to get vaccinated against COVID-19.

https://www.cdc.gov/coronavirus/2019-ncov/vaccines/recommendations/hcp.html

E. **Omissions:**

As noted above, [redacted] neither participated in the Bureau's investigation, nor submitted a request for withdrawal form after indicating her desire not to pursue her claim. The Bureau's communications with [redacted] include the following:

- On July 23, 2021, this investigator mailed [redacted] a copy of the response filed by Benefis and requested that [redacted] submit a rebuttal.
- On August 16, 2021, having not received a response to the previous letter, this investigator mailed [redacted] another copy of the response filed by [redacted] and requested that she submit a rebuttal. This letter also contained a Request for Withdrawal form along with an explanation that [redacted] could complete and return the form if she no longer wished to pursue her claim.
- On August 19, 2021, this investigator received an email from [redacted], the content of which is set forth in Charging Party's Rebuttal above.
- On September 3, 2021, this investigator sent [redacted] a reply email requesting that she either participate in the Bureau's investigation by submitting a rebuttal or return the completed Request for Withdrawal form.

As of the date of this report, [redacted] has not communicated further with the Bureau. As such, the Bureau has drafted a finding based on the limited information contained in the case file.

III. ANALYSIS

[redacted] alleges [redacted] discriminated against her on the basis of vaccination status. [redacted] establishes she filed a timely complaint. The Bureau has jurisdiction over the complaint.

The initial complaint filed by [redacted] does not clearly articulate an adverse act on which she based her claim. However, [redacted] August 19, 2021 email clarifies her claim as follows: "My complaint is that they are mandating a vaccine that is still not FDA-approved and I feel it is my choice to not get a vaccination that is not approved."

House Bill 702 was signed into law by the Governor on May 7, 2021, and has since been codified as Mont. Code Ann. §§ 49-2-312 and 313.

Mont. Code Ann. § 49-2-312(1)(b) makes it an unlawful discriminatory practice for:

> an employer to refuse employment to a person, to bar a person from employment, or to discriminate against a person in compensation or in a term, condition, or privilege of employment based on the person's vaccination status or whether the person has an immunity passport.

This statute also states that "an individual may not be required to receive a vaccine whose use is allowed under emergency use or authorization or any vaccine undergoing safety trials." *Mont Code Ann. § 49-2-312(4)*

[redacted] alleges disparate treatment. To establish a prima facie case for disparate treatment, must show:

1. She is a member of a protected class; and
2. [redacted] subjected her to an adverse action in circumstances raising a reasonable inference [redacted] treated her differently because of membership in a protected class.

This analysis will proceed directly to element two, which is dispositive of [redacted] claim.

In its defense, [redacted] asserts that Mont. Code Ann. §49-2-313 includes the following exemption:

> A licensed nursing home, long-term care facility, or assisted living facility is exempt from compliance with 49-2-312 during any period of time that compliance with 49-2-312 would result in a violation of regulations or guidance issued by the centers for medicare and medicaid services or the centers for disease control and prevention.

[redacted] was asked to rebut [redacted] assertions that her position in senior services falls within the above-cited exemption and that CDC guidance recommends vaccination against COVID-19 for all healthcare personnel. The Bureau notes it has concerns about the application of this section, specifically what constitutes "guidance" issued by the centers for medicare and medicaid. But, the Bureau cannot force participation by a party and [redacted] has chosen not to participate. As such, [redacted] mandatory vaccination policy for senior services employees, including [redacted], did not violate the Montana Human Rights Act as it appears to fall within the exemption.

Accordingly, [redacted] cannot show that [redacted] subjected her to an adverse act and cannot establish a prima facie case for disparate treatment.

IV. CONCLUSION

Based on my investigation, I find **no reasonable cause** to believe unlawful discrimination occurred as alleged in Charging Party's complaint.

Bre Koffman
Bre Koffman
Montana Human Rights Bureau

November 22, 2021
Date

DEFS 000986

HRB CONFIDENTIAL

MONTANA DEPARTMENT OF LABOR & INDUSTRY
EMPLOYMENT RELATIONS DIVISION
HUMAN RIGHTS BUREAU

[redacted] Charging Party, vs. [redacted][1], Respondent.	Final Investigative Report HRB Case No. 0210598

Recommendation: Based on my investigation, I find **no reasonable cause** to believe unlawful discrimination occurred as alleged in Charging Party's complaint.

I. ISSUE PRESENTED

Did the [redacted] discriminate against [redacted] based on his vaccination status in violation of the Montana Human Rights Act (Title 49, Chapter 2, MCA) by subjecting him to quarantine and denying him employment and other opportunities?

II. SUMMARY OF THE INVESTIGATION

This report constitutes a summary of the investigation conducted in this case. Content of this report is limited to witnesses, documents and other evidence relevant to the analysis of the issue presented. The case file may contain additional evidence not included in this report.

A. Charging Party's Position Statement:

[redacted] sent in a self-drafted complaint asserting that he is an inmate serving his sentence with the [redacted] He asserts he is employed by [redacted] and that he was informed on August 16, 2021, that due to his non-vaccinated status, he would have to quarantine in C-Unit and could no longer enjoy his employment at the industries compound. He asserts he witnesses vaccinated inmates being permitted to enjoy their employment status.

[1] Nine complaints were filed by [redacted] inmates using a template containing substantially similar language. On the template, inmates checked whether they were felt they were denied visitation or medical care, some inmates wrote in additional information regarding denials including hobby, haircuts and religious services. The complaints all involve a quarantine by [redacted] in August 2021 at [redacted] The template names [redacted] Defendants." The Bureau sent Charging Parties' complaints to [redacted] which responded on behalf of all named respondents.

EXHIBIT 77
30(b)(6) Designee
Mon, Aug 22, 2022
Reported by:
Mary Sullivan, RMR, CRR

He then states that, "I and all other vaccinated inmates" were allowed to commingle after work for purposes of recreation, laundry pass, food service and other non-restrictive social activities. He asserts that as a result of the quarantine he has been denied services and privileges such as visitation.

B. Respondent's Position Statement:

[redacted] denies that it discriminated. In the week of August 15, 2021, there was a confirmed COVID-19 case in MSP's C-Unit. In the wake of this potential exposure, inmates were quarantined based on vaccination status.

On July 30, 2021, Montana's Department of Public Health and Human Services (DPHHS) provided [redacted] with guidance from the Centers for Disease Control (CDC) stating that vaccinated individuals did not need to be quarantined or restricted from work following a potential exposure to COVID-19. The CDC had developed specific guidance for correctional facilities permitting fully-vaccinated individuals to participate in facility programs rather than quarantine.

[redacted] argues the Bureau does not have jurisdiction. Since jurisdiction is a threshold issue that must be addressed before any further proceeding, [redacted] argues the Human Rights Bureau (the Bureau) should dismiss these complaints. The Bureau is an administrative agency and it cannot consider or investigate claims that are not authorized by the Montana legislature. [redacted] points to § 53-30-152, MCA, this statute states that inmates are not employees and therefore employment rights do not attach. [redacted] then argues "[f]or over 30 years, it has been black letter law that 'general anti-discrimination statutes' in Title 49 cannot 'override the specific legislative intent' to prohibit inmates from asserting work-related discrimination claims."

Additionally, [redacted] argues that the newly passed § 2-9-902, MCA, states that a governmental entity is not liable for civil damages for injuries or death from or relating to exposure or potential exposure to COVID-19. It is [redacted] position that this statute was drafted to broadly cover "every civil claim for damages 'relating to' a potential exposure" to COVID-19. Here, these inmates were quarantined based on a potential exposure they are asserting injuries in the form of inability to go to work or engage in other activities during the limited quarantine period. Since a claim for vaccination discrimination is a civil claim and inmates seek damages, this statute precludes the inmates' ability to recover. This statute affords [redacted] "absolute immunity" from civil actions.

In response to the Bureau's requests for information, [redacted] further argued that COVID-19 presented unique challenges because the prison population was at or near capacity for bed space. [redacted] needed to provide certain services such as food and laundry while simultaneously managing the health crisis. [redacted] contends it relied on the "expertise of clinical services division staff which was receiving regular guidance specific to correctional facilities from the U.S. Centers for Disease Control (CDC), the Montana Department of Health and Human Services, county/local health officials, as well as direction from the Department Director in the event of a conflict between Montana law and guidance provided by the aforementioned resources."

[redacted] argues the inmates complains amount to a 'brief disruption of non-employment "employment" activity,' temporary disruption of haircut services and hobby, and brief disruptions to in-person visitation.

C. Additional Information

The parties were asked to address the application of the health care facility provisions of § 49-2-312, MCA. [redacted] responded and stated that [redacted] is a licensed health care facility/service and provided licensure and accreditation documentation through the National Commission on Correctional Health Care.

Inmates argued [redacted] is not a health care facility given the quality of care and further, if it were, then only the [redacted] building containing the infirmary should be considered as a health care facility. The infirmary is a separate building from the housing units.

D. Witnesses

[redacted] **Inmate.** [redacted] asserts he was denied employment and visitation based on his vaccination status.[2] [redacted] states that all of the housing units have been shut down at various times beginning in 2020, probably for three to four months in the beginning. He believes the C-Unit was shut down for approximately three weeks in July and August 2021. When an inmate tested positive, that inmate was sent to administrative segregation and the rest of his unit was locked down. Now, when an inmate tests positive, he is still sent to administrative segregation, but only the cube is locked down for 14 days.

[redacted] began taking Motor Vocational Maintenance Classes in October 2020. He graduated in October 2021 and did not miss work during this time but missed classes that slightly prolonged his graduation, maybe a day or a week. He says he missed class time when he was quarantined in July and August 2021. [redacted] says it's interesting that inmates that are unvaccinated are not allowed to go to work with vaccinated, but they all eat together. [redacted] says he was supposed to have a visit with his wife, but this visit was cancelled. He says he knows of vaccinated inmates that received visits. He was asked to identify these inmates and said he would send in a list. In this later submission, [redacted] doesn't identify inmates that were allowed visitation rather he lists six inmates "that had seen or heard" that vaccinated inmates were allowed to continue services. [redacted] says Correctional Officers have told him that vaccinated inmates get visits, but [redacted] could not recall the names of the [redacted] staff that told him this.

[redacted] believes the infirmary staff doctors/nurses need more training to provide quality care like a healthcare facility should. Since the quality of care is lacking, he does not believe [redacted] is a healthcare facility.

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[2] [redacted] submitted additional statements and said that on August 16, 2021, he was told that due to his non-vaccinated status he would have to quarantine and no longer enjoy employment, haircuts, religious activities, library, and visitation. He only asserted employment and visitation in his complaint.

In written submissions, [redacted] relayed that more recent quarantining had been done differently. Both vaccinated and unvaccinated inmates were allowed to go to work "except those that were in direct contact."

[redacted] **Inmate.** [redacted] asserts that he was denied employment and visitation. He says when the pandemic began, he was housed up in the Shelby facility. As a result of the outbreak up there, [redacted] says he has natural immunity, and he is not vaccinated. At [redacted] he works on buildings doing HVAC (heating ventilation and air conditioning). He moves all around the campus.

He recalls that someone tested positive in August 2021 and after that the inmates were confined for a week and then [redacted] gave you an option of going back to work if you were vaccinated. The vaccination was not mandatory, but it is his opinion that [redacted] was trying to force inmates to get the vaccine. He believes he recalls the MCE Administrator [redacted] coming to the unit, but later he says maybe it was that he was given the option of doing a waiver. [redacted] says he wishes he would have taken better notes. His recollection is that the quarantine was lifted and then put in place and then lifted again. He says [redacted] asks the inmates to wear masks, he refers to the inmates that wear masks as "sheeple."

[redacted] asserts he was not even allowed to use a phone during this quarantine. Asked if he could identify anyone that was allowed to go to visitation, he says he's not sure. As for any contention that [redacted] is a healthcare facility, [redacted] doesn't believe that [redacted] should qualify because they 'don't provide healthcare at all.'

[redacted] **Inmate.** [redacted] is an inmate at [redacted] He is not vaccinated, and states vaccination is not mandatory at the prison. He asserted he was denied employment, visitation, and the ability to get a haircut. [redacted] was employed by [redacted] as a boilerman in the maintenance department. In this position, he would leave the C-Unit and go to the 'industries compound.' (The industries compound is a separate facility at [redacted]

[redacted] asserts that on or around August 16, 2021, the Administrator for Montana [redacted] and another person from the Clinical Services Division announced that inmates needed to sign a "waiver" regarding their medical information to disclose their vaccination status to work in the "industries compound." [redacted] states he never got to read this waiver. He says if you did not sign the waiver you were assumed to be unvaccinated. It is [redacted] recollection that [redacted] said, "if you're not vaccinated and cannot prove your vaccination status, you will be required to stay in the Unit."

[redacted] says [redacted] posted a notice listing the inmates that could go to work in the "industries compound." [redacted] says only persons that were vaccinated were on the list. Since he could not go to the industries compound, [redacted] asserts his hours were reduced significantly. It is his recollection that shortly after the complaints were filed, he was allowed to return to work. [redacted] states he then lost this position on October 4, 2021.

In August 2021, [redacted] locked down the C-Unit. [redacted] does not take issue with [redacted] quarantining individuals that test positive in accordance with the Centers for Disease Control (CDC). He tested positive in 2020, at that time the whole facility was locked down.

As for [redacted] assertion that he was denied visitation, he says it was "common knowledge" that you could not have visitation if you were not vaccinated. Asked how this was known, he asserted there was a memo posted by [redacted] at the Command Post. [redacted] has been to the infirmary 12 to 15 times in the past year but disagrees that [redacted] as a whole should be a considered a health care facility.

[redacted] **Inmate.** [redacted] is an inmate at [redacted] and he is not vaccinated. He states vaccines are not mandatory at [redacted] He asserted he was denied employment, visitation and hobby. [redacted] says if there is an outbreak on the unit, the unvaccinated are quarantined, whereas the vaccinated are allowed to go to work [redacted] states this has occurred "a couple times" with the last occurring in around August 2021.

[redacted] has been working for Montana [redacted] since March 2021. [redacted] states inmates work in close proximity to one another and are there from 7 a.m. to around 4:15 p.m. He says he was denied visitation once in September 2021, because he wasn't vaccinated. [redacted] says he 'told his family to not bother coming.' [redacted] said the only inmates allowed visitation at that time were the ones who were vaccinated. He doesn't know if other unvaccinated inmates are still being denied visitation.

[redacted] says he was also denied hobby once (and a there was a second time when he wasn't scheduled for hobby). He believes this occurred in around August or September 2021. He said for the past month and a half, they have been on a regular weekly schedule where inmates can go to hobby, regardless of whether they are vaccinated.

[redacted] indicated that he has been to the infirmary several times. He does not feel that [redacted] is a healthcare facility because they do not provide adequate healthcare. [redacted] said he does not want to get the vaccine because, as a Native American he does not believe in vaccines. He has not submitted any sort of religious accommodation relative to vaccines.

[redacted] **Inmate.** [redacted] complaint only asserts he was denied employment based on his vaccination status. In his interview, he said he was not allowed to work to earn money to make earrings or buy commissary items. [redacted] says he was prevented from going to work for two weeks and the unvaccinated restrictions lasted about three weeks. After a month and a half, [redacted] completely changed policies and the quarantines were cube specific. (The entire cube, which is a subsection of the unit, would quarantine regardless of vaccination status.)

[redacted] wants it noted that he does not go to religious services, but he would not have been able to go if he did. Although it is not in his complaint, he also asserted that once he wanted to get a haircut but was stopped in the hall by a Correctional Officer. [redacted] does not recall which officer, but the officer knew [redacted] was not vaccinated. When [redacted] asked how the officer knew his vaccination status, the officer then asked, "Well, are you?" [redacted] said he wouldn't release this information and he was denied his haircut.

[redacted] says an inmate in a different cube tested positive for COVID-19 and inmates in his cube were allowed to go to work if they were vaccinated. He asserts that it doesn't make sense that vaccinated and unvaccinated inmates were allowed to eat, use telephones, go in

the yard and intermingle with each other but they were not allowed to enjoy other opportunities.

[redacted] **Inmate.** [redacted] complaint was substantially similar to the other complaints, but it was handwritten. He asserted he was denied employment, medical care, and religious services.

Initially, [redacted] was asked to explain the assertion in his complaint that he was denied medical care, but he did not remember making this allegation. Later in the interview, he stated that he believes he should have received treatment for a non-emergency back injury. He said another inmate was allowed to get medical services during this time and he was not. ([redacted] believes that inmate had a knee injury, but he is unsure of the inmate's exact medical situation or his vaccination status.)

[redacted] complaint asserts that he was denied employment but he explained that he was in the MCE "education program" for welding. It is his recollection that [redacted] had multiple COVID-19 cases in the facility and initially they tried to do something with testing; if you were negative you could go to work. He believes C-Unit was locked down for a month or a month and a half. He says he wasn't allowed to go back to school for almost two months. [redacted] offered a witness he believes is vaccinated that was allowed to go to work.

[redacted] says he typically attends three religious meetings every week; Fresh Lives, Baptist Bible Studies and Bread of Life, but he has not been able to attend for two to three months. Pressed, [redacted] wasn't sure if anyone was attending religious meetings at this time. [redacted] wanted more time to put together more information on his denial of religious services and stated he would send more information in, but the Bureau has not received anything.

[redacted] **Administrator for Montana** [redacted] [redacted] is unfamiliar with the complaints under investigation by the Bureau, but she is familiar with the vaccination law. She explained that the industries compound is a different area of the prison and that houses MCE programs (training and educational). It also houses some [redacted] programs such as maintenance. [redacted] says that many of the inmates working in the industries compound around this time were making Personal Protected Equipment (PPE).

It is her best recollection that C-Unit went into quarantine and all movement was restricted for both vaccinated and unvaccinated inmates. After this, [redacted] and an [redacted] employee Clinical Services when to C-Unit on August 17, 2021. [redacted] explained that the C-Unit houses inmates that worked over in the industries compound. [redacted] explained to the inmates that they could sign a waiver that would allow an inmate's MCE supervisor to know the inmate's vaccination status. If an inmate was vaccinated, he could continue working pursuant to CDC guidelines. She does not recall any inmate asking her what would happen if he was not vaccinated. She believes Clinical Services then took this information back to check against existing records and then a list was created of inmates that were vaccinated. This list was disseminated to the appropriate supervisor (not the entire list of names but the names relevant to a particular supervisor). [redacted] denies that any sort of list was posted regarding the inmate's vaccination status.

After this, it is [redacted] recollection that there were concerns about the discrimination law and that the Warden sent out an email urging compliance with both the state vaccination law and the CDC guidelines. [redacted] contends this happened as soon as practicable. She does not recall when everyone went back to work, but it wasn't long after this.

[redacted] **Medical Bureau Chief.** [redacted] has been with [redacted] for 20 years. She states that she has previously experienced outbreaks of influenza but nothing like COVID-19. She states that [redacted] routinely provides medical services outside of MSP's infirmary. She says medical staff respond to emergencies providing care at the scene. There are different types of medication and medication administration in the various housing units. If there is a "health care request" or kite by an inmate for medical services, that request needs to be assessed within a certain time frame so the inmate may be visited by medical staff in the housing units. Add to this, [redacted] has several 'satellite offices' for health care services outside of the infirmary (e.g., locked housing unit, high side, low side, work and re-entry unit.) There's medical staff in the intake unit (the [redacted] Diagnostic and Intake Unit) every day.

In terms of addressing the spread of COVID-19 in the institution, [redacted] says there are unique challenges. For example, social distancing can be hard to achieve. [redacted] says there is not an across-the-board-masking requirements at [redacted] rather [redacted] works to educate staff and inmates on the available infection control protocols. If the compound is on "outbreak status" masks are recommended. [redacted] has utilized testing protocols, there are both rapid and PCR (nose swab sent to a lab) types of testing. Rapid testing results will be back in 15 minutes, but PCR can take several days to get results. [redacted] says at times [redacted] has run low on rapid tests and had to use more PCR tests.

[redacted] does not have a clear recollection of the quarantine in August 2021 (she stated she did not review her notes for the interview). [redacted] says the [redacted] has worked DPHHS and relied on CDC guidance for direction. She notes the guidance has changed throughout the pandemic. In C-Unit housing unit, inmates are in cubes and share the same bathroom and have a small common area. A person that tests positive will be removed from the areas. [redacted] acknowledges [redacted] has had to change its approach depending on the circumstances, [redacted] is currently using a "cohorted quarantine" protocol.

E. Documents

- Emails between [redacted] Clinical Services Divisions staff and DPHHS staff on matters relating to masking, testing and vaccination status. (Included are [redacted] who is identified as Communicable Disease Nurse Consultant for the Communicable Disease and Prevention Bureau.)

- [redacted] 4.5.11 – Infection Control Program. Revised 12/23/16. General Requirements: "Each health care unit will monitor infectious and communicable diseases in an effort to minimize their occurrence in accordance with state and federal guidelines." Prevention: "An integral component of the infection control program is the prevention of the occurrence and spread of infectious and communicable diseases."

- Excerpts from CDC Guidance on Management of Coronavirus Disease 2019 (COVID-10) in Correctional and Detention Facilities.
- [redacted] 'contact' visitation logs for August 2021. Contact visits stop on August 15, 2021 and start again on August 19, 2021.
- C-Unit Hobby Night Call Out sheets for July 13, 2021, July 28, 2021, August 4, 2021, August 11, 2021, (there is no August 18, 2021), August 25, 2021, September 1, 2021, and September 8, 2021. At least one of the inmates that filed is on the call out sheet for September 1, 2021 and two are on September 8, 2021.
- Undated "Sunday" Workers Only C-Unit Haircut list, [redacted] is marked as a "No Show"

F. Timeline:

As displayed in the witness interviews **neither** party's witnesses could offer much clarity on dates relevant to the particular quarantine at issue. Albeit based on imperfect evidence, this investigator has put together the following timeline of relevant events:

August 16, 2021	Four positive staff at [redacted] with extensive contacts, [redacted] starts restricting movement by for inmates.
August 17, 2021	Warden [redacted] stopped all movement in various units as the day progresses (including C-Unit). No inmates were allowed any function outside of the unit.
August 17, 2021	[redacted] solicits releases or waivers from inmates to disclose their vaccination status 'for the purpose of returning them to work.'
August 18, 2021	A list of inmates who agreed to have their vaccination status released is circulated to those inmate's supervisors. These inmates 'are available for school, work, and other functions.'
August 19, 2021	Director [redacted] sends email to leadership team and [redacted] clinical director stating [redacted] would 'follow state law' and CDC guidelines "unless they conflict with or violate state law….[h]aving this in mind, we need to allow visitation and programs regardless of vaccination status…"

III. ANALYSIS

[redacted] is alleging [redacted] unlawfully discriminated against him in the area of governmental services because of his vaccination status. He has filed a timely complaint and the Montana Human Rights Bureau has jurisdiction.

In [redacted]'s complaint, he asserts [redacted] quarantined him based on his vaccination status on or about August 16, 2021[3], and that because he was quarantined, he could not work or enjoy other opportunities that inmates that were vaccinated were allowed to enjoy. It is Ellsworth's recollection this occurred in July and August.

To start, this is a new statute. There are no interpreting administrative rules, no hearing officer decisions, much less any court cases to assist the Bureau in the analysis of these complaints. All we have is the language of the applicable statute:

> **49-2-312. Discrimination based on vaccination status or possession of immunity passport prohibited -- definitions.** (1) Except as provided in subsection (2), it is an unlawful discriminatory practice for:
>
> (a) a person or a governmental entity to refuse, withhold from, or deny to a person any local or state services, goods, facilities, advantages, privileges, licensing, educational opportunities, health care access, or employment opportunities based on the person's vaccination status or whether the person has an immunity passport;
>
> (b) an employer to refuse employment to a person, to bar a person from employment, or to discriminate against a person in compensation or in a term, condition, or privilege of employment based on the person's vaccination status or whether the person has an immunity passport; or
>
> (c) a public accommodation to exclude, limit, segregate, refuse to serve, or otherwise discriminate against a person based on the person's vaccination status or whether the person has an immunity passport.
>
> …

In its response to these complaints, [redacted] argued the Bureau should dismiss under the authority of another new statute found in Title 2, Chapter 9, "Limitations on Liability Relating to COVID-19." Under this statute, a governmental entity that takes 'reasonable measures' consistent with public health guidance will have an affirmative defense to any civil damages "for injuries or death from or relating to exposure to or potential exposure to COVID-19." *Mont. Code Ann. § 2-9-902.* In § 2-9-905, MCA, it states that if a governmental entity proves an affirmative defense, it operates as a "complete bar" to any action "relating to COVID-19." *Mont. Code Ann. § 2-9-905(4).*[4] As part of this investigation, [redacted] provided

[3] The inmate's complaints all have a paragraph that states "On or about _____, 2021, I was informed that, due to my non-vaccinated status that I would have to quarantine in C-Unit and could no longer enjoy my employment at the industries compound." Inmates [redacted] and Rodriguez failed to put a date in the blank, [redacted] and [redacted] put August 16, 2021, and [redacted] and [redacted] put August 17, 2021.

[4] **2-9-905.** *(Temporary)* **Affirmative defense -- reasonable measures consistent with regulations, orders, and public health guidance.** (1) In addition to all other defenses, a government entity may assert as an affirmative defense that the government entity took reasonable measures consistent with a federal or state statute, regulation, order, or public health guidance related to covid-19 that was applicable to the government entity or activity at issue at the time of the alleged injury, death, or property damage.

(2) If two or more sources of public health guidance are applicable, a government entity does not breach a duty of care if the person took reasonable measures consistent with one applicable set of public health guidance.

(3) If a government entity proves the affirmative defense contained in this section, the affirmative defense is a complete bar to any action relating to covid-19.

communication between [redacted] Clinical Services and the Department of Public Health and Human Services discussing Centers for Disease Control guidance on how to best handle an outbreak in a correctional setting. [redacted] asserts that because it was operating in accordance with this guidance, it has an affirmative defense that stands as an 'absolute bar' to an inmate complaint.

[redacted] arguments are compelling, but this statute doesn't quite seem to fit. Here, the inmates are not asserting [redacted] is liable for their exposure or potential exposure to COVID-19. The inmates are asserting [redacted] is liable for violating a provision of the Montana Human Rights Act that protects the inmates based on vaccination status. *Mont. Code Ann. § 49-2-312.* Ultimately, a fact finder may agree that this statute stands as a bar to inmate complaints under discrimination laws, but for now the Bureau will continue its analysis.

As we begin, it bears noting that putting together a clean timeline was extremely challenging. [redacted] counsel was asked and created one, the Bureau then talked to two different [redacted] staff as well as six different inmates in C-Unit. Most every witness stated they had some difficulty remembering the details. [redacted] argued any restrictions on unvaccinated inmates were short term, lasting for maybe one day. Meanwhile, the inmates put restrictions on unvaccinated inmates anywhere from a week to several months. Given the testimony and documentation, it seems likely that any restrictions lasted a few days.

Everyone involved acknowledged there have been various quarantines throughout the pandemic and these various quarantines have looked different. At the beginning of the pandemic, it sounds like [redacted] quarantined every inmate due to the scope of the outbreak, later quarantines were by housing unit, and more recently quarantines are done by "cohort" depending on an inmate's exposure (e.g., direct contact). Inmates that are vaccinated are in the same housing units as inmates that are unvaccinated. The charging parties are housed in C-Unit and according to [redacted] C-Unit houses the inmates that work over in the industries compound. An inmate's vaccination status is not necessarily static. An inmate's status may be unvaccinated one day and vaccinated the next. Through interviews, it is apparent that some [redacted] inmates choose to discuss their vaccination status freely, while others do not.

All of the inmates stated that they were allowed to "comingle" for the purposes of recreation, laundry pass, food services and other non-restrictive social activities but denied other services, such as visitation, hobby services, religious activities. In interviewing the inmates, clearly this is what created the most confusion. But, as [redacted] has pointed out in this investigation, the pandemic did not relieve [redacted] of its obligation to provide basic services and keep the facility as operational as possible.

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(4) This section may not be construed to impose liability on a government entity for failing to comply with a federal or state statute, regulation, order, or public health guidance related to covid-19. *(Terminates December 31, 2031--sec. 12, Ch. 516, L. 2021.)*

History: En. Sec. 5, Ch. 516, L. 2021.

(emphasis added)

Four of the inmates asserted that their visitation was restricted because they were unvaccinated, including [redacted] It is difficult to put your arms around these allegations. [redacted] provided visitation logs for August 2021 and only one of the unvaccinated inmates shows up; [redacted] on August 12, 2021. [redacted] asserts visitation with his wife was later cancelled. It also appears visitation was cancelled for everyone between August 15, 2021, and August 18, 2021. If an inmate's visit was supposed to occur in this timeframe, that would not be an issue. (Visitation was cancelled for all inmates.) But no one has a clear recollection of what happened when. If several inmates had tested positive inside the C-Unit, [redacted] stated medical services would have recommended limiting exposure. Several inmates confirmed that both vaccinated and unvaccinated inmates were using a form of "tele-visitation." I find the inmates have not established they were denied visitation based on vaccination status.

[redacted] does not assert that he was denied hobbies in his complaint, but others did. [redacted] argues that given the short time frame of the quarantine, the inmates cannot show they were denied hobby services. [redacted] says C-Unit is called out for hobby on Wednesday nights. Because of the quarantine, there was no C-Unit hobby on August 18, 2021. [redacted] provided the Inmate Call Out Sheets for hobby from July 13, 2021 through September 8, 2021. (A listing of the inmates called out to the activity.) There was no call out sheet for August 18, 2021. There are inmates that filed vaccination complaints on both the September 1, 2021, and September 8, 2021, call out sheets.

Only one inmate alleged a denial of religious services in his complaint, [redacted] He was unsure of the timeframes or whether the services were being offered to anyone. [redacted] was asked to send in additional information, but nothing was provided (nor did he submit a rebuttal). As for [redacted] assertion that he was not allowed to get a haircut, [redacted] argued [redacted] did not show up for his haircut and it produced documentation he was a "no show."

In [redacted]'s timeline of the restrictions for this particular quarantine, [redacted] asserted that on August 16, 2021, there were four COVID-19 positives. Initially, MSP's Warden restricted movement in the A-Unit. But this changed as the day progressed, and by the end of the day, no movement was allowed in either the A-Unit or the C-Unit. There is a lot of testing happening. [redacted] says it sent out 225 PCR tests. [redacted] emails reflect that it is looking to CDC guidance for protocols, including testing strategies. If there is a clear bad act to grab on to, it happens somewhere in here. [redacted] allows persons that are vaccinated to return to work on August 18, 2021, whereas persons that were unvaccinated were not allowed to return to work. Later, the quarantine was lifted for unvaccinated inmates as well.

If the claim at issue involved only employment, [redacted] argued the Bureau does not have jurisdiction over inmates' complaints. *See Quigg v. South, 243 Mont. 218 (1990).* In *Quigg*, the male inmates had filed a discrimination complaint asserting that they were being paid less than female inmates. Our Supreme Court found that there was statutory language, specifically §§ 53-30-151-153, MCA, that precluded this type of discrimination complaint, specifically wage based discrimination complaints. Generally speaking, the Bureau disagrees with [redacted] assertion that *Quigg* is "black letter law." It remains unclear how the ruling in *Quigg* will apply to this new statute.

All this aside, these complaints have raised a whole different question. As noted, the Bureau is working with a new statute and this new statute contains special provisions for health care facilities. *Mont. Code Ann. § 49-2-312(3)(b).* The new statute treats health care facilities differently from other environments and the language suggests that such a facility may have to take measures to protect the health and safety of employees, patients, visitors, and other persons from communicable diseases.

> (b) A health care facility, as defined in **50-5-101**, does not unlawfully discriminate under this section if it complies with both of the following:
>
> (i) asks an employee to volunteer the employee's vaccination or immunization status for the purpose of determining whether the health care facility should implement reasonable accommodation measures to protect the safety and health of employees, patients, visitors, and other persons from communicable diseases. A health care facility may consider an employee to be nonvaccinated or nonimmune if the employee declines to provide the employee's vaccination or immunization status to the health care facility for purposes of determining whether reasonable accommodation measures should be implemented.
>
> (ii) implements reasonable accommodation measures for employees, patients, visitors, and other persons who are not vaccinated or not immune to protect the safety and health of employees, patients, visitors, and other persons from communicable diseases.

The new statute defines health care facility using § 50-5-101, MCA:

> (26) (a) "Health care facility" or "facility" means all or a portion of an institution, building, or agency, private or public, excluding federal facilities, whether organized for profit or not, that is used, operated, or designed to provide health services, medical treatment, or nursing, rehabilitative, or preventive care to any individual. The term includes chemical dependency facilities, critical access hospitals, eating disorder centers, end-stage renal dialysis facilities, home health agencies, home infusion therapy agencies, hospices, hospitals, infirmaries, long-term care facilities, intermediate care facilities for the developmentally disabled, medical assistance facilities, mental health centers, outpatient centers for primary care, outpatient centers for surgical services, rehabilitation facilities, residential care facilities, and residential treatment facilities.

Inmates argue that because [redacted] was not providing "quality" care, it could not be considered a health care facility, but this argument is not compelling. Quality of care may impact licensure but not designation as a health care facility. [redacted] has been issued a health care facility license by DPPHS and [redacted] is accredited by the National Commission on Correctional Healthcare.

The inmates also argued the definition of health care facility should be restricted to MSP's infirmary. The inmates have a point. It would be reasonable for the Bureau to restrict its interpretation of the term "health care facility" to those portions of [redacted] that are labeled as providing health care services, specifically the infirmary. But the definition says a health care facility means "all or portion of an institution" *used* or designed to provide health services, medical treatment, or nursing, rehabilitative or preventative care to any individual. Meaning if [redacted] is providing health services, medical treatment, or nursing, rehabilitative or preventative care outside of the infirmary, then seemingly this expands the scope of that "facility." In interviews, [redacted] provided a laundry list of examples displaying that medical treatment is provided outside of the infirmary. This included emergency treatment, "sick calls," medication distribution, and mental health services. Add to this there are "satellite offices" for medical services throughout the [redacted] campus. Then if you look at the definition of a "health care facility," it seems very broad. It includes hospitals and infirmaries, but it also picks up residential care facilities, home health agencies, medical assistance facilities. The

use of such a broad definition suggests the legislature intended for the term health care facility to be interpreted broadly.

Bottom line, [redacted] is constitutionally obligated to provide health care services for the inmates while the inmate is in MSP's custody and the provision of health care is happening across campus. *See* [redacted] *4.5.2 Responsible Health Authority.* I find [redacted] has presented adequate documentation to show that [redacted] operates as a health care facility. Any argument that only the [redacted] infirmary should be considered a health care facility doesn't hold up given the unique circumstances of this institutional setting.

The statute then says a health care facility does not discriminate if it (1) asks about vaccination status; and then (2) implements reasonable accommodation measures. Here, testimony establishes that [redacted] asked inmates working in the industries compounds about vaccination status on August 16, 2021. Next, the Bureau looks at whether [redacted] implemented reasonable accommodation measures. From information provided by [redacted] it looks like from August 18, 2021, through August 19, 2021 - or as late as August 23, 2021 - inmates that were not vaccinated were restricted in ways inmates that were vaccinated were not, most likely from going to work in the industries compound. So, the relevant question is: Was this a reasonable accommodation measure?

As a quick aside, the Bureau notes Montana's Human Rights Act has a definition for "reasonable accommodation." *Mont. Code Ann. § 49-2-101(19).* A reasonable accommodation is some form of assistance provided to a person with a disability[5] that allows that person to perform in a position or perhaps enjoy a governmental service. In this new statute, the term "reasonable accommodation measures" appears unrelated to this definition. The term reasonable accommodation measures are not intended to attach to a person with a disability. The "measures" are to be taken to "protect the safety and health of employees, patients, visitors and other persons from communicable diseases."

In this investigation, [redacted] has argued it is immune from suit under § 2-9-902, MCA, precisely because the steps it took were reasonable measures consistent with public health guidance, specifically that it restricted the movement of inmates based on vaccination status in accordance with DPHHS and CDC guidance for correctional facilities. A restriction that was lifted shortly after it was imposed.

Could [redacted] have handled this differently? Arguably, it could have required working inmates to wear a full set of personal protective equipment (PPE), or it could have quarantined every inmate regardless of vaccination status similarly. But the law does not ask the Bureau to determine the best way to have handled the situation, it asks the Bureau to determine if the health care facility (1) asked about vaccination status; and (2) then implemented reasonable accommodation measures. Here, I find [redacted] asked about vaccination status and then followed guidance from the CDC for correctional facilities.

If this matter goes forward, [redacted] will ultimately have a variety of defenses available. [redacted] may enjoy the protection of the absolute bar to complaints put forth in § 2-9-902, MCA, and since the inmates have not been able to point to any opportunity that was denied outside of

[5] A person with a disability has a condition or impairment that substantially limits one or more major life activities.

employment *Quigg* may be controlling. Following these investigations, it appears that [redacted] would also be able to show that restrictions on unvaccinated inmates were reasonable accommodation measures.

For these reasons, I find that [redacted] is unable to prove by a preponderance of the evidence that [redacted] discriminated against him on the basis of vaccination status.

CONCLUSION

Based on my investigation, I find **no reasonable cause** to believe unlawful discrimination occurred as alleged in Charging Party's complaint.

Marieke Beck — *February 25, 2022*

Marieke Beck
Montana Human Rights Bureau

Date

DEFS 001384

HRB CONFIDENTIAL

MONTANA DEPARTMENT OF LABOR & INDUSTRY
EMPLOYMENT RELATIONS DIVISION
HUMAN RIGHTS BUREAU

[redacted] Charging Party, vs. [redacted][1], Respondent.	Final Investigative Report HRB Case No. 0210610

Recommendation: Based on my investigation, I find **no reasonable cause** to believe unlawful discrimination occurred as alleged in Charging Party's complaint.

I. ISSUE PRESENTED

Did the [redacted] discriminate against [redacted] based on his vaccination status in violation of the Montana Human Rights Act (Title 49, Chapter 2, MCA) by subjecting him to quarantine and denying him employment and other opportunities?

II. SUMMARY OF THE INVESTIGATION

This report constitutes a summary of the investigation conducted in this case. Content of this report is limited to witnesses, documents and other evidence relevant to the analysis of the issue presented. The case file may contain additional evidence not included in this report.

A. Charging Party's Position Statement:

[redacted] sent in a self-drafted complaint asserting that he is an inmate serving his sentence with the [redacted] ([redacted] He asserts he is employed by Montana [redacted] and that he was informed on August 17, 2021, that due to his non-vaccinated status, he would have to quarantine in C-Unit and could no longer enjoy his employment at the industries compound. He asserts he witnesses vaccinated inmates being permitted to enjoy their employment status.

[1] Nine complaints were filed by [redacted] ([redacted] inmates using a template containing substantially similar language. On the template, inmates checked whether they were felt they were denied visitation or medical care, some inmates wrote in additional information regarding denials including hobby, haircuts and religious services. The complaints all involve a quarantine by [redacted] in August 2021 at [redacted] The template names "[redacted] Defendants." The Bureau sent Charging Parties' complaints to [redacted] which responded on behalf of all named respondents.

He then states that, "I and all other vaccinated inmates" were allowed to commingle after work for purposes of recreation, laundry pass, food service and other non-restrictive social activities. [redacted] asserted that he was denied visitation and access to hobby services.

B. Respondent's Position Statement:

[redacted] denies that it discriminated. In the week of August 15, 2021, there was a confirmed COVID-19 case in MSP's C-Unit. In the wake of this potential exposure, inmates were quarantined based on vaccination status.

On July 30, 2021, Montana's Department of Public Health and Human Services (DPHHS) provided [redacted] with guidance from the Centers for Disease Control (CDC) stating that vaccinated individuals did not need to be quarantined or restricted from work following a potential exposure to COVID-19. The CDC had developed specific guidance for correctional facilities permitting fully-vaccinated individuals to participate in facility programs rather than quarantine.

[redacted] argues the Bureau does not have jurisdiction. Since jurisdiction is a threshold issue that must be addressed before any further proceeding, [redacted] argues the Human Rights Bureau (the Bureau) should dismiss these complaints. The Bureau is an administrative agency and it cannot consider or investigate claims that are not authorized by the Montana legislature. [redacted] points to § 53-30-152, MCA, this statute states that inmates are not employees and therefore employment rights do not attach. [redacted] then argues "[f]or over 30 years, it has been black letter law that 'general anti-discrimination statutes' in Title 49 cannot 'override the specific legislative intent' to prohibit inmates from asserting work-related discrimination claims."

Additionally, [redacted] argues that the newly passed § 2-9-902, MCA, states that a governmental entity is not liable for civil damages for injuries or death from or relating to exposure or potential exposure to COVID-19. It is [redacted] position that this statute was drafted to broadly cover "every civil claim for damages 'relating to' a potential exposure" to COVID-19. Here, these inmates were quarantined based on a potential exposure they are asserting injuries in the form of inability to go to work or engage in other activities during the limited quarantine period. Since a claim for vaccination discrimination is a civil claim and inmates seek damages, this statute precludes the inmates' ability to recover. This statute affords [redacted] "absolute immunity" from civil actions.

In response to the Bureau's requests for information, [redacted] further argued that COVID-19 presented unique challenges because the prison population was at or near capacity for bed space. [redacted] needed to provide certain services such as food and laundry while simultaneously managing the health crisis. [redacted] contends it relied on the "expertise of clinical services division staff which was receiving regular guidance specific to correctional facilities from the U.S. Centers for Disease Control (CDC), the Montana Department of Health and Human Services, county/local health officials, as well as direction from the Department Director in the event of a conflict between Montana law and guidance provided by the aforementioned resources."

[redacted] argues the inmates complains amount to a 'brief disruption of non-employment "employment" activity,' temporary disruption of haircut services and hobby, and brief disruptions to in-person visitation.

C. Additional Information

The parties were asked to address the application of the health care facility provisions of § 49-2-312, MCA. [redacted] responded and stated that [redacted] is a licensed health care facility/service and provided licensure and accreditation documentation through the National Commission on Correctional Health Care.

Inmates argued [redacted] is not a health care facility given the quality of care and further, if it were, then only the [redacted] building containing the infirmary should be considered as a health care facility. The infirmary is a separate building from the housing units.

D. Witnesses

[redacted] **Inmate.** [redacted] is an inmate at [redacted] and he is not vaccinated. He states vaccines are not mandatory at [redacted] He asserted he was denied employment, visitation and hobby. [redacted] says if there is an outbreak on the unit, the unvaccinated are quarantined, whereas the vaccinated are allowed to go to work. [redacted] states this has occurred "a couple times" with the last occurring in around August 2021.

[redacted] has been working for Montana [redacted] (MCE) since March 2021. [redacted] states inmates work in close proximity to one another and are there from 7 a.m. to around 4:15 p.m. He says he was denied visitation once in September 2021, because he wasn't vaccinated. [redacted] says he 'told his family to not bother coming.' [redacted] said the only inmates allowed visitation at that time were the ones who were vaccinated. He doesn't know if other unvaccinated inmates are still being denied visitation.

[redacted] says he was also denied hobby once (and a there was a second time when he wasn't scheduled for hobby). He believes this occurred in around August or September 2021. He said for the past month and a half, they have been on a regular weekly schedule where inmates can go to hobby, regardless of whether they are vaccinated.

[redacted] indicated that he has been to the infirmary several times. He does not feel that [redacted] is a healthcare facility because they do not provide adequate healthcare. [redacted] said he does not want to get the vaccine because, as a Native American he does not believe in vaccines. He has not submitted any sort of religious accommodation relative to vaccines.

[redacted] **Inmate.** [redacted] complaint was substantially similar to the other complaints, but it was handwritten and was submitted later. [redacted] asserted he was denied employment, medical care, and religious services.

Initially, [redacted] was asked to explain the assertion in his complaint that he was denied medical care, but he did not remember making this allegation. Later in the interview, he stated that he believes he should have received treatment for a non-emergency back injury. He said another inmate was allowed to get medical services during this time and he was not.

(believes that inmate had a knee injury, but he is unsure of the inmate's exact medical situation or his vaccination status.)

complaint asserts that he was denied employment but he explained that he was in the MCE "education program" for welding. It is his recollection that had multiple COVID-19 cases in the facility and initially they tried to do something with testing; if you were negative you could go to work. He believes C-Unit was locked down for a month or a month and a half. He says he wasn't allowed to go back to school for almost two months. offered a witness he believes is vaccinated that was allowed to go to work.

says he typically attends three religious meetings every week; Fresh Lives, Baptist Bible Studies and Bread of Life, but he has not been able to attend for two to three months. Pressed, wasn't sure if anyone was attending religious meetings at this time. wanted more time to put together more information on his denial of religious services and stated he would send more information in, but the Bureau has not received anything.

Inmate. complaint only asserts he was denied employment based on his vaccination status. In his interview, he said he was not allowed to work to earn money to make earrings or buy commissary items. says he was prevented from going to work for two weeks and the unvaccinated restrictions lasted about three weeks. After a month and a half, completely changed policies and the quarantines were cube specific. (The entire cube, which is a subsection of the unit, would quarantine regardless of vaccination status.)

wants it noted that he does not go to religious services, but he would not have been able to go if he did. Although it is not in his complaint, he also asserted that once he wanted to get a haircut but was stopped in the hall by a Correctional Officer. does not recall which officer, but the officer knew was not vaccinated. When asked how the officer knew his vaccination status, the officer then asked, "Well, are you?" said he wouldn't release this information and he was denied his haircut.

says an inmate in a different cube tested positive for COVID-19 and inmates in his cube were allowed to go to work if they were vaccinated. He asserts that it doesn't make sense that vaccinated and unvaccinated inmates were allowed to eat, use telephones, go in the yard and intermingle with each other but they were not allowed to enjoy other opportunities.

Inmate. asserts he was denied employment and visitation based on his vaccination status.[2] states that all of the housing units have been shut down at various times beginning in 2020, probably for three to four months in the beginning. He believes the C-Unit was shut down for approximately three weeks in July and August 2021. When an inmate tested positive, that inmate was sent to administrative segregation and the rest of his unit was locked down. Now, when an inmate tests positive, he is still sent to administrative segregation, but only the cube is locked down for 14 days.

[2] submitted additional statements and said that on August 16, 2021, he was told that due to his non-vaccinated status he would have to quarantine and no longer enjoy employment, haircuts, religious activities, library, and visitation. He only asserted employment and visitation in his complaint.

[redacted] began taking Motor Vocational Maintenance Classes in October 2020. He graduated in October 2021 and did not miss work during this time but missed classes that slightly prolonged his graduation, maybe a day or a week. He says he missed class time when he was quarantined in July and August 2021. [redacted] says it's interesting that inmates that are unvaccinated are not allowed to go to work with vaccinated, but they all eat together. [redacted] says he was supposed to have a visit with his wife, but this visit was cancelled. He says he knows of vaccinated inmates that received visits. He was asked to identify these inmates and said he would send in a list. In this later submission, [redacted] doesn't identify inmates that were allowed visitation rather he lists six inmates "that had seen or heard" that vaccinated inmates were allowed to continue services. [redacted] says Correctional Officers have told him that vaccinated inmates get visits, but [redacted] could not recall the names of the [redacted] staff that told him this.

[redacted] believes the infirmary staff doctors/nurses need more training to provide quality care like a healthcare facility should. Since the quality of care is lacking, he does not believe [redacted] is a healthcare facility.

In written submissions, [redacted] relayed that more recent quarantining had been done differently. Both vaccinated and unvaccinated inmates were allowed to go to work "except those that were in direct contact."

[redacted] **Inmate.** [redacted] asserts that he was denied employment and visitation. He says when the pandemic began, he was housed up in the Shelby facility. As a result of the outbreak up there, [redacted] says he has natural immunity, and he is not vaccinated. At [redacted] he works on buildings doing HVAC (heating ventilation and air conditioning). He moves all around the campus.

He recalls that someone tested positive in August 2021 and after that the inmates were confined for a week and then [redacted] gave you an option of going back to work if you were vaccinated. The vaccination was not mandatory, but it is his opinion that [redacted] was trying to force inmates to get the vaccine. He believes he recalls the [redacted] Administrator [redacted] coming to the unit, but later he says maybe it was that he was given the option of doing a waiver. [redacted] says he wishes he would have taken better notes. His recollection is that the quarantine was lifted and then put in place and then lifted again. He says [redacted] asks the inmates to wear masks, he refers to the inmates that wear masks as "sheeple."

[redacted] asserts he was not even allowed to use a phone during this quarantine. Asked if he could identify anyone that was allowed to go to visitation, he says he's not sure. As for any contention that [redacted] is a healthcare facility, [redacted] doesn't believe that [redacted] should qualify because they 'don't provide healthcare at all.'

[redacted] **Inmate.** [redacted] is an inmate at [redacted] He is not vaccinated, and states vaccination is not mandatory at the prison. He asserted he was denied employment, visitation, and the ability to get a haircut. [redacted] was employed by [redacted] as a boilerman in the maintenance department. In this position, he would leave the C-Unit and go to the 'industries compound.' (The industries compound is a separate facility at [redacted]

[redacted] asserts that on or around August 16, 2021, the Administrator for Montana [redacted] and another person from the Clinical Services Division announced that inmates needed to sign a "waiver" regarding their medical information to disclose their vaccination status to work in the "industries compound." [redacted] states he never got to read this waiver. He says if you did not sign the waiver you were assumed to be unvaccinated. It is [redacted] recollection that [redacted] said, "if you're not vaccinated and cannot prove your vaccination status, you will be required to stay in the Unit."

[redacted] says [redacted] posted a notice listing the inmates that could go to work in the "industries compound." [redacted] says only persons that were vaccinated were on the list. Since he could not go to the industries compound, [redacted] asserts his hours were reduced significantly. It is his recollection that shortly after the complaints were filed, he was allowed to return to work. [redacted] states he then lost this position on October 4, 2021.

In August 2021, [redacted] locked down the C-Unit. [redacted] does not take issue with [redacted] quarantining individuals that test positive in accordance with the Centers for Disease Control (CDC). He tested positive in 2020, at that time the whole facility was locked down.

As for [redacted] assertion that he was denied visitation, he says it was "common knowledge" that you could not have visitation if you were not vaccinated. Asked how this was known, he asserted there was a memo posted by [redacted] at the Command Post. [redacted] has been to the infirmary 12 to 15 times in the past year but disagrees that [redacted] as a whole should be a considered a health care facility.

[redacted] **Administrator for Montana** [redacted] [redacted] is unfamiliar with the complaints under investigation by the Bureau, but she is familiar with the vaccination law. She explained that the industries compound is a different area of the prison and that houses MCE programs (training and educational). It also houses some [redacted] programs such as maintenance. [redacted] says that many of the inmates working in the industries compound around this time were making Personal Protected Equipment (PPE).

It is her best recollection that C-Unit went into quarantine and all movement was restricted for both vaccinated and unvaccinated inmates. After this, [redacted] and an [redacted] employee Clinical Services when to C-Unit on August 17, 2021. [redacted] explained that the C-Unit houses inmates that worked over in the industries compound. [redacted] explained to the inmates that they could sign a waiver that would allow an inmate's [redacted] supervisor to know the inmate's vaccination status. If an inmate was vaccinated, he could continue working pursuant to CDC guidelines. She does not recall any inmate asking her what would happen if he was not vaccinated. She believes Clinical Services then took this information back to check against existing records and then a list was created of inmates that were vaccinated. This list was disseminated to the appropriate supervisor (not the entire list of names but the names relevant to a particular supervisor). [redacted] denies that any sort of list was posted regarding the inmate's vaccination status.

After this, it is [redacted] recollection that there were concerns about the discrimination law and that the Warden sent out an email urging compliance with both the state vaccination law and the CDC guidelines. [redacted] contends this happened as soon as practicable. She does not recall when everyone went back to work, but it wasn't long after this.

[redacted] **Medical Bureau Chief.** [redacted] has been with [redacted] for 20 years. She states that she has previously experienced outbreaks of influenza but nothing like COVID-19. She states that [redacted] routinely provides medical services outside of MSP's infirmary. She says medical staff respond to emergencies providing care at the scene. There are different types of medication and medication administration in the various housing units. If there is a "health care request" or kite by an inmate for medical services, that request needs to be assessed within a certain time frame so the inmate may be visited by medical staff in the housing units. Add to this, [redacted] has several 'satellite offices' for health care services outside of the infirmary (e.g., locked housing unit, high side, low side, work and re-entry unit.) There's medical staff in the intake unit (the [redacted] Diagnostic and Intake Unit) every day.

In terms of addressing the spread of COVID-19 in the institution, [redacted] says there are unique challenges. For example, social distancing can be hard to achieve. [redacted] says there is not an across-the-board-masking requirements at [redacted] rather [redacted] works to educate staff and inmates on the available infection control protocols. If the compound is on "outbreak status" masks are recommended. [redacted] has utilized testing protocols, there are both rapid and PCR (nose swab sent to a lab) types of testing. Rapid testing results will be back in 15 minutes, but PCR can take several days to get results. [redacted] says at times [redacted] has run low on rapid tests and had to use more PCR tests.

[redacted] does not have a clear recollection of the quarantine in August 2021 (she stated she did not review her notes for the interview). [redacted] says the [redacted] has worked DPHHS and relied on CDC guidance for direction. She notes the guidance has changed throughout the pandemic. In C-Unit housing unit, inmates are in cubes and share the same bathroom and have a small common area. A person that tests positive will be removed from the areas. [redacted] acknowledges [redacted] has had to change its approach depending on the circumstances, [redacted] is currently using a "cohorted quarantine" protocol.

E. Documents

- Emails between [redacted] Clinical Services Divisions staff and DPHHS staff on matters relating to masking, testing and vaccination status. (Included are [redacted] who is identified as Communicable Disease Nurse Consultant for the Communicable Disease and Prevention Bureau.)

- [redacted] 4.5.11 – Infection Control Program. Revised 12/23/16. General Requirements: "Each health care unit will monitor infectious and communicable diseases in an effort to minimize their occurrence in accordance with state and federal guidelines." Prevention: "An integral component of the infection control program is the prevention of the occurrence and spread of infectious and communicable diseases."

- Excerpts from CDC Guidance on Management of Coronavirus Disease 2019 (COVID-10) in Correctional and Detention Facilities.

- [redacted] 'contact' visitation logs for August 2021. Contact visits stop on August 15, 2021 and start again on August 19, 2021.

- C-Unit Hobby Night Call Out sheets for July 13, 2021, July 28, 2021, August 4, 2021, August 11, 2021, (there is no August 18, 2021), August 25, 2021, September 1, 2021, and September 8, 2021. At least one of the inmates that filed is on the call out sheet for September 1, 2021 and two are on September 8, 2021.

- Undated "Sunday" Workers Only C-Unit Haircut list, [redacted] is marked as a "No Show"

F. Timeline:

As displayed in the witness interviews **neither** party's witnesses could offer much clarity on dates relevant to the particular quarantine at issue. Albeit based on imperfect evidence, this investigator has put together the following timeline of relevant events:

August 16, 2021	Four positive staff at [redacted] with extensive contacts, [redacted] starts restricting movement by for inmates.
August 17, 2021	Warden [redacted] stopped all movement in various units as the day progresses (including C-Unit). No inmates were allowed any function outside of the unit.
August 17, 2021	[redacted] solicits releases or waivers from inmates to disclose their vaccination status 'for the purpose of returning them to work.'
August 18, 2021	A list of inmates who agreed to have their vaccination status released is circulated to those inmate's supervisors. These inmates 'are available for school, work, and other functions.'
August 19, 2021	Director [redacted] sends email to leadership team and [redacted] clinical director stating [redacted] would 'follow state law' and CDC guidelines "unless they conflict with or violate state law….[h]aving this in mind, we need to allow visitation and programs regardless of vaccination status…"

III. ANALYSIS

[redacted] is alleging [redacted] unlawfully discriminated against him in the area of governmental services because of his vaccination status. He has filed a timely complaint and the Montana Human Rights Bureau has jurisdiction.

In [redacted] complaint, he asserts [redacted] quarantined him based on his vaccination status on or about August 17, 2021[3], and that because he was quarantined, he could not work or enjoy other opportunities that inmates that were vaccinated were allowed to enjoy.

To start, this is a new statute. There are no interpreting administrative rules, no hearing officer decisions, much less any court cases to assist the Bureau in the analysis of these complaints. All we have is the language of the applicable statute:

> **49-2-312. Discrimination based on vaccination status or possession of immunity passport prohibited -- definitions.** (1) Except as provided in subsection (2), it is an unlawful discriminatory practice for:
>
> (a) a person or a governmental entity to refuse, withhold from, or deny to a person any local or state services, goods, facilities, advantages, privileges, licensing, educational opportunities, health care access, or employment opportunities based on the person's vaccination status or whether the person has an immunity passport;
>
> (b) an employer to refuse employment to a person, to bar a person from employment, or to discriminate against a person in compensation or in a term, condition, or privilege of employment based on the person's vaccination status or whether the person has an immunity passport; or
>
> (c) a public accommodation to exclude, limit, segregate, refuse to serve, or otherwise discriminate against a person based on the person's vaccination status or whether the person has an immunity passport.
>
> ...

In its response to these complaints, [redacted] argued the Bureau should dismiss under the authority of another new statute found in Title 2, Chapter 9, "Limitations on Liability Relating to COVID-19." Under this statute, a governmental entity that takes 'reasonable measures' consistent with public health guidance will have an affirmative defense to any civil damages "for injuries or death from or relating to exposure to or potential exposure to COVID-19." *Mont. Code Ann. § 2-9-902.* In § 2-9-905, MCA, it states that if a governmental entity proves an affirmative defense, it operates as a "complete bar" to any action "relating to COVID-19." *Mont. Code Ann. § 2-9-905(4).*[4] As part of this investigation, [redacted] provided

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[3] The inmate's complaints all have a paragraph that states "On or about _____, 2021, I was informed that, due to my non-vaccinated status that I would have to quarantine in C-Unit and could no longer enjoy my employment at the industries compound." Inmates [redacted] and [redacted] failed to put a date in the blank, [redacted] and [redacted] put August 16, 2021, and [redacted] and [redacted] put August 17, 2021.

[4] **2-9-905.** *(Temporary)* **Affirmative defense -- reasonable measures consistent with regulations, orders, and public health guidance.** (1) In addition to all other defenses, a government entity may assert as an affirmative defense that the government entity took reasonable measures consistent with a federal or state statute, regulation, order, or public health guidance related to covid-19 that was applicable to the government entity or activity at issue at the time of the alleged injury, death, or property damage.

(2) If two or more sources of public health guidance are applicable, a government entity does not breach a duty of care if the person took reasonable measures consistent with one applicable set of public health guidance.

(3) If a government entity proves the affirmative defense contained in this section, the affirmative defense is a complete bar to any action relating to covid-19.

communication between [redacted] Clinical Services and the Department of Public Health and Human Services discussing Centers for Disease Control guidance on how to best handle an outbreak in a correctional setting. [redacted] asserts that because it was operating in accordance with this guidance, it has an affirmative defense that stands as an 'absolute bar' to an inmate complaint.

[redacted] arguments are compelling, but this statute doesn't quite seem to fit. Here, the inmates are not asserting [redacted] is liable for their exposure or potential exposure to COVID-19. The inmates are asserting [redacted] is liable for violating a provision of the Montana Human Rights Act that protects the inmates based on vaccination status. *Mont. Code Ann. § 49-2-312.* Ultimately, a fact finder may agree that this statute stands as a bar to inmate complaints under discrimination laws, but for now the Bureau will continue its analysis.

As we begin, it bears noting that putting together a clean timeline was extremely challenging. [redacted] counsel was asked and created one, the Bureau then talked to two different [redacted] staff as well as six different inmates in C-Unit. Most every witness stated they had some difficulty remembering the details. [redacted] argued any restrictions on unvaccinated inmates were short term, lasting for maybe one day. Meanwhile, the inmates put restrictions on unvaccinated inmates anywhere from a week to several months. Given the testimony and documentation, it seems likely that any restrictions lasted a few days.

Everyone involved acknowledged there have been various quarantines throughout the pandemic and these various quarantines have looked different. At the beginning of the pandemic, it sounds like [redacted] quarantined every inmate due to the scope of the outbreak, later quarantines were by housing unit, and more recently quarantines are done by "cohort" depending on an inmate's exposure (e.g., direct contact). Inmates that are vaccinated are in the same housing units as inmates that are unvaccinated. The charging parties are housed in C-Unit and according to [redacted] C-Unit houses the inmates that work over in the industries compound. An inmate's vaccination status is not necessarily static. An inmate's status may be unvaccinated one day and vaccinated the next. Through interviews, it is apparent that some [redacted] inmates choose to discuss their vaccination status freely, while others do not.

All of the inmates stated that they were allowed to "comingle" for the purposes of recreation, laundry pass, food services and other non-restrictive social activities but denied other services, such as visitation, hobby services, religious activities. In interviewing the inmates, clearly this is what created the most confusion. But, as [redacted] has pointed out in this investigation, the pandemic did not relieve [redacted] of its obligation to provide basic services and keep the facility as operational as possible.

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(4) This section may not be construed to impose liability on a government entity for failing to comply with a federal or state statute, regulation, order, or public health guidance related to covid-19. *(Terminates December 31, 2031--sec. 12, Ch. 516, L. 2021.)*

History: En. Sec. 5, Ch. 516, L. 2021.

(emphasis added)

[redacted] and other inmates asserted visitation was restricted because they were unvaccinated. It is difficult to put your arms around these allegations. [redacted] provided visitation logs for August 2021 and only one of the unvaccinated inmates shows up; [redacted] on August 12, 2021. It also appears visitation was cancelled for everyone between August 15, 2021, and August 18, 2021. If an inmate's visit was supposed to occur in this timeframe, that would not be an issue. (Visitation was cancelled for all inmates.) But no one has a clear recollection of what happened when. If several inmates had tested positive inside the C-Unit, [redacted] stated medical services would have recommended limiting exposure. Several inmates confirmed that both vaccinated and unvaccinated inmates were using a form of "tele-visitation." I find the inmates have not established they were denied visitation based on vaccination status.

[redacted] also asserted he was denied hobby. [redacted] argues that given the short time frame of the quarantine, the inmates cannot show they were denied hobby services. [redacted] says C-Unit is called out for hobby on Wednesday nights. Because of the quarantine, there was no C-Unit hobby on August 18, 2021. [redacted] provided the Inmate Call Out Sheets for hobby from July 13, 2021 through September 8, 2021. (A listing of the inmates called out to the activity.) There was no call out sheet for August 18, 2021. There are inmates that filed vaccination complaints on both the September 1, 2021, and September 8, 2021, call out sheets.

In [redacted] timeline of the restrictions for this particular quarantine, [redacted] asserted that on August 16, 2021, there were four COVID-19 positives. Initially, [redacted]'s Warden restricted movement in the A-Unit. But this changed as the day progressed, and by the end of the day, no movement was allowed in either the A-Unit or the C-Unit. There is a lot of testing happening. [redacted] says it sent out 225 PCR tests. [redacted] emails reflect that it is looking to CDC guidance for protocols, including testing strategies. If there is a clear bad act to grab on to, it happens somewhere in here. [redacted] allows persons that are vaccinated to return to work on August 18, 2021, whereas persons that were unvaccinated were not allowed to return to work. Later, the quarantine was lifted for unvaccinated inmates as well.

If the claim at issue involved only employment, [redacted] argued the Bureau does not have jurisdiction over inmates' complaints. *See Quigg v. South, 243 Mont. 218 (1990).* In *Quigg*, the male inmates had filed a discrimination complaint asserting that they were being paid less than female inmates. Our Supreme Court found that there was statutory language, specifically §§ 53-30-151-153, MCA, that precluded this type of discrimination complaint, specifically wage based discrimination complaints. Generally speaking, the Bureau disagrees with [redacted] assertion that *Quigg* is "black letter law." It remains unclear how the ruling in *Quigg* will apply to this new statute.

All this aside, these complaints have raised a whole different question. As noted, the Bureau is working with a new statute and this new statute contains special provisions for health care facilities. *Mont. Code Ann. § 49-2-312(3)(b).* The new statute treats health care facilities differently from other environments and the language suggests that such a facility may have to take measures to protect the health and safety of employees, patients, visitors, and other persons from communicable diseases.

> (b) A health care facility, as defined in **50-5-101**, does not unlawfully discriminate under this section if it complies with both of the following:

> (i) asks an employee to volunteer the employee's vaccination or immunization status for the purpose of determining whether the health care facility should implement reasonable accommodation measures to protect the safety and health of employees, patients, visitors, and other persons from communicable diseases. A health care facility may consider an employee to be nonvaccinated or nonimmune if the employee declines to provide the employee's vaccination or immunization status to the health care facility for purposes of determining whether reasonable accommodation measures should be implemented.
>
> (ii) implements reasonable accommodation measures for employees, patients, visitors, and other persons who are not vaccinated or not immune to protect the safety and health of employees, patients, visitors, and other persons from communicable diseases.

The new statute defines health care facility using § 50-5-101, MCA:

> (26) (a) "Health care facility" or "facility" means all or a portion of an institution, building, or agency, private or public, excluding federal facilities, whether organized for profit or not, that is used, operated, or designed to provide health services, medical treatment, or nursing, rehabilitative, or preventive care to any individual. The term includes chemical dependency facilities, critical access hospitals, eating disorder centers, end-stage renal dialysis facilities, home health agencies, home infusion therapy agencies, hospices, hospitals, infirmaries, long-term care facilities, intermediate care facilities for the developmentally disabled, medical assistance facilities, mental health centers, outpatient centers for primary care, outpatient centers for surgical services, rehabilitation facilities, residential care facilities, and residential treatment facilities.

Inmates argue that because [redacted] was not providing "quality" care, it could not be considered a health care facility, but this argument is not compelling. Quality of care may impact licensure but not designation as a health care facility. [redacted] has been issued a health care facility license by DPPHS and [redacted] is accredited by the National Commission on Correctional Healthcare.

The inmates also argued the definition of health care facility should be restricted to MSP's infirmary. The inmates have a point. It would be reasonable for the Bureau to restrict its interpretation of the term "health care facility" to those portions of [redacted] that are labeled as providing health care services, specifically the infirmary. But the definition says a health care facility means "all or portion of an institution" *used* or designed to provide health services, medical treatment, or nursing, rehabilitative or preventative care to any individual. Meaning if [redacted] is providing health services, medical treatment, or nursing, rehabilitative or preventative care outside of the infirmary, then seemingly this expands the scope of that "facility." In interviews, [redacted] provided a laundry list of examples displaying that medical treatment is provided outside of the infirmary. This included emergency treatment, "sick calls," medication distribution, and mental health services. Add to this there are "satellite offices" for medical services throughout the [redacted] campus. Then if you look at the definition of a "health care facility," it seems very broad. It includes hospitals and infirmaries, but it also picks up residential care facilities, home health agencies, medical assistance facilities. The use of such a broad definition suggests the legislature intended for the term health care facility to be interpreted broadly.

Bottom line, [redacted] is constitutionally obligated to provide health care services for the inmates while the inmate is in MSP's custody and the provision of health care is happening across campus. *See* [redacted] *4.5.2 Responsible Health Authority.* I find [redacted] has presented adequate documentation to show that [redacted] operates as a health care facility. Any argument that only the [redacted] infirmary should be considered a health care facility doesn't hold up given the unique circumstances of this institutional setting.

The statute then says a health care facility does not discriminate if it (1) asks about vaccination status; and then (2) implements reasonable accommodation measures. Here, testimony establishes that [redacted] asked inmates working in the industries compounds about vaccination status on August 16, 2021. Next, the Bureau looks at whether [redacted] implemented reasonable accommodation measures. From information provided by [redacted] it looks like from August 18, 2021, through August 19, 2021 - or as late as August 23, 2021 - inmates that were not vaccinated were restricted in ways inmates that were vaccinated were not, most likely from going to work in the industries compound. So, the relevant question is: Was this a reasonable accommodation measure?

As a quick aside, the Bureau notes Montana's Human Rights Act has a definition for "reasonable accommodation." *Mont. Code Ann. § 49-2-101(19).* A reasonable accommodation is some form of assistance provided to a person with a disability[5] that allows that person to perform in a position or perhaps enjoy a governmental service. In this new statute, the term "reasonable accommodation measures" appears unrelated to this definition. The term reasonable accommodation measures are not intended to attach to a person with a disability. The "measures" are to be taken to "protect the safety and health of employees, patients, visitors and other persons from communicable diseases."

In this investigation, [redacted] has argued it is immune from suit under § 2-9-902, MCA, precisely because the steps it took were reasonable measures consistent with public health guidance, specifically that it restricted the movement of inmates based on vaccination status in accordance with DPHHS and CDC guidance for correctional facilities. A restriction that was lifted shortly after it was imposed.

Could [redacted] have handled this differently? Arguably, it could have required working inmates to wear a full set of personal protective equipment (PPE), or it could have quarantined every inmate regardless of vaccination status similarly. But the law does not ask the Bureau to determine the best way to have handled the situation, it asks the Bureau to determine if the health care facility (1) asked about vaccination status; and (2) then implemented reasonable accommodation measures. Here, I find [redacted] asked about vaccination status and then followed guidance from the CDC for correctional facilities.

If this matter goes forward, [redacted] will ultimately have a variety of defenses available. [redacted] may enjoy the protection of the absolute bar to complaints put forth in § 2-9-902, MCA, and since the inmates have not been able to point to any opportunity that was denied outside of employment *Quigg* may be controlling. Following these investigations, it appears that [redacted] would also be able to show that restrictions on unvaccinated inmates were reasonable accommodation measures.

For these reasons, I find that [redacted] is unable to prove by a preponderance of the evidence that [redacted] discriminated against him on the basis of vaccination status.

CONCLUSION

[5] A person with a disability has a condition or impairment that substantially limits one or more major life activities.

HRB CONFIDENTIAL

Based on my investigation, I find **no reasonable cause** to believe unlawful discrimination occurred as alleged in Charging Party's complaint.

Marieke Beck — *February 25, 2022*

Marieke Beck
Montana Human Rights Bureau

Date

HRB CONFIDENTIAL

MONTANA DEPARTMENT OF LABOR & INDUSTRY
EMPLOYMENT RELATIONS DIVISION
HUMAN RIGHTS BUREAU

[redacted] Charging Party, vs. [redacted][1], Respondent.	Final Investigative Report HRB Case No. 0210597

Recommendation: Based on my investigation, I find **no reasonable cause** to believe unlawful discrimination occurred as alleged in Charging Party's complaint.

I. ISSUE PRESENTED

Did the [redacted] discriminate against [redacted] based on his vaccination status in violation of the Montana Human Rights Act (Title 49, Chapter 2, MCA) when he was quarantined and denied employment and other opportunities?

II. SUMMARY OF THE INVESTIGATION

This report constitutes a summary of the investigation conducted in this case. Content of this report is limited to witnesses, documents and other evidence relevant to the analysis of the issue presented. The case file may contain additional evidence not included in this report.

A. Charging Party's Position Statement:

[redacted] sent in a self-drafted complaint asserting that he is an inmate serving his sentence with the [redacted] He asserts he is employed by Montana [redacted] and that on or about August 17, 2021, he was informed that due to his non-vaccinated status, he would have to quarantine in C-Unit and could no longer enjoy his employment at the industries compound. He asserts he witnessed vaccinated inmates being permitted to enjoy their employment status.

B. Respondent's Position Statement:

[1] Nine complaints were filed by [redacted] inmates on a template form containing substantially similar allegations. All these complaints involve a quarantine by [redacted] in August 2021 at [redacted] The template names "[redacted] Clinical Services Division, Montana [redacted] Defendants." The Bureau sent Charging Parties' complaints to [redacted] and [redacted] responded.

[redacted] denies that it discriminated. In the week of August 15, 2021, there was a confirmed COVID-19 case in MSP's Unit C. In the wake of this potential exposure, inmates were quarantined based on vaccination status. On July 30, 2021, Montana's Department of Public Health and Human Services (DPHHS) provided [redacted] with guidance from the Centers for Disease Control (CDC) stating that vaccinated individuals did not need to be quarantined or restricted from work following a potential exposure to COVID-19. The CDC had developed specific guidance for correctional facilities permitting fully-vaccinated individuals to participate in facility programs rather than quarantine.

In its response, [redacted] argues the Bureau does not have jurisdiction. Since jurisdiction is a threshold issue, [redacted] argues HRB should dismiss these complaints. HRB is an administrative agency and it cannot consider or investigate claims that are not authorized by the Montana legislature. [redacted] points to § 53-30-152, MCA, this statute states that inmates are not employees and therefore employment rights do not attach. [redacted] then argues "[f]or over 30 years, it has been black letter law that 'general anti-discrimination statutes' in Title 49 cannot 'override the specific legislative intent' to prohibit inmates from asserting work-related discrimination claims.

Additionally, [redacted] argues that the newly passed § 2-9-902, MCA, states that a governmental entity is not liable for civil damages for injuries or death from or relating to exposure or potential exposure to COVID-19. It is [redacted] position that this statute was drafted to broadly cover "every civil claim for damages 'relating to' a potential exposure" to COVID-19. Here, these inmates were quarantined based on a potential exposure they are asserting injuries in the form of inability to go to work or engage in other activities during the limited quarantine period. Since a claim for vaccination discrimination is a civil claim and inmates seek damages, this statute precludes the inmates' ability to recover. This statute affords [redacted] "absolute immunity" from civil actions

C. Additional Information

On October 20, 2021, [redacted] was asked to address the application of the health care facility provisions of § 49-2-312, MCA. [redacted] responded and stated that [redacted] is a licensed health care facility/service and provided licensure and accreditation documentation through the National Commission on Correctional Health Care.

D. Omissions

The Bureau currently has nine substantially similar complaints filed by inmates regarding a quarantine event on or about August 17, 2021. After [redacted] provided its response, it was sent to the named Charging Parties on October 20, 2021. The inmates were given until November 9, 2021, to provide a rebuttal. [redacted] did not submit a rebuttal.

A second letter was sent on November 30, 2021, stating that if [redacted] did not respond or contact the Bureau on or before December 20, 2021, the Bureau would write the report based on the information contained in the file. A final letter was sent to [redacted] attention on January 11, 2021. The Bureau has not heard from [redacted] The Bureau was able to interview and proceed with five substantially similar complaints.

[redacted] has not participated. The Bureau limited its investigation to the information in the file.

III. ANALYSIS

[redacted] alleges [redacted] unlawfully discriminated against him in the area of governmental services because of his vaccination status. [redacted] establishes he filed a timely complaint. The Montana Human Rights Bureau has jurisdiction over the complaint.

[redacted] asserts [redacted] quarantined him based on his vaccination status on or about August 17, 2021, and that because he was quarantined he could not work or enjoy other opportunities that inmates that were vaccinated were allowed to enjoy.

To start, this is a new statute. There are no interpreting administrative rules, no hearing officer decisions, much less any court cases to assist the Bureau in the analysis. All we have is the language of the applicable statutes:

> **49-2-312. Discrimination based on vaccination status or possession of immunity passport prohibited -- definitions.** (1) Except as provided in subsection (2), it is an unlawful discriminatory practice for:
>
> (a) a person or a governmental entity to refuse, withhold from, or deny to a person any local or state services, goods, facilities, advantages, privileges, licensing, educational opportunities, health care access, or employment opportunities based on the person's vaccination status or whether the person has an immunity passport;
>
> (b) an employer to refuse employment to a person, to bar a person from employment, or to discriminate against a person in compensation or in a term, condition, or privilege of employment based on the person's vaccination status or whether the person has an immunity passport; or
>
> (c) a public accommodation to exclude, limit, segregate, refuse to serve, or otherwise discriminate against a person based on the person's vaccination status or whether the person has an immunity passport.
>
> (2) This section does not apply to vaccination requirements set forth for schools pursuant to Title 20, chapter 5, part 4, or day-care facilities pursuant to Title 52, chapter 2, part 7.
>
> (3) (a) A person, governmental entity, or an employer does not unlawfully discriminate under this section if they recommend that an employee receive a vaccine.
>
> (b) A health care facility, as defined in **50-5-101**, does not unlawfully discriminate under this section if it complies with both of the following:
>
> (i) asks an employee to volunteer the employee's vaccination or immunization status for the purpose of determining whether the health care facility should implement reasonable accommodation measures to protect the safety and health of employees, patients, visitors, and other persons from communicable diseases. A health care facility may consider an employee to be nonvaccinated or nonimmune if the employee declines to provide the employee's vaccination or immunization status to the health care facility for purposes of determining whether reasonable accommodation measures should be implemented.
>
> (ii) implements reasonable accommodation measures for employees, patients, visitors, and other persons who are not vaccinated or not immune to protect the safety and health of employees, patients, visitors, and other persons from communicable diseases.

(4) An individual may not be required to receive any vaccine whose use is allowed under an emergency use authorization or any vaccine undergoing safety trials.

(5) As used in this section, the following definitions apply:

(a) "Immunity passport" means a document, digital record, or software application indicating that a person is immune to a disease, either through vaccination or infection and recovery.

(b) "Vaccination status" means an indication of whether a person has received one or more doses of a vaccine.

History: En. Sec. 1, Ch. 418, L. 2021.

49-2-313. Exemption. A licensed nursing home, long-term care facility, or assisted living facility is exempt from compliance with **49-2-312** during any period of time that compliance with **49-2-312** would result in a violation of regulations or guidance issued by the centers for medicare and medicaid services or the centers for disease control and prevention.

History: En. Sec. 2, Ch. 418, L. 2021.

Here, [redacted] submitted a boilerplate complaint that is substantially similar to complaints filed by other inmates. [redacted] has chosen not to participate in this investigation. The Bureau notes when a party refuses to provide information or evidence reasonably necessary for an investigation, the Bureau can draw an "adverse inference" as to the information sought. *Admin. R. Mont. 24.8.216.*

Without [redacted] participation, the Bureau cannot fully understand the adverse act(s). Further, [redacted] has failed to counter [redacted] various defenses. The Bureau will focus its attention on the remaining Charging Parties with substantially similar allegations.

CONCLUSION

Based on my investigation, I find **no reasonable cause** to believe unlawful discrimination occurred as alleged in Charging Party's complaint.

Bre Koffman

Bre Koffman
Montana Human Rights Bureau

February 11, 2022
Date

DEFS 001402

HRB CONFIDENTIAL

MONTANA DEPARTMENT OF LABOR & INDUSTRY
EMPLOYMENT RELATIONS DIVISION
HUMAN RIGHTS BUREAU

[redacted] Charging Party, vs. [redacted][1], Respondent.	Final Investigative Report HRB Case No. 0220118

Recommendation: Based on my investigation, I find **no reasonable cause** to believe unlawful discrimination occurred as alleged in Charging Party's complaint.

I. ISSUE PRESENTED

Did the [redacted] discriminate against [redacted] based on his vaccination status in violation of the Montana Human Rights Act (Title 49, Chapter 2, MCA) by subjecting him to quarantine and denying him employment and other opportunities?

II. SUMMARY OF THE INVESTIGATION

This report constitutes a summary of the investigation conducted in this case. Content of this report is limited to witnesses, documents and other evidence relevant to the analysis of the issue presented. The case file may contain additional evidence not included in this report.

A. Charging Party's Position Statement:

[redacted] sent in a self-drafted complaint asserting that he is an inmate serving his sentence with the [redacted] He asserts he is employed by Montana [redacted] and that he was informed on August 16, 2021, that due to his non-vaccinated status, he would have to quarantine in C-Unit and could no longer enjoy his employment at the industries compound. He asserts he witnesses vaccinated inmates being permitted to enjoy their employment status.

[1] Nine complaints were filed by [redacted] inmates using a template containing substantially similar language. On the template, inmates checked whether they were felt they were denied visitation or medical care, some inmates wrote in additional information regarding denials including hobby, haircuts and religious services. The complaints all involve a quarantine by [redacted] in August 2021 at [redacted] The template names [redacted] Defendants." The Bureau sent Charging Parties' complaints to [redacted] which responded on behalf of all named respondents.

He then states that, "I and all other vaccinated inmates" were allowed to commingle after work for purposes of recreation, laundry pass, food service and other non-restrictive social activities.

[redacted] also asserted that he was denied medical care and religious services due to not being vaccinated.

B. Respondent's Position Statement:

[redacted] denies that it discriminated. In the week of August 15, 2021, there was a confirmed COVID-19 case in [redacted] C-Unit. In the wake of this potential exposure, inmates were quarantined based on vaccination status.

On July 30, 2021, Montana's Department of Public Health and Human Services (DPHHS) provided [redacted] with guidance from the Centers for Disease Control (CDC) stating that vaccinated individuals did not need to be quarantined or restricted from work following a potential exposure to COVID-19. The CDC had developed specific guidance for correctional facilities permitting fully-vaccinated individuals to participate in facility programs rather than quarantine.

[redacted] argues the Bureau does not have jurisdiction. Since jurisdiction is a threshold issue that must be addressed before any further proceeding, [redacted] argues the Human Rights Bureau (the Bureau) should dismiss these complaints. The Bureau is an administrative agency and it cannot consider or investigate claims that are not authorized by the Montana legislature. [redacted] points to § 53-30-152, MCA, this statute states that inmates are not employees and therefore employment rights do not attach. [redacted] then argues "[f]or over 30 years, it has been black letter law that 'general anti-discrimination statutes' in Title 49 cannot 'override the specific legislative intent' to prohibit inmates from asserting work-related discrimination claims."

Additionally, [redacted] argues that the newly passed § 2-9-902, MCA, states that a governmental entity is not liable for civil damages for injuries or death from or relating to exposure or potential exposure to COVID-19. It is [redacted] position that this statute was drafted to broadly cover "every civil claim for damages 'relating to' a potential exposure" to COVID-19. Here, these inmates were quarantined based on a potential exposure they are asserting injuries in the form of inability to go to work or engage in other activities during the limited quarantine period. Since a claim for vaccination discrimination is a civil claim and inmates seek damages, this statute precludes the inmates' ability to recover. This statute affords [redacted] "absolute immunity" from civil actions.

In response to the Bureau's requests for information, [redacted] further argued that COVID-19 presented unique challenges because the prison population was at or near capacity for bed space. [redacted] needed to provide certain services such as food and laundry while simultaneously managing the health crisis. [redacted] contends it relied on the "expertise of clinical services division staff which was receiving regular guidance specific to correctional facilities from the U.S. Centers for Disease Control (CDC), the Montana Department of Health and Human Services, county/local health officials, as well as direction from the

Department Director in the event of a conflict between Montana law and guidance provided by the aforementioned resources."

[redacted] argues the inmates complains amount to a 'brief disruption of non-employment "employment" activity,' temporary disruption of haircut services and hobby, and brief disruptions to in-person visitation.

C. Additional Information

The parties were asked to address the application of the health care facility provisions of § 49-2-312, MCA. [redacted] responded and stated that [redacted] is a licensed health care facility/service and provided licensure and accreditation documentation through the National Commission on Correctional Health Care.

Inmates argued [redacted] is not a health care facility given the quality of care and further, if it were, then only the [redacted] building containing the infirmary should be considered as a health care facility. The infirmary is a separate building from the housing units.

D. Witnesses

[redacted] **Inmate.** [redacted] complaint was substantially similar to the other complaints, but it was handwritten and was submitted later. [redacted] asserted he was denied employment, medical care, and religious services.

Initially, [redacted] was asked to explain the assertion in his complaint that he was denied medical care, but he did not remember making this allegation. Later in the interview, he stated that he believes he should have received treatment for a non-emergency back injury. He said another inmate was allowed to get medical services during this time and he was not. ([redacted] believes that inmate had a knee injury, but he is unsure of the inmate's exact medical situation or his vaccination status.)

[redacted] complaint asserts that he was denied employment but he explained that he was in the [redacted] "education program" for welding. It is his recollection that [redacted] had multiple COVID-19 cases in the facility and initially they tried to do something with testing; if you were negative you could go to work. He believes C-Unit was locked down for a month or a month and a half. He says he wasn't allowed to go back to school for almost two months. [redacted] offered a witness he believes is vaccinated that was allowed to go to work.

[redacted] says he typically attends three religious meetings every week; Fresh Lives, Baptist Bible Studies and Bread of Life, but he has not been able to attend for two to three months. Pressed, [redacted] wasn't sure if anyone was attending religious meetings at this time. [redacted] wanted more time to put together more information on his denial of religious services and stated he would send more information in, but the Bureau has not received anything.

[redacted] **Inmate.** [redacted] complaint only asserts he was denied employment based on his vaccination status. In his interview, he said he was not allowed to work to earn money to make earrings or buy commissary items. [redacted] says he was prevented from going to work for two weeks and the unvaccinated restrictions lasted about three

weeks. After a month and a half, [redacted] completely changed policies and the quarantines were cube specific. (The entire cube, which is a subsection of the unit, would quarantine regardless of vaccination status.)

[redacted] wants it noted that he does not go to religious services, but he would not have been able to go if he did. Although it is not in his complaint, he also asserted that once he wanted to get a haircut but was stopped in the hall by a Correctional Officer. [redacted] does not recall which officer, but the officer knew [redacted] was not vaccinated. When [redacted] asked how the officer knew his vaccination status, the officer then asked, "Well, are you?" [redacted] said he wouldn't release this information and he was denied his haircut.

[redacted] says an inmate in a different cube tested positive for COVID-19 and inmates in his cube were allowed to go to work if they were vaccinated. He asserts that it doesn't make sense that vaccinated and unvaccinated inmates were allowed to eat, use telephones, go in the yard and intermingle with each other but they were not allowed to enjoy other opportunities.

[redacted] **Inmate.** [redacted] asserts he was denied employment and visitation based on his vaccination status.[2] [redacted] states that all of the housing units have been shut down at various times beginning in 2020, probably for three to four months in the beginning. He believes the C-Unit was shut down for approximately three weeks in July and August 2021. When an inmate tested positive, that inmate was sent to administrative segregation and the rest of his unit was locked down. Now, when an inmate tests positive, he is still sent to administrative segregation, but only the cube is locked down for 14 days.

[redacted] began taking Motor Vocational Maintenance Classes in October 2020. He graduated in October 2021 and did not miss work during this time but missed classes that slightly prolonged his graduation, maybe a day or a week. He says he missed class time when he was quarantined in July and August 2021. [redacted] says it's interesting that inmates that are unvaccinated are not allowed to go to work with vaccinated, but they all eat together. [redacted] says he was supposed to have a visit with his wife, but this visit was cancelled. He says he knows of vaccinated inmates that received visits. He was asked to identify these inmates and said he would send in a list. In this later submission, [redacted] doesn't identify inmates that were allowed visitation rather he lists six inmates "that had seen or heard" that vaccinated inmates were allowed to continue services. [redacted] says Correctional Officers have told him that vaccinated inmates get visits, but [redacted] could not recall the names of the [redacted] staff that told him this.

[redacted] believes the infirmary staff doctors/nurses need more training to provide quality care like a healthcare facility should. Since the quality of care is lacking, he does not believe [redacted] is a healthcare facility.

[2] [redacted] submitted additional statements and said that on August 16, 2021, he was told that due to his non-vaccinated status he would have to quarantine and no longer enjoy employment, haircuts, religious activities, library, and visitation. He only asserted employment and visitation in his complaint.

In written submissions, [redacted] relayed that more recent quarantining had been done differently. Both vaccinated and unvaccinated inmates were allowed to go to work "except those that were in direct contact."

[redacted] **Inmate.** [redacted] asserts that he was denied employment and visitation. He says when the pandemic began, he was housed up in the Shelby facility. As a result of the outbreak up there, [redacted] says he has natural immunity, and he is not vaccinated. At [redacted] he works on buildings doing HVAC (heating ventilation and air conditioning). He moves all around the campus.

He recalls that someone tested positive in August 2021 and after that the inmates were confined for a week and then [redacted] gave you an option of going back to work if you were vaccinated. The vaccination was not mandatory, but it is his opinion that [redacted] was trying to force inmates to get the vaccine. He believes he recalls the [redacted] Administrator [redacted] coming to the unit, but later he says maybe it was that he was given the option of doing a waiver. [redacted] says he wishes he would have taken better notes. His recollection is that the quarantine was lifted and then put in place and then lifted again. He says [redacted] asks the inmates to wear masks, he refers to the inmates that wear masks as "sheeple."

[redacted] asserts he was not even allowed to use a phone during this quarantine. Asked if he could identify anyone that was allowed to go to visitation, he says he's not sure. As for any contention that [redacted] is a healthcare facility, [redacted] doesn't believe that [redacted] should qualify because they 'don't provide healthcare at all.'

[redacted] **Inmate.** [redacted] is an inmate at [redacted] He is not vaccinated, and states vaccination is not mandatory at the prison. He asserted he was denied employment, visitation, and the ability to get a haircut. [redacted] was employed by [redacted] as a boilerman in the maintenance department. In this position, he would leave the C-Unit and go to the 'industries compound.' (The industries compound is a separate facility at [redacted]

[redacted] asserts that on or around August 16, 2021, the Administrator for Montana [redacted] and another person from the Clinical Services Division announced that inmates needed to sign a "waiver" regarding their medical information to disclose their vaccination status to work in the "industries compound." [redacted] states he never got to read this waiver. He says if you did not sign the waiver you were assumed to be unvaccinated. It is [redacted] recollection that [redacted] said, "if you're not vaccinated and cannot prove your vaccination status, you will be required to stay in the Unit."

[redacted] says [redacted] posted a notice listing the inmates that could go to work in the "industries compound." [redacted] says only persons that were vaccinated were on the list. Since he could not go to the industries compound, [redacted] asserts his hours were reduced significantly. It is his recollection that shortly after the complaints were filed, he was allowed to return to work. [redacted] states he then lost this position on October 4, 2021.

In August 2021, [redacted] locked down the C-Unit. [redacted] does not take issue with [redacted] quarantining individuals that test positive in accordance with the Centers for Disease Control (CDC). He tested positive in 2020, at that time the whole facility was locked down.

As for [redacted] assertion that he was denied visitation, he says it was "common knowledge" that you could not have visitation if you were not vaccinated. Asked how this was known, he asserted there was a memo posted by [redacted] at the Command Post. [redacted] has been to the infirmary 12 to 15 times in the past year but disagrees that [redacted] as a whole should be a considered a health care facility.

[redacted] **Inmate.** [redacted] is an inmate at [redacted] and he is not vaccinated. He states vaccines are not mandatory at [redacted] He asserted he was denied employment, visitation and hobby. Johnston says if there is an outbreak on the unit, the unvaccinated are quarantined, whereas the vaccinated are allowed to go to work. Johnston states this has occurred "a couple times" with the last occurring in around August 2021.

[redacted] has been working for Montana [redacted] ([redacted] since March 2021. [redacted] states inmates work in close proximity to one another and are there from 7 a.m. to around 4:15 p.m. He says he was denied visitation once in September 2021, because he wasn't vaccinated. [redacted] says he 'told his family to not bother coming.' [redacted] said the only inmates allowed visitation at that time were the ones who were vaccinated. He doesn't know if other unvaccinated inmates are still being denied visitation.

[redacted] says he was also denied hobby once (and a there was a second time when he wasn't scheduled for hobby). He believes this occurred in around August or September 2021. He said for the past month and a half, they have been on a regular weekly schedule where inmates can go to hobby, regardless of whether they are vaccinated.

[redacted] indicated that he has been to the infirmary several times. He does not feel that [redacted] is a healthcare facility because they do not provide adequate healthcare. [redacted] said he does not want to get the vaccine because, as a Native American he does not believe in vaccines. He has not submitted any sort of religious accommodation relative to vaccines.

[redacted] **Administrator for Montana** [redacted] [redacted] is unfamiliar with the complaints under investigation by the Bureau, but she is familiar with the vaccination law. She explained that the industries compound is a different area of the prison and that houses [redacted] programs (training and educational). It also houses some [redacted] programs such as maintenance. [redacted] says that many of the inmates working in the industries compound around this time were making Personal Protected Equipment (PPE).

It is her best recollection that C-Unit went into quarantine and all movement was restricted for both vaccinated and unvaccinated inmates. After this, [redacted] and an [redacted] employee Clinical Services when to C-Unit on August 17, 2021. [redacted] explained that the C-Unit houses inmates that worked over in the industries compound. [redacted] explained to the inmates that they could sign a waiver that would allow an inmate's [redacted] supervisor to know the inmate's vaccination status. If an inmate was vaccinated, he could continue working pursuant to CDC guidelines. She does not recall any inmate asking her what would happen if he was not vaccinated. She believes Clinical Services then took this information back to check against existing records and then a list was created of inmates that were vaccinated. This list was disseminated to the appropriate supervisor (not the entire list of names but the names relevant to a particular supervisor). [redacted] denies that any sort of list was posted regarding the inmate's vaccination status.

After this, it is [redacted] recollection that there were concerns about the discrimination law and that the Warden sent out an email urging compliance with both the state vaccination law and the CDC guidelines. [redacted] contends this happened as soon as practicable. She does not recall when everyone went back to work, but it wasn't long after this.

[redacted] **Medical Bureau Chief.** [redacted] has been with [redacted] for 20 years. She states that she has previously experienced outbreaks of influenza but nothing like COVID-19. She states that [redacted] routinely provides medical services outside of [redacted] infirmary. She says medical staff respond to emergencies providing care at the scene. There are different types of medication and medication administration in the various housing units. If there is a "health care request" or kite by an inmate for medical services, that request needs to be assessed within a certain time frame so the inmate may be visited by medical staff in the housing units. Add to this, [redacted] has several 'satellite offices' for health care services outside of the infirmary (e.g., locked housing unit, high side, low side, work and re-entry unit.) There's medical staff in the intake unit (the Martz Diagnostic and Intake Unit) every day.

In terms of addressing the spread of COVID-19 in the institution, [redacted] says there are unique challenges. For example, social distancing can be hard to achieve. [redacted] says there is not an across-the-board-masking requirements at [redacted] rather [redacted] works to educate staff and inmates on the available infection control protocols. If the compound is on "outbreak status" masks are recommended. [redacted] has utilized testing protocols, there are both rapid and PCR (nose swab sent to a lab) types of testing. Rapid testing results will be back in 15 minutes, but PCR can take several days to get results. [redacted] says at times [redacted] has run low on rapid tests and had to use more PCR tests.

[redacted] does not have a clear recollection of the quarantine in August 2021 (she stated she did not review her notes for the interview). [redacted] says the [redacted] has worked DPHHS and relied on CDC guidance for direction. She notes the guidance has changed throughout the pandemic. In C-Unit housing unit, inmates are in cubes and share the same bathroom and have a small common area. A person that tests positive will be removed from the areas. [redacted] acknowledges [redacted] has had to change its approach depending on the circumstances, [redacted] is currently using a "cohorted quarantine" protocol.

E. Documents

- Emails between [redacted] Clinical Services Divisions staff and DPHHS staff on matters relating to masking, testing and vaccination status. (Included are [redacted] who is identified as Communicable Disease Nurse Consultant for the Communicable Disease and Prevention Bureau.)

- [redacted] 4.5.11 – Infection Control Program. Revised 12/23/16. General Requirements: "Each health care unit will monitor infectious and communicable diseases in an effort to minimize their occurrence in accordance with state and federal guidelines." Prevention: "An integral component of the infection control

program is the prevention of the occurrence and spread of infectious and communicable diseases."

- Excerpts from CDC Guidance on Management of Coronavirus Disease 2019 (COVID-10) in Correctional and Detention Facilities.
- [redacted] 'contact' visitation logs for August 2021. Contact visits stop on August 15, 2021 and start again on August 19, 2021.
- C-Unit Hobby Night Call Out sheets for July 13, 2021, July 28, 2021, August 4, 2021, August 11, 2021, (there is no August 18, 2021), August 25, 2021, September 1, 2021, and September 8, 2021. At least one of the inmates that filed is on the call out sheet for September 1, 2021 and two are on September 8, 2021.
- Undated "Sunday" Workers Only C-Unit Haircut list, [redacted] is marked as a "No Show"

F. Timeline:

As displayed in the witness interviews **neither** party's witnesses could offer much clarity on dates relevant to the particular quarantine at issue. Albeit based on imperfect evidence, this investigator has put together the following timeline of relevant events:

August 16, 2021	Four positive staff at [redacted] with extensive contacts, [redacted] starts restricting movement by for inmates.
August 17, 2021	Warden [redacted] stopped all movement in various units as the day progresses (including C-Unit). No inmates were allowed any function outside of the unit.
August 17, 2021	[redacted] solicits releases or waivers from inmates to disclose their vaccination status 'for the purpose of returning them to work.'
August 18, 2021	A list of inmates who agreed to have their vaccination status released is circulated to those inmate's supervisors. These inmates 'are available for school, work, and other functions.'
August 19, 2021	Director [redacted] sends email to leadership team and [redacted] clinical director stating [redacted] would 'follow state law' and CDC guidelines "unless they conflict with or violate state law….[h]aving this in mind, we need to allow visitation and programs regardless of vaccination status…"

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III. ANALYSIS

[redacted] is alleging [redacted] unlawfully discriminated against him in the area of governmental services because of his vaccination status. He has filed a timely complaint and the Montana Human Rights Bureau has jurisdiction.

In [redacted] complaint, he asserts [redacted] quarantined him based on his vaccination status on or about August 16, 2021[3], and that because he was quarantined, he could not work or enjoy other opportunities that inmates that were vaccinated were allowed to enjoy. [redacted] believes the restrictions lasted for several months (on religious services).

To start, this is a new statute. There are no interpreting administrative rules, no hearing officer decisions, much less any court cases to assist the Bureau in the analysis of these complaints. All we have is the language of the applicable statute:

> **49-2-312. Discrimination based on vaccination status or possession of immunity passport prohibited -- definitions.** (1) Except as provided in subsection (2), it is an unlawful discriminatory practice for:
>
> (a) a person or a governmental entity to refuse, withhold from, or deny to a person any local or state services, goods, facilities, advantages, privileges, licensing, educational opportunities, health care access, or employment opportunities based on the person's vaccination status or whether the person has an immunity passport;
>
> (b) an employer to refuse employment to a person, to bar a person from employment, or to discriminate against a person in compensation or in a term, condition, or privilege of employment based on the person's vaccination status or whether the person has an immunity passport; or
>
> (c) a public accommodation to exclude, limit, segregate, refuse to serve, or otherwise discriminate against a person based on the person's vaccination status or whether the person has an immunity passport.
>
> ...

In its response to these complaints, [redacted] argued the Bureau should dismiss under the authority of another new statute found in Title 2, Chapter 9, "Limitations on Liability Relating to COVID-19." Under this statute, a governmental entity that takes 'reasonable measures' consistent with public health guidance will have an affirmative defense to any civil damages "for injuries or death from or relating to exposure to or potential exposure to COVID-19." *Mont. Code Ann. § 2-9-902.* In § 2-9-905, MCA, it states that if a governmental entity proves an affirmative defense, it operates as a "complete bar" to any action "relating to COVID-19." *Mont. Code Ann. § 2-9-905(4).*[4] As part of this investigation, [redacted] provided

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[3] The inmate's complaints all have a paragraph that states "On or about _____, 2021, I was informed that, due to my non-vaccinated status that I would have to quarantine in C-Unit and could no longer enjoy my employment at the industries compound." Inmates [redacted] and [redacted] failed to put a date in the blank, [redacted] and [redacted] put August 16, 2021, and [redacted] and [redacted] put August 17, 2021.

[4] **2-9-905.** *(Temporary)* **Affirmative defense -- reasonable measures consistent with regulations, orders, and public health guidance.** (1) In addition to all other defenses, a government entity may assert as an affirmative defense that the government entity took reasonable measures consistent with a federal or state statute,

communication between [redacted] Clinical Services and the Department of Public Health and Human Services discussing Centers for Disease Control guidance on how to best handle an outbreak in a correctional setting. [redacted] asserts that because it was operating in accordance with this guidance, it has an affirmative defense that stands as an 'absolute bar' to an inmate complaint.

[redacted] arguments are compelling, but this statute doesn't quite seem to fit. Here, the inmates are not asserting [redacted] is liable for their exposure or potential exposure to COVID-19. The inmates are asserting [redacted] is liable for violating a provision of the Montana Human Rights Act that protects the inmates based on vaccination status. *Mont. Code Ann. § 49-2-312.* Ultimately, a fact finder may agree that this statute stands as a bar to inmate complaints under discrimination laws, but for now the Bureau will continue its analysis.

As we begin, it bears noting that putting together a clean timeline was extremely challenging. [redacted] counsel was asked and created one, the Bureau then talked to two different [redacted] staff as well as six different inmates in C-Unit. Most every witness stated they had some difficulty remembering the details. [redacted] argued any restrictions on unvaccinated inmates were short term, lasting for maybe one day. Meanwhile, the inmates put restrictions on unvaccinated inmates anywhere from a week to several months. Given the testimony and documentation, it seems likely that any restrictions lasted a few days.

Everyone involved acknowledged there have been various quarantines throughout the pandemic and these various quarantines have looked different. At the beginning of the pandemic, it sounds like [redacted] quarantined every inmate due to the scope of the outbreak, later quarantines were by housing unit, and more recently quarantines are done by "cohort" depending on an inmate's exposure (e.g., direct contact). Inmates that are vaccinated are in the same housing units as inmates that are unvaccinated. The charging parties are housed in C-Unit and according to [redacted] C-Unit houses the inmates that work over in the industries compound. An inmate's vaccination status is not necessarily static. An inmate's status may be unvaccinated one day and vaccinated the next. Through interviews, it is apparent that some [redacted] inmates choose to discuss their vaccination status freely, while others do not.

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regulation, order, or public health guidance related to covid-19 that was applicable to the government entity or activity at issue at the time of the alleged injury, death, or property damage.

(2) If two or more sources of public health guidance are applicable, a government entity does not breach a duty of care if the person took reasonable measures consistent with one applicable set of public health guidance.

(3) If a government entity proves the affirmative defense contained in this section, the affirmative defense is a complete bar to any action relating to covid-19.

(4) This section may not be construed to impose liability on a government entity for failing to comply with a federal or state statute, regulation, order, or public health guidance related to covid-19. *(Terminates December 31, 2031--sec. 12, Ch. 516, L. 2021.)*

History: En. Sec. 5, Ch. 516, L. 2021.

(emphasis added)

All of the inmates stated that they were allowed to "comingle" for the purposes of recreation, laundry pass, food services and other non-restrictive social activities but denied other services, such as visitation, hobby services, religious activities. In interviewing the inmates, clearly this is what created the most confusion. But, as [redacted] has pointed out in this investigation, the pandemic did not relieve [redacted] of its obligation to provide basic services and keep the facility as operational as possible.

[redacted] did not assert that his visitation was restricted because they were unvaccinated, but other inmates did. It is difficult to put your arms around these allegations. [redacted] provided visitation logs for August 2021 and only one of the unvaccinated inmates shows up; [redacted] on August 12, 2021. It also appears visitation was cancelled for everyone between August 15, 2021, and August 18, 2021. If an inmate's visit was supposed to occur in this timeframe, that would not be an issue. (Visitation was cancelled for all inmates.) But no one has a clear recollection of what happened when. If several inmates had tested positive inside the C-Unit, [redacted] stated medical services would have recommended limiting exposure. Several inmates confirmed that both vaccinated and unvaccinated inmates were using a form of "tele-visitation." I find the inmates have not established they were denied visitation based on vaccination status.

[redacted] also did not complain that he was denied hobby, but other inmates did. [redacted] argues that given the short time frame of the quarantine, the inmates cannot show they were denied hobby services. [redacted] says C-Unit is called out for hobby on Wednesday nights. Because of the quarantine, there was no C-Unit hobby on August 18, 2021. [redacted] provided the Inmate Call Out Sheets for hobby from July 13, 2021 through September 8, 2021. (A listing of the inmates called out to the activity.) There was no call out sheet for August 18, 2021. There are inmates that filed vaccination complaints on both the September 1, 2021, and September 8, 2021, call out sheets.

[redacted] asserted a denial of medical services. He initially did not remember this was one of his allegations. Later, [redacted] remembered that maybe he was not allowed to seek treatment for a back injury. Given the lack of details, there's nothing to grab on to here and other witnesses indicated that they continued to receive care. As for religious services, [redacted] explained that he attended three different services in a week. In discussing this, he was unsure of the timeframes or whether the services were being offered to anyone. [redacted] was asked to send in additional information, but nothing was provided (nor did he submit a rebuttal).

In [redacted] timeline of the restrictions for this particular quarantine, [redacted] asserted that on August 16, 2021, there were four COVID-19 positives. Initially, [redacted] Warden restricted movement in the A-Unit. But this changed as the day progressed, and by the end of the day, no movement was allowed in either the A-Unit or the C-Unit. There is a lot of testing happening. [redacted] says it sent out 225 PCR tests. [redacted] emails reflect that it is looking to CDC guidance for protocols, including testing strategies. If there is a clear bad act to grab on to, it happens somewhere in here. [redacted] allows persons that are vaccinated to return to work on August 18, 2021, whereas persons that were unvaccinated were not allowed to return to work. Later, the quarantine was lifted for unvaccinated inmates as well.

If the claim at issue involved only employment, [redacted] argued the Bureau does not have jurisdiction over inmates' complaints. *See Quigg v. South, 243 Mont. 218 (1990).* In *Quigg*, the male inmates had filed a discrimination complaint asserting that they were being paid less than female inmates. Our Supreme Court found that there was statutory language, specifically §§ 53-30-151-153, MCA, that precluded this type of discrimination complaint, specifically wage based discrimination complaints. Generally speaking, the Bureau disagrees with [redacted] assertion that *Quigg* is "black letter law." It remains unclear how the ruling in *Quigg* will apply to this new statute.

All this aside, these complaints have raised a whole different question. As noted, the Bureau is working with a new statute and this new statute contains special provisions for health care facilities. *Mont. Code Ann. § 49-2-312(3)(b).* The new statute treats health care facilities differently from other environments and the language suggests that such a facility may have to take measures to protect the health and safety of employees, patients, visitors, and other persons from communicable diseases.

> (b) A health care facility, as defined in **50-5-101**, does not unlawfully discriminate under this section if it complies with both of the following:
>
> (i) asks an employee to volunteer the employee's vaccination or immunization status for the purpose of determining whether the health care facility should implement reasonable accommodation measures to protect the safety and health of employees, patients, visitors, and other persons from communicable diseases. A health care facility may consider an employee to be nonvaccinated or nonimmune if the employee declines to provide the employee's vaccination or immunization status to the health care facility for purposes of determining whether reasonable accommodation measures should be implemented.
>
> (ii) implements reasonable accommodation measures for employees, patients, visitors, and other persons who are not vaccinated or not immune to protect the safety and health of employees, patients, visitors, and other persons from communicable diseases.

The new statute defines health care facility using § 50-5-101, MCA:

> (26) (a) "Health care facility" or "facility" means all or a portion of an institution, building, or agency, private or public, excluding federal facilities, whether organized for profit or not, that is used, operated, or designed to provide health services, medical treatment, or nursing, rehabilitative, or preventive care to any individual. The term includes chemical dependency facilities, critical access hospitals, eating disorder centers, end-stage renal dialysis facilities, home health agencies, home infusion therapy agencies, hospices, hospitals, infirmaries, long-term care facilities, intermediate care facilities for the developmentally disabled, medical assistance facilities, mental health centers, outpatient centers for primary care, outpatient centers for surgical services, rehabilitation facilities, residential care facilities, and residential treatment facilities.

Inmates argue that because [redacted] was not providing "quality" care, it could not be considered a health care facility, but this argument is not compelling. Quality of care may impact licensure but not designation as a health care facility. [redacted] has been issued a health care facility license by DPPHS and [redacted] is accredited by the National Commission on Correctional Healthcare.

The inmates also argued the definition of health care facility should be restricted to [redacted] infirmary. The inmates have a point. It would be reasonable for the Bureau to restrict its interpretation of the term "health care facility" to those portions of [redacted] that are labeled as providing health care services, specifically the infirmary. But the definition says a health care facility means "all or portion of an institution" *used* or designed to provide health services, medical treatment, or nursing, rehabilitative or preventative care to any individual. Meaning

if [redacted] is providing health services, medical treatment, or nursing, rehabilitative or preventative care outside of the infirmary, then seemingly this expands the scope of that "facility." In interviews, [redacted] provided a laundry list of examples displaying that medical treatment is provided outside of the infirmary. This included emergency treatment, "sick calls," medication distribution, and mental health services. Add to this there are "satellite offices" for medical services throughout the [redacted] campus. Then if you look at the definition of a "health care facility," it seems very broad. It includes hospitals and infirmaries, but it also picks up residential care facilities, home health agencies, medical assistance facilities. The use of such a broad definition suggests the legislature intended for the term health care facility to be interpreted broadly.

Bottom line, [redacted] is constitutionally obligated to provide health care services for the inmates while the inmate is in [redacted] custody and the provision of health care is happening across campus. *See* [redacted] *4.5.2 Responsible Health Authority.* I find [redacted] has presented adequate documentation to show that [redacted] operates as a health care facility. Any argument that only the [redacted] infirmary should be considered a health care facility doesn't hold up given the unique circumstances of this institutional setting.

The statute then says a health care facility does not discriminate if it (1) asks about vaccination status; and then (2) implements reasonable accommodation measures. Here, testimony establishes that [redacted] asked inmates working in the industries compounds about vaccination status on August 16, 2021. Next, the Bureau looks at whether [redacted] implemented reasonable accommodation measures. From information provided by [redacted] it looks like from August 18, 2021, through August 19, 2021 - or as late as August 23, 2021 - inmates that were not vaccinated were restricted in ways inmates that were vaccinated were not, most likely from going to work in the industries compound. So, the relevant question is: Was this a reasonable accommodation measure?

As a quick aside, the Bureau notes Montana's Human Rights Act has a definition for "reasonable accommodation." *Mont. Code Ann. § 49-2-101(19).* A reasonable accommodation is some form of assistance provided to a person with a disability[5] that allows that person to perform in a position or perhaps enjoy a governmental service. In this new statute, the term "reasonable accommodation measures" appears unrelated to this definition. The term reasonable accommodation measures are not intended to attach to a person with a disability. The "measures" are to be taken to "protect the safety and health of employees, patients, visitors and other persons from communicable diseases."

In this investigation, [redacted] has argued it is immune from suit under § 2-9-902, MCA, precisely because the steps it took were reasonable measures consistent with public health guidance, specifically that it restricted the movement of inmates based on vaccination status in accordance with DPHHS and CDC guidance for correctional facilities. A restriction that was lifted shortly after it was imposed.

Could [redacted] have handled this differently? Arguably, it could have required working inmates to wear a full set of personal protective equipment (PPE), or it could have quarantined every inmate regardless of vaccination status similarly. But the law does not ask the Bureau to

[5] A person with a disability has a condition or impairment that substantially limits one or more major life activities.

determine the best way to have handled the situation, it asks the Bureau to determine if the health care facility (1) asked about vaccination status; and (2) then implemented reasonable accommodation measures. Here, I find [redacted] asked about vaccination status and then followed guidance from the CDC for correctional facilities.

If this matter goes forward, [redacted] will ultimately have a variety of defenses available. [redacted] may enjoy the protection of the absolute bar to complaints put forth in § 2-9-902, MCA, and since the inmates have not been able to point to any opportunity that was denied outside of employment *Quigg* may be controlling. Following these investigations, it appears that [redacted] would also be able to show that restrictions on unvaccinated inmates were reasonable accommodation measures.

For these reasons, I find that [redacted] is unable to prove by a preponderance of the evidence that [redacted] discriminated against him on the basis of vaccination status.

CONCLUSION

Based on my investigation, I find **no reasonable cause** to believe unlawful discrimination occurred as alleged in Charging Party's complaint.

Marieke Beck — *February 25, 2022*

Marieke Beck
Montana Human Rights Bureau

Date

DEFS 001416

HRB CONFIDENTIAL

MONTANA DEPARTMENT OF LABOR & INDUSTRY
EMPLOYMENT RELATIONS DIVISION
HUMAN RIGHTS BUREAU

[redacted] Charging Party, vs. [redacted], Respondent.	Final Investigative Report HRB Case No. 0210579

Recommendation: Based on my investigation, I find **no reasonable cause** to believe unlawful discrimination occurred as alleged in Charging Party's complaint.

I. ISSUE PRESENTED

Did the Department of Corrections discriminate against Juan [redacted] based on his vaccination status in violation of the Montana Human Rights Act (Title 49, Chapter 2, MCA) by subjecting him to quarantine and denying him employment and other opportunities?

II. SUMMARY OF THE INVESTIGATION

This report constitutes a summary of the investigation conducted in this case. Content of this report is limited to witnesses, documents and other evidence relevant to the analysis of the issue presented. The case file may contain additional evidence not included in this report.

A. Charging Party's Position Statement:

Juan [redacted] sent in a self-drafted complaint asserting that he is an inmate serving his sentence with the Montana State Prison [redacted]. He asserts he is employed by [redacted] and that he was informed that due to his non-vaccinated status, he would have to quarantine in C-Unit and could no longer enjoy his employment at the industries compound. He asserts he witnesses vaccinated inmates being permitted to enjoy their employment status.

[1] Nine complaints were filed by Montana State Prison [redacted] inmates using a template containing substantially similar language. On the template, inmates checked whether they were felt they were denied visitation or medical care, some inmates wrote in additional information regarding denials including hobby, haircuts and religious services. The complaints all involve a quarantine by [redacted] in August 2021 at [redacted]. The template names "[redacted] Defendants." The Bureau sent Charging Parties' complaints to [redacted] which responded on behalf of all named respondents.

He then states that, "I and all other vaccinated inmates" were allowed to commingle after work for purposes of recreation, laundry pass, food service and other non-restrictive social activities.

B. Respondent's Position Statement:

[redacted] denies that it discriminated. In the week of August 15, 2021, there was a confirmed COVID-19 case in [redacted] C-Unit. In the wake of this potential exposure, inmates were quarantined based on vaccination status.

On July 30, 2021, Montana's Department of Public Health and Human Services (DPHHS) provided [redacted] with guidance from the Centers for Disease Control (CDC) stating that vaccinated individuals did not need to be quarantined or restricted from work following a potential exposure to COVID-19. The CDC had developed specific guidance for correctional facilities permitting fully-vaccinated individuals to participate in facility programs rather than quarantine.

[redacted] argues the Bureau does not have jurisdiction. Since jurisdiction is a threshold issue that must be addressed before any further proceeding, [redacted] argues the Human Rights Bureau (the Bureau) should dismiss these complaints. The Bureau is an administrative agency and it cannot consider or investigate claims that are not authorized by the Montana legislature. [redacted] points to § 53-30-152, MCA, this statute states that inmates are not employees and therefore employment rights do not attach. [redacted] then argues "[f]or over 30 years, it has been black letter law that 'general anti-discrimination statutes' in Title 49 cannot 'override the specific legislative intent' to prohibit inmates from asserting work-related discrimination claims."

Additionally, [redacted] argues that the newly passed § 2-9-902, MCA, states that a governmental entity is not liable for civil damages for injuries or death from or relating to exposure or potential exposure to COVID-19. It is [redacted] position that this statute was drafted to broadly cover "every civil claim for damages 'relating to' a potential exposure" to COVID-19. Here, these inmates were quarantined based on a potential exposure they are asserting injuries in the form of inability to go to work or engage in other activities during the limited quarantine period. Since a claim for vaccination discrimination is a civil claim and inmates seek damages, this statute precludes the inmates' ability to recover. This statute affords [redacted] "absolute immunity" from civil actions.

In response to the Bureau's requests for information, [redacted] further argued that COVID-19 presented unique challenges because the prison population was at or near capacity for bed space. [redacted] needed to provide certain services such as food and laundry while simultaneously managing the health crisis. [redacted] contends it relied on the "expertise of clinical services division staff which was receiving regular guidance specific to correctional facilities from the U.S. Centers for Disease Control (CDC), the Montana Department of Health and Human Services, county/local health officials, as well as direction from the Department Director in the event of a conflict between Montana law and guidance provided by the aforementioned resources."

[redacted] argues the inmates complains amount to a 'brief disruption of non-employment "employment" activity,' temporary disruption of haircut services and hobby, and brief disruptions to in-person visitation.

C. Additional Information

The parties were asked to address the application of the health care facility provisions of § 49-2-312, MCA. [redacted] responded and stated that Montana State Prison is a licensed health care facility/service and provided licensure and accreditation documentation through the National Commission on Correctional Health Care.

Inmates argued [redacted] is not a health care facility given the quality of care and further, if it were, then only the [redacted] building containing the infirmary should be considered as a health care facility. The infirmary is a separate building from the housing units.

D. Witnesses

[redacted] **Inmate.** [redacted] complaint only asserts he was denied employment based on his vaccination status. In his interview, he said he was not allowed to work to earn money to make earrings or buy commissary items. [redacted] says he was prevented from going to work for two weeks and the unvaccinated restrictions lasted about three weeks. After a month and a half, [redacted] completely changed policies and the quarantines were cube specific. (The entire cube, which is a subsection of the unit, would quarantine regardless of vaccination status.)

[redacted] wants it noted that he does not go to religious services, but he would not have been able to go if he did. Although it is not in his complaint, he also asserted that once he wanted to get a haircut but was stopped in the hall by a Correctional Officer. [redacted] does not recall which officer, but the officer knew [redacted] was not vaccinated. When [redacted] asked how the officer knew his vaccination status, the officer then asked, "Well, are you?" [redacted] said he wouldn't release this information and he was denied his haircut.

[redacted] says an inmate in a different cube tested positive for COVID-19 and inmates in his cube were allowed to go to work if they were vaccinated. He asserts that it doesn't make sense that vaccinated and unvaccinated inmates were allowed to eat, use telephones, go in the yard and intermingle with each other but they were not allowed to enjoy other opportunities.

[redacted] **Inmate.** [redacted] asserts he was denied employment and visitation based on his vaccination status.[2] [redacted] states that all of the housing units have been shut down at various times beginning in 2020, probably for three to four months in the beginning. He believes the C-Unit was shut down for approximately three weeks in July and August 2021. When an inmate tested positive, that inmate was sent to administrative

[2] [redacted] submitted additional statements and said that on August 16, 2021, he was told that due to his non-vaccinated status he would have to quarantine and no longer enjoy employment, haircuts, religious activities, library, and visitation. He only asserted employment and visitation in his complaint.

segregation and the rest of his unit was locked down. Now, when an inmate tests positive, he is still sent to administrative segregation, but only the cube is locked down for 14 days.

began taking Motor Vocational Maintenance Classes in October 2020. He graduated in October 2021 and did not miss work during this time but missed classes that slightly prolonged his graduation, maybe a day or a week. He says he missed class time when he was quarantined in July and August 2021. says it's interesting that inmates that are unvaccinated are not allowed to go to work with vaccinated, but they all eat together. says he was supposed to have a visit with his wife, but this visit was cancelled. He says he knows of vaccinated inmates that received visits. He was asked to identify these inmates and said he would send in a list. In this later submission, doesn't identify inmates that were allowed visitation rather he lists six inmates "that had seen or heard" that vaccinated inmates were allowed to continue services. says Correctional Officers have told him that vaccinated inmates get visits, but could not recall the names of the staff that told him this.

believes the infirmary staff doctors/nurses need more training to provide quality care like a healthcare facility should. Since the quality of care is lacking, he does not believe is a healthcare facility.

In written submissions, relayed that more recent quarantining had been done differently. Both vaccinated and unvaccinated inmates were allowed to go to work "except those that were in direct contact."

Inmate. asserts that he was denied employment and visitation. He says when the pandemic began, he was housed up in the Shelby facility. As a result of the outbreak up there, says he has natural immunity, and he is not vaccinated. At he works on buildings doing HVAC (heating ventilation and air conditioning). He moves all around the campus.

He recalls that someone tested positive in August 2021 and after that the inmates were confined for a week and then gave you an option of going back to work if you were vaccinated. The vaccination was not mandatory, but it is his opinion that was trying to force inmates to get the vaccine. He believes he recalls the Administrator coming to the unit, but later he says maybe it was that he was given the option of doing a waiver. says he wishes he would have taken better notes. His recollection is that the quarantine was lifted and then put in place and then lifted again. He says asks the inmates to wear masks, he refers to the inmates that wear masks as "sheeple."

asserts he was not even allowed to use a phone during this quarantine. Asked if he could identify anyone that was allowed to go to visitation, he says he's not sure. As for any contention that is a healthcare facility, doesn't believe that should qualify because they 'don't provide healthcare at all.'

Inmate. is an inmate at He is not vaccinated, and states vaccination is not mandatory at the prison. He asserted he was denied employment, visitation, and the ability to get a haircut. was employed by as a boilerman in the

maintenance department. In this position, he would leave the C-Unit and go to the 'industries compound.' (The industries compound is a separate facility at [redacted]

[redacted] asserts that on or around August 16, 2021, the Administrator for Montana Correctional Enterprises (MEC), [redacted] and another person from the Clinical Services Division announced that inmates needed to sign a "waiver" regarding their medical information to disclose their vaccination status to work in the "industries compound." [redacted] states he never got to read this waiver. He says if you did not sign the waiver you were assumed to be unvaccinated. It is [redacted] recollection that [redacted] said, "if you're not vaccinated and cannot prove your vaccination status, you will be required to stay in the Unit."

[redacted] says [redacted] posted a notice listing the inmates that could go to work in the "industries compound." [redacted] says only persons that were vaccinated were on the list. Since he could not go to the industries compound, [redacted] asserts his hours were reduced significantly. It is his recollection that shortly after the complaints were filed, he was allowed to return to work. [redacted] states he then lost this position on October 4, 2021.

In August 2021, [redacted] locked down the C-Unit. [redacted] does not take issue with [redacted] quarantining individuals that test positive in accordance with the Centers for Disease Control (CDC). He tested positive in 2020, at that time the whole facility was locked down.

As for [redacted] assertion that he was denied visitation, he says it was "common knowledge" that you could not have visitation if you were not vaccinated. Asked how this was known, he asserted there was a memo posted by [redacted] at the Command Post. [redacted] has been to the infirmary 12 to 15 times in the past year but disagrees that [redacted] as a whole should be a considered a health care facility.

[redacted] **Inmate.** [redacted] is an inmate at [redacted] and he is not vaccinated. He states vaccines are not mandatory at [redacted] He asserted he was denied employment, visitation and hobby. [redacted] says if there is an outbreak on the unit, the unvaccinated are quarantined, whereas the vaccinated are allowed to go to work. [redacted] states this has occurred "a couple times" with the last occurring in around August 2021.

[redacted] has been working for Montana Correctional Enterprises [redacted] since March 2021. states inmates work in close proximity to one another and are there from 7 a.m. to around 4:15 p.m. He says he was denied visitation once in September 2021, because he wasn't vaccinated. [redacted] says he 'told his family to not bother coming.' [redacted] said the only inmates allowed visitation at that time were the ones who were vaccinated. He doesn't know if other unvaccinated inmates are still being denied visitation.

[redacted] says he was also denied hobby once (and a there was a second time when he wasn't scheduled for hobby). He believes this occurred in around August or September 2021. He said for the past month and a half, they have been on a regular weekly schedule where inmates can go to hobby, regardless of whether they are vaccinated.

[redacted] indicated that he has been to the infirmary several times. He does not feel that [redacted] is a healthcare facility because they do not provide adequate healthcare. [redacted] said he does not want to get the vaccine because, as a Native American he does not believe in vaccines. He has not submitted any sort of religious accommodation relative to vaccines.

[redacted] **Inmate.** [redacted] complaint was substantially similar to the other complaints, but it was handwritten. He asserted he was denied employment, medical care, and religious services.

Initially, [redacted] was asked to explain the assertion in his complaint that he was denied medical care, but he did not remember making this allegation. Later in the interview, he stated that he believes he should have received treatment for a non-emergency back injury. He said another inmate was allowed to get medical services during this time and he was not. ([redacted] believes that inmate had a knee injury, but he is unsure of the inmate's exact medical situation or his vaccination status.)

[redacted] complaint asserts that he was denied employment but he explained that he was in the [redacted] "education program" for welding. It is his recollection that [redacted] had multiple COVID-19 cases in the facility and initially they tried to do something with testing; if you were negative you could go to work. He believes C-Unit was locked down for a month or a month and a half. He says he wasn't allowed to go back to school for almost two months. [redacted] offered a witness he believes is vaccinated that was allowed to go to work.

[redacted] says he typically attends three religious meetings every week; Fresh Lives, Baptist Bible Studies and Bread of Life, but he has not been able to attend for two to three months. Pressed, [redacted] wasn't sure if anyone was attending religious meetings at this time. [redacted] wanted more time to put together more information on his denial of religious services and stated he would send more information in, but the Bureau has not received anything.

[redacted] **Administrator for Montana Correctional Enterprises.** [redacted] is unfamiliar with the complaints under investigation by the Bureau, but she is familiar with the vaccination law. She explained that the industries compound is a different area of the prison and that houses [redacted] programs (training and educational). It also houses some [redacted] programs such as maintenance. [redacted] says that many of the inmates working in the industries compound around this time were making Personal Protected Equipment (PPE).

It is her best recollection that C-Unit went into quarantine and all movement was restricted for both vaccinated and unvaccinated inmates. After this, [redacted] and an [redacted] employee Clinical Services when to C-Unit on August 17, 2021. [redacted] explained that the C-Unit houses inmates that worked over in the industries compound. [redacted] explained to the inmates that they could sign a waiver that would allow an inmate's [redacted] supervisor to know the inmate's vaccination status. If an inmate was vaccinated, he could continue working pursuant to CDC guidelines. She does not recall any inmate asking her what would happen if he was not vaccinated. She believes Clinical Services then took this information back to check against existing records and then a list was created of inmates that were vaccinated. This list was disseminated to the appropriate supervisor (not the entire list of names but the names relevant to a particular supervisor). [redacted] denies that any sort of list was posted regarding the inmate's vaccination status.

After this, it is [redacted] recollection that there were concerns about the discrimination law and that the Warden sent out an email urging compliance with both the state vaccination law

and the CDC guidelines. [redacted] contends this happened as soon as practicable. She does not recall when everyone went back to work, but it wasn't long after this.

[redacted] Medical Bureau Chief. [redacted] has been with [redacted] for 20 years. She states that she has previously experienced outbreaks of influenza but nothing like COVID-19. She states that [redacted] routinely provides medical services outside of [redacted] infirmary. She says medical staff respond to emergencies providing care at the scene. There are different types of medication and medication administration in the various housing units. If there is a "health care request" or kite by an inmate for medical services, that request needs to be assessed within a certain time frame so the inmate may be visited by medical staff in the housing units. Add to this, [redacted] has several 'satellite offices' for health care services outside of the infirmary (e.g., locked housing unit, high side, low side, work and re-entry unit.) There's medical staff in the intake unit (the [redacted] Diagnostic and Intake Unit) every day.

In terms of addressing the spread of COVID-19 in the institution, [redacted] says there are unique challenges. For example, social distancing can be hard to achieve. [redacted] says there is not an across-the-board-masking requirements at [redacted] rather [redacted] works to educate staff and inmates on the available infection control protocols. If the compound is on "outbreak status" masks are recommended. [redacted] has utilized testing protocols, there are both rapid and PCR (nose swab sent to a lab) types of testing. Rapid testing results will be back in 15 minutes, but PCR can take several days to get results. [redacted] says at times [redacted] has run low on rapid tests and had to use more PCR tests.

[redacted] does not have a clear recollection of the quarantine in August 2021 (she stated she did not review her notes for the interview). [redacted] says the [redacted] has worked DPHHS and relied on CDC guidance for direction. She notes the guidance has changed throughout the pandemic. In C-Unit housing unit, inmates are in cubes and share the same bathroom and have a small common area. A person that tests positive will be removed from the areas. [redacted] acknowledges [redacted] has had to change its approach depending on the circumstances, [redacted] is currently using a "cohorted quarantine" protocol.

E. Documents

- Emails between [redacted] Clinical Services Divisions staff and DPHHS staff on matters relating to masking, testing and vaccination status. (Included are [redacted] who is identified as Communicable Disease Nurse Consultant for the Communicable Disease and Prevention Bureau.)

- [redacted] 4.5.11 – Infection Control Program. Revised 12/23/16. General Requirements: "Each health care unit will monitor infectious and communicable diseases in an effort to minimize their occurrence in accordance with state and federal guidelines." Prevention: "An integral component of the infection control program is the prevention of the occurrence and spread of infectious and communicable diseases."

- Excerpts from CDC Guidance on Management of Coronavirus Disease 2019 (COVID-10) in Correctional and Detention Facilities.
- [redacted] 'contact' visitation logs for August 2021. Contact visits stop on August 15, 2021 and start again on August 19, 2021.
- C-Unit Hobby Night Call Out sheets for July 13, 2021, July 28, 2021, August 4, 2021, August 11, 2021, (there is no August 18, 2021), August 25, 2021, September 1, 2021, and September 8, 2021. At least one of the inmates that filed is on the call out sheet for September 1, 2021 and two are on September 8, 2021.
- Undated "Sunday" Workers Only C-Unit Haircut list, [redacted] is marked as a "No Show"

F. Timeline:

As displayed in the witness interviews **neither** party's witnesses could offer much clarity on dates relevant to the particular quarantine at issue. Albeit based on imperfect evidence, this investigator has put together the following timeline of relevant events:

August 16, 2021	Four positive staff at [redacted] with extensive contacts, [redacted] starts restricting movement by for inmates.
August 17, 2021	Warden [redacted] stopped all movement in various units as the day progresses (including C-Unit). No inmates were allowed any function outside of the unit.
August 17, 2021	[redacted] solicits releases or waivers from inmates to disclose their vaccination status 'for the purpose of returning them to work.'
August 18, 2021	A list of inmates who agreed to have their vaccination status released is circulated to those inmate's supervisors. These inmates 'are available for school, work, and other functions.'
August 19, 2021	Director [redacted] sends email to leadership team and [redacted] clinical director stating [redacted] would 'follow state law' and CDC guidelines "unless they conflict with or violate state law….[h]aving this in mind, we need to allow visitation and programs regardless of vaccination status…"

III. ANALYSIS

[redacted] is alleging [redacted] unlawfully discriminated against him in the area of governmental services because of his vaccination status. He has filed a timely complaint and the Montana Human Rights Bureau has jurisdiction.

In [redacted] complaint, he asserts [redacted] quarantined him based on his vaccination status[3] and that because he was quarantined, he could not work or enjoy other opportunities that inmates that were vaccinated were allowed to enjoy. It is [redacted] recollection this occurred in July and August.

To start, this is a new statute. There are no interpreting administrative rules, no hearing officer decisions, much less any court cases to assist the Bureau in the analysis of these complaints. All we have is the language of the applicable statute:

> **49-2-312. Discrimination based on vaccination status or possession of immunity passport prohibited -- definitions.** (1) Except as provided in subsection (2), it is an unlawful discriminatory practice for:
>
> (a) a person or a governmental entity to refuse, withhold from, or deny to a person any local or state services, goods, facilities, advantages, privileges, licensing, educational opportunities, health care access, or employment opportunities based on the person's vaccination status or whether the person has an immunity passport;
>
> (b) an employer to refuse employment to a person, to bar a person from employment, or to discriminate against a person in compensation or in a term, condition, or privilege of employment based on the person's vaccination status or whether the person has an immunity passport; or
>
> (c) a public accommodation to exclude, limit, segregate, refuse to serve, or otherwise discriminate against a person based on the person's vaccination status or whether the person has an immunity passport.
>
> ...

In its response to these complaints, [redacted] argued the Bureau should dismiss under the authority of another new statute found in Title 2, Chapter 9, "Limitations on Liability Relating to COVID-19." Under this statute, a governmental entity that takes 'reasonable measures' consistent with public health guidance will have an affirmative defense to any civil damages "for injuries or death from or relating to exposure to or potential exposure to COVID-19." *Mont. Code Ann. § 2-9-902.* In § 2-9-905, MCA, it states that if a governmental entity proves an affirmative defense, it operates as a "complete bar" to any action "relating to COVID-19." *Mont. Code Ann. § 2-9-905(4).*[4] As part of this investigation, [redacted] provided

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[3] The inmate's complaints all have a paragraph that states "On or about _____, 2021, I was informed that, due to my non-vaccinated status that I would have to quarantine in C-Unit and could no longer enjoy my employment at the industries compound." Inmates [redacted] and [redacted] failed to put a date in the blank, [redacted] and [redacted] put August 16, 2021, and [redacted] and [redacted] put August 17, 2021.

[4] **2-9-905.** *(Temporary)* **Affirmative defense -- reasonable measures consistent with regulations, orders, and public health guidance.** (1) In addition to all other defenses, a government entity may assert as an affirmative defense that the government entity took reasonable measures consistent with a federal or state statute, regulation, order, or public health guidance related to covid-19 that was applicable to the government entity or activity at issue at the time of the alleged injury, death, or property damage.

(2) If two or more sources of public health guidance are applicable, a government entity does not breach a duty of care if the person took reasonable measures consistent with one applicable set of public health guidance.

(3) If a government entity proves the affirmative defense contained in this section, the affirmative defense is a complete bar to any action relating to covid-19.

communication between [redacted] Clinical Services and the Department of Public Health and Human Services discussing Centers for Disease Control guidance on how to best handle an outbreak in a correctional setting. [redacted] asserts that because it was operating in accordance with this guidance, it has an affirmative defense that stands as an 'absolute bar' to an inmate complaint.

[redacted] arguments are compelling, but this statute doesn't quite seem to fit. Here, the inmates are not asserting [redacted] is liable for their exposure or potential exposure to COVID-19. The inmates are asserting [redacted] is liable for violating a provision of the Montana Human Rights Act that protects the inmates based on vaccination status. *Mont. Code Ann. § 49-2-312.* Ultimately, a fact finder may agree that this statute stands as a bar to inmate complaints under discrimination laws, but for now the Bureau will continue its analysis.

As we begin, it bears noting that putting together a clean timeline was extremely challenging. [redacted] counsel was asked and created one, the Bureau then talked to two different [redacted] staff as well as six different inmates in C-Unit. Most every witness stated they had some difficulty remembering the details. [redacted] argued any restrictions on unvaccinated inmates were short term, lasting for maybe one day. Meanwhile, the inmates put restrictions on unvaccinated inmates anywhere from a week to several months. Given the testimony and documentation, it seems likely that any restrictions lasted a few days.

Everyone involved acknowledged there have been various quarantines throughout the pandemic and these various quarantines have looked different. At the beginning of the pandemic, it sounds like [redacted] quarantined every inmate due to the scope of the outbreak, later quarantines were by housing unit, and more recently quarantines are done by "cohort" depending on an inmate's exposure (e.g., direct contact). Inmates that are vaccinated are in the same housing units as inmates that are unvaccinated. The charging parties are housed in C-Unit and according to [redacted] C-Unit houses the inmates that work over in the industries compound. An inmate's vaccination status is not necessarily static. An inmate's status may be unvaccinated one day and vaccinated the next. Through interviews, it is apparent that some [redacted] inmates choose to discuss their vaccination status freely, while others do not.

All of the inmates stated that they were allowed to "comingle" for the purposes of recreation, laundry pass, food services and other non-restrictive social activities but denied other services, such as visitation, hobby services, religious activities. In interviewing the inmates, clearly this is what created the most confusion. But, as [redacted] has pointed out in this investigation, the pandemic did not relieve [redacted] of its obligation to provide basic services and keep the facility as operational as possible.

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(4) This section may not be construed to impose liability on a government entity for failing to comply with a federal or state statute, regulation, order, or public health guidance related to covid-19. *(Terminates December 31, 2031–sec. 12, Ch. 516, L. 2021.)*

History: **En. Sec. 5, Ch. 516, L. 2021.**

(emphasis added)

[redacted] did not assert that his visitation was restricted because they were unvaccinated, but other inmates did. It is difficult to put your arms around these allegations. [redacted] provided visitation logs for August 2021 and only one of the unvaccinated inmates shows up; [redacted] on August 12, 2021. It also appears visitation was cancelled for everyone between August 15, 2021, and August 18, 2021. If an inmate's visit was supposed to occur in this timeframe, that would not be an issue. (Visitation was cancelled for all inmates.) But no one has a clear recollection of what happened when. If several inmates had tested positive inside the C-Unit, [redacted] stated medical services would have recommended limiting exposure. Several inmates confirmed that both vaccinated and unvaccinated inmates were using a form of "tele-visitation." I find the inmates have not established they were denied visitation based on vaccination status.

In his interview, [redacted] talked about his access to hobbies, but he did not put this in his complaint. [redacted] argues that given the short time frame of the quarantine, the inmates cannot show they were denied hobby services. [redacted] says C-Unit is called out for hobby on Wednesday nights. Because of the quarantine, there was no C-Unit hobby on August 18, 2021. [redacted] provided the Inmate Call Out Sheets for hobby from July 13, 2021 through September 8, 2021. (A listing of the inmates called out to the activity.) There was no call out sheet for August 18, 2021. There are inmates that filed vaccination complaints on both the September 1, 2021, and September 8, 2021, call out sheets.

Only one inmate alleged a denial of religious services in his complaint, [redacted] He was unsure of the timeframes or whether the services were being offered to anyone. [redacted] was asked to send in additional information, but nothing was provided (nor did he submit a rebuttal). As for [redacted] assertion that he was not allowed to get a haircut, [redacted] argued [redacted] did not show up for his haircut and it produced documentation he was a "no show."

In [redacted] timeline of the restrictions for this particular quarantine, [redacted] asserted that on August 16, 2021, there were four COVID-19 positives. Initially, [redacted] Warden restricted movement in the A-Unit. But this changed as the day progressed, and by the end of the day, no movement was allowed in either the A-Unit or the C-Unit. There is a lot of testing happening. [redacted] says it sent out 225 PCR tests. [redacted] emails reflect that it is looking to CDC guidance for protocols, including testing strategies. If there is a clear bad act to grab on to, it happens somewhere in here. [redacted] allows persons that are vaccinated to return to work on August 18, 2021, whereas persons that were unvaccinated were not allowed to return to work. Later, the quarantine was lifted for unvaccinated inmates as well.

If the claim at issue involved only employment, [redacted] argued the Bureau does not have jurisdiction over inmates' complaints. *See Quigg v. South, 243 Mont. 218 (1990).* In *Quigg*, the male inmates had filed a discrimination complaint asserting that they were being paid less than female inmates. Our Supreme Court found that there was statutory language, specifically §§ 53-30-151-153, MCA, that precluded this type of discrimination complaint, specifically wage based discrimination complaints. Generally speaking, the Bureau disagrees with [redacted] assertion that *Quigg* is "black letter law." It remains unclear how the ruling in *Quigg* will apply to this new statute.

All this aside, these complaints have raised a whole different question. As noted, the Bureau is working with a new statute and this new statute contains special provisions for health care

facilities. *Mont. Code Ann. § 49-2-312(3)(b).* The new statute treats health care facilities differently from other environments and the language suggests that such a facility may have to take measures to protect the health and safety of employees, patients, visitors, and other persons from communicable diseases.

> (b) A health care facility, as defined in **50-5-101**, does not unlawfully discriminate under this section if it complies with both of the following:
>
> (i) asks an employee to volunteer the employee's vaccination or immunization status for the purpose of determining whether the health care facility should implement reasonable accommodation measures to protect the safety and health of employees, patients, visitors, and other persons from communicable diseases. A health care facility may consider an employee to be nonvaccinated or nonimmune if the employee declines to provide the employee's vaccination or immunization status to the health care facility for purposes of determining whether reasonable accommodation measures should be implemented.
>
> (ii) implements reasonable accommodation measures for employees, patients, visitors, and other persons who are not vaccinated or not immune to protect the safety and health of employees, patients, visitors, and other persons from communicable diseases.

The new statute defines health care facility using § 50-5-101, MCA:

> (26) (a) "Health care facility" or "facility" means all or a portion of an institution, building, or agency, private or public, excluding federal facilities, whether organized for profit or not, that is used, operated, or designed to provide health services, medical treatment, or nursing, rehabilitative, or preventive care to any individual. The term includes chemical dependency facilities, critical access hospitals, eating disorder centers, end-stage renal dialysis facilities, home health agencies, home infusion therapy agencies, hospices, hospitals, infirmaries, long-term care facilities, intermediate care facilities for the developmentally disabled, medical assistance facilities, mental health centers, outpatient centers for primary care, outpatient centers for surgical services, rehabilitation facilities, residential care facilities, and residential treatment facilities.

Inmates argue that because [redacted] was not providing "quality" care, it could not be considered a health care facility, but this argument is not compelling. Quality of care may impact licensure but not designation as a health care facility. [redacted] has been issued a health care facility license by DPPHS and [redacted] is accredited by the National Commission on Correctional Healthcare.

The inmates also argued the definition of health care facility should be restricted to [redacted] infirmary. The inmates have a point. It would be reasonable for the Bureau to restrict its interpretation of the term "health care facility" to those portions of [redacted] that are labeled as providing health care services, specifically the infirmary. But the definition says a health care facility means "all or portion of an institution" *used* or designed to provide health services, medical treatment, or nursing, rehabilitative or preventative care to any individual. Meaning if [redacted] is providing health services, medical treatment, or nursing, rehabilitative or preventative care outside of the infirmary, then seemingly this expands the scope of that "facility." In interviews, [redacted] provided a laundry list of examples displaying that medical treatment is provided outside of the infirmary. This included emergency treatment, "sick calls," medication distribution, and mental health services. Add to this there are "satellite offices" for medical services throughout the [redacted] campus. Then if you look at the definition of a "health care facility," it seems very broad. It includes hospitals and infirmaries, but it also picks up residential care facilities, home health agencies, medical assistance facilities. The use of such a broad definition suggests the legislature intended for the term health care facility to be interpreted broadly.

Bottom line, [redacted] is constitutionally obligated to provide health care services for the inmates while the inmate is in [redacted] custody and the provision of health care is happening across campus. *See* [redacted] *4.5.2 Responsible Health Authority.* I find [redacted] has presented adequate documentation to show that [redacted] operates as a health care facility. Any argument that only the [redacted] infirmary should be considered a health care facility doesn't hold up given the unique circumstances of this institutional setting.

The statute then says a health care facility does not discriminate if it (1) asks about vaccination status; and then (2) implements reasonable accommodation measures. Here, testimony establishes that [redacted] asked inmates working in the industries compounds about vaccination status on August 16, 2021. Next, the Bureau looks at whether [redacted] implemented reasonable accommodation measures. From information provided by [redacted] it looks like from August 18, 2021, through August 19, 2021 - or as late as August 23, 2021 - inmates that were not vaccinated were restricted in ways inmates that were vaccinated were not, most likely from going to work in the industries compound. So, the relevant question is: Was this a reasonable accommodation measure?

As a quick aside, the Bureau notes Montana's Human Rights Act has a definition for "reasonable accommodation." *Mont. Code Ann. § 49-2-101(19).* A reasonable accommodation is some form of assistance provided to a person with a disability[5] that allows that person to perform in a position or perhaps enjoy a governmental service. In this new statute, the term "reasonable accommodation measures" appears unrelated to this definition. The term reasonable accommodation measures are not intended to attach to a person with a disability. The "measures" are to be taken to "protect the safety and health of employees, patients, visitors and other persons from communicable diseases."

In this investigation, [redacted] has argued it is immune from suit under § 2-9-902, MCA, precisely because the steps it took were reasonable measures consistent with public health guidance, specifically that it restricted the movement of inmates based on vaccination status in accordance with DPHHS and CDC guidance for correctional facilities. A restriction that was lifted shortly after it was imposed.

Could [redacted] have handled this differently? Arguably, it could have required working inmates to wear a full set of personal protective equipment (PPE), or it could have quarantined every inmate regardless of vaccination status similarly. But the law does not ask the Bureau to determine the best way to have handled the situation, it asks the Bureau to determine if the health care facility (1) asked about vaccination status; and (2) then implemented reasonable accommodation measures. Here, I find [redacted] asked about vaccination status and then followed guidance from the CDC for correctional facilities.

If this matter goes forward, [redacted] will ultimately have a variety of defenses available. [redacted] may enjoy the protection of the absolute bar to complaints put forth in § 2-9-902, MCA, and since the inmates have not been able to point to any opportunity that was denied outside of employment *Quigg* may be controlling. Following these investigations, it appears that [redacted]

[5] A person with a disability has a condition or impairment that substantially limits one or more major life activities.

would also be able to show that restrictions on unvaccinated inmates were reasonable accommodation measures.

For these reasons, I find that [redacted] is unable to prove by a preponderance of the evidence that [redacted] discriminated against him on the basis of vaccination status.

CONCLUSION

Based on my investigation, I find **no reasonable cause** to believe unlawful discrimination occurred as alleged in Charging Party's complaint.

Marieke Beck *February 25, 2022*

Marieke Beck
Montana Human Rights Bureau

Date

DEFS 001430

HRB CONFIDENTIAL

MONTANA DEPARTMENT OF LABOR & INDUSTRY
EMPLOYMENT RELATIONS DIVISION
HUMAN RIGHTS BUREAU

[redacted] Charging Party, vs. [redacted][1], Respondent.	Final Investigative Report HRB Case No. 0210599

Recommendation: Based on my investigation, I find **no reasonable cause** to believe unlawful discrimination occurred as alleged in Charging Party's complaint.

I. ISSUE PRESENTED

Did the [redacted] discriminate against [redacted] based on his vaccination status in violation of the Montana Human Rights Act (Title 49, Chapter 2, MCA) by subjecting him to quarantine and denying him employment and other opportunities?

II. SUMMARY OF THE INVESTIGATION

This report constitutes a summary of the investigation conducted in this case. Content of this report is limited to witnesses, documents and other evidence relevant to the analysis of the issue presented. The case file may contain additional evidence not included in this report.

A. Charging Party's Position Statement:

[redacted] sent in a self-drafted complaint asserting that he is an inmate serving his sentence with the [redacted] ([redacted]) He asserts he is employed by [redacted] and that he was informed that due to his non-vaccinated status, he would have to quarantine in C-Unit and could no longer enjoy his employment at the industries compound. He asserts he witnesses vaccinated inmates being permitted to enjoy their employment status.

He then states that, "I and all other vaccinated inmates" were allowed to commingle after work for purposes of recreation, laundry pass, food service and other non-restrictive social

[1] Nine complaints were filed by [redacted] ([redacted]) inmates using a template containing substantially similar language. On the template, inmates checked whether they were felt they were denied visitation or medical care, some inmates wrote in additional information regarding denials including hobby, haircuts and religious services. The complaints all involve a quarantine by [redacted] in August 2021 at [redacted] The template names [redacted] Defendants." The Bureau sent Charging Parties' complaints to [redacted] which responded on behalf of all named respondents.

activities. He asserts that as a result of the quarantine he has been denied services and privileges such as visitation and the "ability to get a haircut."

B. Respondent's Position Statement:

[redacted] denies that it discriminated. In the week of August 15, 2021, there was a confirmed COVID-19 case in [redacted] C-Unit. In the wake of this potential exposure, inmates were quarantined based on vaccination status.

On July 30, 2021, Montana's Department of Public Health and Human Services (DPHHS) provided [redacted] with guidance from the Centers for Disease Control (CDC) stating that vaccinated individuals did not need to be quarantined or restricted from work following a potential exposure to COVID-19. The CDC had developed specific guidance for correctional facilities permitting fully-vaccinated individuals to participate in facility programs rather than quarantine.

[redacted] argues the Bureau does not have jurisdiction. Since jurisdiction is a threshold issue that must be addressed before any further proceeding, [redacted] argues the Human Rights Bureau (the Bureau) should dismiss these complaints. The Bureau is an administrative agency and it cannot consider or investigate claims that are not authorized by the Montana legislature. [redacted] points to § 53-30-152, MCA, this statute states that inmates are not employees and therefore employment rights do not attach. [redacted] then argues "[f]or over 30 years, it has been black letter law that 'general anti-discrimination statutes' in Title 49 cannot 'override the specific legislative intent' to prohibit inmates from asserting work-related discrimination claims."

Additionally, [redacted] argues that the newly passed § 2-9-902, MCA, states that a governmental entity is not liable for civil damages for injuries or death from or relating to exposure or potential exposure to COVID-19. It is [redacted] position that this statute was drafted to broadly cover "every civil claim for damages 'relating to' a potential exposure" to COVID-19. Here, these inmates were quarantined based on a potential exposure they are asserting injuries in the form of inability to go to work or engage in other activities during the limited quarantine period. Since a claim for vaccination discrimination is a civil claim and inmates seek damages, this statute precludes the inmates' ability to recover. This statute affords [redacted] "absolute immunity" from civil actions.

In response to the Bureau's requests for information, [redacted] further argued that COVID-19 presented unique challenges because the prison population was at or near capacity for bed space. [redacted] needed to provide certain services such as food and laundry while simultaneously managing the health crisis. [redacted] contends it relied on the "expertise of clinical services division staff which was receiving regular guidance specific to correctional facilities from the U.S. Centers for Disease Control (CDC), the Montana Department of Health and Human Services, county/local health officials, as well as direction from the Department Director in the event of a conflict between Montana law and guidance provided by the aforementioned resources."

[redacted] argues the inmates complains amount to a 'brief disruption of non-employment "employment" activity,' temporary disruption of haircut services and hobby, and brief disruptions to in-person visitation.

C. Additional Information

The parties were asked to address the application of the health care facility provisions of § 49-2-312, MCA. [redacted] responded and stated that [redacted] is a licensed health care facility/service and provided licensure and accreditation documentation through the National Commission on Correctional Health Care.

Inmates argued [redacted] is not a health care facility given the quality of care and further, if it were, then only the [redacted] building containing the infirmary should be considered as a health care facility. The infirmary is a separate building from the housing units.

D. Witnesses

[redacted] **Inmate.** [redacted] is an inmate at [redacted] He is not vaccinated, and states vaccination is not mandatory at the prison. He asserted he was denied employment, visitation, and the ability to get a haircut. [redacted] was employed by [redacted] as a boilerman in the maintenance department. In this position, he would leave the C-Unit and go to the 'industries compound.' (The industries compound is a separate facility at [redacted]

[redacted] asserts that on or around August 16, 2021, the Administrator for Montana [redacted] and another person from the Clinical Services Division announced that inmates needed to sign a "waiver" regarding their medical information to disclose their vaccination status to work in the "industries compound." [redacted] states he never got to read this waiver. He says if you did not sign the waiver you were assumed to be unvaccinated. It is [redacted] recollection that [redacted] said, "if you're not vaccinated and cannot prove your vaccination status, you will be required to stay in the Unit."

[redacted] says [redacted] posted a notice listing the inmates that could go to work in the "industries compound." [redacted] says only persons that were vaccinated were on the list. Since he could not go to the industries compound, [redacted] asserts his hours were reduced significantly. It is his recollection that shortly after the complaints were filed, he was allowed to return to work. [redacted] states he then lost this position on October 4, 2021.[2]

In August 2021, [redacted] locked down the C-Unit. [redacted] does not take issue with [redacted] quarantining individuals that test positive in accordance with the Centers for Disease Control (CDC). He tested positive in 2020, at that time the whole facility was locked down.

As for [redacted] assertion that he was denied visitation, he says it was "common knowledge" that you could not have visitation if you were not vaccinated. Asked how this was known, he asserted there was a memo posted by [redacted] at the Command Post. [redacted] has been to the infirmary 12 to 15 times in the past year but disagrees that [redacted] as a whole should be a considered a health care facility.

[2] [redacted] indicated he was retaliated against for filing this complaint. The Bureau informed [redacted] he could pursue a claim of retaliation, but he would need to file a new complaint to initiate an investigation of that claim.

[redacted] **Inmate.** [redacted] is an inmate at [redacted] and he is not vaccinated. He states vaccines are not mandatory at [redacted] He asserted he was denied employment, visitation and hobby. [redacted] says if there is an outbreak on the unit, the unvaccinated are quarantined, whereas the vaccinated are allowed to go to work. [redacted] states this has occurred "a couple times" with the last occurring in around August 2021.

[redacted] has been working for Montana [redacted] since March 2021. [redacted] states inmates work in close proximity to one another and are there from 7 a.m. to around 4:15 p.m. He says he was denied visitation once in September 2021, because he wasn't vaccinated. [redacted] says he 'told his family to not bother coming.' [redacted] said the only inmates allowed visitation at that time were the ones who were vaccinated. He doesn't know if other unvaccinated inmates are still being denied visitation.

[redacted] says he was also denied hobby once (and a there was a second time when he wasn't scheduled for hobby). He believes this occurred in around August or September 2021. He said for the past month and a half, they have been on a regular weekly schedule where inmates can go to hobby, regardless of whether they are vaccinated.

[redacted] indicated that he has been to the infirmary several times. He does not feel that [redacted] is a healthcare facility because they do not provide adequate healthcare. [redacted] said he does not want to get the vaccine because, as a Native American he does not believe in vaccines. He has not submitted any sort of religious accommodation relative to vaccines.

[redacted] **Inmate.** [redacted] complaint only asserts he was denied employment based on his vaccination status. In his interview, he said he was not allowed to work to earn money to make earrings or buy commissary items. [redacted] says he was prevented from going to work for two weeks and the unvaccinated restrictions lasted about three weeks. After a month and a half, [redacted] completely changed policies and the quarantines were cube specific. (The entire cube, which is a subsection of the unit, would quarantine regardless of vaccination status.)

[redacted] wants it noted that he does not go to religious services, but he would not have been able to go if he did. Although it is not in his complaint, he also asserted that once he wanted to get a haircut but was stopped in the hall by a Correctional Officer. [redacted] does not recall which officer, but the officer knew [redacted] was not vaccinated. When [redacted] asked how the officer knew his vaccination status, the officer then asked, "Well, are you?" [redacted] said he wouldn't release this information and he was denied his haircut.

[redacted] says an inmate in a different cube tested positive for COVID-19 and inmates in his cube were allowed to go to work if they were vaccinated. He asserts that it doesn't make sense that vaccinated and unvaccinated inmates were allowed to eat, use telephones, go in the yard and intermingle with each other but they were not allowed to enjoy other opportunities.

[redacted] **Inmate.** [redacted] asserts he was denied employment and visitation based on his vaccination status.[3] [redacted] states that all of the housing units have been shut down at various times beginning in 2020, probably for three to four months in the beginning. He believes the C-Unit was shut down for approximately three weeks in July and August 2021. When an inmate tested positive, that inmate was sent to administrative segregation and the rest of his unit was locked down. Now, when an inmate tests positive, he is still sent to administrative segregation, but only the cube is locked down for 14 days.

[redacted] began taking Motor Vocational Maintenance Classes in October 2020. He graduated in October 2021 and did not miss work during this time but missed classes that slightly prolonged his graduation, maybe a day or a week. He says he missed class time when he was quarantined in July and August 2021. [redacted] says it's interesting that inmates that are unvaccinated are not allowed to go to work with vaccinated, but they all eat together. [redacted] says he was supposed to have a visit with his wife, but this visit was cancelled. He says he knows of vaccinated inmates that received visits. He was asked to identify these inmates and said he would send in a list. In this later submission, [redacted] doesn't identify inmates that were allowed visitation rather he lists six inmates "that had seen or heard" that vaccinated inmates were allowed to continue services. [redacted] says Correctional Officers have told him that vaccinated inmates get visits, but [redacted] could not recall the names of the [redacted] staff that told him this.

[redacted] believes the infirmary staff doctors/nurses need more training to provide quality care like a healthcare facility should. Since the quality of care is lacking, he does not believe [redacted] is a healthcare facility.

In written submissions, [redacted] relayed that more recent quarantining had been done differently. Both vaccinated and unvaccinated inmates were allowed to go to work "except those that were in direct contact."

[redacted] **Inmate.** [redacted] asserts that he was denied employment and visitation. He says when the pandemic began, he was housed up in the Shelby facility. As a result of the outbreak up there, [redacted] says he has natural immunity, and he is not vaccinated. At [redacted] he works on buildings doing HVAC (heating ventilation and air conditioning). He moves all around the campus.

He recalls that someone tested positive in August 2021 and after that the inmates were confined for a week and then [redacted] gave you an option of going back to work if you were vaccinated. The vaccination was not mandatory, but it is his opinion that [redacted] was trying to force inmates to get the vaccine. He believes he recalls the [redacted] Administrator [redacted] coming to the unit, but later he says maybe it was that he was given the option of doing a waiver. [redacted] says he wishes he would have taken better notes. His recollection is that the quarantine was lifted and then put in place and then lifted again. He says [redacted] asks the inmates to wear masks, he refers to the inmates that wear masks as "sheeple."

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[3] [redacted] submitted additional statements and said that on August 16, 2021, he was told that due to his non-vaccinated status he would have to quarantine and no longer enjoy employment, haircuts, religious activities, library, and visitation. He only asserted employment and visitation in his complaint.

[redacted] asserts he was not even allowed to use a phone during this quarantine. Asked if he could identify anyone that was allowed to go to visitation, he says he's not sure. As for any contention that [redacted] is a healthcare facility, [redacted] doesn't believe that [redacted] should qualify because they 'don't provide healthcare at all.'

[redacted] **Inmate.** [redacted] complaint was substantially similar to the other complaints, but it was handwritten. He asserted he was denied employment, medical care, and religious services.

Initially, [redacted] was asked to explain the assertion in his complaint that he was denied medical care, but he did not remember making this allegation. Later in the interview, he stated that he believes he should have received treatment for a non-emergency back injury. He said another inmate was allowed to get medical services during this time and he was not. ([redacted] believes that inmate had a knee injury, but he is unsure of the inmate's exact medical situation or his vaccination status.)

[redacted] complaint asserts that he was denied employment but he explained that he was in the MCE "education program" for welding. It is his recollection that [redacted] had multiple COVID-19 cases in the facility and initially they tried to do something with testing; if you were negative you could go to work. He believes C-Unit was locked down for a month or a month and a half. He says he wasn't allowed to go back to school for almost two months. [redacted] offered a witness he believes is vaccinated that was allowed to go to work.

[redacted] says he typically attends three religious meetings every week; Fresh Lives, Baptist Bible Studies and Bread of Life, but he has not been able to attend for two to three months. Pressed, [redacted] wasn't sure if anyone was attending religious meetings at this time. [redacted] wanted more time to put together more information on his denial of religious services and stated he would send more information in, but the Bureau has not received anything.

[redacted] **Administrator** [redacted] is unfamiliar with the complaints under investigation by the Bureau, but she is familiar with the vaccination law. She explained that the industries compound is a different area of the prison and that houses MCE programs (training and educational). It also houses some [redacted] programs such as maintenance. [redacted] says that many of the inmates working in the industries compound around this time were making Personal Protected Equipment (PPE).

It is her best recollection that C-Unit went into quarantine and all movement was restricted for both vaccinated and unvaccinated inmates. After this, [redacted] and an [redacted] employee Clinical Services when to C-Unit on August 17, 2021. [redacted] explained that the C-Unit houses inmates that worked over in the industries compound. [redacted] explained to the inmates that they could sign a waiver that would allow an inmate's [redacted] supervisor to know the inmate's vaccination status. If an inmate was vaccinated, he could continue working pursuant to CDC guidelines. She does not recall any inmate asking her what would happen if he was not vaccinated. She believes Clinical Services then took this information back to check against existing records and then a list was created of inmates that were vaccinated. This list was disseminated to the appropriate supervisor (not the entire list of names but the

names relevant to a particular supervisor). [redacted] denies that any sort of list was posted regarding the inmate's vaccination status.

After this, it is [redacted] recollection that there were concerns about the discrimination law and that the Warden sent out an email urging compliance with both the state vaccination law and the CDC guidelines. [redacted] contends this happened as soon as practicable. She does not recall when everyone went back to work, but it wasn't long after this.

[redacted] **Medical Bureau Chief.** [redacted] has been with [redacted] for 20 years. She states that she has previously experienced outbreaks of influenza but nothing like COVID-19. She states that [redacted] routinely provides medical services outside of [redacted] infirmary. She says medical staff respond to emergencies providing care at the scene. There are different types of medication and medication administration in the various housing units. If there is a "health care request" or kite by an inmate for medical services, that request needs to be assessed within a certain time frame so the inmate may be visited by medical staff in the housing units. Add to this, [redacted] has several 'satellite offices' for health care services outside of the infirmary (e.g., locked housing unit, high side, low side, work and re-entry unit.) There's medical staff in the intake unit (the Martz Diagnostic and Intake Unit) every day.

In terms of addressing the spread of COVID-19 in the institution, [redacted] says there are unique challenges. For example, social distancing can be hard to achieve. [redacted] says there is not an across-the-board-masking requirements at [redacted] rather [redacted] works to educate staff and inmates on the available infection control protocols. If the compound is on "outbreak status" masks are recommended. [redacted] has utilized testing protocols, there are both rapid and PCR (nose swab sent to a lab) types of testing. Rapid testing results will be back in 15 minutes, but PCR can take several days to get results. [redacted] says at times [redacted] has run low on rapid tests and had to use more PCR tests.

[redacted] does not have a clear recollection of the quarantine in August 2021 (she stated she did not review her notes for the interview). [redacted] says the [redacted] has worked DPHHS and relied on CDC guidance for direction. She notes the guidance has changed throughout the pandemic. In C-Unit housing unit, inmates are in cubes and share the same bathroom and have a small common area. A person that tests positive will be removed from the areas. [redacted] acknowledges [redacted] has had to change its approach depending on the circumstances, [redacted] is currently using a "cohorted quarantine" protocol.

E. Documents

- Emails between [redacted] Clinical Services Divisions staff and DPHHS staff on matters relating to masking, testing and vaccination status. (Included are [redacted] who is identified as Communicable Disease Nurse Consultant for the Communicable Disease and Prevention Bureau.)

- [redacted] 4.5.11 – Infection Control Program. Revised 12/23/16. General Requirements: "Each health care unit will monitor infectious and communicable diseases in an effort to minimize their occurrence in accordance with state and

federal guidelines." Prevention: "An integral component of the infection control program is the prevention of the occurrence and spread of infectious and communicable diseases."

- Excerpts from CDC Guidance on Management of Coronavirus Disease 2019 (COVID-10) in Correctional and Detention Facilities.
- [redacted] 'contact' visitation logs for August 2021. Contact visits stop on August 15, 2021 and start again on August 19, 2021.
- C-Unit Hobby Night Call Out sheets for July 13, 2021, July 28, 2021, August 4, 2021, August 11, 2021, (there is no August 18, 2021), August 25, 2021, September 1, 2021, and September 8, 2021. At least one of the inmates that filed is on the call out sheet for September 1, 2021 and two are on September 8, 2021.
- Undated "Sunday" Workers Only C-Unit Haircut list, [redacted] is marked as a "No Show"

F. **Timeline:**

As displayed in the witness interviews **neither** party's witnesses could offer much clarity on dates relevant to the particular quarantine at issue. Albeit based on imperfect evidence, this investigator has put together the following timeline of relevant events:

August 16, 2021	Four positive staff at [redacted] with extensive contacts, [redacted] starts restricting movement by for inmates.
August 17, 2021	Warden [redacted] stopped all movement in various units as the day progresses (including C-Unit). No inmates were allowed any function outside of the unit.
August 17, 2021	[redacted] solicits releases or waivers from inmates to disclose their vaccination status 'for the purpose of returning them to work.'
August 18, 2021	A list of inmates who agreed to have their vaccination status released is circulated to those inmate's supervisors. These inmates 'are available for school, work, and other functions.'
August 19, 2021	Director [redacted] sends email to leadership team and [redacted] clinical director stating [redacted] would 'follow state law' and CDC guidelines "unless they conflict with or violate state law….[h]aving this in mind, we need to allow visitation and programs regardless of vaccination status…"

III. ANALYSIS

[redacted] is alleging [redacted] unlawfully discriminated against him in the area of governmental services because of his vaccination status. He has filed a timely complaint and the Montana Human Rights Bureau has jurisdiction.

In [redacted] complaint, he asserts [redacted] quarantined him based on his vaccination status on or about August 17, 2021[4], and that because he was quarantined, he could not work or enjoy other opportunities that inmates that were vaccinated were allowed to enjoy. It is [redacted] assertion that these restrictions lasted until he filed his complaint with the Bureau on or around September 1, 2021.

To start, this is a new statute. There are no interpreting administrative rules, no hearing officer decisions, much less any court cases to assist the Bureau in the analysis of these complaints. All we have is the language of the applicable statute:

> **49-2-312. Discrimination based on vaccination status or possession of immunity passport prohibited -- definitions.** (1) Except as provided in subsection (2), it is an unlawful discriminatory practice for:
>
> (a) a person or a governmental entity to refuse, withhold from, or deny to a person any local or state services, goods, facilities, advantages, privileges, licensing, educational opportunities, health care access, or employment opportunities based on the person's vaccination status or whether the person has an immunity passport;
>
> (b) an employer to refuse employment to a person, to bar a person from employment, or to discriminate against a person in compensation or in a term, condition, or privilege of employment based on the person's vaccination status or whether the person has an immunity passport; or
>
> (c) a public accommodation to exclude, limit, segregate, refuse to serve, or otherwise discriminate against a person based on the person's vaccination status or whether the person has an immunity passport.
>
> ...

In its response to these complaints, [redacted] argued the Bureau should dismiss under the authority of another new statute found in Title 2, Chapter 9, "Limitations on Liability Relating to COVID-19." Under this statute, a governmental entity that takes 'reasonable measures' consistent with public health guidance will have an affirmative defense to any civil damages "for injuries or death from or relating to exposure to or potential exposure to COVID-19." *Mont. Code Ann. § 2-9-902.* In § 2-9-905, MCA, it states that if a governmental entity proves an affirmative defense, it operates as a "complete bar" to any action "relating to COVID-19." *Mont. Code Ann. § 2-9-905(4).*[5] As part of this investigation, [redacted] provided

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[4] The inmate's complaints all have a paragraph that states "On or about _____, 2021, I was informed that, due to my non-vaccinated status that I would have to quarantine in C-Unit and could no longer enjoy my employment at the industries compound." Inmates [redacted] and [redacted] failed to put a date in the blank, [redacted] and [redacted] put August 16, 2021, and [redacted] and [redacted] put August 17, 2021.

[5] **2-9-905.** *(Temporary)* **Affirmative defense -- reasonable measures consistent with regulations, orders, and public health guidance.** (1) In addition to all other defenses, a government entity may assert as an affirmative defense that the government entity took reasonable measures consistent with a federal or state statute,

communication between [redacted] Clinical Services and the Department of Public Health and Human Services discussing Centers for Disease Control guidance on how to best handle an outbreak in a correctional setting. [redacted] asserts that because it was operating in accordance with this guidance, it has an affirmative defense that stands as an 'absolute bar' to an inmate complaint.

[redacted] arguments are compelling, but this statute doesn't quite seem to fit. Here, the inmates are not asserting [redacted] is liable for their exposure or potential exposure to COVID-19. The inmates are asserting [redacted] is liable for violating a provision of the Montana Human Rights Act that protects the inmates based on vaccination status. *Mont. Code Ann. § 49-2-312.* Ultimately, a fact finder may agree that this statute stands as a bar to inmate complaints under discrimination laws, but for now the Bureau will continue its analysis.

As we begin, it bears noting that putting together a clean timeline was extremely challenging. [redacted] counsel was asked and created one, the Bureau then talked to two different [redacted] staff as well as six different inmates in C-Unit. Most every witness stated they had some difficulty remembering the details. [redacted] argued any restrictions on unvaccinated inmates were short term, lasting for maybe one day. Meanwhile, the inmates put restrictions on unvaccinated inmates anywhere from a week to several months. Given the testimony and documentation, it seems likely that any restrictions lasted a few days.

Everyone involved acknowledged there have been various quarantines throughout the pandemic and these various quarantines have looked different. At the beginning of the pandemic, it sounds like [redacted] quarantined every inmate due to the scope of the outbreak, later quarantines were by housing unit, and more recently quarantines are done by "cohort" depending on an inmate's exposure (e.g., direct contact). Inmates that are vaccinated are in the same housing units as inmates that are unvaccinated. The charging parties are housed in C-Unit and according to [redacted] C-Unit houses the inmates that work over in the industries compound. An inmate's vaccination status is not necessarily static. An inmate's status may be unvaccinated one day and vaccinated the next. Through interviews, it is apparent that some [redacted] inmates choose to discuss their vaccination status freely, while others do not.

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regulation, order, or public health guidance related to covid-19 that was applicable to the government entity or activity at issue at the time of the alleged injury, death, or property damage.

(2) If two or more sources of public health guidance are applicable, a government entity does not breach a duty of care if the person took reasonable measures consistent with one applicable set of public health guidance.

(3) If a government entity proves the affirmative defense contained in this section, the affirmative defense is a complete bar to any action relating to covid-19.

(4) This section may not be construed to impose liability on a government entity for failing to comply with a federal or state statute, regulation, order, or public health guidance related to covid-19. *(Terminates December 31, 2031--sec. 12, Ch. 516, L. 2021.)*

History: En. Sec. 5, Ch. 516, L. 2021.

(emphasis added)

All of the inmates stated that they were allowed to "comingle" for the purposes of recreation, laundry pass, food services and other non-restrictive social activities but denied other services, such as visitation, hobby services, religious activities. In interviewing the inmates, clearly this is what created the most confusion. But, as [redacted] has pointed out in this investigation, the pandemic did not relieve [redacted] of its obligation to provide basic services and keep the facility as operational as possible.

Four of the inmates asserted that their visitation was restricted because they were unvaccinated. It is difficult to put your arms around these allegations. [redacted] provided visitation logs for August 2021 and only one of the unvaccinated inmates shows up; [redacted] on August 12, 2021. It also appears visitation was cancelled for everyone between August 15, 2021, and August 18, 2021. If an inmate's visit was supposed to occur in this timeframe, that would not be an issue. (Visitation was cancelled for all inmates.) But, no one has a clear recollection of what happened when. If several inmates had tested positive inside the C-Unit, [redacted] stated medical services would have recommended limiting exposure. Several inmates confirmed that both vaccinated and unvaccinated inmates were using a form of "tele-visitation." I find the inmates have not established they were denied visitation based on vaccination status.

Similarly, [redacted] argues that given the short time frame of the quarantine, the inmates cannot show they were denied hobby services. [redacted] says C-Unit is called out for hobby on Wednesday nights. Because of the quarantine, there was no C-Unit hobby on August 18, 2021. [redacted] provided the Inmate Call Out Sheets for hobby from July 13, 2021 through September 8, 2021. (A listing of the inmates called out to the activity.) There was no call out sheet for August 18, 2021. There are inmates that filed vaccination complaints on both the September 1, 2021, and September 8, 2021, call out sheets.

Only one inmate alleged a denial of religious services in his complaint, [redacted] He was unsure of the timeframes or whether the services were being offered to anyone. [redacted] was asked to send in additional information, but nothing was provided (nor did he submit a rebuttal). As for [redacted] assertion that he was not allowed to get a haircut, [redacted] argued [redacted] did not show up for his haircut and it produced documentation he was a "no show."

In [redacted] timeline of the restrictions for this particular quarantine, [redacted] asserted that on August 16, 2021, there were four COVID-19 positives. Initially, [redacted] Warden restricted movement in the A-Unit. But this changed as the day progressed, and by the end of the day, no movement was allowed in either the A-Unit or the C-Unit. There is a lot of testing happening. [redacted] says it sent out 225 PCR tests. [redacted] emails reflect that it is looking to CDC guidance for protocols, including testing strategies. If there is a clear bad act to grab on to, it happens somewhere in here. [redacted] allows persons that are vaccinated to return to work on August 18, 2021, whereas persons that were unvaccinated were not allowed to return to work. Later, the quarantine was lifted for unvaccinated inmates as well.

If the claim at issue involved only employment, [redacted] argued the Bureau does not have jurisdiction over inmates' complaints. *See Quigg v. South, 243 Mont. 218 (1990).* In *Quigg*, the male inmates had filed a discrimination complaint asserting that they were being paid less than female inmates. Our Supreme Court found that there was statutory language, specifically §§ 53-30-151-153, MCA, that precluded this type of discrimination complaint,

specifically wage based discrimination complaints. Generally speaking, the Bureau disagrees with [redacted] assertion that *Quigg* is "black letter law." It remains unclear how the ruling in *Quigg* will apply to this new statute.

All this aside, these complaints have raised a whole different question. As noted, the Bureau is working with a new statute and this new statute contains special provisions for health care facilities. *Mont. Code Ann. § 49-2-312(3)(b).* The new statute treats health care facilities differently from other environments and the language suggests that such a facility may have to take measures to protect the health and safety of employees, patients, visitors, and other persons from communicable diseases.

> (b) A health care facility, as defined in **50-5-101**, does not unlawfully discriminate under this section if it complies with both of the following:
>
> (i) asks an employee to volunteer the employee's vaccination or immunization status for the purpose of determining whether the health care facility should implement reasonable accommodation measures to protect the safety and health of employees, patients, visitors, and other persons from communicable diseases. A health care facility may consider an employee to be nonvaccinated or nonimmune if the employee declines to provide the employee's vaccination or immunization status to the health care facility for purposes of determining whether reasonable accommodation measures should be implemented.
>
> (ii) implements reasonable accommodation measures for employees, patients, visitors, and other persons who are not vaccinated or not immune to protect the safety and health of employees, patients, visitors, and other persons from communicable diseases.

The new statute defines health care facility using § 50-5-101, MCA:

> (26) (a) "Health care facility" or "facility" means all or a portion of an institution, building, or agency, private or public, excluding federal facilities, whether organized for profit or not, that is used, operated, or designed to provide health services, medical treatment, or nursing, rehabilitative, or preventive care to any individual. The term includes chemical dependency facilities, critical access hospitals, eating disorder centers, end-stage renal dialysis facilities, home health agencies, home infusion therapy agencies, hospices, hospitals, infirmaries, long-term care facilities, intermediate care facilities for the developmentally disabled, medical assistance facilities, mental health centers, outpatient centers for primary care, outpatient centers for surgical services, rehabilitation facilities, residential care facilities, and residential treatment facilities.

Inmates argue that because [redacted] was not providing "quality" care, it could not be considered a health care facility, but this argument is not compelling. Quality of care may impact licensure but not designation as a health care facility. [redacted] has been issued a health care facility license by DPPHS and [redacted] is accredited by the National Commission on Correctional Healthcare.

The inmates also argued the definition of health care facility should be restricted to [redacted] infirmary. The inmates have a point. It would be reasonable for the Bureau to restrict its interpretation of the term "health care facility" to those portions of [redacted] that are labeled as providing health care services, specifically the infirmary. But the definition says a health care facility means "all or portion of an institution" *used* or designed to provide health services, medical treatment, or nursing, rehabilitative or preventative care to any individual. Meaning if [redacted] is providing health services, medical treatment, or nursing, rehabilitative or preventative care outside of the infirmary, then seemingly this expands the scope of that "facility." In interviews, [redacted] provided a laundry list of examples displaying that medical treatment is provided outside of the infirmary. This included emergency treatment, "sick calls," medication distribution, and mental health services. Add to this there are "satellite

offices" for medical services throughout the [redacted] campus. Then if you look at the definition of a "health care facility," it seems very broad. It includes hospitals and infirmaries, but it also picks up residential care facilities, home health agencies, medical assistance facilities. The use of such a broad definition suggests the legislature intended for the term health care facility to be interpreted broadly.

Bottom line, [redacted] is constitutionally obligated to provide health care services for the inmates while the inmate is in [redacted] custody and the provision of health care is happening across campus. *See* [redacted] *4.5.2 Responsible Health Authority.* I find [redacted] has presented adequate documentation to show that [redacted] operates as a health care facility. Any argument that only the [redacted] infirmary should be considered a health care facility doesn't hold up given the unique circumstances of this institutional setting.

The statute then says a health care facility does not discriminate if it (1) asks about vaccination status; and then (2) implements reasonable accommodation measures. Here, testimony establishes that [redacted] asked inmates working in the industries compounds about vaccination status on August 16, 2021. Next, the Bureau looks at whether [redacted] implemented reasonable accommodation measures. From information provided by [redacted] it looks like from August 18, 2021, through August 19, 2021 - or as late as August 23, 2021 - inmates that were not vaccinated were restricted in ways inmates that were vaccinated were not, most likely from going to work in the industries compound. So, the relevant question is: Was this a reasonable accommodation measure?

As a quick aside, the Bureau notes Montana's Human Rights Act has a definition for "reasonable accommodation." *Mont. Code Ann. § 49-2-101(19).* A reasonable accommodation is some form of assistance provided to a person with a disability[6] that allows that person to perform in a position or perhaps enjoy a governmental service. In this new statute, the term "reasonable accommodation measures" appears unrelated to this definition. The term reasonable accommodation measures are not intended to attach to a person with a disability. The "measures" are to be taken to "protect the safety and health of employees, patients, visitors and other persons from communicable diseases."

In this investigation, [redacted] has argued it is immune from suit under § 2-9-902, MCA, precisely because the steps it took were reasonable measures consistent with public health guidance, specifically that it restricted the movement of inmates based on vaccination status in accordance with DPHHS and CDC guidance for correctional facilities. A restriction that was lifted shortly after it was imposed.

Could [redacted] have handled this differently? Arguably, it could have required working inmates to wear a full set of personal protective equipment (PPE), or it could have quarantined every inmate regardless of vaccination status similarly. But the law does not ask the Bureau to determine the best way to have handled the situation, it asks the Bureau to determine if the health care facility (1) asked about vaccination status; and (2) then implemented reasonable accommodation measures. Here, I find [redacted] asked about vaccination status and then followed guidance from the CDC for correctional facilities.

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[6] A person with a disability has a condition or impairment that substantially limits one or more major life activities.

No. 23-35014

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

MONTANA MEDICAL ASSOCIATION; FIVE VALLEYS UROLOGY, PLLC; PROVIDENCE HEALTH & SERVICES – MONTANA; WESTERN MONTANA CLINIC, PC; PAT APPLEBY; MARK CARPENTER; DIANA JO PAGE; WALLACE L. PAGE; CHEYENNE SMITH,

Plaintiffs - Appellees,

MONTANA NURSES ASSOCIATION,

Intervenor-Plaintiff – Appellee,

v.

AUSTIN KNUDSEN, Montana Attorney General; LAURIE ESAU, Montana Commissioner of Labor and Industry,

Defendants – Appellants.

On Appeal from the Missoula Division of the
United State District Court, District of Montana
No. 9:21-cv-00108-DWM
Hon. Donald W. Molloy

APPELLEES' SUPPLEMENTAL EXCERPTS OF RECORD
VOLUME 2 OF 3

Justin K. Cole
Kathryn S. Mahe
GARLINGTON, LOHN & ROBINSON, PLLP
350 Ryman Street • P.O. Box 7909
Missoula, MT 59807-7909
Phone (406) 523-2500
Fax (406) 523-2595
jkcole@garlington.com
ksmahe@garlington.com
Attorneys for Plaintiffs - Appellees

Raph Graybill
GRAYBILL LAW FIRM, PC
300 4th Street North
Great Falls, MT 59403
Phone: (406) 452-8566
rgraybill@silverstatelaw.net
Attorney for Plaintiff-Intervenor - Appellee

If this matter goes forward, [redacted] will ultimately have a variety of defenses available. [redacted] may enjoy the protection of the absolute bar to complaints put forth in § 2-9-902, MCA, and since the inmates have not been able to point to any opportunity that was denied outside of employment *Quigg* may be controlling. Following these investigations, it appears that [redacted] would also be able to show that restrictions on unvaccinated inmates were reasonable accommodation measures.

For these reasons, I find that [redacted] is unable to prove by a preponderance of the evidence that [redacted] discriminated against him on the basis of vaccination status.

CONCLUSION

Based on my investigation, I find **no reasonable cause** to believe unlawful discrimination occurred as alleged in Charging Party's complaint.

Marieke Beck — *February 25, 2022*

Marieke Beck
Montana Human Rights Bureau

Date

HRB CONFIDENTIAL

MONTANA DEPARTMENT OF LABOR & INDUSTRY
EMPLOYMENT RELATIONS DIVISION
HUMAN RIGHTS BUREAU

[redacted] Charging Party, vs. [redacted][1], Respondent.	Final Investigative Report HRB Case No. 0210580

Recommendation: Based on my investigation, I find **no reasonable cause** to believe unlawful discrimination occurred as alleged in Charging Party's complaint.

I. ISSUE PRESENTED

Did the [redacted] discriminate against Robert Lee [redacted] based on his vaccination status in violation of the Montana Human Rights Act (Title 49, Chapter 2, MCA) when he was quarantined and denied employment and other opportunities?

II. SUMMARY OF THE INVESTIGATION

This report constitutes a summary of the investigation conducted in this case. Content of this report is limited to witnesses, documents and other evidence relevant to the analysis of the issue presented. The case file may contain additional evidence not included in this report.

A. Charging Party's Position Statement:

[redacted] sent in a self-drafted complaint asserting that he is an inmate serving his sentence with the [redacted] He asserts he is employed by Montana [redacted] and that on or about August 17, 2021, he was informed that due to his non-vaccinated status, he would have to quarantine in C-Unit and could no longer enjoy his employment at the industries compound. He asserts he witnessed vaccinated inmates being permitted to enjoy their employment status. [redacted] also asserts he was informed he could not visit due to being vaccinated.

B. Respondent's Position Statement:

[1] Nine complaints were filed by [redacted] inmates on a template form containing substantially similar allegations. All these complaints involve a quarantine by [redacted] in August 2021 at [redacted] The template names '[redacted] Defendants." The Bureau sent Charging Parties' complaints to [redacted] and [redacted] responded.

[redacted] denies that it discriminated. In the week of August 15, 2021, there was a confirmed COVID-19 case in MSP's Unit C. In the wake of this potential exposure, inmates were quarantined based on vaccination status. On July 30, 2021, Montana's Department of Public Health and Human Services (DPHHS) provided [redacted] with guidance from the Centers for Disease Control (CDC) stating that vaccinated individuals did not need to be quarantined or restricted from work following a potential exposure to COVID-19. The CDC had developed specific guidance for correctional facilities permitting fully-vaccinated individuals to participate in facility programs rather than quarantine.

In its response, [redacted] argues the Bureau does not have jurisdiction. Since jurisdiction is a threshold issue, [redacted] argues HRB should dismiss these complaints. HRB is an administrative agency and it cannot consider or investigate claims that are not authorized by the Montana legislature. [redacted] points to § 53-30-152, MCA, this statute states that inmates are not employees and therefore employment rights do not attach. [redacted] then argues "[f]or over 30 years, it has been black letter law that 'general anti-discrimination statutes' in Title 49 cannot 'override the specific legislative intent' to prohibit inmates from asserting work-related discrimination claims.

Additionally, [redacted] argues that the newly passed § 2-9-902, MCA, states that a governmental entity is not liable for civil damages for injuries or death from or relating to exposure or potential exposure to COVID-19. It is [redacted] position that this statute was drafted to broadly cover "every civil claim for damages 'relating to' a potential exposure" to COVID-19. Here, these inmates were quarantined based on a potential exposure they are asserting injuries in the form of inability to go to work or engage in other activities during the limited quarantine period. Since a claim for vaccination discrimination is a civil claim and inmates seek damages, this statute precludes the inmates' ability to recover. This statute affords [redacted] "absolute immunity" from civil actions

C. Additional Information

On October 20, 2021, [redacted] was asked to address the application of the health care facility provisions of § 49-2-312, MCA. [redacted] responded and stated that [redacted] is a licensed health care facility/service and provided licensure and accreditation documentation through the National Commission on Correctional Health Care.

D. Omissions

The Bureau currently has nine substantially similar complaints filed by inmates regarding a quarantine event on or about August 17, 2021. After [redacted] provided its response, it was sent to the named Charging Parties on October 20, 2021. The inmates were given until November 9, 2021, to provide a rebuttal. [redacted] did not submit a rebuttal.

A second letter was sent on November 30, 2021, stating that if [redacted] did not respond or contact the Bureau on or before December 20, 2021, the Bureau would write the report based on the information contained in the file. A final letter was sent to [redacted] attention on January 11, 2021. The Bureau has not heard from [redacted] The Bureau was able to interview and proceed with five substantially similar complaints.

[redacted] has not participated. The Bureau limited its investigation to the information in the file.

III. ANALYSIS

[redacted] alleges [redacted] unlawfully discriminated against him in the area of governmental services because of his vaccination status. [redacted] establishes he filed a timely complaint. The Montana Human Rights Bureau has jurisdiction over the complaint.

[redacted] asserts [redacted] quarantined him based on his vaccination status on or about August 17, 2021, and that because he was quarantined he could not work or enjoy other opportunities that inmates that were vaccinated were allowed to enjoy.

To start, this is a new statute. There are no interpreting administrative rules, no hearing officer decisions, much less any court cases to assist the Bureau in the analysis. All we have is the language of the applicable statutes:

> **49-2-312. Discrimination based on vaccination status or possession of immunity passport prohibited -- definitions.** (1) Except as provided in subsection (2), it is an unlawful discriminatory practice for:
>
> (a) a person or a governmental entity to refuse, withhold from, or deny to a person any local or state services, goods, facilities, advantages, privileges, licensing, educational opportunities, health care access, or employment opportunities based on the person's vaccination status or whether the person has an immunity passport;
>
> (b) an employer to refuse employment to a person, to bar a person from employment, or to discriminate against a person in compensation or in a term, condition, or privilege of employment based on the person's vaccination status or whether the person has an immunity passport; or
>
> (c) a public accommodation to exclude, limit, segregate, refuse to serve, or otherwise discriminate against a person based on the person's vaccination status or whether the person has an immunity passport.
>
> (2) This section does not apply to vaccination requirements set forth for schools pursuant to Title 20, chapter 5, part 4, or day-care facilities pursuant to Title 52, chapter 2, part 7.
>
> (3) (a) A person, governmental entity, or an employer does not unlawfully discriminate under this section if they recommend that an employee receive a vaccine.
>
> (b) A health care facility, as defined in **50-5-101**, does not unlawfully discriminate under this section if it complies with both of the following:
>
> (i) asks an employee to volunteer the employee's vaccination or immunization status for the purpose of determining whether the health care facility should implement reasonable accommodation measures to protect the safety and health of employees, patients, visitors, and other persons from communicable diseases. A health care facility may consider an employee to be nonvaccinated or nonimmune if the employee declines to provide the employee's vaccination or immunization status to the health care facility for purposes of determining whether reasonable accommodation measures should be implemented.
>
> (ii) implements reasonable accommodation measures for employees, patients, visitors, and other persons who are not vaccinated or not immune to protect the safety and health of employees, patients, visitors, and other persons from communicable diseases.

(4) An individual may not be required to receive any vaccine whose use is allowed under an emergency use authorization or any vaccine undergoing safety trials.

(5) As used in this section, the following definitions apply:

(a) "Immunity passport" means a document, digital record, or software application indicating that a person is immune to a disease, either through vaccination or infection and recovery.

(b) "Vaccination status" means an indication of whether a person has received one or more doses of a vaccine.

History: En. Sec. 1, Ch. 418, L. 2021.

49-2-313. Exemption. A licensed nursing home, long-term care facility, or assisted living facility is exempt from compliance with **49-2-312** during any period of time that compliance with **49-2-312** would result in a violation of regulations or guidance issued by the centers for medicare and medicaid services or the centers for disease control and prevention.

History: En. Sec. 2, Ch. 418, L. 2021.

Here, [redacted] submitted a boilerplate complaint that is substantially similar to complaints filed by other inmates. [redacted] has chosen not to participate in this investigation. The Bureau notes when a party refuses to provide information or evidence reasonably necessary for an investigation, the Bureau can draw an "adverse inference" as to the information sought. *Admin. R. Mont. 24.8.216.*

Without [redacted] participation, the Bureau cannot fully understand the adverse act(s). Further, [redacted] has failed to counter [redacted] various defenses. The Bureau will focus its attention on the remaining Charging Parties with substantially similar allegations.

CONCLUSION

Based on my investigation, I find **no reasonable cause** to believe unlawful discrimination occurred as alleged in Charging Party's complaint.

Bre Koffman

Bre Koffman
Montana Human Rights Bureau

February 11, 2022
Date

HRB CONFIDENTIAL

MONTANA DEPARTMENT OF LABOR & INDUSTRY
EMPLOYMENT RELATIONS DIVISION
HUMAN RIGHTS BUREAU

[redacted] Charging Party, vs. [redacted][1], Respondent.	Final Investigative Report HRB Case No. 0210581

Recommendation: Based on my investigation, I find **no reasonable cause** to believe unlawful discrimination occurred as alleged in Charging Party's complaint.

I. ISSUE PRESENTED

Did the [redacted] discriminate against [redacted] based on his vaccination status in violation of the Montana Human Rights Act (Title 49, Chapter 2, MCA) by subjecting him to quarantine and denying him employment and other opportunities?

II. SUMMARY OF THE INVESTIGATION

This report constitutes a summary of the investigation conducted in this case. Content of this report is limited to witnesses, documents and other evidence relevant to the analysis of the issue presented. The case file may contain additional evidence not included in this report.

A. Charging Party's Position Statement:

[redacted] sent in a self-drafted complaint asserting that he is an inmate serving his sentence with the [redacted] ([redacted]. He asserts he is employed by [redacted] and that he was informed on August 17, 2021, that due to his non-vaccinated status, he would have to quarantine in C-Unit and could no longer enjoy his employment at the industries compound. He asserts he witnesses vaccinated inmates being permitted to enjoy their employment status.

[1] Nine complaints were filed by [redacted] ([redacted] inmates using a template containing substantially similar language. On the template, inmates checked whether they were felt they were denied visitation or medical care, some inmates wrote in additional information regarding denials including hobby, haircuts and religious services. The complaints all involve a quarantine by [redacted] in August 2021 at [redacted]. The template names "MDOC Clinical Services Division, [redacted] Defendants." The Bureau sent Charging Parties' complaints to [redacted] which responded on behalf of all named respondents.

He then states that, "I and all other vaccinated inmates" were allowed to commingle after work for purposes of recreation, laundry pass, food service and other non-restrictive social activities. He asserts that as a result of the quarantine he has been denied services and privileges such as visitation.

B. Respondent's Position Statement:

[redacted] denies that it discriminated. In the week of August 15, 2021, there was a confirmed COVID-19 case in MSP's C-Unit. In the wake of this potential exposure, inmates were quarantined based on vaccination status.

On July 30, 2021, Montana's Department of Public Health and Human Services (DPHHS) provided [redacted] with guidance from the Centers for Disease Control (CDC) stating that vaccinated individuals did not need to be quarantined or restricted from work following a potential exposure to COVID-19. The CDC had developed specific guidance for correctional facilities permitting fully-vaccinated individuals to participate in facility programs rather than quarantine.

[redacted] argues the Bureau does not have jurisdiction. Since jurisdiction is a threshold issue that must be addressed before any further proceeding, [redacted] argues the Human Rights Bureau (the Bureau) should dismiss these complaints. The Bureau is an administrative agency and it cannot consider or investigate claims that are not authorized by the Montana legislature. [redacted] points to § 53-30-152, MCA, this statute states that inmates are not employees and therefore employment rights do not attach. [redacted] then argues "[f]or over 30 years, it has been black letter law that 'general anti-discrimination statutes' in Title 49 cannot 'override the specific legislative intent' to prohibit inmates from asserting work-related discrimination claims."

Additionally, [redacted] argues that the newly passed § 2-9-902, MCA, states that a governmental entity is not liable for civil damages for injuries or death from or relating to exposure or potential exposure to COVID-19. It is [redacted] position that this statute was drafted to broadly cover "every civil claim for damages 'relating to' a potential exposure" to COVID-19. Here, these inmates were quarantined based on a potential exposure they are asserting injuries in the form of inability to go to work or engage in other activities during the limited quarantine period. Since a claim for vaccination discrimination is a civil claim and inmates seek damages, this statute precludes the inmates' ability to recover. This statute affords [redacted] "absolute immunity" from civil actions.

In response to the Bureau's requests for information, [redacted] further argued that COVID-19 presented unique challenges because the prison population was at or near capacity for bed space. [redacted] needed to provide certain services such as food and laundry while simultaneously managing the health crisis. [redacted] contends it relied on the "expertise of clinical services division staff which was receiving regular guidance specific to correctional facilities from the U.S. Centers for Disease Control (CDC), the Montana Department of Health and Human Services, county/local health officials, as well as direction from the Department Director in the event of a conflict between Montana law and guidance provided by the aforementioned resources."

[redacted] argues the inmates complains amount to a 'brief disruption of non-employment "employment" activity,' temporary disruption of haircut services and hobby, and brief disruptions to in-person visitation.

C. Additional Information

The parties were asked to address the application of the health care facility provisions of § 49-2-312, MCA. [redacted] responded and stated that [redacted] is a licensed health care facility/service and provided licensure and accreditation documentation through the National Commission on Correctional Health Care.

Inmates argued [redacted] is not a health care facility given the quality of care and further, if it were, then only the [redacted] building containing the infirmary should be considered as a health care facility. The infirmary is a separate building from the housing units.

D. Witnesses

Don [redacted] Inmate. [redacted] asserts that he was denied employment and visitation. He says when the pandemic began, he was housed up in the Shelby facility. As a result of the outbreak up there, [redacted] says he has natural immunity, and he is not vaccinated. At [redacted] he works on buildings doing HVAC (heating ventilation and air conditioning). He moves all around the campus.

He recalls that someone tested positive in August 2021 and after that the inmates were confined for a week and then [redacted] gave you an option of going back to work if you were vaccinated. The vaccination was not mandatory, but it is his opinion that [redacted] was trying to force inmates to get the vaccine. He believes he recalls the [redacted] Administrator [redacted] coming to the unit, but later he says maybe it was that he was given the option of doing a waiver. [redacted] says he wishes he would have taken better notes. His recollection is that the quarantine was lifted and then put in place and then lifted again. He says [redacted] asks the inmates to wear masks, he refers to the inmates that wear masks as "sheeple."

[redacted] asserts he was not even allowed to use a phone during this quarantine. Asked if he could identify anyone that was allowed to go to visitation, he says he's not sure. As for any contention that [redacted] is a healthcare facility, [redacted] doesn't believe that [redacted] should qualify because they 'don't provide healthcare at all.'

[redacted] Inmate. [redacted] is an inmate at [redacted] He is not vaccinated, and states vaccination is not mandatory at the prison. He asserted he was denied employment, visitation, and the ability to get a haircut. [redacted] was employed by [redacted] as a boilerman in the maintenance department. In this position, he would leave the C-Unit and go to the 'industries compound.' (The industries compound is a separate facility at [redacted]

[redacted] asserts that on or around August 16, 2021, the Administrator for Montana [redacted] and another person from the Clinical Services Division announced that inmates needed to sign a "waiver" regarding their medical information to disclose their vaccination status to work in the "industries compound." [redacted] states he never got to read this waiver. He says if you did not sign the waiver you were assumed to be

unvaccinated. It is [redacted] recollection that [redacted] said, "if you're not vaccinated and cannot prove your vaccination status, you will be required to stay in the Unit."

[redacted] says [redacted] posted a notice listing the inmates that could go to work in the "industries compound." [redacted] says only persons that were vaccinated were on the list. Since he could not go to the industries compound, [redacted] asserts his hours were reduced significantly. It is his recollection that shortly after the complaints were filed, he was allowed to return to work. [redacted] states he then lost this position on October 4, 2021.

In August 2021, [redacted] locked down the C-Unit. [redacted] does not take issue with [redacted] quarantining individuals that test positive in accordance with the Centers for Disease Control (CDC). He tested positive in 2020, at that time the whole facility was locked down.

As for [redacted] assertion that he was denied visitation, he says it was "common knowledge" that you could not have visitation if you were not vaccinated. Asked how this was known, he asserted there was a memo posted by [redacted] at the Command Post. [redacted] has been to the infirmary 12 to 15 times in the past year but disagrees that [redacted] as a whole should be a considered a health care facility.

[redacted] **Inmate.** [redacted] is an inmate at [redacted] and he is not vaccinated. He states vaccines are not mandatory at [redacted] He asserted he was denied employment, visitation and hobby. [redacted] says if there is an outbreak on the unit, the unvaccinated are quarantined, whereas the vaccinated are allowed to go to work. [redacted] states this has occurred "a couple times" with the last occurring in around August 2021.

[redacted] has been working for Montana [redacted] since March 2021. [redacted] states inmates work in close proximity to one another and are there from 7 a.m. to around 4:15 p.m. He says he was denied visitation once in September 2021, because he wasn't vaccinated. [redacted] says he 'told his family to not bother coming.' [redacted] said the only inmates allowed visitation at that time were the ones who were vaccinated. He doesn't know if other unvaccinated inmates are still being denied visitation.

[redacted] says he was also denied hobby once (and a there was a second time when he wasn't scheduled for hobby). He believes this occurred in around August or September 2021. He said for the past month and a half, they have been on a regular weekly schedule where inmates can go to hobby, regardless of whether they are vaccinated.

[redacted] indicated that he has been to the infirmary several times. He does not feel that [redacted] is a healthcare facility because they do not provide adequate healthcare. [redacted] said he does not want to get the vaccine because, as a Native American he does not believe in vaccines. He has not submitted any sort of religious accommodation relative to vaccines.

[redacted] **Inmate.** [redacted] complaint only asserts he was denied employment based on his vaccination status. In his interview, he said he was not allowed to work to earn money to make earrings or buy commissary items. [redacted] says he was prevented from going to work for two weeks and the unvaccinated restrictions lasted about three weeks. After a month and a half, [redacted] completely changed policies and the quarantines were

cube specific. (The entire cube, which is a subsection of the unit, would quarantine regardless of vaccination status.)

[redacted] wants it noted that he does not go to religious services, but he would not have been able to go if he did. Although it is not in his complaint, he also asserted that once he wanted to get a haircut but was stopped in the hall by a Correctional Officer. [redacted] does not recall which officer, but the officer knew [redacted] was not vaccinated. When [redacted] asked how the officer knew his vaccination status, the officer then asked, "Well, are you?" [redacted] said he wouldn't release this information and he was denied his haircut.

[redacted] says an inmate in a different cube tested positive for COVID-19 and inmates in his cube were allowed to go to work if they were vaccinated. He asserts that it doesn't make sense that vaccinated and unvaccinated inmates were allowed to eat, use telephones, go in the yard and intermingle with each other but they were not allowed to enjoy other opportunities.

[redacted] **Inmate.** [redacted] asserts he was denied employment and visitation based on his vaccination status.[2] [redacted] states that all of the housing units have been shut down at various times beginning in 2020, probably for three to four months in the beginning. He believes the C-Unit was shut down for approximately three weeks in July and August 2021. When an inmate tested positive, that inmate was sent to administrative segregation and the rest of his unit was locked down. Now, when an inmate tests positive, he is still sent to administrative segregation, but only the cube is locked down for 14 days.

[redacted] began taking Motor Vocational Maintenance Classes in October 2020. He graduated in October 2021 and did not miss work during this time but missed classes that slightly prolonged his graduation, maybe a day or a week. He says he missed class time when he was quarantined in July and August 2021. [redacted] says it's interesting that inmates that are unvaccinated are not allowed to go to work with vaccinated, but they all eat together. [redacted] says he was supposed to have a visit with his wife, but this visit was cancelled. He says he knows of vaccinated inmates that received visits. He was asked to identify these inmates and said he would send in a list. In this later submission, [redacted] doesn't identify inmates that were allowed visitation rather he lists six inmates "that had seen or heard" that vaccinated inmates were allowed to continue services. [redacted] says Correctional Officers have told him that vaccinated inmates get visits, but [redacted] could not recall the names of the [redacted] staff that told him this.

[redacted] believes the infirmary staff doctors/nurses need more training to provide quality care like a healthcare facility should. Since the quality of care is lacking, he does not believe [redacted] is a healthcare facility.

In written submissions, [redacted] relayed that more recent quarantining had been done differently. Both vaccinated and unvaccinated inmates were allowed to go to work "except those that were in direct contact."

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[2] [redacted] submitted additional statements and said that on August 16, 2021, he was told that due to his non-vaccinated status he would have to quarantine and no longer enjoy employment, haircuts, religious activities, library, and visitation. He only asserted employment and visitation in his complaint.

[redacted] **Inmate.** [redacted] complaint was substantially similar to the other complaints, but it was handwritten. He asserted he was denied employment, medical care, and religious services.

Initially, [redacted] **was asked to explain the assertion** in his complaint that he was denied **medical care,** but he did not remember making this allegation. Later in the interview, he stated that he believes he should have received treatment for a non-emergency back injury. He said another inmate was allowed to get medical services during this time and he was not. ([redacted] believes that inmate had a knee injury, but he is unsure of the inmate's exact medical situation or his vaccination status.)

[redacted] complaint asserts that he was denied employment but he explained that he was in the MCE "education program" for welding. It is his recollection that [redacted] had multiple COVID-19 cases in the facility and initially they tried to do something with testing; if you were negative you could go to work. He believes C-Unit was locked down for a month or a month and a half. He says he wasn't allowed to go back to school for almost two months. [redacted] offered a witness he believes is vaccinated that was allowed to go to work.

[redacted] says he typically attends three religious meetings every week; Fresh Lives, Baptist Bible Studies and Bread of Life, but he has not been able to attend for two to three months. **Pressed,** [redacted] **wasn't sure if anyone was attending religious meetings at this time.** [redacted] wanted more time to put together more information on his denial of religious services and stated he would send more information in, but the Bureau has not received anything.

[redacted] **Administrator for** [redacted] [redacted] is unfamiliar with the complaints under investigation by the Bureau, but she is familiar with the vaccination law. She explained that the industries compound is a different area of the prison and that houses MCE programs (training and educational). It also houses some [redacted] programs such as maintenance. [redacted] says that many of the inmates working in the industries compound around this time were making Personal Protected Equipment (PPE).

It is her best recollection that C-Unit went into quarantine and all movement was restricted for both vaccinated and unvaccinated inmates. After this, [redacted] and an [redacted] employee Clinical Services when to C-Unit on August 17, 2021. [redacted] explained that the C-Unit houses inmates that worked over in the industries compound. [redacted] explained to the inmates that they could sign a waiver that would allow an inmate's [redacted] supervisor to know the inmate's vaccination status. If an inmate was vaccinated, he could continue working pursuant to CDC guidelines. She does not recall any inmate asking her what would happen if he was not vaccinated. She believes Clinical Services then took this information back to check against existing records and then a list was created of inmates that were vaccinated. This list was disseminated to the appropriate supervisor (not the entire list of names but the names relevant to a particular supervisor). [redacted] denies that any sort of list was posted regarding the inmate's vaccination status.

After this, it is [redacted] recollection that there were concerns about the discrimination law and that the Warden sent out an email urging compliance with both the state vaccination law

and the CDC guidelines. [redacted] contends this happened as soon as practicable. She does not recall when everyone went back to work, but it wasn't long after this.

[redacted] Medical Bureau Chief. [redacted] has been with [redacted] for 20 years. She states that she has previously experienced outbreaks of influenza but nothing like COVID-19. She states that [redacted] routinely provides medical services outside of MSP's infirmary. She says medical staff respond to emergencies providing care at the scene. There are different types of medication and medication administration in the various housing units. If there is a "health care request" or kite by an inmate for medical services, that request needs to be assessed within a certain time frame so the inmate may be visited by medical staff in the housing units. Add to this, [redacted] has several 'satellite offices' for health care services outside of the infirmary (e.g., locked housing unit, high side, low side, work and re-entry unit.) There's medical staff in the intake unit (the [redacted] Diagnostic and Intake Unit) every day.

In terms of addressing the spread of COVID-19 in the institution, [redacted] says there are unique challenges. For example, social distancing can be hard to achieve. [redacted] says there is not an across-the-board-masking requirements at [redacted] rather [redacted] works to educate staff and inmates on the available infection control protocols. If the compound is on "outbreak status" masks are recommended. [redacted] has utilized testing protocols, there are both rapid and PCR (nose swab sent to a lab) types of testing. Rapid testing results will be back in 15 minutes, but PCR can take several days to get results. [redacted] says at times [redacted] has run low on rapid tests and had to use more PCR tests.

[redacted] does not have a clear recollection of the quarantine in August 2021 (she stated she did not review her notes for the interview). [redacted] says the [redacted] has worked DPHHS and relied on CDC guidance for direction. She notes the guidance has changed throughout the pandemic. In C-Unit housing unit, inmates are in cubes and share the same bathroom and have a small common area. A person that tests positive will be removed from the areas. [redacted] acknowledges [redacted] has had to change its approach depending on the circumstances, [redacted] is currently using a "cohorted quarantine" protocol.

E. Documents

- Emails between [redacted] Clinical Services Divisions staff and DPHHS staff on matters relating to masking, testing and vaccination status. (Included are [redacted] who is identified as Communicable Disease Nurse Consultant for the Communicable Disease and Prevention Bureau.)

- [redacted] 4.5.11 – Infection Control Program. Revised 12/23/16. General Requirements: "Each health care unit will monitor infectious and communicable diseases in an effort to minimize their occurrence in accordance with state and federal guidelines." Prevention: "An integral component of the infection control program is the prevention of the occurrence and spread of infectious and communicable diseases."

- Excerpts from CDC Guidance on Management of Coronavirus Disease 2019 (COVID-10) in Correctional and Detention Facilities.
- [redacted] 'contact' visitation logs for August 2021. Contact visits stop on August 15, 2021 and start again on August 19, 2021.
- C-Unit Hobby Night Call Out sheets for July 13, 2021, July 28, 2021, August 4, 2021, August 11, 2021, (there is no August 18, 2021), August 25, 2021, September 1, 2021, and September 8, 2021. At least one of the inmates that filed is on the call out sheet for September 1, 2021 and two are on September 8, 2021.
- Undated "Sunday" Workers Only C-Unit Haircut list, [redacted] is marked as a "No Show"

F. Timeline:

As displayed in the witness interviews **neither** party's witnesses could offer much clarity on dates relevant to the particular quarantine at issue. Albeit based on imperfect evidence, this investigator has put together the following timeline of relevant events:

August 16, 2021	Four positive staff at [redacted] with extensive contacts, [redacted] starts restricting movement by for inmates.
August 17, 2021	Warden [redacted] stopped all movement in various units as the day progresses (including C-Unit). No inmates were allowed any function outside of the unit.
August 17, 2021	[redacted] solicits releases or waivers from inmates to disclose their vaccination status 'for the purpose of returning them to work.'
August 18, 2021	A list of inmates who agreed to have their vaccination status released is circulated to those inmate's supervisors. These inmates 'are available for school, work, and other functions.'
August 19, 2021	Director [redacted] sends email to leadership team and [redacted] clinical director stating [redacted] would 'follow state law' and CDC guidelines "unless they conflict with or violate state law….[h]aving this in mind, we need to allow visitation and programs regardless of vaccination status…"

III. ANALYSIS

[redacted] is alleging [redacted] unlawfully discriminated against him in the area of governmental services because of his vaccination status. He has filed a timely complaint and the Montana Human Rights Bureau has jurisdiction.

In [redacted] complaint, he asserts [redacted] quarantined him based on his vaccination status on or about August 17, 2021[3], and that because he was quarantined, he could not work or enjoy other opportunities that inmates that were vaccinated were allowed to enjoy. It is [redacted] assertion that these restrictions were off and on.

To start, this is a new statute. There are no interpreting administrative rules, no hearing officer decisions, much less any court cases to assist the Bureau in the analysis of these complaints. All we have is the language of the applicable statute:

> **49-2-312. Discrimination based on vaccination status or possession of immunity passport prohibited -- definitions.** (1) Except as provided in subsection (2), it is an unlawful discriminatory practice for:
>
> (a) a person or a governmental entity to refuse, withhold from, or deny to a person any local or state services, goods, facilities, advantages, privileges, licensing, educational opportunities, health care access, or employment opportunities based on the person's vaccination status or whether the person has an immunity passport;
>
> (b) an employer to refuse employment to a person, to bar a person from employment, or to discriminate against a person in compensation or in a term, condition, or privilege of employment based on the person's vaccination status or whether the person has an immunity passport; or
>
> (c) a public accommodation to exclude, limit, segregate, refuse to serve, or otherwise discriminate against a person based on the person's vaccination status or whether the person has an immunity passport.
>
> ...

In its response to these complaints, [redacted] argued the Bureau should dismiss under the authority of another new statute found in Title 2, Chapter 9, "Limitations on Liability Relating to COVID-19." Under this statute, a governmental entity that takes 'reasonable measures' consistent with public health guidance will have an affirmative defense to any civil damages "for injuries or death from or relating to exposure to or potential exposure to COVID-19." *Mont. Code Ann. § 2-9-902.* In § 2-9-905, MCA, it states that if a governmental entity proves an affirmative defense, it operates as a "complete bar" to any action "relating to COVID-19." *Mont. Code Ann. § 2-9-905(4).*[4] As part of this investigation, [redacted] provided

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[3] The inmate's complaints all have a paragraph that states "On or about _____, 2021, I was informed that, due to my non-vaccinated status that I would have to quarantine in C-Unit and could no longer enjoy my employment at the industries compound." Inmates [redacted] and [redacted] failed to put a date in the blank, [redacted] and [redacted] put August 16, 2021, and [redacted] and [redacted] put August 17, 2021.

[4] **2-9-905.** *(Temporary)* **Affirmative defense -- reasonable measures consistent with regulations, orders, and public health guidance.** (1) In addition to all other defenses, a government entity may assert as an affirmative defense that the government entity took reasonable measures consistent with a federal or state statute, regulation, order, or public health guidance related to covid-19 that was applicable to the government entity or activity at issue at the time of the alleged injury, death, or property damage.

(2) If two or more sources of public health guidance are applicable, a government entity does not breach a duty of care if the person took reasonable measures consistent with one applicable set of public health guidance.

(3) If a government entity proves the affirmative defense contained in this section, the affirmative defense is a complete bar to any action relating to covid-19.

communication between [redacted] Clinical Services and the Department of Public Health and Human Services discussing Centers for Disease Control guidance on how to best handle an outbreak in a correctional setting. [redacted] asserts that because it was operating in accordance with this guidance, it has an affirmative defense that stands as an 'absolute bar' to an inmate complaint.

[redacted] arguments are compelling, but this statute doesn't quite seem to fit. Here, the inmates are not asserting [redacted] is liable for their exposure or potential exposure to COVID-19. The inmates are asserting [redacted] is liable for violating a provision of the Montana Human Rights Act that protects the inmates based on vaccination status. *Mont. Code Ann. § 49-2-312.* Ultimately, a fact finder may agree that this statute stands as a bar to inmate complaints under discrimination laws, but for now the Bureau will continue its analysis.

As we begin, it bears noting that putting together a clean timeline was extremely challenging. [redacted] counsel was asked and created one, the Bureau then talked to two different [redacted] staff as well as six different inmates in C-Unit. Most every witness stated they had some difficulty remembering the details. [redacted] argued any restrictions on unvaccinated inmates were short term, lasting for maybe one day. Meanwhile, the inmates put restrictions on unvaccinated inmates anywhere from a week to several months. Given the testimony and documentation, it seems likely that any restrictions lasted a few days.

Everyone involved acknowledged there have been various quarantines throughout the pandemic and these various quarantines have looked different. At the beginning of the pandemic, it sounds like [redacted] quarantined every inmate due to the scope of the outbreak, later quarantines were by housing unit, and more recently quarantines are done by "cohort" depending on an inmate's exposure (e.g., direct contact). Inmates that are vaccinated are in the same housing units as inmates that are unvaccinated. The charging parties are housed in C-Unit and according to [redacted] C-Unit houses the inmates that work over in the industries compound. An inmate's vaccination status is not necessarily static. An inmate's status may be unvaccinated one day and vaccinated the next. Through interviews, it is apparent that some [redacted] inmates choose to discuss their vaccination status freely, while others do not.

All of the inmates stated that they were allowed to "comingle" for the purposes of recreation, laundry pass, food services and other non-restrictive social activities but denied other services, such as visitation, hobby services, religious activities. In interviewing the inmates, clearly this is what created the most confusion. But, as [redacted] has pointed out in this investigation, the pandemic did not relieve [redacted] of its obligation to provide basic services and keep the facility as operational as possible.

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(4) This section may not be construed to impose liability on a government entity for failing to comply with a federal or state statute, regulation, order, or public health guidance related to covid-19. *(Terminates December 31, 2031--sec. 12, Ch. 516, L. 2021.)*

History: En. Sec. 5, Ch. 516, L. 2021.

(emphasis added)

Four of the inmates asserted that their visitation was restricted because they were unvaccinated, including [redacted] It is difficult to put your arms around these allegations. [redacted] provided visitation logs for August 2021 and only one of the unvaccinated inmates shows up; [redacted] on August 12, 2021. It also appears visitation was cancelled for everyone between August 15, 2021, and August 18, 2021. If an inmate's visit was supposed to occur in this timeframe, that would not be an issue. (Visitation was cancelled for all inmates.) But, no one has a clear recollection of what happened when. If several inmates had tested positive inside the C-Unit, [redacted] stated medical services would have recommended limiting exposure. Several inmates confirmed that both vaccinated and unvaccinated inmates were using a form of "tele-visitation." I find the inmates have not established they were denied visitation based on vaccination status.

Similarly, [redacted] argues that given the short time frame of the quarantine, the inmates cannot show they were denied hobby services. [redacted] says C-Unit is called out for hobby on Wednesday nights. Because of the quarantine, there was no C-Unit hobby on August 18, 2021. [redacted] provided the Inmate Call Out Sheets for hobby from July 13, 2021 through September 8, 2021. (A listing of the inmates called out to the activity.) There was no call out sheet for August 18, 2021. There are inmates that filed vaccination complaints on both the September 1, 2021, and September 8, 2021, call out sheets.

Only one inmate alleged a denial of religious services in his complaint, [redacted] He was unsure of the timeframes or whether the services were being offered to anyone. [redacted] was asked to send in additional information, but nothing was provided (nor did he submit a rebuttal). As for [redacted] assertion that he was not allowed to get a haircut, [redacted] argued [redacted] did not show up for his haircut and it produced documentation he was a "no show."

In [redacted] timeline of the restrictions for this particular quarantine, [redacted] asserted that on August 16, 2021, there were four COVID-19 positives. Initially, MSP's Warden restricted movement in the A-Unit. But this changed as the day progressed, and by the end of the day, no movement was allowed in either the A-Unit or the C-Unit. There is a lot of testing happening. [redacted] says it sent out 225 PCR tests. [redacted] emails reflect that it is looking to CDC guidance for protocols, including testing strategies. If there is a clear bad act to grab on to, it happens somewhere in here. [redacted] allows persons that are vaccinated to return to work on August 18, 2021, whereas persons that were unvaccinated were not allowed to return to work. Later, the quarantine was lifted for unvaccinated inmates as well.

If the claim at issue involved only employment, [redacted] argued the Bureau does not have jurisdiction over inmates' complaints. *See Quigg v. South, 243 Mont. 218 (1990).* In *Quigg*, the male inmates had filed a discrimination complaint asserting that they were being paid less than female inmates. Our Supreme Court found that there was statutory language, specifically §§ 53-30-151-153, MCA, that precluded this type of discrimination complaint, specifically wage based discrimination complaints. Generally speaking, the Bureau disagrees with [redacted] assertion that *Quigg* is "black letter law." It remains unclear how the ruling in *Quigg* will apply to this new statute.

All this aside, these complaints have raised a whole different question. As noted, the Bureau is working with a new statute and this new statute contains special provisions for health care facilities. *Mont. Code Ann. § 49-2-312(3)(b).* The new statute treats health care facilities

differently from other environments and the language suggests that such a facility may have to take measures to protect the health and safety of employees, patients, visitors, and other persons from communicable diseases.

> (b) A health care facility, as defined in **50-5-101**, does not unlawfully discriminate under this section if it complies with both of the following:
>
> (i) asks an employee to volunteer the employee's vaccination or immunization status for the purpose of determining whether the health care facility should implement reasonable accommodation measures to protect the safety and health of employees, patients, visitors, and other persons from communicable diseases. A health care facility may consider an employee to be nonvaccinated or nonimmune if the employee declines to provide the employee's vaccination or immunization status to the health care facility for purposes of determining whether reasonable accommodation measures should be implemented.
>
> (ii) implements reasonable accommodation measures for employees, patients, visitors, and other persons who are not vaccinated or not immune to protect the safety and health of employees, patients, visitors, and other persons from communicable diseases.

The new statute defines health care facility using § 50-5-101, MCA:

> (26) (a) "Health care facility" or "facility" means all or a portion of an institution, building, or agency, private or public, excluding federal facilities, whether organized for profit or not, that is used, operated, or designed to provide health services, medical treatment, or nursing, rehabilitative, or preventive care to any individual. The term includes chemical dependency facilities, critical access hospitals, eating disorder centers, end-stage renal dialysis facilities, home health agencies, home infusion therapy agencies, hospices, hospitals, infirmaries, long-term care facilities, intermediate care facilities for the developmentally disabled, medical assistance facilities, mental health centers, outpatient centers for primary care, outpatient centers for surgical services, rehabilitation facilities, residential care facilities, and residential treatment facilities.

Inmates argue that because [redacted] was not providing "quality" care, it could not be considered a health care facility, but this argument is not compelling. Quality of care may impact licensure but not designation as a health care facility. [redacted] has been issued a health care facility license by DPPHS and [redacted] is accredited by the National Commission on Correctional Healthcare.

The inmates also argued the definition of health care facility should be restricted to MSP's infirmary. The inmates have a point. It would be reasonable for the Bureau to restrict its interpretation of the term "health care facility" to those portions of [redacted] that are labeled as providing health care services, specifically the infirmary. But the definition says a health care facility means "all or portion of an institution" *used* or designed to provide health services, medical treatment, or nursing, rehabilitative or preventative care to any individual. Meaning if [redacted] is providing health services, medical treatment, or nursing, rehabilitative or preventative care outside of the infirmary, then seemingly this expands the scope of that "facility." In interviews, [redacted] provided a laundry list of examples displaying that medical treatment is provided outside of the infirmary. This included emergency treatment, "sick calls," medication distribution, and mental health services. Add to this there are "satellite offices" for medical services throughout the [redacted] campus. Then if you look at the definition of a "health care facility," it seems very broad. It includes hospitals and infirmaries, but it also picks up residential care facilities, home health agencies, medical assistance facilities. The use of such a broad definition suggests the legislature intended for the term health care facility to be interpreted broadly.

Bottom line, [redacted] is constitutionally obligated to provide health care services for the inmates while the inmate is in MSP's custody and the provision of health care is happening

across campus. *See* [redacted] *4.5.2 Responsible Health Authority.* I find [redacted] has presented adequate documentation to show that [redacted] operates as a health care facility. Any argument that only the [redacted] infirmary should be considered a health care facility doesn't hold up given the unique circumstances of this institutional setting.

The statute then says a health care facility does not discriminate if it (1) asks about vaccination status; and then (2) implements reasonable accommodation measures. Here, testimony establishes that [redacted] asked inmates working in the industries compounds about vaccination status on August 16, 2021. Next, the Bureau looks at whether [redacted] implemented reasonable accommodation measures. From information provided by [redacted] it looks like from August 18, 2021, through August 19, 2021 - or as late as August 23, 2021 - inmates that were not vaccinated were restricted in ways inmates that were vaccinated were not, most likely from going to work in the industries compound. So, the relevant question is: Was this a reasonable accommodation measure?

As a quick aside, the Bureau notes Montana's Human Rights Act has a definition for "reasonable accommodation." *Mont. Code Ann. § 49-2-101(19).* A reasonable accommodation is some form of assistance provided to a person with a disability[5] that allows that person to perform in a position or perhaps enjoy a governmental service. In this new statute, the term "reasonable accommodation measures" appears unrelated to this definition. The term reasonable accommodation measures are not intended to attach to a person with a disability. The "measures" are to be taken to "protect the safety and health of employees, patients, visitors and other persons from communicable diseases."

In this investigation, [redacted] has argued it is immune from suit under § 2-9-902, MCA, precisely because the steps it took were reasonable measures consistent with public health guidance, specifically that it restricted the movement of inmates based on vaccination status in accordance with DPHHS and CDC guidance for correctional facilities. A restriction that was lifted shortly after it was imposed.

Could [redacted] have handled this differently? Arguably, it could have required working inmates to wear a full set of personal protective equipment (PPE), or it could have quarantined every inmate regardless of vaccination status similarly. But the law does not ask the Bureau to determine the best way to have handled the situation, it asks the Bureau to determine if the health care facility (1) asked about vaccination status; and (2) then implemented reasonable accommodation measures. Here, I find [redacted] asked about vaccination status and then followed guidance from the CDC for correctional facilities.

If this matter goes forward, [redacted] will ultimately have a variety of defenses available. [redacted] may enjoy the protection of the absolute bar to complaints put forth in § 2-9-902, MCA, and since the inmates have not been able to point to any opportunity that was denied outside of employment *Quigg* may be controlling. Following these investigations, it appears that [redacted] would also be able to show that restrictions on unvaccinated inmates were reasonable accommodation measures.

[5] A person with a disability has a condition or impairment that substantially limits one or more major life activities.

For these reasons, I find that [redacted] is unable to prove by a preponderance of the evidence that [redacted] discriminated against him on the basis of vaccination status.

CONCLUSION

Based on my investigation, I find **no reasonable cause** to believe unlawful discrimination occurred as alleged in Charging Party's complaint.

Marieke Beck — *February 25, 2022*

Marieke Beck
Montana Human Rights Bureau

Date

DEFS 001462

HRB CONFIDENTIAL

MONTANA DEPARTMENT OF LABOR & INDUSTRY
EMPLOYMENT RELATIONS DIVISION
HUMAN RIGHTS BUREAU

[redacted] Charging Party, vs. [redacted][1], Respondent.	Final Investigative Report HRB Case No. 0210582

Recommendation: Based on my investigation, I find **no reasonable cause** to believe unlawful discrimination occurred as alleged in Charging Party's complaint.

I. ISSUE PRESENTED

Did the [redacted] discriminate against [redacted] based on his vaccination status in violation of the Montana Human Rights Act (Title 49, Chapter 2, MCA) when he was quarantined and denied employment and other opportunities?

II. SUMMARY OF THE INVESTIGATION

This report constitutes a summary of the investigation conducted in this case. Content of this report is limited to witnesses, documents and other evidence relevant to the analysis of the issue presented. The case file may contain additional evidence not included in this report.

A. Charging Party's Position Statement:

[redacted] sent in a self-drafted complaint asserting that he is an inmate serving his sentence with the [redacted] He asserts he is employed by Montana [redacted] and that on or about August 17, 2021, he was informed that due to his non-vaccinated status, he would have to quarantine in C-Unit and could no longer enjoy his employment at the industries compound. He asserts he witnessed vaccinated inmates being permitted to enjoy their employment status. [redacted] also asserts he was informed he could not attend "hobby" on his scheduled day.

//

[1] Nine complaints were filed by [redacted] inmates on a template form containing substantially similar allegations. All these complaints involve a quarantine by [redacted] in August 2021 at [redacted] The template names "[redacted] Defendants." The Bureau sent Charging Parties' complaints to [redacted] and [redacted] responded.

B. Respondent's Position Statement:

[redacted] denies that it discriminated. In the week of August 15, 2021, there was a confirmed COVID-19 case in MSP's Unit C. In the wake of this potential exposure, inmates were quarantined based on vaccination status. On July 30, 2021, Montana's Department of Public Health and Human Services (DPHHS) provided [redacted] with guidance from the Centers for Disease Control (CDC) stating that vaccinated individuals did not need to be quarantined or restricted from work following a potential exposure to COVID-19. The CDC had developed specific guidance for correctional facilities permitting fully-vaccinated individuals to participate in facility programs rather than quarantine.

In its response, [redacted] argues the Bureau does not have jurisdiction. Since jurisdiction is a threshold issue, [redacted] argues HRB should dismiss these complaints. HRB is an administrative agency and it cannot consider or investigate claims that are not authorized by the Montana legislature. [redacted] points to § 53-30-152, MCA, this statute states that inmates are not employees and therefore employment rights do not attach. [redacted] then argues "[f]or over 30 years, it has been black letter law that 'general anti-discrimination statutes' in Title 49 cannot 'override the specific legislative intent' to prohibit inmates from asserting work-related discrimination claims.

Additionally, [redacted] argues that the newly passed § 2-9-902, MCA, states that a governmental entity is not liable for civil damages for injuries or death from or relating to exposure or potential exposure to COVID-19. It is [redacted] position that this statute was drafted to broadly cover "every civil claim for damages 'relating to' a potential exposure" to COVID-19. Here, these inmates were quarantined based on a potential exposure they are asserting injuries in the form of inability to go to work or engage in other activities during the limited quarantine period. Since a claim for vaccination discrimination is a civil claim and inmates seek damages, this statute precludes the inmates' ability to recover. This statute affords [redacted] "absolute immunity" from civil actions

C. Additional Information

On October 20, 2021, [redacted] was asked to address the application of the health care facility provisions of § 49-2-312, MCA. [redacted] responded and stated that [redacted] is a licensed health care facility/service and provided licensure and accreditation documentation through the National Commission on Correctional Health Care.

D. Omissions

The Bureau currently has nine substantially similar complaints filed by inmates regarding a quarantine event on or about August 17, 2021. After [redacted] provided its response, it was sent to the named Charging Parties on October 20, 2021. The inmates were given until November 9, 2021, to provide a rebuttal. [redacted] did not submit a rebuttal.

A second letter was sent on November 30, 2021, stating that if [redacted] did not respond or contact the Bureau on or before December 20, 2021, the Bureau would write the report based on the information contained in the file. A final letter was sent to [redacted] attention on

January 11, 2021. The Bureau has not heard from [redacted] The Bureau was able to interview and proceed with five substantially similar complaints.

[redacted] has not participated. The Bureau limited its investigation to the information in the file.

III. ANALYSIS

[redacted] alleges [redacted] unlawfully discriminated against him in the area of governmental services because of his vaccination status. [redacted] establishes he filed a timely complaint. The Montana Human Rights Bureau has jurisdiction over the complaint.

[redacted] asserts [redacted] quarantined him based on his vaccination status on or about August 17, 2021, and that because he was quarantined he could not work or enjoy other opportunities that inmates that were vaccinated were allowed to enjoy.

To start, this is a new statute. There are no interpreting administrative rules, no hearing officer decisions, much less any court cases to assist the Bureau in the analysis. All we have is the language of the applicable statutes:

> **49-2-312. Discrimination based on vaccination status or possession of immunity passport prohibited -- definitions.** (1) Except as provided in subsection (2), it is an unlawful discriminatory practice for:
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> (a) a person or a governmental entity to refuse, withhold from, or deny to a person any local or state services, goods, facilities, advantages, privileges, licensing, educational opportunities, health care access, or employment opportunities based on the person's vaccination status or whether the person has an immunity passport;
>
> (b) an employer to refuse employment to a person, to bar a person from employment, or to discriminate against a person in compensation or in a term, condition, or privilege of employment based on the person's vaccination status or whether the person has an immunity passport; or
>
> (c) a public accommodation to exclude, limit, segregate, refuse to serve, or otherwise discriminate against a person based on the person's vaccination status or whether the person has an immunity passport.
>
> (2) This section does not apply to vaccination requirements set forth for schools pursuant to Title 20, chapter 5, part 4, or day-care facilities pursuant to Title 52, chapter 2, part 7.
>
> (3) (a) A person, governmental entity, or an employer does not unlawfully discriminate under this section if they recommend that an employee receive a vaccine.
>
> (b) A health care facility, as defined in **50-5-101**, does not unlawfully discriminate under this section if it complies with both of the following:
>
> (i) asks an employee to volunteer the employee's vaccination or immunization status for the purpose of determining whether the health care facility should implement reasonable accommodation measures to protect the safety and health of employees, patients, visitors, and other persons from communicable diseases. A health care facility may consider an employee to be nonvaccinated or nonimmune if the employee declines to provide the employee's vaccination or immunization status to the health care facility for purposes of determining whether reasonable accommodation measures should be implemented.

(ii) implements reasonable accommodation measures for employees, patients, visitors, and other persons who are not vaccinated or not immune to protect the safety and health of employees, patients, visitors, and other persons from communicable diseases.

(4) An individual may not be required to receive any vaccine whose use is allowed under an emergency use authorization or any vaccine undergoing safety trials.

(5) As used in this section, the following definitions apply:

(a) "Immunity passport" means a document, digital record, or software application indicating that a person is immune to a disease, either through vaccination or infection and recovery.

(b) "Vaccination status" means an indication of whether a person has received one or more doses of a vaccine.

History: En. Sec. 1, Ch. 418, L. 2021.

49-2-313. Exemption. A licensed nursing home, long-term care facility, or assisted living facility is exempt from compliance with **49-2-312** during any period of time that compliance with **49-2-312** would result in a violation of regulations or guidance issued by the centers for medicare and medicaid services or the centers for disease control and prevention.

History: En. Sec. 2, Ch. 418, L. 2021.

Here, [redacted] submitted a boilerplate complaint that is substantially similar to complaints filed by other inmates. [redacted] has chosen not to participate in this investigation. The Bureau notes when a party refuses to provide information or evidence reasonably necessary for an investigation, the Bureau can draw an "adverse inference" as to the information sought. *Admin. R. Mont. 24.8.216.*

Without [redacted] participation, the Bureau cannot fully understand the adverse act(s). Further, [redacted] has failed to counter [redacted] various defenses. The Bureau will focus its attention on the remaining Charging Parties with substantially similar allegations.

CONCLUSION

Based on my investigation, I find **no reasonable cause** to believe unlawful discrimination occurred as alleged in Charging Party's complaint.

Bre Koffman February 11, 2022

Bre Koffman
Montana Human Rights Bureau

Date

MONTANA DEPARTMENT OF LABOR & INDUSTRY
EMPLOYMENT RELATIONS DIVISION
HUMAN RIGHTS BUREAU

[redacted] Charging Party, vs. [redacted], Respondent.	Final Investigative Report HRB Case No. 0220164

Recommendation: Based on my investigation, I find **reasonable cause** to believe unlawful discrimination occurred as alleged in Charging Party's complaint.

I. ISSUE PRESENTED

Did [redacted][1] ([redacted]) discriminate against [redacted] in the area of public accommodation based on her vaccination status in violation of the Montana Human Rights Act (Title 49, Chapter 2, MCA) when it limited in-person attendance for an organizational retreat to include only persons vaccinated against COVID-19?

II. SUMMARY OF THE INVESTIGATION

This report constitutes a summary of the investigation conducted in this case. Content of this report is limited to witnesses, documents and other evidence relevant to the analysis of the issue presented. The case file may contain additional evidence not included in this report.

A. Charging Party's Position Statement:

On or about June 9, 2021, [redacted] contacted [redacted] in an attempt to sign up for the [redacted], being held [redacted], 2021, through [redacted], 2021. [redacted] informed [redacted] she needed to be vaccinated against COVID-19 in order to attend the retreat in person. [redacted] is unvaccinated and felt excluded by [redacted] requirement. [redacted] alleges [redacted] discriminated against her on the basis of her vaccination status by denying her access to the retreat.

B. Respondent's Position Statement:

[1] In her Charge of Discrimination, Charging Party named Respondent as [redacted]. Respondent provided its true and correct business name as [redacted], here within referred as such.

EXHIBIT 76
30(b)(6) Designee
Mon, Aug 22, 2022
Reported by:
Mary Sullivan, RMR, CRR

DEFS 001020

Respondent denies the allegations of discrimination as set forth in [redacted] complaint.

[redacted] is a 501c3 nonprofit located in [redacted], Montana, offering over [redacted] programs and [redacted] events for individuals diagnosed [redacted], along with their family members – all free of charge.

On March 15, 2020, [redacted] shut its physical door to program participants due to the COVID-19 pandemic. On March 18, 2020, [redacted] began and continues to offer its programming via ZOOM for all Montana residents. [redacted] was fully aware of [redacted] virtual programing, since [redacted] had attended a virtual program on December 20, 2020. This was the only time [redacted] utilized [redacted] programing.

On June 9, 2021, [redacted] reached out to [redacted] employee, [redacted], via ZOOM to inquire about the [redacted] to be held [redacted] 2021, through [redacted] 2021. [redacted] inquired whether participants needed to be vaccinated against COVID-19 and [redacted] chief executive officer, [redacted], provided that under the guidance of the Centers for Disease Control, [redacted] would require in-person participants of the retreat to be vaccinated. The following day, on June 10, 2021, [redacted] emailed [redacted] and informed [redacted] that she no longer desired to participate in [redacted] programs and requested to be removed from the [redacted] mailing list.

[redacted] did not withhold, refuse or deny [redacted] the ability to participate in the [redacted] since all participants, to include [redacted] were provided an opportunity to participate via ZOOM, if requested. [redacted] did not request to attend via ZOOM.

C. Omissions:

Due to Respondent acknowledging the alleged adverse act, as alleged by Charging Party, this report is presented in an abbreviated format. Accordingly, witness statements, documents and comparative evidence are not presented herein.

III. ANALYSIS

[redacted] alleges [redacted] discriminated against her in the area of public accommodation because of her vaccination status. [redacted] establishes she filed a timely complaint. The Montana Human Rights Bureau has jurisdiction over the complaint.

Montana House Bill 702 was signed into law by Montana's Governor, Greg Gianforte, on May 7, 2021, and has since been codified as *Mont. Code Ann. §§ 49-2-312* and *313*.

Mont. Code Ann.§ 49-2-312(1)(c) makes it an unlawful discriminatory practice for:

> a public accommodation to exclude, limit, segregate, refuse to serve, or otherwise discriminate against a person based on the person's vaccination status or whether the person has an immunity passport.

[redacted] alleges—and [redacted] acknowledges—[redacted] required proof of COVID-19 vaccination in order to attend the [redacted] to be held [redacted], 2021, through [redacted], 2021, in person.

Additionally, [redacted] notes this mandate was implemented for the retreat beginning [redacted], 2021, subsequent to the date on which Montana's vaccination status law went into effect.

As a threshold matter, [redacted] must show that she has standing as an aggrieved party. Under the Montana Human Rights Act (MHRA), a complainant must be aggrieved.

The MHRA defines "aggrieved party" as "a person who can demonstrate a specific personal and legal interest, as distinguished from a general interest, and who has been or is likely to be specially and injuriously affected by a violation of this chapter."

Mont. Code Ann. 49-3-101(2)

Here, the parties acknowledge [redacted] is a past participant of [redacted] programs, having attended a program via ZOOM, in December 2020. The parties also acknowledge [redacted] contacted [redacted] on June 9, 2021, to inquire about the [redacted] scheduled to begin [redacted] 2021. During that interaction, [redacted] informed [redacted] that in-person attendance was only allowed for participants vaccinated against COVID-19. Because [redacted] is unvaccinated, she was not allowed to attend in-person. Accordingly, [redacted] establishes standing as an aggrieved party.

In cases where there is no dispute that the adverse act happened based on a party's protected class, the Bureau uses a direct evidence analysis. By rule, in a direct evidence analysis:

> If a charging party has established a prima facie case with direct evidence of unlawful discrimination or illegal retaliation, the respondent must prove by a preponderance of the evidence that an unlawful motive played no role in the challenged action or that that direct evidence of discrimination in not credible and is unworthy of belief.

Admin. R. Mont. 24.9.610(5).

Applying the above-cited rule, [redacted] bears the burden to prove by a preponderance of the evidence that an unlawful motive played no role in its requirement that only persons vaccinated against COVID-19 could attend the retreat. In response to [redacted] discrimination complaint, [redacted] asserts it followed the guidance of the Centers for Disease Control.

The Bureau acknowledges [redacted] was clearly addressing difficult and necessary health and safety issues amidst unprecedented circumstances created by the COVID-19 pandemic. Nonetheless, by limiting in-person attendance for the [redacted] to include only persons vaccinated against COVID-19 was a clear violation of the Montana Human Rights Act. Such a position could have been avoided by choosing to allow only virtual attendance (thereby treating vaccinated and unvaccinated attendees the same).

[redacted] is unable to prove by a preponderance of the evidence that an unlawful motive played no role in its requirement that only persons vaccinated against COVID-19 could attend the [redacted].

IV. CONCLUSION

Based on my investigation, I find **reasonable cause** to believe unlawful discrimination occurred as alleged in Charging Party's complaint.

Carla Lott
Montana Human Rights Bureau

May 19, 2022
Date

MONTANA DEPARTMENT OF LABOR & INDUSTRY
EMPLOYMENT RELATIONS DIVISION
HUMAN RIGHTS BUREAU

[redacted], Charging Party, vs. [redacted], Respondent.	Final Investigative Report HRB Case No. 0220103

Recommendation: Based on my investigation, I find **reasonable cause** to believe unlawful discrimination occurred as alleged in Charging Party's complaint.

I. ISSUE PRESENTED

Did [redacted] ([redacted]) discriminate against [redacted] based on his vaccination status in violation of the Montana Human Rights Act (Title 49, Chapter 2, MCA) by threatening to terminate his employment unless he receives an influenza vaccine?

II. SUMMARY OF THE INVESTIGATION

This report constitutes a summary of the investigation conducted in this case. Content of this report is limited to witnesses, documents and other evidence relevant to the analysis of the issue presented. The case file may contain additional evidence not included in this report.

A. Charging Party's Position Statement:

[redacted] was working as a Flight Paramedic for [redacted] on October 7, 2021 when he received notice he was required to be vaccinated with the influenza vaccine. [redacted] believed the notice was sent in error until he received another notice on November 8, 2021 stating he would be removed from the work schedule unless he provided proof of vaccination by end of business day. Due to the impending threat to his employment, [redacted] quickly received the influenza vaccine and provided the required documentation to [redacted]. As a result, [redacted] maintains [redacted] discriminated against him due to his vaccination status by threatening to terminate his employment if he did not receive an influenza vaccine.

B. Respondent's Position Statement:

[redacted] acknowledges it required employees to receive the influenza vaccine by November 8, 2021 due to a longstanding influenza vaccination policy. Although [redacted]

EXHIBIT 75
30(b)(6) Designee
Mon, Aug 22, 2022
Reported by:
Mary Sullivan, RMR, CRR

DEFS 001013

has since changed the policy and no longer enforces it for Montana employees, [redacted] did provide documentation he received the influenza vaccine.

C. Omissions:

The parties do not dispute the facts of this case. Accordingly, this report is presented in an abbreviated format.

III. ANALYSIS

[redacted] alleges [redacted] unlawfully discriminated against him in the area of employment because of his vaccination status. [redacted] establishes he filed a timely complaint. The Montana Human Rights Bureau has jurisdiction over the complaint.

Montana House Bill 702 was signed into law by Montana's Governor, Greg Gianforte, on May 7, 2021, and has since been codified as Mont. Code Ann. §§ 49-2-312 and 313.

Mont. Code Ann.§ 49-2-312(1)(b) makes it an unlawful discriminatory practice for:

> an employer to refuse employment to a person, to bar a person from employment, or to discriminate against a person in compensation or in a term, condition, or privilege of employment based on the person's vaccination status or whether the person has an immunity passport.

On, November 8, 2021, [redacted] was notified via text message from his supervisor he was required to provide proof of influenza vaccination by end of business day or be removed from the work schedule. By requiring an unvaccinated employee to receive a vaccine or be discharged, the text message establishes [redacted] took an adverse action against [redacted] and made a clear statement of overt discrimination.

In cases where there is no dispute the adverse act happened based on a party's protected class, the Bureau applies a direct evidence analysis. By rule, in a direct evidence analysis:

> If a charging party has established a prima facie case with direct evidence of unlawful discrimination or illegal retaliation, the respondent must prove by a preponderance of the evidence that an unlawful motive played no role in the challenged action or that that direct evidence of discrimination in not credible and is unworthy of belief.

Admin. R. Mont. 24.9.610(5).

Applying the above-cited rule, [redacted] bears the burden to prove by a preponderance of the evidence an unlawful motive played no role when it threatened to terminate [redacted] employment unless he came into compliance with [redacted] longstanding policy requiring vaccination against influenza.

The Bureau acknowledges [redacted] was clearly addressing difficult and necessary health and safety issues amidst unpresented circumstances created by the Covid-19

pandemic. Add to that, [redacted] was attempting to navigate the shifting legal terrain in Montana around the novel protected class of vaccination status. A resulting effect of HB 702 becoming law was that [redacted] longstanding influenza policy was suddenly a violation of Montana law. [redacted], when it conditioned [redacted] continued employment on his compliance with the vaccination policy, engaged in an unlawful discriminatory practice.

[redacted] is unable to prove by a preponderance of the evidence an unlawful motive played no role in its enforcement of an influenza vaccination policy.

CONCLUSION

Based on my investigation, I find **reasonable cause** to believe unlawful discrimination occurred as alleged in Charging Party's complaint.

Chad Day
Montana Human Rights Bureau

5/10/2022
Date

EXHIBIT 74
30(b)(6) Designee
Mon, Aug 22, 2022
Reported by:
Mary Sullivan, RMR, CRR

U.S. Equal Employment Opportunity Commission

What You Should Know About COVID-19 and the ADA, the Rehabilitation Act, and Other EEO Laws

INTRODUCTION

Technical Assistance Questions and Answers - Updated on July 12, 2022.

- *All EEOC materials related to COVID-19 are collected at* ***www.eeoc.gov/coronavirus (https://www.eeoc.gov/coronavirus)*** .
- The EEOC enforces workplace anti-discrimination laws, including the Americans with Disabilities Act (ADA) and the Rehabilitation Act (which include the requirement for reasonable accommodation and non-discrimination based on disability, and rules about employer medical examinations and inquiries), Title VII of the Civil Rights Act (which prohibits discrimination based on race, color, national origin, religion, and sex, including pregnancy), the Age Discrimination in Employment Act (which prohibits discrimination based on age, 40 or older), and the Genetic Information Nondiscrimination Act. Note: Other federal laws, as well as state or local laws, may provide employees with additional protections.
- Title I of the ADA applies to private employers with 15 or more employees. It also applies to state and local government employers, employment agencies, and labor unions. All nondiscrimination standards under Title I of the ADA also apply to federal agencies under Section 501 of the Rehabilitation Act. Basic background information about the ADA and the Rehabilitation Act is available on EEOC's **disability page (https://www.eeoc.gov/eeoc-disability-related-resources)** .

- The EEO laws, including Title I of the ADA and the Rehabilitation Act, continue to apply during the time of the COVID-19 pandemic, but they do not interfere with or prevent employers from following current guidance and suggestions made by CDC or state/local public health authorities about steps employers should take regarding COVID-19.

- The EEOC has provided guidance (a publication entitled **Pandemic Preparedness in the Workplace and the Americans With Disabilities Act (https://www.eeoc.gov/laws/guidance/pandemic-preparedness-workplace-and-americans-disabilities-act) [PDF version (https://www.eeoc.gov/sites/default/files/2020-04/pandemic_flu.pdf)]**) ("Pandemic Preparedness"), consistent with these workplace protections and rules, that can help employers implement strategies to navigate the impact of COVID-19 in the workplace. This pandemic publication, which was written during the prior H1N1 outbreak, is still relevant today and identifies established ADA and Rehabilitation Act principles to answer questions frequently asked about the workplace during a pandemic. It has been updated as of March 19, 2020 to address examples and information regarding COVID-19; **the new 2020 information appears in bold and is marked with an asterisk**.

- On March 27, 2020 the EEOC provided a webinar ("3/27/20 Webinar") which was recorded and transcribed and is available at **www.eeoc.gov/coronavirus (https://www.eeoc.gov/coronavirus)**. The World Health Organization (WHO) has declared COVID-19 to be an international pandemic. The EEOC pandemic publication includes a **separate section (https://www.eeoc.gov/laws/guidance/pandemic-preparedness-workplace-and-americans-disabilities-act#secB)** that answers common employer questions about what to do after a pandemic has been declared.

- **Find COVID-19 Guidance for Your Community (https://www.covid.gov)**: This website provides information on a wide range of COVID-related topics, including treatments, testing, specific considerations for those who are immunocompromised, and a variety of information concerning long COVID (including the possibility of joining a research study). This information is also available by telephone (1-800-232-0233) or TTY (1-888-720-7489).

A. Disability-Related Inquiries and Medical Exams

The ADA has restrictions on when and how much medical information an employer may obtain from any applicant or employee.

Prior to making a conditional job offer to an applicant, disability-related inquiries and medical exams are generally prohibited. They are permitted between the time of the offer and when the applicant begins work, provided they are required for everyone in the same job category. For more information on the timing of disability-related inquiries and medical examinations for applicants, see ***Section C.***

Under the ADA (which is applicable to the Federal sector through the Rehabilitation Act of 1973), once an employee begins work, any disability-related inquiries or medical exams must be "job-related and consistent with business necessity." One way inquiries and medical examinations meet this "business necessity" standard is if they are necessary to determine whether a specific employee has a medical condition that would pose a "direct threat" to health or safety (a significant risk of substantial harm to self or others that cannot be addressed with reasonable accommodation). For more information on reasonable accommodation, see ***Section D****. Where met, the "business necessity" standard allows for consideration of whether a person may have COVID-19, and thus might pose a "direct threat." For information on disability-related questions and COVID-19 vaccinations, see* ***K.7.*** *-* ***K.9.***

CDC has updated its guidance (https://www.cdc.gov/coronavirus/2019-ncov/communication/guidance.html) *over the course of the pandemic and may continue to do so as the pandemic evolves and as CDC acquires more information about the virus and different variants. The ADA "business necessity" standard requires that employers utilize the most current medical and public health information to determine what inquiries/medical examinations are appropriate.*

A.1. How much information may an employer request from an employee who calls in sick, in order to protect the rest of its workforce during the COVID-19 pandemic? *(3/17/20)*

During a pandemic, ADA-covered employers may ask such employees if they are experiencing symptoms of the pandemic virus. For COVID-19, these include symptoms such as fever, chills, cough, shortness of breath, or sore throat.

Employers must maintain all information about employee illness as a confidential medical record in compliance with the ADA.

A.2. When screening employees entering the workplace during this time, may an employer only ask employees about the COVID-19 symptoms EEOC has identified as examples (https://www.eeoc.gov/transcript-march-27-2020-outreach-webinar#q1) , or may it ask about any symptoms identified by public health authorities as associated with COVID-19? *(4/9/20)*

As public health authorities and doctors learn more about COVID-19, they may expand the list of associated symptoms. Employers should rely on the CDC, other public health authorities, and reputable medical sources for guidance on emerging symptoms associated with the disease. These sources may guide employers when choosing questions to ask employees to determine whether they would pose a direct threat to health in the workplace. For example, additional symptoms beyond fever or cough may include new loss of smell or taste as well as gastrointestinal problems, such as nausea, diarrhea, and vomiting.

A.3. When may an ADA-covered employer take the body temperature of employees during the COVID-19 pandemic? *(3/17/20)*

Generally, measuring an employee's body temperature is a medical examination. Because the CDC and state/local health authorities have acknowledged community spread of COVID-19 and issued attendant precautions, employers may measure employees' body temperature. However, employers should be aware that some people with COVID-19 do not have a fever.

A.4. Does the ADA allow employers to require employees to stay home if they have symptoms of the COVID-19? *(3/17/20)*

Yes. The CDC states that employees who become ill with symptoms of COVID-19 should leave the workplace. The ADA does not interfere with employers following this advice.

A.5. When an employee returns to the workplace after being out with COVID-19, does the ADA allow employers to require a note from a qualified medical professional explaining that it is safe for the employee to return (i.e., no risk of transmission) and that the employee is able to perform the job duties? *(Updated 7/12/22)*

Yes. Alternatively, employers may follow **CDC guidance (https://www.cdc.gov/coronavirus/2019-ncov/your-health/quarantine-isolation.html)** to determine whether it is safe to allow an employee to return to the workplace without confirmation from a medical professional.

When an employee returns to the workplace after being out with COVID-19, the ADA allows an employer to require confirmation from a qualified medical professional explaining that the individual is able to safely return. Such a request is permitted under the ADA. First, because COVID-19 is not always a disability, a request for confirmation may not be a disability-related inquiry. Alternatively, if the request is considered a **disability-related inquiry**, it would be justified under the ADA standard requiring that such employee inquiries be job-related and consistent with business necessity. Here, the request meets the "business necessity" standard because it is related to the possibility of transmission and/or related to an employer's objective concern about the employee's ability to resume working. For example, an employer may require confirmation from a medical professional addressing whether an employee may resume specific job duties requiring physical exertion.

As a practical matter, employers may wish to consider other ways to determine the safety of allowing an employee to return to work if doctors and other healthcare professionals are unable to provide such documentation either in a timely manner or at all. This might include reliance on local clinics to provide a form, a stamp, or an e-mail to confirm that an individual is no longer infectious and is able to resume working.

A.6. Under the ADA, may an employer, as a mandatory screening measure, administer a COVID-19 viral test (a test to detect the presence of the COVID-19 virus) when evaluating an employee's initial or continued presence in the workplace? *(Updated 7/12/22)*

Yes, if the employer can show it is job-related and consistent with business necessity.

A COVID-19 **viral test (https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/testing.html)** is a medical examination within the meaning of the ADA. Therefore, if an employer implements screening protocols that include COVID-19 viral testing, the ADA requires that any mandatory medical test of employees be "job-related and consistent with business necessity." Employer use of a COVID-19

viral test to screen employees who are or will be in the workplace will meet the "business necessity" standard when it is consistent with guidance from Centers for Disease Control and Prevention (CDC), Food and Drug Administration (FDA), and/or state/local public health authorities that is current at the time of testing. Be aware that CDC and other public health authorities periodically update and revise their recommendations about COVID-19 testing, and FDA may revise its guidance or emergency use authorizations, based on new information and changing conditions.

A **positive** viral test result means that the test detected SARS-CoV-2, the virus that causes COVID-19, at the time of testing, and that the individual most likely has a current infection and may be able to transmit the virus to others. A **negative** test result means the test did not detect SARS-CoV-2 at the time of testing. However, a negative test does not mean the employee does not have any virus, or will not later get the virus. It means only that the virus causing SARS-CoV-2 was not detected by the test.

If an employer seeks to implement screening testing for employees such testing must meet the "business necessity" standard based on relevant facts. Possible considerations in making the "business necessity" assessment may include the **level of community transmission (https://www.cdc.gov/coronavirus/2019-ncov/science/community-levels.html)**, the **vaccination status of employees (https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html)**, the accuracy and speed of processing for different types of COVID-19 viral tests, the **degree to which breakthrough (https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html) infections are possible for employees who are "up to date" on vaccinations (https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html)**, **the ease of transmissibility of the current variant(s), the possible severity of illness from the current variant (https://www.cdc.gov/coronavirus/2019-ncov/variants/about-variants.html)**, what types of contacts employees may have with others in the workplace or elsewhere that they are required to work (e.g., working with medically vulnerable individuals), and the potential impact on operations if an employee enters the workplace with COVID-19. In making these assessments, employers should check the latest **CDC guidance (https://www.cdc.gov/coronavirus/2019-ncov/hcp/testing-overview.html)** (and any other relevant sources) to determine whether **screening testing is appropriate (https://www.cdc.gov/coronavirus/2019-**

ncov/community/organizations/testing-non-healthcare-workplaces.html) for these employees.

Note: Question A.6. and A.8. address screening of employees generally. See Question A.9. regarding decisions to test only individual employees.

A.7. Under the ADA, may an employer require antibody testing before permitting employees to re-enter the workplace? *(Updated 7/12/22)*

No. An antibody test, as a medical examination under the ADA, must be job-related and consistent with business necessity. As of July 2022, CDC **guidance (https://www.cdc.gov/coronavirus/2019-ncov/lab/resources/antibody-tests.html)** explains that antibody testing may not show whether an employee has a current infection, nor establish that an employee is immune to infection; as a result, it should not be used to determine whether an employee may enter the workplace. Based on this CDC guidance, at this time such testing does not meet the ADA's "business necessity" standard for medical examinations or inquiries for employees. Therefore, requiring antibody testing before allowing employees to re-enter the workplace is not allowed under the ADA. An **antibody test (https://www.cdc.gov/coronavirus/2019-ncov/lab/resources/antibody-tests.html)** is different from a **test to determine if someone has evidence of infection with SARS-CoV-2 or has COVID-19 (i.e., a viral test) (https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/testing.html)**. The EEOC addresses COVID-19 viral screening tests in **A.6.**

A.8. May employers ask all employees physically entering the workplace if they have been diagnosed with or tested for COVID-19? *(9/8/20; adapted from 3/27/20 Webinar Question 1)*

Yes. Employers may ask all employees who will be physically entering the workplace if they have COVID-19 or symptoms associated with COVID-19, and ask if they have been tested for COVID-19. Symptoms associated with COVID-19 include, for example, fever, chills, cough, and shortness of breath. The CDC has identified a **current list of symptoms (https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html)**.

An employer may exclude those with COVID-19, or symptoms associated with COVID-19, from the workplace because, as EEOC has stated, their presence would pose a direct threat to the health or safety of others. However, for those employees

who are teleworking and are not physically interacting with coworkers or others (for example, customers), the employer would generally not be permitted to ask these questions.

A.9. May a manager ask only one employee—as opposed to asking all employees—questions designed to determine if the employee has COVID-19, or require that this employee alone have a temperature reading or undergo other screening or testing? *(9/8/20; adapted from 3/27/20 Webinar Question 3)*

If an employer wishes to ask only a particular employee to answer such questions, or to have a temperature reading or undergo other screening or testing, the ADA requires the employer to have a reasonable belief based on objective evidence that this person might have the disease. So, it is important for the employer to consider why it wishes to take these actions regarding this particular employee, such as a display of COVID-19 symptoms. In addition, the ADA does not interfere with employers following **recommendations by the CDC (https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/testing-non-healthcare-workplaces.html)** or other public health authorities regarding whether, when, and for whom testing or other screening is appropriate.

A.10. May an employer ask an employee who is physically coming into the workplace whether they have family members who have COVID-19 or symptoms associated with COVID-19? *(9/8/20; adapted from 3/27/20 Webinar Question 4)*

No. The Genetic Information Nondiscrimination Act (GINA) prohibits employers from asking employees medical questions about family members. GINA, however, does not prohibit an employer from asking employees whether they have had contact with anyone diagnosed with COVID-19 or who may have symptoms associated with the disease. Moreover, from a public health perspective, only asking about an employee's contact with family members would unnecessarily limit the information obtained about an employee's potential exposure to COVID-19.

A.11. What may an employer do under the ADA if an employee refuses to permit the employer to take the employee's temperature or refuses to answer questions about whether the employee has COVID-19, has symptoms associated with COVID-19, or has been tested for COVID-19? *(9/8/20; adapted from 3/27/20 Webinar Question 2)*

Under the circumstances existing currently, the ADA allows an employer to bar an employee from physical presence in the workplace if the employee refuses to have a temperature reading taken or refuses to answer questions about whether the employee has COVID-19, has symptoms associated with COVID-19, or has been tested for COVID-19. To gain the cooperation of employees, however, employers may wish to ask the reasons for the employee's refusal. The employer may be able to provide information or reassurance that they are taking these steps to ensure the safety of everyone in the workplace, and that these steps are consistent with health screening recommendations from CDC. Sometimes, employees are reluctant to provide medical information because they fear an employer may widely spread such personal medical information throughout the workplace. The ADA prohibits such broad disclosures. Alternatively, if an employee requests reasonable accommodation with respect to screening, the usual accommodation process should be followed; this is discussed in Question G.7.

A.12. During the COVID-19 pandemic, may an employer request information from employees who work on-site, whether regularly or occasionally, who report feeling ill or who call in sick? *(9/8/20; adapted from Pandemic Preparedness Question 6)*

Due to the COVID-19 pandemic, at this time employers may ask employees who work on-site, whether regularly or occasionally, and report feeling ill or who call in sick, questions about their symptoms as part of workplace screening for COVID-19.

A.13. May an employer ask an employee why the employee has been absent from work? *(9/8/20; adapted from Pandemic Preparedness Question 15)*

Yes. Asking why an individual did not report to work is not a disability-related inquiry. An employer is always entitled to know why an employee has not reported for work.

A.14. When an employee returns from travel during a pandemic, must an employer wait until the employee develops COVID-19 symptoms to ask questions about where the person has traveled? *(9/8/20; adapted from Pandemic Preparedness Question 8)*

No. Questions about where a person traveled would not be disability-related inquiries. If the CDC or state or local public health officials recommend that people who visit specified locations remain at home for a certain period of time, an

employer may ask whether employees are returning from these locations, even if the travel was personal.

B. Confidentiality of Medical Information

With limited exceptions, the ADA requires employers to keep confidential any medical information they learn about any applicant or employee. Medical information includes not only a diagnosis or treatments, but also the fact that an individual has requested or is receiving a reasonable accommodation.

B.1. May an employer store in existing medical files information it obtains related to COVID-19, including the results of taking an employee's temperature or the employee's self-identification as having this disease, or must the employer create a new medical file system solely for this information? *(4/9/20)*

The ADA requires that all medical information about a particular employee be stored separately from the employee's personnel file, thus limiting access to this **confidential information (https://www.eeoc.gov/transcript-march-27-2020-outreach-webinar#q9)**. An employer may store all medical information related to COVID-19 in existing medical files. This includes an employee's statement that the employee has the disease or suspects so, or the employer's notes or other documentation from questioning an employee about symptoms. For information on confidentiality and COVID-19 vaccinations, see **K.4.**

B.2. If an employer requires all employees to have a daily temperature check before entering the workplace, may the employer maintain a log of the results? *(4/9/20)*

Yes. The employer needs to maintain the confidentiality of this information.

B.3. May an employer disclose the name of an employee to a public health agency when it learns that the employee has COVID-19? *(4/9/20)*

Yes (https://www.cdc.gov/coronavirus/2019-ncov/community/contact-tracing-nonhealthcare-workplaces.html).

B.4. May a temporary staffing agency or a contractor that places an employee in an employer's workplace notify the employer if it learns the employee has COVID-19? *(4/9/20)*

disclosure

Yes. The staffing agency or contractor may notify the employer and disclose the name of the employee, because the employer may need to determine if this employee had contact with anyone in the workplace.

B.5. Suppose a manager learns that an employee has COVID-19, or has symptoms associated with the disease. The manager knows it must be reported but is worried about violating ADA confidentiality. What should the manager do? *(9/8/20; adapted from 3/27/20 Webinar Question 5)*

The ADA requires that an employer keep all medical information about employees confidential, even if that information is not about a disability. Clearly, the information that an employee has symptoms of, or a diagnosis of, COVID-19, is medical information. But the fact that this is medical information does not prevent the manager from reporting to appropriate employer officials so that they can take actions consistent with guidance from the CDC and other public health authorities.

The question is really what information to report: is it the fact that an employee—unnamed—has symptoms of COVID-19 or a diagnosis, or is it the identity of that employee? Who in the organization needs to know the identity of the employee will depend on each workplace and why a specific official needs this information. Employers should make every effort to limit the number of people who get to know the name of the employee.

limit release of info.

The ADA does not interfere with a designated representative of the employer interviewing the employee to get a list of people with whom the employee possibly had contact through the workplace, so that the employer can then take action to notify those who may have come into contact with the employee, without revealing the employee's identity. For example, using a generic descriptor, such as telling employees that "someone at this location" or "someone on the fourth floor" has COVID-19, provides notice and does not violate the ADA's prohibition of disclosure of confidential medical information. For small employers, coworkers might be able to figure out who the employee is, but employers in that situation are still prohibited from confirming or revealing the employee's identity. Also, all employer officials who are designated as needing to know the identity of an employee should be specifically instructed that they must maintain the confidentiality of this

information. Employers may want to plan in advance what supervisors and managers should do if this situation arises and determine who will be responsible for receiving information and taking next steps.

B.6. An employee who must report to the workplace knows that a coworker who reports to the same workplace has symptoms associated with COVID-19. Does ADA confidentiality prevent the first employee from disclosing the coworker's symptoms to a supervisor? *(9/8/20; adapted from 3/27/20 Webinar Question 6)*

No. ADA confidentiality does not prevent this employee from communicating to the employee's supervisor about a coworker's symptoms. In other words, it is not an ADA confidentiality violation for this employee to inform the supervisor about a coworker's symptoms. After learning about this situation, the supervisor should contact appropriate management officials to report this information and discuss next steps.

B.7. An employer knows that an employee is teleworking because the person has COVID-19 or symptoms associated with the disease, and is in self-quarantine. May the employer tell staff that this particular employee is teleworking without saying why? *(9/8/20; adapted from 3/27/20 Webinar Question 7)*

Yes. If staff need to know how to contact the employee, and that the employee is working even if not present in the workplace, then disclosure that the employee is teleworking without saying why is permissible. Also, if the employee was on leave rather than teleworking because the employee has COVID-19 or symptoms associated with the disease, or any other medical condition, then an employer cannot disclose the reason for the leave, just the fact that the fact that the individual is on leave.

B.8. Many employees, including managers and supervisors, are now teleworking as a result of COVID-19. How are they supposed to keep medical information of employees confidential while working remotely? *(9/8/20; adapted from 3/27/20 Webinar Question 9)*

The ADA requirement that medical information be kept confidential includes a requirement that it be stored separately from regular personnel files. If a manager or supervisor receives medical information involving COVID-19, or any other medical

information, while teleworking, and is able to follow an employer's existing confidentiality protocols while working remotely, the supervisor has to do so. But to the extent that is not feasible, the supervisor still must safeguard this information to the greatest extent possible until the supervisor can properly store it. This means that paper notepads, laptops, or other devices should not be left where others can access the protected information.

Similarly, documentation must not be stored electronically where others would have access. A manager may even wish to use initials or another code to further ensure confidentiality of the name of an employee.

C. Hiring and Onboarding

Under the ADA, prior to making a conditional job offer to an applicant, disability-related inquiries and medical exams are generally prohibited. They are permitted between the time of the offer and when the applicant begins work, provided they are required for everyone in the same job category.

C.1. If an employer is hiring, may it screen applicants for symptoms of COVID-19? *(Updated 7/12/22)*

Yes. An employer may screen job applicants for symptoms of COVID-19 after making a conditional job offer, as long as it does so for all entering employees in the same type of job. This ADA rule applies whether or not the applicant has a disability.

In addition, if an employer screens **everyone** (i.e., applicants, employees, contractors, visitors) for COVID-19 before permitting entry to the worksite, then an applicant in the pre-offer stage who needs to be in the workplace as part of the application process (e.g., for a job interview) may likewise be screened for COVID-19. The screening is limited to the same screening that everyone else undergoes; an employer that goes beyond that screening will have engaged in an illegal pre-offer disability-related inquiry and/or medical examination. For information on the ADA rules governing such inquiries and examination, see **Section A**.

C.2. May an employer take an applicant's temperature as part of a post-offer, pre-employment medical exam? *(3/18/20)*

Yes. Any medical exams are permitted after an employer has made a conditional offer of employment. However, employers should be aware that some people with COVID-19 do not have a fever.

C.3. May an employer delay the start date of an applicant who has COVID-19 or symptoms associated with it? *(3/18/20)*

Yes. According to CDC guidance, an individual who has COVID-19 or symptoms associated with it should not be in the workplace.

C.4. May an employer withdraw a job offer when it needs an applicant to start working immediately, whether at the worksite or in the physical presence of others outside of the worksite, because the individual has tested positive for the virus that causes COVID-19, has symptoms of COVID-19, or has been exposed recently to someone with COVID-19? *(Updated 7/12/22)*

An employer should consult and follow current **CDC guidance (https://www.cdc.gov/coronavirus/2019-ncov/your-health/quarantine-isolation.html)** that explains when and how it would be safe for an individual who currently has COVID-19, symptoms of COVID-19, or has been exposed recently to someone with COVID-19, to end **isolation or quarantine (https://www.cdc.gov/coronavirus/2019-ncov/your-health/quarantine-isolation.html)** and thus safely enter a workplace or otherwise work in the physical presence of others. An employer who follows current CDC guidance addressing the individual's situation may withdraw the job offer if (1) the job requires an immediate start date, (2) CDC guidance recommends the person not be in proximity to others, **and** (3) the job requires such proximity to others, whether at the workplace or elsewhere. Given that for some individuals there may only be a short period of time required for isolation or quarantine, employers may be able to adjust a start date or permit telework (if job duties can be performed remotely).

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C.5. May an employer postpone the start date or withdraw a job offer because of the employer's concern that the individual is older, pregnant, or has an underlying medical condition that puts the individual at increased risk from COVID-19? *(Updated 7/12/22)*

No. An employer's concern for an applicant's well-being -- an intent to protect them from what it perceives as a risk of illness from COVID-19 -- does not excuse an action that is otherwise unlawful discrimination. The fact that **CDC**

(https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html) has noted that older adults, people with certain medical conditions, or pregnant and recently pregnant people may be at greater risk of severe illness from COVID-19 does not justify unilaterally postponing the start date or withdrawing a job offer. Therefore, an employer may not discriminate based on age (40 or older) or pregnancy and related conditions. If an underlying medical condition is a disability, an employer must determine whether the individual's disability poses a "direct threat" by starting work immediately and, if so, whether reasonable accommodation can be provided to sufficiently lessen or eliminate any risks without causing an undue hardship. For more information on assessing direct threat and reasonable accommodation in this situation, see **G.4.** and **G.5.** For more information on potential issues regarding discrimination based on age or pregnancy, see Sections **H** and **J.**

D. Disability and Reasonable Accommodation

Under the ADA, reasonable accommodations are adjustments or modifications provided by an employer to enable people with disabilities to enjoy equal employment opportunities. If a reasonable accommodation is needed and requested by an individual with a disability to apply for a job, perform a job, or enjoy benefits and privileges of employment, the employer must provide it unless it would pose an undue hardship, meaning significant difficulty or expense. An employer has the discretion to choose among effective accommodations. Where a requested accommodation would result in undue hardship, the employer must offer an alternative accommodation if one is available absent undue hardship. In discussing accommodation requests, employers and employees may find it helpful to consult the Job Accommodation Network (JAN) website for types of accommodations, ***www.askjan.org (http://www.askjan.org/)****. JAN's materials specific to COVID-19 are at* ***https://askjan.org/topics/COVID-19.cfm (https://askjan.org/topics/COVID-19.cfm)****.*

For more information on reasonable accommodation issues that may arise when employees return to the workplace, see ***Section G****. For more information on reasonable accommodation and pregnancy-related disabilities, see* ***Section J****. For*

more information on reasonable accommodation and COVID-19 vaccinations, see ***K.1.***, ***K.2.***, ***K.5.***, ***K.6.***, *and* ***K.11****.*

D.1. If a job may only be performed at the workplace, are there reasonable accommodations (https://www.eeoc.gov/laws/guidance/enforcement-guidance-reasonable-accommodation-and-undue-hardship-under-ada#general) for individuals with disabilities, absent undue hardship (https://www.eeoc.gov/laws/guidance/enforcement-guidance-reasonable-accommodation-and-undue-hardship-under-ada#undue), that could offer protection to an employee who, due to a preexisting disability, is at higher risk from COVID-19? *(4/9/20)*

There may be reasonable accommodations that **could offer protection to an individual whose disability puts that person at greater risk from COVID-19 (https://www.eeoc.gov/transcript-march-27-2020-outreach-webinar#q17)** and who therefore requests such actions to eliminate possible exposure. Even with the constraints imposed by a pandemic, some accommodations may meet an employee's needs on a temporary basis without causing undue hardship on the employer.

Low-cost solutions achieved with materials already on hand or easily obtained may be effective. If not already implemented for all employees, accommodations for those who request reduced contact with others due to a disability may include changes to the work environment such as designating one-way aisles; using plexiglass, tables, or other barriers to ensure minimum distances between customers and coworkers whenever feasible per **CDC guidance (https://www.cdc.gov/coronavirus/2019-ncov/community/index.html)** or other accommodations that reduce chances of exposure.

Flexibility by employers and employees is important in determining if some accommodation is possible in the circumstances. Temporary job restructuring of marginal job duties, temporary transfers to a different position, or modifying a work schedule or shift assignment may also permit an individual with a disability to perform safely the essential functions of the job while reducing exposure to others in the workplace or while commuting.

D.2. If an employee has a preexisting mental illness or disorder that has been exacerbated by the COVID-19 pandemic, may the employee now be entitled to a reasonable accommodation (absent undue hardship)? *(4/9/20)*

Although many people feel significant stress due to the COVID-19 pandemic, employees with certain preexisting mental health conditions, for example, anxiety disorder, obsessive-compulsive disorder, or post-traumatic stress disorder, may have more difficulty handling the disruption to daily life that has accompanied the COVID-19 pandemic.

As with any accommodation request, employers may: ask questions to determine whether the condition is a disability; discuss with the employee how the requested accommodation would assist the employee and enable the employee to keep working; explore alternative accommodations that may effectively meet the employee's needs; and request medical documentation if needed.

D.3. In a workplace where all employees are required to telework during this time, should an employer postpone discussing a request from an employee with a disability for an accommodation that will not be needed until the employee returns to the workplace when mandatory telework ends? *(4/9/20)*

Not necessarily. An employer may give higher priority to discussing requests for reasonable accommodations that are needed while teleworking, but the employer may begin discussing this request now. The employer may be able to acquire all the information it needs to make a decision. If a reasonable accommodation is granted, the employer also may be able to make some arrangements for the accommodation in advance.

D.4. What if an employee was already receiving a reasonable accommodation prior to the COVID-19 pandemic and now requests an additional or altered accommodation? *(4/9/20)*

An employee who was already receiving a reasonable accommodation prior to the COVID-19 pandemic may be entitled to an additional or altered accommodation, absent undue hardship. For example, an employee who is teleworking because of the pandemic may need a different type of accommodation than what the employee **uses in the workplace (https://www.eeoc.gov/transcript-march-27-2020-outreach-webinar#q20)**. The employer **may discuss (https://www.eeoc.gov/laws/guidance/enforcement-guidance-reasonable-accommodation-and-undue-hardship-under-ada#requesting)** with the employee whether the same or a different disability is the basis for this new request and why an additional or altered accommodation is needed.

D.5. During the pandemic, if an employee requests an accommodation for a medical condition either at home or in the workplace, may an employer still request information to determine if the condition is a disability? *(4/17/20)*

Yes, if it is not obvious or already known, an employer may ask questions or request medical documentation to determine whether the employee has a "disability" as defined by the ADA (a physical or mental impairment that substantially limits a major life activity, or a history of a substantially limiting impairment).

D.6. During the pandemic, may an employer still engage in the interactive process and request information from an employee about why an accommodation is needed? *(4/17/20)*

Yes, if it is not obvious or already known, an employer may ask questions or request **medical documentation (https://www.eeoc.gov/transcript-march-27-2020-outreach-webinar#q17)** to determine whether the employee's disability necessitates an accommodation, either the one the employee requested or any other. **Possible questions (https://www.eeoc.gov/laws/guidance/enforcement-guidance-reasonable-accommodation-and-undue-hardship-under-ada#requesting)** for the employee may include: (1) how the disability creates a limitation, (2) how the requested accommodation will effectively address the limitation, (3) whether another form of accommodation could effectively address the issue, and (4) how a proposed accommodation will enable the employee to continue performing the "essential functions" of the employee's position (that is, the fundamental job duties).

D.7. If there is some urgency to providing an accommodation, or the employer has limited time available to discuss the request during the pandemic, may an employer provide a temporary accommodation? *(4/17/20)*

Yes. Given the pandemic, some employers may choose to forgo or shorten the exchange of information between an employer and employee known as the "interactive process" (discussed in D.5 and D.6., above) and grant the request. In addition, when government restrictions change, or are partially or fully lifted, the need for accommodations may also change. This may result in more requests for short-term accommodations. Employers may wish to adapt the interactive process —and devise end dates for the accommodation—to suit changing circumstances based on public health directives.

Whatever the reason for shortening or adapting the interactive process, an employer may also choose to place an end date on the accommodation (for example, either a specific date such as May 30, or when the employee returns to the workplace part- or full-time due to changes in government restrictions limiting the number of people who may congregate). Employers may also opt to provide a requested accommodation on an interim or trial basis, with an end date, while awaiting receipt of medical documentation. Choosing one of these alternatives may be particularly helpful where the requested accommodation would provide protection that an employee may need because of a pre-existing disability that puts the employee at greater risk during this pandemic. This **could also apply (https://www.eeoc.gov/wysk/what-you-should-know-about-covid-19-and-ada-rehabilitation-act-and-other-eeo-laws#D.2)** to employees who have disabilities exacerbated by the pandemic.

Employees may request an extension that an employer must consider, particularly if current government restrictions are extended or new ones adopted.

D.8. May an employer invite employees now to ask for reasonable accommodations they may need in the future when they are permitted to return to the workplace? *(4/17/20; updated 9/8/20 to address stakeholder questions)*

Yes. Employers may inform the workforce that employees with disabilities may request accommodations in advance that they believe they may need when the workplace re-opens. This is discussed in greater detail in Question G.6. If advance requests are received, employers may begin the "interactive process" – the discussion between the employer and employee focused on whether the impairment is a disability and the reasons that an accommodation is needed. If an employee chooses not to request accommodation in advance, and instead requests it at a later time, the employer must still consider the request at that time.

D.9. Are the circumstances of the pandemic relevant to whether a requested accommodation can be denied because it poses an undue hardship? *(4/17/20)*

Yes. An employer does not have to provide a particular reasonable accommodation if it poses an "**undue hardship (https://www.eeoc.gov/laws/guidance/enforcement-guidance-reasonable-accommodation-and-undue-hardship-under-ada#undue)**," which means "significant difficulty or expense." As described in the two questions that follow, in

some instances, an accommodation that would not have posed an undue hardship prior to the pandemic may pose one now.

D.10. What types of undue hardship considerations may be relevant to determine if a requested accommodation poses "significant difficulty" during the COVID-19 pandemic? *(4/17/20)*

An employer may consider whether current circumstances create "significant difficulty" in acquiring or providing certain accommodations, considering the facts of the particular job and workplace. For example, it may be significantly more difficult in this pandemic to conduct a needs assessment or to acquire certain items, and delivery may be impacted, particularly for employees who may be teleworking. Or, it may be significantly more difficult to provide employees with temporary assignments, to remove marginal functions, or to readily hire temporary workers for specialized positions. If a particular accommodation poses an undue hardship, employers and employees should work together to determine if there may be an alternative that could be provided that does not pose such problems.

D.11. What types of undue hardship considerations may be relevant to determine if a requested accommodation poses "significant expense" during the COVID-19 pandemic? *(4/17/20)*

Prior to the COVID-19 pandemic, most accommodations did not pose a significant expense when considered against an employer's overall budget and resources (always considering the budget/resources of the entire entity and not just its components). But, the sudden loss of some or all of an employer's income stream because of this pandemic is a relevant consideration. Also relevant is the amount of discretionary funds available at this time—when considering other expenses—and whether there is an expected date that current restrictions on an employer's operations will be lifted (or new restrictions will be added or substituted). These considerations do not mean that an employer can reject any accommodation that costs money; an employer must weigh the cost of an accommodation against its current budget while taking into account constraints created by this pandemic. For example, even under current circumstances, there may be many no-cost or very low-cost accommodations.

D.12. Do the ADA and the Rehabilitation Act apply to applicants or employees who are classified as "critical infrastructure workers (https://www.cdc.gov/coronavirus/2019-ncov/downloads/Essential-Critical-

Workers_Dos-and-Donts.pdf)" or "essential critical workers (https://www.cdc.gov/coronavirus/2019-ncov/community/critical-workers/implementing-safety-practices.html)" by the CDC? *(4/23/20)*

Yes. These CDC designations, or any other designations of certain employees, do not eliminate coverage under the ADA or the Rehabilitation Act, or any other equal employment opportunity law. Therefore, employers receiving requests for reasonable accommodation under the ADA or the Rehabilitation Act from employees falling in these categories of jobs must accept and process the requests as they would for any other employee. Whether the request is granted will depend on whether the worker is an individual with a disability, and whether there is a reasonable accommodation that can be provided absent undue hardship.

D.13. Is an employee entitled to an accommodation under the ADA in order to avoid exposing a family member who is at higher risk of severe illness from COVID-19 due to an underlying medical condition? *(6/11/20)*

No. Although the ADA prohibits discrimination based on association with an individual with a disability, that protection is limited to disparate treatment or harassment. The ADA does not require that an employer accommodate an employee without a disability based on the disability-related needs of a family member or other person with whom the employee is associated.

D.14. When an employer requires some or all of its employees to telework because of COVID-19 or government officials require employers to shut down their facilities and have workers telework, is the employer required to provide a teleworking employee with the same reasonable accommodations for disability under the ADA or the Rehabilitation Act that it provides to this individual in the workplace? *(9/8/20; adapted from 3/27/20 Webinar Question 20)*

If such a request is made, the employer and employee should discuss what the employee needs and why, and whether the same or a different accommodation could suffice in the home setting. For example, an employee may already have certain things in their home to enable them to do their job so that they do not need to have all of the accommodations that are provided in the workplace.

Also, the undue hardship considerations might be different when evaluating a request for accommodation when teleworking rather than working in the workplace. A reasonable accommodation that is feasible and does not pose an

undue hardship in the workplace might pose one when considering circumstances, such as the place where it is needed and the reason for telework. For example, the fact that the period of telework may be of a temporary or unknown duration may render certain accommodations either not feasible or an undue hardship. There may also be constraints on the normal availability of items or on the ability of an employer to conduct a necessary assessment.

As a practical matter, and in light of the circumstances that led to the need for telework, employers and employees should both be creative and flexible about what can be done when an employee needs a reasonable accommodation for telework at home. If possible, providing interim accommodations might be appropriate while an employer discusses a request with the employee or is waiting for additional information.

D.15. Assume that an employer grants telework to employees for the purpose of slowing or stopping the spread of COVID-19. When an employer reopens the workplace and recalls employees to the worksite, does the employer automatically have to grant telework as a reasonable accommodation to every employee with a disability who requests to continue this arrangement as an ADA/Rehabilitation Act accommodation? *(9/8/20; adapted from 3/27/20 Webinar Question 21)*

No. Any time an employee requests a reasonable accommodation, the employer is entitled to understand the disability-related limitation that necessitates an accommodation. If there is no disability-related limitation that requires teleworking, then the employer does not have to provide telework as an accommodation. Or, if there is a disability-related limitation but the employer can effectively address the need with another form of reasonable accommodation at the workplace, then the employer can choose that alternative to telework.

To the extent that an employer is permitting telework to employees because of COVID-19 and is choosing to excuse an employee from performing one or more essential functions, then a request—after the workplace reopens—to continue telework as a reasonable accommodation does not have to be granted if it requires continuing to excuse the employee from performing an essential function. The ADA never requires an employer to eliminate an essential function as an accommodation for an individual with a disability.

The fact that an employer temporarily excused performance of one or more essential functions when it closed the workplace and enabled employees to telework for the purpose of protecting their safety from COVID-19, or otherwise chose to permit telework, does not mean that the employer permanently changed a job's essential functions, that telework is always a feasible accommodation, or that it does not pose an undue hardship. These are fact-specific determinations. The employer has no obligation under the ADA to refrain from restoring all of an employee's essential duties at such time as it chooses to restore the prior work arrangement, and then evaluating any requests for continued or new accommodations under the usual ADA rules.

D.16. Assume that prior to the emergence of the COVID-19 pandemic, an employee with a disability had requested telework as a reasonable accommodation. The employee had shown a disability-related need for this accommodation, but the employer denied it because of concerns that the employee would not be able to perform the essential functions remotely. In the past, the employee therefore continued to come to the workplace. However, after the COVID-19 crisis has subsided and temporary telework ends, the employee renews the request for telework as a reasonable accommodation. Can the employer again refuse the request? *(9/8/20; adapted from 3/27/20 Webinar Question 22)*

Assuming all the requirements for such a reasonable accommodation are satisfied, the temporary telework experience could be relevant to considering the renewed request. In this situation, for example, the period of providing telework because of the COVID-19 pandemic could serve as a trial period that showed whether or not this employee with a disability could satisfactorily perform all essential functions while working remotely, and the employer should consider any new requests in light of this information. As with all accommodation requests, the employee and the employer should engage in a flexible, cooperative interactive process going forward if this issue does arise.

D.17. Might the pandemic result in excusable delays during the interactive process? *(Updated 7/12/22)*

Yes. Some of the issues initially created by the pandemic that delayed engaging in an interactive process and/or providing reasonable accommodation may no longer exist. But, as the pandemic continues to evolve and new issues arise, it is possible that an employer may face new challenges that interfere with responding

expeditiously to a request for accommodation. Similarly, reopening a workplace may bring a higher number of requests for reasonable accommodation. In all these situations, an employer must show specific pandemic-related circumstances justified the delay in providing a reasonable accommodation to which the employee was legally entitled. To the extent that evolving circumstances created by the pandemic cause a justifiable delay in the interactive process–thereby delaying a decision on a request–employers and employees are encouraged to use interim solutions to enable employees to keep working as much as possible.

D.18. Federal agencies are required to have timelines in their written reasonable accommodation procedures governing how quickly they will process requests and provide reasonable accommodations. What happens if circumstances created by the pandemic prevent an agency from meeting this timeline? *(Updated 7/12/22)*

Situations created by the current COVID-19 pandemic may constitute an "extenuating circumstance"—something beyond a federal agency's control—that may justify exceeding the normal timeline that an agency has adopted in its internal reasonable accommodation procedures.

Some of the issues initially created by the pandemic that delayed engaging in an interactive process and/or providing reasonable accommodation may no longer exist. But, as the pandemic continues to evolve and new issues arise, it is possible that an agency may face new challenges that interfere with responding to a request for accommodation within an agency's timeline. Similarly, reopening a workplace may bring a higher number of requests for reasonable accommodation. In all these situations, an agency must show specific pandemic-related circumstances that constitute an "extenuating circumstance." To the extent that there is an extenuating circumstance, agencies and employees are encouraged to use interim solutions to enable employees to keep working as much as possible.

E. Pandemic-Related Harassment Due to National Origin, Race, or Other Protected Characteristics

E.1. What practical tools are available to employers to reduce and address workplace harassment that may arise as a result of the COVID-19 pandemic? *(4/9/20)*

Employers can help reduce the chance of harassment by explicitly communicating to the workforce that fear of the COVID-19 pandemic should not be misdirected against individuals because of a protected characteristic, including their **national origin, race (https://www.eeoc.gov/wysk/message-eeoc-chair-janet-dhillon-national-origin-and-race-discrimination-during-covid-19)** , or other prohibited bases.

Practical anti-harassment tools provided by the EEOC for small businesses can be found here:

- Anti-harassment **policy tips (https://www.eeoc.gov/employers/small-business/harassment-policy-tips)** for small businesses
- Select Task Force on the Study of Harassment in the Workplace (includes detailed recommendations and tools to aid in designing effective anti-harassment policies; developing training curricula; implementing complaint, reporting, and investigation procedures; creating an organizational culture in which harassment is not tolerated):
    - **report (https://www.eeoc.gov/select-task-force-study-harassment-workplace#_Toc453686319)** ;
    - **checklists (https://www.eeoc.gov/select-task-force-study-harassment-workplace#_Toc453686319)** for employers who want to reduce and address harassment in the workplace; and
    - **chart (https://www.eeoc.gov/chart-risk-factors-harassment-and-responsive-strategies)** of risk factors that lead to harassment and appropriate responses.

E.2. Are there steps an employer should take to address possible harassment and discrimination against coworkers when it re-opens the workplace? *(4/17/20)*

Yes. An employer may remind all employees that it is against the federal EEO laws to harass or otherwise discriminate against coworkers based on race, national origin, color, sex, religion, age (40 or over), disability, or genetic information. It may be particularly helpful for employers to advise supervisors and managers of their roles

in watching for, stopping, and reporting any harassment or other discrimination. An employer may also make clear that it will immediately review any allegations of harassment or discrimination and take appropriate action.

E.3. How may employers respond to pandemic-related harassment, in particular against employees who are or are perceived to be Asian? *(6/11/20)*

Managers should be alert to demeaning, derogatory, or hostile remarks directed to employees who are or are perceived to be of Chinese or other Asian national origin, including about the coronavirus or its origins.

All employers covered by Title VII should ensure that management understands in advance how to recognize such harassment. Harassment may occur using electronic communication tools—regardless of whether employees are in the workplace, teleworking, or on leave—and also in person between employees at the worksite. Harassment of employees at the worksite may also originate with contractors, customers or clients, or, for example, with patients or their family members at health care facilities, assisted living facilities, and nursing homes. Managers should know their legal obligations and be **instructed (https://www.eeoc.gov/wysk/what-you-should-know-about-covid-19-and-ada-rehabilitation-act-and-other-eeo-laws#E.2)** to quickly identify and resolve potential problems, before they rise to the level of unlawful discrimination.

Employers may choose to send a reminder to the entire workforce noting Title VII's prohibitions on harassment, reminding employees that harassment will not be tolerated, and inviting anyone who experiences or witnesses workplace harassment to report it to management. Employers may remind employees that harassment can result in disciplinary action up to and including termination.

E.4. An employer learns that an employee who is teleworking due to the pandemic is sending harassing emails to another worker. What actions should the employer take? *(6/11/20)*

The employer should take the same actions it would take if the employee was in the workplace. Employees may not harass other employees through, for example, emails, calls, or platforms for video or chat communication and collaboration.

F. Furloughs and Layoffs

F.1. Under the EEOC's laws, what waiver responsibilities apply when an employer is conducting layoffs? *(4/9/20)*

Special rules apply when an employer is offering employees severance packages in exchange for a general release of all discrimination claims against the employer. More information is available in EEOC's **technical assistance document on severance agreements (https://www.eeoc.gov/laws/guidance/qa-understanding-waivers-discrimination-claims-employee-severance-agreements)** .

F.2. What are additional EEO considerations in planning furloughs or layoffs? *(9/8/20; adapted from 3/27/20 Webinar Question 13)*

The laws enforced by the EEOC prohibit covered employers from selecting people for furlough or layoff because of that individual's race, color, religion, national origin, sex, age, disability, protected genetic information, or in retaliation for protected EEO activity.

G. Return to the Workplace

G.1. As government restrictions are lifted or modified , how will employers know what steps they can take consistent with the ADA to screen employees for the virus that causes COVID-19 when entering the workplace? *(Updated 7/12/22)*

The ADA permits employers to make disability-related inquiries and conduct medical exams to screen employees for COVID-19 when entering the workplace if such screening is "job-related and consistent with business necessity." For more information on disability-related inquiries and medical examinations, see **Section A**. For information on reasonable accommodation requests related to screening protocols, see **G.7**.

Employers should make sure not to engage in unlawful disparate treatment based on protected characteristics in decisions related to screening and exclusion.

G.2. An employer requires workers to wear personal protective equipment and engage in other infection control practices. Some employees ask for accommodations due to a disability or a sincerely held religious belief, practice, or observance that affects the ability to wear personal protective equipment

and/or engage in other infection control practices. How should an employer respond? *(Updated 7/12/22)*

In most instances, federal EEO laws permit an employer to require employees to wear personal protective equipment (PPE) (for example, **masks (https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/about-face-coverings.html)** and/or gloves) and observe other infection control practices (for example, regular hand washing or physical distancing protocols). Some employers may need to comply with regulations issued by the Occupational Safety and Health Administration (OSHA) that require the use of PPE. OSHA regulations do not prohibit the use of reasonable accommodations under the EEO laws as long as those accommodations do not violate OSHA requirements. Employers also may follow current CDC guidance about who should wear **masks (https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/about-face-coverings.html)**.

Regardless of the reason an employer requires PPE (or other infection control measures), when an employee with a disability needs a reasonable accommodation under the ADA to comply with an employer's requirement to wear PPE (e.g., non-latex gloves, modified face masks for interpreters or others who communicate with an employee who uses lip reading, or gowns designed for individuals who use wheelchairs), or when an employee requires a religious accommodation under Title VII (such as modified or alternative equipment due to religious attire or grooming practices), the employer should discuss the request and provide accommodation (either what is requested by the employee or an alternative that is effective in meeting the employee's needs) if it does not cause an undue hardship on the operation of the employer's business under the ADA or Title VII. For general information on reasonable accommodation under the ADA, see **Section D**.

G.3. What does an employee need to do in order to request reasonable accommodation from an employer because the employee has one of the medical conditions (https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html) that CDC says may put a person at higher risk for severe illness from COVID-19? *(Updated 7/12/22)*

An employee—or a third party, such as an employee's doctor—must **let the employer know (https://www.eeoc.gov/laws/guidance/enforcement-guidance-reasonable-accommodation-and-undue-hardship-under-ada#requesting)** that

the employee needs a change for a reason related to a medical condition . Individuals may request accommodation orally or in writing. While the employee (or third party) does not need to use the term "reasonable accommodation" or reference the ADA, the employee may do so.

The employee or the employee's representative should communicate that the employee has a medical condition necessitating a change to meet a medical need. After receiving a request, the employer may **ask questions or seek medical documentation (https://www.eeoc.gov/wysk/what-you-should-know-about-covid-19-and-ada-rehabilitation-act-and-other-eeo-laws#D.6)** to help decide if the individual has a disability—not all medical conditions meet the ADA's definition of "disability"—and if there is a reasonable accommodation, barring **undue hardship (https://www.eeoc.gov/wysk/what-you-should-know-about-covid-19-and-ada-rehabilitation-act-and-other-eeo-laws#D)** , that can be provided. For additional information on reasonable accommodation under the ADA, see **Section D**. For information on pregnancy-related disabilities covered under the ADA, see **J.2**. For general information on reasonable accommodation requests related to a sincerely held religious belief, practice, or observance, see **K.12**.

G.4. CDC identifies a number of medical conditions (https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html) that are more likely to cause people to get severely ill if they get COVID-19. An employer knows that an employee has one of these conditions and is concerned that the employee's health will be jeopardized upon returning to the workplace, but the employee has not requested accommodation. How does the ADA apply to this situation? *(Updated 7/12/22)*

The ADA does not mandate that the employer take action in this situation if the employee has not requested reasonable accommodation. Also, an employer's duty to provide reasonable accommodation applies only if an employee has an actual disability or a record of a disability, as defined in the ADA; this means not every individual with one of the medical conditions that might place them at higher risk of COVID-19 complications will automatically satisfy these ADA definitions of **disability**.

Assuming the employee has a "disability" as discussed above, if the employer is concerned that the health of an employee with a disability may be jeopardized upon returning to the workplace, the ADA generally does not allow the employer to

exclude the employee—or take any other adverse action—because the employee has a disability that CDC identifies as potentially placing the employee at higher risk for severe illness if the employee gets COVID-19. Under the ADA, such an adverse action is not allowed unless the employee's disability poses a "direct threat" to the employee's health or safety that cannot be eliminated or reduced by reasonable accommodation.

The ADA direct threat requirement is a high standard. As an affirmative defense for the employer, direct threat requires an employer to show that the individual has a disability that poses a "significant risk of substantial harm" to the employee's own health or safety, or that of others in the workplace under 29 C.F.R. section 1630.2(r) (regulation addressing direct threat to health or safety of self or others). A direct threat assessment cannot be based solely on the disability being identified in CDC's guidance; the determination must be an individualized assessment based on a reasonable medical judgment about this employee's disability—not the disability in general—using the most current medical knowledge and/or on the best available objective evidence. Thus, an employer analyzing a potential direct threat must consider the duration of the risk, the nature and severity of the potential harm, the likelihood that the potential harm will occur, and the imminence of the potential harm. Analysis of these factors will likely include considerations based on the severity of the pandemic in a particular area and the employee's own health (for example, is the employee's disability well-controlled), and the employee's particular job duties. A determination of direct threat also would include whether the employee is **up to date on vaccinations (https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html)** and the likelihood that an individual may be exposed to the virus at the worksite. Measures that an employer may be taking in general to protect all workers, such as mandatory physical distancing, also would be relevant.

Even if an employer determines that an employee's disability poses a "significant risk of substantial harm" to the employee's own health or safety, the employer still cannot exclude the employee from the workplace—or take any other adverse action—unless there is no way to provide a reasonable accommodation (absent undue hardship). The ADA regulations require an employer to consider whether there are reasonable accommodations that would eliminate or sufficiently reduce the risk so that it would be safe for the employee to return to the workplace, while still permitting the employee to perform the essential functions of the job.

An employer's consideration of a possible reasonable accommodation should involve an interactive process with the employee. If there are no accommodations in an employee's current position that sufficiently reduce or eliminate direct threat in the workplace, then an employer must consider accommodations such as telework, leave, or—as a last resort—reassignment (perhaps to a different job in a place where it may be safer for the employee to work or that permits telework).

An employer may only bar an employee from working based on the direct threat analysis if, after going through all these steps, the facts support the conclusion that the employee poses a significant risk of substantial harm to the employee's own health or safety that cannot be reduced or eliminated by reasonable accommodation. For general information on reasonable accommodation under the ADA (i.e., where an individual's request for reasonable accommodation has nothing to do with potential direct threat concerns), see **Section D**.

G.5. What are examples of reasonable accommodation that, absent undue hardship, may eliminate (or reduce to an acceptable level) a direct threat to self or others? *(Updated 7/12/22)*

Reasonable accommodations that may eliminate (or reduce to an acceptable level) a direct threat to self or others may include additional or enhanced protective gowns, masks, gloves, or other gear beyond what the employer may generally provide to, or require from, employees returning to its workplace. Reasonable accommodations also may include additional or enhanced protective measures, such as High Efficiency Particulate Air (HEPA) filtration systems/units or other enhanced air filtration measures, erecting a barrier that provides separation between an employee with a disability and coworkers/the public, or increasing the space between an employee with a disability and others. Another possible reasonable accommodation may be elimination or substitution of particular "marginal" functions (less critical or incidental job duties as distinguished from the "essential" functions of a particular position). In addition, accommodations may include telework, modification of work schedules (if that decreases contact with coworkers and/or the public when on duty or commuting), or moving the location of where one performs work (for example, moving a person to the end of a production line rather than in the middle of it if that provides more physical distancing).

These are only a few ideas. Identifying an effective accommodation depends, among other things, on an employee's job duties and the design of the workspace. An employer and employee should discuss possible ideas; the Job Accommodation

Network (**www.askjan.org (http://www.askjan.org/)**) also may be able to assist in helping identify possible accommodations. As with all discussions of reasonable accommodation during this pandemic, employers and employees are encouraged to be creative and flexible. For general information on reasonable accommodation under the ADA, see **Section D**.

G.6. As a best practice, and in advance of having some or all employees return to the workplace, are there ways for an employer to invite employees to request flexibility in work arrangements? *(Updated 7/12/22)*

Yes. The ADA, the Rehabilitation Act, and Title VII of the Civil Rights Act do not prohibit employers from making information available in advance to **all** employees about whom to contact—if they wish—to request reasonable accommodation that they may need for a disability or a sincerely held religious belief, practice or observance upon return to the workplace. Once requests are received, the employer may begin the interactive process. An employer may choose to include in such a notice all medical conditions identified in **CDC guidance (https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html)** that may place people at higher risk of serious illness if they contract COVID-19, provide instructions about whom to contact, and explain that the employer is willing to consider on a case-by-case basis any requests from employees who have these or other medical conditions which may qualify as disabilities.

Alternatively, an employer may send a general notice explaining that the employer is willing to consider employee requests for reasonable accommodation for employees with a disability or a sincerely held religious belief, practice, or observance, or to consider flexibility on an individualized basis for employees not eligible for reasonable accommodation (e.g., employees who request flexibility due to age). The employer should specify if the point of contact is different depending on whether the request is based on disability, sincerely held religious beliefs, pregnancy, age, or child-care responsibilities.

Either approach is consistent with the Age Discrimination in Employment Act (ADEA), the ADA, the Rehabilitation Act, and Title VII.

Regardless of the approach, employers should ensure that those employees who receive, review, or process these requests are sufficiently trained in how to handle them in accordance with the federal employment nondiscrimination laws that may

apply, for instance, with respect to accommodations due to a disability or a sincerely held religious belief, observance, or practice; or a request related to pregnancy. For additional information on reasonable accommodation under the ADA/Rehabilitation Act, see **Section D**.

G.7. What should an employer do if an employee entering the worksite requests an alternative method of screening due to a medical condition? *(6/11/20)*

This is a request for reasonable accommodation, and an employer should proceed as it would for any other request for accommodation under the ADA or the Rehabilitation Act. If the requested change is easy to provide and inexpensive, the employer might voluntarily choose to make it available to anyone who asks, without going through an interactive process. Alternatively, if a disability is not obvious or already known, an employer may ask the employee for information to establish that the condition is a **disability (https://www.eeoc.gov/wysk/what-you-should-know-about-covid-19-and-ada-rehabilitation-act-and-other-eeo-laws#D.5)** and what specific limitations require an accommodation. If necessary, an employer also may request medical documentation to support the employee's request, and then determine if that accommodation or an alternative effective accommodation can be provided, absent undue hardship.

Similarly, if an employee requested an alternative method of screening as a religious accommodation, the employer should determine if accommodation is **available under Title VII (https://www.eeoc.gov/laws/guidance/questions-and-answers-religious-discrimination-workplace)**.

H. Age

H.1. CDC has explained (https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html) that the risk for severe illness with COVID-19 increases with age, with older adults at the highest risk. Do older adults have protections under the federal employment discrimination laws? *(Updated 7/12/22)*

Yes. The Age Discrimination in Employment Act (ADEA) prohibits employment discrimination against individuals age 40 and older. The ADEA would prohibit a covered employer from excluding an individual involuntarily from the workplace based on being older, even if the employer acted for benevolent reasons such as

protecting the employee due to higher risk of severe illness from COVID-19. For more information on postponing a start date or withdrawing a job offer due to older age, see **C.5**.

Unlike the ADA, the ADEA does not include a right to reasonable accommodation for workers due to age. However, employers are free to provide flexibility to older workers; the ADEA does not prohibit this, even if it results in younger workers being treated less favorably based on age in comparison.

Older workers also may have medical conditions that bring them under the protection of the ADA as individuals with disabilities. As such, they may request reasonable **accommodation for their disability (https://www.eeoc.gov/wysk/what-you-should-know-about-covid-19-and-ada-rehabilitation-act-and-other-eeo-laws#D.1)** .

H.2. If an employer is choosing to offer flexibilities to other workers, may older comparable workers be treated less favorably based on age? *(9/8/20; adapted from 3/27/20 Webinar Question 12)*

No. If an employer is allowing other comparable workers to telework, it should make sure it is not treating older workers less favorably based on their age.

I. Caregivers/Family Responsibilities

For additional information about pandemic-related caregiver discrimination under the laws enforced by the EEOC, see the EEOC's technical assistance document, **The COVID-19 Pandemic and Caregiver Discrimination Under Federal Employment Discrimination Laws. (https://www.eeoc.gov/laws/guidance/covid-19-pandemic-and-caregiver-discrimination-under-federal-employment)**

I.1. If an employer provides telework, modified schedules, or other benefits to employees with school-age children due to school closures or distance learning during the pandemic, are there sex discrimination considerations? *(3/14/22)*

Employers may provide any flexibilities as long as they are not treating employees differently based on sex or other EEO-protected characteristics. For example, under Title VII, female employees cannot be given more favorable treatment than male employees because of a gender-based assumption about who may have **caregiving**

responsibilities (https://www.eeoc.gov/laws/guidance/enforcement-guidance-unlawful-disparate-treatment-workers-caregiving-responsibilities) for children.

I.2. How might unlawful caregiver discrimination related to the COVID-19 pandemic arise under the laws enforced by the EEOC? *(3/14/22)*

Caregiver discrimination violates the laws enforced by the EEOC if it is based on an applicant's or employee's sex (including pregnancy, sexual orientation, or gender identity), race, national origin, disability, age (40 or older), or another **characteristic covered by federal employment discrimination laws (https://www.eeoc.gov/discrimination-type)**. Caregiver discrimination also is unlawful if it is based on the caregiver's association with an individual with a disability, or on the race, ethnicity, or other protected characteristic of the individual receiving care.

Caregiver discrimination related to the pandemic may arise in a variety of ways. For instance, under Title VII, employers may not discriminate against employees with pandemic-related caregiving responsibilities based on their sex, including gender stereotypes associated with caregiving responsibilities or roles. For example, employers may not decline to assign female employees with caregiving responsibilities demanding or high-profile projects that increase employees' advancement potential but require significant overtime or travel. Likewise, employers may not reassign such projects to other employees based on assumptions that female caregivers cannot, should not, or would not want to work extra hours or be away from their families if a family member is infected with or exposed to COVID-19. Employers also may not deny male employees permission to telework or to adjust their schedules to enable them to perform pandemic-related caregiving obligations, such as caring for young children or parents, while granting such requests when made by similarly situated female employees.

Title VII also prohibits employers from discriminating against employees with pandemic-related caregiving duties based on their race or national origin. For example, employers may not require more burdensome processes for employees of a certain race or national origin who are requesting schedule changes or leave related to COVID-19 caregiving. Employers also may not deny such requests more frequently, or penalize employees for requesting or receiving schedule changes or leave for caregiving purposes, based on employees' race or national origin. Discrimination based on citizenship or immigration status against workers with caregiving responsibilities also can be unlawful under a law enforced by the

Department of Justice (https://www.justice.gov/crt/immigrant-and-employee-rights-section) .

Under the ADA, employers may not discriminate against workers based on stereotypes or assumptions about workers' caregiving responsibilities for an individual with a disability, such as a child, spouse, or parent with a disability. For example, if an applicant is the primary caregiver of an individual with a disability who is at higher risk of complications from COVID-19, an employer may not refuse to hire the applicant out of fear that the care recipient will increase the employer's healthcare costs. If the applicant is hired, the employer may not refuse to allow the care recipient to be added as a dependent on the employer's health insurance because of that individual's disability. An employer also may not refuse to promote employees with caregiving responsibilities for an individual with a disability based on the assumption that they will take a significant amount of leave for caregiving purposes.

I.3. Are these legal protections available only to workers caring for children, or are they also available to workers with other caregiving obligations? *(3/14/22)*

This response includes hyperlinks to non-governmental sources. The EEOC includes these resources solely for informational purposes. The EEOC does not endorse these resources or the entities responsible for them, and it does not vouch for the accuracy of the information provided by referencing the non-governmental sources in this response.

Employers may not discriminate against applicants or employees with caregiving responsibilities based on characteristics protected by the laws enforced by the EEOC, including caregivers' sex (including pregnancy, sexual orientation, or gender identity), race, color, religion, national origin, age (40 or older), disability, association with an individual with a disability, or genetic information (including family medical history). These protections are available to workers with any type of caregiving responsibilities, including care for children, spouses, partners, relatives, individuals with disabilities, or others.

State or local laws may provide additional protections for workers with caregiving responsibilities. Employees with caregiving responsibilities also may have rights under other laws, including the **Family and Medical Leave Act (https://www.dol.gov/agencies/whd/fmla)** or similar **state**

(https://www.ncsl.org/research/labor-and-employment/state-family-and-medical-leave-laws.aspx) or local laws.

I.4. Should employers and employees be aware of any other pandemic-related caregiver discrimination issues? *(3/14/22)*

Yes. In this What You Should Know document, the EEOC addresses several different types of potential pandemic-related caregiver discrimination. For example:

- **A.10** addresses employer inquiries about family members with COVID-19 or related symptoms.
- **C.5** addresses employer-imposed start date postponements or offer withdrawals for pregnant applicants.
- **D.13** addresses whether employees are entitled to accommodations to avoid exposing family members at high risk of complications from COVID-19.
- **J.1** and **J.2** address excluding employees from the workplace based on pregnancy and accommodating pregnancy.
- **K.2** addresses pregnancy accommodation requests related to vaccination.
- **K.3** addresses employer encouragement of vaccination of family members.
- **K.13** addresses decisions not to be vaccinated due to pregnancy.
- **K.18** addresses GINA and incentives for non-employer-provided family member vaccinations or employer requests for documentation of family member vaccinations.
- **K.20** addresses GINA and incentives for employer-provided family member vaccinations.
- **K.21** addresses GINA and family member vaccinations without incentives.

For general information about caregiver discrimination and federal employment discrimination laws, see the EEOC's **policy guidance (https://www.eeoc.gov/laws/guidance/enforcement-guidance-unlawful-disparate-treatment-workers-caregiving-responsibilities)**, associated **fact sheet (https://www.eeoc.gov/questions-and-answers-about-eeocs-enforcement-guidance-unlawful-disparate-treatment-workers)**, and **best practices**

(https://www.eeoc.gov/laws/guidance/employer-best-practices-workers-caregiving-responsibilities) document.

J. Pregnancy

J.1. Due to the pandemic, may an employer exclude an employee from the workplace involuntarily due to pregnancy (https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/pregnancy-breastfeeding.html) ? *(6/11/20)*

No. Sex discrimination under Title VII of the Civil Rights Act includes discrimination based on pregnancy. Even if motivated by benevolent concern, an employer is not permitted to single out workers on the basis of pregnancy for adverse employment actions, including involuntary leave, layoff, or furlough. For more information on postponing a start date or withdrawing a job offer due to pregnancy, see **C.5**.

J.2. Is there a right to accommodation based on pregnancy during the pandemic? *(6/11/20)*

There are two federal employment discrimination laws that may trigger **accommodation for employees based on pregnancy (https://www.eeoc.gov/laws/guidance/legal-rights-pregnant-workers-under-federal-law)** .

First, pregnancy-related medical conditions may themselves be disabilities under the ADA, even though pregnancy itself is not an ADA disability. If an employee makes a request for reasonable accommodation due to a pregnancy-related medical condition, the employer must consider it under the usual ADA rules.

Second, Title VII as amended by the Pregnancy Discrimination Act specifically requires that women affected by pregnancy, childbirth, and related medical conditions be treated the same as others who are similar in their ability or inability to work. This means that a pregnant employee may be entitled to job modifications, including telework, changes to work schedules or assignments, and leave to the extent provided for other employees who are similar in their ability or inability to work. Employers should ensure that supervisors, managers, and human resources personnel know how to handle such requests to avoid disparate treatment in

violation of Title VII. For information on pregnancy and COVID-19 vaccination, see **K.13**.

K. Vaccinations – Overview, ADA, Title VII, and GINA

Note: Court decisions upholding or rejecting federal vaccination requirements do not affect any statements made in this publication regarding employer and employee rights and responsibilities under the equal employment opportunity laws with respect to employers that require COVID-19 vaccinations.

The availability of COVID-19 vaccinations raises questions under the federal equal employment opportunity (EEO) laws, including the Americans with Disabilities Act (ADA), the Rehabilitation Act, the Genetic Information Nondiscrimination Act (GINA), and Title VII of the Civil Rights Act, as amended, inter alia, by the Pregnancy Discrimination Act (Title VII) (see also ***Section J, EEO rights relating to pregnancy*** and **Section L, Vaccinations – Title VII Religious Objections to COVID-19 Vaccine Requirements**.*)*

This section was originally issued on December 16, 2020, and was updated on October 25, 2021. Note that the Centers for Disease Control and Prevention (CDC) has ***issued guidance (https://www.cdc.gov/coronavirus/2019-ncov/vaccines/fully-vaccinated.html)*** *for fully vaccinated individuals that addresses, among other things, when they need to wear a mask indoors.*

The EEOC has received many inquiries from employers and employees about the type of authorization granted by the U.S. Department of Health and Human Services (HHS) Food and Drug Administration (FDA) for the administration of COVID-19 vaccines. On August 23, 2021, the FDA approved the Biologics License Application for the Pfizer-BioNTech COVID-19 vaccine for use in individuals 16 years of age and older. Previously, the FDA granted Emergency Use Authorizations (EUAs) for the two other vaccines—one made by Moderna and the other by Janssen/Johnson & Johnson—authorizing them for use in the United States for individuals 18 years of age and older. The Pfizer-BioNTech vaccine is authorized under an EUA for individuals 12 years of age and older and for the administration of a ***third dose (https://www.cdc.gov/coronavirus/2019-ncov/vaccines/booster-shot.html)*** *in certain immunocompromised individuals.* For the current status of vaccines

authorized or approved by the FDA, please visit: **https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html (https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html)**

Also of note, on July 6, 2021, the U.S. Department of Justice's Office of Legal Counsel issued a Memorandum Opinion concluding that section 564 of the Federal Food, Drug, and Cosmetic Act does not prohibit public or private entities from imposing vaccination requirements for a vaccine that is subject to an EUA.

Other federal, state, and local laws and regulations govern COVID-19 vaccination of employees, including requirements for the federal government as an employer. The federal government as an employer is subject to the EEO laws. Federal departments and agencies should consult the website of the ***Safer Federal Workforce Task Force (https://www.saferfederalworkforce.gov/)*** *for the latest guidance on federal agency operations during the COVID-19 pandemic.*

This technical assistance on vaccinations was written to help employees and employers better understand how federal laws related to workplace discrimination apply during the COVID-19 pandemic. The EEOC questions and answers provided here set forth applicable EEO legal standards consistent with the federal civil rights laws enforced by the EEOC and with EEOC regulations, guidance, and technical assistance, unless another source is expressly cited. In addition, whether an employer meets the EEO standards will depend on the application of these standards to particular factual situations.

COVID-19 Vaccinations: EEO Overview

K.1. Under the ADA, Title VII, and other federal employment nondiscrimination laws, may an employer require all employees to be vaccinated against COVID-19? *(Updated 7/12/22)*

The federal EEO laws do not prevent an employer from requiring all employees to be vaccinated against COVID-19, subject to the **reasonable accommodation provisions of Title VII and the ADA and other EEO considerations discussed below (https://www.eeoc.gov/wysk/what-you-should-know-about-covid-19-and-ada-rehabilitation-act-and-other-eeo-laws#K.5)**. (See also **Section L, Vaccinations – Title VII Religious Objections to COVID-19 Vaccine Requirements (https://www.eeoc.gov/wysk/what-you-should-know-about-covid-19-and-ada-**

rehabilitation-act-and-other-eeo-laws#L)). If there is such an employer requirement, the EEO laws do not prevent employers from requiring documentation or other confirmation that employees are **up to date (https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html)** on their vaccinations (**see K.9**.), but the EEO laws may require employers to make exceptions to a vaccination requirement for some employees.

The ADA and Title VII require an employer to provide reasonable accommodations for employees who, because of a disability or a sincerely held religious belief, practice, or observance, do not get vaccinated against COVID-19, unless providing an accommodation would pose an undue hardship on the operation of the employer's business. The analysis for undue hardship depends on whether the accommodation is for a disability (including pregnancy-related conditions that constitute a disability) (**see K.6**.) or for religion (**see K.12**.).

As with any employment policy, employers that have a vaccination requirement may need to respond to allegations that the requirement has a disparate impact on —or disproportionately excludes—employees based on their race, color, religion, sex, or national origin under Title VII (or age under the Age Discrimination in Employment Act [40+]). Employers should keep in mind that because some individuals or demographic groups may face barriers to receiving a COVID-19 vaccination, some employees may be more likely to be negatively impacted by a vaccination requirement.

It would also be unlawful to apply a vaccination requirement to employees in a way that treats employees differently based on disability, race, color, religion, sex (including pregnancy, sexual orientation, and gender identity), national origin, age, or genetic information, unless there is a legitimate non-discriminatory reason.

K.2. What are some examples of reasonable accommodations or modifications that employers may have to provide to employees who do not get vaccinated due to disability; religious beliefs, practices, or observance; or pregnancy? *(5/28/21)*

An employee who does not get vaccinated due to a disability (covered by the ADA) or a sincerely held religious belief, practice, or observance (covered by Title VII) may be entitled to a reasonable accommodation that does not pose an undue hardship on the operation of the employer's business. For example, as a reasonable accommodation, an unvaccinated employee entering the workplace might wear a

face mask, work at a social distance from coworkers or non-employees, work a modified shift, get periodic tests for COVID-19, be given the opportunity to telework, or finally, accept a reassignment.

Employees who are not vaccinated because of pregnancy may be entitled (under Title VII) to adjustments to keep working, if the employer makes modifications or exceptions for other employees. These modifications may be the same as the accommodations made for an employee based on disability or religion.

K.3. How can employers encourage employees and their family members to be vaccinated against COVID-19 without violating the EEO laws, especially the ADA and GINA? *(Updated 10/13/21)*

Employers may provide employees and their family members with information to educate them about COVID-19 vaccines, raise awareness about the benefits of vaccination, and address common questions and concerns. Employers also may work with local public health authorities, medical providers, or pharmacies to make vaccinations available for unvaccinated workers in the workplace. Also, under certain circumstances employers may offer incentives to employees who receive COVID-19 vaccinations, as discussed in K.16 - K.21. The federal government is providing COVID-19 vaccines at no cost to everyone 5 years of age and older.

There are many resources available to employees seeking more information about how to get vaccinated against COVID-19:

- The federal government's online **vaccines.gov (https://www.vaccines.gov/)** site can identify vaccination sites anywhere in the country (or **https://www.vacunas.gov (https://www.vacunas.gov)** for Spanish). Individuals also can text their ZIP code to "GETVAX" (438829)–or "VACUNA" (822862) for Spanish–to find three vaccination locations near them.
- Employees with disabilities (or employees' family members with disabilities) may need extra support to obtain a vaccination, such as transportation or in-home vaccinations. The HHS/Administration for Community Living has launched the Disability Information and Assistance Line (DIAL) to assist individuals with disabilities in obtaining such help. DIAL can be reached at: 888-677-1199 from 9 am to 8 pm (Eastern Standard Time) Mondays through Fridays or by emailing **DIAL@n4a.org**.

- CDC's website offers a link to a listing of **local health departments (https://www.cdc.gov/publichealthgateway/healthdirectories/index.html)**, which can provide more information about local vaccination efforts.
- In addition, CDC provides a complete communication "tool kit" for employers to use with their workforce to educate people about getting a COVID-19 vaccine. Although originally written for essential workers and employers, it is useful for all workers and employers. *See* **Workplace Vaccination Program | CDC (https://www.cdc.gov/coronavirus/2019-ncov/vaccines/recommendations/essentialworker/workplace-vaccination-program.html)**.
- Some employees may not have reliable access to the internet to identify nearby vaccination locations or may speak no English or have limited English proficiency and find it difficult to make an appointment for a vaccination over the phone. CDC operates a toll-free telephone line that can provide assistance in many languages for individuals seeking more information about vaccinations: 800-232-4636; TTY 888-232-6348.
- Some employees also may require assistance with transportation to vaccination sites. Employers may gather and disseminate information to their employees on low-cost and no-cost transportation resources serving vaccination sites available in their community and offer paid time-off for vaccination, particularly if transportation is not readily available outside regular work hours.
- Employers should provide the contact information of a management representative for employees who need to request a reasonable accommodation for a disability or religious belief, practice, or observance, or to ensure nondiscrimination for an employee who is pregnant.

The ADA and COVID-19 Vaccinations

K.4. Is information about an employee's COVID-19 vaccination confidential medical information under the ADA? *(Updated 7/12/22)*

Yes. The ADA requires an employer to maintain the confidentiality of employee medical information. Although the EEO laws do not prevent employers from requiring employees to provide documentation or other confirmation of

vaccination, this information, like all medical information, must be kept confidential and stored separately from the employee's personnel files under the ADA.

An employer may share confidential medical information, such as confirmation of employee vaccinations (or COVID-19 test results), with employees who need it to perform their job duties. However, such employees also must keep the information confidential. Some possible scenarios include:

- An administrative employee assigned to perform recordkeeping of employees' documentation of vaccination may receive needed access to the information for this purpose but must keep this information confidential.
- An employee assigned to permit building entry only by employees who are in compliance with a work restriction, such as COVID-19 vaccinations, testing, and/or masking, should only receive a list of the individuals who may (or may not) enter, but not any confidential medical information about why they are on (or not on) the list.
- An employee tasked to ensure compliance with a testing requirement for employees would need to review testing documentation submitted by those employees but must keep that testing information confidential.

Mandatory Employer Vaccination Programs

K.5. May an employer require an employee to comply with a COVID-19 vaccination requirement applicable to all employees entering the workplace if that employee has sought an exemption based on disability? *(Updated 7/12/22)*

Under the ADA, an employer may require an individual with a disability to meet a qualification standard applied to all employees, such as a safety-related standard requiring COVID-19 vaccination, if the standard is job-related and consistent with business necessity as applied to that employee. An employer does not have to show that a qualification standard in general (i.e., as applied to all employees) meets the "business necessity" standard. Under the ADA it must satisfy this standard only as applied to an employee who informs the employer that a disability prevents compliance. If a particular employee cannot meet such a safety-related qualification standard because of a disability, the employer may not require compliance for that employee unless it can demonstrate that the individual would pose a "direct threat" to the health or safety of the employee or others while performing their job. A "direct threat" is a "significant risk of substantial harm" that

cannot be eliminated or reduced by reasonable accommodation. **29 C.F.R. 1630.2(r) (https://www.govinfo.gov/content/pkg/CFR-2012-title29-vol4/xml/CFR-2012-title29-vol4-sec1630-2.xml)**. This determination can be broken down into two steps: determining if there is a "significant risk of substantial harm" and, if there is, assessing whether a reasonable accommodation would reduce or eliminate the threat.

To determine if an employee who is not vaccinated due to a disability poses a "direct threat" in the workplace, an employer first must make an individualized assessment of the employee's present ability to safely perform the essential functions of the job. The factors that make up this assessment are: (1) the duration of the risk; (2) the nature and severity of the potential harm; (3) the likelihood that the potential harm will occur; and (4) the imminence of the potential harm. The determination that a particular employee poses a direct threat should be based on a reasonable medical judgment that relies on the most current medical knowledge about COVID-19. Such medical knowledge may include, for example, the level of community spread at the time of the assessment. Statements from the CDC provide an important source of current medical knowledge about COVID-19, and the employee's health care provider, with the employee's consent, also may provide useful information about the employee. Additionally, the assessment of direct threat should take account of the type of work environment, such as: whether the employee works alone or with others or works inside or outside; the available ventilation; the frequency and duration of direct interaction the employee typically will have with other employees and/or non-employees; the number of partially or fully vaccinated individuals already in the workplace; whether other employees are wearing masks or undergoing routine screening testing; and the space available for social distancing.

If the assessment demonstrates that an employee with a disability who is not vaccinated would pose a direct threat to self or others, the employer must consider whether providing a reasonable accommodation, absent undue hardship, would reduce or eliminate that threat. Potential reasonable accommodations could include requiring the employee to wear a mask, work a staggered shift, making changes in the work environment (such as improving ventilation systems or limiting contact with other employees and non-employees), permitting telework if feasible, or reassigning the employee to a vacant position in a different workspace.

As a best practice, an employer introducing a COVID-19 vaccination policy and requiring documentation or other confirmation of vaccination should notify all employees that the employer will consider requests for reasonable accommodation based on disability on an individualized basis. (See also **K.12** recommending the same best practice for religious accommodations.)

K.6. Under the ADA, if an employer requires COVID-19 vaccinations for employees physically entering the workplace, how should an employee who does not get a COVID-19 vaccination because of a disability inform the employer, and what should the employer do? *(Updated 5/28/21)*

An employee with a disability who does not get vaccinated for COVID-19 because of a disability must let the employer know that the employee needs an exemption from the requirement or a change at work, known as a reasonable accommodation. To request an accommodation, an individual does not need to mention the ADA or use the phrase "reasonable accommodation."

Managers and supervisors responsible for communicating with employees about compliance with the employer's vaccination requirement should know **how to recognize an accommodation request from an employee with a disability (https://www.eeoc.gov/laws/guidance/enforcement-guidance-reasonable-accommodation-and-undue-hardship-under-ada#requesting)** and know to whom to refer the request for full consideration. As a best practice, before instituting a mandatory vaccination policy, employers should provide managers, supervisors, and those responsible for implementing the policy with clear information about how to handle accommodation requests related to the policy.

Employers and employees typically engage in a flexible, interactive process to identify **workplace accommodation options** that do not impose an undue hardship (significant difficulty or expense) on the employer. This process may include determining whether it is necessary to obtain supporting medical documentation about the employee's disability.

In discussing accommodation requests, employers and employees may find it helpful to consult the **Job Accommodation Network (JAN) website (https://www.askjan.org)** as a resource for different types of accommodations. JAN's materials about COVID-19 are available at **https://askjan.org/topics/COVID-19.cfm (https://askjan.org/topics/COVID-19.cfm)** .

Employers also may consult applicable **Occupational Safety and Health Administration (OSHA) COVID-specific resources (https://www.osha.gov/SLTC/covid-19/)**. Even if there is no reasonable accommodation that will allow the unvaccinated employee to be physically present to perform the employee's current job without posing a direct threat, the employer must consider if telework is an option for that particular job as an accommodation and, as a last resort, whether reassignment to another position is possible.

The ADA requires that employers offer an available accommodation if one exists that does not pose an undue hardship, meaning a significant difficulty or expense. See 29 C.F.R. 1630.2(p). Employers are advised to consider all the options before denying an accommodation request. The proportion of employees in the workplace who already are partially or fully vaccinated against COVID-19 and the extent of employee contact with non-employees, who may be ineligible for a vaccination or whose vaccination status may be unknown, can impact the ADA undue hardship consideration. Employers may rely on **CDC recommendations (https://www.cdc.gov/coronavirus/2019-ncov/)** when deciding whether an effective accommodation is available that would not pose an undue hardship.

Under the ADA, it is unlawful for an employer **to disclose that an employee is receiving a reasonable accommodation (https://www.eeoc.gov/laws/guidance/enforcement-guidance-reasonable-accommodation-and-undue-hardship-under-ada#li42)** or **to retaliate against an employee for requesting an accommodation (https://www.eeoc.gov/laws/guidance/enforcement-guidance-reasonable-accommodation-and-undue-hardship-under-ada#li19)**.

K.7. If an employer requires employees to get a COVID-19 vaccination from the employer or its agent, do the ADA's restrictions on an employer making disability-related inquiries or medical examinations of its employees apply to any part of the vaccination process? *(Updated 5/28/21)*

Yes. The ADA's restrictions apply to the screening questions that must be asked immediately prior to administering the vaccine if the vaccine is administered by the employer or its agent. An **employer's agent (https://www.eeoc.gov/laws/guidance/section-2-threshold-issues#2-III-B-2)** is an individual or entity having the authority to act on behalf of, or at the direction of, the employer.

The ADA generally restricts when employers may require medical examinations (procedures or tests that seek information about an individual's physical or mental impairments or health) or make disability-related inquiries (questions that are likely to elicit information about an individual's disability). The act of administering the vaccine is not a "medical examination" under the ADA because it does not seek information about the employee's physical or mental health.

However, because the pre-vaccination screening questions are likely to elicit information about a disability, the ADA requires that they must be "job related and consistent with business necessity" when an employer or its agent administers the COVID-19 vaccine. To meet this standard, an employer would need to have a reasonable belief, based on objective evidence, that an employee who does not answer the questions and, therefore, cannot be vaccinated, will pose a direct threat to the employee's own health or safety or to the health and safety of others in the workplace. (See general discussion in **Question K.5**.) Therefore, when an employer requires that employees be vaccinated by the employer or its agent, the employer should be aware that an employee may challenge the mandatory pre-vaccination inquiries, and an employer would have to justify them under the ADA.

The ADA also requires employers to keep any employee medical information obtained in the course of an employer vaccination program confidential.

Voluntary Employer Vaccination Programs

K.8. Under the ADA, are there circumstances in which an employer or its agent may ask disability-related screening questions before administering a COVID-19 vaccine *without* needing to satisfy the "job-related and consistent with business necessity" standard? *(Updated 5/28/21)*

Yes. If the employer offers to vaccinate its employees on a voluntary basis, meaning that employees can choose whether or not to get the COVID-19 vaccine from the employer or its agent, the employer does not have to show that the pre-vaccination screening questions are job-related and consistent with business necessity. However, the employee's decision to answer the questions must be voluntary. (See also Questions **K.16 – 17**.) The ADA prohibits taking an adverse action against an employee, including harassing the employee, for refusing to participate in a voluntary employer-administered vaccination program. An employer also must keep any medical information it obtains from any voluntary vaccination program confidential.

K.9. Does the ADA prevent an employer from inquiring about or requesting documentation or other confirmation that an employee obtained a COVID-19 vaccination? *(Updated 10/13/21)*

No. When an employer asks employees whether they obtained a COVID-19 vaccination, the employer is not asking the employee a question that is likely to disclose the existence of a disability; there are many reasons an employee may not show documentation or other confirmation of vaccination besides having a disability. Therefore, requesting documentation or other confirmation of vaccination is not a disability-related inquiry under the ADA, and the ADA's rules about making such inquiries do not apply.

However, documentation or other confirmation of vaccination provided by the employee to the employer is medical information about the employee and must be kept confidential, as discussed in K.4.

K.10. May an employer offer voluntary vaccinations only to certain groups of employees? *(5/28/21)*

If an employer or its agent offers voluntary vaccinations to employees, the employer must comply with federal employment nondiscrimination laws. For example, not offering voluntary vaccinations to certain employees based on national origin or another protected basis under the EEO laws would not be permissible.

K.11. What should an employer do if an employee who is fully vaccinated for COVID-19 requests accommodation for an underlying disability because of a continuing concern that the employee faces a heightened risk of severe illness from a COVID-19 infection, despite being vaccinated? *(5/28/21)*

Employers who receive a reasonable accommodation request from an employee should process the request in accordance with applicable ADA standards.

When an employee asks for a reasonable accommodation, whether the employee is fully vaccinated or not, the employer should engage in an interactive process to determine if there is a disability-related need for reasonable accommodation. This process typically includes seeking information from the employee's health care provider with the employee's consent explaining why an accommodation is needed.

For example, some individuals who are immunocompromised might still need reasonable accommodations because their conditions may mean that the vaccines may not offer them the same measure of protection as other vaccinated individuals. If there is a disability-related need for accommodation, an employer must explore potential reasonable accommodations that may be provided absent undue hardship.

Title VII and COVID-19 Vaccinations

K.12. Under Title VII, how should an employer respond to employees who communicate that they are unable to be vaccinated for COVID-19 (or provide documentation or other confirmation of vaccination) because of a sincerely held religious belief, practice, or observance? (*Updated 5/28/21*)

Once an employer is on notice that an employee's sincerely held religious belief, practice, or observance prevents the employee from getting a COVID-19 vaccine, the employer must provide a reasonable accommodation unless it would pose an undue hardship. Employers also may receive religious accommodation requests from individuals who wish to wait until an alternative version or specific brand of COVID-19 vaccine is available to the employee. Such requests should be processed according to the same standards that apply to other accommodation requests. For more information on requests for religious accommodations related to COVID-19 vaccination requirements, see **Section L, Vaccinations – Title VII Religious Objections to COVID-19 Vaccine Requirements**.

EEOC guidance explains that the definition of religion is broad and protects beliefs, practices, and observances with which the employer may be unfamiliar. Therefore, the employer should ordinarily assume that an employee's request for religious accommodation is based on a sincerely held religious belief, practice, or observance. However, if an employee requests a religious accommodation, and an employer is aware of facts that provide an objective basis for questioning either the religious nature or the sincerity of a particular belief, practice, or observance, the employer would be justified in requesting additional supporting information. See also 29 CFR 1605.

Under Title VII, an employer should thoroughly consider all possible reasonable accommodations, including telework and reassignment. For suggestions about types of reasonable accommodation for unvaccinated employees, see **question and**

answer K.6., above. In many circumstances, it may be possible to accommodate those seeking reasonable accommodations for their religious beliefs, practices, or observances.

Under Title VII, courts define "undue hardship" as having more than minimal cost or burden on the employer. This is an easier standard for employers to meet than the ADA's undue hardship standard, which applies to requests for accommodations due to a disability. Considerations relevant to undue hardship can include, among other things, the proportion of employees in the workplace who already are partially or fully vaccinated against COVID-19 and the extent of employee contact with non-employees, whose vaccination status could be unknown or who may be ineligible for the vaccine. Ultimately, if an employee cannot be accommodated, employers should determine if any other rights apply under the EEO laws or other federal, state, and local authorities before taking adverse employment action against an unvaccinated employee

K.13. Under Title VII, what should an employer do if an employee chooses not to receive a COVID-19 vaccination due to pregnancy? *(Updated 10/13/21)*

CDC recommends (https://emergency.cdc.gov/han/2021/han00453.asp) COVID-19 vaccinations for everyone aged 12 years and older, including people who are pregnant, breastfeeding, trying to get pregnant now, or planning to become pregnant in the future. Despite these recommendations, some pregnant employees may seek job adjustments or may request exemption from a COVID-19 vaccination requirement.

If an employee seeks an exemption from a vaccination requirement due to pregnancy, the employer must ensure that the employee is not being discriminated against compared to other employees similar in their ability or inability to work. This means that a pregnant employee may be entitled to job modifications, including telework, changes to work schedules or assignments, and leave to the extent such modifications are provided for other employees who are similar in their ability or inability to work. Employers should ensure that supervisors, managers, and human resources personnel know how to handle such requests to avoid **disparate treatment in violation of Title VII**.

GINA And COVID-19 Vaccinations

Title II of GINA prohibits covered employers from using the genetic information of employees to make employment decisions. It also restricts employers from requesting, requiring, purchasing, or disclosing genetic information of employees. Under Title II of GINA, genetic information includes information about the manifestation of disease or disorder in a family member (which is referred to as "family medical history") and information from genetic tests of the individual employee or a family member, among other things.

K.14. Is Title II of GINA implicated if an employer requires an employee to receive a COVID-19 vaccine administered by the employer or its agent? *(Updated 5/28/21)*

No. Requiring an employee to receive a COVID-19 vaccination administered by the employer or its agent would not implicate Title II of GINA unless the pre-vaccination medical screening questions include questions about the employee's genetic information, such as asking about the employee's family medical history. As of May 27, 2021, the pre-vaccination medical screening questions for the first three COVID-19 vaccines to receive Emergency Use Authorization (EUA) from the FDA do not seek family medical history or any other type of genetic information. See **CDC's Pre-vaccination Checklist (https://www.cdc.gov/vaccines/covid-19/downloads/pre-vaccination-screening-form.pdf)** (last visited May 27, 2021). Therefore, an employer or its agent may ask these questions without violating Title II of GINA.

The act of administering a COVID-19 vaccine does not involve the use of the employee's genetic information to make employment decisions or the acquisition or disclosure of genetic information and, therefore, does not implicate Title II of GINA.

K.15. Is Title II of GINA implicated when an employer requires employees to provide documentation or other confirmation that they received a vaccination from a health care provider *that is not affiliated with their employer* (such as from the employee's personal physician or other health care provider, a pharmacy, or a public health department)? *(Updated 10/13/21)*

No. An employer requiring an employee to show documentation or other confirmation of vaccination from a health care provider unaffiliated with the employer, such as the employee's personal physician or other health care provider, a pharmacy, or a public health department, is not using, acquiring, or disclosing genetic information and, therefore, is not implicating Title II of GINA. This is the

case even if the medical screening questions that must be asked before vaccination include questions about genetic information, because documentation or other confirmation of vaccination would not reveal genetic information. Title II of GINA does not prohibit an employee's *own* health care provider from asking questions about genetic information. This GINA Title II prohibition only applies to the employer or its agent.

Employer Incentives For COVID-19 Voluntary Vaccinations Under ADA and GINA

ADA: Employer Incentives for Voluntary COVID-19 Vaccinations

K.16. Does the ADA limit the value of the incentive employers may offer to employees for voluntarily receiving a COVID-19 vaccination from a health care provider *that is not affiliated with their employer* (such as the employee's personal physician or other health care provider, a pharmacy, or a public health department)? *(Updated 7/12/22)*

No. The ADA does not limit the incentives (which includes both rewards and penalties) an employer may offer to encourage employees to voluntarily receive a COVID-19 vaccination, or to provide confirmation of vaccination, if the health care provider administering a COVID-19 vaccine *is not the employer or its agent*. By contrast, if an employer offers an incentive to employees to voluntarily receive a vaccination *administered by the employer or its agent*, the ADA's rules on disability-related inquiries apply and the value of the incentive may not be so substantial as to be coercive. See K.17.

As noted in K 4., the employer is required to keep vaccination information confidential under the ADA.

K.17. Under the ADA, are there limits on the value of the incentive employers may offer to employees for voluntarily receiving a COVID-19 vaccination *administered by the employer or its agent*? *(Updated 10/13/21)*

Yes. When the employer or its agent administers a COVID-19 vaccine, the value of the incentive (which includes both rewards and penalties) may not be so substantial as to be coercive. Because vaccinations require employees to answer pre-vaccination disability-related screening questions, a very large incentive could make employees feel pressured to disclose protected medical information to their

employers or their agents. As explained in K.16., however, this incentive limit does not apply if an employer offers an incentive to encourage employees to be voluntarily vaccinated by a health care provider that is not their employer or an agent of their employer.

GINA: Employer Incentives for Voluntary COVID-19 Vaccinations

K.18. Does GINA limit the value of the incentive employers may offer employees if employees or their family members get a COVID-19 vaccination from a health care provider *that is not affiliated with the employer* (such as the employee's personal physician or other health care provider, a pharmacy, or a public health department)? (*Updated 10/13/21*)

No. GINA does not limit the incentives an employer may offer to employees to encourage them or their family members to get a COVID-19 vaccine or provide confirmation of vaccination if the health care provider administering the vaccine is not the employer or its agent. If an employer asks an employee to show documentation or other confirmation that the employee or a family member has been vaccinated, it is not an unlawful request for genetic information under GINA because the fact that someone received a vaccination is not information about the manifestation of a disease or disorder in a family member (known as "family medical history" under GINA), nor is it any other form of genetic information. GINA's restrictions on employers acquiring genetic information (including those prohibiting incentives in exchange for genetic information), therefore, do not apply.

K.19. Under GINA, may an employer offer an incentive to employees in exchange for the employee getting vaccinated by the employer or its agent? *(5/28/21)*

Yes. Under GINA, as long as an employer does not acquire genetic information while administering the vaccines, employers may offer incentives to employees for getting vaccinated. Because the pre-vaccination medical screening questions for the three COVID-19 vaccines now available do not inquire about genetic information, employers may offer incentives to their employees for getting vaccinated. See **K.14** for more about GINA and pre-vaccination medical screening questions.

K.20. Under GINA, may an employer offer an incentive to an employee in return for an employee's *family member* getting vaccinated by the employer or its agent? *(5/28/21)*

No. Under GINA's Title II health and genetic services provision, an employer may not offer any incentives to an employee in exchange for a family member's receipt of a vaccination from an employer or its agent. Providing such an incentive to an employee because a family member was vaccinated by the employer or its agent would require the vaccinator to ask the family member the pre-vaccination medical screening questions, which include medical questions about the family member. Asking these medical questions would lead to the employer's receipt of genetic information in the form of family medical history *of the employee*. The regulations implementing Title II of GINA prohibit employers from providing incentives in exchange for genetic information. Therefore, the employer may not offer incentives in exchange for the family member getting vaccinated. However, employers may still offer an employee's family member the opportunity to be vaccinated by the employer or its agent, if they take certain steps to ensure GINA compliance.

K.21. Under GINA, may an employer offer an employee's family member an opportunity to be vaccinated *without* offering the employee an incentive? *(5/28/21)*

Yes. GINA permits an employer to offer vaccinations to an employee's family members if it takes certain steps to comply with GINA. Employers must not require employees to have their family members get vaccinated and must not penalize employees if their family members decide not to get vaccinated. Employers must also ensure that all medical information obtained from family members during the screening process is only used for the purpose of providing the vaccination, is kept confidential, and is not provided to any managers, supervisors, or others who make employment decisions for the employees. In addition, employers need to ensure that they obtain prior, knowing, voluntary, and written authorization from the family member before the family member is asked any questions about the family member's medical conditions. If these requirements are met, GINA permits the collection of genetic information.

L. Vaccinations – Title VII Religious Objections to COVID-19 Vaccine Requirements

The EEOC enforces Title VII of the Civil Rights Act of 1964 (Title VII), which prohibits employment discrimination based on religion. This includes a right for job applicants and employees to request an exception, called a religious or reasonable accommodation, from an employer requirement that conflicts with their sincerely held religious beliefs, practices, or observances. If an employer shows that it cannot reasonably accommodate an employee's religious beliefs, practices, or observances without undue hardship on its operations, the employer is not required to grant the accommodation. *See generally* **Section 12: Religious Discrimination (https://www.eeoc.gov/laws/guidance/section-12-religious-discrimination#h_71848579934051610749830452)** ; EEOC **Guidelines on Discrimination Because of Religion (https://www.govinfo.gov/content/pkg/CFR-2016-title29-vol4/xml/CFR-2016-title29-vol4-part1605.xml)** . Although other laws, such as the Religious Freedom Restoration Act, also may protect religious freedom in some circumstances, this technical assistance only describes employment rights and obligations under Title VII.

L.1. Do employees who have a religious objection to receiving a COVID-19 vaccination need to tell their employer? If so, is there specific language that must be used under Title VII? *(3/1/22)*

Employees must tell their employer if they are requesting an exception to a COVID-19 vaccination requirement because of a conflict between that requirement and their sincerely held religious beliefs, practices, or observances. Under Title VII, this is called a request for a "religious accommodation" or a "reasonable accommodation."

When making the request, employees do not need to use any "magic words," such as "religious accommodation" or "Title VII." However, they need to explain the conflict and the religious basis for it.

The same principles apply if employees have a religious conflict with getting a particular vaccine and wish to wait until an alternative version or specific brand of COVID-19 vaccine is available to them. *See* Introduction to Section K, above.

As a best practice, an employer should provide employees and applicants with information about whom to contact and the proper procedures for requesting a religious accommodation.

As an example, here is how ***EEOC designed its own form for its own workplace (https://www.eeoc.gov/sites/default/files/2021-10/EEOC%20Religious%20Accommodation%20Request%20Form%20-%20for%20web.pdf)****. Although the EEOC's internal forms typically are not made public, it is included here given the extraordinary circumstances facing employers and employees due to the COVID-19 pandemic. (Note: Individuals not employed by the EEOC should not submit this form to the EEOC to request a religious accommodation.)*

L.2. Does an employer have to accept an employee's assertion of a religious objection to a COVID-19 vaccination at face value? May the employer ask for additional information? *(3/1/22)*

Generally, under Title VII, an employer should proceed on the assumption that a request for religious accommodation is based on sincerely held religious beliefs, practices, or observances. However, if an employer has an objective basis for questioning either the religious nature or the sincerity of a particular belief, the employer would be justified in making a limited factual inquiry and seeking additional supporting information. An employee who fails to cooperate with an employer's reasonable requests for verification of the sincerity or religious nature of a professed belief, practice, or observance risks losing any subsequent claim that the employer improperly denied an accommodation. *See generally* **Section 12-IV.A.2: Religious Discrimination (https://www.eeoc.gov/laws/guidance/section-12-religious-discrimination#h_790763467358216107498601 35)**.

The **definition of "religion" (https://www.eeoc.gov/laws/guidance/section-12-religious-discrimination#h_95936825968216107486470 76)** under Title VII protects both traditional and nontraditional religious beliefs, practices, or observances, including those that may be unfamiliar to employers. While the employer should not assume that a request is invalid simply because it is based on unfamiliar religious beliefs, practices, or observances, employees may be asked to explain the religious nature of their belief, practice, or observance and should not assume that the employer already knows or understands it.

Title VII does not protect social, political, or economic views or personal preferences. Thus, objections to a COVID-19 vaccination requirement that are purely based on social, political, or economic views or personal preferences, or any other nonreligious concerns (including about the possible effects of the vaccine), do not qualify as religious beliefs, practices, or observances under Title VII. However, overlap between a religious and political view does not place it outside the scope of

Title VII's religious protections, as long as the view is part of a comprehensive religious belief system and is not simply an isolated teaching. *See generally* **Section 12-I.A.1: Religious Discrimination (definition of religion) (https://www.eeoc.gov/laws/guidance/section-12-religious-discrimination#_ftnref18)**; *see also* discussion of "sincerity" below.

The **sincerity (https://www.eeoc.gov/laws/guidance/section-12-religious-discrimination#h_954654327776161074865518 6)** of an employee's stated religious beliefs, practices, or observances is usually not in dispute. The employee's sincerity in holding a religious belief is "largely a matter of individual credibility." **Section 12-I.A.2: Religious Discrimination (credibility and sincerity) (https://www.eeoc.gov/laws/guidance/section-12-religious-discrimination#_ftnref42)**. Factors that—either alone or in combination—might undermine an employee's credibility include: whether the employee has acted in a manner inconsistent with the professed belief (although employees need not be scrupulous in their observance); whether the accommodation sought is a particularly desirable benefit that is likely to be sought for nonreligious reasons; whether the timing of the request renders it suspect (for example, it follows an earlier request by the employee for the same benefit for secular reasons); and whether the employer otherwise has reason to believe the accommodation is not sought for religious reasons.

The employer **may ask for an explanation (https://www.eeoc.gov/laws/guidance/section-12-religious-discrimination#h_790763467358216107498601 35)** of how the employee's religious beliefs, practices, or observances conflict with the employer's COVID-19 vaccination requirement. Although prior inconsistent conduct is relevant to the question of sincerity, an individual's beliefs—or degree of adherence—may change over time and, therefore, an employee's newly adopted or inconsistently observed practices may nevertheless be sincerely held. An employer should not assume that an employee is insincere simply because some of the employee's practices deviate from the commonly followed tenets of the employee's religion, or because the employee adheres to some common practices but not others. No one factor or consideration is determinative, and employers should evaluate religious objections on an individual basis.

If an employee's objection to a COVID-19 vaccination requirement is not religious in nature, or is not sincerely held, Title VII does not require the employer to provide an

exception to the vaccination requirement as a religious accommodation.

L.3. How does an employer show that it would be an "undue hardship" to accommodate an employee's request for religious accommodation? *(3/1/22)*

Under Title VII, an employer should thoroughly consider all possible reasonable accommodations, including telework and reassignment. For suggestions about types of reasonable accommodations for unvaccinated employees, *see* K.2, K.6, and K.12, above. In many circumstances, it may be possible to accommodate those seeking reasonable accommodations for their religious beliefs, practices, or observances without imposing an undue hardship.

If an employer demonstrates that it is unable to reasonably accommodate an employee's religious belief, practice, or observance without an "undue hardship" on its operations, then Title VII does not require the employer to provide the accommodation. 42 U.S.C. § 2000e(j). The Supreme Court has held that requiring an employer to bear more than a "de minimis," or a minimal, cost to accommodate an employee's religious belief is an undue hardship. Costs to be considered include not only direct monetary costs but also the burden on the conduct of the employer's business—including, in this instance, the risk of the spread of COVID-19 to other employees or to the public.

Courts have found Title VII undue hardship where, for example, the religious accommodation would violate federal law, impair workplace safety, diminish efficiency in other jobs, or cause coworkers to carry the accommodated employee's share of potentially hazardous or burdensome work. For a more detailed discussion, *see* **Section 12-IV.B: Religious Discrimination (discussing undue hardship) (https://www.eeoc.gov/laws/guidance/section-12-religious-discrimination#h_1292940343695161074987855 6)** ..

An employer will need to assess undue hardship by considering the particular facts of each situation and will need to demonstrate how much cost or disruption the employee's proposed accommodation would involve. An employer cannot rely on speculative or hypothetical hardship when faced with an employee's religious objection but, rather, should rely on objective information. Certain common and relevant considerations during the COVID-19 pandemic include, for example, whether the employee requesting a religious accommodation to a COVID-19 vaccination requirement works outdoors or indoors, works in a solitary or group work setting, or has close contact with other employees or members of the public

(especially medically vulnerable individuals). Another relevant consideration is the number of employees who are seeking a similar accommodation, i.e., the cumulative cost or burden on the employer. *See* K.12 for additional considerations relevant to the undue hardship analysis.

L.4. If an employer grants some employees a religious accommodation from a COVID-19 vaccination requirement because of sincerely held religious beliefs, practices, or observances, does it have to grant all such requests? *(3/1/22)*

No. The determination of whether a particular proposed accommodation imposes an undue hardship on the conduct of the employer's business depends on its specific factual context. When an employer is assessing whether exempting employees from getting a vaccination would impair workplace safety, it may consider, for example, the type of workplace, the nature of the employees' duties, the location in which the employees must or can perform their duties, the number of employees who are fully vaccinated, how many employees and nonemployees physically enter the workplace, and the number of employees who will in fact need a particular accommodation. A mere assumption that many more employees might seek a religious accommodation—or the same accommodation—to the vaccination requirement in the future is not evidence of undue hardship, but the employer may consider the cumulative cost or burden of granting accommodations to other employees.

L.5. Must an employer provide the religious accommodation preferred by an employee if there are other possible accommodations that also are effective in eliminating the religious conflict and do not cause an undue hardship under Title VII? *(3/1/22)*

If there is more than one reasonable accommodation that would resolve the conflict between the vaccination requirement and the sincerely held religious belief, practice, or observance without causing an undue hardship under Title VII, the employer may choose which accommodation to offer. If more than one accommodation would be effective in eliminating the religious conflict, the employer should consider the employee's preference but is not obligated to provide the reasonable accommodation preferred by the employee. However, an employer's proposed accommodation will not be "reasonable" if the accommodation requires the employee to accept a reduction in pay or some other loss of a benefit or privilege of employment (for example, if unpaid leave is the employer's proposed accommodation) and there is a reasonable alternative accommodation that does

not require that and would not impose undue hardship on the employer's business. *See* **Section 12-IV.A.3: Religious Discrimination (reasonable accommodation) (https://www.eeoc.gov/laws/guidance/section-12-religious-discrimination#h_255006745363916107498678 44)**. If the employer denies the employee's proposed accommodation, the employer should explain to the employee why the preferred accommodation is not being granted.

An employer should consider all possible alternatives to determine whether exempting an employee from a vaccination requirement would impose an undue hardship. *See, e.g.*, K.2. Employers may rely on **CDC recommendations (https://www.cdc.gov/coronavirus/2019-ncov/)** when deciding whether an effective accommodation is available that would not pose an undue hardship.

L.6. If an employer grants a religious accommodation to an employee, can the employer later reconsider it? *(3/1/22)*

The obligation to provide religious accommodations absent undue hardship is a continuing obligation that allows for changing circumstances. Employees' sincerely held religious beliefs, practices, or observances may evolve or change over time and may result in requests for additional or different religious accommodations. Similarly, an employer has the right to discontinue a previously granted accommodation if it is no longer utilized for religious purposes, or if a provided accommodation subsequently poses an undue hardship on the employer's operations due to changed circumstances. Employers must consider whether there are alternative accommodations that would not impose an undue hardship. As a best practice, an employer should discuss with the employee any concerns it has about continuing a religious accommodation before revoking it.

M. Retaliation and Interference

*The **anti-retaliation protections (https://www.eeoc.gov/laws/guidance/questions-and-answers-enforcement-guidance-retaliation-and-related-issues)** discussed here only apply to the exercise of rights under the federal equal employment opportunity (EEO) laws. Information about similar protections under other federal workplace laws, such as the **Family and Medical Leave Act (https://www.dol.gov/agencies/whd/fmla)** or the **Occupational Safety and Health Act (https://www.osha.gov/workers)**, is available from the U.S. Department of*

Labor. Information about similar protections under the Immigration and Nationality Act's anti-discrimination provision, which prohibits some types of workplace discrimination based on citizenship status, immigration status, or national origin, and ***protects against retaliation for asserting those rights (http://www.justice.gov/crt/types-discrimination)****, is available from the Civil Rights Division of the U.S. Department of Justice.*

M.1. Do job applicants and employees (including former employees) have protections from retaliation for exercising equal employment opportunity (EEO) rights in connection with COVID-19? *(11/17/21)*

Yes. Job applicants and current and former employees are protected from retaliation by employers for asserting their rights under any of the federal **EEO laws (https://www.eeoc.gov/statutes/laws-enforced-eeoc)**. The EEO laws prohibit workplace discrimination based on race, color, sex (including pregnancy, sexual orientation, and gender identity), national origin, religion, age (40 or over), disability, or genetic information. Speaking out about or exercising rights related to workplace discrimination is called "protected activity."

Protected activity can take many forms. For example, an employee complaining to a supervisor about coworker harassment based on race or national origin is protected activity. Witnesses to discrimination who seek to assist individuals affected by discrimination are also protected. Engaging in protected activity, however, does not shield an employee from discipline, discharge, or other employer actions taken for reasons unrelated to the protected activity.

M.2. What are some examples of employee activities that are protected from employer retaliation? *(11/17/21)*

- **Filing a charge, complaint, or lawsuit, regardless of whether the underlying discrimination allegation is successful or timely**. For example, employers may not retaliate against employees who file charges with the EEOC alleging that their supervisor unlawfully disclosed confidential medical information (such as a COVID-19 diagnosis), even if the EEOC later decides there is no merit to the underlying charges. Moreover, a supervisor may not give a false negative job reference to punish a former employee for making an EEO complaint, or refuse to hire an applicant because of the applicant's EEO complaint against a prior employer.

- **Reporting alleged EEO violations to a supervisor or answering questions during an employer investigation of the alleged harassment**. For example, an Asian American employee who tells a manager or human resources official that a coworker made abusive comments accusing Asian people of spreading COVID-19 is protected from retaliation for reporting the harassment. Workplace discrimination laws also prohibit retaliation against employees for reporting harassing workplace comments about their religious reasons for not being vaccinated. Similarly, workplace discrimination laws prohibit retaliation against an employee for reporting sexually harassing comments made during a work video conference meeting.

- **Resisting harassment, intervening to protect coworkers from harassment, or refusing to follow orders that would result in discrimination**. For example, workplace discrimination laws protect a supervisor who refuses to carry out management's instruction not to hire certain applicants based on the sex-based presumption that they might use parental leave or have childcare needs, or to steer them to particular types of jobs.

- **Requesting accommodation of a disability (potentially including a pregnancy-related medical condition) or a religious belief, practice, or observance regardless of whether the request is granted or denied**. For example, the EEO laws prohibit an employer from retaliating against an employee for requesting continued telework as a disability accommodation after a workplace reopens. Similarly, requesting religious accommodation, such as modified protective gear that can be worn with religious garb, is protected activity. Requests for accommodation are protected activity even if the individual is not legally entitled to accommodation, such as where the employee's medical condition is not ultimately deemed a disability under the ADA, or where accommodation would pose an undue hardship.

M.3. Who is protected from retaliation? *(11/17/21)*

Retaliation protections apply to current employees, whether they are full-time, part-time, probationary, seasonal, or temporary. Retaliation protections also apply to job applicants and to former employees (such as when an employer provides a job reference). In addition, these protections apply regardless of an applicant's or employee's citizenship or work authorization status.

M.4. When do retaliation protections apply? *(11/17/21)*

Participating in an EEO complaint process is protected from retaliation under all circumstances.

Other acts by a current, prospective, or former employee to oppose discrimination are protected as long as the employee is acting on a reasonable good faith belief that something in the workplace may violate **EEO laws (https://www.eeoc.gov/statutes/laws-enforced-eeoc)**, and expresses those beliefs in a reasonable manner. An employee is still protected from retaliation for making a complaint about workplace discrimination even if the employee does not use legal terminology to describe the situation.

M.5. When is an employer action based on an employee's EEO activity serious enough to be unlawful retaliation? *(11/17/21)*

Retaliation includes any employer action in response to EEO activity that could deter a reasonable person from engaging in protected EEO activity. Depending on the facts, this might include actions such as denial of promotion or job benefits, non-hire, suspension, discharge, work-related threats, warnings, negative or lowered evaluations, or transfers to less desirable work or work locations. Retaliation could also include an action that has no tangible effect on employment, or even an action that takes place only outside of work, if it might deter a reasonable person from exercising EEO rights. The fact that an individual is not actually deterred from opposing discrimination or participating in an EEO complaint-related process or activity does not preclude an employer's action from being considered retaliatory.

However, depending on the specific situation, retaliation likely would not include a petty slight, minor annoyance, or a trivial punishment.

M.6. Does this mean that an employer can never take action against someone who has engaged in EEO activity? *(11/17/21)*

No. Engaging in protected EEO activity does not prevent discipline of an employee for legitimate reasons. Employers are permitted to act based on *non-retaliatory and non-discriminatory* reasons that would otherwise result in discipline. For example, if an employee performs poorly, has low productivity, or engages in misconduct, an employer may respond as it normally would, even if the employee has engaged in protected activity. Similarly, an employer may take non-retaliatory, non-

discriminatory action to enforce COVID-19 health and safety protocols, even if such actions follow EEO activity (e.g., an accommodation request).

M.7. Does the law provide any additional protections to safeguard ADA rights? *(11/17/21)*

Yes. The ADA prohibits not only retaliation for protected EEO activity, but also "interference" with an individual's exercise of ADA rights. Under the ADA, employers may not coerce, intimidate, threaten, or otherwise interfere with the exercise of ADA rights by job applicants or current or former employees. For instance, it is unlawful for an employer to use threats to discourage someone from asking for a reasonable accommodation. It is also unlawful for an employer to pressure an employee not to file a disability discrimination complaint. The ADA also prohibits employers from interfering with employees helping others to exercise their ADA rights.

The employer's actions may still violate the ADA's interference provision even if an employer does not actually carry out a threat, and even if the employee is not deterred from exercising ADA rights.

N. COVID-19 and the Definition of "Disability" Under the ADA/Rehabilitation Act

Employees and employers alike have asked when COVID-19 is a "disability" under Title I of the ADA, which includes reasonable accommodation and nondiscrimination requirements in the employment context. These questions and answers clarify circumstances in which COVID-19 may or may not cause effects sufficient to meet the definition of "actual" or "record of" a disability for various purposes under Title I, as well as section 501 of the Rehabilitation Act, both of which are enforced by the EEOC. Other topics covered in this section include disabilities arising from conditions that were caused or worsened by COVID-19. This section also addresses the ADA's "regarded as" definition of disability with respect to COVID-19.

On July 26, 2021, the Department of Justice (DOJ) and the Department of Health and Human Services (HHS) issued ***"Guidance on 'Long COVID' as a Disability Under the ADA, Section 504, and Section 1557" (https://www.ada.gov/long_covid_joint_guidance.pdf)*** *(DOJ/HHS Guidance).* ***The***

CDC uses the terms "long COVID (https://www.cdc.gov/coronavirus/2019-ncov/long-term-effects/)," "post-COVID," "long-haul COVID," "post-acute COVID-19," "long-term effects of COVID," or "chronic COVID" to describe various post-COVID conditions, where individuals experience new, returning, or ongoing health problems four or more weeks after being infected with the virus that causes COVID-19. The DOJ/HHS Guidance focuses solely on long COVID in the context of Titles II and III of the ADA, Section 504 of the Rehabilitation Act of 1973, and Section 1557 of the Patient Protection and Affordable Care Act. These EEOC questions and answers focus more broadly on COVID-19 and do so in the context of Title I of the ADA and section 501 of the Rehabilitation Act, which cover employment. This discussion does not pertain to other contexts, such as eligibility determinations for federal benefit programs.

N.1. How does the ADA define disability, and how does the definition apply to COVID-19? *(12/14/21)*

The ADA's three-part definition of disability applies to COVID-19 in the same way it applies to any other medical condition. A person can be an individual with a "disability" for purposes of the ADA in one of three ways:

- "Actual" Disability: The person has a physical or mental impairment that substantially limits a major life activity (such as walking, talking, seeing, hearing, or learning, or operation of a major bodily function);
- "Record of" a Disability: The person has a history or "record of" an actual disability (such as cancer that is in remission); or
- "Regarded as" an Individual with a Disability: The person is subject to an adverse action because of an individual's impairment or an impairment the employer believes the individual has, whether or not the impairment limits or is perceived to limit a major life activity, unless the impairment is objectively both transitory (lasting or expected to last six months or less) and minor.

The definition of disability is construed broadly in favor of expansive coverage, to the maximum extent permitted by the law. Nonetheless, not every impairment will constitute a disability under the ADA. The ADA uses a case-by-case approach to determine if an applicant or employee meets any one of the three above definitions of "disability."

COVID-19 and the ADA

"Actual" Disability

N.2. When is COVID-19 an actual disability under the ADA? *(12/14/21)*

Applying the ADA rules stated in **N.1.** and depending on the specific facts involved in an individual employee's condition, a person with COVID-19 has an actual disability if the person's medical condition or any of its symptoms is a "physical or mental" impairment that "substantially limits one or more major life activities." An individualized assessment is necessary to determine whether the effects of a person's COVID-19 substantially limit a major life activity. This will always be a case-by-case determination that applies existing legal standards to the facts of a particular individual's circumstances. A person infected with the virus causing COVID-19 who is asymptomatic or a person whose COVID-19 results in mild symptoms similar to those of the common cold or flu that resolve in a matter of weeks—with no other consequences—will not have an actual disability within the meaning of the ADA. However, depending on the specific facts involved in a particular employee's medical condition, an individual with COVID-19 might have an actual disability, as illustrated below.

Physical or Mental Impairment: Under the ADA, a physical impairment includes any physiological disorder or condition affecting one or more body systems. A mental impairment includes any mental or psychological disorder. COVID-19 is a physiological condition affecting one or more body systems. As a result, it is a "physical or mental impairment" under the ADA.

Major Life Activities: "Major life activities" include both major bodily functions, such as respiratory, lung, or heart function, and major activities in which someone engages, such as walking or concentrating. COVID-19 may affect major bodily functions, such as functions of the immune system, special sense organs (such as for smell and taste), digestive, neurological, brain, respiratory, circulatory, or cardiovascular functions, or the operation of an individual organ. In some instances, COVID-19 also may affect other major life activities, such as caring for oneself, eating, walking, breathing, concentrating, thinking, or interacting with others. An impairment need only substantially limit one major bodily function or other major life activity to be substantially limiting. However, limitations in more than one major life activity may combine to meet the standard.

Substantially Limiting: "Substantially limits" is construed broadly and should not demand extensive analysis. COVID-19 need not prevent, or significantly or severely

restrict, a person from performing a major life activity to be considered substantially limiting under Title I of the ADA.

The limitations from COVID-19 do not necessarily have to last any particular length of time to be substantially limiting. They also need not be long-term. For example, in discussing a hypothetical physical impairment resulting in a 20-pound lifting restriction that lasts or is expected to last several months, the EEOC has said that such an impairment is substantially limiting. App. to 29 C.F.R. § 1630.2(j)(1)(ix). By contrast, "[i]mpairments that last only for a short period of time are typically not covered, although they may be covered if sufficiently severe." Id.

Mitigating Measures: Whether COVID-19 substantially limits a major life activity is determined based on how limited the individual would have been without the benefit of any mitigating measures–i.e., any medical treatment received or other step used to lessen or prevent symptoms or other negative effects of an impairment. At the same time, in determining whether COVID-19 substantially limits a major life activity, any negative side effects of a mitigating measure are taken into account.

Some examples of mitigating measures for COVID-19 include medication or medical devices or treatments, such as antiviral drugs, supplemental oxygen, inhaled steroids and other asthma-related medicines, breathing exercises and respiratory therapy, physical or occupational therapy, or other steps to address complications of COVID-19.

Episodic Conditions: Even if the symptoms related to COVID-19 come and go, COVID-19 is an actual disability if it substantially limits a major life activity when active.

N.3. Is COVID-19 always an actual disability under the ADA? *(12/14/21)*

No. Determining whether a specific employee's COVID-19 is an actual disability always requires an individualized assessment, and such assessments cannot be made categorically. See **29 C.F.R. § 1630.2 (https://www.law.cornell.edu/cfr/text/29/1630.2)** for further information on the ADA's requirements relating to individualized assessment.

N.4. What are some examples of ways in which an individual with COVID-19 might or might not be substantially limited in a major life activity? *(12/14/21)*

As noted above, while COVID-19 may substantially limit a major life activity in some circumstances, someone infected with the virus causing COVID-19 who is

asymptomatic or a person whose COVID-19 results in mild symptoms similar to the common cold or flu that resolve in a matter of weeks—with no other consequences—will not be substantially limited in a major life activity for purposes of the ADA. Based on an individualized assessment in each instance, examples of fact patterns include:

Examples of Individuals with an Impairment that Substantially Limits a Major Life Activity:

- An individual diagnosed with COVID-19 who experiences ongoing but intermittent multiple-day headaches, dizziness, brain fog, and difficulty remembering or concentrating, which the employee's doctor attributes to the virus, is substantially limited in neurological and brain function, concentrating, and/or thinking, among other major life activities.
- An individual diagnosed with COVID-19 who initially receives supplemental oxygen for breathing difficulties and has shortness of breath, associated fatigue, and other virus-related effects that last, or are expected to last, for several months, is substantially limited in respiratory function, and possibly major life activities involving exertion, such as walking.
- An individual who has been diagnosed with COVID-19 experiences heart palpitations, chest pain, shortness of breath, and related effects due to the virus that last, or are expected to last, for several months. The individual is substantially limited in cardiovascular function and circulatory function, among others.
- An individual diagnosed with "**long COVID (https://www.cdc.gov/coronavirus/2019-ncov/long-term-effects/index.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Flong-term-effects.html)**," who experiences COVID-19-related intestinal pain, vomiting, and nausea that linger for many months, even if intermittently, is substantially limited in gastrointestinal function, among other major life activities, and therefore has an actual disability under the ADA.

Examples of Individuals with an Impairment that Does Not Substantially Limit a Major Life Activity:

- An individual who is diagnosed with COVID-19 who experiences congestion, sore throat, fever, headaches, and/or gastrointestinal discomfort, which resolve within several weeks, but experiences no further symptoms or effects, is not substantially limited in a major bodily function or other major life activity, and therefore does not have an actual disability under the ADA. This is so even though this person is subject to CDC guidance for isolation during the period of infectiousness.
- An individual who is infected with the virus causing COVID-19 but is asymptomatic—that is, does not experience any symptoms or effects—is not substantially limited in a major bodily function or other major life activity, and therefore does not have an actual disability under the ADA. This is the case even though this person is still subject to CDC guidance for isolation during the period of infectiousness.

As noted above, even if the symptoms of COVID-19 occur intermittently, they will be deemed to substantially limit a major life activity if they are substantially limiting when active, based on an individualized assessment.

For information on possible services and supports for individuals with Long COVID, see the **report (https://www.covid.gov/assets/files/Services-and-Supports-for-Longer-Term-Impacts-of-COVID-19-08012022.pdf)** issued by the U.S. Dept. of Health and Human Services.

"Record of" Disability

N.5. Can a person who has or had COVID-19 be an individual with a "record of" a disability? *(12/14/21)*

Yes, depending on the facts. A person who has or had COVID-19 can be an individual with a "record of" a disability if the person has "a history of, or has been misclassified as having," **29 C.F.R. § 1630.2(k)(2) (https://www.law.cornell.edu/cfr/text/29/1630.2)**, an impairment that substantially limits one or more major life activities, based on an individualized assessment.

"Regarded As" Disability

N.6. Can a person be "regarded as" an individual with a disability if the person has COVID-19 or the person's employer mistakenly believes the person has

COVID-19? *(12/14/21)*

Yes, depending on the facts. A person is "regarded as" an individual with a disability if the person is subjected to an adverse action (e.g., being fired, not hired, or harassed) because the person has an impairment, such as COVID-19, or the employer mistakenly believes the person has such an impairment, unless the actual or perceived impairment is objectively both transitory (lasting or expected to last six months or less) and minor. For this definition of disability, whether the actual or perceived impairment substantially limits or is perceived to substantially limit a major life activity is irrelevant.

N.7. What are some examples of an employer regarding a person with COVID-19 as an individual with a disability? *(12/14/21)*

The situations in which an employer might "regard" an applicant or employee with COVID-19 as an individual with a disability are varied. Some examples include:

- An employer would regard an employee as having a disability if the employer fires the individual because the employee had symptoms of COVID-19, which, although minor, lasted or were expected to last more than six months. The employer could not show that the impairment was both transitory and minor.
- An employer would regard an employee as having a disability if the employer fires the individual for having COVID-19, and the COVID-19, although lasting or expected to last less than six months, caused non-minor symptoms. In these circumstances, the employer could not show that the impairment was both transitory and minor.

N.8. If an employer regards a person as having a disability, for example by taking an adverse action because the person has COVID-19 that is not both transitory and minor, does that automatically mean the employer has discriminated for purposes of the ADA? *(12/14/21)*

No. It is possible that an employer may not have engaged in unlawful discrimination under the ADA even if the employer took an adverse action based on an impairment. For example, an individual still needs to be qualified for the job held or desired. Additionally, in some instances, an employer may have a defense to an action taken on the basis of the impairment. For example, the ADA's "direct threat" defense could permit an employer to require an employee with COVID-19 or its symptoms to refrain from physically entering the workplace during the CDC-

recommended period of isolation, due to the significant risk of substantial harm to the health of others. See **WYSK Question A.8**. Of course, an employer risks violating the ADA if it relies on myths, fears, or stereotypes about a condition to disallow the employee's return to work once the employee is no longer infectious and, therefore, medically able to return without posing a direct threat to others.

Other Conditions Caused or Worsened by COVID-19 and the ADA

N.9. Can a condition caused or worsened by COVID-19 be a disability under the ADA? *(12/14/21)*

Yes. In some cases, regardless of whether an individual's initial case of COVID-19 itself constitutes an actual disability, an individual's COVID-19 may end up causing impairments that are themselves disabilities under the ADA. For example:

- An individual who had COVID-19 develops heart inflammation. This inflammation itself may be an impairment that substantially limits a major bodily function, such as the circulatory function, or other major life activity, such as lifting.
- During the course of COVID-19, an individual suffers an acute ischemic stroke. Due to the stroke, the individual may be substantially limited in neurological and brain (or cerebrovascular) function.
- After an individual's COVID-19 resolves, the individual develops diabetes attributed to the COVID-19. This individual should easily be found to be substantially limited in the major life activity of endocrine function. See **Diabetes in the Workplace and the ADA (https://www.eeoc.gov/laws/guidance/diabetes-workplace-and-ada)** for more information.

In some cases, an individual's COVID-19 may also worsen the individual's pre-existing condition that was not previously substantially limiting, making that impairment now substantially limiting. For example:

- An individual initially has a heart condition that is not substantially limiting. The individual is infected with COVID-19. The COVID-19 worsens the person's heart condition so that the condition now substantially limits the person's circulatory function.

Definition of Disability and Requests for Reasonable Accommodation

N.10. Does an individual have to establish coverage under a particular definition of disability to be eligible for a reasonable accommodation? *(12/14/21)*

Yes. Individuals must meet either the "actual" or "record of" definitions of disability to be eligible for a reasonable accommodation. Individuals who only meet the "regarded as" definition are not entitled to receive reasonable accommodation.

Of course, coverage under the "actual" or "record of" definitions does not, alone, entitle a person to a reasonable accommodation. Individuals are not entitled to an accommodation unless their disability requires it, and an employer is not obligated to provide an accommodation that would pose an undue hardship. See **WYSK Section D**, and **Enforcement Guidance on Reasonable Accommodation and Undue Hardship under the ADA (https://www.eeoc.gov/laws/guidance/enforcement-guidance-reasonable-accommodation-and-undue-hardship-under-ada)** for more information.

N.11. When an employee requests a reasonable accommodation related to COVID-19 under the ADA, may the employer request supporting medical documentation before granting the request? *(12/14/21)*

Yes. As with employment accommodation requests under the ADA for any other potential disability, when the disability or need for accommodation is not obvious or already known, an employer may ask the employee to provide reasonable documentation about disability and/or need for reasonable accommodation. Often, the only information needed will be the individual's diagnosis and any restrictions or limitations. The employer also may ask about whether alternative accommodations would be effective in meeting the disability-related needs of the individual. See WYSK Questions D.5. and D.6. for more information.

The employer may either ask the employee to obtain the requested information or request that the employee sign a limited release allowing the employer to contact the employee's health care provider directly. If the employee does not cooperate in providing the requested reasonable supporting medical information, the employer can lawfully deny the accommodation request.

N.12. May an employer voluntarily provide accommodations requested by an applicant or employee due to COVID-19, even if not required to do so under the ADA? *(12/14/21)*

Yes. Employers may choose to provide accommodations beyond what the ADA mandates. Of course, employers must provide a reasonable accommodation under the ADA, absent undue hardship, if the applicant or employee meets the definition of disability, requires an accommodation for the disability, and is qualified for the job with the accommodation. Accommodations might consist of schedule changes, physical modifications to the workplace, telework, or special or modified equipment. See, e.g., **WYSK Section D** or U.S. Department of Labor Blog, **Workers with Long COVID-19: You May Be Entitled to Workplace Accommodations (https://blog.dol.gov/2021/07/06/workers-with-long-covid-19-may-be-entitled-to-accommodations)** for more information.

Applicability of Definition of Disability

N.13. If an employer subjected an applicant or employee to an adverse action, and the applicant or employee is covered under any one of the three ADA definitions of disability, does that mean the employer violated the ADA? *(12/14/21)*

No. Having a disability, alone, does not mean an individual was subjected to an unlawful employment action under the ADA.

For example, the fact that an applicant or employee has a current disability, or a record of disability, does not mean that an employer violated the ADA by not providing an individual with a reasonable accommodation. As discussed in **Section D.**, there are several considerations in making reasonable accommodation determinations, including the employee's need for the accommodation due to a disability and whether there is an accommodation that does not pose an undue hardship to the employer.

Similarly, the fact that an employer regarded an applicant or employee as an individual with a disability does not necessarily mean that the employer engaged in unlawful discrimination. For example, the ADA does not require an employer to hire anyone who is not qualified for the job. Moreover, in some instances, an employer may have a defense to an employment action taken based on an actual impairment, such as where the individual poses a **direct threat (https://www.eeoc.gov/wysk/what-you-should-know-about-covid-19-and-ada-rehabilitation-act-and-other-eeo-laws)** to the health or safety of themselves or others in the workplace.

N.14. Do any ADA protections apply to applicants or employees who do not meet an ADA definition of disability? *(12/14/21)*

Yes. The ADA's requirements about disability-related inquiries and medical exams, **medical confidentiality**, **retaliation, and interference** apply to all applicants and employees, regardless of whether they have an ADA disability. By contrast, an individual must have a "disability" to challenge employment decisions based on disability, denial of reasonable accommodation (see **N.10**), or disability-based harassment.

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AUSTIN KNUDSEN

STATE OF MONTANA

January 14, 2021

To all Montana Head Start Program Directors and Employees:

It is our understanding that your Head Start program received a "Litigation Update" from the federal Office of Head Start ("OHS") regarding its COVID-19 vaccine and mask mandates earlier this week. While this update correctly notes that a court has enjoined the federal government from implementing and enforcing these requirements in Montana, OHS incorrectly implies that your program is permitted to develop and implement your own policy to require masks and vaccines. Understandably, this implication has caused confusion. This letter serves to caution that any such masking or vaccination policy developed by your Head Start program must comply with Montana law.

Under Montana law, an employer is prohibited from refusing employment, barring a person from employment, or discriminating against an individual in any term, condition, or privilege of employment based on vaccination status. While you may ask employees their vaccination status, you cannot treat them differently for their answer or non-answer.

Some examples of vaccination-based discrimination include, but *are not limited to*, requiring only staff who have not received the COVID-19 vaccine to wear a mask; telling staff members they must resign or will have their employment terminated if they do not receive the COVID-19 vaccine; and refusing to schedule unvaccinated employees for work shifts. Employees who are illegally discriminated against based on their vaccination status are encouraged to seek legal advice from a private attorney and to contact the Montana Human Rights Bureau at the Department of Labor to seek redress.

If you have any questions regarding this letter please contact our office.

Derek J. Oestreicher
General Counsel

DEPARTMENT OF JUSTICE
215 North Sanders
PO Box 201401
Helena, MT 59620-1401
(406) 444-2026
Contactdoj@mt.gov
mtdoj.gov

EXHIBIT 63
30(b)(6) Designee
Fri, Aug 19, 2022
Reported by:
Mary Sullivan, RMR, CRR

DEFS 000227

+ Can a public accommodation require you to wear a mask on their premises or present...

Excerpt from Production: DEF's 326

Can a public accommodation require you to wear a mask on their premises or present evidence of a neg

The law states that a public accommodation cannot discriminate against you based on your vaccination status. A public accommodation cannot require you to wear a mask on their premises or present evidence of a negative COVID-19 test if you are unvaccinated or choose not to share your vaccination status. HB 702 (codified at Mont. Code Ann. § 49-2-312) does **not** preclude a public accommodation from requiring **everyone** to present evidence of a negative COVID-19 test or wear a mask (as long as it allows for reasonable accommodations based on sincerely held religious beliefs and disability). Note, the law includes exceptions for health care facilities, licensed nursing homes, long-term care facilities, and assisted living facilities. These facilities may require you to wear a mask in certain situations.

Last Updated: 1/24/22

+ I am an employee of a health care facility. How does the United States Supreme Court...

I am an employee of a health care facility. How does the United States Supreme Court ruling on CMS's

The Department of Public Health and Human Services has issued guidance for health care facilities and providers regarding the CMS vaccine mandate. It can be viewed here.

DPHHS encourages covered health care facilities and providers to review and adopt its religious exemption form, which can be found here.

EXHIBIT 55
30(b)(6) Designee
Thu, Aug 18, 2022
Reported by:
Mary Sullivan, RMR, CRR

PROVIDER QUESTIONS

CRITICAL ACCESS HOSPITAL

Q1: CAH vs LTC vs ALF Surveys (continued)

A1b: Assisted Living Facilities (ALF) Surveys are conducted by the Licensure Bureau of OIG. These are not certified providers (facilities types) so they are not reviewed under CMS Certification regulations or the Montana OIG Certification Bureau.

ALF questions contact Tara Wooten, Health Care License Program Manager, at 406-444-1575 or Tara.Wooten@mt.gov

EXHIBIT 44
30(b)(6) Designee
Thu, Aug 18, 2022
Reported by:
Mary Sullivan, RMR, CRR

Raph Graybill
GRAYBILL LAW FIRM, PC
300 4th Street North
Great Falls, MT 59403
Phone: (406) 452-8566
Email: rgraybill@silverstatelaw.net

Attorney for Plaintiff-Intervenor

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MONTANA
MISSOULA DIVISION

MONTANA MEDICAL ASSOCIATION, et al., Plaintiffs, and MONTANA NURSES ASSOCIATION, Plaintiff-Intervenor v. AUSTIN KNUDSEN, Montana Attorney General, and LAURIE ESAU, Montana Commissioner of Labor and Industry, Defendants.	Cause No. 9:21-cv-108 Hon. Donald W. Molloy **PLAINTIFF-INTERVENOR'S EXPERT DISCLOSURE**

Plaintiff-Intervenor the Montana Nurses Association, pursuant to the Court's Order dated May 20, 2022 (Doc. 77), hereby provides its Expert Disclosures.

Plaintiff-Intervenors may call one or more of the following witnesses to testify at



trial:

Rule 26(a)(2)(B) Retained Expert Witnesses

1. **Lauren Wilson, M.D.**, 2827 Fort Missoula Road, Missoula, MT 59804. Dr. Wilson's expert report and curriculum vitae are attached to this disclosure as Exhibit A.

   a. Dr. Wilson's report contains a complete statement of the opinions Dr. Wilson will express and the basis and reasons for them;

   b. Dr. Wilson's report contains the facts and data considered by Dr. Wilson in forming her opinions;

   c. Dr. Wilson's report contains and/or references the exhibits that will be used to summarize and/or support her opinions;

   d. Dr. Wilson's CV outlines her qualifications and all publications she has authored in the previous ten years;

   e. Dr. Wilson report describes her testimony as a witness during the previous 4 years; and

   f. Dr. Wilson is being compensated $400/hour for her testimony in this matter.

   g. Dr. Wilson reserves the right to supplement her opinions. She also reserves the right to offer rebuttal opinions.

2. **Greg Holzman, M.D., M.P.H.**, 1311 E. Broadway St, Helena, MT

59601. Dr. Holzman's expert report and curriculum vitae are attached to this disclosure as Exhibit B.

a. Dr. Holzman's report contains a complete statement of the opinions Dr. Holzman will express and the basis and reasons for them;

b. Dr. Holzman's report contains the facts and data considered by Dr. Holzman in forming his opinions;

c. Dr. Holzman's report contains and/or references the exhibits that will be used to summarize and/or support his opinions;

d. Dr. Holzman's CV outlines his qualifications and all publications he has authored in the previous ten years;

e. Dr. Holzman's report describes his testimony as a witness in the previous 4 years; and

f. Dr. Holzman is being compensated $500/hour for his testimony in this matter.

g. Dr. Holzman reserves the right to supplement his opinions. He also reserves the right to offer rebuttal opinions.

Rule 26(a)(2)(C) Non-Retained, Hybrid Fact/Expert Witnesses

3. **Vicky Byrd, M.S.N., R.N.**, Chief Executive Officer, Montana Nurses Association, 20 Old Montana State Hwy, Clancy, MT 59634, (406) 442-6710. In

addition to her factual testimony, Ms. Byrd may provide opinion testimony on the following matters:

a. The role of vaccines in preventing the spread of vaccine-preventable diseases in the workplace.

b. The role of actual knowledge of immunity status in redressing the workplace hazard of vaccine-preventable diseases.

c. Recognized hazards for nurses in the workplace.

d. The effects of vaccine-preventable illnesses and pandemics/illness outbreaks on healthcare settings.

e. The requirements of participation in CMS programs and importance of the same to Montana healthcare facilities, vaccination requirements of CMS participating Montana healthcare facilities prior to implementation of House Bill 702.

f. The effects of HB 702 on workplace safety for Montana nurses.

g. The ability of Montana APRN-led practices to comply with the Americans with Disabilities Act, and the effects of HB702.

h. The ability of Montana APRN-led practices to comply with workplace safety requirements, and the effects of HB702.

i. Implications of the Americans with Disabilities Act (ADA) on the workplace, requests for reasonable accommodations from both an

employer standpoint and a public accommodations standpoint, and the interactive process required by the ADA.

j. Requirements and implications of Occupational Health and Safety Administration (OSHA) rules and regulations as it applies to a variety of different care settings, including what is generally required by the general duty clause's requirement to maintain a workplace free from recognized hazards, including infectious disease.

k. The effects of HB702 on Montana APRN-led practices' ability to respond to obligations under both the ADA and OSHA.

l. The effects of HB702 on nurses in Montana who enjoy protection under the ADA and OSHA.

m. The makeup of MNA's membership, including that its membership includes nurses with disabilities and those who are at high risk or vulnerable to vaccine-preventable diseases.

4. **Robin Haux**, Labor Program Director, Montana Nurses Association, 20 Old Montana State Hwy, Clancy, MT 59634, (406) 442-6710. In addition to her factual testimony, Ms. Haux may provide opinion testimony on the following matters:

a. Recognized hazards for nurses in the workplace.

b. The effects of vaccine-preventable illnesses and pandemics/illness outbreaks on healthcare settings.

c. The effects of HB 702 on workplace safety for Montana nurses.

d. The effects of HB702 on nurses in Montana who enjoy protection under the ADA and OSHA.

e. The makeup of MNA's membership, including that its membership includes nurses with disabilities and those who are at high risk or vulnerable to vaccine-preventable diseases.

Cross-Designation of Experts Disclosed by Plaintiffs Montana Medical Association, et al.

5. The Montana Nurses Association cross-designates all retained and non-retained experts disclosed by Plaintiffs the Montana Medical Association, et al. ("MMA"), and incorporates MMA's Expert Disclosure by this reference.

Other Experts

6. Any expert witness identified by any party, whether called or not.

7. Expert witnesses for appropriate impeachment or rebuttal.

DATED this 15th day of July, 2022.

/s/ Raph Graybill
Raph Graybill

Attorney for Plaintiff-Intervenor

CERTIFICATE OF SERVICE

I hereby certify that on May 27, 2022, an accurate copy of the foregoing document was served by email and U.S. mail on the following:

DAVID M.S. DEWHIRST
CHRISTIAN B. CORRIGAN
BRENT MEAD
P.O. Box 201401
Helena, MT 59620-1401
Phone: 406-444-2026
david.dewhirst@mt.gov
christian.corrigan@mt.gov.
brent.mead2@mt.gov

EMILY JONES
Jones Law Firm, PLLC
115 N. Broadway, Suite 410
Billings, MT 59101
Phone: 406-384-7990
emily@joneslawmt.com

Justin K. Cole
Kathryn S. Mahe
GARLINGTON, LOHN & ROBINSON, PLLP
P.O. Box 7909
Missoula, MT 59807-7909
Phone (406) 523-2500
Fax (406) 523-2595
jkcole@garlington.com
ksmahe@garlington.com

/s/ Raph Graybill
Raph Graybill

Attorney for Plaintiff-Intervenor

Exhibit A

Raph Graybill
GRAYBILL LAW FIRM, PC
300 4th Street North
Great Falls, MT 59403
Phone: (406) 452-8566
Email: rgraybill@silverstatelaw.net

Attorney for Plaintiff-Intervenor

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MONTANA
MISSOULA DIVISION

MONTANA MEDICAL ASSOCIATION, et al., Plaintiffs, and MONTANA NURSES ASSOCIATION, Plaintiff-Intervenor v. AUSTIN KNUDSEN, Montana Attorney General, and LAURIE ESAU, Montana Commissioner of Labor and Industry, Defendants.	Cause No. 9:21-cv-108 Hon. Donald W. Molloy **DECLARATION AND EXPERT REPORT OF LAUREN WILSON, M.D.**

I, Lauren Wilson, M.D., declare, pursuant to 28 U.S.C. § 1746 and under penalty of perjury, that the foregoing is true and correct:

1. The facts and opinions set forth in this Declaration are known to me

based on my personal knowledge and belief, and based upon my knowledge, training, research, education, and experience.

2. I have been retained by the Plaintiff-Intervenor in the above-captioned matter to render certain opinions as contained in this document. I am charging $400 per hour for my work on this matter. I reserve the right to modify, expand upon, or otherwise change these opinions as new or additional information is provided to me.

EXPERIENCE AND CREDENTIALS

3. I was granted a medical doctorate from McGill University in Montreal, Canada. I completed residency training in pediatrics at the University of Vermont, after which I served as Chief Resident for Vermont Children's Hospital. I have been board certified in Pediatrics since 2010 and additionally became board certified in the subspecialty of Pediatric Hospital Medicine in 2019. I am licensed to practice medicine in Montana.

4. I have approximately 12 years of experience as a practicing pediatric hospitalist. I currently take care of hospitalized pediatric patients in a general pediatric inpatient unit, as well as in a pediatric intensive care unit (PICU) and in the newborn nursery. I have recently served as Medical Director for the Pediatric Service Line at Community Medical Center.

5. I have been credentialed to provide care at three hospitals in Seattle

(Seattle Children's, Harborview Medical Center, and EvergreenHealth) as well as both hospitals in Missoula (Community Medical Center and Providence St. Patrick's Hospital). At Community Medical Center, I serve on the Credentialing Committee, which reviews the medical staff membership applications of other physicians.

6. I currently hold the rank of Clinical Associate Professor of Pediatrics at the University of Washington School of Medicine.

7. I was elected by my peers to serve in a voluntary position as Vice President of the Montana Chapter of the American Academy of Pediatrics.

8. Further information about my education, training and clinical responsibilities as well as my publications can be found in my curriculum vitae, attached (Exhibit 1).

9. I testified before in court in a case called *Montana Smoke Free Association v. Montana Department of Public Health and Human Services*, Ravalli County District Court, on behalf of the State of Montana about the risks associated with flavored e-cigarette products.

OPINIONS

10. Vaccination is an effective way of preventing the transmission of disease and of preventing death from disease. Historical data shows that vaccines have led to enormous declines in disease burden. As two examples: (1) pertussis

vaccination led a greater than 92% decline in pertussis cases and greater than 99% decline in deaths, when comparing the average number of pre-vaccine cases and deaths to those in post-vaccine years, and (2) measles vaccination led to a greater than 99% decline in cases when comparing average pre-vaccine measles cases to those in post-vaccine years.[1]

11. Serious adverse effects from vaccines are rare. The benefit of vaccination in preventing disease outweighs the risk of vaccination.

12. Outbreaks of vaccine preventable diseases are much less common than they once were. However, cases of measles, varicella, pertussis and hepatitis B continue to occur. Additionally, there is ongoing transmission of COVID-19, and seasonal transmission of influenza.

13. Measles can be transmitted via aerosol or contact with contaminated surfaces. It is extremely transmissible; transmission can occur up to 2 hours after an infected individual has left a room. Influenza and pertussis can be transmitted via respiratory droplets or contact with contaminated surfaces. Varicella and COVID-19 can be transmitted via respiratory droplets or contact with contaminated surfaces, and also via aerosol. Hepatitis B can be transmitted vertically from mother to child, via blood transfusion or needlestick injury, via

[1] Roush SW, Murphy TV, Vaccine-Preventable Disease Table Working Group AT. Historical Comparisons of Morbidity and Mortality for Vaccine-Preventable Diseases in the United States. *JAMA*. 2007;298(18):2155–2163. doi:10.1001/jama.298.18.2155

intravenous drug use or sexually.[2]

14. There have been pertussis outbreaks in Montana while I have been practicing here, and I have cared for patients with pertussis. I have had patients I have cared for in Montana who were affected by a measles outbreak in Washington state as well, because some Montana patients are cared for in Washington hospitals.

15. There was a measles outbreak primarily in Flathead County in 1989-1990. In many places in Montana, vaccination rates are now lower than the 95% which is generally felt to be the threshold to prevent outbreaks. Due to areas with lower vaccine rates, areas of Montana would be considered at risk during future measles outbreaks in the U.S.

16. Vaccine-preventable diseases can cause severe consequences. Measles can cause pneumonia and encephalitis, which can be fatal during the acute illness, as subacute sclerosing pan encephalitis (SSPE), which is a fatal complication that can occur years later. Pertussis is most commonly fatal in young infants less than 6 months of age. It can also cause severe illness and hospitalization in older children and adults, often due to pneumonia or complications of cough. Varicella can lead

[2] Centers for Disease Control. Type and Duration of Precautions Recommended for Selected Infections and Conditions: Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007). https://www.cdc.gov/infectioncontrol/guidelines/isolation/appendix/type-duration-precautions.html. Accessed 7/15/2022.

to skin superinfections with bacteria, as well as encephalitis or cerebellar infection in the brain, and can cause children to die. Hepatitis B can cause liver failure and death. Influenza can cause respiratory failure and death. COVID can cause respiratory failure and death.[3]

17. Vaccine preventable diseases are often more severe in patients who are very young, very old, or lack functioning immune systems. These special populations require more frequent care in hospitals and making that setting safe for them is an important focus for me as a pediatrician.

Several examples from my current practice include:

a. Babies in the newborn nursery or NICU who are < 2 months old cannot yet be immunized. Due to their age, they are also more vulnerable to severe outcomes from many diseases, including pertussis and influenza.

b. Children who have undergone transplantation (heart, kidney, lung) are especially vulnerable to viral infections with varicella and measles, among others. Their immune systems are not normal because they must take immunosuppressive medication. If

[3] Kimberlin DW, Barnett ED, Lynfield R, Sawyer MH. *Red Book : 2021-2024 Report of the Committee on Infectious Diseases / Committee on Infectious Diseases, American Academy of Pediatrics ; David W. Kimberlin, Editor ; Elizabeth D. Barnett, Associate Editor ; Ruth Lynfield, Associate Editor ; Mark H. Sawyer, Associate Editor.* 32nd ed. (Kimberlin DW, Barnett ED (Elizabeth D, Lynfield R, Sawyer MH, eds.). American Academy of Pediatrics; 2021.

exposed, they may require an intervention such as post-exposure prophylaxis with immune globulin. Nonetheless, fatal outcomes can still occur.

c. Children undergoing chemotherapy are also vulnerable to viral and bacterial illness because they have fewer white blood cells to fight infection.

d. Children undergoing invasive procedures (surgeries, blood draws) are at risk for transmission of a blood borne illnesses like Hepatitis B, should a needle stick occur from an infected caregiver.

18. Verifying vaccination or providing proof of immunity is a standard part of the onboarding process for hospital workers. Every hospital in which I have been credentialed to work as a physician has required me to submit proof of vaccination or immunity (in the form of antibody measurements, for example) for vaccine preventable diseases as part of my credentialing for medical staff membership in order to protect healthcare workers and patients from the risks associated with vaccine-preventable diseases.

19. A health care worker who is unvaccinated against measles, pertussis, varicella, influenza, COVID-19 or hepatitis B presents an increased risk to patients and to other co-workers.

20. There are no adjunctive measures (hand washing, mask wearing) that

can completely mitigate the risk an unvaccinated caregiver could present to patients or co-workers in the course of his or her usual clinical duties in a hospital. Several examples:

a. Needlestick injuries are not entirely preventable, and can transmit Hepatitis B.

b. Measles is primarily transmitted via airborne particles, so a standard surgical mask would not be sufficient to prevent transmission. Rooms in which someone with measles have been sitting must be closed off for 2 hours before being used again, as cases of transmission have been reported even after a patient has left a hospital room. The same would be true of a staff member – even if he or she were no longer present in a room, there is the potential for transmission if a patient or co-worker were to enter afterwards.

c. Masks are helpful in preventing droplet transmission of disease (for example, COVID-19, influenza, varicella, pertussis) but not 100% effective.

d. For infections transmitted via contact with infected surfaces, wearing gloves and gowns is helpful but not 100% effective.

21. During an outbreak of disease, unvaccinated health care workers

exposed to a disease may be recommended to quarantine (i.e. not work) by current CDC guidance.

22. Accordingly, it is my opinion that healthcare settings must have actual knowledge of the immunity status of their workers. It is also my opinion that healthcare settings must be able to condition and treat healthcare workers differently based on actual knowledge of their immunity status in order to secure a safe work environment and to secure a safe environment for patients.

23. The risk presented by the transmission of vaccine-preventable diseases is greatest for patients typically found in the newborn nursery, NICU, oncology, or transplant services. In the pediatric unit in which I work, we care for newborns, children with cancer and children with organ transplants. It is my opinion that in order to secure a safe work environment and a safe environment for patients in this setting, the healthcare setting must have actual knowledge of a worker's immunization status and must have the flexibility to condition the worker's employment in ways that respond to their actual immunity status.



Lauren Wilson, M.D.

Wilson Report – Exhibit 1

LAUREN WILSON, MD

1. CONTACT INFORMATION

Office Address: Community Medical Center
Pediatrics
2827 Fort Missoula Road
Missoula, MT 59804
Email: lswilson@communitymed.org

2. EDUCATION

B.A., *summa cum laude*, German and Mathematics 8/1999-5/2003
Rice University, Houston, TX

M.D.C.M., McGill University, Montreal, Quebec 8/2003-5/2007

3. POSTGRADUATE TRAINING

Pediatric Resident 6/2007-6/2010
University of Vermont, Burlington, VT

Pediatric Chief Resident 7/2010-7/2011
University of Vermont, Burlington, VT

4. FACULTY POSITIONS HELD

Clinical Instructor 7/2007-6/2011
University of Vermont College of Medicine, Burlington, VT

Clinical Assistant Professor 7/2011-10/2014
University of Washington School of Medicine, Seattle, WA

Acting Assistant Professor 11/2014-12/2015
University of Washington School of Medicine, Seattle, WA

Associate Program Director, Pediatric Residency Program 7/2014-12/2015
Seattle Children's Hospital, Seattle, WA
Clinical Assistant Professor 12/2015-7/2018
University of Washington School of Medicine, Seattle, WA

Clinical Associate Professor 7/2018-present
University of Washington School of Medicine, Seattle, WA

Adjunct Faculty 12/2015-present
University of Montana, Missoula, MT

6. HOSPITAL POSITIONS HELD

Attending Physician, Division of Inpatient Medicine 7/2010-6/2011
Vermont Children's Hospital at Fletcher Allen Health Care, Burlington, VT

Member, Neonatal Intensive Care Transport Team 7/2012-6/2011
Vermont Children's Hospital at Fletcher Allen Health Care, Burlington, VT

Attending Physician, Division of Hospital Medicine 7/2011-12/2015
Seattle Children's Hospital, Seattle, WA

Pediatric Hospitalist 7/2014-12/2015
Evergreen Health, Kirkland, WA

Pediatric Inpatient Attending 7/2015-12/2015
Harborview Medical Center, Seattle, WA

Pediatric Hospitalist 12/2015-present
Community Medical Center, Missoula, MT

Pediatric Hospitalist 12/2015-present
Providence St. Patrick's Hospital, Missoula, MT

Medical Director, Pediatric Service Line 5/2017-present
Community Medical Center, Missoula, MT

7. HONORS

Herbert Allen (Half Tuition) Scholarship, Rice University School of Humanities	1999-2003
Institute for International Education of Students Excellence in Sciences Award	1/2002
Phi Beta Kappa	5/2003
Mark Nickerson Prize in Pharmacology, McGill University	4/2005
Osler Medical Aid Foundation Scholarship, McGill University	6/2005
Quebec Medical Association Scholarship and Prix Robert-Gourdeau	4/2006
P.E.O. (Philanthropic Educational Organization) Scholar Award	6/2006
James McGill Prize (Top 5% of class), McGill University	2005-2006
Dean's Honor List (Top 10% of class), Faculty of Medicine, McGill University	2003-2007
Alexander D. Stewart Prize (Top graduate, selected by peers), McGill University	5/2007
Resident Outstanding Teacher Award (Three times), University of Vermont	2008-2010
Montana Medical Association Healthcare Leadership Program selectee	2019-2020

8. BOARD CERTIFICATION

Diplomate, American Board of Pediatrics, General Pediatrics, 10/18/2010
Diplomate, American Board of Pediatrics, Pediatric Hospital Medicine, 11/13/2019

9. CURRENT LICENSE TO PRACTICE

Montana Medical License, #MED-PHYS-LIC-42164

10. PROFESSIONAL ORGANIZATIONS

Montana Chapter of American Academy of Pediatrics – 1/2016-present
Neonatal Resuscitation Program, 5/2010-5/2012 and 10/2015 to present
Pediatric Advanced Life Support (American Heart Association), Provider, 6/2007-present
Pediatric Fundamental Critical Care Support, 10/2016-present
Pediatric Fundamental Critical Care Support Instructor, 2/2018-present
AAP Section on Hospital Medicine, Member, 6/2011-present
AAP Council on Quality Improvement and Patient Safety (COQIPS), Member, 11/2013-8/2017
Quality Improvement Innovation Networks (QuIIN), Member, 6/2013-present
Academic Pediatric Association, Member, 1/2014-12/2014
American Academy of Pediatrics, Member, 6/2007-8/2013, Fellow, 8/2013-present
Society of Hospital Medicine, 1/2016-present

11. TEACHING RESPONSIBILITIES

Small Group Leader, McGill University College of Medicine 3/2007
Helped lead "Physicianship" course for first-year medical students

Pediatric Grand Rounds, "Cystinosis: Failure to Thrive and Really Big Diapers" 12/2007
University of Vermont College of Medicine

Pediatric Grand Rounds (1/2009), Obstetric Grand Rounds (2/2009) 1/2009-2/2009
"Neonatal Alloimmune Thrombocytopenia", University of Vermont College of Medicine

Resident Education Committee, University of Vermont College of Medicine 06/2009-6/2011
Help review the pediatric residency curriculum and evaluate program changes.

Pediatric Professor Rounds, University of Vermont College of Medicine 7/2010-6/2011
As Pediatric Chief Resident, led bi-weekly didactic sessions for "Pediatric Professor Rounds", a case-focused morning conference attended by faculty, community physicians, and house staff. 98 sessions total, with 55 presented entirely by me and the remainder with 30% contribution. Attendees eligible for CME credits.

Resident Night Curriculum, Seattle Children's Hospital 6/2011- 12/2015
Helped to develop and lead interactive teaching cases based on typical on-call scenarios for night float residents. Occurred weekly when on service.

Medical Student Observership Preceptor, Seattle Children's Hospital 1/2012-5/2012
Introduced first year medical student to pediatrics; directly observed patient interactions.

Resident Noon Lectures, Seattle Children's Hospital 5/2012-12/2015
"Bronchiolitis", "Pertussis", "Cellulitis", "Childhood Exanthems" (repeat yearly)

Pediatric Medicine Inpatient Service, Seattle Children's Hospital 7/2013-12/2015
Clinical preceptor for pediatric residents and medical students.

Clinical Competency Committee, Seattle Children's Hospital 7/2014-12/2015
Evaluate and mentor residents to enable progression along learning milestones.

Residency Committee, Seattle Children's Hospital 7/2014-12/2015
Help review the pediatric residency curriculum and evaluate program changes.

WWAMI Pediatric Clerkship Site Co-Coordinator, University of Washington 12/2015-9/2019
Responsible for overseeing pediatric core clerkship in Missoula, MT

Family Medicine Residency of Western Montana, University of Montana 12/2015-present
Instruct family medicine residents in clinical pediatrics

Coordinator, Community Hospital Medicine Elective, University of Washington 6/2017-present
Design and coordinate elective for third year pediatric residents

12. EDITORIAL RESPONSIBILITIES

Reviewer, Hospital Pediatrics 2015

13. SPECIAL NATIONAL RESPONSIBILITIES

Legislative Affairs Intern, American Medical Student Association (AMSA) 11/2006-12/2006
Washington, DC

14. SPECIAL LOCAL RESPONSIBILITIES

Member, Family Centered Rounding Quality Improvement Committee 06/2009-06/2010
Fletcher Allen Health Care, Burlington VT
Improve the ability of rounding teams to communicate effectively with patients and families about their care, while simultaneously allowing the team to make treatment plans and educate trainees.

Visioning Committee, Division of Hospital Medicine 12/2011-2/2013
Seattle Children's Hospital
Participate in the development of a vision, mission, and strategic plan for the division. Designed and implemented faculty satisfaction survey for the division.

Bronchiolitis Clinical Pathway Owner 7/2012-12/2015
Seattle Children's Hospital
Manage established evidence-based clinical pathway for patients with bronchiolitis. Develop a new pathway for treatment of patients in the Emergency Department and acute care wards with High Flow Nasal Cannula; develop and track metrics to ascertain quality of care.

Cellulitis and Abscess Clinical Pathway Owner 9/2012-12/2015
Seattle Children's Hospital
Develop new evidence-based clinical pathway for patients in both the Emergency Department and acute care wards with skin and soft tissue infections; develop and track metrics to ascertain quality of care.

Inpatient Medicine Reaggregation Project Leader 8/2014-12/2015
Help design changes to medical unit structure to take advantage of geographic-based teams and improve inpatient work flow. Apply Lean Methodology to improve efficiency.

Executive Committee 10/2018-present
Montana Chapter, American Association of Pediatrics
Secretary-Treasurer 10/2018-10/2020, Vice President 10/2020-present
As a member of the executive committee of the MT AAP, help with minutes, finances, as well as advocacy priorities and chapter conferences and activities.

Physician Advisory Council Member 1/2019-present
Blue Cross Blue Shield of Montana
Help advise Montana's major private insurer with regards to policy priorities in the state.

Legislative Committee Member 12/2018-present
Montana Medical Association

Board of Trustees Member 12/2020-present
Montana Medical Association

Legislative Committee Chair 12/2018-present
Montana Chapter, American Academy of Pediatrics

Medical Executive Committee 1/2020-1/2022
Community Medical Center

Bylaws Committee 1/2020-present
Community Medical Center

Credentials Committee 7/2021-present
Community Medical Center

15. RESEARCH FUNDING

Completed: PI, AAP Community Access to Child Health (CATCH) Grant, "Parenting Support Groups for Somali Bantu Refugees", 1/2009 – 6/2010, $3,000 with 100% effort

Completed: Co-PI (with D Caglar), Academic Enrichment Fund Award, Seattle Children's Hospital. "Impact of a comprehensive clinical protocol on outcomes for patients with skin and soft tissue infections", 1/2015 – 1/2017. $37,250 with 50% effort.

16. BIBLIOGRAPHY

Manuscripts in Refereed Journals

1. Davis-Kirsch S, **Wilson L**, Albin D, Harkins M, Del Beccaro M. "A Feasibility Study Using a Pediatric Call Center as Part of a Readmission Prevention Strategy." *J Pediatr Nursing*. In press. Published online 19 Aug 2014. S0882-5963(14)00239. PMID: 25193689.

2. **Wilson L.** "Index of Suspicion: Recurrent vomiting and a 60 lb weight loss in a 17-year-old girl." *Pediatr Rev.* 2016 Jun; 37(6):264-6.

3. Bryan M, Desai A, **Wilson L,** Wright D, Mangione-Smith R. "Association of Bronchiolitis Clinical Pathway Adherence with Length of Stay and Costs." *Pediatrics* Feb 2017, e20163432; DOI: 10.1542/peds.2016-3432.

Book Chapters

1. Taxier R, **Wilson L**. (2015) Imperforate Anus. In EK Chung (Ed.) *Visual Diagnosis and Treatment in Pediatrics, 3rd Edition*. (pp. 43-47) Philadelphia, PA: Wolters Kluwer.

2. **Wilson L**, Taxier R. (2015) Hand Swelling. In EK Chung (Ed.) *Visual Diagnosis and Treatment in Pediatrics, 3rd Edition*. (pp. 337-342) Philadelphia, PA: Wolters Kluwer.

Abstracts

1. **Wilson L**, Reincke K, Fondacaro K, Green A. "Parenting Groups for Somali Bantu Refugees". Poster Presentation. Pediatric Academic Societies Annual Meeting, Vancouver, B.C. 5/2010

2. **Wilson L**, Foti J, Ringer C, Magin J, Spencer S, Roberts J, Slater A, Beardsley E. "Effects of a Clinical Pathway for High Flow Nasal Cannula Therapy in Bronchiolitis Outside of the Intensive Care Unit." Poster Presentation. National Conference and Exhibition. American Academy of Pediatrics. San Diego, CA. 10/2014.

3. Bryan M, **Wilson L**, Desai A, Wright D, Mangione-Smith R. "Adherence to a Bronchiolitis Clinical Pathway is Associated with Decreased Length of Stay and Costs." Poster Presentation. 5th Annual Advancing Quality Improvement Science for Children's Health Care Research Conference, Academic Pediatric Association. 4/24/15. San Diego, CA.

4. Bryan M, **Wilson L**, Desai A, Wright D, Mangione-Smith R. "Adherence to a Bronchiolitis Clinical Pathway is Associated with Decreased Length of Stay and Costs." Platform Presentation. Pediatric Academic Societies Annual Meeting. 4/25-4/28/2015. San Diego, CA.

5. Collins C, Chan T, Haaland W, Roberts J, Spencer S, **Wilson L,** Wright D. "Simulating the Economic Effects of a Ward-Based High Flow Nasal Cannula Protocol." Poster Presentation. Pediatric Academic Societies Annual Meeting. 4/30 – 5/3/2016. Baltimore, MD.

6. Caglar D, **Wilson L,** Kronman M, Vora S, Lion C, Rutman L. "Effect of a Clinical Pathway on Treatment of Skin and Soft Tissue Infections." American Academy of Pediatrics National Conference & Exhibition. 10/21-10/25/16. San Francisco, CA.

7. **Wilson L**, Caglar D, Rutman L, Lion C, Kronman M, Vora S. "Standardizing Care for Skin and Soft Tissue Infections in Children: Impact on Antimicrobial Stewardship." Pediatric Academic Societies Annual Meeting. 4/30 – 5/3/2016. Baltimore, MD.

8. **Wilson L,** Caglar D, Rutman L, Lion C, Kronman M, Vora S. "Standardizing Care for Skin and Soft Tissue Infections in Children: Impact on Antimicrobial Stewardship." Pediatric Hospital Medicine Conference. 7/28-7/31/2017. Chicago, IL.

Workshops

1. McPhillips H, Kendermore D, Batra M, Olson S, **Wilson L**, Konecki K, Grow M, Quitiquit C, Wild J, Schook C, Dixon S. Enhancing Teamwork in Your GME Office: A Workshop for Program Directors and Coordinators. 3/25-3/28/2016. Orlando, FL.

2. Beck J, Rooholamini S, **Wilson L**, McDaniel C, Griego E, Long M, Shen M, Ravid N, Kupono B, Kinkel H, Blankenburg B. Choose Your Own Adventure: Leading Effective Case-Based Learning Sessions Using Evidence-based Strategies. Pediatric Hospital Medicine Conference. 7/28-7/31/2016. Chicago, IL.

3. Beck J, Rooholamini S, **Wilson L,** Long M, Shen M, Louden D, Gribben V, Peterson J, Blankenburg B. Choose Your Own Adventure: Leading Effective Case-Based Learning Sessions Using Evidence-based Strategies. Workshop presented at: Pediatric Academic Societies Annual Meeting. 4/30 – 5/3/2016. Baltimore, MD.

4. Russo C, Hodo L, **Wilson L**, Bachta S, Fletcher C, Hofmann M, Joseph-Griffin M., Krugman S., Marek S, Marlow L, Rowinsky P, and Snow C. It Doesn't Take a Village, It

Takes a Community: How to Design and Improve Your Educational Program for Trainees in a Community Hospital. Workshop presented at: Pediatric Academic Societies; May 2016; Baltimore, MD.

5. Russo C, Hodo L, **Wilson L**, Bachta S, Fletcher C, Hofmann M, Joseph-Griffin M., Krugman S., Marek S, Marlow L, Rowinsky P, and Snow C. It Doesn't Take a Village, It Takes a Community: How to Design and Improve Your Educational Program for Trainees in a Community Hospital. Workshop presented at: Pediatric Hospital Medicine; July 2016; Chicago, IL.

17. OTHER ACTIVITIES

Member, McGill International Health Initiative	9/2003-5/2007
Leader, McGill International Health Initiative	8/2004-6/2005
Co-Organizer, World AIDS Day lecture and rally, McGill Campus	9/2003-5/2007
Conference Co-Organizer, "Global Health Equality", McGill University	3/2004
Organizer, Community dengue prevention campaign, Santa Lucia, Honduras	7/2005-8/2005
Volunteer, "Dans La Rue", program for homeless street youth in Montreal	10/2005-9/2006
Physician Volunteer, Partners in Health, Port au Prince, Haiti	4/2011

Local Invited Lecture:

Invited speaker, "Dengue Prevention in Rural Honduras." 9/2005
Osler Medical Aid Foundation Scholar Lecture, McGill University. Montreal, Canada.

National Invited Lectures:

Invited speaker (co-presenter with Kenneth Roberts), "Visual Diagnosis" 7/25/2014
Pediatric Hospital Medicine Conference, Orlando, FL.

Invited speaker, "Bronchiolitis: Improving Care after the New Guidelines" 11/6/2015
UW Continuing Nursing Education Advanced Practice in Primary and Acute Care Conference, Seattle, WA.

Exhibit B

Raph Graybill
GRAYBILL LAW FIRM, PC
300 4th Street North
Great Falls, MT 59403
Phone: (406) 452-8566
Email: rgraybill@silverstatelaw.net

Attorney for Plaintiff-Intervenor

**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MONTANA
MISSOULA DIVISION**

MONTANA MEDICAL ASSOCIATION, et al., Plaintiffs, and MONTANA NURSES ASSOCIATION, Plaintiff-Intervenor v. AUSTIN KNUDSEN, Montana Attorney General, and LAURIE ESAU, Montana Commissioner of Labor and Industry, Defendants.	Cause No. 9:21-cv-108 Hon. Donald W. Molloy **DECLARATION AND EXPERT REPORT OF GREG HOLZMAN, M.D., MPH**

I, Gregory S. Holzman, M.D., MPH, declare, pursuant to 28 U.S.C. § 1746 and under penalty of perjury, that the foregoing is true and correct:

1. The facts and opinions set forth in this Declaration are known to me

based on my personal knowledge and belief, and based upon my knowledge, training, research, education, and experience.

2. I have been retained by the Plaintiff-Intervenor in the above-captioned matter to render certain opinions as contained in this document. I am charging $500 per hour for my work on this matter. I reserve the right to modify, expand upon, or otherwise change these opinions as new or additional information is provided to me.

EXPERIENCE AND CREDENTIALS

3. I obtained my medical doctorate from the University of Florida, College of Medicine, and my Master of Public Health from the University of Washington, School of Public Health. I completed a residency in Family Medicine at the Carolina Medical Center and a Preventive Medicine residency at the University of Washington. I am board certified by the American Board of Family Medicine. I am also board certified by the American Board of Preventive Medicine. According to the American Board of Preventive Medicine, "Preventive Medicine is the specialty of medical practice that focuses on the health of individuals, communities, and defined populations. Its goal is to protect, promote, and maintain health and well-being and to prevent disease, disability, and death. Preventive medicine specialists have core competencies in biostatistics, epidemiology, environmental and occupational medicine, planning and evaluation

of health services, management of healthcare organizations, research into causes of disease and injury in population groups, and the practice of prevention in clinical medicine."

4. I have worked in clinical medicine, academia, and State and Federal governmental public health. I have held leadership positions in public health as the Chief Medical Executive for the Michigan Department of Community Health for the State of Michigan. I served with the Centers for Disease Control and Prevention as the Deputy Director for the Office for State, Tribal, Local and Territorial Support. Most recently, I served as the State Medical Officer for the State of Montana, Montana Department of Public Health and Human Services. I am currently working as a consultant on different public health issues. Attached as Exhibit 1 is my curriculum vitae, which further summarizes my credentials and professional and clinical education and experience.

5. I have not previously given deposition or trial testimony as a retained expert. However, I provided affidavit testimony in my capacity as State Medical Officer about the risk of COVID-19 transmission in polling places in a 2020 case called *Trump v. Bullock*, Case No. No. CV-20-67-H-DLC at the United States District Court for the District of Montana, Missoula Division. I also provided deposition testimony in my capacity as State Medical Officer in a 2020-2021 case called *Gallatin County v. Rocking R Bar* in state district court in Gallatin County.

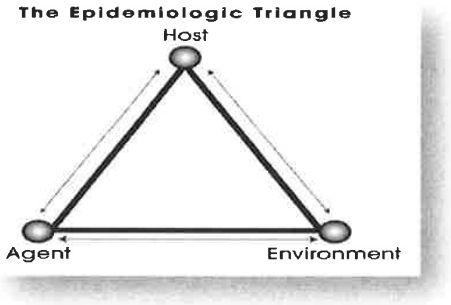
OPINIONS

6. It is well-settled in the fields of public health and preventive medicine that infectious diseases have been responsible for significant morbidity and mortality throughout the millennium. Even before the advent of life-saving antibiotics, antiviral, antifungal, and antiparasitic medications, scientists looked for ways to prevent infectious diseases and their spread within communities. Early interventions included tools like handwashing, source control such as masks for respiratory disease, and the concepts of isolation and quarantine. The advent of vaccines has significantly improved the ability to prevent the spread of disease, suffering, and deaths worldwide. A Centers for Disease Control and Prevention on April 2, 1999, Vol. 48, No 12 Morbidity and Mortality Weekly Report ("MMWR") identified vaccines as one of the Ten Great Public Health Achievements of the 20th century.[1] Some infectious diseases, such as smallpox, have been eradicated from the world, while diseases such as measles and polio have been eliminated from the U.S. due to vaccination programs. Many other vaccine-preventable diseases have been significantly reduced, leading to a decrease in suffering and premature death. In the MMWR report from May 20, 2011, the authors highlight an economic analysis by Zhou indicating "… that vaccinations of

[1] Centers for Disease Control and Prevention (CDC). Ten great public health achievements – United States, 1900 – 1999. MMWR Morb Mortal Wkly Rep. 1999 Apr 2;48(12): 241-3. PMID 10220250

each U.S. birth cohort with the current childhood immunization schedule prevents approximately 42,000 deaths and 20 million cases of the disease, with net savings of nearly $14 billion in direct costs and $69 billion in total societal cost."[2]

7. Public health and preventive medicine experts use a model called the Epidemiological Triangle to discuss the spread of, and ways to control, infectious disease.



The host is the "who" of the triangle. Public health and preventive medicine experts focus on how vulnerable the host (individual or population) is to the infectious disease. The Agent is the "what" of the triangle. Public health and preventive medicine experts focus on understanding the infectious disease's transmissibility and virulence within a given individual or population. The Environment is the "where" of the triangle. Public health and preventive medicine experts focus on understanding external factors that help support the spread of a

[2] Centers for Disease Control and Prevention (CDC). Ten great public health achievements – United States, 2001 - 2010. MMWR Morb Mortal Wkly Rep. 2011 May 20:60(19):619-23. PMID 21597455

given contagious disease. Our goal in public health is to interrupt the triangle, at least on one of the sides, to stop the spread of diseases.

8. Acquiring an infectious disease is a recognized hazard to working within the medical field and in healthcare settings. This includes the acquisition of vaccine-preventable diseases. Healthcare workers, such as nurses, risk exposure to infectious diseases within their routine work requirements. Also, a healthcare worker who acquires an infectious disease can be a vector to spread that infection to others, including coworkers and patients, leading to an increased risk for longer hospital stays, increased medical cost, suffering, and even death.

9. Healthcare settings host vulnerable individuals at higher risk for morbidity and mortality if they acquire a vaccine-preventable infectious disease. Therefore, healthcare settings put forth significant resources to prevent the spread of diseases within their facilities through types of occupational health services.

10. Healthcare settings employ people, including nurses, who could be vulnerable or at higher risk for morbidity and mortality if they acquire a vaccine-preventable infectious disease.

11. Hospitals, clinics, and other healthcare settings implement evidence-based and standard of care practices such as using appropriate personal protective equipment, properly cleaning healthcare facilities and equipment, cohorting or isolating specific types of patients, and even limiting access to certain areas of the

facility or specific patients to limit the risk for disease transmission. Some precautions to prevent the spread of disease are universal throughout healthcare settings. At the same time, the risk of exposure to unique infectious diseases requires more specific prevention measures; for example, contact, bloodborne, droplet, or airborne precautions may be implemented.

12. In certain situations in healthcare settings, it is necessary to know the vaccination status of healthcare workers to prevent the spread of a vaccine-preventable disease. Likewise, there are situations in healthcare settings where it is essential to treat employees differently in the conditions of their employment based on their vaccination or immunity status in order to secure a safe workplace and protect patients. For example, a healthcare worker who is not immune to measles or varicella cannot be in direct contact with a patient who has an active infection of these diseases without creating a significant risk to the worker of infection. And because these viruses can be spread before an individual is aware they have measles or varicella, the risk can be compounded with the further spread of the disease to unknowing patients and/or healthcare workers.

13. It is well-established in the fields of public health and preventive medicine that vaccines can prevent or decrease the severity of vaccine-preventable diseases. High vaccination rates within a population can decrease the risk of the spread of disease within a population. High vaccination rates in a population can

decrease the risk of the nonimmune, such as individuals who are unable to be vaccinated or are immunosuppressed from possibly acquiring the infection. An example is the practice of vaccinating individuals against pertussis who are around a newborn who is too young to be vaccinated and is at the greatest risk for severe disease.

14. The CDC's Immunization of Health-Care Personnel – Recommendation of the Advisory Committee on Immunization Practice[3] (document) highlights that healthcare providers "… are considered to be at substantial risk for acquiring or transmitting hepatitis B, influenza, measles, mumps, rubella, pertussis, and varicella." These are all vaccine-preventable diseases. We would add COVID-19 to this list. Other vaccines are recommended to certain healthcare providers in certain situations.

15. In my opinion, other preventive measures are not a substitute for immunizations but are part of the comprehensive strategy to decrease the risk of disease spread in healthcare settings. For one reason, some infectious diseases can be spread without the host knowing they are infected. For example, a percentage of individuals actively infected with the SARS-CoV 2 virus has shown no overt symptoms of COVID-19. Other examples include measles which can spread up to

[3] Advisory Committee on Immunization Practices; Centers for Disease Control and Prevention (CDC). Immunization of health-care personnel: recommendations of the Advisory Committee on Immunization Practices (ACIP) MMWR Recomm Rep. 2011 Nov 25;60(RR-7):1-45. PMID: 22108587

four days before a rash appears and varicella up to two days before the rash onset. Another example is influenza, where an individual could start spreading the virus a day before symptoms. Another reason is that none of the other prevention measures are foolproof. Human error can decrease their effectiveness, such as incorrectly wearing a mask, not appropriately washing one's hands, or even having an accidental needle stick. Immunizations are also not 100% effective at preventing infection or reducing disease spread in all circumstances. Rather, it is through a comprehensive program that includes immunizations that healthcare setting can best minimize the risk of the spread of vaccine-preventable diseases to patients and healthcare workers.

16. Actual knowledge of a healthcare worker's immunization status allows a healthcare setting to assess not only the risk to the individual in certain situations, but the risk to others in a population. Passive assumptions about an individual's vaccination status are no substitute for actual knowledge of their vaccination status. In medicine and public health, we take a medical history or use investigative tools to gather pertinent information to help us understand risk and implement treatment and/or prevention plans.

17. In my opinion, to care for patients and employees in certain situations, public health and preventive medicine require healthcare settings to treat immune and unimmune individuals differently. Medically recommended intervention may

be different for an immune or non-immune individual. For example, a healthcare provider may need to move quickly with post-exposure prophylaxis to decrease the risk of an individual acquiring the disease. Infection Control Preventionists use the knowledge of vaccine status when determining quarantine or possible work restriction to help prevent risk to others and further spread of disease.

18. I understand that House Bill 702 does not allow healthcare settings to treat employees differently based on their vaccination status. Based on my experience and knowledge in the fields of public health and preventive medicine, it is my opinion that in specific scenarios, healthcare settings must be able to treat employees differently in the conditions of their work and employment based on their vaccination status to secure a work environment free from known hazards for healthcare workers and their patients.

19. I also understand that it HB 702 allows certain health care facilities to assume that some employees are not vaccinated and make accommodations. As described above, assumptions about immunity or vaccination status are no substitute for actual knowledge of immunity or vaccination status when a healthcare setting is responding to an active transmission of vaccine-preventable disease, or developing and implementing plans to prevent further transmission of disease. It is my opinion that in order to provide a workplace free from known hazards, healthcare settings must be able to treat employees differently based on

knowledge of a healthcare worker's actual immunity status—and that in certain situations, this is the only option that does not jeopardize workplace safety.

20. Healthcare workers have an increased risk of exposure to vaccine-preventable diseases. Healthcare workers also pose the risk of transmitting vaccine-preventable diseases to vulnerable patients, and other healthcare workers, among others. It is my opinion that all healthcare workers that can, should be vaccinated in accordance with the Advisory Committee for Immunization Practices recommendation for healthcare personnel. It is my further opinion that healthcare settings must have the flexibility to require immunizations described by the Advisory Committee—or to treat employees differently based on actual knowledge of their immunization status—in order to address the recognized workplace hazard of vaccine-preventable disease and to provide a safe environment for workers and patients at risk.

21. Based on my knowledge and experience, it is my opinion that healthcare workers in long term care settings face the same or similar workplace risks associated with vaccine-preventable diseases as those who do not work in long term care settings.

MD, MPH

Greg Holzman, M.D., MPH

Holzman Report – Exhibit 1

GREGORY SCOTT HOLZMAN MD, MPH

PERSONAL

Home Address:	1311 E Broadway St Helena, MT 59601
Telephone	517-488-7161
Email	Holzmangreg99@gmail.com
Citizenship	USA

EDUCATION

University of Washington	2000 – 2002	MPH Preventive Medicine Residency
Maniilaq Health Center, Kotzebue, Alaska	1998 (March)	One-month clinical rotation
Carolina Medical Center, Department of Family Practice	1995 – 1998	Family Medicine Residency
University of Florida College of Medicine	1990 – 1995	MD with Honors
Michigan State University	1985 – 1988	BS with High Honors
Tulane University	1984 – 1985	

LICENSES

Michigan	Active
Montana	Active

CERTIFICATIONS

Advanced Trauma Life Support	2018
Advanced Cardiac Life Support	2021
Basic Life Support	2021
American Board of Preventive Medicine – Re-Certification	2016
American Board of Preventive Medicine - Certification	2005
American Board of Family Practice – Re-Certification	2004, 2014
American Board of Family Practice – Certification	1998

LEADERSHIP TRAINING

2017 Physician Leadership Effectiveness Program	2016 - 2017
Public Sector Leadership: Values, Vision & Vital Strategies: The Federal Executive Institute	September 9 - 13, 2012

PROFESSIONAL EXPERIENCE

Consulting Contracts	
Montana Primary Care Association	2021 – present
Association of State and Territorial Health Officials	2022 – present
Senior Leadership Reserve Corp	
Montana Medical Association	2021 – 2022
Montana Department of Public Health and Human Services	
State Medical Officer	2015 – 2021
State Health Officer	2020 – 2021
State Health Officer Designee	2018 – 2020
Medicaid Medical Director	2015 – 2021
State Refugee Health Coordinator	2015 – 2017
Michigan State University	
Adjunct Associate Professor of Epidemiology	2007 – 2020, 2022 – present
Associate Professor, Department of Family Medicine	2007 – 2015
Associate Chair for Preventive Medicine, Family Medicine	2013 – 2015
Director Healthy Campus Initiative – MSU	2014 – 2015
Medical Director, Family Medicine Residency Network	2013 – 2014
Acting Co-Director GRIN (Great Lakes Research into Practice Network)	2013 – 2014
Institute for Health Policy	2013 – 2014
Sparrow Residency Program, Educator	2013 – 2014
University of Michigan	
Preventive Medicine Residency	
Residency Advisory Committee	2006 – 2017
Chair	2010 – 2013
Adjunct Associate Professor of Health Management and Policy	2007 – 2014
Deputy Director – Office for State, Tribal, Local and Territorial Support, Centers for Disease Control and Prevention	2011 – 2013
Chief Medical Executive – State of Michigan	2006 – 2011
BioWatch Advisory Committee	2010 – 2011
Executive Medical Director	
Michigan's WISEWOMAN program – Medical Oversight	2008 – 2011
Michigan Resource Allocation Ethics Advisory Committee	2008 – 2011
Institutional Review Board – Signatory Official	2007 – 2011
Michigan Primary Care Consortium	2007 – 2009
Member of Steering Committee	
Michigan Advisory Committee on Immunizations	2006 – 2011
Ex-Officio Member	
Michigan Public Health Institute – Preventive Medicine	2006 – 2011
Residency Site Director	
University of Michigan School of Public Health Practice	2006
Lindblad Expeditions – Ship Doctor 1- 4 weeks per year	2002 – present

PROFESSIONAL EXPERIENCE– Continued

Consulting Contracts

Wyoming Diabetes Prevention and Control Program	2006 (Misc. Events)
University of North Dakota School of Medicine and Health Sciences	Aug 2005 – June 2006
Montana Department of Public Health and Human Services	
Montana Tobacco Use Prevention Program	Nov 2005 – Oct 2006
Maternal and Child Health	June 2005 – Sept 2006

Central Maine Medical Center

Faculty, Family Practice Residency Program	2004 – 2005

University of Minnesota, School of Public Health

Adjunct Assistant Professor, Public Health Practice	2003 – 2005
Midwest Center for Life-Long-Learning in Public Health Advisory Cooperative Board, North Dakota Educational Liaison	2002 – 2004

University of North Dakota School of Medicine and Health Sciences

Clinical Adjunct Associate Professor, Department of Community Medicine	2004 – 2006
Associate Professor, Department of Community Medicine	2002 – 2004
Associate Professor, Department of Family Medicine	2003 – 2004
Visiting Associate Professor accompanying UND Clerkship Students, B.P. Koirala Institute of Health Science, Dharan, Nepal	2005 (April)
Co-director of Block 5, Introduction to Patient Care, Evidence Based Medicine	Fall 2002, 2003, 2004, 2005
Center for Health Promotion and Translation Research (CHPTR)	
Director of Asthma Studies	2002 – 2004
Consultant to Diabetes Studies	2002 – 2004
Medical Director, Physician Assistant Program	2002 – 2003

Indian Health Service, Browning Montana

Staff Physician, Blackfeet Community Hospital	1998 – 2000
Medical Director, Blackfeet Nursing Home	1998 – 2000

Berkeley Preparatory School, Tampa, Florida

High School Teacher	1989 – 1990
Honors Biology 9th Grade / Chemistry 11th & 12th Grade	
JV Girls' Basketball Coach	

HONORS

Professional	2020 Governor's Award for Excellence in Performance, State of Montana 2020 Vivian A. Paladin Award, Montana The Magazine of Western History Award of Merit, Montana Medical Association, 2020 Award of Excellence, Montana Department of Justice, Division of Criminal Investigation, 2018 Public Health Leadership Award, Michigan State Medical Society, 2011 Mosquito Award, Tobacco-Free Michigan, 2008 Presidential Citation, Michigan State Medical Society, 2008 Outstanding Block Instructor Award, Block 5, 2003 -2004 Outstanding Block Instructor Award, Block 5, 2002 -2003 Rookie Physician of the Year 2000, Indian Health Service Outstanding Service Provider of the Quarter, Blackfeet Community Hospital
Residency	Resident Award 2003 – American College of Preventive Medicine
Medical School	American School Health Association Scholarship Samuel D. Harris Scholarship Award – Pulmonary Alpha Omega Alpha
College	Dean's List every quarter enrolled as a full-time student Phi Kappa Eta Golden Key Honor Society Overseas Study Scholarship

ORGANIZATIONS

Montana Medical Association	2015 – present
American College of Preventive Medicine	2001 – present
American Academy of Family Physicians	1992 – present
Michigan Association of Preventive Medicine	2009 – 2016
Public Health Physicians	

NATIONAL COMMITTEES

ASTHO, Tobacco Issues Forum	2019 - 2021
Co-Chair	2019 - 2021
ASTHO, Community Health and Prevention Committee	2017 - 2021
American College of Preventive Medicine	2013 - 2019
Policy Committee	
Chair	2013 - 2017

APPOINTMENTS

Governor's Coronavirus Taskforce	2020 - 2021
Violent Death Reporting System Advisory Board	2019 - 2021
Governor's Challenge to Prevent Suicide Among Servicemembers, Veterans, and Their Families	2018 - 2021
Montana Public Health Systems Work Group	2017 - 2021
Montana Medical Association (MMA)	2016 - 2021
MMA Substance Use Disorder Committee	2016 - 2021
Legislative Committee, Ex-Officio	2016 - 2021
MMA Public Health Committee	2017 - 2021
Substance Use Disorder Taskforce	2016 - 2021
Montana Mortality Review Committee	2015 - 2021
Public Health and Safety Division – Communication Work Group	2015 - 2021
Montana Central Tumor Registry Data Use Committee	2015 - 2021
Graduate Medical Education Council, Ex-Officio	2015 – 2021
Public Health Institute – Design Team	2019 – 2020
MSU Faculty Health Care Council (Ex-Officio Member)	2013 – 2015
MSU CHM Public Health Search Committee	2013 – 2015
MSU Family Medicine Executive Committee	2013 – 2015
MSU CHM Admissions Committee	2013 – 2015
Board for Michigan Quality Improvement Consortium	2013 – 2014
ICMS – Board of Trustees – Executive Committee at Large (Elected Position)	2009 – 2011
Michigan Health & Hospital Association (MHA) Keystone Center Advisory Group	2008 – 2011
Animal Agriculture and the Environment Team - MSU	2007 – 2011
Michigan Health Council Board of Trustees	2007 – 2011
Michigan State University (MSU) Master of Public Health Program - Steering Committee Member	2007 – 2011
Tomorrow's Child Board Member	2007 – 2011

PLANNING COMMITTEES

2019 Preventive Medicine Conference, (Policy Track Chair)	2018 – 2019
Montana – Canada Conference on Addressing The Opioid Crisis, (Planning Coordinator)	2019
Big Sky Pulmonary Conference	2017, 2018, 2019, 2020
Montana's Diabetes Professional Conference	2016, 2017, 2018, 2019
2018 Montana Public Health Association	2017 – 2018

INTERVIEW TEAMS

Bureau Chief, Family and Community Health	2017
Toxicologist	2017

THESIS

Evaluating a media campaign to promote pneumococcal immunizations: Is a random digit dial telephone survey an effective strategy? (University of Washington School of Public Health)

GUEST EDITORIAL

Tobacco Control and the Ill Effects of Smoking. Michigan Journal of Public Health, Volume 1, Issue 2, Summer 2007

SELECTED PRESENTATIONS

Event	Topic	Date(s)
Montana Medical Association "The Future of Medicine after COVID" series, Virtual, Helena, MT	State Public Health: What we learned, where are we headed, and where to find help	09/2020
2020 Big Sky Pulmonary Conference, Fairmont, MT	Continuum of Care Where Healthcare & Public Health Meet – What's the Mission, and Are We Using the Right Tools to Get There?	03/2020
Healthcare Training and Delivery for Rural and Minority Underserved: An Interprofessional Perspective, Whitefish, MT	Montana Public Health Trends: Where Clinical Medicine and Public Health Meet	10/2019
Governor's Conference on Workers Compensation, Big Sky, MT	Opioid Transition Care	09/2019
2019 Preventive Medicine Conference, Pittsburgh, PA	Are E-Cigarettes the Solution to the Tobacco Use Epidemic or a Wolf in Sheep's Clothing? (Co-presented)	05/2019
REACT - Montana's teen-led Movement Against Big Tobacco, Anaconda, MT	The Tobacco Epidemic: Déjà vu all over again	04/2019
Montana – Canada Conference on Addressing the Opioid Crisis, Helena, MT	Setting the Context: The Opioid Crisis in the US and Canada (Co-presented)	03/2019
American Cancer Society – Cancer Action Network – Day at the Capitol Legislative Briefing, Helena, MT	E-Cigarettes: What We Know in 2019	03/2019

SELECTED PRESENTATIONS – Continued

Event	Topic	Date(s)
Big Mountain Medical Conference, Whitefish, MT	"No More War; No More Plague" The Spanish Influenza Pandemic Toll on Montana	01/2019
2018 ASTHO's Senior Deputies Annual Meeting, Washington, D.C.	Overcoming Stigma: Normalization Medication Assisted Treatment (Co-presented)	06/2018
ASTHO Expert Panel Meeting on Systems Level Change: Behavioral Health and Public Health, Atlanta, GA	Systems Level Changes Use of Data, Montana's Experience	06/2018
ASTHO National Webinar	Reflections on the 1918 Influenza Pandemic (Co-presented)	04/2018
MT Colorectal Cancer Roundtable Meeting, Helena, MT	Colorectal Cancer Screening: Improving Rates and Quality	03/2018
2018 Montana Pharmacy Association Winter Conference, Big Sky, MT	Cost, Access and Outcomes: The Struggle Continues	01/2018
2017 Montana Substance Use Disorder Summit, Helena, MT	Directions for Action in Montana – Summary of Themes and Opportunities for Action (Panel Discussion including Dr. Vivek Murthy, Former US Surgeon General)	11/2017
2017 Montana Public Health Association Conference, Missoula, MT	Public Health: What's in it for Me? What's in it for My Community?	09/2017
2017 Preventive Medicine Conference, Portland, OR	The Broad Street Pump: That was then, what is now? (Co-presented)	05/2017
For Pills to Heroin: A Montana Opioid Health Threat, Bozeman, MT	Opioid Health Crisis Solutions: A Community Model (Panel Discussion)	10/2016
2016 Montana Pediatric Round Up, Chico Hot Springs, Pray, MT	Suicide in Montana: Let's Stop the Pain	10/2016
Public Health and Safety Division Summer Institute	History of Public Health (Abridged)	07/2016

SELECTED PRESENTATIONS – Continued

Event	Topic	Date(s)
Public Health and Safety Division Summer Institute	Overview of the US Federal Public Health System	07/2016
2016 Montana Employer Conference, Billings, MT	Health, Me, My Job, My Community	05/2016
American Indian Tobacco Prevention Specialist's Planning Meeting, Great Falls, MT	Tobacco's Targeting of American Indians: Selling Dependence, Ill-Health and Death	03/2016
Council on Healthcare Innovation and Reform Meeting, Helena, MT	Health in Big Sky Country: Cost, Access, Outcomes, Oh My	01/2016
2015 Montana Public Health Association Conference, Bozeman, MT	Why Clinical Medicine Can Not Fix the Health System Alone	10/2015
Pediatric Roundup 2015, Big Sky, MT	Immunizations: Putting the Odds in Your Favor	09/2015
Your Health Lecture Series – Multiple locations throughout MI	Why Medicine cannot fix the Health Care System Alone? Does Your Community Impact Your Health	Multiple dates 2014
Michigan State University College of Human Medicine Alumni Weekend 2013, Grand Rapids, MI	Overview of the Affordable Care Act: How did we get here and where might we go?	10/2013
Sparrow Pediatrics Grand Rounds Lansing, MI	Vaccinations: Protecting Ourselves and Our World	08/2013
Family Medicine Senior Resident Retreat, Tustin, MI	Leading Change Through Practice Transformation and the Affordable Care Act	05/2013
2012 Keynote Address, University of Florida, College of Medicine Graduation, Gainesville, FL	What Kind of Doctor are You Going to Be...A Good One	05/2012
2013 Preventive Medicine Conference, Phoenix – Scottsdale, AZ	Unique Careers in Preventive Medicine and Public Health (Co-presented)	02/2012
Association of State and Territorial Health Officers Annual Meeting, Portland, OR	*Rediscovering Our Roots: Physicians and Public Health*	10/2011

SELECTED PRESENTATIONS – Continued

Event	Topic	Date(s)
28th National Indian Health Board Annual Consumer Conference, Anchorage, AK	*CDC & Tribes: Working Together to Improve the Health of American Indians and Alaska Natives*	09/2011
2010 Andrew D. Hunt Memorial Lecture, Lansing, MI	Happiness is … Finding a Fulfilling Career in Medicine	10/2010
Shaping the Future of Family Medicine, Lansing, MI	Issues in Healthcare	10/2010
Michigan Osteopathic Association (MOA) Annual Scientific Convention, Dearborn, MI	It Takes a Community to Have an Effective Patient-Centered Medical Home	05/2009
MSU College of Nursing 2007 Case Mgt. Conference, Kellogg Ctr. – East Lansing, MI	Evidence-Based Medicine (EBM): Why do we need EBM and what does EBM mean?	11/2007
Michigan's Premier Public Health Conference, Dearborn, MI	Building Bridges – Clinical Medicine, Public Health and the Community	10/2007
Sinai-Grace Hospital's Research Day 2007, Detroit, MI	Research: A Crucial Part of the Medical Question	08/2007
4th International Bird Flu Summit, Washington, D.C.	Preparing for the Pandemic: MI Flu Focus – A Novel, Comprehensive Influenza Surveillance System	03/2007

Additional list of national, state, and local conferences and classroom presentations – including poster presentations – available upon request

NEWSLETTERS

Holzman GS, Sahmoun AE, Brosseau JD, Helgerson SD, Pickard SP. Arthritis is the Leading Cause of Disability, 2005;1(7):1-2

Holzman GS, Sahmoun AE, Brosseau JD, Helgerson SD. The Number One Killer: Smoking. Healthy North Dakota-Highlights, 2004; 1(1):1-2

Holzman GS, Sahmoun AE, Brosseau JD, Helgerson SD. Misuse of Alcohol: North Dakota is Nationally Ranked (#2) and Needs to Get Out of the Top Ten. Healthy North Dakota-Highlights, 2004:1(3):1-2

Holzman GS, Sahmoun AE, Brosseau JD, Helgerson SD, Pickard SP. Older North Dakotans Need to be Vaccinated Against Influenza, 2004;1(4):1-2

NEWSLETTERS – Continued

Smoking Cessation: An Essential Part of Diabetes Care, Quality Improvement Report, Department of Community Medicine, University of North Dakota School of Medicine and Health Sciences 2003;1(2): Page 1

Assessing and Improving Asthma Care in Provider Practices: The CHPTR Approach. Center for Health Promotion and Translation Research, University of North Dakota School of Medicine and Health Sciences 2002;1(3): Page 3

Additional Newsletters – available upon request

ARTICLES IN REFEREED JOURNALS

Williamson LL, Harwell TS, Koch TM, Anderson SL, Scott MK, Murphy JS, Holzman GS, Tesfai H. 2021. COVID-19 Incidence and Mortality among American Indian/Alaska Native and White Persons – Montana, March 13–November 30, 2020. MMWR Morb Mortal Wkly Rep. 2021;70:510-513.

Williamson L, Nelson D, Zimmerman H, Cook-Shimanek M, Harwell T, Holzman G. 2020. High incidence of brain and other nervous system cancer identified in two mining counties, 2001-2015: insufficient evidence to support association with heavy metal exposure. *Spatial and spatio-temporal epidemiology*, *35*, 100378. https://doi.org/10.1016/j.sste.2020.100378

Harwell TS, Anderson SL, Holzman GS, Helgerson SD. "The Biggest Public Health Experiment Ever" The polio pioneers and Montana's contribution to the elimination of polio in the United States. Montana - The Magazine of Western History. 2019;69(3):47-69, 94-96.

Harwell TS, Holzman GS, Helgerson SD. "No more war, no more plague" The Spanish influenza pandemic toll on Montana. Montana – The Magazine of Western History. 2018;68(2):27-44, 93-94

Neuberger M, Dontje K, Holzman G, Corser W, Keskimaki A, Chant E. (2014). "An Examination of Office Visit Patient Preferences for the After-Visit Summary (AVS)." Sept, 2014. Perspect Health Inform Management.

Dontje K., Corser WD, Holzman G. (2014). "Understanding Patient Perceptions of the Electronic Personal Health Record." J Nurse Pracit. 10(10): 824-828.

Devlin HM, Desai J, Holzman GS, Gilbertson DT, Trends and disparities among diabetes-complicated births in Minnesota, 1993-2003. AM J Public Health 2008 Jan;98(1):59-62

Harwell TS, Lee L, Haugland C, Wilson SM, Campbell SL, Holzman GS, Gohdes D, Helgerson SD; Utilization of a tobacco quit line prior to and after a tobacco tax increase. J Public Health Manag Pract 2007 November/December; 13(6):637-641.

Folden DV, Machayya JA, Sahmoun AE, Beal JR, Holzman GS, Helgerson SD, Lo TS, Estimating the proportion of community-associated methicillin-resistant Staphylococcus aureus: two definitions used in the USA yield dramatically different estimates. J Hosp Infect. 2005 Aug;60(4):329-32.

ARTICLES IN REFEREED JOURNALS – Continued

Holzman GS, Harwell TS, Johnson E, Goldbaum G, Helgerson SE, A media campaign to promote pneumococcal vaccinations: is a telephone survey an effective evaluation strategy? J Public Health Manag Pract. 2005 May-Jun;11(3):228-34.

Moum KR, Holzman GS, Harwell TS, Parsons SL, Adams SD, Spence MR, Helgerson SD, Gohdes D, Increasing Rate of Diabetes in Pregnancy among American Indian and White Mothers in Montana and North Dakota, 1989-2000. Maternal and Child Health Journal 8(2):71-76, June 2004.

Johnson E, Harwell TS, Donahue P, Weisner MA, McInerney MI, Holzman GS, Helgerson SD, Promoting pneumococcal immunizations among rural Medicare beneficiaries using multiple strategies. J Rural Health 2003; 19:506-510.

Holzman GS, Muus K, Haugland B, Blueshield M, Hefta C, Morin B, Helgerson SD, Asthma Prevalence and Care for American Indian Youth in North Dakota, IHS Primary Care Provider. 2003; 28:20-223.

BOOK REVIEWS

Helgerson SD, Holzman GS, Clinical epidemiology. How to Do Clinical Practice Research, 3rd edition, by DL Sackett, GH Gordon, and P Tugwell. JAMA 2006; 295:446.

CHAPTERS

Holzman GS, Harwell TS, Gohdes D, Helgerson SD. Smoking Cessation for American Indians: The Need is Great and the Opportunity Clear. In: Roberts AR, Yeager KR, eds. Evidence-Based Practice Manual: Research and Outcome Measures in Health and Human Services, New York, NY: Oxford University Press; 2004:389-396.

Television, radio, and written interviews including public information commercials – available on request

AWAY ROTATIONS DURING MEDICAL SCHOOL TRAINING

Glasgow, Scotland	Pediatrics	6 weeks
Honolulu, Hawaii	OB/GYN	1 month
Jerusalem, Israel	OB/GYN	1 month
London, England	Cardiology	1 month
Zimbabwe, Chiredzi	General Practice	3 weeks
Zimbabwe, Harare	Pediatrics	1 month

PAST REVIEWER

Journal of Public Health Management and Practice
American Journal of Kidney Diseases
American Journal of Preventive Medicine

PROFESSIONAL INTERESTS

Better Integration of Public Health and Clinical Medicine, Epidemiology, Health Promotion and Disease Prevention, Evidence Based Medicine, Health Equity, Chronic Disease Management, Tobacco Cessation and Control, Social Determinants of Health, Medical and Public Health History

CURRICULUM VITAE
BONNIE STEPHENS, MD

Community Medical Center
2827 Fort Missoula Rd
Missoula MT 59804
NICU : 406-327-4058
Cell : 406-274-1856
fax 406-327-4535
bstephens@communitymed.org

Education

Fellowship	Women and Infants' Hospital/ Rhode Island Hospital Fellowship, Neonatal/Perinatal Medicine 2003-2008 Fellowship, Developmental/Behavioral Pediatrics, 2003-2008
Residency	Children's Memorial Hospital, Chicago, Illinois Pediatric Resident, 1997-2000
Medical School	Northwestern University Medical School, Chicago, Illinois MD, 1993-1997
Undergraduate	Northwestern University, Evanston, Illinois BA, Biology/Neurobiology, 1990-1993

Hospital Appointments

Community Medical Center, Missoula, MT

Chief Medical Officer, May 1, 2022 - present

Medical Staff President, January 1, 2021 – May 1, 2022

- Lead the re-write of the Medical Staff Bylaws, Rules and Regulations
- Lead the Medical Staff through a transition in senior leadership including the replacement of our CEO and CNO
- Co-chair of the Hospital Patient Safety and Clinical Quality Program

Pediatric Section Chief, October 3, 2017 – December 31, 2020

- Established and ran a Pediatric Section after the reorganization of Medical Staff Departments led to the combination of Obstetric and Pediatric Departments into a joint Women and Children's Department

Medical Director of NICU, Nov 1, 2011-present

- Implemented infection control measures including hand washing policy, VAP protocol, PICC line team, visitor policies, that reduced rates of sepsis, CLABSI, VAP. Last CLABSI > 5 years ago
- Implemented nutrition protocol for VLBW infants that includes exclusive breast milk feeds for all VLBW infants, reduced sepsis and NEC rates



Exhibit 3A - 1

- Introduced developmental care including the training and staffing of a team of Neonatal therapists in our NICU
- Implemented 24/7 neonatal respiratory therapy coverage for our NICU
- Overhaul and re-engagement of neonatal transport program
- Built our practice from 2 FTE neonatologist to 3 FTE neonatologist and 4 FTE NNP, increased annual admissions by 15%
- Trained and hired a team of Neonatal Nurse Practitioners to become the first NICU in Montana to provide 24/7 in-house provider coverage
- Held a NICU Strategic planning session with a multidisciplinary group for the NICU including MDs, NNPs, RNs, RTs, NTs, administration.
- Built and maintained outreach/referral relationships throughout western MT to increase admissions to our unit from ~ 200/year to ~ 250/year
- Assisted with development of Pediatric/NICU PSCQ dashboards

Staff Neonatologist Aug 1, 2011-present
Staff Developmental-Behavioral Pediatrician Aug 1, 2011-present

- Developed the only multidisciplinary clinic in Montana for children with complex developmental and behavioral problems

Providence St Patrick's Hospital, Missoula, MT
Staff Neonatologist, July 1, 2020 - present
Medical Director of Level 2 NICU, July 1, 2020 - present

Kootenai Health, Coeur d'Alene, ID
Locums Neonatologist, August 1, 2014 – December 31, 2016

Women and Infants Hospital, Providence, RI
Staff Neonatologist, Department of Pediatrics, Sept 17, 2007 – June 30, 2011
Courtesy Staff Neonatologist, Department of Pediatrics, July 1, 2011-2013

Southcoast Healthcare System, Southeastern MA
House Physician, Neonatology, May 2004-June 2011

Kent County Hospital, Warwick, RI
House Physician, Department of Pediatrics, Dec 2003-June 2011

Evanston Northwestern Healthcare, Evanston, IL
Staff Physician, Division of Neonatology, July 2000-July 2006

Children's Memorial Hospital, Chicago, IL
Program Associate, Behavioral/Developmental Pediatrics, May 2001-June 2002
In House Physician, NICU, Jan 2000-June 2003
In House Physician, Transitional Care Unit, June 2001-June 2003
Transport Team Physician, June 1999-June 2001

Academic Appointments
University of Washington School of Medicine, Seattle, WA
Clinical Assistant Professor, July 2013-present

Brown University Medical School, Providence, RI
Clinical Instructor, Pediatrics, July 2003-July 2008
Assistant Professor, Pediatrics, August 2008-June 2011
Adjunct Assistant Professor, Pediatrics, July 2011-June 2017

Northwestern University Medical School, Chicago, IL
Clinical Instructor, Pediatrics, 2000-2003

Other Appointments
Healthy Foundations Steering Committee
2020 - present

Ronald MacDonald House, Missoula MT
Board of Directors Feb 2016-present

Montana Medical Association
Executive Committee Member/Board of Directors, Sept 2015-Sept 2017

Child Development Center, Missoula MT
Medical Director, Aug 2013-present

Mother's Milk Bank of Montana, Missoula, MT
Medical Director of Inpatient Services, Aug 2013-present

Fetal, Infant, Child, Maternal Mortality Review Committee, Missoula County
Committee Member, 2013-present

Hospital Committees
Medical Executive Committee, Community Medical Center, 2017-present
Bylaws Committee (chair), Community Medical Center, 2020
Pediatric Service Line Committee, Community Medical Center, 2016-present
Perinatal Executive Committee, Community Medical Center, 2015-present
Infection Control Committee, Community Medical Center, 2014-present
PICC Line Committee, NICU, Community Medical Center, 2014-present
Physician Leadership Counsel, Community Medical Center, 2016-2020
Community Physician Group Executive Committee, Community Medical Center, 2017-2018
Complex NICU Discharges Committee, Chair, Women and Infants' Hospital, 2010-2011
Pharmacy and Therapeutics Committee, Women and Infants' Hospital, 2010-2011
Millennium Neonatal Symposium Planning Committee, 2009-2010
Family Centered Care Committee, Women and Infants' Hospital, 2007-2011
Indomethacin Task Force, Women and Infants' Hospital, 2007
Pulse Oximetry Clinical Practice Guideline, Women and Infants' Hospital, 2007

Medical Model for new NICU, Women and Infants' Hospital, 2006-2009
Trophic Feeding Protocol Committee, Women and Infants' Hospital, 2006-2007
Fellow/Assistant Nurse Manager Liaison, Women and Infants' Hospital, 2003-2006
Limits of Viability Committee, Women and Infants' Hospital, 2003-2005

Professional Memberships
Montana Medical Association 2013-present
American Academy of Pediatrics 1997-present
American Medical Student's Association 1993-97

Honors
Honor's Program in Medical Education 1990-1997
Young Investigator Travel Award, SPR 2005
Young Investigator Travel Award, ESPR 2006
Young Investigator Travel Award, ESPR 2007
Young Investigator Travel Award, SPR-RC 2007
NIH-Loan Repayment Program Grant, 08/2009-08/2011

Professional Licenses
Montana 12488 – current
Idaho M-12543 - inactive
Rhode Island MD11634 - inactive
Illinois 036-100894 - inactive
Massachusetts 219759 - inactive

Certification
National Board of Medical Examiners
American Board of Pediatrics, General Pediatrics - current
American Board of Pediatrics, Developmental-Behavioral Pediatrics - current
American Board of Pediatrics, Neonatal-Perinatal Medicine – current
Autism Diagnostic Observation Schedule 2010-current
Prectl General Movements Assessment 2019-present

Peer Review Activities
1. Journal of Pediatrics, reviewer, 2010-present
2. Journal of the American Medical Association, reviewer, 2010-present
3. Pediatrics, reviewer, 2010-present
4. American Journal of Perinatology, reviewer, 2011-present
5. Clinical Nutrition, reviewer, 2011-present

Peer Reviewed Publications
1. Stephens BE, Bann CM, Poole WK, Vohr BR for the NICHD Neonatal Research Network. Neurodevelopmental Impairment – Predictors of Its Impact on the Families of Extremely Low Birth Weight Infants at 18 Months. Infant Mental Health Journal. 2008 Nov 1;29(6):570-587

2. Stephens BE, Gargus RA, Vogt R, Mance M, Nye J, McKinley L, Tucker R, Vohr BR. Fluid Regimen in the First Week of Life Increases Risk of Patent Ductus Arteriosus in Extremely Low Birth Weight Infants. Journal of Perinatology. 2008 Feb;28(2):123-8.

3. Stephens BE, Walden R, Gargus RA, Tucker R, McKinley L, Mance M, Nye J, Vohr BR. First Week Protein and Calorie Intake is Associated with 18 Month Developmental Outcomes in Extremely Low Birth Weight Infants. Pediatrics. 2009 May;123(5):1337-43.

4. Stephens BE, Liu J, Lester B, Lagasse L, Shankaran S, Bada H, Bauer C, Das A, Higgins R. Neurobehavioral Assessment Predicts Motor Outcomes in ELBW Infants. Journal of Pediatrics. 2010 Mar;156(3):366-71.

5. Stephens BE, Tucker R, Vohr BR. Special Health Care Needs of Infants Born at the Threshold of Viability. Pediatrics. 2010;125:1152-1158.

6. Balakrishnan A, Stephens B, Burke R, Yatchmink Y, Alksninis B, Tucker R, Cavanaugh E, Collins A, Vohr B. Impact of Very Low Birth Weight Infants on the Family at 3 Months Corrected Age. Early Human Development. 2011 Jan;87(1):31-5.

7. Balakrishnan M, Tucker R, Stephens BE, Bliss JM. Blood urea nitrogen and serum bicarbonate in extremely low birth weight infants receiving higher protein intake in the first week after birth. Journal of Perinatol. 2011 Aug;31(8):535-9.

8. Caskey M, Stephens B, Tucker R, Vohr B. Importance of Parent Talk on the Development of Preterm Infant Vocalizations. Pediatrics. 2011 Nov;128(5):910-916.

9. Vohr BR, Yatchmink YY, Burke RT, Stephens BE, Cavanaugh EC, Alskinis B, Nye JH, Bacani D, McCourt MF, Collinc AM, Tucker R. Factors Associated with Rehospitalizations of Very Low Birthweight Infants: Impact of a Transition Home Support and Education Program. Early Human Development. 2011.

10. Vohr BR, Stephens BE, Higgins R, Hintz S, Bann CM. Are Outcomes of extremely preterm infants improving? Impact of Bayley Assessment on Outcomes. J Pediatr, Mar 14 2012

11. Stephens BE, Bann CM, Watson VE, Peralta M, Vohr BR, Higgins R for the NICHD Neonatal Research Network. Screening for Autism Spectrum Disorder in Extremely Preterm Infants. J Dev Behav Pediatr. 2012 Sep;33(7):535-41

12. Laptook AR, McDonald SA, Shankaran S, Stephens BE, Vohr BR, Guillet R, Higgins RD, Das A; Extended Hypothermia Follow-up Subcommittee of the National Institute of Child Health and Human Development Neonatal Research Network. Elevated temperature and 6- to 7-year outcome of neonatal encephalopathy. Ann Neurol. Jan 29 2013

13. Vohr BR, Stephens BE, McDonald SA, Ehrenkranz RA, Laptook AR, Pappas A, Hintz SR, Shankaran S, Higgins RD, Das A; Extended Hypothermia Follow-up Subcommittee of the National Institute of Child Health and Human Development Neonatal Research Network Cerebral Palsy and Growth Failure at 6-7 years of Age. Pediatrics. 132(4):e905-14, Oct 2013.

14. Caskey M, Stephens B, Tucker R, Vohr B. Adult talk in the NICU with preterm infants and developmental outcomes. Pediatrics. 133(3):e578-84, 2014

15. Balakrishnan M, Jennings A, Przystac L, Phornphutkul C, Tucker R, Mance M, Vohr B, Stephens BE, Bliss JM. Growth and Neurodevelopmental Outcomes of Early, High Dose Parenteral Amino Acid Intake in Very Low Birth Weight Infants: A Randomized Controlled Trial. Journal of Parenteral and Enteral Nutrition. Accepted for publication, publication pending

Invited Articles/Chapters

1. Stephens BE, Vohr BR. Neurodevelopmental Outcome of the Premature Infant. Pediatric Clinics of North America. 2009 June;56(3):631-46.

2. Vohr BR and Stephens BE. Normal and Abnormal Neurodevelopmental and Behavioral Outcomes of Preterm Infants. In G. Buonocore, R. Bracci, M Weindling (Eds), Textbook of Neonatology. Springer-Verlag 2009

3. Vohr, Stephens. Neurodevelopmental Follow-up and Outcomes. In: Elzouki AY (Ed). Textbook of Clinical Pediatrics, Second Edition. Springer. Chapter 36, page 431

4. Stephens BE, McKinley L, Vohr BR. Medical Care of Neonatal Intensive Care Unit Graduates. Dr Oh's Handbook of Neonatology.

5. Vohr, Stephens. Follow-up Assessment of Preterm Infants. Dr Oh's Handbook of Neonatology.

6. Vohr, Stephens, Tucker. Thirty-five Years of Neonatal Follow-up in Rhode Island. Med Health R I. 2010 May;93(5):151-3

7. Stephens BE, Vohr BR. Protein and Neurodevelpmental Outcomes. Clinics in Perinatology. 2014 June; 41(2):323-9

Abstracts

1. Berger S, Stephens BE, Glusman M. Understanding others by learning about ourselves: A training exercise in child development, behavior, & parenting. Poster Presentation, Pediatric Academic Societies, Seattle, WA, May 2003.

2. Berger S, Stephens BE, Paine A, et al. Every picture tells a story when you know where to look. Poster Presentation, Pediatric Academic Societies, San Francisco,CA, May 2004.

3. Gargus RA, Vogt R, Stephens BE, Tucker R, McKinley L, Mance M, Nye J, Vohr BR. Outcome at 18months in AGA ELBW Infants with Postnatal Growth Restriction. Poster Presentation, Pediatric Academic Societies, Washington DC, May 15, 2005.

4. Gargus RA, Stephens BE, Vogt R, Tucker R, Mance M, Nye J, Vohr BR. SNAPPE-II Score: Prediction of NICU and 18month Outcomes. Poster Presentation, Pediatric Academic Societies, Washington DC, May 16, 2005

5. Stephens BE, Bann CM, Poole WK, Vohr BR for the NICHD Neonatal Research Network. Impact on the family of Neurodevelopmental Impairment in ELBW infants at 18 months. Platform Presentation, Pediatric Academic Societies, Washington DC, May 16, 2005.

6. Stephens BE, Gargus RA, Vogt R, Mance M, Nye J, McKinley L, Tucker R, Vohr BR. Do Current Fluid Regimens in the First Week of Life Increase Morbidity in ELBW Infants? Poster Presentation, Pediatric Academic Societies, Washington DC, May 17, 2005.

7. Gargus RA, Vogt R, Stephens BE, Tucker R, McKinley L, Mance M, Nye J, Vohr BR. Impact of Gender on 18-22 month Outcome in ELBW Infants. Platform Presentation, Society of Developmental and Behavioral Pediatrics Annual Meeting, San Diego, CA, Sept 25, 2005.

8. Stephens BE, Tucker R, Vohr, BR. Special Health Care Needs Of Infants Born at the Threshold of Viability. Poster Presentation, Pediatric Academic Societies, San Francisco, CA, May 2, 2006.

9. Stephens BE, Liu J, Lester B, Lagasse L, Shankaran S, Bada H, Bauer C, Das A, Higgins R. Neurobehavioral Assessment Predicts Motor Outcomes in ELBW Infants. Poster Presentation, Pediatric Academic Societies, Toronto, ON, May 5, 2007.

10. Stephens BE, Vogt R , Gargus RA, Tucker R, McKinley L, Mance M, Nye J, Vohr BR. Adequate First Week Protein and Calorie Intake is Critical for 18 month Developmental Outcome in ELBW Infants. Poster Presentaton, SPR-RC, Woodlands, TX, Oct, 17, 2007

11. Balakrishnan M, Tucker R, Stephens BE, Bliss JM. Protein Safety in Extremely Low Birth Weight Infants. Poster Presentation, Pediatric Academic Societies, Baltimore, MD, May 5, 2009

12. Stephens BE, Miller R, Bigsby R, Tucker R, Lester B. Normative Neurobehavior of Extremely Low Birth Weight Infants on the Neonatal Intensive Care Unit Network Neurobehavioral Scale. Poster Presentation, Pediatric Academic Societies, Vancouver, BC, May 3, 2010

13. Vohr BR, Stephens BE, Alksninis B, Yatchmink YE, Burke RT, Tucker R. Plagiocephaly in Preterm Infants: An Early Marker of Motor Dysfunction. Poster Presentation, Pediatric Academic Societies, Vancouver, BC, May 3, 2010

14. Vohr BR, Stephens BE, Higgins R, Hintz S, Bann CM. Are Outcomes of extremely preterm infants improving? Impact of Bayley Assessment on Outcomes. Poster Presentation, Pediatric Academic Societies, Vancouver, BC, May 3, 2010

15. Caskey M, Stephens BE, Tucker R, Vohr BR. Impact of Language Exposure in the NICU on the Development of Vocalizations in Preterm Infants. Poster Presentation, Pediatric Academic Societies, Vancouver, BC, May 3, 2010

16. Caskey M, Stephens B, Tucker R, Vohr B. Adult-Infant Conversations in the NICU and Language and Cognitive Outcomes in Preterm Infants. Platform Presentation, Pediatric Academic Societies, Denver, CO, April 30, 2011

17. Stephens B, Watson V, Tucker R, Sheinkopf S, Vohr B. Screening for Autism Spectrum Disorder at 18 vs. 30 months in Extremely Preterm Infants. Poster Symposium, Pediatric Academic Societies, Denver, CO, May 1, 2011

18. Stephens B, Bann C, Watson V, Peralta-Carcelen M, Sheinkopf S, Higgins R, Vohr B, for NICHD NRN. Screening for Autism Spectrum Disorder in Extremely Preterm Infants. Poster Symposium, Pediatric Academic Societies, Denver, CO, May 1, 2011

19. Johnson K, Stephens B, Tucker R, Vohr, B. Very Early Language Skills of Late Preterm Compared to Term Infants at Birth and 44 Weeks Corrected Age. Poster Presentation, Pediatric Academic Societies, Denver, CO, May 2, 2011

20. Johnson K, Stephens B, Tucker R, Vohr, B. Reciprocal Vocalizations between Female Caregivers and their Infants Surpass those of Male Caregivers in the First Months of Life. Poster Presentation, Pediatric Academic Societies, Denver, CO, May 2, 2011

21. Stephens B, Bann C, Higgins R, Vohr B, for NICHD NRN. Autism Spectrum Disorder Phenotype in Extremely Preterm Infants. Poster Presentation, Pediatric Academic Societies, Denver, CO, May 3, 2011

22. Sommers R, Vohr B, Stephens B, Tucker R, Laptook A. Does the Amplitude Integrated EEG (aEEG) at 36 Weeks Post-Menstrual Age Correlate with Bayley Scores at 18 Months Corrected Age? Poster Presentation, Pediatric Academic Societies, Denver, CO, May 3, 2011

23. Vohr B, Stephens B, McDonald S, Ehrenkranz R, Laptook A, Das A, Higgins R, ShankaranS. Associations between Disability and Growth at 7 years of age for Children who Experienced Perinatal Hypoxia Ischemia and Participated in the Hypothermia Trial.

24. Laptook A, McDonald S, Shankaran S, Stephens B, Vohr B, Guillet R, Higgins R. Outcome at 6-7 years of Infants with Elevated Temperatures Following Hypoxia-Ischemia. Platform Presentation, Pediatric Academic Societies, Boston, MA, May 1, 2012

25. Balakrishnan M, Przystac LE, Jennings AV, Phornphutkal C, Tucker R, Mance MJ, Stephens BE, Vohr BR, Bliss JM. Growth Outcomes following Early, High Dose Parenteral Amino Acids in Very Low Birth Weight Infants: A Randomized Trial. Pediatric Academic Societies, Vancouver, BC, May 2014

Invited Presentations

1. Neural Tube Defects, Perinatal Management Conference, Women and Infants' Hospital, Providence, RI, October, 2003.

2. Neural Tube Defects, Pediatric Grand Rounds, Rhode Island Hospital, Providence, RI, February 20, 2004.

3. Do Current Fluid Regimens in the First Weeks of Life Increase Morbidity in ELBW Infants? New England Regional Perinatal Conference, Chatham, MA, October 7, 2004.

4. Congenital Lymphatic Disorders, Perinatal Management Conference, Women and Infants' Hospital, Providence, RI, December 22, 2004.

5. Perinatal Asphyxia, Perinatal Management Conference, Women and Infants' Hospital, Providence, RI, March 2, 2005.

6. Do Current Fluid Regimens in the First Weeks of Life Increase Morbidity in ELBW Infants? Pediatric Research Colloquium, Women and Infants' Hospital, Providence, RI, April 1, 2005.

7. Impact on the Family of Neurodevelopmental Impairment in ELBW infants at 18months. Pediatric Academic Societies, Washington DC, May 16, 2005.

8. Do Current Fluid Regimens in the First Weeks of Life Increase Morbidity in ELBW Infants? Poster Presentation, Pediatric Academic Societies, Washington DC, May 17, 2005.

9. Impact on the Family of Neurodevelopmental Impairment in ELBW infants at 18months. Harvard Poster Symposium, Sept 20, 2005

10. Impact on the Family of Neurodevelopmental Impairment in ELBW infants at 18months. New England Regional Perinatal Conference, Chatham, MA, Sept 30, 2005

11. Neonatal Gastroesophageal Reflux Disease, Perinatal Management Conference, Women and Infants' Hospital, Providence, RI, Nov 9, 2005

12. Do Current Fluid Regimens in the First Weeks of Life Increase Morbidity in ELBW Infants? Platform Presentation, Neonatal Nutrition and Gastrointestinal Symposium, Key Biscayne, FI, Dec 10, 2005

13. Prematurity, Lecture to RIC Master's Program in Special Education, Feb 14, 2006

14. Special Health Care Needs of Infants Born at the Threshold of Viability, Platform Presentation, Eastern Society for Pediatric Research, March 18, 2006

15. Special Health Care Needs of Infants Born at the Threshold of Viability, Poster Presentation, Pediatric Academic Societies, San Francisco, CA, May 2, 2006

16. Special Health Care Needs of Infants Born at the Threshold of Viability, Platform Presentation, New England Regional Perinatal Conference, Newport, RI, Sept 28, 2006.

17. Neurobehavioral Assessment of the Preterm Infant, Perinatal Management Conference, Women and Infants' Hospital, Providence, RI, Nov 1, 2006

18. Predicting Motor Outcomes in Extremely Low Birth Weight Infants, Pediatric Research Colloquium, Women and Infants' Hospital, Providence, RI, Nov, 17, 2006.

19. Stephens BE, Liu J, Lester B, Lagasse L, Shankaran S, Bada H, Bauer C, Das A, Higgins R. Neurobehavioral Assessment Predicts Motor Outcomes in ELBW Infants. Poster Presentation, Eastern Society for Pediatric Research, March 10, 2007.

20. Predicting Motor Outcomes in ELBW Infants, Platform Presentation, ByConn, April 11, 2007

21. Stephens BE, Liu J, Lester B, Lagasse L, Shankaran S, Bada H, Bauer C, Das A, Higgins R. Neurobehavioral Assessment Predicts Motor Outcomes in ELBW Infants. Poster Presentation, Pediatric Academic Societies, Toronto, ON, May 5, 2007

22. Educational Workshop, Favorite Interactive Teaching Methods for Resident Education. Society for Developmental and Behavioral Pediatrics, Providence, RI, Sept 28, 2007

23. Stephens BE, Liu J, Lester B, Lagasse L, Shankaran S, Bada H, Bauer C, Das A, Higgins R. Neurobehavioral Assessment Predicts Motor Outcomes in ELBW Infants. Poster Presentation, Society for Developmental and Behavioral Pediatrics, Providence, RI, Sept 30, 2007

24. Stephens BE, Vogt R , Gargus RA, Tucker R, McKinley L, Mance M, Nye J, Vohr BR. Adequate First Week Protein and Calorie Intake is Critical for 18 month Developmental Outcome in ELBW Infants. Poster Presentaton, SPR-RC, Woodlands, TX, Oct, 17, 2007

25. Developmental Delay and Mental Retardation, Resident Noon Conference, Hasbro Children's Hospital, Providence, RI, Nov 9. 2007

26. Early TPN, Are We Doing Enough?, Perinatal Management Conference, Women and Infants' Hospital, Providence, RI, April 23, 2008

27. Autism Spectrum Disorder in Extremely Preterm Infants, Pediatric Research Colloquium, Women and Infants' Hospital, Providence, RI, Oct 30, 2009

28. Stephens BE, Miller R, Bigsby R, Tucker R, Lester B. Normative Neurobehavior of Extremely Low Birth Weight Infants on the Neonatal Intensive Care Unit Network Neurobehavioral Scale. Poster Presentation, Pediatric Academic Societies, Vancouver, BC, May 3, 2010

29. Stephens BE, Alksninis B, Yatchmink YE, Burke RT, Tucker R, Vohr BR. Plagiocephaly in Preterm Infants: An Early Marker of Motor Dysfunction. Platform Presentation, New England Regional Perinatal Conference, Chatham, MA, Oct 18, 2010

30. Discharge of the Medically Complex Infant, Perinatal Management Conference, Women and Infants' Hospital, Providence, RI, January 5, 2011

31. Pharmacovigilance: A multidisciplinary approach to perinatal medication safety, Perinatal Management Conference, Women and Infants' Hospital, Providence, RI, January 12, 2011

32. Caskey M, Stephens B, Tucker R, Vohr B. Adult-Infant Conversations in the NICU and Language and Cognitive Outcomes in Preterm Infants. Platform Presentation, Pediatric Academic Societies, Denver, CO, April 30, 2011

33. Stephens B, Watson V, Tucker R, Sheinkopf S, Vohr B. Screening for Autism Spectrum Disorder at 18 vs. 30 months in Extremely Preterm Infants. Poster Symposium, Pediatric Academic Societies, Denver, CO, May 1, 2011

34. Stephens B, Bann C, Watson V, Peralta-Carcelen M, Sheinkopf S, Higgins R, Vohr B, for NICHD NRN. Screening for Autism Spectrum Disorder in Extremely Preterm Infants. Poster Symposium, Pediatric Academic Societies, Denver, CO, May 1, 2011

35. Stephens B, Bann C, Higgins R, Vohr B, for NICHD NRN. Autism Spectrum Disorder Phenotype in Extremely Preterm Infants. Poster Presentation, Pediatric Academic Societies, Denver, CO, May 3, 2011

36. Late Preterm Infants, Grand Rounds, St Joseph's Hospital, Polson, MT, June 11, 2013

37. Neonatal Abstinence Syndrome, Grand Rounds, St Joseph's Hospital, Polson, MT, Aug 27, 2013

38. Developmental Care, the role of the Physical Therapist in the NICU and beyond, University of Montana, Physical Therapy Student Lecture Nov 13, 2013

39. Developmental Care in the NICU, March of Dimes Prematurity Summit, Missoula, MT, Nov 15, 2013

40. Interpretation of ABG's in the Neonate, Grand Rounds, Bozeman Deaconess Hospital, Bozeman, MT, May 9, 2014

41. Complex Congenital Heart Disease Screening, Grand Rounds, St Joseph's Hospital, Polson, MT, July 18, 2014

42. Developmental Follow-up Care of the NICU Graduate, Timely Topics, Kalispell, MT, Sept 12, 2014

43. Neonatal Abstinence Syndrome, Rocky Mountain Childbirth Conference, Missoula, MT, Oct 3, 2014

44. Neurobehavioral Assessment in the NICU and Its Role in Predicting Outcomes in High Risk Neonates, National Association of Neonatal Therapists, Phoenix, AZ, April 10, 2015

45. Therapeutic Hypothermia for Neonatal Hypoxic Ischemic Encephalopathy. Grand Rounds, Bozeman Deaconess Hospital, Bozeman, MT, June 5, 2015

46. Therapeutic Hypothermia for Neonatal Hypoxic Ischemic Encephalopathy. Timely Topics, Missoula, MT, Oct 23, 2015

47. Neonatal Abstinence Syndrome, Workshop, St Joseph's Hospital, Polson, MT, Oct 29, 2015

48. New NRP Guidelines, Overview and Mock Codes, St James Healthcare, Butte, MT, Jan 13, 2016

49. Developmental and Behavioral Pediatrics in Primary Care, Montana AAFP Conference, Whitefish, MT, Jan 28, 2016

50. Survival is Not Enough: Improving Outcomes of Extremely Preterm Infants. Annual Sauer Lecture, Pediatric Ground Rounds, Evanston Hospital, NorthShore University HealthSystem, Evanston, IL, Apr 12, 2016

51. Individualizing Care at the Limits of Viability. Timely Topics. Missoula, MT. Oct 27, 2017.

52. Common Developmental Disorders: Screening, Diagnosis and Management. Montana AAFP Winter Conference. Whitefish, MT. January 25, 2018

53. Priorities for Safe and Secure Care After Birth. First 1000 Days Conference. Missoula, MT. June 13, 2018

54. Therapeutic Hypothermia for Hypoxic Ischemic Encephalopathy. Montana AAP Roundup. Pray, MT Oct 6, 2018

55. Individualizing Care at the Limits of Viability. Rocky Mountain Childbirth Conference. Fairmont Hot Springs, MT. Oct 12, 2018

56. Therapeutic Hypothermia for Hypoxic Ischemic Encephalopathy. Rocky Mountain Childbirth Conference. Fairmont Hot Springs, MT. Oct 12, 2018

57. Abdominal Wall Defects, A Multi-Disciplinary Approach. Timely Topics. Missoula, MT. Sept 13, 2019

58. Updates in Neonatal Care. BCBS. Helena, MT. March 6, 2020.

59. Eat, Sleep and Console. Multiple neonatal/perinatal conferences

Conference Moderator/Invited Participant

1. Moderator, Neonatology – Epidemiology and Follow-up, Platform Session, ESPR, Philadelphia, PA, March 27, 2010

2. Moderator, PAS/SPR, Boston, MA, 2012

Justin K. Cole
Kathryn S. Mahe
GARLINGTON, LOHN & ROBINSON, PLLP
350 Ryman Street • P. O. Box 7909
Missoula, MT 59807-7909
Phone (406) 523-2500
Fax (406) 523-2595
jkcole@garlington.com
ksmahe@garlington.com

Attorneys for Plaintiffs

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MONTANA
MISSOULA DIVISION

MONTANA MEDICAL ASSOCIATION, et al.,

Plaintiffs,

and

MONTANA NURSES ASSOCIATION,

Plaintiff-Intervenors,

v.

AUSTIN KNUDSEN, et al.,

Defendants.

Case No. CV 21-00108-DWM

DECLARATION AND EXPERT REPORT OF BONNIE STEPHENS, M.D.

EXHIBIT 21
Bonnie Stephens
Mon, Aug 15, 2022
Reported by:
Mary Sullivan, RMR, CRR

I, Bonnie Stephens, M.D., declare, pursuant to 28 U.S.C. § 1746 and under penalty of perjury, that the foregoing is true and correct:

1. The facts and opinions set forth in this Declaration are known to me based on my personal knowledge and belief, and based upon my knowledge, training, research, education, and experience.

2. I have been retained by the Plaintiffs in the above-captioned matter to render certain opinions as contained in this document. I am charging $500 per hour for my work on this matter. I reserve the right to modify, expand upon, or otherwise change these opinions as new or additional information is provided to me.

EXPERIENCE AND CREDENTIALS

3. I obtained my medical doctorate from Northwestern University Medical School. I performed a pediatric residency at Children's Memorial Hospital in Chicago, IL, and a neonatal/perinatal medicine fellowship and a developmental/behavioral pediatrics fellowship at Brown University Women/Infants' Hospital/Rhode Island Hospital. I am board certified in Pediatrics, Neonatal-Perinatal Medicine, as well as Developmental-Behavioral Pediatrics.

4. I have approximately 10 years' experience as a neonatal intensivist and medical director of the NICU at Community Medical Center. I have worked in

a number of intensive care settings, including the neonatal intensive care unit (NICU) and pediatric intensive care unit (PICU). I currently serve as the Chief Medical Officer for Community Medical Center. Attached as Exhibit A is my curriculum vitae, which further summarizes my credentials and professional and clinical education and experience.

OPINIONS

5. NICUs provide around-the-clock care to infants who need intensive medical care due to critical illness, a need for specialized care, being premature, or other reasons. Infants in a NICU setting are particularly vulnerable to infectious disease. These infants have compromised immune systems and are too young to receive vaccinations to protect them from vaccine preventable illness. For these reasons, infectious disease prevention is critical in intensive care settings. It is standard of care in a NICU setting to confirm the vaccination and/or immunity status of all individuals working in, and providing care to, patients in the NICU.

6. For the safety of these patients, providers in the NICU setting should have current vaccination for Measles, Mumps, and Rubella (MMR), Pertussis (through the Tetanus-Diptheria-Petussis, or TDaP vaccine), Chickenpox/varicella, influenza and COVID. Remaining current on all other available vaccines is crucial for patient safety.

7. Current vaccination also protects fellow staff members from contracting infectious disease and passing them on to the infants for whom they are providing care. This includes vaccination against airborne diseases (such as measles, influenza, and COVID), as well as blood-borne diseases such as Hepatitis.

8. In particular, pertussis is a highly contagious disease that can cause death in infants. Pertussis is vaccine-preventable, and pertussis vaccination is routinely required for staff in NICU settings. Other diseases, such as measles, also pose a direct threat to infants in these intensive care settings. Infants are more likely to suffer serious harm or death from illnesses than adults. This is even more true for infants being treated in the NICU setting. It is critical that these vulnerable patients be treated by vaccinated staff.

9. Infants are unable to obtain common vaccination against these and other diseases until they reach a certain age. The typical minimum age for obtaining vaccines is as follows:

a. MMR (measles, mumps, rubella) – 12 months

b. DTaP (diptheria, tetanus, pertussis) – 2 months,

c. Varicella (Chicken pox) – 12 months

d. Influenza – 6 months

10. Other intensive care settings, as well as cancer care settings, are places where particularly vulnerable and immunocompromised patients seek care.

It is important to protect these patients by observing all available infection control measures, including vaccination of caregivers and staff and tracking vaccination or immunity status of caregivers and staff.

11. Providers and staff who are not currently vaccinated against these diseases should not be permitted to treat vulnerable patients in a NICU or cancer care setting. Patients in the NICU and cancer care settings will most often fall under the protections of the ADA because of their underlying disease processes and disabilities. Their conditions make them more susceptible to vaccine-preventable illnesses and increase their risk of serious harm or death from such illnesses. Faced with a situation where an employee is unvaccinated, a facility needs to be informed, so that they can perform an individualized assessment of whether a reasonable accommodation under the ADA is available, absent an undue hardship or direct threat to the hospital's operations, including the safety of its patients. In order to do that analysis, facilities need to know the vaccination status of the healthcare workers, and be able to take appropriate steps to address such status.

12. The standard of care requires an individual assessment of a patient care encounter and determination of whether the particular patient requires treatment only by vaccinated staff members. If so, then the facility needs to be able to ensure that the patient is only treated by vaccinated staff members. This

would require the facility to treat vaccinated staff members differently than unvaccinated staff members.

13. Requirements for vaccination and immunization status has been a common feature of healthcare in hospitals. Hospitals routinely require individuals be vaccinated prior to being allowed to treat patients in the NICU and settings treating particularly vulnerable patients.

14. I have experienced both firsthand and through my position at the hospital, occasions in which patients have specifically requested to be treated by vaccinated staff. It is my opinion that these request from patients should be honored. In order to honor these requests, hospitals would be required to treat vaccinated and non-vaccinated staff differently.

15. Vaccination is safe and effective. In my opinion, every eligible healthcare provider should be vaccinated against vaccine preventable diseases. Risk of side effects from vaccines are extremely low compared to the risks caused by infection with vaccine preventable diseases. Lower vaccination rates place individuals at unnecessary risk. In particular, lower rates of immunity lead to increased presence of variants of the COVID virus, which will perpetuate the pandemic and place people at unnecessary risk. COVID vaccination and other long-standing and well-accepted vaccinations are critical to protect the safety and health of our community's kids

16. Montana has a relatively high rate of exemption from the COVID vaccine requirements. When staff are not vaccinated against COVID, more staff will contract COVID. Staff who contract COVID are at risk of injury and possibly death from the infection. Staff who contract COVID are required to quarantine, exacerbating the shortage of needed healthcare workers.

17. As CMO, I am very aware of the importance of hospitals complying with CMS conditions of participation to participate in the Medicare and Medicaid systems. This includes remaining current and compliant on all general infectious disease prevention (i.e. following national standards of care), as well as complying with the new COVID vaccine requirements, or risk losing CMS funding, which would result in hospital closures due to inadequate funding

18. If the current injunction is lifted, Montana HB 702 directly conflicts with the CMS conditions of participation.

MD

Bonnie Stephens, M.D.

Justin K. Cole
Kathryn S. Mahe
GARLINGTON, LOHN & ROBINSON, PLLP
350 Ryman Street • P. O. Box 7909
Missoula, MT 59807-7909
Phone (406) 523-2500
Fax (406) 523-2595
jkcole@garlington.com
ksmahe@garlington.com

Attorneys for Plaintiffs

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and

MONTANA NURSES ASSOCIATION,

Plaintiff-Intervenors,

v.

AUSTIN KNUDSEN, et al.,

Defendants.

Case No. CV 21-00108-DWM

DECLARATION AND EXPERT REPORT OF DAVID TAYLOR, M.D.



I, David Taylor, M.D., declare, pursuant to 28 U.S.C. § 1746 and under penalty of perjury, that the foregoing is true and correct:

1. The facts and opinions set forth in this Declaration are known to me based on my personal knowledge and belief, and based upon my knowledge, research, education, and experience.

2. I have been retained by the Plaintiffs in the above-captioned matter to render certain opinions as contained in this document. I am charging $400 per hour for my work on this matter. I reserve the right to modify, expand upon, or otherwise change these opinions as new or additional information is provided to me.

EXPERIENCE AND CREDENTIALS

3. I obtained my medical doctorate from Harvard Medical School in 1974, and an advanced masters degree in Medical Parasitology from the London School of Hygiene and Tropical Medicine in 1978. I performed an internship and residency at the State University of New York, and a fellowship as in Geographic Medicine at Johns Hopkins University International Center for Medical Research in Panama.

4. I am board certified in internal medicine with a subspeciality in infectious disease. I am a Fellow in the American College of Physicians and the Infectious Diseases Society of America, and a Member of the American Society of

Microbiology and American Epidemiological Society. I served in the US Army from 1980 to 2002, retiring as a Colonel in the US Army Medical Corps. Over the course of my career, I served in many positions with Walter Reed Army Institute of Research, including: Investigator, Department of Bacterial disease; Investigator, Department of Enteric Infections; Chief, Department of Clinical Trials; Clinical Director, Department of Enteric Infections; and Acting Director, Division of Communicable Diseases and Immunology. Further, from 2002 through 2004, I was a Research Professor at the Department of International Health with Johns Hopkins Bloomberg School of Public Health. From 2015 through 2018, I worked for PATH, an international, nonprofit global health organization--serving as Senior Medical Officer for its Vaccine Development Global Program and Senior Medical Officer of its Drug Development Global Program. Attached as Exhibit A is my curriculum vitae, which further summarizes my professional and clinical education and experience, credentials, editorial activities and professional publications.

OPINIONS

5. Vaccination is the single best strategy to protect the health of the US population against communicable diseases. FDA approved vaccines, including those under an Emergency Use Authorization, are safe and effective.

6. Vaccine is defined as a substance used to stimulate the production of

antibodies and provides immunity against one or several diseases, prepared from the causative agent of a disease, its products, or a synthetic substitute, treated to act as an antigen without inducing the disease. Vaccines are used to prevent disease.

7. The public health strategy related to vaccination is two-fold; one is to protect the vaccinated individual and the other is to protect the general population by providing what is called "herd immunity". Herd immunity occurs when enough people become immune to a disease to make its spread unlikely. As a result, the entire community is protected, even those who are not themselves immune. Herd immunity is usually achieved through vaccination, but it can also occur through natural infection. Because of this, vaccination and immunity status are critical in protecting against communicable disease, both at a micro and macro level.

8. Edward Jenner discovered the smallpox vaccine in 1796 and began the era of scientific inquiry into vaccines to prevent infectious diseases. By 2020, the list of childhood recommended vaccines included: Diphtheria, Tetanus, Pertussis--given in combination as DTaP; Measles, Mumps and Rubella--given in combination as MMR, inactivated Polio (IPV), Haemophilus influenzae type B (Hib), Hepatitis B, Varicella, Hepatitis A, Pneumococcal, Influenza and Rotavirus. These vaccines were introduced after decades of research and clinical studies.

9. DTaP was developed in the 1940s and was the first childhood immunization that went into widespread distribution. These vaccines are

composed of inactivated toxins known as toxoids. The pertussis vaccine has undergone improvements and is now referred to as the acellular pertussis vaccine which contains other components in addition to the toxoid.

10. In the 1950s, the polio vaccine was developed. The Salk vaccine was made from an inactivated polio virus (IPV) and the Sabin vaccine was made from an attenuated (weakened) polio virus (OPV).

11. In the 1960s vaccines for measles, mumps and rubella were developed and combined into the MMR vaccine. All three components of the MMR vaccine are live, attenuated viruses.

12. In the 1980s the vaccine for Haemophilus influenza type B was developed. This vaccine was composed a subunit of the bacteria called the capsule that was stabilized by conjugating it to a carrier protein.

13. The hepatitis B vaccine was also developed in the 1980s. This vaccine is also a subunit vaccine and was the first recombinant vaccine. The surface protein of hepatitis B is produced in a yeast culture.

14. The 1990s saw the introduction of the varicella (chickenpox) vaccine, rotavirus, hepatitis A and pneumococcal vaccines.

15. All of these vaccines are recommended for all infants usually before the age of 2 years. Because immunization programs have been so successful, it is hard to imagine how terrible these diseases were and how fortunate we are to have

vaccines to so successfully protect against these diseases. These vaccines have been extraordinarily successful in preventing childhood infectious diseases. Table 1 summarizes the decline in vaccine preventable diseases in the United States in the years since these vaccines were introduced.

Table 1. Baseline 20th century annual morbidity and 1998 provisional morbidity from diseases with vaccines recommended before 1990 for universal use in children – United States

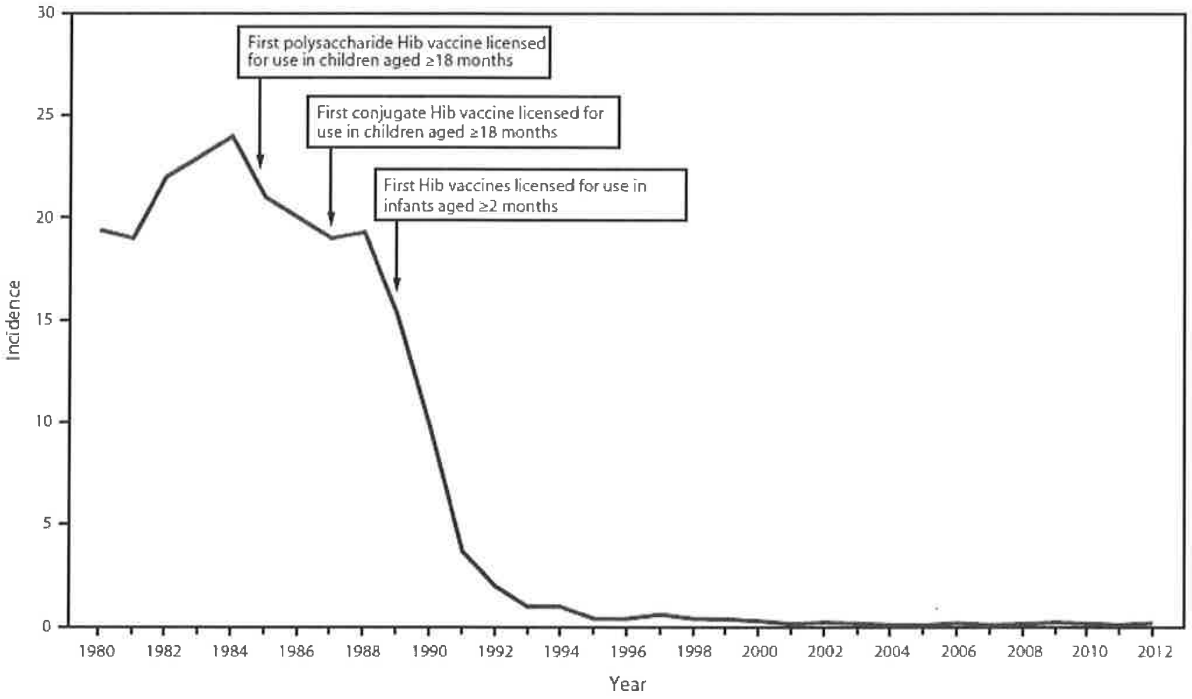
Disease	Pre-vaccine era deaths	Post vaccine era deaths	Percent mortality decrease
Diphtheria	175,885	1	100.0%
Pertussis	147,271	6,279	95.7%
Tetanus	1,314	34	97.4%
Poliomyelitis	16,316	0	100.0%
Measles	503,209	89	100.0%
Mumps	152,209	606	99.6%
Rubella	47,745	345	99.3%
H. influenzae type B	20,000	54	99.7%

Summarized from Roush SW, Murphy TV; Vaccine-Preventable Disease Table Working Group. Historical comparisons of morbidity and mortality for vaccine-preventable diseases in the United States. JAMA. 2007;298:2155-63. doi: 10.1001/jama.298.18.2155. PMID: 18000199.

Also see Ventola CL. Immunization in the United States: Recommendations, Barriers, and Measures to Improve Compliance: Part 1: Childhood Vaccinations. P T. 2016;41(7):426-436.

16. Figure 1 demonstrates the temporal relationship between the introduction of Haemophilus influenzae type b vaccines (Hib) and the steep decline of the disease in the United States. Hib caused sepsis and meningitis in infants and, in addition to the numerous children who died from Hib, many children never fully recovered after Hib infection. Critically, after the Hib conjugate vaccine was introduced and vaccination was encouraged, the disease virtually disappeared.

Figure 1. Impact of Haemophilus influenzae type b (Hib) vaccines on the annual incidence per 100,000 children <5 years old in the United States, 1980-2012



Reference for Figure 1. Briere EC, Rubin L, Moro PL, Cohn A, Clark T, Messonnier N; Division of Bacterial Diseases, National Center for Immunization and Respiratory Diseases, CDC. Prevention and control of Haemophilus influenzae type b disease: recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR Recomm Rep 2014; 63(RR-01):1–14.

17. The modern age of school-based vaccination programs began in the 1950s with the Salk or inactivated polio vaccine (IPV). IPV was first tested in 1954 in a vaccine study that enrolled over 600,000 children. The results were reported in April 1955 and mass school-based vaccination programs began thereafter. Much like the Covid vaccine, IPV showed high (~90%) protection against paralytic polio but only 60-70% protection against infection and mild disease. In a short time, nearly all Americans under the age of 40 were vaccinated for polio. In subsequent years poliomyelitis cases fell by half each year from 30,000 cases in 1955, to 15,000 cases in 1956, to 7,000 cases in 1957 etc. The Sabin oral attenuated polio vaccine (OPV) came into use in the 1960s. Because of the near eradication of polio in the US, the OPV trials were conducted overseas in areas of high endemicity. These overseas trials were successful and gave credence to the idea that polio could be controlled, even in the most remote parts of the world. The World Health Organization ("WHO") oversees the distribution of polio vaccine to the poorest nations through the expanded program for immunization. Through these efforts and many others there, has been a 99% reduction in paralytic polio worldwide, since vaccination has become prevalent. The last case of polio in the US occurred in 1979 and the last case in the Western

Hemisphere was reported in 1991 in Peru—essentially indicating that polio has been eradicated in the Western Hemisphere due to widespread use of vaccines.

18. The second disease that encouraged school-based mandatory immunization programs was measles. Measles is a highly infectious viral disease of childhood. Measles can cause high fever, peeling of the skin, and encephalitis. Complications due to Measles can result in brain damage, blindness, or death. In the 1960s, there were many school-based measles outbreaks. Using the same tissue culture techniques that were used for polio vaccine an attenuated vaccine was developed and became widely available, first as a monovalent vaccine and then combined with the mumps and rubella vaccine (MMR). Similar to the measles, mumps can cause meningitis, encephalitis, decreased fertility/sterility, and death. Rubella can cause heart defects, brain disorders, and other damages. Significantly, if a pregnant person contracts rubella, it can result in severe and permanent birth defects or death.

19. In 1977, the US federal government set up the Childhood Immunization Initiative aimed at increasing vaccination rates for seven vaccine preventable diseases-- diphtheria, pertussis, tetanus (DTaP), measles, mumps, rubella (MMR), and polio. Today, all states, the District of Columbia and US territories have vaccination requirement for children to attend school and childcare facilities. State laws establish vaccination requirements, as well as mechanisms for

enforcement and rules for exemption. These programs have increased immunization rates to over 90% nationwide. Although the great increase in vaccination rates have substantially reduced incidences of these diseases, even the 90% immunization rate may not stop all outbreaks. For example, outbreaks of measles and pertussis are still common in areas with low vaccination rates.

20. From babies to teenagers to adults, people need vaccines throughout their lives to provide them with immunity from potentially dangerous infectious diseases. Without vaccines, children are at risk for serious illness, disability, or death, from complications from diseases such as meningitis due to Haemophilus influenzae type b (Hib), measles, and whooping cough (pertussis).

21. Vaccines for human papillomavirus (HPV) and influenza are also frequently included as requirements or, at a minimum, strongly recommended. Meningococcal vaccines have also been required in older children.

22. In addition to the required vaccines, other safe and effective vaccines such as hepatitis A and B, pneumococcal, varicella, and rotavirus are all part of the Centers for Disease Control's ("CDC") list of recommended vaccines.

23. The Covid epidemic has had both direct and indirect impact on childhood immunizations. According to a recent report from the CDC (1), nearly 400,000 fewer children entered kindergarten during the 2020-21 school year because of pandemic-related disruptions. Since childhood immunizations are

the workplace is critical to maintaining a safe care environment and reduce the risk of transmissibility of infectious diseases.

25. Certain diseases, such as Covid-19 and influenza, can mutate into variant strains of the original virus, and some diseases have the ability to mutate more frequently than others. A disease is more likely to mutate the more often it is allowed to replicate, which occurs based upon its opportunity for growth, including the number of times it is transmitted from person to person. These mutations and variants cause a reduction in the durability of an individual's immunity to the disease. The duration of an individual's immunity levels naturally decrease as to certain diseases, some more slowly than others. Immunity to certain respiratory and gastrointestinal illnesses (again, like Covid-19 and influenza) fades more quickly than other diseases. The waning of immunity has led to the implementation of vaccine boosters for a number of vaccines. Vaccine boosters are also utilized after natural infection, to address waning immunity.

26. All of the vaccines discussed herein are approved by the U.S. Food and Drug Administration (FDA), including the Pfizer-BioNTech Covid-19 vaccine (ages 15 and older). Further, several of the Covid-19 vaccines were approved by the FDA under an Emergency Use Authorization—the Moderna Covid-19 vaccine (ages 18 and up), Pfizer-BioNTech Covid-19 vaccine (ages 5 to 15), and

verified upon entry to kindergarten, it is unknown how many of those kids received childhood vaccinations for common diseases.

1. Seither R, Laury J, Mugerwa-Kasujja A, Knighton CL, Black CL. Vaccination Coverage with Selected Vaccines and Exemption Rates Among Children in Kindergarten - United States, 2020-21 School Year. MMWR Morb Mortal Wkly Rep. 2022 Apr 22;71(16):561-568. doi: 10.15585/mmwr.mm7116a1. PMID: 35446828; PMCID: PMC9042357.

Along with school attendance, there has also been a decrease in well-child visits during the Covid epidemic. When parents do bring their children for well-child visits, concerns about coronavirus vaccines are now reflected in attitudes toward routine immunizations. Covid vaccine hesitation can influence acceptance of the routine childhood immunizations.

24. Immunization rates are critical in preventing outbreaks. Immunization rates of 95% are needed to interrupt disease transmission. Thus, the unknown vaccination status of 10% of kindergarten-aged children is concerning. Vaccination coverage among kindergartners nationwide for the 2020-21 school year dropped to 94% - below the CDC target rate of 95%. *See* (1), *supra*. In Montana, Covid vaccine exemptions in health care facilities were approximately twice as high as the national average which in part is caused by the opposing state and federal mandates. Given these declining vaccination rates, healthcare providers' ability to embrace and act upon vaccination and immunization status in

Janssen/Johnson & Johnson Covid-19 vaccine (ages 18 and older). Subsequently, the Moderna and Pfizer vaccines were fully approved by the FDA (table 2).

Table 2. FDA approval timelines for the mRNA Covid vaccines

			FDA approval dates	
Company	Covid vaccine	Marketing name	EUA	Full
Pfizer	mRNA	Comirnaty	Dec. 2020	Aug. 2021
Moderna	mRNA	Spikevax	Dec. 2020	Jan. 2022

27. The FDA ensures that the vaccines children receive are safe and effective. A vaccine is a medical product. Like any medicine, vaccines can cause side effects, but most are minor and short-lived, such as a low-grade fever, or pain and redness at the injection site. Severe, long-lasting side effects of vaccines are extremely rare. The risk of being harmed by vaccines is much smaller than the risk of serious illness from the diseases they prevent. Ensuring the safety and effectiveness of vaccines is one of the FDA's top priorities.

28. The FDA ensures that vaccines undergo a rigorous and extensive development program. The development programs for vaccines include studies conducted by the manufacturers to meet FDA standards for safety and effectiveness in the target population. Manufacturers conduct clinical trials according to plans that have been evaluated by the FDA and reflect the FDA's

considerable expertise in clinical trial design and methods. The FDA approves a vaccine only if it determines that the vaccine's benefits outweigh its risks.

29. The National Foundation for Infectious Diseases has summarized the importance of vaccination as follows:

(1) Vaccine-preventable diseases have not gone away.

The viruses and bacteria that cause illness and death still exist and can be passed on to those who are not protected by vaccines. While many diseases are not common in the US, global travel makes it easy for diseases to spread.

(2) Vaccines will help keep you healthy.

The Centers for Disease Control and Prevention (CDC) recommends vaccinations throughout your life to protect against many infections. When you skip vaccines, you leave yourself vulnerable to illnesses such as shingles, pneumococcal disease, flu; as well as HPV and hepatitis B, both leading causes of cancer.

(3) Vaccines are as important to your overall health as diet and exercise.

Like eating healthy foods, exercising, and getting regular check-ups, vaccines play a vital role in keeping you healthy. Vaccines are one of the most convenient and safest preventive care measures available.

(4) Vaccination can mean the difference between life and death.

Vaccine-preventable infections can be deadly. Every year in the US, prior to the COVID-19 pandemic, approximately 50,000 adults died from vaccine-preventable diseases.

(5) Vaccines are safe.

The US has a robust approval process to ensure that all licensed vaccines are safe. Potential side effects associated with vaccines are uncommon and much less severe than the diseases they prevent.

(6) Vaccines will not cause the diseases they are designed to prevent.

Vaccines contain either killed or weakened viruses or bacteria, making it impossible to get the disease from the vaccine.

(7) Young and healthy people can get very sick, too.

Infants and older adults are at increased risk for serious infections and complications, but vaccine-preventable diseases can strike anyone. If you are young and healthy, getting vaccinated can help you stay that way.

(8) Vaccine-preventable diseases are expensive.

Diseases not only have a direct impact on individuals and their families, but also carry a high price tag for society as a whole, exceeding $10 billion per year. An average flu illness can last up to 15 days, typically with five or six missed work or school days. Adults who get hepatitis A lose an average of one month of work.

(9) When you get sick, your children, grandchildren, and parents may be at risk, too.

Adults are the most common source of pertussis (whooping cough) infection in infants which can be deadly for babies. When you get vaccinated, you are protecting yourself and your family as well as those in your community who may not be able to be vaccinated.

(10) Your family and co-workers need you.

In the US each year, millions of adults get sick from vaccine-preventable diseases, causing them to miss work and leaving them unable to care for those who depend on them, including their children and/or aging parents.

From the National Foundation For Infectious Diseases
https://www.nfid.org/immunization/10-reasons-to-get-vaccinated/

30. Since the Covid pandemic began in January 2020 until today (May 17, 2022), there have been 84 million cases and over 1 million deaths reported in the US and 553 million cases and 6 million deaths worldwide. The enormity of the pandemic has almost no modern precedent.

31. In 1918-19 flu epidemic, the mortality rate in the US was 6 per 1,000, thus far in the Covid pandemic (2020-21) the mortality rate is 2 per 1,000 and counting.

32. The number of Covid cases and mortality rate in the US and worldwide was, as follows:

Table 3. Covid cases and death as of May 17, 2022

	Cases	Deaths
US	84,357,607	1,026,899
Worldwide	523,559,119	6,291,622

33. The below table summarizes the comparative mortality rates for Covid and the 1918 influenza epidemic in the US:

Table 4 Comparison of Mortality rate of Covid 2020-22 and Influenza (1918-19) Pandemics

	Covid	1918 flu
Deaths	1,026,899	675,000
US Population	330,000,000	105,000,000
Mortality Rate	0.0031	0.0064
Deaths/100	0.31	0.64
Deaths/1,000	3	6

34. Vaccine development for the Covid-19 virus began as soon as the virus was isolated and sequenced to determine the genetic structure of the virus. The US government under President Donald Trump established Operation Warp Speed to provide funding for vaccines, drugs, diagnostics, and other public health measures. Two companies, Pfizer in collaboration with BioNTech and Moderna, began to develop messenger RNA vaccines (based on years of research that had already been conducted on mRNA vaccines) which was a new and potentially more rapid method of vaccine development and manufacture.

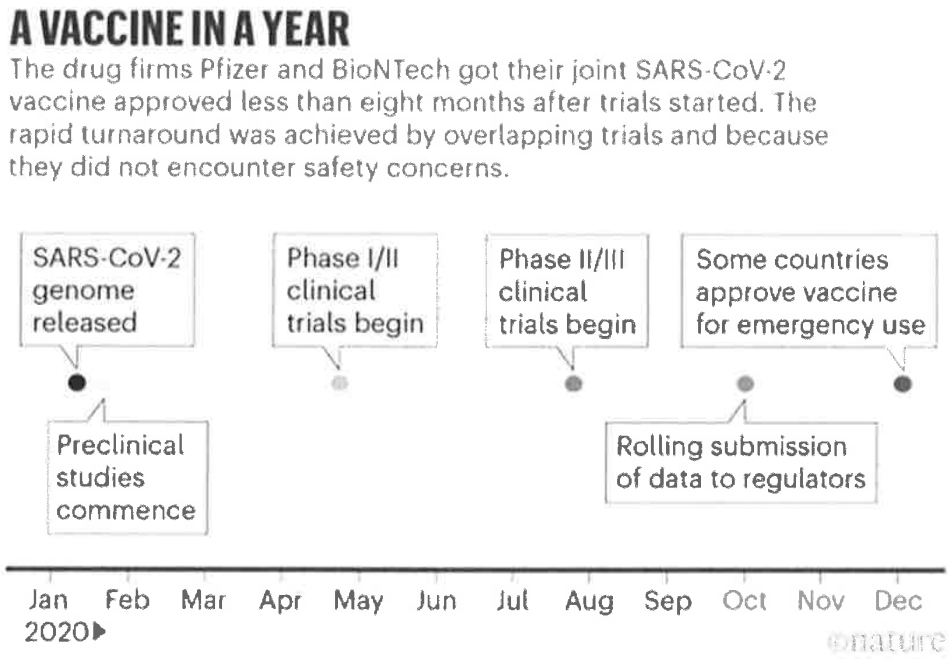
35. Research related to the two previous SARS outbreaks, coupled with the technology advancements in mRNA vaccine development, provided a basic approach and led to the rapid development of the vaccines for SARS-COV2

(Covid-19). An mRNA vaccine was previously developed to address SARS-COV1.

36. Vaccines based upon mRNA technology began research and development in the 1950's and 1960's. Moderna, specifically, had been working on the technology for a significant period of time and had recently developed a strategy to reduce immune response to allow humans to better tolerate mRNA vaccines. Additionally, there were other recent breakthroughs, including the development of a nano-lipid particle that allowed the mRNA to be labile and the ability to stabilize certain proteins' configuration to get optimum immune response, that allowed for the rapid development of these vaccines.

37. The Pfizer-BioNTech vaccine was manufactured for human use and Phase I/II and III trials were completed within a year (Figure 2). These successful trials were submitted to the FDA and the vaccine received emergency use authorization (EUA), and has subsequently received full FDA approval. The Moderna mRNA vaccine and the J&J adenovirus vectored vaccine were not far behind. All three vaccines were authorized in the US and ready for widespread use in early 2021.

38. Figure 2: Timeline for development of the Pfizer Covid mRNA vaccine



39. The speed of development of these vaccines was completely unprecedented, made possible by the coinciding of decades worth of development of mRNA technology and a surge of financial resources. This timeline is remarkable, particularly given the fact that these vaccines also underwent extraordinarily large clinical trials as compared to other vaccines. Typical vaccine clinical trials for FDA approval involve a few hundred participants. However, the clinical trials for these vaccines were upwards of 40,000 participants.

40. More important, the data coming from these trials showed that two doses of the mRNA vaccines were extraordinarily safe and highly effective. The study by Polack et al. which described the findings for the Pfizer-BioNTech mRNA vaccine was published in the New England Journal of Medicine on December 10, 2020. The information collected in this trial led to the FDA providing emergency use authorization on December 11, 2020. The study reports the results from vaccination in August 2020 until December 2020 during the period that the SARS-CoV2 alpha variant was circulating.

41. The study reported that a total of 43,548 participants, age 16 years or older, underwent randomization. 43,448 participants received injections: 21,720 with the Pfizer-BioNTech mRNA vaccine (BNT162b2) and 21,728 with a placebo. During the surveillance period of 100 days, there were eight cases of Covid-19 in the vaccine group and 162 cases among placebo recipients—establishing BNT162b2 was 95% effective in preventing Covid-19 which was highly statistically significant. The safety profile of BNT162b2 was characterized by short-term, mild-to-moderate pain at the injection site, fatigue, and headache.

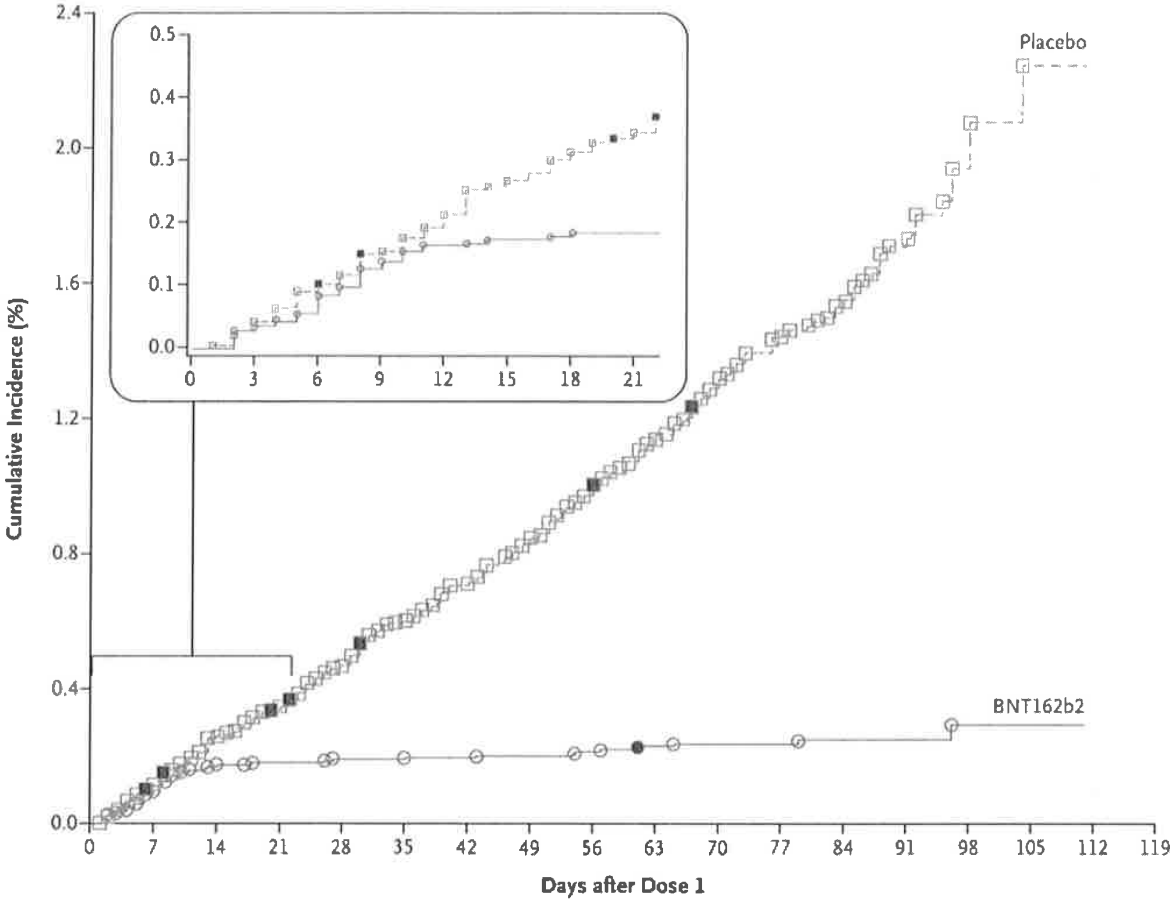
42. Figure 3 demonstrates the efficacy of BNT162b2 (Pfizer-BioNTech) against Covid-19 after the First Dose. Each symbol represents Covid-19 cases starting on a given day; filled symbols represent severe Covid-19 cases. Some symbols represent more than one case, owing to overlapping dates. Surveillance

time is the total time in 1,000 person-years for the given end point across all participants within each group at risk for the end point. The time period for Covid-19 case accrual is from the first dose to the end of the surveillance period.

> *See* Polack FP, Thomas SJ, Kitchin N, et al. Safety and Efficacy of the BNT162b2 mRNA Covid-19 Vaccine. N Engl J Med. 2020 Dec 31;383(27):2603-2615. Doi: 10.1056/NEJMoa2034577. Epub 2020 Dec 10. PMID: 33301246; PMCID: PMC7745181.

This figure illustrates that, for the first 7-10 days, the number of incidences of Covid-19 in vaccinated and unvaccinated individuals remained fairly similar. However, beginning about day 14 and continuing over time, the number of Covid-19 cases in vaccinated individuals remained low, while the number of Covid-19 cases in non-vaccinated individuals grew dramatically.

Figure 3:



Efficacy End-Point Subgroup	BNT162b2, 30 μg (N=21,669)		Placebo (N=21,686)		VE (95% CI)
	No. of participants	Surveillance time *person-yr (no. at risk)*	No. of participants	Surveillance time *person-yr (no. at risk)*	*percent*
Covid-19 occurrence					
After dose 1	50	4.015 (21,314)	275	3.982 (21,258)	82.0 (75.6–86.9)
After dose 1 to before dose 2	39		82		52.4 (29.5–68.4)
Dose 2 to 7 days after dose 2	2		21		90.5 (61.0–98.9)
≥7 Days after dose 2	9		172		94.8 (89.8–97.6)

43. The results from the Moderna vaccine trial were very similar to the Pfizer-BioNTech vaccine trial (Baden). In the Moderna trial, there were 30 cases of severe Covid in the placebo group compared to none in the vaccine group—demonstrating that, for the trial group, there was 100% efficacy for severe disease.

> *See* Baden LR, El Sahly HM, Essink B, et al. Efficacy and Safety of the mRNA-1273 SARS-CoV-2 Vaccine. N Engl J Med. 2021 Feb 4;384(5):403-416. Doi: 10.1056/NEJMoa2035389. Epub 2020 Dec 30. PMID: 33378609; PMCID: PMC7787219.

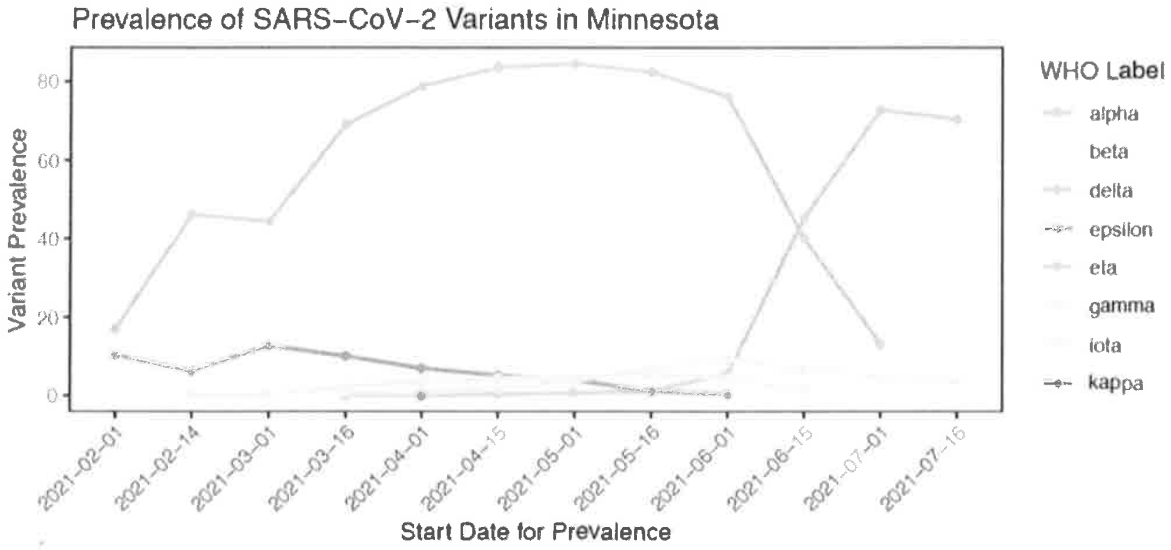
44. In the first 10 months after the authorization of the Covid-19 vaccines, the CDC reports that nearly 195 million people have been fully vaccinated in the US. The Pfizer-BioNTech vaccine accounted for 55% of those vaccinated, the Moderna vaccine accounted for 36%, and the Janssen/Johnson & Johnson vaccine accounted for 8% (table). As of May 17, 2022, 582 million doses have been given and 221 million persons are fully vaccinated. 67% of the US population is fully vaccinated. The highest vaccination rate is among persons 65 years and older at 86%.

https://covid.cdc.gov/covid-data-tracker/#vaccinations_vacc-total-admin-rate-total

45. The next wave of the pandemic occurred in July 2021 when the alpha variant was replaced by the delta variant. The delta variant started to increase in the US in May 2021 and quickly became the predominant strain in the US. Figure 4

below shows that, beginning in June 2021, the delta variant replaced the alpha variant over a period of only one month in Minnesota.

Figure 4:



Puranik A, Lenehan PJ, Silvert E, et al. Comparison of two highly-effective mRNA vaccines for COVID-19 during periods of Alpha and Delta variant prevalence. medRxiv [Preprint]. 2021 Aug 9:2021.08.06.21261707. doi: 10.1101/2021.08.06.21261707. PMID: 34401884; PMCID: PMC8366801.

46. The delta variant is of concern because it was more transmissible than the alpha variant. Since this summer the US underwent a resurgence of Covid illness due to the delta variant of SARS-CoV2. The increase in transmissibility meant that it was no longer possible to create herd immunity where those immunized would be able to protect the unimmunized. However, the vaccines

were still remarkably effective. Although the vaccines were significantly effective, they were not 100% effective, resulting in some breakthrough cases.

47. Figures 5 and 6 depict the rates of Covid-19 cases by vaccination status and the rates of Covid-19 deaths by vaccination status for the time period of April 4, 2021 through September 4, 2021, when the delta variant became prevalent. The black line on both figures represents the reported number of unvaccinated individuals, per 100,000, who contracted Covid-19 or died from Covid-19 during that time frame. The blue line on both figures represents the reported number of vaccinated individuals, per 100,000, who contracted Covid-19 or died from Covid-19 during that time frame. As illustrated by these figures, vaccinated individuals were much less likely to contract and/or die from Covid-19 than unvaccinated individuals. Unvaccinated persons were at a 6-fold greater risk of illness and an 11-fold greater risk of dying from Covid-19.

Figure 5:

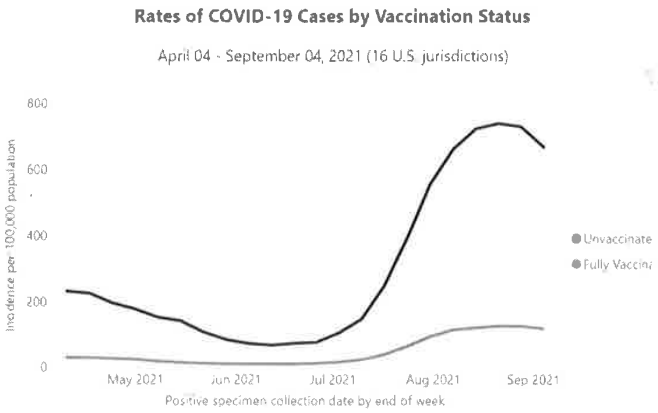
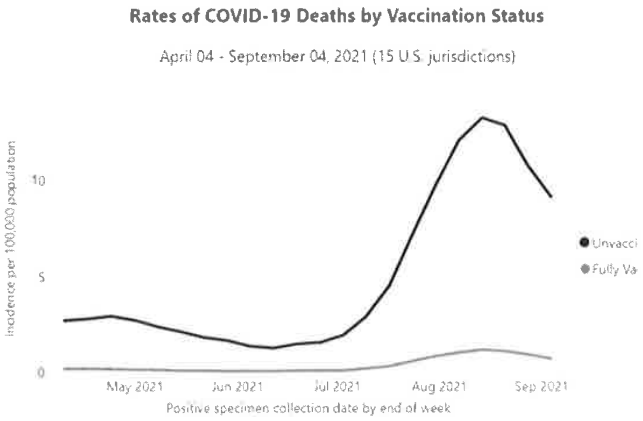


Figure 6:



Source: https://covid.cdc.gov/covid-data-tracker/#rates-by-vaccine-status, as of November 21, 2021.

48. In summary:

- For all adults aged 18 years and older, the cumulative COVID-19-associated hospitalization rate was about 12 times higher in unvaccinated persons.
- The cumulative rate of COVID-19-associated hospitalizations in unvaccinated adults ages 18-49 years was about 14 times higher than fully vaccinated adults aged 18-49 years.
- The cumulative rate of COVID-19-associated hospitalizations in unvaccinated adults ages 50-64 years was about 15 times higher than fully vaccinated adults aged 50-64 years.

49. The experience in Montana and other parts of the US is that the hospitals are full of Covid-19 patients who are unvaccinated. This is particularly true for persons under the age of 70, where vaccines are highly effective. The elderly do not have as robust an immune response after vaccination and are more

vulnerable to infection with the Covid-19 delta variant. The unvaccinated are a risk to themselves and a risk to others who, for a multitude of reasons, cannot produce a strong immune response after vaccination.

> Moline HL, Whitaker M, Deng L, et al. Effectiveness of COVID-19 Vaccines in Preventing Hospitalization Among Adults Aged ≥ 65 Years — COVID-NET, 13 States, February–April 2021. MMWR Morb Mortal Wkly Rep 2021;70:1088-1093.

50. The Covid-19 vaccines provide better protection than natural infection. For example, in Kentucky among people who were previously infected with COVID-19, unvaccinated persons were more than twice as likely to be reinfected with COVID-19 than those who were fully vaccinated after initially contracting the virus (Cavanaugh). These data further indicate that COVID-19 vaccines offer better protection than natural immunity alone and that vaccines, even after prior infection, help prevent reinfections. Observations such as these led to the recommendation that all persons should be vaccinated, regardless of previous COVID infection.

> Cavanaugh AM, Spicer KB, Thoroughman D, Glick C, Winter K. Reduced Risk of Reinfection with SARS-CoV-2 After COVID-19 Vaccination — Kentucky, May–June 2021. MMWR Morb Mortal Wkly Rep 2021;70:1081-1083.

51. In another study, the CDC examined data on 7,348 people hospitalized with a Covid-like illness at 187 hospitals in nine states from January 1 to September 2, 2021. All patients were ages 18 and older and had a Covid-19 test

between 14 days before hospital admission and 72 hours after. Unvaccinated people with a prior Covid-19 infection were more than five times as likely to test positive for Covid-19 than those who had been fully vaccinated and never had the disease.

> Bozio CH, Grannis SJ, Naleway AL, et al. Laboratory-Confirmed COVID-19 Among Adults Hospitalized with COVID-19–Like Illness with Infection-Induced or mRNA Vaccine-Induced SARS-CoV-2 Immunity — Nine States, January–September 2021. MMWR Morb Mortal Wkly Rep 2021;70:1539–1544.

52. These two studies show that vaccines are effective at preventing COVID-19 related hospitalizations among the highest risk age groups. As cases, hospitalizations, and deaths rise, the data reinforce that COVID-19 vaccines are the best way to prevent COVID-19.

53. COVID-19 vaccines remain safe and effective. They prevent severe illness, hospitalization, and death. Additionally, even among the uncommon cases of COVID-19 among the fully or partially vaccinated, vaccinated individuals are more likely to have a milder and shorter illness compared to those who are unvaccinated.

54. Most recently, Pfizer-BioNTech completed an efficacy trial among 2,268 children 5-11 years old. They were randomly assigned to receive two 10-µg doses of the BNT162b2 vaccine or placebo in a 2-to-1 ratio. The trial revealed that the vaccine was safe and produced a similar antibody response as had been

demonstrated in the older children and adults. Covid-19 with onset 7 days or more after the second dose was reported in three recipients of the BNT162b2 vaccine and in 16 placebo recipients (vaccine efficacy, 90.7%; 95% CI, 67.7 to 98.3). The study demonstrated that a Covid-19 vaccination regimen consisting of two 10-µg doses of BNT162b2 administered 21 days apart was found to be safe, immunogenic, and efficacious in children 5 to 11 years of age.

> Walter EB, Talaat KR, Sabharwal C, et al. Evaluation of the BNT162b2 Covid-19 Vaccine in Children 5 to 11 Years of Age. N Engl J Med. 2021 Nov 9. doi: 10.1056/NEJMoa2116298. Epub ahead of print. PMID: 34752019.

55. Individuals who are not vaccinated for vaccine preventable diseases pose a risk to themselves and to others, including "high risk" individuals. High risk individuals are those who cannot produce a robust immune response after vaccination—i.e. immunocompromised individuals, elderly individuals, etc.—and those who cannot, for a variety of reasons, receive vaccines—i.e. infants, individuals with severe allergic reactions to vaccines, individuals with health conditions that make vaccination medically contraindicated, etc. Health care workers are more likely to come into contact with these high risk individuals.

56. Vaccination and immunity status are important to know, as immunized individuals (either through vaccination or infections and recovery) are much less likely to become infected and, therefore, less likely to transmit the

diseases. Because non-immune individuals are more likely to become infected, they are more likely to spread pathogens through airborne, bloodborne, surface contamination, and other transmission mechanisms than immune individuals.

57. Covid-19 remains a fairly new virus, which has contributed to the confusion surrounding it and the vaccines for it. For example, one confusing area is the risk of Covid-19 transmission from vaccinated and unvaccinated persons. From the discussion above it should be clear that vaccinated persons are not as likely to become infected with Covid-19 as the unvaccinated. In the US as well as other parts of the world, the unvaccinated are responsible for most of the transmission because vaccinated persons are over five times less likely to contract the illness than the unvaccinated. You must have an infection to transmit the virus and vaccinated people are much less likely to be infected.

58. An outbreak in Provincetown, Massachusetts in July 2021 in which 74 percent of the 469 cases were in the fully vaccinated indicated that breakthrough infections can certainly occur with the delta variant, especially in indoor settings (Brown).

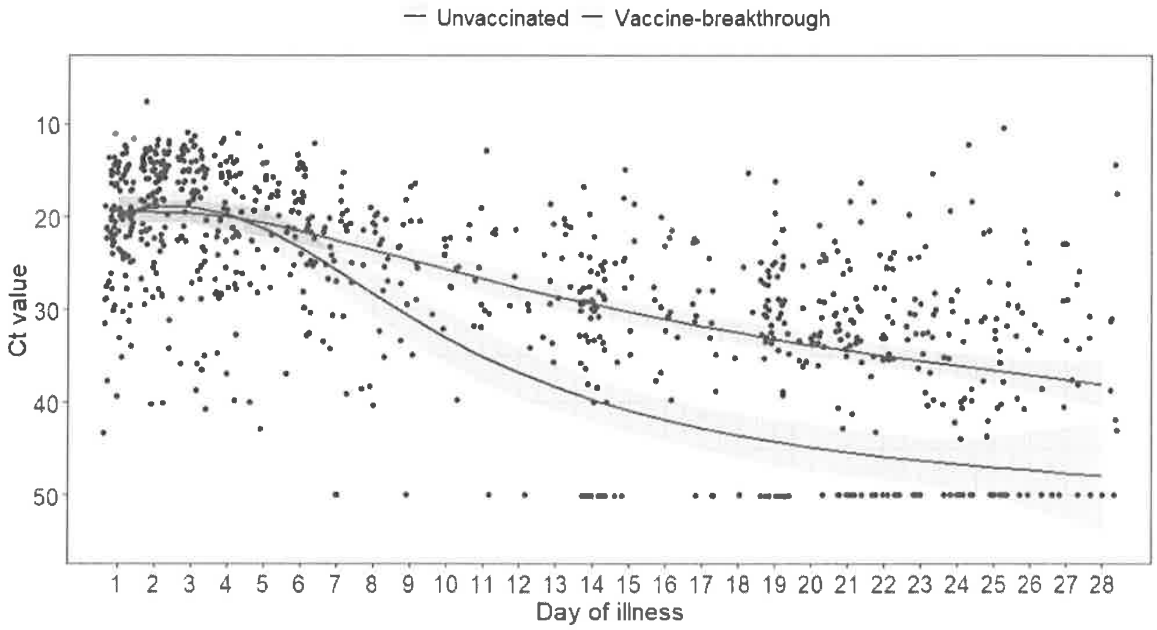
> Brown CM, Vostok J, Johnson H, et al. Outbreak of SARS-CoV-2 Infections, Including COVID-19 Vaccine Breakthrough Infections, Associated with Large Public Gatherings — Barnstable County, Massachusetts, July 2021. MMWR Morb Mortal Wkly Rep 2021;70:1059-1062.

59. In those instances where there is a breakthrough case in a vaccinated person, there is virus shedding which can be infectious. However, vaccinated persons are likely to be contagious for a shorter period of time and harbor less infectious virus compared to unvaccinated persons. Two studies illustrate these points.

60. First, Chia et al. studied 218 individuals with B.1.617.2 infection, 84 received an mRNA vaccine of which 71 were fully vaccinated, 130 were unvaccinated and four received a non-mRNA vaccine. These infections occurred in Singapore from April to June 2021. Figure 7 illustrates viral shedding identified by PCR as described for 30 days after the virus was first detected. PCR cycle time (CT) = 30 was used as the cutoff for viable or transmissible virus. In the first few days of infection, the viral load was similar in the vaccinated and unvaccinated groups. But the vaccinated group had a much more rapid decline in viral load over time. The vaccinated group reached the CT threshold of 30 at 8 days compared to 14 days for the unvaccinated. The amount of viral load correlates with transmission rates—those with a higher viral load are more likely to transmit the virus.

Chia PY, Ong SWX, Chiew CJ, et al. Virological and serological kinetics of SARS-CoV-2 Delta variant vaccine breakthrough infections: a multicentre cohort study. Clin Microbiol Infect. 2022 Apr;28(4):612.e1-612.e7.

Figure 7



61. A study from the Netherlands followed 24,706 vaccinated health care workers using sensitive methods of detection (PCR and viral culture), they identified 161 breakthrough infections. Ninety percent of the breakthrough infections were caused by the delta variant. All of the breakthrough infections were mild and did not require hospitalization. Infectious virus by culture was found in 68.6% of breakthrough infection in vaccinated vs. 84.9% in unvaccinated. The investigators concluded that vaccine breakthrough infections were rare (0.6%), usually mild and associated with a lower viral load in the respiratory tract.

Shamier MC, Tostmann A, Bogers S et al. Virological characteristics of SARS-CoV-2 breakthrough infections in health care workers. 2021 medRxiv preprint.

62. In conclusion, unvaccinated persons are six times more likely to become infected than vaccinated persons. While breakthrough infections occur, they are rare--occurring in less than one percent of vaccinated people. When vaccinated persons become infected they are likely to shed the virus at lower levels and for a shorter time than unvaccinated persons. These factors tend to reduce transmission. While vaccines are not perfect, they reduce the infection and transmission risk, and are by far the best tool we have in the fight against COVID-19 for protecting the community. Since there remains a number of unvaccinated individuals, masking and ventilation are still important ways to also continue to reduce the transmission risk of airborne pathogens.[1] These additional prevention methods should be used in conjunction with vaccination, not as a substitute for vaccination.[2]

63. While infections with the delta variant have waned in some areas, they have increased in other areas. SARS-CoV-2 may become like influenza showing an increase in the winter months when people are indoors. As of November 2021

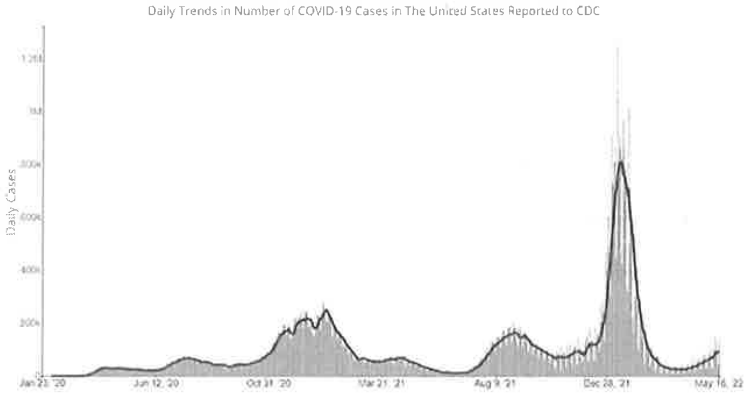
[1] These safeguards apply only to airborne pathogens as opposed to bloodborne.

[2] Other references used herein noted on Exhibit B

boosters shots are now recommended for all people in the US. This will strengthen our immunity which may be waning over time since the first vaccination. Further, unvaccinated individuals are being encouraged and more frequently mandated to receive their vaccines, which will strengthen immunity. Finally, new orally administered anti-viral agents have been tested and are likely to play an important role in reducing symptoms, decreasing secondary transmission, and decreasing the need for hospitalization.

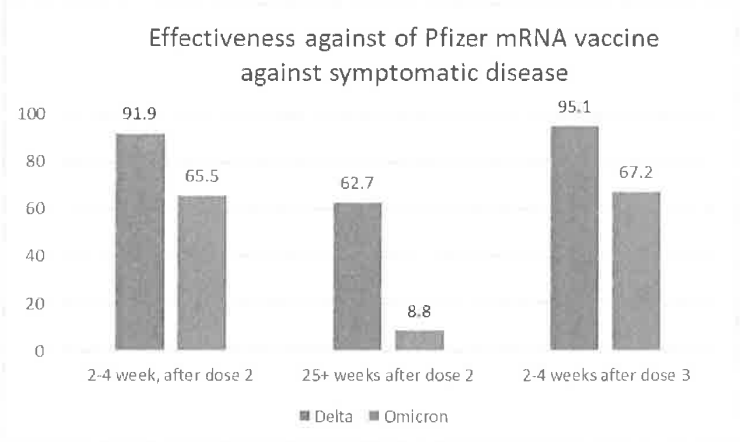
64. The Omicron outbreak:

As the outbreak with the delta variant began to wane in October 2021, another variant was identified in November 2021 in South Africa. This variant, designated the omicron, was more transmissible than delta. Omicron was identified in the US in early December and within a few weeks completely replaced the delta variant and caused a massive outbreak in the first 3 months of 2022 (Figure). Fortunately, the illness caused by omicron was less severe than the infections caused by the earlier Covid variants.



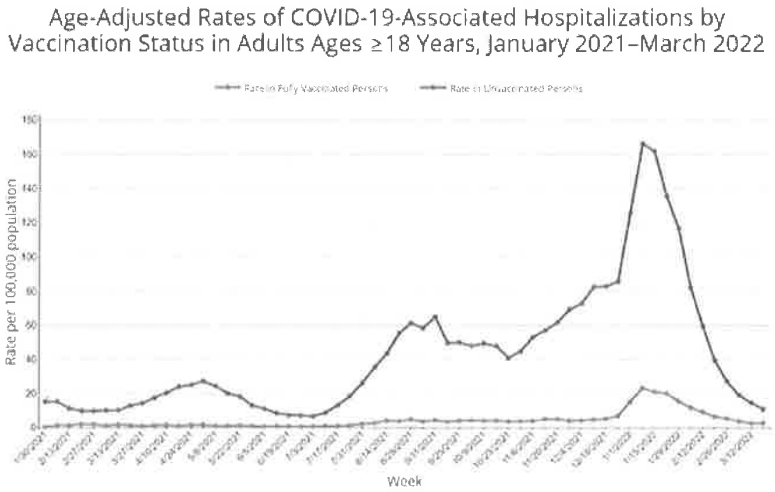
From CDC CDC COVID Data Tracker: Daily and Total Trends

Covid vaccination continued to play a significant protective role in protecting against symptomatic disease caused by the omicron variant. In a study from the United Kingdom the vaccine effectiveness was 65% in the period 2-4 weeks after the second dose. Protection decreased to less than 10% after 25 weeks but could be improved to 67% with a third vaccine dose (Figure).



From N. Andrews et al. N Engl J Med 2022; 386:1532-1546 DOI: 10.1056/NEJMoa2119451

Covid vaccination was also found to significantly reduce the severity of infection as measured by hospitalization rate. Data collected from a network of over 250 acute-care hospitals in 14 US states indicated that the risk of hospitalization was nearly 5-fold higher in unvaccinated adults aged 18 years and older (Figure).



Data from CDC Covid website

The omicron outbreak has emphasized that Covid epidemiology has not settled into a predictable pattern as has been the case with seasonal influenza. However, seasonal influenza may be the future model. Influenza vaccines are based on predicting the influenza strains that are likely to circulate in the next season and preparing a single dose vaccine given before the season starts.

65. Fighting viruses requires a multipronged approach. Vaccination can be combined with public health measures, such as social distancing and masking. Vaccination can also be constantly improved. The introduction of the mRNA Covid vaccines was a major advance and saved millions of lives. There is hope that future vaccines will be more effective against a wide variety of Covid strains. In summary, vaccines are a safe, effective and essential public health tool to insure the good health of our nation and world. Every effort should be made to promote their use.

DATED this 5th day of July, 2022.

David Taylor, M.D.

October 2021

CURRICULUM VITAE

DAVID N. TAYLOR, MD, MSc (Medical Parasitology)

CONTACT INFORMATION

Office	Home
Bozeman Health 915 Highland Boulevard Bozeman, MT 59715	518 S. 3rd Avenue Bozeman, MT 59715
Tel: 406-414-3750 Cell: 919-349-6109 dataylor@bozemanhealth.org www.bozemanhealth.org	Cell: 919-349-6109 Email: dnt731@yahoo.com

Citizenship: U.S.A.

EDUCATION AND TRAINING

1970	B.S.	With honors in biology, Kenyon College, Gambier, Ohio
1972	DMS	Dartmouth Medical School, Hanover, New Hampshire
1974	M.D.	Harvard Medical School, Boston, Massachusetts
1978	MSc.	Medical Parasitology, London School of Hygiene and Tropical Medicine, London, England

Internship

1974-1975 State University of New York at Buffalo Affiliated Hospitals, Buffalo, New York

Residency

1975-1977 State University of New York at Buffalo Affiliated Hospitals, Buffalo, New York

Fellowship

1978-1980 Research Fellow in Geographic Medicine, Johns Hopkins University International Center for Medical Research (Panama)

CERTIFICATION

1975 Diplomate, National Board of Medical Examiners
1977 Diplomate, American Board of Internal Medicine
1988 Diplomate, American Board of Internal Medicine, Subspecialty of Infectious Diseases

2008	Advanced Vaccinology Course, Fondation Merieux & University of Geneva

MEDICAL LICENSURE

2021-present	Montana, 101045
1988-2021	Maryland, D35854

MILITARY SERVICE

1980-1982	Senior Assistant Surgeon, USPHS
1982-1987	Major, Medical Corps, U.S. Army
1987-1993	Lieutenant Colonel, Medical Corps, U.S. Army
1993-2002	Colonel, Medical Corps, U.S. Army

PROFESSIONAL EXPERIENCE

2021-	Director of Clinical Research, Bozeman Health, Bozeman, MT
2020-21	Independent Consultant, Healthcare technologies
2018-19	Chief Medical Officer, Vaxart Inc., S. San Francisco, CA
2016-18	Senior Medical Officer, Drug Development Global Program (DRG), PATH
2015-16	Senior Medical Officer, Vaccine Development Global Program, PATH
2013-14	Senior Medical Director, Vaccines, Takeda Vaccines
2007-13	Chief Medical Officer, VaxInnate Corporation
2004-06	Vice President Medical and Safety & Chief Medical Officer, Salix Pharmaceuticals
2002-04	Research Professor, Dept of International Health, Johns Hopkins Bloomberg School of Public Health, Baltimore, MD
2001-02	Acting Director, Division of Communicable Diseases and Immunology, Walter Reed Army Institute of Research, Silver Spring, MD
2000-02	Research Coordinator, Prevention of Diarrheal Diseases, Military Infectious Diseases Research Program, US Army Medical Research and Materiel Command, Fort Detrick, MD
1997-02	Clinical Director, Dept. of Enteric Infections, Division of Communicable Diseases and Immunology, WRAIR
1995-2010	Adjunct Professor of Preventive Medicine/Biometrics, Uniformed Services University of the Health Sciences, Bethesda, MD
1994-97	Chief, Cholera Vaccine Project, Naval Medical Research Institute Detachment, Lima, Peru.
1992-94	Chief, Department of Clinical Trials, Walter Reed Army Institute of Research, Washington, D.C.
1990-92	Investigator, Department of Enteric Infections, Walter Reed Army Institute of Research, Washington, D.C.
1988-90	Investigator, Department of Bacterial Diseases, Walter Reed Army Institute of Research, Washington, D.C.
1983-88	Assistant Chief, Department of Bacteriology and Clinical, Laboratory Sciences, US Army Medical Component, Armed Forces Research Institute of Medical Sciences,

	Bangkok, Thailand
1980-82	Epidemic Intelligence Service Officer, Enteric Diseases Branch, Centers for Disease Control, United States Public Health Service, Atlanta, Georgia

PROFESSIONAL ACTIVITIES
Board of Directors, National Emergency Medicine Foundation (2015-present)

CONTINUING EDUCATION

1993 -- Good Clinical Practices Training, WRAIR, Washington DC
2000 – Effective Project Management, Center for Professional Advancement

1989 – 1st Conference of the International Society of Travel Medicine	Zurich
1991 – 2nd Conference of the International Society of Travel Medicine	Atlanta
1993 – 3rd Conference of the International Society of Travel Medicine	Paris
1995 – 4th Conference of the International Society of Travel Medicine	Acapulco
1997 – 5th Conference of the International Society of Travel Medicine	Geneva
1999 – 6th Conference of the International Society of Travel Medicine	Montreal
2003 – 8th Conference of the International Society of Travel Medicine	New York
2005 – 9th Conference of the International Society of Travel Medicine	Lisbon

PROFESSIONAL ACTIVITIES

Society membership

Fellow, American College of Physicians
Fellow, Infectious Diseases Society of America
Member, American Society of Microbiology
Member, American Epidemiological Society

International Experience

1972	Two month medical elective, Guatemala
1974	Two month medical elective, Colombia
1978-1980	Research Fellowship, Panama
1982	Two months research project, Chile
1983-1988	Thailand
1986-1987	WHO consultant to oral typhoid vaccine trial, Plagu, Sumatra, Indonesia
1994-1997	Peru
2002-4	Guatemala
2015-6	Vietnam and Serbia

LANGUAGE ABILITIES

Spanish, Thai

EDITORIAL ACTIVITIES

Peer Review Activities

Review for
Journal of Infectious Diseases
Clinical Infectious Diseases
Infection and Immunity
Journal of Clinical Microbiology
Annals of Internal Medicine
New England Journal of Medicine
Pediatrics
American Journal of Epidemiology
Pediatric Infectious Diseases
Vaccine

HONORS AND AWARDS

1988 Army Meritorious Service Medal
1995 Legion of Merit
1997 Navy Letter of Commendation
1998 Army Meritorious Service Medal (Second award)
2000 Certificate of Recognition for service during cold war (2 Sep 1945 to 26 Dec 1991).

PUBLICATIONS

Chapters, Reviews, and Editorials

1. Blaser MJ, Taylor DN, Feldman RA. Epidemiology of Campylobacter infections. In: Campylobacter infections in man and animals. CRC Press Inc., Boca Raton, FL, USA 1983:144-161

2. Sethabutr O, Echeverria P, Taylor DN, Pal T, Rowe B. DNA hybridization in the identification of enteroinvasive Escherichia coli and Shigella in children with dysentery. In Infectious Diarrhea in the Young, Elsevier Science Publishers, S Tzipori et al. eds. 1985

3. Echeverria P, Seriwatana J, Sethabutr O, Taylor DN. DNA hybridization in the diagnosis of Bacterial Diarrhea. In: Clinics in Laboratory Medicine. W.B. Saunders Co. 1985; 5:447-462

4. Echeverria P, Taylor DN. New approaches to the diagnosis of enteric infections. In: Farthing MJG and Keusch GT, eds. Enteric Infection. Chapman and Hall, London. 1989:417-437

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PRESENTATIONS

Upon Request

EXHIBIT B

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AUSTIN KNUDSEN
Montana Attorney General
DAVID M.S. DEWHIRST
Solicitor General
CHRISTIAN B. CORRIGAN
Deputy Solicitor General
BRENT MEAD
Assistant Solicitor General
P.O. Box 201401
Helena, MT 59620-1401
Phone: (406) 444-2026
Fax: (406) 444-3549
david.dewhirst@mt.gov
christian.corrigan@mt.gov
brent.mead2@mt.gov

EMILY JONES
Special Assistant Attorney General
Jones Law Firm, PLLC
115 N. Broadway, Suite 410
Billings, MT 59101
Phone: (406) 384-7990
emily@joneslawmt.com

Attorneys for Defendants

UNITED STATES DISTRICT COURT FOR THE DISTRICT OF MONTANA, MISSOULA DIVISION

MONTANA MEDICAL ASSOCIATION, ET. AL.,

Plaintiffs,

and

MONTANA NURSES ASSOCIATION,

Plaintiff-Intervenors,

v.

AUSTIN KNUDSEN, ET AL.,

DEFENDANTS.

No. CV-21-108-M-DWM

EXPERT REPORT OF RAM DURISETI MD, PHD

Expert Report of Ram Duriseti MD, PhD

July 15th, 2022

I, Ram Duriseti, MD, PhD, declare as follows:

I am a clinical associate professor at the Stanford Emergency Department. I have been a practicing Board Certified Emergency Physician for over 20 years. My PhD background is in computational decision modeling, simulation, and optimization algorithms. I have personal knowledge of the facts set forth below and could testify competently to them if called to do so. A true and correct copy of my *curriculum vitae* is attached to this declaration.

I am being compensated $300.00 per hour for my effort in this case. My compensation is in no way contingent upon my conclusions in this case.

COVID-19 is the disease caused by infection with the SARS-CoV-2 virus. The current generation of COVID-19 vaccines do not significantly limit transmission. Transmission of an infectious disease is both a function of behavior and presence of infection. A vaccine mandate with

the purpose of limiting transmission must not simply decrease the risk of infection, but must do so by a substantial margin.

We must first acknowledge, using the Pfizer COVID-19 mRNA vaccine as a canonical example, that the vaccine trials were never designed to test for preventing transmission. Pfizer themselves pointed this out to the FDA.[1] The "data gaps" identified by Pfizer were:

- Duration of protection
- Effectiveness in certain populations at high risk of severe COVID-19
- Effectiveness in individuals previously infected with SARS-CoV-2
- Future vaccine effectiveness as influenced by characteristics of the pandemic, changes in the virus, and/or potential effects of co-infections
- Vaccine effectiveness against asymptomatic infection
- Vaccine effectiveness against long-term effects of COVID-19 disease

[1] https://www.fda.gov/media/148542/download#page=38

- Vaccine effectiveness against mortality
- Vaccine effectiveness against transmission of SARS-CoV-2

It's important to remember that the original Pfizer trial supporting its FDA approval was never structured to test for transmission reduction and this is part of the record in the Emergency Use Authorization (EUA) review. As noted by Dr. Patrick Moore of the University of Pittsburgh Cancer Institute,

> "One question that addresses these two discussion items, I find is really, really central, and important, is that FDA did not ask in its guidance and Pfizer has presented no evidence in its data today that the vaccine has any effect on virus carriage or shedding, which is the fundamental basis for herd immunity (page 342 of transcription)." [2]

While many COVID-19 immune naïve individuals (no prior infection by SARS-CoV-2 which is the virus that causes COVID-19) likely benefitted from having their immune systems primed by a vaccine prior to a subsequent infection thereby increasing their protection from more severe disease progression, any imputed impact on disease transmission has been fleeting at best.

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[2] https://www.fda.gov/media/144859/download

As early as Summer 2021, emerging data suggested that vaccinated individuals' net reduction in "viral load" during an infection was no more than 30%.[3] Since that time, between waning efficacy and partial "immune escape" from SARS-CoV-2 variants, it's become clear that even that degree of reduction is not sustained. In a more recent study, researchers used longitudinal sampling of nasal swabs for determination of viral load, sequencing, and viral culture in outpatients with newly diagnosed coronavirus disease 2019 (Covid-19). From July 2021 through January 2022 and concluded that, "we did not find large differences in the median duration of viral shedding among participants who were unvaccinated, those who were vaccinated but not boosted, and those who were vaccinated and boosted".[4]

When discussing the topic of transmission in a health care setting and staff vaccination rates, a July 2021 paper examined infection rates among different vaccinated patient cohorts in a nursing home at different levels of staff vaccination. The most telling table was in the supplement.

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[3] https://www.medrxiv.org/content/10.1101/2021.08.20.21262158v1.full-text

[4] https://www.nejm.org/doi/full/10.1056/NEJMc2202092

In table S3, there was no association between staff vaccination rates and transmission to residents regardless of the residents' vaccination status.[5] As this study was pre-Delta and pre-Omicron, given increased escape from vaccine induced immunity with both Delta and Omicron variants, there is no reason to believe that this trend would not hold.

NURSING HOME VACCINATIONS 8

Table S3. Incident SARS-CoV-2 infections in residents living in nursing homes with low, moderate, and high staff vaccination rates

	Low staff vaccination (Less than 58.7% of staff vaccinated)		Moderate staff vaccination (58.7 - 69.2% of staff vaccinated)		High staff vaccination (69.3 - 95.7% of staff vaccinated)	
	Total	Percent (%) asymptomatic	Total	Percent (%) asymptomatic	Total	Percent (%) asymptomatic
Residents vaccinated with at least dose 1, n	5691		6291		6260	
Tested positive 0-14 days after dose 1, n(%)	266 (4.7%)	71.1%	267 (4.2%)	74.2%	289 (4.6%)	69.2%
Tested positive 15-28 days after dose 1, n(%)	83 (1.5%)	75.9%	50 (0.8%)	62.0%	117 (1.9%)	72.6%
Residents vaccinated with doses 1 & 2, n	4001		4579		4468	
Tested positive 0-14 days after dose 2, n(%)	46 (1.1%)	80.4%	32 (0.7%)	87.5%	52 (1.2%)	86.5%
Tested positive >14 days after dose 2, n(%)	18 (0.4%)	72.2%	8 (0.2%)	75.0%	12 (0.3%)	83.3%
Unvaccinated residents	1629		1296		1065	
Tested positive 0-14 days after clinic 1 held, n(%)	73 (4.5%)	65.8%	65 (5.0%)	66.2%	35 (3.3%)	68.6%
Tested positive 15-28 days after clinic 1 held, n(%)	31 (1.9%)	64.5%	15 (1.2%)	46.7%	23 (2.2%)	65.2%
Tested positive 29-42 days after clinic 1 held, n(%)	6 (0.4%)	83.3%	4 (0.3%)	75.0%	6 (0.6%)	83.3%
Tested positive >42 days after clinic 1 held, n(%)	6 (0.4%)	83.3%	3 (0.2%)	66.7%	3 (0.3%)	100.0%

Notes. Nursing homes stratified by tertiles of staff vaccination rates as of February 17, 2021. Staff vaccinations occurred simultaneously with resident vaccinations and rates were tracked by the organization.

What about transmission and vaccination/booster status with Omicron? An early December 2021 paper in Danish Households demonstrated a roughly 40% reduction in household secondary attack rate (SAR) with boosting when compared to the unvaccinated or

5 https://www.nejm.org/doi/suppl/10.1056/NEJMc2104849/suppl_file/nejmc2104849_appendix.pdf

vaccinated.[6] Most importantly, there was no such reduction in susceptibility to infection when comparing vaccinated alone compared to the vaccinated. Focusing on table 2, during the early December 2021 study period, booster vaccination cut the risk of contracting Omicron by roughly 45%+ and passing on Omicron by roughly 40%.[5] While this appeared promising for boosters, the subsequent ecological waves from late December 2022 forward in heavily boosted countries previously lauded for the "COVID success" demonstrated otherwise. Denmark, Iceland, Norway, New Zealand, Australia, Hong Kong, South Korea all experienced per-capital COVID waves larger than any experienced by the United States.[7] So the advantage of boosting, while demonstrable in an 8-week time frame, appears to rapidly devolve over time.

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6 https://www.medrxiv.org/content/10.1101/2021.12.27.21268278v1.full.pdf

7 https://ourworldindata.org/explorers/coronavirus-data-explorer?zoomToSelection=true&time=2020-03-01..latest&facet=none&pickerSort=asc&pickerMetric=location&Metric=Confirmed+cases&Interval=7-day+rolling+average&Relative+to+Population=true&Color+by+test+positivity=false&country=USA~ISL~DNK~NOR~KOR~NZL~AU

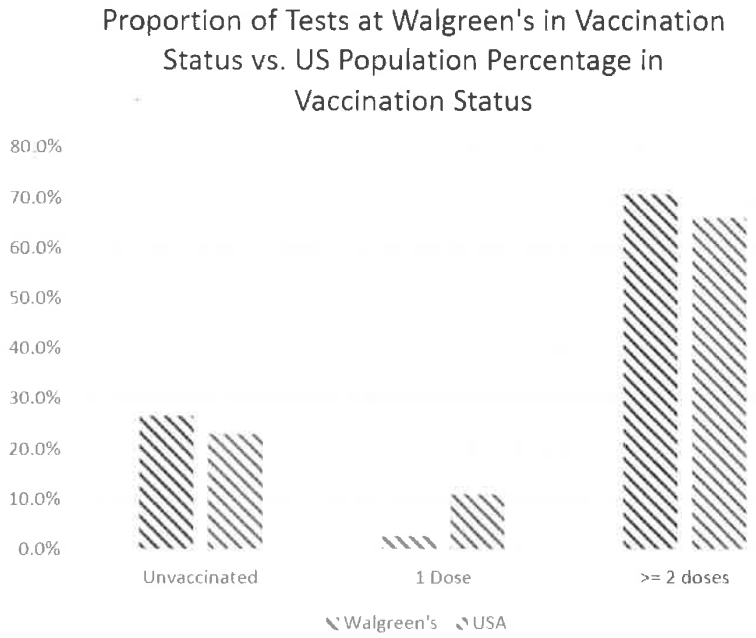
Indeed, we are seeing this effect even more so now across multiple data sets: both national and local.

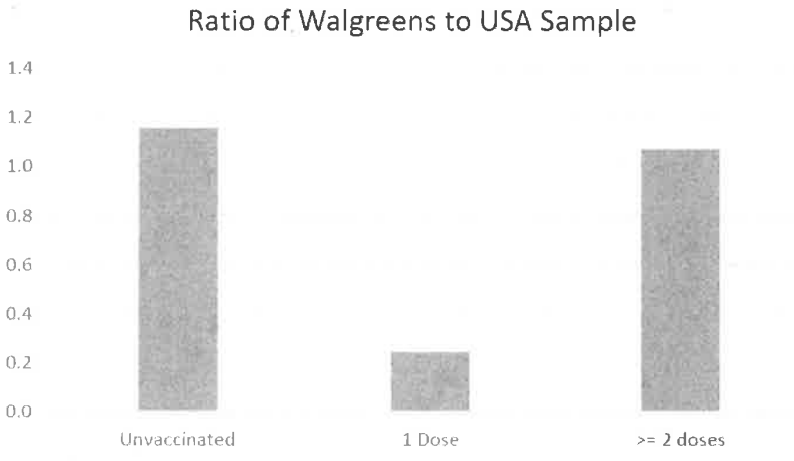
Walgreens is a leading nationwide provider of COVID vaccination and testing provider. They maintain a remarkable COVID dashboard that details test positivity by vaccination status broken down by age cohort.[8] Correcting for vaccination rates and population representation. The data show that vaccinated and boosted individuals are testing positive for COVID-19 at a higher rate than unvaccinated individuals. While there is a chance this reflects the fact that unvaccinated individuals are more likely to have had protection from a prior infection and more likely required to obtain surveillance testing, this does not impact our discussion here as the vast majority of Americans, vaccinated or not, have had a COVID-19 infection (approximately 75% through February 2022 alone).[9]

The Walgreen's data is not excessively sampling vaccinated patients. In fact, the population tested by Walgreens has a small number of single-dose vaccinated than the USA population, with higher

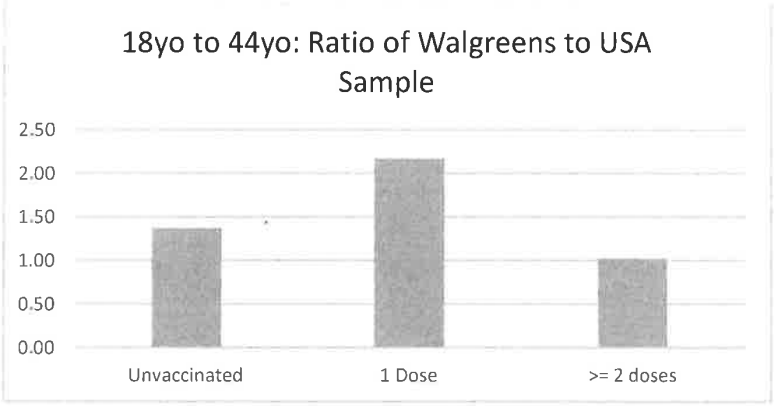
[8] https://www.walgreens.com/businesssolutions/covid-19-index.jsp
[9] https://covid19serohub.nih.gov/

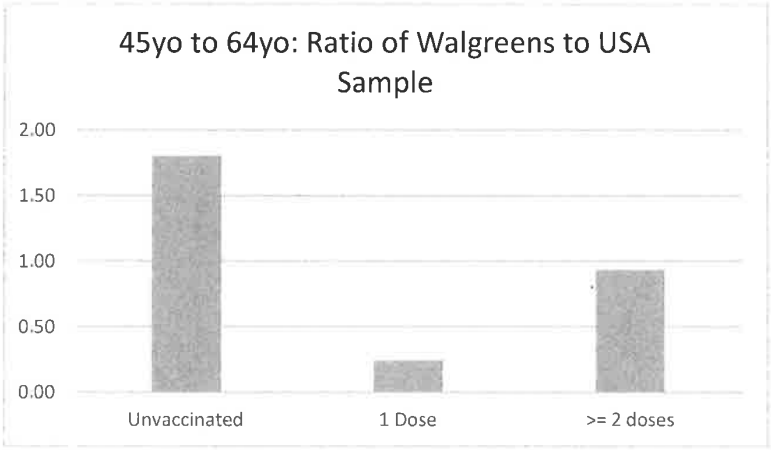
proportions of vaccinated and unvaccinated patients – particularly the unvaccinated.

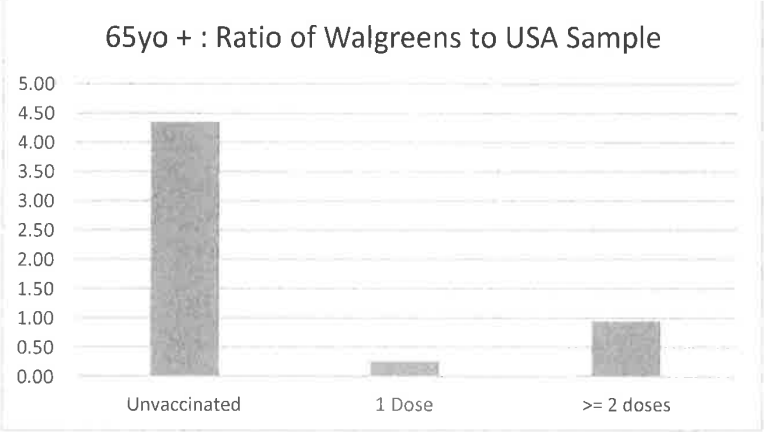




In fact, in the over 18-year-old age cohorts, Walgreen's tests unvaccinated patients at significantly higher rate than their representation in the USA population:

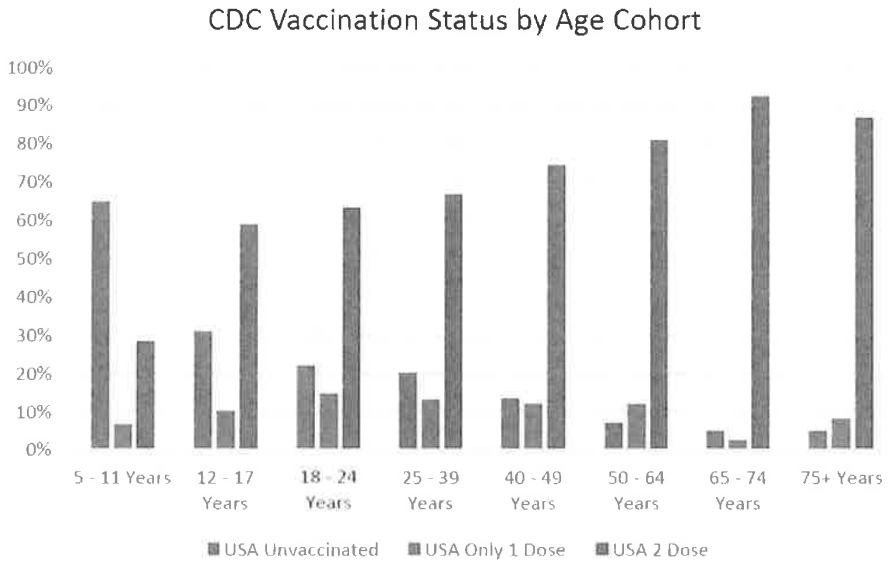




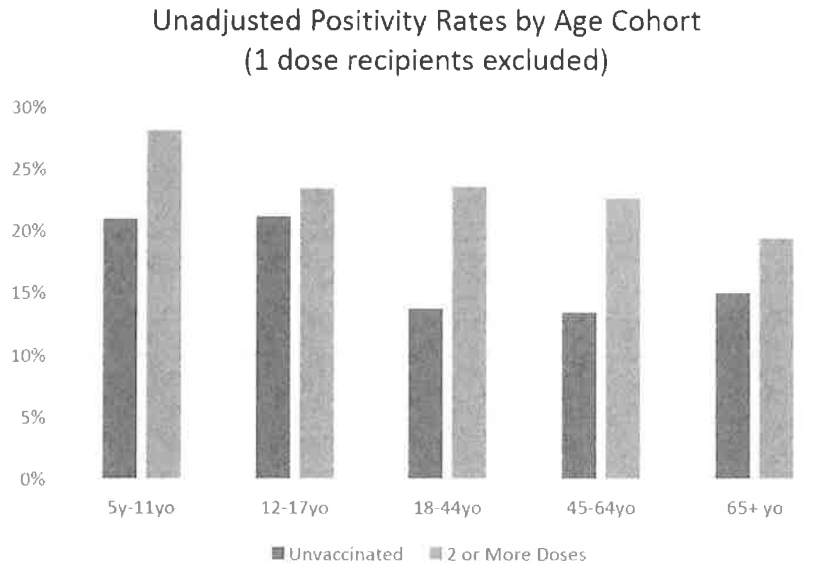


When collecting Walgreens data for a testing week April 28th, 2022, for every age cohort, vaccinated individuals are testing positive at a *higher rate*. It's important to understand that these are rates so there is no "base rate fallacy". In other words, just because vaccinated individuals are a larger percentage of the population, they will not register a higher rate of positivity.

CDC data by dose per age cohort through April 2022:

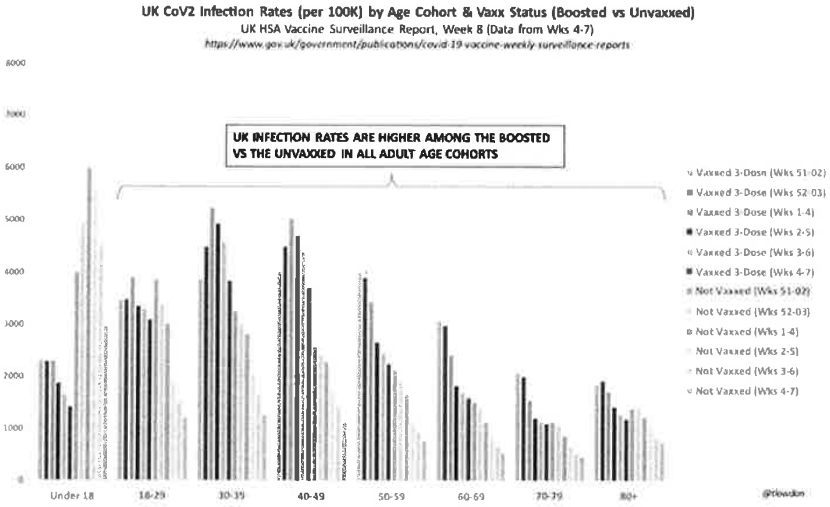


Consolidating fully vaccinated and boosted individuals into a "2 or more doses" category to correspond to the CDC data above, we see the following across all age cohorts from Walgreens:

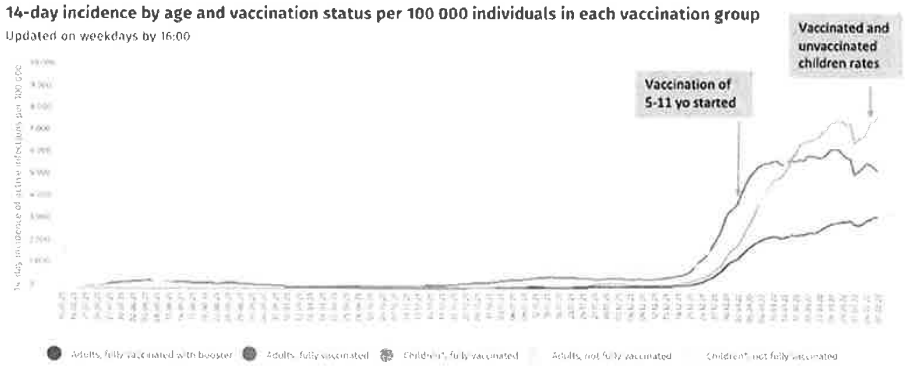


These high positivity rates in vaccinated individuals are duplicated across multiple countries.

The United Kingdom[10]:



Iceland:



[10] https://www.gov.uk/government/publications/covid-19-vaccine-weekly-surveillance-reports

And the high infection rates in vaccinated, and even near universally boosted populations is evident in multiple local data sets such as the University of California campuses.

The University of California at Irvine:[11]

Daily snapshot: 5/27/2022 6:04:04 AM

Positive cases reported yesterday

57

All Students: 53
Students in Campus Housing 36
Students not in Campus Housing 17
Staff and Faculty/Academics: 4

Cumulative positive cases

5,426

All Students: 4,563
Students in Campus Housing: 2,336
Students not in Campus Housing: 2,227
Staff and Faculty/Academics: 863

Total number of people testing positive starting September 5, 2021

Active positive cases

429

All Students: 390
Students in Campus Housing 256
Students not in Campus Housing 134
Staff and Faculty/Academics: 39

Those who are currently recuperating

Cumulative recovered cases

4,997

All Students: 4,173
Students in Campus Housing: 2,080
Students not in Campus Housing: 2,093
Staff and Faculty/Academics: 824

Those cleared to return to normal daily activity

Isolation and quarantine beds available

257

Out of 362 total beds

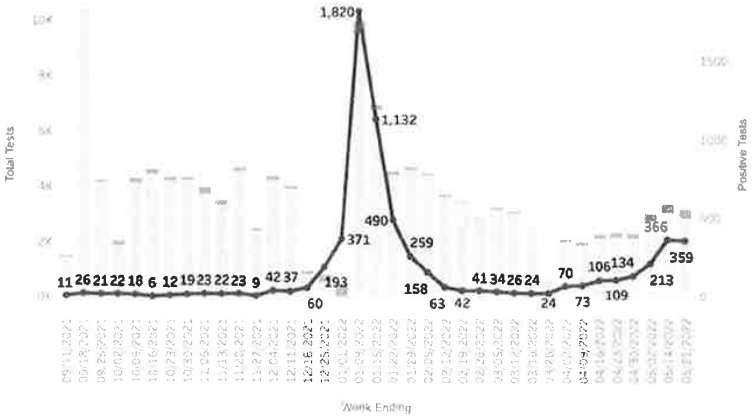
Vaccination and Booster Data

	% Vaccinated	% Boosted*	Total Vaccinated	Total Population
All Students	98%	97%	33,711	34,484
Students in Campus Housing	99%		14,074	14,214
Students not in Campus Housing	97%		19,637	20,270
Staff and Faculty/Academics	95%	99%	6,683	7,007

* % boosted is a subset of total vaccinated who are eligible to be boosted

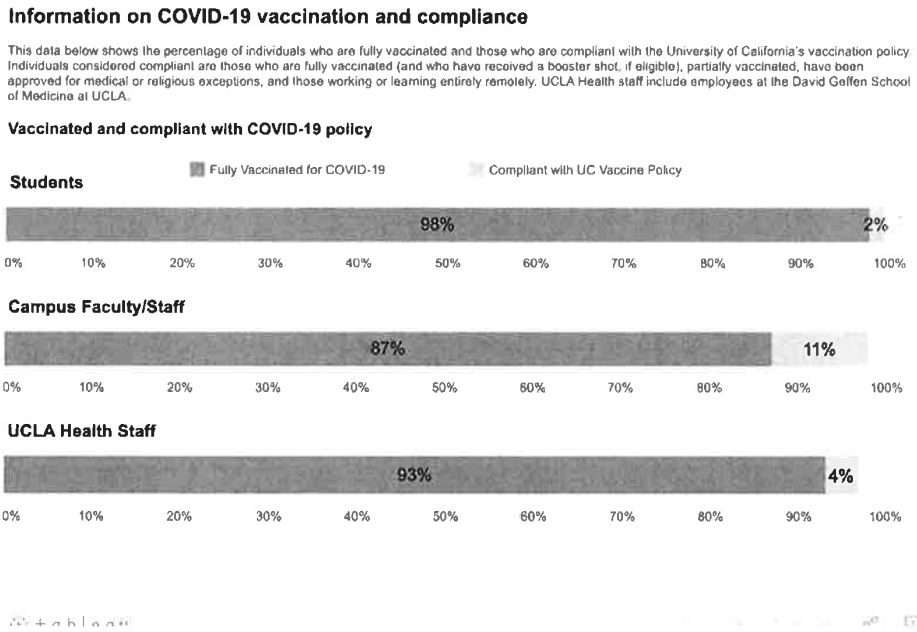
Symptomatic and asymptomatic testing

Testing since September 5, 2021. The following chart combines asymptomatic and symptomatic results.

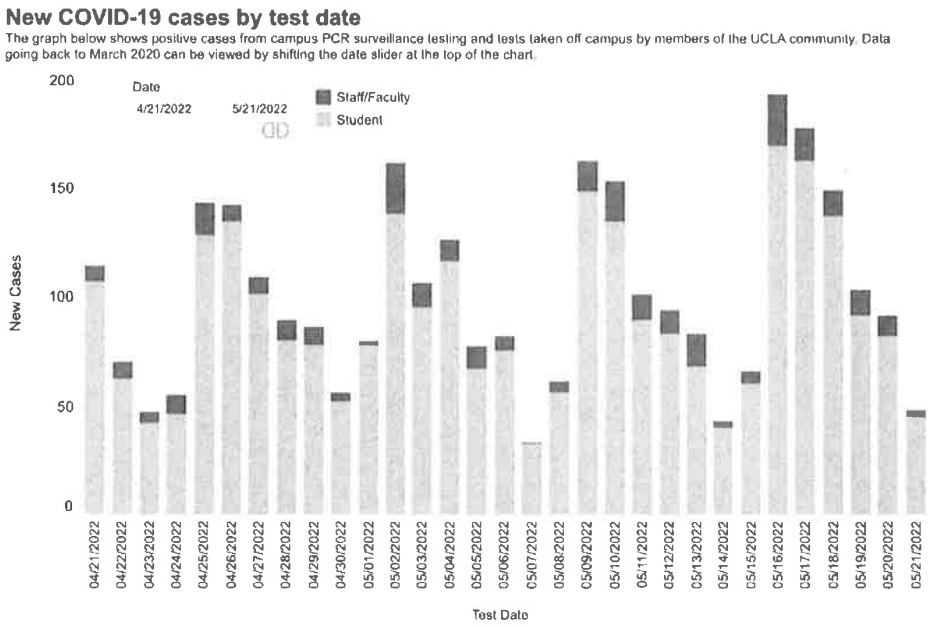


[11] https://uci.edu/coronavirus/dashboard/index.php

University of California at Los Angeles:[12]



[12] https://covid-19.ucla.edu/confirmed-cases-of-covid-19-among-the-ucla-campus-community/



Coming back to Danish research on transmission with the BA.2 Omicron variant (dominant now) versus the BA.1 Omicron variant (dominant through the winter of 2021-22), they noted:[13]

> Both unvaccinated, fully vaccinated and booster-vaccinated individuals had a higher susceptibility for BA.2 compared to BA.1, indicating an inherent increased transmissibility of BA.2 (Table 3). However, the relative increase in susceptibility was significantly greater in vaccinated individuals compared to unvaccinated individuals (appendix Figure 6, which points towards immune evasive properties of the BA.2 conferring an even greater advantage for BA.2 in a highly vaccinated population such as Denmark. Because previous studies of the Omicron VOC has focused on the BA.1 (Pearson et al., 2021; Planas et al., 2021), new studies are needed to further investigate these properties for BA.2.

[13] https://www.medrxiv.org/content/10.1101/2022.01.28.22270044v1

Vaccine mandates for COVID-19 vaccines were an ill-conceived policy more than a year ago. As noted by Dr. Patrick Moore during the original Pfizer FDA review meeting, "FDA did not ask in its guidance and Pfizer has presented no evidence in its data today that the vaccine has any effect on virus carriage or shedding" (page 342 of the transcript).[14]

Having said the above, it is well past time to reconsider our approach to COVID-19 especially as it pertains to COVID-19 vaccine mandates even if one truly believes that *any* reduction in transmission is demonstrable. When considering the susceptibility of the general population to COVID-19 in May of 2022, at least 97% of Americans are no longer immune-naïve to SARS-CoV-2 through either vaccination, infection, or hybrid immunity.[15] As noted by FDA voting member Dr. Paul Offitt, it is clear that neither vaccination or mass testing will stop COVID-19, but both vaccination and prior infection will confer resistance to severe disease.[16] This "herd resistance to severe disease " will not confer iron-clad protection from an "infection" moving forward, but it's

[14] https://www.fda.gov/media/144859/download (page 342)
[15] https://covid19serohub.nih.gov/
[16] https://www.inquirer.com/health/expert-opinions/covid-19-pandemic-immunity-boosters-normal-20220304.html?

main value will be protection from severe disease and there is historical precedent for this belief.[17] By July 13th, 2022, with likely well over 97% of Americans (was 97% through February 18th, 2022) falling into a category of prior vaccination and/or prior infection, as a population, we have achieved as much meaningful population level protection as is possible. Moving forward, every individual, based upon their individual age, metabolic risks, immune status, and personal preferences, will have to decide how best to proceed with future vaccine doses or therapeutics.[18]

Influenza

This brings us full circle to Influenza as the parallels are dramatic. Both are RNA viruses of roughly the same size, both are transmitted by droplets and aerosols, and the impacts of vaccination are quite similar. COVID-19 has followed the path of Influenza: now, as with influenza, cases of COVID-19 will continue to appear, but the number and severity of those infections will be significantly reduced even while neither vaccination or prior infection represents an impenetrable shield to

[17] https://www.eurekalert.org/news-releases/694958
[18] https://www.nature.com/articles/s41574-021-00608-9

subsequent infection.[19,20] In fact, a 2018 study positively correlated amount of virus in exhaled breath with vaccination status thereby suggesting that in the study population, those vaccinated with the Influenza vaccine were spreading more viral particles.[21] It is well established that the benefits of Influenza vaccination extend to the individual receiving the vaccination which is traditionally why Influenza vaccination in health care settings has been recommended and not mandated (until recently at some institutions). Indeed, a 2017 study established that patient benefit from healthcare worker was not established:

> "The impression that unvaccinated HCWs place their patients at great influenza peril is exaggerated. Instead, the HCW-attributable risk and vaccine-preventable fraction both remain unknown and the NNV to achieve patient benefit still requires better understanding. Although current scientific data are inadequate to support the ethical implementation of enforced HCW influenza vaccination, they do not refute approaches to support voluntary vaccination or other more broadly protective practices, such as staying home or masking when acutely ill." [22]

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[19] https://www.eurekalert.org/news-releases/694958
[20] https://www.thelancet.com/journals/lanmic/article/PIIS2666-5247(21)00180-4/fulltext
[21] https://www.pnas.org/doi/10.1073/pnas.1716561115
[22] https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0163586

This has led Dr. Michael Osterholm, formerly a member of the Biden Administration's COVID Task Force to state:

> "We have to make public health recommendations based on good science," Osterholm added, "but we do not have the justification to take punitive action against healthcare workers if they don't get vaccinated [for Influenza]." [23]

"Sterilizing Vaccines" and Mandates

When we refer to "sterilizing vaccines", we are referring to vaccines that confer both protection from infection thereby effectively eliminating infection risk as well as providing protection from severe illness. Traditionally, as canonical examples of "sterilizing vaccines", we consider the Measles/Mumps/Rubella (MMR) vaccine as it pertains to Measles and the Hepatitis B vaccine. Measles, like Influenza and SARS-CoV-2 (the virus that causes COVID-19) are respiratory viruses. Measles transmission while through droplets and aerosols, is more droplet mediated than with COVID-19 or Influenza, and yet remains highly contagious. In the case of Measles and Hepatitis B, there is a major component of the infection that is bloodborne (unlike SARS-CoV-2 or

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[23] https://www.cidrap.umn.edu/news-perspective/2017/01/health-worker-flu-vaccine-data-insufficient-show-protection-patients

Influenza) such that blood-borne vaccine or infection induced antibodies can perform a pivotal role in preventing infection. But even in the context of Measles and Hepatitis B vaccines, "sterilizing" is a relative term.

Numerous studies have shown that those vaccinated against Measles can develop infections, even as the primary value remains protection from severe illness. In a recent 2018 study of an outbreak in a French Psychiatric ward, 14% of fully vaccinated index cases from a primary unvaccinated case developed Measles. 2 of the cases had 2 Measles vaccinations and one even had vaccination with a prior infection in the preceding 6 years.[24] A less contained outbreak in New York was traced to a vaccinated index case.[25]

All of this said, an outbreak of Measles in the Marshall Islands demonstrated that non-vaccine eligible infants were more likely to be infected as secondary contacts than adults (46% versus 13%).[26] In this outbreak, the largest in the United States or associated area in more than a decade, 41% of cases were reported to have been previously vaccinated.

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[24]https://journals.lww.com/pidj/FullText/2019/09000/Measles_Transmission_in_a_Fully_Vaccinated_Closed.27.aspx

[25] https://academic.oup.com/cid/article/58/9/1205/2895266

[26] https://pubmed.ncbi.nlm.nih.gov/16392073/

Given that Measles vaccine is not recommended under 12 months of age, the biggest lesson of the Marshall Islands outbreak was the susceptibility of vulnerable non-vaccine eligible populations. It is thought that 90% vaccine coverage is required for the prevention of such outbreaks.

In the case of Hepatitis B, transmission is through body fluid contact. Vaccination, or infection, followed by documented threshold antibody levels is highly effective in preventing infection and transmission. Once again, "sterilizing immunity" in this context remains "relative" with documented Hepatitis B cases in previously vaccinated individuals. In one study, roughly 10% of previously vaccinated individuals with no evidence of prior infection had detectable Hepatitis B virus through DNA-testing suggesting evidence of an undetected "breakthrough" infection.[27] Once again, as with protection from a Measles vaccination, the benefit accrued to the vaccinated individual is substantial. In East Asian countries, Hepatitis B is endemic (spreads at baseline through the population). With the advent of universal Hepatitis B vaccination of newborns in Taiwan, the infant mortality rate from

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[27] https://journals.lww.com/md-journal/fulltext/2016/12060/hepatitis_b_viremia_in_completely_immunized.92.aspx

hepatitis B dropped by 3-fold and severe hepatitis almost disappeared in older children.[28,29,30]

Summary

While we can establish significant distinctions between "sterilizing vaccines" and vaccines such as the ones for COVID-19 and Influenza, it remains the case that the main benefit of vaccination is accrued to the individual receiving the vaccination. For vaccines such as the COVID-19 and Influenza vaccines where there is minimal prevention of subsequent infection and transmission, it's extremely difficult to supplant individual bodily autonomy particularly at threat of unemployment or violation of one's religious beliefs.

However, for "sterilizing vaccines", even while they do not absolutely prevent subsequent infection, clearly demonstrated reduction in transmission with high community vaccination rates requires more consideration than one's personal autonomy. Specifically, nuance is required when considering populations that are at risk of disease, but are

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[28] https://pubmed.ncbi.nlm.nih.gov/11562612/
[29] https://pubmed.ncbi.nlm.nih.gov/14752823/
[30] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3630933/

not eligible, either through age or circumstance, to receive a particular "sterilizing vaccine". In these cases, caregivers who do not accept such "sterilizing vaccines" where said vaccination can markedly attenuate transmission when community vaccine coverage is more than 90%, may need to accept special precautions when caring for vulnerable populations. While one might argue that these precautions should be entertained regardless of vaccination status, community vaccination rates for such "sterilizing vaccines" will affect the risk of infection and transmission irrespective of any one individual's vaccination status. These special precautions may include, but are not limited to, use of fit-tested N95 masking, enhanced barrier precautions, and even surveillance testing.

I declare under penalty of perjury, under the laws of the State of Montana, that the foregoing is true and correct.



Ram Duriseti MD, PhD
July 15th, 2022

Ram Duriseti, M.D., Ph.D.
(650) 521-4517
ramduriseti@gmail.com

Educational Background:

Engineering:

- 9/01-5/07: Doctoral degree from the Stanford University School of Engineering with a concentration in Decision/Risk Analysis, Machine Learning, and Clinical Decision Support. Coursework included Decision and Risk Analysis, Probability and Statistical Inference, Bayesian Networks, Machine Learning, Computer Science, and Clinical Informatics. Funded through a VA Medical Informatics Fellowship.
  - Computing Background: C++, Java, Matlab, C, Ruby On Rails, Javascript and HTML with Ajax, Drools (JBoss Rules Engine), controlled medical terminology deployment (IMO services, SNOMED-CT, RxNorm, and other UMLS resources), Apelon server deployment, LISP, PostGreSQL, MySQL, JBoss application server, UNIX environment, Visual Basic (Excel Modules), Git, Subversion and Mercurial version control

Medical and Undergraduate:

- 11/97-11/2001: Residency training in Emergency Medicine at Stanford Medical Center.
- 5/96: M.D. with highest honors, University of Michigan Medical School
- 6/92: B.S. in Biololgy, and B.A in Political Economy, with distinction Stanford University.

Select Relevant Employment Experience:

11/00 – Present: Clinical Associate Professor, Stanford Emergency Department. Contacts: Dr. Bernard Dannenberg and Dr. Matthew Strehlow. Numbers available upon request.

3/01- Present: Mills Peninsula Emergency Medical Associates shareholder. President and CEO until 6/2017

6/08 – Present: Founder, CEO, and Product Engineer (principle algorithm and product design architect) for ShiftRx, L.L.C. ShiftRx provides the ShiftGen service that provides a cloud based enterprise workforce management tool. Key elements: machine learning algorithms, schedule optimization, workforce management, revenue cycle management with payroll integration, Java, Ruby on Rails, MySQL, SaaS on ec2.

10/08 – Present: Special consultant and subject matter expert to Sutter Health for Epic EHR implementation. Provided technical design for the billing extracts to migrate clinical information into a file sharing framework for billing companies supporting Sutter Emergency Medicine groups. Contacts: Multiple. Numbers available upon request.

4/15 – 3/2017: CEO and subsequently CTO and CMO of LifeQode Inc. which provides the Lifesquare product. Helped craft and secure 4 different patents, with continuations, around the central business processes for the product. Contacts: Larry Leisure and Steve Shulman. Numbers available upon request.

7/09 – 10/09: Technical consultant to Rise Health, Inc.. Contacts: Eric Langshur, Forrest Claypool, and Inder-Jeet Gujral. Numbers available upon request.

1/07 – 9/08: Chief Medical Officer and Director of Medical Informatics for Enfold, Inc. Responsibilities include design and implementation of intelligent medical functionality and a taxonomy engine as well as oversight of medical content driving the system. Implementation

EXHIBIT A

details: Java, Ruby on Rails, Drools, Apelon Server, Oracle 10g Database, MySQL. Contacts: Inder-jeet Gujral, Kimberly Higgins-Mays. Numbers are available upon request.
10/06 – 3/08: Medical Informatics Director Working Group Stanford University Hospitals and Clinics CIS Initiative. Particular emphasis on hand held technology integration into the Epic Initiative and organizing patient encounter level reportable data on clinical documentation events. Contacts: Kevin Tabb, President and CEO Beth Israel Deaconess Medical Center. Contact information is available upon request.
6/05 –12/06: Design and implementation of an attribute matching expert system in Java as a consultant to Wellnet Inc. Implemented in a Java environment with Hibernate DBMS and MySQL. Contacts: Kimberly Higgins-Mays. Number available upon request.

Select Research Experience:
7/11-Present: Design and implementation of a computational model for stochastic stimulation of the cost-effectiveness of various strategies to diagnose pediatric appendicitis (manuscript in progress).
10/05-Present: Design and implementation of an asymmetric cost Support Vector Machine to evaluate a large clinical database on chest pain patients presenting to the University of Pennsylvania Hospital Emergency Department (manuscript in progress).
09/02-9/04: Medical Informatics Fellow, Palo Alto Veteran's Administration Hospital.
04/03-Present: Development of Bayesian decision network for evaluation of the clinical utility of the quantitative Vidas ELISA Ddimer Assay. Published work listed.
02/04-Present: Bayesian decision network implementation modeling reasoning in the clinical domain of chest pain and associated pathology in the Emergency Department.
6/05-3/06: Using portable digital devices to generate a standard electronic medical record that can be downloaded directly to a relational database to facilitate data mining for prospective clinical research.
11/99 – 4/00: Retrospective chart review to examine the incidence of electrolyte and cardiac enzyme abnormalities in patients presenting to the Stanford Emergency Department with Supraventricular Tachycardia.

Select Administrative Experience:
6/09 – Present: CEO and Founder of ShiftRx, LLC
6/09 – Present: Regional Information Services Steering Committee for Sutter Health
6/08 – 6/18: President of CEO of Mills Peninsula Emergency Medical Associates
9/12 – 3/17: Acting CMO and CEO of Lifesquare, Inc.
6/07 – 9/08: Chief Medical Officer and Director of Medical Informatics at Enfold, Inc.
5/05-9/08: Member of Medical Informatics Director Working Group and RFP phase of evaluation for the Epic initiative at Stanford University Hospitals and Clinics
4/05-6/06: Served on the Mills-Peninsula Health Information Management and Medical Records Committee.

Current Volunteer Activities
3/22 – Present: Board of Director of Restore Childhood which is a non-profit focused on research initiatives quantifying risks to children in schools in the 'COVID Era". The goals are both legal and scientific. The scientific goal is to generate novel research and support mitigation measures that are both effective and maintain in person education.

EXHIBIT A

12/21 – Present: Co-author of Urgency of Normal. We are a group of physicians focused on collating and presenting data as it pertains to children and COVID. We help facilitate safe school openings.
Guest Lecturer at the Wharton School of Business (University of Pennsylvania) 2007/2008/2009 for health economics and information technology course

Select Honors and Distinctions:

- Guest Lecturer at the Wharton School of Business (University of Pennsylvania) 2007/2008/2009 for health economics and information technology course
- VA Medical Informatics Fellowship
- Alpha Omega Alpha Medical Honor Society
- Graduation with Distinction from the University of Michigan Medical School (top 5%)
- Recommended for Graduation with Distinction from Stanford University
- National Merit Scholarship Recipient
- Telluride Foundation Fellow

Select Papers and Publications:

- Lowe, T., Brown, I., Duriseti, R. "Emergency Department Access During COVID-19: Dis parities in Utilization by Race/Ethnicity, Insurance, and Income", Western Journal of Emergency Medicine; April, 2021

- Duriseti, R., Brandeau M. "Cost-Effectiveness of Strategies for Diagnosing Pulmonary Embolism Among Emergency Department Patients Presenting with Undifferentiated Symptoms", Annals of Emergency Medicine; October, 2010

- Duriseti, R., Wu, T. "Gastrointestinal introduction and abdominal pain – Pediatric Abdominal Pain in the Emergency Department", A Practical Guide to Pediatric Emergency Medicine, Cambridge University Press, Cambridge, 2010

- Duriseti, R. "Musculoskeletal Trauma: fractures", A Practical Guide to Pediatric Emergency Medicine, Cambridge University Press, Cambridge, 2010

- Duriseti, R. "Using Influence Diagrams in Cost Effectiveness Analysis for Medical Decisions", Optimization in Biology and Medicine, Auerbach Press, New York, 2008

- Duriseti, R. "Non-Bayesian Classification to Obtain High Quality Clinical Decisions", Optimization in Biology and Medicine, Auerbach Press, New York, 2008

- Duriseti, R., Shachter R., Brandeau M. "Implications of a Sequential Decision Model on the Use of Quantitative D-Dimer Assays in the Diagnosis of Pulmonary Embolism", Academic Emergency Medicine; July, 2006

- Duriseti R, VanderVlugt T. Paroxysmal supraventricular tachycardia is not associated with clinically significant coronary ischemia. ACEP Abstracts. ACEP Scientific Assembly 10/2001

EXHIBIT A

•VanderVlugt T., Duriseti R. Electrolyte findings in patients with paroxysmal supraventricular tachycardia. ACEP Abstracts. ACEP Scientific Assembly 10/2001

•Contributing Editor for Trauma Reports for the topic, "Trauma in Pregnancy"; published 2/2001

•Duriseti R. Cost Effective Management of Common Infections in the Emergency Department. Resident Reporter. Wyeth Ayerst Resident Scholars Program. March, 2000

Select Professional Lectures:

- Commonly Encountered Statistical Concepts in the Emergency Medicine Literature
- Medical Decision Making, Clinical Information Systems, and Cost Control: Complexity Collides with Uncertainty

Previous Expert Witness Testimony

- *Elijah Brown, et al. v. Mills-Peninsula, et al.*, No. CIV536321 (Cal. Super. Ct. Cty of San Mateo 2015)
- *Julia Sullivan v. The Superior Court of Santa Clara*, No. 18FL001837 (Cal. Super. Ct. Cty of Santa Clara 2018)
- *UNIFYSCC, et al. v. Sara H. Cody, et al.*, No. 22-cv-01019-BLF (N.D. Cal. 2022)
- *Vincent Tsai, et al. v. County of Los Angeles*, No. 21STCV36298 (Cal. Super. Ct. Los Angeles Cty 2021)
- *Jennifer Guilfoyle et al. v. Austin Beutner et al.*, No. 2:2021-cv-05009-VAP (C.D. Cal. 2021)

EXHIBIT A

Justin K. Cole
Kathryn S. Mahe
GARLINGTON, LOHN & ROBINSON, PLLP
350 Ryman Street • P. O. Box 7909
Missoula, MT 59807-7909
Phone (406) 523-2500
Fax (406) 523-2595
jkcole@garlington.com
ksmahe@garlington.com

Attorneys for Plaintiffs



IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MONTANA
MISSOULA DIVISION

MONTANA MEDICAL ASSOCIATION, et al., Plaintiffs, and MONTANA NURSES ASSOCIATION, Plaintiff-Intervenors, v. AUSTIN KNUDSEN, et al., Defendants.	Case No. CV 21-00108-DWM DECLARATION OF DAVID KING, M.D.

I, David King, M.D., declare, pursuant to 28 U.S.C. § 1746 and under penalty of perjury, that the foregoing is true and correct:

1. The facts and opinions set forth in this Declaration are known to me based on my personal knowledge and belief, and based upon my knowledge, research, education, and experience.

2. I have been retained by the Plaintiffs in the above-captioned matter to render certain opinions as contained in this document. I am charging $400 per hour for my work on this matter. I reserve the right to modify, expand upon, or otherwise change these opinions as new or additional information is provided to me.

EXPERIENCE AND CREDENTIALS

3. I obtained my medical doctorate from the University of Washington in 1981, with honors. I performed a family medicine internship and residency at the University of New Mexico from 1981-1984. I am board certified in family medicine, and have been in practice since 1984.

4. I served as the Medical Director of the Clinical Research program at Bozeman Health from 2016 until November 2021. As Medical Director, I facilitated and conducted a number of clinical trials for the Pfizer COVID-19 vaccine at Bozeman Health. I have conducted numerous clinical trials and studies of a number of different vaccines and medication therapies. As a practicing

physician and Medical Director of a Skilled Nursing Facility and of Bozeman Health's Geriatrics Team, I have also had direct experience in the prevention and treatment of COVID infections. Attached as Exhibit A is my curriculum vitae, which further summarizes my professional and clinical education and experience, credentials, and clinical research experience.

OPINIONS

5. Vaccine-preventable communicable diseases are recognized hazards that can cause death or serious harm to those who contract those diseases.

6. There is copious evidence showing that vaccination of individuals helps them stay well or avoid serious illness, hospitalization, or death. Vaccination also markedly reduces reinfection risk. The evidence is overwhelmingly positive. The scientist whose research directly led to the development and use of eight of the fourteen vaccines currently in use by Montana children and adults was a Montana native and Montana State University graduate. Maurice Hilleman's brilliance brought us the vaccines we now use, around the world, to prevent measles, mumps, chickenpox, Hepatitis A, Hepatitis B, Neisseria meningitis, pneumococcal pneumonia, and Hemophilus influenzae.

7. Pertinent studies on this topic are numerous. For purposes of my opinions, I have reviewed numerous such studies over the course of my career and will address several herein.

8. In 1975, a study called "A School Immunization Law is Successful in Texas", authored by Lon Gee and R.F. Sowell, was published in Public Health Reports (vol 90, Jan-Feb 1975 pp. 21-24). The authors noted that compulsory immunization laws have been in effect since the 1800's, and upheld by the U.S. Supreme Court as early as 1905. In 1970, Texas was, as was usual, a nursery of vaccine-preventable diseases. From 1967 to 1971, at 5 ½% of the US population, Texas accounted for, depending on the year, 31%-53% of the ***national*** cases of diphtheria, 10%-17% of US cases of tetanus, 25%-79% of US polio cases, 1%-15% of our rubella cases, and 18%-23% of measles cases in the nation. A new law mandating school vaccine compliance, fostered by a currently unimaginable coalition of citizens, health care advocates and providers, and politicians, was passed in 1971. Comparing 1970 to 1973, Texas saw a drop from 234 to 18 cases of diphtheria, from 14 to 10 cases of tetanus, from 437 to 115 cases of pertussis, from 8,494 to 533 cases of measles, from 8,409 to 1,129 cases of rubella, and from 22 to 0 cases of polio.

9. A study published in the New England Journal of Medicine (NEJM 2020:383(27):2603 Epub 12/10/2020) addressed the COVID vaccine. In 43,548 patients, half of whom were vaccinated with two doses of Pfizer COVID vaccine and half given placebo, there were 8 symptomatic cases in the vaccinated group versus 162 cases in the placebo group. In this study, the vaccines were 95%

effective in preventing symptomatic disease. Similar studies in Israel, UK, Qatar, Scotland, USA, Canada, the US V.A. system, other US health care settings, and US Skilled Nursing Facilities (SNFs) had similar findings.

10. A report in the Morbidity and Mortality Weekly Report (MMWR 2021;70(17):632 Epub 04/30/2021 compared COVID-19 cases in vaccinated vs. unvaccinated residents in 78 Chicago SNFs. "Vaccinated" meant receipt of two doses of mRNA vaccines. Of 627 COVID-19 infections found, only 22 occurred in residents who were 14 days or more past their second injection, showing 28 times the number of infections in the unvaccinated group compared to those who were vaccinated, or 96% efficacy. And, of the 22 who had infections proved after vaccination, two-thirds were asymptomatic, two were hospitalized, and only one died.

11. A MMWR report in August 2021 involving Los Angeles County after the delta variant became dominant showed the delta variant to be more dangerous than previous variants, but still showed extraordinary vaccine efficacy. During the study period, 43,127 residents were found to have COVID. Among those, 25% of fully vaccinated people were positive, compared to 71% of the unvaccinated people. But only 3.2% of the vaccinated subjects were hospitalized, compared to 7.6% of the unvaccinated. In all 29 times as many unvaccinated people were hospitalized than fully vaccinated people, again showing over 96% efficacy in the

vaccine's ability to prevent serious disease. Hospitalization, ICU care, and mechanical ventilation were similarly predominant in the unvaccinated cohort.

12. Multiple studies have been done showing that natural infection is immunogenic. Earlier studies done before the delta variant appeared showed more durable and robust immune responses than more recent studies have done. The problem remains that immune response is variable after natural infection, with no response at all in some patients to robust if temporary immunity in others, whereas the doses of the vaccines are standard, measurable, and trackable. The publicized and incorrect contention that immunity derived from natural infection is both highly effective and highly durable has contributed to vaccine avoidance and abetted the destructiveness of the current pandemic.

13. In 2020 in Denmark a study was done (The Lancet, vol.379, issue 10280, p.1204-1212, Pub Mar 27, 2021 Hansen, Michlmayr, Gubbels, Molbak, Ethelberg) to assess the protection against reinfection with Sars-CoV-2 provided by initial infection alone. It found that "those [unvaccinated] aged 65 and older had less than 50% protection against repeat SARS-CoV-2 infection after the first infection."

14. A study (MMWR Aug 13, 2021/70(32); 1081-1083) by Cavanaugh, Spicer, Thoroughman, Glick, and Winter in Kentucky, with data again preceding the Delta variant surge, compared unvaccinated people with initial infection in

2020 and reinfection in late May and June of 2021. They found that "Kentucky residents who were not vaccinated had 2.34 times the odds of reinfection compared with those who were fully vaccinated…" Their conclusions were that "…among previously infected persons, full vaccination is associated with reduced likelihood of reinfection, and, conversely, being unvaccinated is associated with higher likelihood of being reinfected."

15. Another study (The Lancet, Microbe vol2, issue 12, E666-E675 Pub 12/01/2021 "The Durability of Immunity Against Reinfection by SARS-CoV-2: a Comparative Evolutionary Study, Townsend, Hassler, Wang, Miura, Singh, Kumar, et.al.) led to this comment from the authors: "Reinfection by SARS-CoV-2 under endemic conditions would likely occur between 3 and 63 months after peak antibody response, with a median of 16 months." In other words, based on their work, which, unlike the above, takes into account the behavior of the Delta variant but not that of the far more contagious Omicron variants, unvaccinated people would catch COVID again every year or two. Further, the authors state that

> "Our estimate argues strongly against the claim that a long-standing resolution of the epidemic could arise due to herd immunity from natural infection or that mitigation of the long-term risks of morbidity and mortality can be achieved without vaccination.

16. Another Delta-era study published in MMWR on 11/05/2021 (CDC MMWR Report 11/05/2021/ 70(44); 1539-1544, Laboratory-Confirmed COVID-19 Among Adults Hospitalized with COVID-19-like illness with Infection-Induced or mRNA Vaccine-Induced SARS-CoV-2 Immunity, Bozio et. al.) compared unvaccinated persons newly diagnosed with COVID-19 and with a prior history of COVID-19 infection which occurred between 90 and 179 days previously with newly diagnosed persons with COVID-19 who were fully vaccinated 90-179 days prior to infection with an mRNA vaccine (2 doses). Those unvaccinated persons with only "natural immunity" were found to have 5.49 times greater risk of recurrent infection than those whose immunity was from vaccination. As infection, whether symptomatic or not, is a prerequisite for spread and for viral mutation, it is inescapable to infer that previous infection with SARS-CoV-2 provides inadequate protection if the public health goal is to prevent spread and associated morbidity and mortality, not to mention the societal costs engendered by further spread.

17. Studies done more recently have shown the expected rise in anti-COVID antibodies and improved efficacy with the boosters which are currently being deployed. Pfizer's data shows that neutralizing antibodies are 5 times higher one month after the third dose than one month after the second dose in young and middle-aged subjects, and 11-fold higher in subjects over the age of 65.

18. Much of the information above relates to early waves of the COVID pandemic, through Delta's late 2021 phase. Since then, the COVID threat has been carried by Omicron and its seemingly endless generations of mutant offspring. It has been well established and widely reported that Omicron's successes are because of its remarkable ability to mutate, which has led to an equally remarkable infectiousness. It is far better at spreading than previous COVID strains. Thankfully Omicron has proved, so far, to cause less severe disease than previous COVID strains.

19. Omicron causes illness far more readily than previous strains, but fewer severe illnesses, hospitalizations, and deaths. It more readily infects vaccinated people and those with previous COVID illness, especially those with medical risk factors. These notably include as powerful risk predictors advancing age and obesity, as well as the medical illnesses listed above. Hospitalizations and deaths are largely concentrated in those with medical risk factors, and especially those with multiple risks.

20. As Omicron causes far more infections and earlier infections in vaccinated people (breakthrough infections) and in those who have had previous COVID infection (reinfection) than previous strains, how are we to judge the value of immunization against COVID now? Are vaccination immunity and herd immunity both obsolete concepts with COVID? The answer is apparently yes with

herd immunity, as the inherent mutability of COVID and the unpredictable and rapidly waning duration and effectiveness of the immunity provided by infection coupled with its high infectiousness hold little promise of the benefit of this approach. The answer, however, with vaccination remains no. It does appear that herd immunity with vaccines will be difficult to attain. Given the lack of vaccine availability in large parts of the world, vaccine hesitancy where vaccine availability exists, and outright opposition to vaccination (exemplified by Montana House Bill 702), and given COVID's ability to mutate, prevention of the spread of this disease no longer appears possible. But with our current vaccines we have robust proof that, while being less durable and effective at preventing disease transmission caused by Omicron, they remain highly effective in fully vaccinated people at preventing severe illness requiring hospitalization and at preventing death. As noted in a March 29, 2022 summary from the CDC, "COVID-19 vaccines remain the best public health measure to protect people from COVID-19 and reduce the likelihood of new variants emerging. This includes primary series, booster shots, and additional doses for those who need them."

21. Current vaccines protect against severe illness, hospitalizations, and deaths due to infection with the Omicron variant. However, breakthrough infections in people who are vaccinated can occur. People who are up to date with

their COVID vaccines and get COVID-19 are less likely to develop serious illness than those who are unvaccinated and get COVID-19, as noted above.

As we see in the table below, which includes data from early iterations of Omicron, vaccines (especially mRNA vaccines), while not as effective at preventing infection with Omicron, remain very effective in preventing severe disease.

	Effectiveness at preventing											
	Ancestral		Alpha		Beta		Gamma		Delta		Omicron	
Vaccine	Severe disease	Infection	Severe disease	Infection	Severe disease	Infection	Severe disease	Infection	Severe disease	Infection	Severe disease	Infection
AstraZeneca	94%	63%	94%	63%	94%	69%	94%	69%	94%	69%	71%	36%
CanSino	66%	62%	66%	62%	64%	61%	64%	61%	64%	61%	48%	32%
CoronaVac	50%	47%	50%	47%	49%	46%	49%	46%	49%	46%	37%	24%
Covaxin	78%	73%	78%	73%	76%	72%	76%	72%	76%	72%	57%	38%
Johnson & Johnson	86%	72%	86%	72%	76%	64%	76%	64%	76%	64%	57%	33%
Moderna	97%	92%	97%	92%	97%	91%	97%	91%	97%	91%	73%	48%
Novavax	89%	83%	89%	83%	86%	82%	86%	82%	86%	82%	65%	43%
Pfizer/BioNTech	95%	86%	95%	86%	95%	84%	95%	84%	95%	84%	72%	44%
Sinopharm	73%	68%	73%	68%	71%	67%	71%	67%	71%	67%	53%	35%
Sputnik-V	92%	86%	92%	86%	89%	85%	89%	85%	89%	85%	67%	44%
Other vaccines	75%	70%	75%	70%	73%	69%	73%	69%	73%	69%	55%	36%
Other vaccines (mRNA)	91%	86%	91%	86%	88%	85%	88%	85%	88%	85%	67%	45%

Figure 1: https://www.healthdata.org/covid/covid-19-vaccine-efficacy-summary

Vaccination has been and remains our most effective tool to prevent both the spread and the severity of disease.

22. As we have seen, certain diseases, such as COVID-19 and influenza, can mutate into variant strains of the original virus, and some diseases have the ability to mutate more frequently than others. A disease is more likely to mutate the more often it is allowed to replicate, which is determined by the number of times it is transmitted from person to person. These mutations and variants cause a reduction in the durability of an individual's immunity to the disease. The duration of an individual's immunity levels naturally decreases in certain diseases, some more rapidly than others. Immunity to infectious diseases like COVID-19 and influenza fades more quickly than with other diseases. The waning of immunity has led to the implementation of vaccine boosters for a number of vaccines. Vaccine boosters are also utilized after natural infection, to address waning immunity.

23. As it pertains to other vaccine-preventable diseases, such as polio, measles, mumps, rubella, hepatitis, pertussis, chickenpox and others, vaccination remains a critically important form of infectious disease prevention, particularly in healthcare settings.

24. As the studies discussed above and hundreds of others have shown, vaccination is highly effective and critically important in reducing the destruction vaccine-preventable illnesses cause to our way of life, and to our lives themselves. Vaccination is a critical infectious disease prevention tool. Vaccination has been

and remains our most effective tool to prevent both the spread and the severity of disease.

25. Although they are (surprisingly) not accepted by some individuals, the safety and efficacy of vaccines, including the current COVID-19 vaccines, in preventing or lessening severity of illness have been robustly and redundantly proved.

26. Research on how vaccination affects transmissibility of COVID has been later in starting and is still less developed than research regarding safety and efficacy. We will focus on the two mRNA vaccines, as the "single-dose" vaccine available in the US is not as robustly efficacious or as well studied as the mRNA vaccines.

27. Without plunging deeply into basic science, two concepts are worth discussing first.

28. "Viral load" is simply a measurement of the number of virions (individual viruses) which can be counted in a volume of body fluid. The fluid can be blood, urine, nasopharyngeal secretions, etc. High viral loads mean high numbers of viruses.

29. Since "inoculum size" (the number of infectious organisms entering our body in an exposure event) is an important determinant in most infectious diseases, indicating whether we get sick from an exposure, how sick we get, and

how fast we get sick, it is not surprising that it would have impact in COVID cases as well. The more COVID virions we inhale, the faster we get sick and the sicker we get. The more we exhale, the more risk we spread to those around us. The inoculum size in COVID-19 infection relates predominantly to the viral load in the nasopharynx, as the disease is spread largely by exposure to respiratory droplets.

30. On September 15, 2021, the CDC released its "Science Brief: COVID-19 Vaccines and Vaccination" from which, unless otherwise specified, following quotations and conclusions are taken. The CDC noted that multiple studies done in multiple countries showed that fully vaccinated people who nonetheless contracted COVID generally had a lower viral load than unvaccinated people. As "viral load has been identified as a key driver of transmission…", it is reasonable to assume that after vaccinating people they will have lower viral loads, and will be less able to spread COVID. Multiple other studies from multiple countries found significantly reduced likelihood of transmission to household contacts from people infected with SARS-CoV-2 (COVID-19 infection) who were previously vaccinated for COVID-19. The delta variant, characterized by much higher viral loads, particularly in the nasopharynx, has caused more infections in fully vaccinated individuals, but research has shown that while they may be able to transmit the virus, they clear the virus much more rapidly than those who are unvaccinated, reducing the time that they are potentially infectious, and thereby the

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risk of transmission. Another study found that "Delta infection in fully vaccinated persons was associated with significantly less transmission to contacts than persons who were unvaccinated or incompletely vaccinated…" (published as a preprint on medRxiv, a forum supported by, among others, Yale and The British Medical Journal, on August 15, 2021). It was a large trial in Guangdong province in China, and included both wild-type (original type of COVID-19 virus) and Delta variant cases. Viral loads were higher in the Delta cases, and duration of infectivity longer. And in fully-vaccinated individuals, they found a three-fold decrease in viral load in the pharynx of those who tested positive for COVID, compared to unvaccinated individuals.

31. While the volume of evidence proving the efficacy of vaccination for COVID is huge, that proving the reduction of transmissibility is not as large. Yet data is accumulating that viral load is generally lower and faster to resolve in fully vaccinated individuals who nonetheless contract COVID infection (including asymptomatic cases), as is data proving that fully vaccinated individuals spread infection less.

32. Unvaccinated individuals are more likely than vaccinated individuals to contract vaccine-preventable diseases and are also more likely to transmit those diseases to others.

33. In short, vaccination does reduce illness and death from COVID-19 infection, as it does for a host of other vaccine-preventable diseases, and does reduce transmission as well.

34. Hippocrates, in his work *Of The Epidemics,* circa 400 BC, wrote "The physician ***must***…have two special objects in view with regard to disease, namely, to do good or ***to do no harm.***" (emphasis mine). This last phrase has evolved over the intervening millennia into "First, do no harm." While not historically accurate, it captures the intent of Hippocrates well. It means, simply, that providers of health care, at all levels, must put the health and safety of their patients as their foremost priority.

35. Historically, this has meant healthcare providers remain current on their own vaccinations to protect their patients from unnecessary risk of contracting vaccine-preventable diseases. Vaccination requirements have been a common staple of healthcare in America. This includes the ability of a healthcare provider or healthcare facility to know a caregiver's vaccination status, and take meaningful steps to address situations where unvaccinated workers seek to treat patients, especially immunocompromised and particularly vulnerable ones. Medical standard of care principles require knowing and addressing the immunization status of healthcare workers in healthcare settings, particularly settings where physicians and other providers provide treatment to particularly

vulnerable patient populations, such as intensive care settings (i.e. ICU), neonatal or pediatric intensive care settings, and cancer care settings, among others. It becomes particularly important for healthcare providers to be vaccinated when they treat patients with vulnerable immune systems, who are unable to develop individual protection through vaccination due to health conditions or age.

36. Healthcare facilities and workers have an obligation to comply with national standards of care in the care and treatment of patients.

37. Montana House Bill 702 prevents Montana healthcare providers from complying with the nationally recognized standard of mandating vaccinations for healthcare workers, ensuring certain patient populations are not exposed to unvaccinated individuals, and tracking vaccination status/records for healthcare workers.

38. Healthcare providers have an obligation to treat their patients in a safe and individualized manner.

39. Hospitals, Critical Access Hospitals, and Offices of Private Physicians treat patients that have physical impairments that substantially impact major life activities. Those impairments can make them more susceptible to vaccine-preventable illnesses and increase their risk of serious harm or death from such illnesses. Faced with such a situation, a facility would perform an individualized assessment of whether a reasonable accommodation under the ADA is available to

the patient absent an undue hardship or direct threat to the hospital's operations, including the safety of its patients. In order to do that analysis, facilities need to know the vaccination status of the healthcare workers, so they can ensure that nonvaccinated individuals will not be providing care to such patients.

40. The standard of care requires an individual assessment of a patient care encounter and determination of whether the particular patient requires treatment only by vaccinated staff members. If so, then the facility needs to be able to ensure that the patient is only treated by vaccinated staff members. This would require the facility to treat vaccinated staff members differently than unvaccinated staff members.

41. Healthcare providers occasionally have to transfer patients to different facilities during the course of their care. Transferring patients to a facility that does not protect patients against unvaccinated individuals can jeopardize patient care.

42. Immunocompromised people, more specifically those with conditions such as cancer, HIV infection, impaired immunity as the direct result of autoimmune diseases and the medications needed to treat them, advanced age, diabetes, organ transplants, those with heart, lung, kidney, and liver diseases, and those who reside in long-term care facilities, are well-known to be more easily sickened by COVID-19 or other infectious diseases, to catch these transmittable

diseases more easily, and to require hospitalization or die more often from these diseases than those who are not immunocompromised. There are numerous physical impairments that substantially limit major life activities that also impact a person's ability to fight off infection and risk of serious illness. These individuals should limit contact with non-vaccinated individuals for their safety.

43. This fact applies to a number of diseases, but recent statistics from the current and ongoing COVID pandemic highlight this reality. The immune impairment is significant enough that a CDC report on August 13, 2021 noted that over 40% of U.S. breakthrough infections (those occurring in fully vaccinated individuals) were in immunocompromised patients, despite the fact that such patients make up only 2.7% of the population. This led to the CDC recommendation that "Close contacts of immunocompromised people should be strongly encouraged to be vaccinated against COVID-19". This was in reference to non-medical close contacts, as it should have not required stating that providers of medical care to those individuals, in deference to the "Hippocratic Oath" and their own consciences, would already have been fully vaccinated. Alas, vaccination in health care workers is far from complete. We also know of patients who have avoided needed medical care because they are afraid to be cared for by unvaccinated providers.

44. Certain immunocompromised individuals should not be exposed to unvaccinated individuals.

45. On July 21st, 2021 a joint statement of over 50 medical associations, including the American Medical Association, the American College of Physicians, the American Public Health Association and the like, published a *Joint Statement in Support of COVID-19 Vaccination Mandates for All Workers in Health and Long-Term Care.* (This is attached in its entirety). It says, in summary, "This is the logical fulfillment of the ethical commitment to put patients…first and take all steps necessary to ensure their health and well-being."

46. Health care providers must put the health and safety of their patients first. Now that there are effective and safe vaccines readily available at no cost, there can be no more excusing those who carry COVID-19 and its detrimental impacts into the workplaces where they care for patients, whether immunocompromised or not. No more of these patients should be sickened or die because of the disregard of their safety posed by unvaccinated individuals charged with the responsibility of their care. This applies with equal force to other, long-standing vaccines that have minimized or effectively eliminated the risks of diseases such as smallpox, polio, and measles. To continue to contain these deadly diseases, further contain COVID-19, and be prepared to address the next pandemic, an increased embrace of vaccines in the healthcare setting is needed.

Montana House Bill 702 does the opposite. Montana House Bill 702 stands in the way of health care providers providing a safe environment for their patients and staff.

47. Vaccination cannot be abandoned as a critical infectious disease prevention measure. Other forms of disease prevention, such as masking, while certainly helpful, cannot serve as a substitute for vaccination. Simple masking is not equally as effective as vaccination in preventing the spread and severity of disease. Masking does not protect against bloodborne pathogens, or the spread of pathogens through surface contact. Masking is less effective than vaccination, especially when the mask wearer is noncompliant or semi-noncompliant with wearing the mask (i.e. allowing a mask to slip down, not wearing the mask at all times, or using ill-fitting or ineffective masks).

48. These principles should apply with equal force in all healthcare settings. For instance, hospitals and physician offices are similarly situated in all meaningful ways when it comes to treating patients. Physicians of all types of specialties treat similar types of patients in acute hospital settings as well as outpatient physician clinic or office settings. Physician offices and hospitals are similarly situated to long-term care settings such as assisted living facilities and skilled nursing facilities. Primary care physicians as well as subspecialists treat elderly and immunocompromised patients in clinic settings, hospital settings, rural

swing-bed hospital settings, and nursing homes and long-term care settings. The similarity of these facilities is highlighted by the use of swing-beds in critical access hospitals. Very often, those beds are used in the exact same manner as nursing homes and long-term care facilities. The facilities provide the same (or similar) care to similarly situated patients by similarly situated healthcare workers. The ethical principles of these healthcare providers and duties to their patients and fellow coworkers are unchanged whether the healthcare provider is providing treatment in a hospital, physician office, or long-term care setting. There is no basis for treating these different facilities in a different manner when it comes to the ability to mandate vaccines for vaccine-preventable illnesses.

49. Montana House Bill 702's dangers are not limited to COVID, but all vaccine-preventable illnesses. While technology has changed, with mechanical ventilators having replaced iron lungs, polio has not. It remains eager to cripple and kill our family members if we allow vaccinations to lapse. Polio has been largely eradicated due to the use of vaccines. Smallpox has been eradicated, outside of the lab setting, due to the use of vaccines. Measles and mumps severely injure or kill far fewer individuals due to the use of vaccines.

50. Patients seek out healthcare facilities for help and to receive medical care in order to get better. Exposing patients to non-vaccinated workers exposes those patients to injury or even death.

51. Additionally, the presence of unvaccinated medical workers undermines the credibility of health care providers when they urge vaccine-hesitant patients to become vaccinated, even when the vaccines may be in the best interest of the patients and of the public at large.

52. Requiring vaccination or preventing unvaccinated individuals from direct contact with certain patient populations is a reasonable step to protect and accommodate those with compromised immune systems or other serious illnesses that impact their ability to fight off disease or increase their risk for serious injury or death.

53. In short, Montana House Bill 702 endangers patients and, indeed, all Montanans and Montana visitors. It does so by opposing the hard-won knowledge and proven strategies in infectious disease prevention of the last 2 ½ centuries, putting us again at risk of the social disruption and unnecessary sickness, maiming, and death caused by vaccine-preventable diseases.

David King, M.D.

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Montana Medical Association, et al. v
Austin Knudsen,et al.

Carter Anderson 30(b)(6)
August 18, 2022

Charles Fisher Court Reporting
442 East Mendenhall
Bozeman, MT 59715
(406) 587-9016
maindesk@fishercourtreporting.com

Min-U-Script® with Word Index

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THURSDAY, AUGUST 18, 2022

THE VIDEOGRAPHER: This is the video-recorded and videoconference deposition of Carter Anderson, 30(b)(6) representative of the Department of Health and Human Services, taken in the United States District Court for the District of Montana, Missoula Division. Cause No. CV-21-00108-DWM, Montana Medical Association, et al., and Montana Nurses Association vs. Austin Knudsen, et al.

Today is August 18th, 2022. The time is 9:21 a.m.

We are present with the witness at the offices of Fisher Court Reporting at 800 North Last Chance Gulch, No. 101 in Helena, Montana.

The court reporter is Mary Sullivan, and the video operator is Nicole Tomac of Fisher Court Reporting.

The deposition is being taken pursuant to notice.

I would now ask the attorneys to identify themselves, who they represent, and whoever else is present. For those attending remotely, please note from where you are appearing.

MS. MAHE: My name is Katie Mahe, and

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with me today is Justin Cole, and we represent the plaintiffs.

MR. GRAYBILL: My name is Raph Graybill on behalf of the Montana Nurses Association.

MR. MEAD: Brent Mead on behalf of defendant Austin Knudsen and Laurie Esau in their official capacities. On the line appearing remotely from Helena, Montana is David Dewhirst also representing the defendants.

MR. KRASKE: And Justin Kraske representing Department of Public Health and Human Services.

THE VIDEOGRAPHER: The court reporter will now administer the oath.

Thereupon,

DPHHS 30(b)(6) DESIGNEE CARTER ANDERSON, a witness of lawful age, having been sworn to tell the truth, the whole truth, and nothing but the truth, testified as follows:

EXAMINATION

BY MS. MAHE:

Q. Mr. Anderson, we met a little bit before we began today. Have you ever had your deposition taken before?

A. No.

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Q. Okay. So before we get started, I'm just gonna to go over some kind of the ground rules about the deposition to help you understand what's happening here today.

We have our court reporter. She's taking down everything that we're saying, and so we want to make sure that we get a clear record. So it's important for you and I not to talk over each other if we can.

Do you understand that?

A. We're good.

Q. Well, that brings me to my next point that it's very important that you answer verbally to my questions because the transcript can't pick up hand gestures and things like you did.

Can you answer verbally for me today?

A. Yes.

Q. And I'm not trying to trick you today. I'm -- I'm trying to get your full and complete testimony. I want to make sure you understand my questions, so if you don't understand my question, will you let me know?

A. Yes.

Q. And if you answer my question, is it safe for me to assume that you understood what I was

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asking?

A. Yes.

Q. And this is not an endurance contest. If you need a break at any time, you just let me know, okay?

A. Thank you.

Q. The only thing I ask is if I have a question pending, that you will answer that question before we take a break. Is that okay?

A. Yes.

Q. And if I ask you a question today and during the course of your deposition you think of additional information or clarification, will you provide that to me?

A. Yes.

Q. Is there any reason that you're prevented from giving complete and accurate answers today?

A. No.

EXHIBIT:

(Deposition Exhibit 34 marked for identification.)

BY MS. MAHE:

Q. The court reporter has handed you what has been marked as Deposition Exhibit 34. Have you seen this document before?

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A. Yes.
Q. And is this the subpoena to testify at the deposition for the Department of Public Health and Human Services?
A. Yes.
Q. And you're -- you're here today, so I'm assuming that you are coming in response to this subpoena?
A. Yes.
Q. And there's also a Subpoena Duces Tecum, which is a fancy word for a subpoena to produce documents, in this document as well. Do you see that there?
A. Yes.
Q. And were you part or did you participate in compiling the documents that were produced in response to the subpoena?
A. I'm not exactly sure what all they submitted. I did submit some information to my attorneys, but I'm not sure what they submitted in response. I can't answer that.
Q. Well, yesterday we got about a thousand -- 1,153 documents from DPHHS. Does -- Have you seen those documents?
A. I can't say I've seen them all, but I've

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-- I've seen quite a few.
MS. MAHE: And we'll have that marked as Exhibit 35.
EXHIBIT:
(Deposition Exhibit 35 marked for identification.)
BY MS. MAHE:
Q. The court reporter has handed you what's been marked as Exhibit 35. That's the privilege log that we received in response to the subpoena. Have you seen that document before?
A. Yes.
Q. Okay. And I might have given away all my copies. I didn't.
I just have some quick questions for you on this.
Did you help create this document?
A. No.
Q. Okay. So when it says "Author(s)" and then it has an author and then says "and recipients," do you know what that means? Is that all of the people listed in the box next to it? That's my -- That's my question.
MR. MEAD: Objection. Vague.
///

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BY MS. MAHE:
Q. Did you understand my question?
A. Not really.
Q. Okay. What I'm trying to figure out is you see under the "Author" box. Let's just look at the first one.
A. Yes.
Q. It says "Robert Lishman and recipients."
A. Mm-hmm.
Q. Does that "recipients" reference the box next to it, do you know?
A. Okay. Yeah.
Q. Okay. And I don't know, so that's why I'm asking you.
A. And I -- And I don't really know either. I mean, I understand the way this reads it looks like these -- this person wrote it and these people received it.
Q. Okay. And is Robert Lishman an attorney?
A. Yes.
Q. Okay. Is Paula Stannard -- Stannard an attorney?
A. Yes.
Q. Okay. You have been designated by the Montana Department of Public Health and Human

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Services to testify on its behalf related to the topics in the 30(b)(6) subpoena. Correct?
A. Yes.
Q. And you were informed that you were going to be testifying on behalf of DPHHS?
A. Yes.
Q. And if I say "DPHHS," do you know what I'm talking about?
A. Yes.
Q. If I also say "the department," would you know that I was talking about DPHHS?
A. Yes.
Q. Did DPHHS gather all the information known or reasonably known to it regarding the topics in the 30(b)(6) subpoena?
MR. MEAD: Objection. DPHHS objected to those topics.
You can answer subject to those objections.
A. To my knowledge, yes.
BY MS. MAHE:
Q. And describe the process that DPHHS did to make sure that you have all of the information and knowledge of DPHHS on those topics for which you are designated to testify.

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DPHHS done anything to make you aware of documents in this case?
A. No.
Q. Are you confident that you possess the relevant and discoverable information to testify on topics for which you've been designated?
A. Yes, with a caveat as long as I have the documents in front of me that you're -- that I'm questioned on, then I would feel confident to make sure that I'm refreshing my memory.
Q. And you understand that today you're testifying as to the collective knowledge of DPHHS?
A. Yes.
Q. You understand you have an affirmative duty to be prepared to testify fully and knowledgeably on behalf of DPHHS today on the topics upon which you have been designated to testify?
A. Yes.
Q. And you understand that your testimony here today is not in your individual capacity.
A. Yes.
Q. And that when you're answering my questions, you are answering on behalf of DPHHS.

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A. Yes.
Q. Are you an employee of DPHHS?
A. Yes.
Q. Okay. What is your job title?
A. Currently the acting CEO of the Montana State Hospital.
Q. And what were you -- we talked a little bit before your deposition, but what did you do before that?
A. Prior to that assignment I was the inspector general for the OIG office.
Q. And how long have you been the CEO of Montana State Hospital?
A. Since May 9th.
Q. And, I'm sorry, before that you said you were?
A. The inspector general for -- the office of the inspector general with DPHHS.
Q. And how long did you hold that position?
A. It started as the division administrator of quality assurance in June of -- of 2018, and then it was converted -- the same job was converted to the OIG office about a year and a half ago. Roughly. I couldn't give you an exact date.

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Q. And prior to that did you hold a position with DPHHS?
A. No. Prior to 2018, no.
Q. And what did you do before that?
A. I've been the CEO of Acadia Hospital, and I worked for AWARE as a COO for 16 years. I've done various other things prior to that.
Q. How much time did you spend preparing for this deposition?
A. Six hours, possibly.
Q. And how much time do you think you spent reviewing documents?
A. Four hours, maybe.
Q. You understand today that when I say "you" when I'm referring to these questions, I'm referring to DPHHS?
A. I understand that now.
Q. Okay. What is DPHHS's role in relation to determining whether healthcare facilities are in compliance with the conditions of participation for Medicare and Medicaid?
A. DPHHS has a contract with the Center for Medicaid -- as far as CMS to provide certification services.
Q. And we need to make sure that we're

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really articulating 'cause I think the court reporter's having a hard time. I talk very fast --
A. Mm-hmm.
Q. -- so I'm going to work on that, and if you can work on articulating, hopefully we won't have her throwing things at us.
A. Yes.
Q. You mentioned that you had a contract with CMS?
A. Mm-hmm.
Q. Is that a yes?
A. Yes.
Q. And as part of that contract you -- DPHHS performs compliance reviews and surveys?
A. Yes.
MR. MEAD: Objection. Compound.
BY MS. MAHE:
Q. Did you understand my question?
A. The terminology's not right, but the answer is yes.
Q. Well, give me the correct terminology.
A. We did recertification surveys as well as complaint surveys as well as initial surveys for CMS.

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Q. To determine compliance with the conditions of participation?
A. Yes.
Q. And once you do those surveys, then do you certify your findings to CMS?
A. Yes.
Q. And if DPHHS finds that a facility is not in compliance with the conditions of participation, then DPHHS provides a statement of deficiencies; is that right?
A. Yes.
Q. And then the facility is given a time period to come into compliance. Correct?
MR. MEAD: Objection. Vague.
A. They're given a timeframe for presenting with a plan of correction, and then we review the plan of correction.
BY MS. MAHE:
Q. And then do you adopt the plan of correction or approve it, I guess, is probably the better word?
A. "Accept" would be the term.
Q. Okay. So you accept the plan of correction. What happens if they don't make the corrections within the timeframe?

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MR. MEAD: Objection. Vague.
A. What you're asking is very situational, but generally speaking we would do a resurvey to make sure that they've already complied, and if they're not, they could be re-cited for -- for the -- for whatever the deficiency was.
BY MS. MAHE:
Q. And does DPHHS ultimately determine what the penalty is if they do not come into compliance?
A. No.
MR. MEAD: Objection. Vague.
BY MS. MAHE:
Q. CMS determines the appropriate penalties. Correct?
A. Yes.
Q. And what are those penalties?
MR. MEAD: Objection. Overbroad.
A. It can range between civil monetary penalties, CMPs they're referred to as, for restrictions in admissions. There are various things that CMS can impose based on the severity and the scope of the deficiencies.
BY MS. MAHE:
Q. One of the penalties could be to lose the

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provider contract. Correct?
A. Yes.
Q. And that would result in a loss of Medicare and Medicaid reimbursement?
A. Rare, but yes.
Q. If I talk about the omnibus COVID-19 healthcare staff vaccination final rule, do you know what that is?
A. Yes.
Q. Is it all right if I call it the CMS vaccine mandate?
A. Sure.
Q. It's a little bit shorter.
What is DPHHS's's involvement in determining compliance with that vaccine mandate?
A. Our certification unit was required to check vaccine compliance upon any recertification surveys, initial surveys, or complaint surveys.
Q. And in determining compliance, it's my understanding that the facility has to have a policy or procedure to have their staff fully vaccinated for COVID-19. Is that correct?
A. Yes, with the caveat that they can have exceptions or exemptions.
Q. Correct. Religious exemptions is one.

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Correct?
A. Correct.
Q. And then the medical exemption would be the other?
A. Yes.
Q. Are there any other exemptions?
A. Yes. There's one other. I have a hard time pulling it out of my --
Q. Are you thinking about the temporary delay?
A. Yes.
Q. And -- And that temporary delay is based upon medical factors that indicate that there should be some timeframe before having that COVID vaccine. Correct?
A. Yes.
Q. And other than that temporary delay, are there any other exceptions?
A. Not that I recall.
Q. And are the facilities required to maintain documentation proving that their staff has received a vaccine?
A. Yes.
Q. And those facilities would have to show that documentation upon a survey, potentially.

No. 23-35014

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

MONTANA MEDICAL ASSOCIATION; FIVE VALLEYS UROLOGY, PLLC; PROVIDENCE HEALTH & SERVICES – MONTANA; WESTERN MONTANA CLINIC, PC; PAT APPLEBY; MARK CARPENTER; DIANA JO PAGE; WALLACE L. PAGE; CHEYENNE SMITH,

Plaintiffs - Appellees,

MONTANA NURSES ASSOCIATION,

Intervenor-Plaintiff – Appellee,

v.

AUSTIN KNUDSEN, Montana Attorney General; LAURIE ESAU, Montana Commissioner of Labor and Industry,

Defendants – Appellants.

On Appeal from the Missoula Division of the
United State District Court, District of Montana
No. 9:21-cv-00108-DWM
Hon. Donald W. Molloy

APPELLEES' SUPPLEMENTAL EXCERPTS OF RECORD
VOLUME 3 OF 3

Justin K. Cole
Kathryn S. Mahe
GARLINGTON, LOHN & ROBINSON, PLLP
350 Ryman Street • P.O. Box 7909
Missoula, MT 59807-7909
Phone (406) 523-2500
Fax (406) 523-2595
jkcole@garlington.com
ksmahe@garlington.com
Attorneys for Plaintiffs - Appellees

Raph Graybill
GRAYBILL LAW FIRM, PC
300 4th Street North
Great Falls, MT 59403
Phone: (406) 452-8566
rgraybill@silverstatelaw.net
Attorney for Plaintiff-Intervenor - Appellee

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A. Yes.
EXHIBIT:
(Deposition Exhibit 36 marked for identification.)
BY MS. MAHE:
Q. The court reporter has just handed you what has been marked Deposition Exhibit 36, and I'll represent to you that this is a document that we received -- I believe we received it in discovery, but that those first pages are the FAQs from Department of Labor & Industry's website on House Bill 702?
A. Mm-hmm.
Q. The frequently asked questions.
A. Mm-hmm.
Q. And if you look at page 2 of Exhibit 36, there's a question that says [As Read]: "I'm an employee of a health care facility. How does the United States Supreme Court ruling on the CMS's vaccine rule impact me?"
And the answer says, "The Department of Public Health and Human Services has issued guidance for health care facilities and providers regarding the CMS vaccine mandate." And then it says "View Guidance."

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Do you see that?
MR. MEAD: Counsel, can I -- can I stop you? Where are we at here?
MS. MAHE: On page 2.
MR. MEAD: So --
MS. MAHE: Yeah.
MR. MEAD: -- objection. This is outside the scope of his designation. You represented this document came from Department of Labor. He's here to represent Department of Health and Human Services.
BY MS. MAHE:
Q. Do you see where it says [As Read]: "The Department of Public Health and Human Services has issued guidance for health care facilities and performs -- and providers regarding the CMS vaccine mandate"?
MR. MEAD: You're asking him to testify to a document that you just said was produced by Department of Labor.
MS. MAHE: Well, Brent, let's be careful here. You're objecting quite a bit, and I haven't actually asked him any questions yet. I asked him if he saw where I was reading.
///

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BY MS. MAHE:
Q. So do you see where I was reading on there?
A. No.
Q. Okay. The very top. And the reason this prints weird because these are -- you have to click on each one. So the very top of the page where it says [As Read]: "I am an employee of the health care facility. How does the United States Supreme Court ruling on CMS vaccine"?
A. Okay.
Q. Do you see where I am now?
A. Yes.
Q. Okay. And you see that the answer says "The Department of Public Health and Human Services has issued guidance for health care facilities and providers regarding the CMS vaccine mandate."
Do you see that?
A. Yes.
Q. And then there's a "View Guidance" button.
Do you see that?
A. Yes.
Q. Okay. If you turn to page 5 of

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Exhibit 36, is that the guidance that DPHHS issued regarding the CMS vaccine mandate?
A. Yes.
Q. Do you know why the Department of Labor & Industry references guidance put out by DPHHS in these FAQs?
A. No.
Q. Did you assist in preparing these FAQs?
A. No.
Q. On this page 5 of Exhibit 36, why did DPHHS issue this guidance?
MR. MEAD: Objection to the extent it calls for a legal conclusion.
BY MS. MAHE:
Q. Well, let's just get something out of the way right now. I know you're not a lawyer, right?
A. No.
Q. So when I'm asking you these questions, I'm asking on behalf of DPHHS, so I'm not asking for your legal conclusion about why things were done.
A. Mm-hmm.
Q. I want to understand why the department did things. Do you understand that?
A. Mm-hmm.

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Q. I'm sorry, was that a yes?
A. Yes. This would have been in an effort to help providers to understand what -- what their expectations would be under the CMS guidance that was issued.
Q. And do you know when this was created?
A. No.
Q. Do you know who created it?
A. No.
Q. Do you know who would know that information?
A. Maybe.
Q. And who would that be?
A. I would say Charlie Brereton was most -- most likely involved in this type of a -- of a documentation that would go out. I would assume that our legal team would have reviewed it.
Q. And, I'm sorry, you said Charlie Britton [phonetic]?
A. Britton, yeah. Bareton, Brereton. Charlie Brereton. He's our current director. At the time I would say he was either at the governor's office or he was our chief operating officer. I'm not sure what his role was when this was produced.

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Q. And did you speak with him to get his information about the topics in the 30(b)(6) notice before today?
A. No.
Q. And you mentioned the legal team. Is there anyone else with DPHHS that would know information about this guidance?
A. Possibly Jon Ebelt, our public information officer.
Q. Jon?
A. Ebelt. E -- Just like it says. Ebelt.
Q. Did you speak with Jon before coming today in preparation for this deposition?
A. No.
Q. So I have some questions about this guidance. Are you the person with DPHHS that is most knowledgeable about this document?
A. No.
Q. So you have not been prepared to testify about this document today? And by "this document," I'm just talking about the guidance, not the FAQs.
A. I understand what's written in here if that's what you're asking.
Q. Would you have information about why it was written?
A. No.
Q. Because, for example, you know, it talks about the OSHA standard in here. Do you see that on page 1?
A. Yeah. Yes.
Q. DPHHS isn't responsible for anything related to OSHA, is it?
MR. MEAD: Objection. Calls for a legal conclusion.
A. No.
BY MS. MAHE:
Q. So you don't know why that was included in here?
A. It was -- The initial information that we received from CMS included this documentation. This is right out of what was written from the -- the Biden administration on why they were implementing vaccine requirements.
Q. Okay. So this is a direct quote from what the Biden administration provided?
A. Yes.
Q. On page -- it's going to be page 6 of Exhibit 36, but it's page 2 of the guidance?
A. Mm-hmm.

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Q. There's a bunch of bullet points, and following that is a paragraph. Do you see that? It starts with "Religious Nonmedical"?
A. Yes.
Q. Okay. The second sentence of that paragraph says "The CMS mandate also does not apply to Assisted Living Facilities, Group Homes, physician offices, noncertified therapy providers," et cetera.
Do you see that there?
A. Yes.
Q. And is that because assisted living -- living -- I can't talk today, sorry -- assisted living facilities are not covered by the conditions of participation for facilities under Medicare and Medicaid?
A. Yes.
MR. MEAD: Objection. Calls for a legal conclusion.
BY MS. MAHE:
Q. I want to make sure we got your answer on the record there.
A. Yes.
Q. On the -- It's the second full paragraph from the bottom of that page. It starts with "CMS

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has indicated."
Do you see that paragraph?
A. Yes.
Q. The last two sentences of that paragraph -- Well, maybe just read that whole paragraph to yourself.
A. Yes.
Q. And -- And that paragraph says that [As Read]: "CMS has indicated that facilities are not required to ensure vaccination of their vendors and volunteers who infrequently provide ad hoc services."
Do you see that there?
A. Yes.
Q. And is that still accurate?
A. Yes.
Q. Okay. Then it says "CMS guidance indicates that facilities may choose to extend COVID-19 vaccination requirements to these individuals."
Do you see that?
A. Yes.
Q. The next sentence says "However, such action would be inconsistent with, and not permitted under, Montana law. See MCA 49-2-312."

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Do you see that there?
A. Yes.
Q. Why was that included in this?
MR. MEAD: Objection to the extent it calls for a legal conclusion.
A. I -- I don't know. I wasn't part of creating this document.
BY MS. MAHE:
Q. Does DPHHS have any enforcement authority related to Montana Code Annotated 49-2-312?
MR. MEAD: Objection. Calls for a legal conclusion.
A. Possibly.
BY MS. MAHE:
Q. Okay. And what do you mean by "possibly"?
A. It wouldn't be through CMS guidance, it would be under licensing, that they were in compliance with all of the laws, 'cause they also --- not only are they certified, but they're licensed, so we'd have to look at our licensing rules and see if we had any authority under there and -- but I -- I don't recall seeing anything where we actually would have an enforcement of that under licensing. I mean, if they're out of

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compliance, but the actual ARMs and licensing don't give us that kind of authority, they do in certain areas, but I'd have to go back and re-review those to be a hundred percent accurate on that.
Q. And you understand that 49-2-312 is where House Bill 702 was --
A. Yes, I understand.
Q. -- was codified. I have to finish my question before you can answer.
A. Sorry.
Q. That's all right. This is an awkward situation, but otherwise our transcript's going to be a mess, so...
A. Okay.
Q. On page 4 of that guidance --
A. Okay.
Q. -- there's a bullet point. It's the third main bullet point from the top that says "To track."
Do you see that?
A. Yes.
Q. And these are bullet points that are talking about the obligations of the facilities. Correct?

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A. Yes.
Q. And so facilities have an obligation to track and document the COVID-19 vaccination status of all covered staff, including those who have obtained any booster doses. Correct?
A. Yes, those of which are under CMS COPs, yes.
Q. Right. The facilities that are covered by this guidance which applies to those facilities that are covered by the conditions of participation.
A. Yes.
Q. So when you say "COPs," I know what you mean. We're talking about conditions of participation. Correct?
A. Correct.
Q. Okay. There's a lot of acronyms, and so I just want to make sure that you and I are both talking about the same thing.
A. Okay.
Q. You probably know them a lot better than I do, but I want to make sure that we're talking about the same thing. You can use them, we just -- I just might have to stop and clarify.
And so this requires those facilities to

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also track whether staff has obtained boosters. Correct?
A. Yes.
Q. On the next page, page 5 of the guidance, there's a whole section there that's talked about "The following guidance is derived from EEOC Compliance Manual."
Do you see that?
A. Yes.
Q. Now I'm using an acronym. "EEOC" stands for the Equal Employment Opportunities Commission. Is that correct?
A. Yes.
Q. And that's a federal commission --
A. Yes.
Q. -- related to equal employment opportunities. Correct?
A. Yes.
Q. So why is --
MR. MEAD: I just want to get on the record. Objection to the extent you're asking him to testify to knowledge to an agency that is outside of what DPHHS deals with.
MS. MAHE: Brent, he already answered the question, so...

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BY MS. MAHE:
Q. That section that's really derived from the compliance manual, do you see that?
A. Yes.
Q. Why was the EEOC guidance included in this guidance from DPHHS?
MR. MEAD: Objection to the extent it calls for a legal conclusion, and objection to relevance.
MS. MAHE: So let's talk about that, Brent. What's -- What's the legal conclusion that it's asking him to draw?
MR. MEAD: Counsel, you're asking him about why something was included in a guidance document, and to the extent you're asking him to enter a legal conclusion as to why it was necessary to include it in a guidance document, that's a legal conclusion.
MS. MAHE: Is this a legal guidance document? Is that your position?
MR. MEAD: The objection's been lodged.
MS. MAHE: Right, but I -- I get to fix the question. That's the whole point of form objections. So I need to understand -- I still don't understand how it's a legal conclusion.

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This is a guidance document put out by DPHHS. Are you saying that said --
MR. GRAYBILL: I believe he testified that a nonlawyer, Mr. Bremerton [phonetic] -- Brereton authored it as well, at least in part.
MR. MEAD: So, Counsel, she's going through her questions right now. To keep the record clean --
MS. MAHE: Oh, Raph gets to jump in.
MR. MEAD: The -- The objection to the legal conclusion is that if you're asking him to state a legal position as to why the EEOC was included in this, the objection is to the extent it calls for him to reach that conclusion.
MS. MAHE: Well, Counsel, we already established for the record that I'm not asking him for a legal conclusions, so it feels like your objections are actually --
MR. MEAD: And second --
MS. MAHE: -- just being obstructionist.
MR. MEAD: And second, there's an objection to relevance. DPHHS is not a party to this litigation.
MS. MAHE: Relevance isn't an objection in a deposition. You can object to the form of my

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question and that's it.
MR. MEAD: Counsel, as we have sent you authority, relevance does matter for third-party depositions, and to the extent that you are asking DPHHS to interpret --
MS. MAHE: A document they created.
MR. MEAD: -- 702.
MS. MAHE: I'm not. I'm asking him to interpret a document.
MR. MEAD: Their interpretation of 702 is not at issue in this case.
MS. MAHE: Brent, I'm asking him to interpret a document that DPHHS created. It's not my fault that you guys didn't prepare him to talk about the things that were in the notice. I mean, this is a situation where this is absolutely not a legal --
MR. MEAD: Objection to your characterization there, Counsel. Like, you can continue with questioning.
MS. MAHE: Oh -- Oh, I will, but here's the deal. Your objections are starting to become obstructionist and there's no legitimate basis for them. So you can keep doing it and we can take it up with Judge Molloy, but I guarantee you it's not

going to end well because I am not asking him for a legal conclusion, and I established that with him. I'm asking him why DPHHS included this in a document that DPHHS created.

MR. MEAD: You can continue with your questions.

A. Can you restate the question, please?

BY MS. MAHE:

Q. I can. We were talking about the portion of this guidance that starts with "The following guidance is derived from the EEOC Compliance Manual." Remember that portion?

A. Yes.

Q. Okay. And I asked you why it was included in this document.

A. In an effort to comply with federal guidance.

Q. What federal guidance?

A. The EEOC compliance manual. They -- They -- They wanted to incorporate compliance with federal guidelines into the -- the -- the MCA 49-2-303.

Q. Does DPHHS usually reference EEOC compliance guidelines in their guidance?

A. It's the first time I've ever --

MR. MEAD: Objection. That -- In that that calls for speculation.

BY MS. MAHE:

Q. You can answer.

A. It's the first time I've ever seen it.

Q. And do you know why it was included within this guidance and not others?

MR. MEAD: Objection. Speculation.

A. No.

BY MS. MAHE:

Q. On the last page of that guidance there's a paragraph that's bolded. Do you see that?

A. Yes.

Q. Why did DPHHS bold that paragraph?

A. I do not know.

EXHIBIT:

(Deposition Exhibit 37 marked for identification.)

BY MS. MAHE:

Q. The court reporter has handed you what has been marked as Deposition Exhibit 37. Have you seen that document before?

A. Yes.

Q. And what is that document?

A. An application for exemption from the

COVID-19 vaccination.

Q. Did DPHHS create this document?

A. Yes.

Q. Do you know who created it?

A. No.

Q. Why was it created?

A. In an effort to help facilities be able to meet the requirements under the -- the requirements for CMS for COVID vaccines.

Q. Did DPHHS create a medical exemption form?

A. Not that I've seen.

Q. Why not?

MR. MEAD: Objection. Speculation.

A. I do not know.

BY MS. MAHE:

Q. Did DPHHS ever create a religious exemption form not related to the COVID vaccine?

MR. MEAD: Objection in that it's broad. And to be specific, DPHHS has thousands of employees, and if you want to clarify it to external forms that they've sent.

MR. GRAYBILL: Counsel, this is a little close to -- to coaching. You can object to the form, but I think he can answer as to whether he

understands the question.

BY MS. MAHE:

Q. Did you understand my question?

A. Yes.

Q. Okay. And have they ever created other --

A. Not that I'm aware of.

Q. So they never created one to help with people who are subjected to flu shot requirements.

A. Not that I'm aware of.

Q. And does DPHHS, did they encourage providers to adopt and use this form?

MR. MEAD: Objection. Vague as to what you mean by "encourage."

BY MS. MAHE:

Q. Well, in the FAQs it says DPHHS encourages covered health facilities and providers to review and adopt its religious exemption form. Does DPHHS encourage providers to do that?

A. Yes.

Q. We haven't been going that long, but if you need a break because you've been sitting here the whole time, we can take a break.

A. I'm good --

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Q. Okay.
A. -- if you guys are good. Ask me in ten minutes.
Q. All right. Before we mark these for an exhibit, it might make more sense for me to just ask you which one is current, so I'm gonna ask you about the QSOs. Do you know what those are?
A. Yes.
Q. Okay. So there is a QSO from January 14th, and you can look at both of these. I'm pretty sure the revised QSO is the current one, but if you want to just peek at those and tell me.
A. The revised one would be your current QSO.
Q. Okay. Then we won't muck up the record with the noncurrent one.
EXHIBIT:
(Deposition Exhibit 38 marked for identification.)
BY MS. MAHE:
Q. The court reporter has handed you what has been marked Deposition Exhibit 38. Have you seen this document before?
A. Yes.

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Q. And is this the current QSO from CMS related to the COVID CMS vaccine mandate?
A. Yes.
Q. Okay. And it looks like this one is dated January 14th, 2022, but revised April 5th, 2022. Is that right?
A. Yes.
Q. And in the memorandum summary, that section, is this guidance that CMS provides to the state survey agency directors related to the COVID vaccine mandate?
A. Yes.
Q. And it's for the procedures for assessing and maintaining compliance with the regulatory requirements?
A. Yes.
Q. And in that box there it says that this one applies to Montana?
A. Yes.
Q. Under the second page of Exhibit 38, there's a paragraph entitled "Vaccination Enforcement - Surveying For Compliance."
Do you see that?
A. Yes.
Q. And we talked a little bit before about

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some of the potential penalties for failing to comply with the conditions of participation. That last sentence in that paragraph says "The sole enforcement remedy for non-compliance for hospitals and certain other acute and continuing care providers is termination."
Do you see that there?
MR. MEAD: Objection. That's not the whole sentence.
BY MS. MAHE:
Q. Do you see that there?
A. Yes.
Q. Thanks. And then it says "however, CMS's primary goal is to bring health care facilities into compliance." Correct?
A. Yes.
Q. So this -- but the sole penalty is termination if they don't come into compliance. Correct?
A. The ultimate penalty.
Q. And in that next paragraph in bolded letters it says "Facility staff vaccination rates under 100% constitute non-compliance under this rule." Is that accurate?
A. Yes.

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Q. And your surveyors, when they go out, they are looking for compliance with this QSO. Correct?
A. Yes.
Q. And on page 4 there it says "Within 90 days and thereafter following issuance of this memorandum, facilities failing to maintain compliance with the 100% standard may be subject to enforcement action."
Do you see that?
A. Yes.
Q. Okay. And then there is a list of the provider-specific guidance, and I did not include all those attachments in your exhibit today, but I am going to ask you some questions about some of them.
So I'm assuming that the revised QSO hospital attachment is the most current version. Is that accurate?
A. Yes.
Q. Again, I won't muck the record with the other one.
EXHIBIT:
(Deposition Exhibit 39 marked for identification.)

BY MS. MAHE:
Q. The court reporter has handed you what has been marked Deposition Exhibit 39. Have you seen this before?
A. Yes.
Q. And what is this document?
A. It's a supplemental attachment with some guidance on -- for our surveyors on the process for reviewing vaccine compliance and other things.
Q. So this is guidance that your surveyors use when they go and do on-site compliance --
A. Yes.
Q. -- surveys? And this particular one is for hospitals. Correct?
A. Correct.
Q. If you turn to page -- well, it's marked at the bottom DPHHS 67.
A. Okay.
Q. The paragraph says "The policy must also ensure." Do you see where I'm reading? It's under "Policies" --
A. Yes.
Q. Says [As Read]: "The policies must also ensure those staff who are not yet fully vaccinated, or who've been granted an exemption or

accommodation as authorized by law, or who have a temporary delay, adhere to additional precautions that are intended to mitigate the spread of COVID-19."
Do you see that?
A. Yes.
Q. So when your surveyors go in, are they making sure that those staff who are not vaccinated are required to have additional precautions?
A. Yes.
Q. And some of those precautions are listed there below in those bullet points. Is that correct?
A. Yes.
Q. And some of them can be requiring at least weekly testing for those nonvaccinated staff?
A. That's an option.
Q. Another option would be requiring the nonvaccinated staff to wear an N95 mask?
A. Yes.
Q. Or a higher level respirator?
A. Yes.
Q. And the hospitals also have to provide a

process for how they're ensuring their contracted staff are compliant with the vaccine requirement. Correct? You can look at page DPHHS 72.
A. Yes.
Q. On the next page, page 73 --
A. Mm-hmm.
Q. -- it goes through what are acceptable forms of proof of vaccination. Do you see that there?
A. Up top?
Q. Yep. So it says "For each individual identified by the hospital as vaccinated."
A. Yeah.
Q. Then it says "surveyors will: Review hospital records to verify vaccination status." Correct?
A. Yes.
Q. So your surveyors are actually having to look at the records. Right?
A. Yes.
Q. And the records that they can look at are the CDC COVID-19 vaccination record card. That's one, right?
A. Mm-hmm. Yes.
Q. Or documentation of vaccination from a

healthcare provider or an electronic health care record. That's another.
A. Yes.
Q. And then the only other one is the state immunization information system.
A. Yes.
Q. And they also have to have that proof from their contract staff as well.
A. Yes.
Q. Same question with the critical access hospital attachment. The revised one is the most current?
A. Yes.
EXHIBIT:
(Deposition Exhibit 40 marked for identification.)
BY MS. MAHE:
Q. The court reporter has handed you what has been marked as Exhibit 40. Do you know what that document is?
A. Yes.
Q. What is it?
A. It's the critical access hospital guidance from CMS for vaccine requirements.
Q. So, again, this is some guidance that

your surveyors use to conduct the compliance surveys for CMS?
A. Yes.
Q. And this one applies to critical access hospitals.
A. Yes.
Q. Are the requirements for critical access hospitals generally the same as those we just talked about for hospitals?
A. Generally, yes.
Q. Was there anything that we just talked about for hospitals that is different for critical access hospitals?
A. I -- I mean, I haven't done a side-by-side comparison, but I would -- but generally, yes.
Q. Why don't we go ahead and take a break. Are you needing a little bit of a break?
A. Sure. I'll take a break.
Q. Okay. We'll take a break. Come back.
THE VIDEOGRAPHER: We are going off the record. The time is 10:12 a.m.
(Recess taken from 10:12 a.m. to 10:20 a.m.)
THE VIDEOGRAPHER: We are back on the

record. The time is 10:20 a.m.
BY MS. MAHE:
Q. Mr. Anderson, you understand you're still under oath?
A. Yes.
Q. You understand you're still testifying on behalf of DPHHS?
A. Yes.
Q. Has DPHHS found deficiencies for any hospital in Montana related to failure to comply with the CMS vaccine mandate?
A. I -- I don't recall any off, but I'd have to actually check the spirit report to confirm.
Q. Okay. And what's that report that you just mentioned?
A. Just a report we get from CMS that tells me what -- what all -- there's -- are out there. It's a -- I'd have to check the report.
Q. What did you call it, though?
A. Call it a spirit report.
Q. Spirit?
A. Yeah.
Q. Okay.
A. That list all the -- the deficiencies that have been cited across the state, and at

least in a gross number you can get the detail also.
Q. And you said that's the spirit report?
A. Yes.
Q. Did you review that before your deposition today?
A. Yes.
Q. And you don't recall what information it had?
A. Not on that specific. I was reviewing it more for infection control citations.
Q. And would the failure to comply with the CMS vaccine mandate fall under the infection control provisions?
A. Yes.
Q. Was that report produced by DPHHS in response to the subpoena?
A. I don't know.
Q. Did you compile it and give it to the attorneys to produce?
A. That report's considered proprietary to CMS. It's not public information. The -- The information might be available through the QCOR website publicly. You'd have to dig -- dig through that.

Q. Q --
A. QCOR.
Q. COR.
A. QCOR. It's the public information website for CMS for deficiencies.
Q. So you said that you looked at it for infection -- Tell me again what you said.
A. Infection control.
Q. Infection control. Which would include these.
A. Yes, but I -- I would not have the specifics of whether it was handwashing or whether or not it was for lack of -- of compliance with that.
Q. And is that spirit report also -- is it just for hospitals?
A. No, there's two different ones. There's one that does for long-term care, which is the one that I reviewed, but there's also one they originally developed for non long-term care, but again, those are proprietary to CMS and to people who are contracted with CMS.
Q. Like DPHHS.
A. Yes.
Q. So you reviewed the long-term care spirit

Q. Are those plans of correction completed?
A. Define "completed," please.
Q. Well, where they're not at risk for immediate jeopardy.
A. No, there was no immediate jeopardy. Well, back up. There was an IJ for the state hospital related to infection control, and I believe in that document they stated some not appropriate use of masking, but that was...
Q. We're going to get into that, so we can talk about that one then. Other than the state hospital.
A. No, I don't recall any. Okay.
Q. I want to talk a little bit -- You said that you looked into the long-term care deficiencies. Correct?
A. Yes. You have to understand it was more in wondering what information was out there than in researching the information specific. That I was just wondering what was on there that might help me to understand what I needed to testify on more so than trying to find specific information.
Q. So do you know how many long-term care facilities have had deficiencies found for violation of the CMS vaccine mandate?

A. I know how many had citations for infection control, which --
Q. And how many?
A. Five. And that was over a set period of time for -- That was basically about a 18-month period.
Q. And when would that 18-month period start?
A. March 2021, I think, it was when I first read the -- the report. The things we read you have to generate in timeframes.
Q. March of '21 through?
A. Current.
Q. Current. And there were five, you said?
A. Yeah.
Q. Are those five facilities that had deficiencies?
A. Deficiencies for infection control.
Q. Not five deficiencies.
A. Not five deficiencies.
Q. Okay. And were any of those related to the vaccine mandate?
A. I can't answer that. I don't know for sure. I know they were infection control citations that -- but I don't recall any

specifically coming up for noncompliance with the vaccine requirement, not off the top of my head. But infection control covers a broad spectrum.
Q. Do those five that you're talking about, those five facilities, do those include the two facilities that you referenced in your declaration you submitted in this case? And we can look at that if you want.
A. Please.
EXHIBIT:
(Deposition Exhibit 41 marked for identification.)
BY MS. MAHE:
Q. The court reporter has handed you what has been marked Deposition Exhibit 41. Have you seen that document before?
A. Yes.
Q. Is that the declaration that you submitted in this case?
A. Yes.
Q. And you declared -- Made this declaration under penalty of perjury?
A. Yes.
Q. In your declaration there it talks about facilities that were looked at for a period

between February 14th, 2022 and March 15th, 2022. Do you see that? Page -- Paragraph 12.
A. Yes.
Q. And -- And maybe I'm actually not correct. I think -- Well, why don't you tell me. So if you need to read through 11 and 12 again, I'm not entirely clear when the surveys were conducted. Were they just conducted during the week of February 14th?
MR. MEAD: Objection to form, I think.
A. We conduct surveys every other week and have consistently throughout the years, other than the timeframes that we were only required to do infection control surveys there was a period of time March '21 through for about a four-month period we were only allowed to do offsite death surveys and -- but we did those every other week as well, and we were all -- we were required to complete infection control surveys, what's called a FIC survey, on every facility, every long-term care facility. We were instructed not to be doing surveys on non long-term care.
BY MS. MAHE:
Q. And I asked a poor question, I apologize. In your declaration you are talking about a --

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specific seven surveys. Do you see that in paragraph 11?
A. Yes.
Q. And I think that I understand your declaration but I want to confirm with you saying that those seven surveys occurred the week of February 14th, 2022?
A. Yes.
Q. So in paragraph 13 you mention that there were deficiencies with respect to long-term care facilities in those seven surveys. Is that right?
A. Yes.
Q. So my question for you is are those two long-term care facilities included in the five that you just mentioned?
A. I honestly would have to go back and read the surveys to know that.
Q. And looks like in your declaration one of the deficiencies in those surveys was because the facility policy did not include the use of N95 masks for vaccine-exempt employees. Is that correct?
A. Yes.
Q. So that would be in addition to the ones that we talked about that were non long-term care

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facilities earlier. Right?
A. Yes.
Q. In paragraph 14, you said "to this point, we have not received any complaints that a Montana health care facility is in noncompliance with the CMS Rule."
I'm assuming you're referring to the vaccine mandate?
A. Yes.
Q. Since this point -- so you -- you did this declaration on March 2nd, 2022 -- have you received any complaints that a Montana healthcare facility is in noncompliance with the CMS vaccine mandate?
A. Up till May 9th I can say no.
Q. Okay. After May 9th?
A. I wouldn't -- I can't answer. I've been on another assignment since May 9th of 2022.
Q. So you didn't review whether there were any deficiencies or complaints made after May 9th to prepare for your deposition today.
A. No.
Q. And who at DPHHS would know that information?
A. Either Michelle Truax, the acting IG; or

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possibly Todd Boucher, the bureau chief working out of the certification unit.
Q. So did you speak with Michelle Truax in preparation for your deposition on behalf of DPHHS today?
A. No.
Q. Did you speak with Todd Boucher?
A. Yes.
Q. And what did you talk to him about?
MR. MEAD: Objection to if this calls for any attorney-client information.
BY MS. MAHE:
Q. Is Mr. Boucher an attorney?
A. No.
Q. Okay. What did you talk to him about?
A. To help me refresh my memory on dates and times; especially for related to the timeframe that we were doing the FIC surveys and are required to do FIC surveys, I wanted to make sure I had the right timeframes in mind and the -- the death surveys that we were doing.
Q. Did you -- Other than that, did you ask him any other questions?
A. No.
Q. Did he provide you any other information?

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A. No.
Q. Did you ask him about any complaints regarding noncompliance with the CMS vaccination rule?
A. No.
Q. Why did you include that in your declaration? And I don't want legal opinion or conversations with your counsel, but why did you include that piece of information?
MR. MEAD: Objection that this is approaching a line that's outside the scope of today's deposition. That this was a declaration that he had in his personal capacity.
BY MS. MAHE:
Q. You get to answer.
A. Could you be specific to what you're referring to?
Q. Sure. In paragraph 14 you say "We generally receive complaints about facility infection control." The next sentence says "However, to this point, we have not received any complaints that a Montana health care facility is in noncompliance with the CMS Rule."
Why did you include that?
A. It seemed relevant.

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Q. How?
A. We do -- We do surveys based on either recertification dates, initial requests, or on complaints, so -- and complaints generate us -- have a -- a scale of -- of severity, which generate us doing surveys based on timeframes. So seemed relevant that we have not had any complaints come in about the vaccine requirement to me.
Q. So it seemed relevant for you to include it in this declaration, right?
A. At the time.
Q. But it didn't seem relevant for you to prepare on that topic for the DPHHS deposition today?
A. I think I am prepared short of being beyond May 9th. I can't tell you what happened after May 9th. I've been on another assignment that's a full-time job.
Q. And May 9th is a little over three months ago?
A. Yeah.
EXHIBIT:
(Deposition Exhibit 42 marked for identification.)

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BY MS. MAHE:
Q. The court reporter has handed you what has been marked Deposition Exhibit 42. Have you seen this before?
A. Yes.
Q. Okay. And is this another QSO that is sent to state survey agency directors from CMS regarding surveys that are performed by DPHHS?
A. Well, yes, but it's regarding the vaccination expectations for surveyors.
Q. Correct. And -- And what is -- what is the vaccination expectation for surveyors in this QSO?
A. Generally that they have received the vaccination or they have an exemption similar to would be in the requirement for the other facilities.
Q. And so on the second page of that under the "Guidance For State Survey Agency and Accrediting Organization Surveyors" --
A. Mm-hmm.
Q. -- do you see where it says [As Read]: "Surveyors who are not fully vaccinated (unless vaccination is medically contraindicated or the individual is legally entitled to a reasonable

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accommodation under federal civil rights laws because they have a disability or sincerely held religious beliefs, practices, or observations that conflict with the vaccination requirement) should not participate as part of the we do that survey team performing federal oversight of certified providers and suppliers (including accreditation surveys performed under an AO's deeming authority."
Do you see that sentence?
A. Yes.
Q. And did DPHHS comply with this provision while this QSO was in effect?
MR. MEAD: Objection. That calls for a legal conclusion.
A. Yes.
BY MS. MAHE:
Q. So you required your surveyors to have vaccination to go on-site?
A. Or an exemption.
Q. And this QSO was in effect looks like from January 25th, 2022, and I think it was rescinded in June of this year. Is that right?
A. Yes.
Q. So DPHHS describes itself as improving

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and protecting the health, well-being, and self-reliance of all Montanans. Correct?
A. Correct.
Q. And you'd agree with me that infection prevention protocols and healthcare facilities are designed to protect the health of patients and staff. Right?
MR. MEAD: Objection. Vague.
A. Yes.
BY MS. MAHE:
Q. And infection prevention protocols promote public health. Correct?
A. Yes.
Q. I want to turn to the state hospital now. I know that you're currently the CEO. Correct?
A. Yes.
Q. And you haven't been in that role very long. Correct?
A. Since May 9th.
Q. It might feel like a long time to you.
A. Been a couple years now.
Q. And in April of this year, CMS terminated the state hospitals provider agreement for failure to comply with the conditions of participation. Correct?

A. Yes.
Q. That was prior to your tenure there.
A. Yes.
EXHIBIT:
(Deposition Exhibit 43 marked for identification.)
BY MS. MAHE:
Q. The court reporter has handed you what has been marked Exhibit 43. Have you seen this document before?
A. Yes.
Q. And what is this document?
A. It's an involuntary termination of the Medicare provider disagreement with Medicaid between the Montana State Hospital and Center for Medicare and Medicaid Services.
Q. And it looks like here that it goes through sort of the process that DPHHS went through with the survey. Correct?
A. Yes.
Q. So it looks like the original complaint survey was in February of 2022?
A. Correct.
Q. And then on February 18th CMS issued a statement of deficiencies regarding noncompliance.

Is that correct?
A. Yes.
Q. And one of the reasons it was out of compliance was related to 42 CFR 482.42, which is the infection control. Correct?
A. Yes.
Q. And that was related to infection control related to COVID. Right?
A. Yes.
Q. Then it looks like there was a revisit survey that occurred in February 23rd of 2022. Is that right?
A. Yes.
Q. And that survey found that those previously cited deficiencies, which resulted in immediate jeopardy, were still not corrected. Correct?
A. Correct.
MR. MEAD: Objection. This -- So long as this is limited to the infection control IJs, not the other IJ findings. Those other IJ findings are irrelevant.
MR. GRAYBILL: Is your objection relevance?
MR. MEAD: Yes.

BY MS. MAHE:
Q. Okay. You can answer.
A. Could you ask the question again?
Q. Maybe. The revisit survey --
A. Yes.
Q. -- February 23rd, 24th --
A. Yeah.
Q. -- found that those previous deficiencies which resulted in immediate jeopardy had still not been corrected. Correct?
A. Yes, but I believe they were related more to the -- the psychotropic medications, right?
Q. Well, there was an additional --
A. Okay.
Q. -- immediate jeopardy that was related to the psychotropic medications. Right?
A. Correct.
Q. And --
A. That's right. So yes, you're right.
Q. And then they did a second revisit on March 9th, 2022, right?
A. Correct.
Q. And all three of those deficiencies that resulted in immediate jeopardy were still there. Right?

A. Correct.
Q. Okay. And then it looks like there was another survey that was a complaint survey that happened on March 24th and 25th of 2022. Right?
MR. MEAD: Objection. Relevance.
A. Yes.
BY MS. MAHE:
Q. Yeah. And in that investigation they found that the three other previously cited deficiencies, which were immediate jeopardy level deficiencies, remained. Correct?
A. Yes.
Q. And ultimately the state hospital lost the ability to participate in Medicare and Medicaid under this letter. Correct?
A. Yes.
Q. And how much to date has the state hospital lost in reimbursement?
MR. MEAD: Objection. Speculation.
A. The -- The stated amount was about 7 million. What we determined so far, it's a little -- somewhat less than that, but I don't have exact numbers. But it was closer to about 6 million is what I've come up with.
///

BY MS. MAHE:
Q. Have you done any projections about what the future loss of reimbursement will be?
MR. MEAD: Objection. Speculation.
MS. MAHE: I asked has he done any.
BY MS. MAHE:
Q. Have you?
A. Yes.
Q. And what is the projected loss?
MR. MEAD: Same objection.
A. I really can't answer that accurately because there's too many variables of things that would happen. In other words, I've done projections in my head of if this, then that would equal into different dollar amounts. And those if then and then thats are -- are -- are not really relevant to anything, they're just my hypotheticals of well, if we do this, we do that, what will happen, and some of those things are determined that they're not eligible to do. We looked at the options of trying to get Medicaid eligibility for our group homes, but we didn't meet the -- the actual setting rules, and the projection there would have been close to about 4 million that -- that we could have generated, but

we didn't -- we were outside of the settings rule, if you understand the settings rule and the -- the way CMS determines things. So I've done some projections that didn't work out, but right now I think had we not lost that, that's hard to say too because you have the -- the IMD exclusion and did that -- that didn't come to fruition as a result of losing that, so there's a whole different set of projections that you would do based on that.
BY MS. MAHE:
Q. Is the state hospital currently being subsidized through the general fund?
MR. MEAD: Objection. Vague as to what you mean by "subsidized."
A. I'm not -- I'm not sure what you mean by "subsidized," but our revenue does come from general fund and other areas throughout state government. We might get -- I call -- I call tax money. I -- You'd have to talk to BFSD about how they're funding things.
BY MS. MAHE:
Q. Has that -- Has that loss of reimbursement made it difficult to operate the state hospital?
MR. MEAD: Objection. Vague.

A. Not yet.
BY MS. MAHE:
Q. Do you think it's coming?
MR. MEAD: Objection. Speculation.
BY MS. MAHE:
Q. You can answer.
A. Yes.
Q. That's the problem when preparing late last night. All over the place.
EXHIBIT:
(Deposition Exhibit 44 marked for identification.)
BY MS. MAHE:
Q. The court reporter has handed you what has been marked as Deposition Exhibit 44, and I'll represent to you that this is part of a PowerPoint presentation that was provided to us by DPHHS in response to the subpoena. So I just want to make sure I understand. Assisted living facilities are not Medicare or Medicaid certified facility providers. Correct?
A. Correct.
Q. So they are not subject to the CMS conditions of participation. Correct?
A. Correct.

Q. Okay. And they are not surveyed under those conditions of participation.
A. That's correct.
Q. And they don't risk losing funding from Medicare and Medicaid based on not complying with the conditions of participation.
A. Correct.
EXHIBIT:
(Deposition Exhibit 45 marked for identification.)
BY MS. MAHE:
Q. The court reporter has handed you what has been marked Exhibit 45. Have you seen that document before?
A. Yes.
Q. And is -- what is this document?
A. It's the House Bill 702 guidance for -- It's the House Bill 702 guidance.
Q. From DPHHS.
A. Yes.
Q. And is it dated on September 1st, 2021? It's at the very bottom.
A. Yes.
Q. Okay. It says it was updated on that date. Do you know what it said prior to

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September 1st, 2021?
A. No.
Q. Did you create this document?
A. No.
Q. Do you know who created the document?
A. Well, it says it was sent out by Jon Ebelt, our public information officer. I assumed that he would be part of the creation of the document.
Q. Did you talk to Jon Ebelt in preparation for your deposition today?
A. No.
Q. Who was this document given to?
A. It was posted publicly for anyone who needed -- who was interested.
Q. Why was -- Why did DPHHS put out guidance on House Bill 702?
MR. MEAD: Objection. Deliberative process.
MS. MAHE: What is your objection?
MR. MEAD: To the extent you're asking him to enunciate the views of why the department chose to do something, the DPHHS has lodged objections based on deliberative -- excuse me, deliberative process.

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MS. MAHE: You know that that only applies to federal agencies, right?
MR. GRAYBILL: There is no such privilege in Montana government. The state has taken the position in O'Neill v. Gianforte that no Montana court has ever recognized such a privilege. It's not a thing. The very purpose of a 30(b)(6) deposition is to find out why the government agency did what it did. That is why we are here.
MR. MEAD: Restating the privilege objections that are found within DPHHS's letter to you.
MS. MAHE: Are you instructing him not to answer?
MR. MEAD: He can answer as to the nonprivileged portion.
BY MS. MAHE:
Q. Why -- Why did DPHHS create this document?
A. So the public, in general, would understand how to comply with the -- the House Bill 702.
Q. So does DPHHS determine compliance with House Bill 702?
A. No.

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Q. Did DPHHS put out written guidance for hospitals about how they can comply with 702 and the CMS vaccine mandate?
MR. MEAD: Objection. Compound.
A. No. We did hold public meetings with conversations about it, but I don't recall any -- any written documentation.
BY MS. MAHE:
Q. And how -- how do you make the decision of whether to give written documentation versus a public meeting?
MR. MEAD: Objection. That that -- that's again going into the privilege that's been noted by DPHHS in their letter to counsel.
MS. MAHE: Are you instructing him not to answer?
MR. MEAD: He can answer as to the nonprivileged portion.
MR. GRAYBILL: And I'll just reiterate this is a privilege that the state of Montana has taken the position that no court has ever recognized as to the state of Montana.
BY MS. MAHE:
Q. You can answer.
A. Do you want to ask the question again?

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Q. I can't remember it.
MS. MAHE: Mary, could you read it?
THE COURT REPORTER: "How do you make the decision of whether to give written documentation versus a public meeting?"
A. When we feel like that there needs to be information out there for people to have, we try to put it out there publicly as much as possible such as developing the PowerPoints that -- that your -- so that people can have those. As far as public meetings are there to help clarify if there's questions about what we've put out there. So when we feel it's important the people have the guidance we -- we place it out there for them to have that, and if they have questions about the guidance to get clarification, we'll have public meetings or conversations about those things.
BY MS. MAHE:
Q. Okay. So in this particular instance why wasn't there written guidance provided to hospitals about how they can comply with 702 and the CMS vaccine mandate?
MR. MEAD: Objection. Compound.
A. I think the guidance applied that we did put out -- put out covers for everyone. It wasn't

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specific to any one provider.
BY MS. MAHE:
Q. And what is the guidance of DPHHS on how hospitals could comply with the CMS vaccine mandate and House Bill 702?
MR. MEAD: Objection. Compound; vague.
A. They should review QSO 22-09, the guidance produced by CMS.
BY MS. MAHE:
Q. So they should comply with the federal conditions of participation guidance?
A. Correct.
Q. On Exhibit 45, the second paragraph under the "Considerations For Local Government."
Do you see that?
A. Mm-hmm.
Q. There's a sentence, it's the last sentence of that paragraph, it says [As Read]: "Additionally, depending on the circumstances, unvaccinated individuals who do not quarantine or isolate despite having knowledge of having come into close contact with an infected person or being infected could potentially be subject to claims of legal liability from individuals -- individuals they infect within the community."

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Do you see that there?
A. Yes.
Q. So when you're talking about unvaccinated individuals, would that also apply to unvaccinated individuals who are employees of hospitals?
A. I would think so if it -- if they didn't have an exemption.
Q. Okay. And same thing for critical access hospital employees.
MR. MEAD: Objection. The document that you are quoting from says "Considerations For Local Government," not critical access hospitals.
A. Again, I would assume this is generated by one of the legal team 'cause it talks about legal liability. So in my view of this, it -- it would apply to all.
BY MS. MAHE:
Q. How are you doing? Do you need a break?
A. I'm good. How are you?
Q. I'm doing fine. Thank you.
A. Okay. I'm worried about you.
Q. You're the first person who ever has.
EXHIBIT:
(Deposition Exhibit 46 marked for identification.)

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BY MS. MAHE:
Q. The court reporter has handed you what has been marked Exhibit 46. Again, this was part of the production DPHHS gave us in response to the subpoena.
A. Mm-hmm.
Q. It's an email chain, and whenever we print these out, they work backwards. So if we start on the last page, that'll be the first email in the chain, and then we go backwards through it.
A. Mm-hmm.
Q. So have you seen this document before?
A. Yes.
Q. And it looks like it's an email -- It starts off with email correspondence to you from Duane Preshinger?
A. Mm-hmm.
Q. Is that a yes?
A. Yes.
Q. And who is Duane?
A. Duane Preshinger works for the Montana Hospital Association. He's the vice president, I guess.
Q. Okay. And that -- We didn't actually get the original email with the attachment, but it

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says "Hi Carter, here is the document that was being shared with Bitterroot Health regarding their survey."
Do you see that?
A. Yes.
Q. Do you recall what document that was?
A. No.
Q. Okay. Then there's some -- some conversations there if you look starting on page 2 on to page 3, looks like another email from Duane to you. If you want to just take a second to read that.
A. Which one are you looking at?
Q. Yeah. I'm starting the one that starts at the very bottom of page 2. Says "Yes, Bitterroot is a CAH."
A. Okay. I've read it.
Q. Okay. So he mentions that "Other issues that were apparently discussed during the survey are that N95 masks need to be worn throughout the facility, weekly testing of all staff and that non-vaccinated staff should be reassigned."
Do you see that?
A. Yes.
Q. Okay. Do you recall what he was talking

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about in that email?
A. Yes.
Q. What was he talking about?
A. Surveyors were attempting to cite them for not wearing masks throughout the facility and for not providing weekly testing of staff -- of the nonvaccinated staff.
Q. And what was DPHHS's response to that?
A. As I recall, we didn't cite them for all of those -- those particular things. We went back and reviewed everything to make sure we were -- our surveyors were correct. There were some things that the surveyor were right on and some things they were -- were a little -- weren't interpreting quite correctly, so we went back and made the corrections is the way I recall it, and then we produced the guidance that we put out the -- that's kind of what prompted us to do the public meetings when do the P -- the PowerPoints that you reviewed, so the people would have the information and make sure that we were all on the same page when doing these.
Q. Okay. And --
A. This was right in the very beginning of all this, so --

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Q. Well, this was March of 2022.
A. Yeah.
Q. Then it looks like he asks "Is QAD willing to do a webinar on the survey process?"
Do you see that on the first page?
A. Yeah.
Q. And then you responded question mark, "I am hesitant."
Do you see that?
A. Yes.
Q. And it looks like you didn't respond that to him, you responded that to Todd Boucher.
A. Yes.
Q. And why were you hesitant?
A. Because I wanted to review all the information that we put out publicly prior to just having anything developed.
Q. And who's Todd again?
A. Todd Boucher's the bureau chief for the certification unit.
Q. Did you ultimately put out a PowerPoint of how facilities can comply with both 702 and the CMS vaccine mandate?
A. Our PowerPoint was related to the vaccine mandate. There were questions related to 702 that

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were responded to by Charlie Brereton.
Q. And what did Charlie -- how did he respond to those questions?
A. Basically that 702 was not a factor in our certification process.
Q. And so that the certification process was to look for compliance with the conditions of participation.
A. Correct.
Q. My stack is dwindling.
A. Does that mean it's almost over?
Q. I never make those sorts of promises.
EXHIBIT:
(Deposition Exhibit 47 marked for identification.)
BY MS. MAHE:
Q. The court reporter has handed you what has been marked Deposition Exhibit 47.
A. Mm-hmm.
Q. Have you seen that document before?
A. Yes.
Q. These are email strings, and you are on the emails from March 14th, 2022. Correct?
A. Yes.
Q. Who is Erika Baldry?

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A. Erika works for public health.
Q. Is she an attorney?
A. Not that I'm aware of.
Q. Okay. Who is -- I'm -- I'm on the last page of that Exhibit 47. Again, it starts backwards. Second-to-last page. Sorry.
A. Okay.
Q. Who is Tensina or Tina Smith?
A. She's a survey supervisor.
Q. With DPHHS?
A. Yes.
Q. Is Erika also with DPHHS?
A. Yes.
Q. Who is Tyler Smith?
A. He also is a survey supervisor with DPHHS.
Q. And who is Todd Harwell?
A. Todd Harwell's a division administrator for public health with DPHHS.
Q. And who is Laura Williamson?
A. Laura Williamson is with DLI or DEQ, one of the two. I'm not -- I can't really remember which one. It's -- It's one of those, but I think it's DEQ, actually.
Q. And do you know what her position title

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is?
A. I do not.
Q. Do you know why she was copied on this email?
A. I do not.
Q. This email is from Erika to those recipients. Correct?
A. Correct.
Q. And she says [As Read]: "I'm so sorry to be bringing this up again, however, HB 702 is causing some concerns for our acute care facilities."
Do you see that?
A. Yes.
Q. And had she brought up this issue to you before?
MR. MEAD: Objection in -- are you referring to Carter individually?
BY MS. MAHE:
Q. He is testifying on behalf of DPHHS.
A. Yes.
Q. And what -- what had she said before?
A. That there was concerns amongst some of the acute care facilities of how House Bill 702 interacted with the guidance in 22-09.

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Q. And what were those concerns?
A. Ones that I recall were specifically hospitals --I'm sorry. The ones I recall specifically were the hospitals that weren't clear on how they did the additional guide -- the additional precautions with staff who were under the exemptions, and how -- how they would not be able to treat them differently from other staff was their concern. So that's what I recall.
Q. So the concern is -- was whether the nonvaccinated staff that had exemptions under the CMS vaccine mandate were required to be treated differently than vaccinated staff under the conditions of participation. Is that right?
A. The guidance stated there had to be additional precautions for them that were unvaccinated and that, for the hospital, created a concern that they were treating people differently.
Q. And that would have been prohibited by 702.
A. The way I read 702, and I'm not an attorney again, 702 prohibited from discrimination in their employment from hiring and that kind of thing. I don't know whether it applies in terms

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of what we're talking about here.
Q. But that's what they were concerned about.
A. Yes. Well, they were -- they weren't concerned about -- Well, I guess 702 was a concern. They were just concerned that that, to them, seemed like it was a problem.
Q. And it looks like she then asks -- she goes through some of that concern, and then says [As Read]: "Since this is coming from a federal level, facilities could be cited and fined for not taking appropriate steps. Do we have any guidance we can provide to our hospitals?"
Do you see where she said that there?
A. Yes.
Q. Okay. And then it looks like Todd responded and said [As Read]: "This is the question that Epidemiology still keeps asking us because they are getting questions from providers."
A. Mm-hmm.
Q. Do you see that there?
A. Yes.
Q. What's epidemiology?
A. That's the division that Erika Baldry's

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in charge of. Epidemiology is part of the public -- Department of Public Health's group.
Q. Thank you. And then Todd -- it -- it looks like Todd is asking you do you have "any thoughts on this one would be appreciated." Right? In that email.
A. Right. Okay.
Q. And then it looks like you respond "Let's let Charlie field this one for Erika."
Do you see that?
A. Yes.
Q. Okay. And why did you turn it over to Charlie?
A. House Bill 702, I mean, was not really a factor on what we were doing over in our division. That was something that would be part of the -- the -- the more overreaching DPHHS folks to deal with. Charlie specifically.
Q. And we're talking about Charlie Brereton?
A. Yes.
Q. And I apologize if I'm butchering his name.
A. I do it all the time.
Q. And what was his role again?
A. At that time he was the chief operations

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officer, I believe, for DPHHS.
Q. Okay. And just for the record, "Brereton" is B-r-e-r-e-t-o-n.
A. Correct.
Q. And then starting on page 1, it looks like Charlie responds to Erika. You see that there?
A. Not yet.
Q. Oh.
A. Page 1 you said?
Q. Yes. And continues to page 2.
A. Yes.
Q. It looks like he says "Erika, Thanks for the separate note that clarifies which facilities have expressed related concerns with the department."
I don't believe that document was provided in response to the subpoena. Do you know why?
A. No.
Q. He says "At this point in time," which is underlined, [As Read]: "it is the position of the administration that 22-09 ALL triggers the following exemptions provided for in House Bill 702."

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Do you see that?
A. Yes.
Q. Why is "At this point in time" underlined?
A. I don't know. I didn't write this email.
Q. And did you talk to Charlie about this in preparation for your deposition?
A. No.
Q. And Charlie was with DPHHS at the time he wrote this email?
A. I believe so. He -- He transitioned over from the governor's office at some point, and I couldn't tell you the exact date, but I believe he was acting COO -- or he was the COO at the time.
Q. Did DPHHS take a different position on this issue at other times?
A. Not that I'm aware of.
Q. At the end of his email there -- this is on page 2 -- it says "This information must only be communicated verbally."
Do you see that?
A. Yes.
Q. Why?
MR. MEAD: Objection to the extent it gets into the privileges noted by DPHHS in their

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objection letter.
MS. MAHE: I'll restate there are no such privileges.
BY MS. MAHE:
Q. Go ahead.
A. No, I have no idea or knowledge put in there.
Q. Is that common practice to only allow DPHHS to respond to things verbally?
MR. MEAD: Objection. Speculation.
A. It wasn't common practice for the OIG office.
BY MS. MAHE:
Q. Had you seen that before when you were with DPHHS, someone telling you can only communicate verbally about something?
MR. MEAD: Objection. Vague as to time.
A. No.
BY MS. MAHE:
Q. Then it looks like Erika responds on that page 1, and says [As Read]: "One final question, since this information should only be communicated verbally, is there anything that OIG or my team can share with facilities so they have the documentation?"

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Do you see that question?
A. Yes.
Q. Do you know whether Charlie ever responded to this email?
A. No.
Q. Do you know whether Erika was ever provided with documentation to share with the facilities?
A. Yes.
Q. Regarding this particular issue.
A. Well, we provided documentation in terms of providing PowerPoints for -- for facilities on how to comply with the QSO 22-09.
Q. And did those PowerPoints state that healthcare facilities trigger the exemptions provided in House Bill 702?
A. I do not believe so.
Q. Still doing okay?
A. Yeah. Two more documents, then we'll call time.
Q. We can call time now if you want.
A. No, I'm good.
EXHIBIT:
(Deposition Exhibit 48 marked for identification.)

BY MS. MAHE:
Q. The court reporter has handed you what has been marked Deposition Exhibit 48. This was a document that was produced by DPHHS in response to the subpoena. It appears to be an email from Erika Baldry to Heath Hall and Susan Woods. Have you seen this document before?
A. No.
Q. It's a June 30th, 2022 -- It's dated June 30th, 2022. Correct?
A. Correct.
Q. From Erika who is with Department of Public Health and Human Services?
A. Correct.
Q. And she says [As Read]: "As a CAH, you must apply House Bill 702 which means you can't discriminate based on vaccination status."
Do you see that?
A. Yes.
Q. So is DPHHS taking the position that critical access hospitals are not subject to the injunction that has been entered in in this case?
MR. MEAD: Objection. Calls for a legal conclusion.
A. I really don't know how to answer that.

I don't really understand the question --
BY MS. MAHE:
Q. Sure.
A. -- to tell you the truth. I'm not a lawyer, so...
Q. Are you aware of that there has been an injunction in this case that healthcare facilities who are subject to the conditions of participation are -- cannot -- Let me start over. There's an injunction in place that enjoins the state from applying House Bill 702 to healthcare facilities that are subject to the conditions of participation related to the CMS vaccine mandate?
A. Yes.
Q. And do you know whether it's DPHHS's position that critical access hospitals are subject to that?
A. Yes.
Q. So do you know why Erika said this to Heath on June 30th, 2022?
A. I do not.
Q. Let's go ahead and take a quick break.
A. Okay.
THE VIDEOGRAPHER: We are going off the record. The time is 11:16 a.m.

(Recess taken from 11:16 a.m. to 11:27 a.m.)
THE VIDEOGRAPHER: We are back on the record. The time is 11:28 a.m.
BY MS. MAHE:
Q. Mr. Anderson, have you answered all my questions today truthfully and accurately?
A. Yes.
Q. I don't have anything further at this time.
EXAMINATION
BY MR. GRAYBILL:
Q. All right. We have -- I have just a couple questions for you, Mr. Anderson.
MR. GRAYBILL: We're on Exhibit 49, correct?
THE COURT REPORTER: Yes.
MR. GRAYBILL: All right.
EXHIBIT:
(Deposition Exhibit 49 marked for identification.)
BY MR. GRAYBILL:
Q. Court reporter's handed you what's been marked as Exhibit 49. Do you remember you were asked earlier about a system for public reporting

and deficiencies called QCOR?
A. Mm-hmm.
Q. Is that a yes?
A. Yes.
Q. The document in front of you, Exhibit 49, does this appear to be a QCOR report?
A. Yes. I've never actually printed one out, but, yes.
Q. Okay. And if you look in about the middle of the document it says [As Read]: "Surveys for -- for FY 22."
Do you see that?
A. Yes.
Q. Okay. And then below there's a little table. Do you see that?
A. Yes.
Q. And the table, in the third from the left bottom row, says "COVID-19 Vaccination of Facility Staff."
Do you see that?
A. Yes.
Q. Okay. Do you have any reason to doubt whether or not this is a QCOR report?
A. No.
Q. Okay. The court reporter will now hand

you what's marked Exhibit 50.
EXHIBIT:
(Deposition Exhibit 50 marked for identification.)
BY MR. GRAYBILL:
Q. Does this appear to be a QCOR report?
A. Yes.
Q. I'd like to direct your attention to the same place in this document, a little table in the middle. Do you see that?
A. Yes.
Q. And it reads "COVID-19 Vaccination of Facility Staff" under "Deficiency Description."
A. Yes.
Q. Did I read that accurately?
A. Yes.
MR. GRAYBILL: No further questions.
EXAMINATION
BY MR. MEAD:
Q. So Carter, I -- staying with the documents you have in front of you --
A. Yes.
Q. -- the document marked No. 49 first, in that box labeled "Deficiency Description," does that deficiency description state the nature of

what would create the violation?
A. Not --
Q. Like the specifics of it.
A. No.
Q. And with document No. 50, does -- again, looking at that box labeled Deficiency Description, does that state with any specificity what would have led to the deficiency?
A. No.
Q. So it could have been a -- a failure to -- staff could have failed to have their masks worn in appropriate areas?
MS. MAHE: Object to the form.
MR. GRAYBILL: Join.
BY MR. MEAD:
Q. So let -- let me rephrase that. Is there a -- Is it fair to say that there is a large universe of facts that could have -- that could exist that would have led to that deficiency description?
MS. MAHE: Object to the form.
MR. GRAYBILL: Join.
A. There -- There's numerous things that could have created these types of citations. I'd have to read the report to actually know what they

-- what they were citing.
BY MR. MEAD:
Q. Thanks. And so now I want to go to the document that was marked Exhibit No. 38, which was QSO 22-09 revised April 5th.
A. Mm-hmm.
Q. And I believe this is -- Well, I can't remember exactly which one this refers to, but I want to turn to page 3 of that document.
So that first full paragraph, do you see the bolded sentence, "Facility Staff Vaccination Rates"?
A. Yes.
Q. Can you read the sentence that follows that one that starts "Non-compliance"?
A. "Non-compliance does not necessarily lead to termination, and facilities will generally be given opportunities to return to compliance."
Q. In your experience, does CMS generally afford facilities noncompliance opportunities to return to compliance prior to termination?
A. A hundred percent of the time.
Q. Okay. Thank you. And now I just want to turn to DPHHS's role in enforcing House Bill 702. Is it your understanding that DPHHS does not levy

any civil or criminal penalties related to House Bill 702?
MS. MAHE: Object to the form.
MR. GRAYBILL: Join.
A. Yes.
BY MR. MEAD:
Q. And when DPHHS surveys CMS-covered facilities, when you are conducting those survey activities, you check for whether -- Strike that.
So regarding the CMS vaccine mandate, you look to see whether the covered facility has granted medical or religious exemptions. Correct?
MS. MAHE: Object to the form.
MR. GRAYBILL: Join.
A. Yes.
BY MR. MEAD:
Q. Does DPHHS investigate as to the validity of a granted religious request?
MS. MAHE: Object to the form.
MR. GRAYBILL: Join.
A. No.
MR. MEAD: Okay. I think that is all the questions I have.
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EXAMINATION

BY MS. MAHE:

Q. I have a quick follow-up.

Exhibit 49 and 50, these are the QCOR reports.

A. Mm-hmm.

Q. In the deficiency description where it says "COVID-19 Vaccination of Facility Staff."

A. Mm-hmm.

Q. Do you see that part?

A. Yes.

Q. Is that a reference to the CMS vaccine mandate?

A. Yes.

MS. MAHE: I don't have any further questions.

MR. GRAYBILL: None from me.

MR. MEAD: We'll reserve any.

THE VIDEOGRAPHER: That concludes the deposition. The time is 11:34 a.m.

(Deposition concluded at 11:34 a.m. Deponent excused; signature reserved.)

DEPONENT'S CERTIFICATE

I, DPHHS 30(b)(6) DESIGNEE CARTER ANDERSON, the deponent in the foregoing deposition, DO HEREBY CERTIFY, that I have read the foregoing pages of typewritten material and that the same is, with any changes thereon made in ink on the corrections sheet, and signed by me, a full, true and correct transcript of my oral deposition given at the time and place hereinbefore mentioned.

DPHHS 30(b)(6) DESIGNEE CARTER ANDERSON, Deponent.

Subscribed and sworn to before me this day of , 2022.

PRINT NAME:
Notary Public, State of
Residing at:
My commission expires:

MRS - Montana Medical Association, et al. vs. Austin Knudsen, et al.

C E R T I F I C A T E

STATE OF MONTANA)
: ss
COUNTY OF MISSOULA)

I, Mary R. Sullivan, RMR, CRR, and Notary Public for the State of Montana, residing in Missoula, do hereby certify:

That I was duly authorized to and did swear in the witness and report the deposition of DPHHS 30(b)(6) DESIGNEE CARTER ANDERSON in the above-entitled cause; that the foregoing pages of this deposition constitute a true and accurate transcription of my stenotype notes of the testimony of said witness, all done to the best of my skill and ability; that the reading and signing of the deposition by the witness have been expressly reserved.

I further certify that I am not an attorney nor counsel of any of the parties, nor a relative or employee of any attorney or counsel connected with the action, nor financially interested in the action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal on August 21, 2022.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MONTANA
MISSOULA DIVISION

MONTANA MEDICAL ASSOCIATION, et al., Plaintiffs, and MONTANA NURSES ASSOCIATION, Plaintiff-Intervenor, vs. AUSTIN KNUDSEN, et al., Defendants.	CV 21–108–M–DWM OPINION and ORDER

This case challenges parts of Mont. Code Ann. §§ 49–2–312 and 49–2–313. In short, the former statute prohibits persons and entities—with limited exceptions—from withholding goods, services, or employment "based on the person's vaccination status or whether the person has an immunity passport."[1] The

[1] The timing of the law's enactment suggests it is meant to address COVID-19 vaccination mandates or concerns. However, "vaccine" has a broader meaning: "a preparation that is used to stimulate the body's immune response against diseases. Vaccines are usually administered through needle injections, but some can be administered by mouth or sprayed into the nose." CTR. FOR DISEASE CONTROL, Definition of Terms, http://www.cdc.gov/healthyschools/bam/diseases/vaccine-basics.htm (last visited Mar. 17, 2022); *see also* Mont. Code Ann. § 20–5–402

latter statute then exempts certain facilities from § 49–2–312, such as licensed nursing homes, long-term care facilities, or assisted living facilities (collectively, "Exempted Facilities"). In light of this statutory scheme, multiple parties sued Austin Knudsen, in his official capacity as the Montana Attorney General, and Laurie Esau, in her official capacity as the Montana Commissioner of Labor and Industry (collectively "Defendants"). The plaintiffs include multiple private physician offices, the Montana Medical Association, and multiple individuals. The Montana Nurses Association ("the Nurses") appeared in this case as a plaintiff-intervenor, (the plaintiffs and the Nurses are collectively referred to as "Plaintiffs"). Plaintiffs now seek to preliminarily enjoin enforcement of §§ 49–2–312 and 49–2–313. A motion hearing and argument occurred on March 3, 2022. For the reasons stated below, the motion for a preliminary injunction is granted in part and denied in part.

BACKGROUND

I. Montana's Statutory Scheme

In early 2021, the Montana Legislature passed Montana House Bill 702. (Doc. 14 at ¶ 3.) House Bill 702 is codified at §§ 49–2–312 and 49–2–313. Section 49–2–312 is entitled "Discrimination based on vaccination status or

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("'Immunization' means induction of a state of resistance to a disease through administration of an immunizing agent.").

possession of immunity passport prohibited – definitions." In sum, it makes it "an unlawful discriminatory practice" for any person, governmental entities, or public accommodation to deny benefits or services or condition such benefits or services "based on a person's vaccination status or whether the person has an immunity passport." § 49–2–312(1). An "immunity passport" is "a document, digital record, or software application indicating that a person is immune to a disease, either through vaccination or infection and recovery" while "'vaccination status' means an indication of whether a person has received one or more doses of a vaccine." § 49–2–312(5). The statute specifically exempts schools from its requirements, and it permits "health care facility[ies], as defined in 50–5–101" to ask an employee or volunteer for their vaccination status, but the employee or volunteer need not answer such inquiry. § 49–2–312(2), (3). For the purposes of § 49–2–312, a "health care facility" is a term that "*does not include* offices of private physicians, dentists, or other physical or mental health care workers regulated under Title 37, including licensed addiction counselors." § 50–5–101(26) (emphasis added). A non-answer to a vaccine inquiry may be treated as an indication that an employee or volunteer is not vaccinated, and that indication may inform an employer's decision to implement reasonable accommodations. § 49–2–312(3). The statute also prohibits private employers and others from imposing the

requirement of any vaccine that is authorized under an "emergency use" designation. § 49–2–312(4).

The Exempted Facilities are included in § 49–2–313. Exempted Facilities are "exempt from compliance with 49–2–312 during any period of time that compliance with 49–2–312 would result in a violation of regulations or guidance issued by the centers for medicare and medicaid services or the centers for disease control and prevention." § 49–2–313.

II. Federal Regulation

The Centers for Medicare and Medicaid Services ("CMS") is the agency responsible for establishing health and safety standards with which healthcare facilities must comply in order to receive federal Medicare and Medicaid funding.[2] 86 Fed. Reg. 61,555, 61,556 (Nov. 5, 2021). "CMS contracts . . . with State Survey Agencies to conduct surveys (inspections) for these oversight and compliance determinations." (Doc. 51-1 at ¶ 4.) These surveys are unannounced, and they include investigations of the facility—including a review of books and records—and interviews of staff and patients. (*Id.* ¶ 8.) The findings from state surveys are certified to CMS, and when a facility is found to be out of substantial compliance with

[2] At least one Plaintiff, Providence Health and Services, "receives a majority of its reimbursement through CMS." (Doc. 45 at ¶ 7.)

one or more of the applicable federal regulations, a "Statement of Deficiencies" issues detailing the findings of non-compliance. (*Id.* ¶ 10.) The noncompliant facility then has ten days to respond with a "Plan of Correction" for each deficiency, and if the facility fails to come into compliance with the relevant CMS regulation, CMS determines the appropriate penalty. (*Id.*)

In November 2021, the CMS issued an interim final rule entitled "Medicare and Medicaid Programs; Omnibus COVID-19 Health Care Staff Vaccination" ("Interim Final Rule"). The Interim Final Rule "requires most Medicare- and Medicaid-certified providers and suppliers to ensure that their staff are fully vaccinated for COVID-19." 86 Fed. Reg. at 61,568.[3] The Interim Final Rule notes that employers must comply with federal anti-discrimination and civil rights protections, and they must "provide appropriate accommodations, to the extent required by Federal law, for employees who request and receive exemption from vaccination because of a disability, medical condition, or sincerely held religious belief, practice, or

[3] The Interim Final Rule "directly applies only to the Medicare- and Medicaid-certified providers and suppliers [identified in the Rule]. It does not directly apply to other health care entities, such as physician offices, that are not regulated by CMS." 86 Fed. Reg. at 61,556.

observance." *Id.* at 61,568–69. Two groups of states[4] challenged the Interim Final Rule, and district courts in Louisiana and Missouri enjoined it. *Biden v. Missouri*, 142 S. Ct. 647, 651 (2022) (per curiam). The Fifth and Eighth Circuits denied the government's request for a stay of the preliminary injunction, and the government successfully appealed the denial of the stay to the Supreme Court. *Id.*

The Supreme Court determined that the Secretary of Health and Human Services did not exceed his authority in promulgating the Interim Final Rule and determined that the Secretary issued the Interim Final Rule based on his "determin[ation] that a COVID-19 vaccine mandate will substantially reduce the likelihood that healthcare workers will contract the virus and transmit it to their patients." *Id.* at 652. The Court also cited "conditions of participation" that are routinely imposed on healthcare workers. *See id.* at 653. The Court noted that "[v]accination requirements are a common feature of the provision of healthcare in America: Healthcare workers are ordinarily required to be vaccinated for diseases such as hepatitis B, influenza, and measles, mumps, or rubella." *Id.*

Subsequently, on January 14, 2022, CMS issued a memorandum titled "Guidance for the Interim Final Rule" ("the Guidance"). (Doc. 44-1.) The initial

[4] The Montana Attorney General joined the litigation brought by Louisiana, arguing Montana had the same or a similar interest. (*See* Doc. 27 (citing *Louisiana & Montana, et. al. v. Becerra*, No. 3:21-CV-0370).)

page of the memorandum explicitly states that the "guidance in th[e] memorandum specifically applies" to a number of states, including Montana. (*Id.* at 1.) The Guidance establishes benchmarks for compliance on 30-day, 60-day, and 90-day intervals. (*Id.* at 3–4.) It also states the penalties for non-compliance. Given that the Guidance was issued on January 14, 2022, the 30-day deadline for compliance was February 13, 2022. To be in compliance with the 30-day benchmark, facilities must demonstrate two things: (1) policies and procedures are in place "for ensuring all facility staff, regardless of clinical responsibility or patient or resident contact are vaccinated for COVID-19" and (2) "100% of staff have received at least one dose of COVID-19 vaccine, or have a pending request for, or have been granted qualifying exemption, or identified as having a temporary delay as recommended by the CDC." (*Id.* at 3.) If either the first or second requirement is not met, the facility is not in compliance with the Interim Final Rule. (*Id.*) If a facility fails to meet the 30-day benchmark—or the 60- or 90-day benchmarks—the facility is subject to "enforcement actions" that include "plans of correction, civil monetary penalties, denial of payment, [or] termination" depending on the extent of the violation and the type of facility. (*Id.*)

In the week after the Guidance issued, surveys were conducted on seven facilities in Montana: six long-term care facilities and one home health agency. (Doc. 51-1 at ¶ 11.) Five of these facilities were found to be compliant with the

Interim Final Rule, while two of the facilities were noncompliant with respect to vaccination deficiencies. (*Id.* ¶ 13.)

III. Procedural Posture

Previously, Defendants filed a motion to dismiss Plaintiffs' claims, and that motion was mostly denied. (*See* Doc. 35.) Subsequently, Plaintiffs filed amended complaints that are materially the same as the previous complaints, but they omit the claims that were dismissed and add an additional claim ("Count VIII"). (Docs. 37, 38.) Count VIII alleges that § 49–2–312 is preempted by 42 C.F.R. Part 482, of which the Interim Final Rule is part, so that § 49–2–312 is invalid and unenforceable as a consequence of the Supremacy Clause of the United States Constitution. (*See* Doc. 37 at 23–25; *see also* Doc. 38 at 23–26.)

Plaintiffs now seek relief by joint motion for a preliminary injunction. (Doc. 42.) They argue that a preliminary injunction of §§ 49–2–312 and 49–2–313 is warranted because the Interim Final Rule preempts § 49–2–312. Plaintiffs also argue that an injunction is appropriate because both statutes violate the Equal Protection Clause. However, Plaintiffs minimize their equal protection argument in their briefing. In response, Defendants insist that the Interim Final Rule is invalid, and, like ships passing in the night, they devote the majority of their briefing to the equal protection argument; they are correct that it has not been adequately briefed by Plaintiffs.

Before the March 3, 2022 hearing, the Court provided notice that it was considering consolidating the preliminary injunction hearing with a trial on the merits on Claim VIII, consistent with Federal Rule of Civil Procedure 65(a)(2). (Doc. 49.) Defendants objected and stated they opposed any such consolidation, (Doc. 50), reiterating that position at the March 3 hearing.

ANALYSIS

There are multiple issues encompassed in Plaintiffs' request for an injunction. First, it is unclear whether Plaintiffs seek to enjoin both §§ 49–2–312 and 49–2–313, or just the former. Second is the problem of whether the applicable legal standard is the preliminary injunction standard or whether the higher standard for permanent injunctions applies. Third is the question of whether Plaintiffs have carried their burden under the applicable injunction standard. And finally, assuming Plaintiffs can satisfy the relevant burden, what the proper scope of any injunction should be. For the reasons explained below, Plaintiffs' motion is, for the most part, granted. The injunction is limited only to the provisions of § 49–2–312, and the preliminary injunction standard is determinative. Under that standard, Plaintiffs have carried their burden as it relates only to Claim VIII. Accordingly, injunctive relief that is limited to Montana health care facilities and individual practitioners and clinics subject to the Interim Final Rule is granted, and that relief is temporally limited by the duration of the Interim Final Rule.

I. Section 49–2–313

It is unclear whether Plaintiffs want to enjoin § 49–2–313 in addition to § 49–2–312. (*Compare* Doc. 42 at 2 (moving "for a preliminary injunction prohibiting enforcement of House Bill 702, codified as Montana Code Annotated § 49–2–312 and § 49–2–313 . . .") *with* (Doc. 43 at 25 ("Plaintiffs respectfully ask the Court to . . . enjoin defendants from enforcing MCA § 49–2–312 . . .").) In any event, § 49–2–313 is not enjoined because it is not preempted by the Interim Final Rule. The plain text of the Montana statute exempts compliance with § 49–2–312 when such compliance would contradict "regulations or guidance issued by the centers for medicare and medicaid services or the centers for disease control and prevention." § 49–2–313.

Nor can § 49–2–313 be enjoined at this point on the basis that Plaintiffs are likely to succeed on the merits of their equal protection claim. Plaintiffs did not make any arguments concerning their equal protection claims as those claims relate to the preliminary injunction factors of irreparable harm and the public interest, and they made only passing reference to the equal protection claims as they relate to the balance of the equities. As a result, to the extent Plaintiffs seek an injunction of § 49–2–313, that request is denied.

II. Section 49–2–312

A. Applicable Standard

In addressing § 49–2–312, the threshold question is whether the preliminary injunction standard applies to Plaintiffs' request, or whether the more onerous permanent injunction standard applies. The former standard governs here.

To succeed on a motion for a preliminary injunction, a plaintiff "must establish that he is likely to succeed on the merits, that he is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in his favor, and that an injunction is in the public interest." *Winter v. Nat. Res. Def. Council*, 555 U.S. 7, 20 (2008). Similarly, "[t]o be entitled to a permanent injunction, a plaintiff must demonstrate: (1) actual success on the merits; (2) that it has suffered an irreparable injury; (3) that remedies at law are inadequate; (4) that the balance of hardships justify a remedy in equity; and (5) that the public interest would not be disserved by a permanent injunction." *Edmo v. Corizon, Inc.*, 935 F.3d 757, 784 (9th Cir. 2019) (quotation marks omitted). The standard stated in *Edmo* is applicable when the court "advance[s] the trial on the merits and consolidate[s] it with the hearing" on a motion for preliminary injunction. Fed. R. Civ. P. 65(a)(2). Where such consolidation is considered, "the court should provide the parties with clear and unambiguous notice of the intended consolidation either before the hearing commences or at a time which will afford the parties a full opportunity to present their respective cases." *Air Line Pilots Ass'n, Int'l v. Alaska Airlines, Inc.*, 898 F.2d 1393, 1397 (9th Cir. 1990) (quotation

marks and alteration omitted). The plain text of Rule 65(a)(2) makes clear that any consolidation may occur "[b]efore or after beginning the hearing on a motion for a preliminary injunction."

After the Court issued notice that it was considering consolidation, Plaintiffs argued at the March 3 hearing that consolidating the preliminary injunction hearing with a trial on the merits of Claim VIII was appropriate. Defendants, on the other hand, restated their objection to proceeding on the merits. Defendants' objection is based in large part on timing. (*See* Doc. 50 at 3.) While the fact that the Court indicated it was *considering* consolidation the day before the preliminary injunction hearing was entirely permissible under the plain language of Rule 65(a)(2), following argument and after reviewing the limited record, consolidation on the merits is not warranted. Accordingly, the preliminary injunction standard based on the familiar *Winter* factors applies.

B. Preliminary Injunction

Under the *Winter* evaluation, each factor tips in Plaintiffs' favor. Because of the doctrine of federal preemption, Plaintiffs are likely to succeed on the merits of Claim VIII. They also demonstrate they are likely to suffer irreparable harm in the absence of preliminary relief. Finally, the balance of the equities and the public interest both inure to Plaintiffs. As for the scope of the injunction, Defendants are

correct that it should be narrow in duration and substance, so § 49–2–312 is enjoined only so long as the Interim Final Rule remains in effect.

1. Likelihood of Success on the Merits

The doctrine of preemption flows from the Supremacy Clause of the United States Constitution, which identifies the Constitution and "the Laws of the United States" as "the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding." U.S. Const. art. VI cl. 2. There are three recognized ways in which a federal statute[5] might preempt state law: "First, Congress can adopt express language defining the existence and scope of pre-emption. Second, state law is pre-empted where Congress creates a scheme of federal regulation so pervasive as to leave no room for supplementary state regulation. And third, state law is pre-empted to the extent that it actually conflicts with federal law." *Gade v. Nat'l Solid Wastes Mgmt. Ass'n*, 505 U.S. 88, 109 (1992) (Kennedy, J., concurring in part) (quotation marks omitted).

Under the third approach, often referred to as "conflict preemption," state law must give way to federal law "where it is impossible for a private party to comply with both state and federal requirements, or where state law stands as an

[5] Federal regulations may preempt state law as well. *Hillsborough Cnty. v. Auto. Med. Labs., Inc.*, 471 U.S. 707, 713 (1985).

obstacle to the accomplishment and execution of the full purposes and objectives of Congress." *English v. Gen. Elec. Co.*, 496 U.S. 72, 79 (1990) (quotation marks and citations omitted). "[T]he purpose of Congress is the ultimate touchstone in every pre-emption case." *Altria Group, Inc. v. Good*, 555 U.S. 70, 76 (2008) (quotation marks omitted). Thus, the preemption analysis begins "with the assumption that the historic police powers of the States are not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress." *Id.* at 77 (quoting *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947)) (alteration omitted).

To begin with, Plaintiffs argue that they are likely to succeed on the merits of Claim VIII based on federal preemption, and express the view that their claims rooted in equal protection are also impervious. (*See* Doc. 43 at 15.) But, as noted above, they barely addressed any equal protection argument in the briefing. Given that the focus of Plaintiffs' motion is preemption, in conjunction with the canon of constitutional avoidance, *see, e.g.*, *Kim Ho Ma v. Ashcroft*, 257 F.3d 1092, 1106 (9th Cir. 2001), Plaintiffs' equal protection claim is not considered in resolving the present motion.

Plaintiffs allege multiple preemption claims, but the only one relevant here is Claim VIII: that § 49–2–312 is preempted by the Interim Final Rule. The language of the Interim Final Rule makes it likely that Plaintiffs will succeed in

showing that it is "impossible for a private party to comply with both [the Montana] and federal requirements." *See English*, 496 U.S. at 79. For example, the Guidance requires that, to comply with the Interim Final Rule, facilities must demonstrate that all staff have received a vaccine for COVID-19 or have applied for or received a qualifying exemption. On the other hand, § 49–2–312(3) prohibits health care facilities from meaningfully inquiring into the vaccination status of their employees. While the statute permits health care facilities to "ask[] an employee to volunteer the employee's vaccination or immunization status for the purpose of determining whether the health care facility should implement reasonable accommodation measures," it does not require that the employee respond. *See* § 49–2–312(3)(b)(i). Basically, no meaningful answer is required. Consequently, even though the statute permits health care facilities to consider an employee's refusal to answer about his or her vaccination status as an indication that the employee is unvaccinated, that "consideration" is not a suitable substitute for the data required for a health care facility to prove compliance with the Interim Final Rule. Without such quantifiable data it will be nearly impossible for facilities to demonstrate compliance during the unannounced surveys that investigate the facilities' records and interview staff. (*See* Doc. 51-1 at ¶ 8.)

Moreover, the Supreme Court in the recent *Biden* case noted that the Interim Final Rule was implemented because it was "necessary to promote and protect

patient health and safety in the face of the ongoing pandemic." 142 S. Ct. at 652. The "clear and manifest purpose" of the Interim Final Rule is public health. By contrast, Defendants previously emphasized at the motion to dismiss stage an argument that Montana's statutory scheme was enacted to promote an individual's right to privacy, placing the individual's interest on a pedestal of importance exceeding public health and safety in a pandemic. While these two purposes are not inherently irreconcilable, the current codification of the state's attempt to elevate individual privacy rights above all other rights is likely to be superseded by the clear purpose evinced in the Interim Final Rule. *Cf. Altria Group, Inc.*, 555 U.S. at 76 (emphasizing the importance of Congress's intent).

Ultimately, given the clear preemption language in the Guidance, Plaintiffs have demonstrated they are likely to succeed on the merits of Claim VIII as it relates to § 49–2–312.

2. Irreparable Harm

Plaintiffs must establish that the prospect of irreparable harm is not merely possible but that it is "likely." *Winter*, 555 U.S. at 22. Monetary injury alone is not usually considered "irreparable" in the context of an injunction. *See L.A. Mem. Coliseum Comm'n v. Nat'l Football League*, 634 F.2d 1197, 1202 (9th Cir. 1980). A significant concern is whether the moving party has an adequate remedy at law. *Morales v. Trans World Airlines, Inc.*, 504 U.S. 374, 381 (1992). "When

enforcement actions are imminent—and at least when repetitive penalties attach to continuing or repeated violations and the moving party lacks the realistic option of violating the law once and raising its federal defenses—there is no adequate remedy at law." *Id.* A constitutional violation alone can suffice to show irreparable harm, as can the loss of business goodwill and reputation. *See Am. Trucking Ass'ns, Inc. v. City of L.A.*, 559 F.3d 1046, 1057 (9th Cir. 2009).

American Trucking is instructive. In that case, the plaintiffs challenged mandatory "Concession Agreements" implemented by California on the basis that the Concession Agreements improperly attempted to regulate "the price, route, or service of any motor carrier" in violation of the Federal Aviation Administration Authorization Act. *Id.* at 1048. The plaintiff sought to preliminarily enjoin the Concession Agreements, a request the district court denied largely based on its finding that the plaintiffs failed to establish irreparable harm. *Id.* The Ninth Circuit reversed the district court on the basis that "a very real penalty attaches to the motor carriers regardless of how they proceed. That is an imminent harm." *Id.* at 1058. The court emphasized that the plaintiff could refuse to sign "the likely unconstitutional Concession agreements" and likely face a loss of business goodwill, or it could sign the agreements, in which case "its plight is not much better" for two reasons. First, the plaintiff "will have been forced to sign an agreement to conditions which are likely unconstitutional because they are

preempted." *Id.* Second, the plaintiff "will be forced to incur such large costs which, if it manages to survive those, will disrupt and change the whole nature of its business in ways that most likely cannot be compensated with damages alone." *Id.* Essentially, the Ninth Circuit determined that "motor carriers should not be required to adhere to the various unconstitutional provisions in the [Concession] agreements, and are likely to suffer irrevocably if forced to do that or give up their business." *Id.* at 1059.

Here, Plaintiffs argue that the "impossible choice" of complying with either the Interim Final Rule or § 49–2–312, but not both, creates irreparable harm. (*See* Doc. 43 at 16.) Plaintiffs argue they will sustain additional harm absent a preliminary injunction, including potential termination from the Medicaid and Medicare programs and the resulting loss of healthcare capabilities to people in Montana. Defendants respond that Plaintiffs' alleged harm is both too speculative and not "irreparable." Specifically, Defendants emphasize that, if the Interim Final Rule preempts § 49–2–312, "the [] Rule acts as an affirmative defense to any action taken by the State pursuant to [the statute]—a defense that may be raised throughout the administrative process before subjecting Plaintiffs to liability." (Doc. 51 at 25 (citing *Whole Woman's Health v. Jackson*, 142 S. Ct. 522, 530 n.1 (2021).) Defendants also argue that there is no evidence to show that compliance with the Interim Final Rule will result in irreparable harm. (*Id.* at 28–29.) That

argument seems to be that if charged with wrongdoing, the Plaintiffs would not be liable because their preemption argument is probably well-taken.

Plaintiffs demonstrate that irreparable harm is likely to occur absent injunctive relief. Under the Guidance's 30-, 60-, and 90-day benchmarks for compliance with the Interim Final Rule, health care facilities that fail to demonstrate compliance may be subject to "enforcement action," such as civil monetary penalties. While Defendants correctly note monetary penalties do not satisfy the irreparable harm showing on their own, *see L.A. Mem. Coliseum Comm'n*, 634 F.2d at 1202, like the plaintiff in *American Trucking*, Plaintiffs here face more than mere monetary penalties. The failure to comply with the Interim Final Rule could result in a range of penalties, including termination of participation in Medicaid and Medicare. (*See* Doc. 43 at 17.) In addition, the Guidance specifically targets Montana as a state to which the Interim Final Rule and the Guidance benchmarks apply. (Doc. 44-1 at 1.) That callout increases the likelihood that penalties will be enforced.

Moreover, Defendants submitted a letter from the Montana Health Network that describes the "difficult position" in which Montana health care facilities find themselves given the contradiction between § 49–2–312 and the Interim Final Rule. (Doc. 51-2 at 5.) This letter emphasizes the Hobson's choice Montana's health care facilities find themselves facing, similar to the choice in *American*

Trucking. On one hand, facilities can comply with § 49–2–312 and violate the Interim Final Rule, which requires them to "risk being decertified by the [CMS] program." (Doc. 51-2 at 4.) But, if facilities ignore the Interim Final Rule "and continue billing Medicare and Medicaid, they are committing fraud against the program, which could result in steep fines and jail time for some of its employees." (*Id.*) On the other hand, if health care facilities comply with the Interim Final Rule, the Montana Health Network avers such compliance would naturally result in the loss of goodwill for health care facilities in Montana because compliance with the Interim Final Rule will effectively shutter rural health care facilities and "[b]ecause of this, many will forego care because of the inconvenience or impossibility of travel and added costs associated with it." (*Id.* at 5.)

Defendants' suggested affirmative defense argument likewise fails. First, *Whole Woman's Health* is inapposite to the argument that the Interim Final Rule could defeat an action before the Montana Human Rights Commission. In noting that "applicable federal constitutional defenses always stand fully available when properly asserted," the Supreme Court presumed that the body reviewing the claim would have the power to adjudicate constitutional questions. *See Whole Woman's Health*, 142 S. Ct. at 530 n.1. The Montana Constitution states that constitutional questions must only be decided by a judicial body, not an administrative body, and so the federal preemption defense would necessarily fail if raised before the

Montana Human Rights Commission. *See* Mont. Const. Art. III, § 1. Additionally, while Defendants are correct that the mere cost of litigation is not an irreparable harm, (Doc. 51 at 27 (citing *FTC v. Standard Oil Co.*, 449 U.S. 232, 244 (1980)), as explained above, the irreparable harm here stretches beyond the "mere cost of litigation." Unlike the plaintiffs in *Standard Oil*, Plaintiffs face the harms described above: they will be penalized for complying with either the Interim Final Rule or § 49–2–312. Plaintiffs cannot be forced to choose between "two roads diverging in a wood" when they face dire consequences that could make "all the difference."

The record shows that "a very real penalty attaches to the [health care facilities] regardless of how they proceed. That is an imminent harm." *Am. Trucking*, 559 F.3d at 1058. The imminence of this harm is further demonstrated by the fact that CMS compliance surveys are presently occurring and noncompliance is being documented. (Doc. 51-1 at ¶ 1; *see also* Doc. 51-2 at 5 ("[W]e cannot defy the mandate by continuing to employ [unvaccinated] workers without punitive action being taken by the CMS.")) The harm of non-compliance is also likely to be irreparable. If facilities comply with § 49–2–312, they risk termination from the CMS program. (Doc. 45 at ¶¶ 3, 7; Doc. 51-1 at ¶ 10; Doc. 51-2 at 4.) And given that Plaintiffs have shown they are likely to succeed on the merits of their preemption claim, ignoring the Interim Final Rule means complying

with a statute that is "likely unconstitutional because [it is] preempted." *Am. Trucking*, 559 F.3d at 1058. This kind of constitutional injury shows a likelihood of irreparable harm. Plaintiffs have therefore shown irreparable harm will result absent injunctive relief.

3. Balance of the Equities and the Public Interest

Where the government is the opposing party, the third and fourth factors of the preliminary injunction inquiry merge, so that the balance of the equities and the public interest are considered together. *See Nken v. Holder*, 556 U.S. 418, 435 (2009) (so stating in the context of a stay). In balancing the equities, considerations include whether "the impact of an injunction reaches beyond the parties, carrying with it a potential for public consequences." *Boardman v. Pac. Seafood Grp.*, 822 F.3d 1011, 1023–24 (9th Cir. 2016) (quotation marks omitted). While "[t]he public interest may be declared in the form of a statute," *Golden Gate Rest. Ass'n v. City & Cnty. of S.F.*, 512 F.3d 1112, 1126 (9th Cir. 2008), "it would not be equitable or in the public's interest to allow the state to violate the requirements of federal law, especially when there are no adequate remedies available," *Ariz. Dream Coal. v. Brewer*, 757 F.3d 1053, 1069 (9th Cir. 2014) (quotation marks and alteration omitted).

In addition, Montana has an interest in administering its police power to "protect the public health and the public safety." *Jacobson v. Massachusetts*, 197

U.S. 11, 25 (1905). But the State's police power is circumscribed by principles of federalism, and "[t]he mode or manner in which those results are to be accomplished is within the discretion of the state, subject . . . to the condition that no rule prescribed by a state, nor any regulation adopted by a local governmental agency acting under the sanction of state legislation, shall contravene the Constitution of the United States." *Id.* There is also a public interest in a functioning society. "Real liberty for all could not exist under the operation of a principle which recognizes the right of each individual to use his own, whether in respect of his person or his property, regardless of the injury that may be done to others." *Id.* at 26.

Here, as Defendants argue, the codification of House Bill 702 in §§ 49–2–312 and 49–2–313 in some way expresses the public's interest because the legislature passed the law. *See Golden Gate*, 512 F.3d at 1126. But, as Plaintiffs point out, it is inherently against the public interest to allow a state statute to violate federal law, *see Ariz. Dream Coal.*, 757 F.3d at 1069, and here Plaintiffs have shown that § 49–2–312 is likely a violation of federal law based on the preemption question discussed above.

Each party also emphasizes the purported consequences to public health should the adverse party's requested relief be granted. According to Plaintiffs, the public is best served by enjoining the law because health care facilities would then

be able to ensure that all staff are vaccinated (against COVID-19) or have approved accommodation requests. According to Defendants, the public would be best served by allowing the statute to actively remain on the books, to protect Montana workers from the fear of losing their jobs, and to protect individual choice, even in a pandemic. Given that the police power of the State should operate to "protect the public health and the public safety" and also submit to federal law in the event of conflict, *Jacobson*, 197 U.S. at 25, the scales tip in favor of Plaintiffs' more persuasive argument concerning public health. As the Supreme Court in *Jacobson* recognized, certain restraints on an individual are occasionally reasonable to promote the common good and actualize the public interest in a civil society. Therefore, while there is undeniably tension between the Interim Final Rule and § 49–2–312, principles of federalism, including the Supremacy Clause, elevate the interests expressed in the Interim Final Rule to favor the Plaintiffs' argument.

III. Scope of the Injunction

"Crafting a preliminary injunction is an exercise of discretion and judgment, often dependent as much on the equities of a given case as the substance of the legal issues it presents." *Trump v. Int'l Refugee Assistance Project*, 137 S. Ct. 2080, 2087 (2017). A preliminary injunction should be crafted to "meet the exigencies of the particular case." *Id.* (quotation marks omitted). With these

considerations in mind, the preliminary injunction here is limited in application to the law set forth in § 49–2–312, and it will only be in place so long as the Interim Final Rule remains in effect. Because all Montana facilities receiving CMS funds must comply with the Interim Final Rule, the enforcement of § 49–2–312 is enjoined against all such facilities.

CONCLUSION

For the reasons stated above, a limited preliminary injunction of § 49–2–312 is warranted. Accordingly,

IT IS ORDERED that the joint motion seeking a preliminary injunction, (Doc. 42), is GRANTED IN PART and DENIED IN PART. It is GRANTED in that enforcement of § 49–2–312 as it relates to the COVID-19 vaccine is enjoined from enforcement against all Montana health care facilities and individual practitioners and clinics subject to the Interim Final Rule for so long as the Interim Final Rule remains in effect. It is DENIED in all other respects.

IT IS FURTHER ORDERED that the parties shall notify the Court within ten days of any changes to or the expiration of the Interim Final Rule.

DATED this 18th day of March, 2022.

10:30 A.M

Donald W. Molloy, District Judge
United States District Court

Raph Graybill
GRAYBILL LAW FIRM, PC
300 4th Street North
Great Falls, MT 59403
Phone: (406) 452-8566
Email: rgraybill@silverstatelaw.net

Attorney for Plaintiff-Intervenor

**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MONTANA
MISSOULA DIVISION**

MONTANA MEDICAL ASSOCIATION, et al., Plaintiffs, and MONTANA NURSES ASSOCIATION, Plaintiff-Intervenor v. AUSTIN KNUDSEN, Montana Attorney General, and LAURIE ESAU, Montana Commissioner of Labor and Industry, Defendants.	Cause No. 9:21-cv-108 Hon. Donald W. Molloy **PLAINTIFF-INTERVENOR'S RESPONSE TO MOTION TO DISMISS**

Plaintiff-Intervenor the Montana Nurses Association ("MNA" or "the Nurses") satisfies all the elements of constitutional standing and the requirements for an association to litigate on behalf of its members. The State's arguments for

dismissal either overlook the actual contents of the Complaint, misstate the controlling law, or presume the ultimate merits questions of the case. The motion should be denied.

STANDARD

Taken together, Rules 8 and 12 require a plaintiff's allegations to be clear and plausible—not loquacious. *See Ashcroft v. Iqbal*, 556 U.S. 662, 678, 129 S. Ct. 1937, 1949, 173 L. Ed. 2d 868 (2009) ("the pleading standard Rule 8 announces does not require 'detailed factual allegations,' but it demands more than an unadorned, the-defendant-unlawfully-harmed-me accusation." (citing *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 555 (2007)).

To establish the elements of constitutional standing, "[a]t the pleading stage, [the plaintiff] is merely required to allege facts demonstrating each element." *All. for Wild Rockies v. Savage*, No. CV 18-67-M-DWM, 2018 WL 10731198, at *4 (D. Mont. Dec. 20, 2018) (citing *Spokeo, Inc. v. Robins*, 578 U.S. 330, 337 (2016)).

A defendant's desire for more information may be satisfied through a motion for a more definite statement under Rule 12(e), or through discovery and the development of a case in the normal course. But a defendant's mere dissatisfaction with a plaintiffs' legal arguments in the complaint, or with the granularity of a plaintiff's factual allegations, rarely sounds in dismissal under Rule 12(b)(1) or

12(b)(6) if the allegations exist, are clear, and reach a threshold level of plausibility. *See Twombly*, 550 U.S. at 555 ("Factual allegations must be enough to raise a right to relief above the speculative level . . . on the assumption that all the allegations in the complaint are true (even if doubtful in fact)." (cleaned up)); *All. for Wild Rockies*, 2018 WL 10731198, at *4-5 (defendant's disagreement with allegations not enough to dismiss plaintiff's complaint on standing grounds).

ARGUMENT

I. The Nurses incorporate by reference responsive arguments made by the Doctors in response to the State's Second Motion to Dismiss.

Consistent with the Court's order, Doc. 26, the Nurses hereby incorporate by reference the arguments made by the Montana Medical Association, et al. ("the Doctors"), in response to the State's Second Motion to Dismiss. *See* Doc. 23. Of note when extending the Doctors' arguments to MNA, MNA's members include both employees and employers (typically, APRNs who own and manage their own practices). Doc. 11-1 ("MNA Complaint" or "Complaint"), ¶ 15. This arises from MNA's dual role as both a professional association and a labor union.

II. The Nurses have constitutional and associational standing.

The requirements for constitutional standing are well-established and the Nurses satisfy them. In their complaint, the Nurses allege that the operation of HB702 invades their statutory and constitutional rights 1) to manage or to enjoy a

safe workplace, 2) to be free from discrimination, and 3) to equal protection, for example. *E.g.*, Complaint, ¶¶ 20; 23-78. *See Babbitt v. United Farm Workers Nat. Union*, 442 U.S. 289, 298 (1979) ("A plaintiff who challenges a statute must demonstrate a realistic danger of sustaining a direct injury as a result of the statute's operation or enforcement." (emphasis added)). The Nurses trace the invasion of their rights to HB702, for which Defendants are responsible. *E.g.*, Complaint, ¶¶ 21-22; 26-30; 35-37; 41-44; 49; 52-54; 57-60; 63-68; 72-76. A favorable decision by the Court enjoining HB702 in the limited circumstances sought by the Nurses would redress HB702's invasion of their rights. *Id.* Just as in *Alliance for Wild Rockies*, "Defendants' disagreement with the allegations in the . . . Complaint does not undercut [MNA]'s assertion of [constitutional standing] at this stage of the proceeding." 2018 WL 10731198, at *5. As vigorously as the State disputes the Nurses' allegations on their merits, the allegations giving rise to standing are plainly contained within the Complaint and do not warrant dismissal under Rule 12.

The Nurses satisfy the requirements for associational standing as well. "An association . . . has standing if (1) its individual members would have standing in their own right, (2) the interests at stake in the litigation are germane to the organization's purposes, and (3) the case may be litigated without participation by individual members of the association." *Airline Serv. Providers Ass'n v. Los*

Angeles World Airports, 873 F.3d 1074, 1078 (9th Cir. 2017) (citing *Friends of the Earth, Inc. v. Laidlaw Envtl. Servs. (TOC), Inc.*, 528 U.S. 167, 181 (2000)).

The Nurses satisfy these requirements in the Complaint. Whether a plaintiff has sufficiently alleged jurisdiction "is ascertained by looking at the entire complaint, not merely to what purports to be the jurisdictional statement." 5 Charles Alan Wright & Arthur R. Miller, Federal Practice and Procedure § 1206 (4th ed. 2021). Throughout, the Complaint clearly and plausibly alleges that individual nurses will suffer the invasion of legally protected interests because of the operation of HB702. *E.g.*, Complaint ¶¶ 15-20; 29-30; 36-37; 42-43; 48; 52-53; 58-59; 63-68; 73-76. It is both clearly stated and beyond serious dispute that workplace safety for nurses is germane to the purposes of a professional organization for nurses. Complaint, ¶ 12 (MNA "advocates to protect the practice of professional nursing and to protect the public in all areas of healthcare. MNA has an established focus on workplace environment issues for nurses in Montana, especially issues related to workplace safety"). And the State has "identified no reason that the [association]'s members must participate individually in this case." *Airline Serv. Providers Ass'n*, 873 F.3d at 1079 (holding that association satisfied third prong for associational standing where adverse party failed to contest it).

There is no requirement that the Nurses name an individual member to establish associational standing. In arguing otherwise, the State appears to

misapprehend *Summers v. Earth Island Institute*, 555 U.S. 488 (2009). The Ninth Circuit has expressly rejected the argument,

> that *Summers*, an environmental case brought under the National Environmental Policy Act, stands for the proposition that an injured member of an organization must always be specifically identified in order to establish Article III standing for the organization.
>
> The *Summers* Court refused to find standing based only on speculation that unidentified members would be injured by a proposed action of the National Forest Service . . . Where it is relatively clear, rather than merely speculative, that one or more members have been or will be adversely affected by a defendant's action, and where the defendant need not know the identity of a particular member to understand and respond to an organization's claim of injury, we see no purpose to be served by requiring an organization to identify by name the member or members injured.

Nat'l Council of La Raza v. Cegavske, 800 F.3d 1032, 1041 (9th Cir. 2015) (citing *Summers*, 555 U.S. at 488-89). The Ninth Circuit has repeatedly rejected attacks on standing under *Summers*, emphasizing the unique facts of that case in which "the [Supreme] Court concluded that there was 'a chance, but . . . hardly a likelihood, that [member]'s wanderings w[ould] bring him to a parcel about to be affected by a project unlawfully subject to the regulations.'" *Cottonwood Env't L. Ctr. v. U.S. Forest Serv.*, 789 F.3d 1075, 1080 (9th Cir. 2015) (quoting *Summers*, 555 U.S. at 495).

Here, the Complaint leaves no doubt that the nurses who are MNA's members do, in fact, work in healthcare settings where HB702 operates. *E.g.*,

Complaint ¶¶ 15-20. In the words of the *La Raza* court, 800 F.3d at 1041, "it is relatively clear, rather than merely speculative, that one or more [MNA] members have been or will be adversely affected by" HB702 on the Complaint's allegations. *E.g.*, Complaint ¶¶ 15-20; 29-30; 36-37; 42-43; 48; 52-53; 58-59; 63-68; 73-76. Thus, "the defendant need not know the identity of a particular member to understand and respond to [MNA]'s claim of injury." *La Raza*, 800 F.3d at 1041. It is unclear how naming an affected MNA member nurse would change the State's understanding of the claims at issue in this litigation.

Finally, though the State proceeds on a misapprehension of *Summers*, should the Court determine that MNA must name an individual member, MNA should be permitted leave to amend so that it may name an individual member. *See id.* (holding it was further error for district court to dismiss complaint without granting leave to amend).

III. The Nurses' allegations are sufficient.

The remainder of the State's arguments attack the Complaint's writing. Though the State fashions its contentions as coming under Rule 12(b)(1), they appear equally to invoke Rule 12(b)(6) and Rule 8. None of the arguments require dismissal at the pleading stage.

First, the State threads its motion with arguments that the Nurses have simply not said enough about their claims in the 23-page complaint. For example,

the State argues that "MNA's statement that its members are employed and provide direct nursing care in various medical settings is . . . insufficient." Doc 30 ("State's Brief"), at 5. Surely this statement is sufficient for the proposition it advances, and requires no more adornment or elaboration. The statewide organization that represents over 18,000 nurses both professionally and as a labor union states that its members work as nurses in healthcare settings. Complaint, ¶ 12. There is nothing implausible about that. But the State says it simply wants more and that the Complaint must be dismissed without it. This is not the law of dismissal at the pleading stage. A complaint must be more than "labels and conclusions, . . . a formulaic recitation of the elements of a cause of action," or "naked assertion[s]." *Iqbal*, 556 U.S. at 678 (citing *Twombly*, 550 U.S., at 555). But it need not be garrulous, either. The Complaint, as written, clearly satisfies the technical requirements of Rule 8 and Rule 12 as well as the interests they advance: the State is well-apprised of the character of MNA's claims. *Twombly*, 550 U.S. at 555 (Rules 8 and 12 serve to provide defendant notice of plaintiff's claims). The case should proceed.

Second, the State renews its argument that only employers may assert claims against HB702. MNA cannot bring claims because it only represents employees, the State says. Not so. The Complaint has not changed since the last time the State raised this argument, when it opposed intervention: MNA represents both

employees *and* employers. Complaint, ¶ 15 ("APRNs, who have enjoyed full practice authority for over 40 years in Montana, also provide primary and specialty healthcare as independent practitioners in the healthcare settings defined above. In many instances, APRNs own or manage their own private practice to provide primary and/or specialty care."). Thus, even if the State were right that only employers may challenge HB702, the argument fails on its own terms against MNA.

Third, the State's other arguments largely presume the answers to the ultimate merits questions in the case. For example, the State argues that "this litigation will not alter existing health protocols at the healthcare settings employing MNA members." Doc. 30 at 8. Of course, the effects of this litigation hinge on its outcome, and MNA has alleged that the opposite will happen. In essence, the State's argument is this: because the State's interpretation of HB702 is correct and will win, the Nurses suffer no injury and therefore have no standing. The State has it all backwards. Proceedings at the pleading stage determine whether a case will proceed—not the resolution of merits issues that are the ultimate questions in the case. If disagreement with a plaintiff's pleadings alone could halt a complaint, no case would proceed. *Cf. Alliance for Wild Rockies*, 2018 WL 10731198, at *5.

Rule 12 measures the sufficiency of a complaint by its contents—not by a defendant's subjective reaction to them. The motion should be denied.

CONCLUSION

For the foregoing reasons, the Court should deny the motion to dismiss.

DATED this 14th day of January, 2022.

/s/ Raph Graybill
Raph Graybill

Attorney for Plaintiff-Intervenor

CERTIFICATE OF COMPLIANCE

The undersigned certifies that the foregoing brief complies with the requirements of Rule 1.5 and 7.1 USDCR, is double spaced, except for footnotes, quoted, and indented material, and it is proportionately spaced utilizing a 14 point Times New Roman type face. The total word count for this document is 1991 words, as calculated by the undersigned's word processing program.

/s/ Raph Graybill
Raph Graybill

Attorney for Plaintiff-Intervenor

CERTIFICATE OF SERVICE

I hereby certify that on January 14, 2022, an accurate copy of the foregoing document was served electronically through the Court's CM/ECF system on registered counsel.

/s/ Raph Graybill
Raph Graybill

Attorney for Plaintiff-Intervenor

Justin K. Cole
Kathryn S. Mahe
GARLINGTON, LOHN & ROBINSON, PLLP
350 Ryman Street • P. O. Box 7909
Missoula, MT 59807-7909
Phone (406) 523-2500
Fax (406) 523-2595
jkcole@garlington.com
ksmahe@garlington.com

Attorneys for Plaintiffs

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MONTANA
MISSOULA DIVISION

MONTANA MEDICAL ASSOCIATION, FIVE VALLEYS UROLOGY, PLLC, PROVIDENCE HEALTH & SERVICES – MT, WESTERN MONTANA CLINIC, PC, PAT APPLEBY, MARK CARPENTER, LOIS FITZPATRICK, JOEL PEDEN, DIANA JO PAGE, WALLACE L. PAGE, and CHEYENNE SMITH,

Plaintiffs,

v.

AUSTEN KNUDSEN, Montana Attorney General, and LAURIE ESAU, Montana Commissioner of Labor and Industry,

Defendants.

Case No. CV 21-00108-DWM

PLAINTIFFS' BRIEF IN OPPOSITION TO SECOND MOTION TO DISMISS UNDER FED. R. CIV. P. 12

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Plaintiffs, Montana Medical Association ("MMA"), Five Valleys Urology, PLLC ("FVU"), Providence Health & Services – MT ("PH&S"), Western Montana Clinic, PC ("WMC") (collectively "Providers"), Pat Appleby, Mark Carpenter, Lois Fitzpatrick, Joel Peden, Diana Jo Page, Wallace L. Page, and Cheyenne Smith (collectively "Patients"), respectfully file this Brief in Opposition to Defendants' Second Motion to Dismiss ("Motion").

Defendants' Motion presents the same grounds and, but for minor changes, the exact same arguments as their first motion. For purposes of a clean record, Plaintiffs reiterate a complete response to the Motion, though substantially repetitive of Plaintiffs' prior response.

I. INTRODUCTION

Health care providers put themselves in harm's way, opening up their doors to the most vulnerable, and sickest, members of our community. Patients with communicable diseases seek out physicians and hospitals for treatment—exposing providers, staff, and other patients to the risk of contracting disease. To first do no harm in treating their patients, physicians must take reasonable and appropriate steps to protect patients from unnecessary exposure to additional harm, including protecting patients from vaccine-preventable infectious diseases. Physician offices and hospitals also have an obligation to implement reasonable safety measures to protect themselves and their staff. This is not "misguided groupthink;" it is the

product of evidence-based practices to provide health care in a safe and prudent manner. Defendants' unsupported rhetoric that this case is based upon health care providers' desire to discriminate not only obfuscates the issues, it is offensive to those who put themselves and their families at risk to provide health care to our communities.

Plaintiffs' Amended Complaint is narrowly crafted to challenge specific provisions of Montana Code Annotated § 49-2-312 ("MCA 49-2-312") – as those provisions apply to themselves and to others with identical interests. This case is not brought as a wholesale challenge to a legislative determination with which the Plaintiffs may disagree. It is a pinpoint claim based on well-grounded and well-articulated legal theories and supported by science.

Defendants' Motion outright fails to acknowledge the breadth and scope of MCA 49-2-312 and its impact on the health care community. Defendants continue to focus only on COVID-19 and fail to recognize that MCA 49-2-312 applies to all vaccines and, therefore, all vaccine-preventable illnesses. Defendants' Motion fundamentally misconstrues the basis and nature of Plaintiffs' claims. This lawsuit is about Plaintiffs' challenge to Defendants' ability to usurp the independent medical judgment of physicians in treating their patients and protecting themselves and their staff.

Plaintiffs have standing to assert these claims and assert valid and sufficient claims for relief. Defendants' Motion should be denied.

II. LEGAL STANDARDS

"[S]tanding typically requires three elements—injury-in-fact, traceability, and redressability." *Suda v. United States Customs & Border Prot.*, No. CV-19-10-GF-BMM, 2020 U.S. Dist. LEXIS 33143, at *10-11 (D. Mont. Feb. 26, 2020) (citations omitted). Plaintiffs who seek injunctive relief must also show "'a sufficient likelihood that [they] will be wronged again in a similar way.'" *Suda*, at 11 (citing *Fortyune v. Am. Multi-Cinema, Inc.*, 364 F.3d 1075, 1081 (9th Cir. 2004)).

Under Federal Rule of Civil Procedure 8(a)(2), a complaint must state "a short and plain statement of the claim showing that the pleader is entitled to relief[.]" On a motion to dismiss, the factual allegations are to be taken as true and all reasonable factual inferences are drawn in the Plaintiffs' favor. *Estate of Gould v. United States*, No. CV 20-177-M-DWM, 2021 U.S. Dist. LEXIS 104712, at *2 (D. Mont. June 3, 2021) (citing *Benavidez v. Cty. of San Diego*, 993 F.3d 1134, 1144 (9th Cir. 2021). A claim survives a Rule 12(b)(6) challenge if it pleads "'sufficient factual matter, accepted as true, to 'state a claim to relief that is plausible on its face.'" *Gould*, at *2 (quoting *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009)).

Defendants continue to reply upon unsupported allegations from material outside of the pleadings, without any proper foundation. Defendants have not properly presented affidavits or otherwise complied with the Federal Rules of Evidence, and such information should not be considered by the Court. *See* Fed. R. Civ. P. 12(b)(6); Fed. R. Evid. 602, 701, 702, 802, 901. This extraneous material fails the judicial notice standard required by Federal Rule of Evidence 201(b). "Just because [a] document itself is susceptible to judicial notice does not mean that every assertion of fact within that document is judicially noticeable for its truth." *Khoja v. Orexigen Therapeutics, Inc.*, 899 F.3d 988, 999 (9th Cir. 2018).

III. ARGUMENT

A. Plaintiffs have standing to assert the claims pled in the Amended Complaint.

Defendants' standing argument is unchanged and focuses solely on whether Plaintiffs have suffered an "injury in fact." (Doc. 21 at 11-22). "At the pleading stage, general factual allegations of injury resulting from the defendant's conduct may suffice, for on a motion to dismiss we 'presum[e] that general allegations embrace those specific facts that are necessary to support the claim.'" *Lujan v. Defs. of Wildlife*, 504 U.S. 555, 561 (1992) (citation omitted).

Plaintiffs have established all elements necessary for standing. Plaintiffs have suffered an injury in fact; such injury is directly and causally related to

Defendants' enforcement of MCA 49-2-312; the injury will be redressed by injunctive relief preventing Defendants from enforcing MCA 49-2-312 against physician offices and hospitals; and there is a real and imminent threat of repeated injury if Defendants are allowed to enforce MCA 49-2-312 against hospitals and physician offices.

Defendants concede sufficient injury in fact by citing the CDC for the proposition that: "Available evidence shows that fully vaccinated individuals and those previously infected with SARS-CoV-2 each have a low risk of subsequent infection for at least 6 months." (Doc. 21 at 17, n. 7) (emphasis added). Defendants seemingly ignore that MCA 49-2-312's prohibitions apply both to "vaccination status" and "immunity passports," defining immunity passport as "a document, digital record, or software application indicating that a person is immune to a disease, either through vaccination or infection and recovery." MCA 49-2-312(5)(a) (emphasis added). Based on the cited CDC Science Brief,[1] Plaintiffs should be able to know whether and to what extent an individual has immunity to COVID-19 and take reasonable precautions accordingly. The need for these precautions goes beyond COVID-19, and applies to all infectious

[1] Which also concluded: "vaccination after infection significantly enhances protection and further reduces risk of reinfection . . . ." While not properly presented, the CDC Science Briefs only further support Plaintiffs' standing and substantive bases of Plaintiffs claims.

diseases. MCA 49-2-312 prohibits implementing these precautions based upon vaccination status *or* immunity status, thus injuring Plaintiffs.

Providers' standing is established by the fact they are statutorily barred from taking steps to protect their patients and staff against the spread of communicable diseases. The Patients are individuals in special danger of contracting communicable diseases, and are constrained from using health care facilities that could cause them to be infected. Plaintiffs are not merely part of the Montana population at large. They are the individuals most directly affected by the portions of MCA 49-2-312 at issue and preventing enforcement of MCA 49-2-312 will redress the harm. *See Lujan*, 504 U.S. at 561-62 (when a plaintiff is the object of the challenged governmental action, "there is ordinarily little question that the action or inaction has caused him injury, and that a judgment preventing or requiring the action will redress it").

Even if this Court should find some Plaintiffs lack standing to assert some of the claims, Plaintiffs as a group have standing to sue. *Leonard v. Clark*, 12 F.3d 885, 888 (9th Cir. 1993) ("The general rule applicable to federal court suits with multiple plaintiffs is that once the court determines that one of the plaintiffs has standing, it need not decide the standing of the others." (citing *Carey v. Population Servs. Int'l*, 431 U.S. 678, 682 (1977)).

Defendants' assertion that Plaintiffs' injury is somehow conjectural or hypothetical is off base. Similar arguments were recently rejected by the Western District of Texas, finding immunocompromised students were actually and sufficiently injured by an executive order banning mask mandates in schools, and thereby had standing. Memo. Op., *E.T., et al. v. Morath, et al.*, No. 1:21-CV-717-LY, Doc. 82 at 14 (W.D. Tex. Nov. 10, 2021) (finding students did not need to show enforcement of the ban on mask mandates would actually cause any of them to contract COVID; increased risk of harm was sufficient). This reasoning applies to all Plaintiffs in this case.

Every day, COVID-19 puts Montanans in the hospital and kills Montanans. But, again, MCA 49-2-312 is not limited to COVID-19. Montana has, in recent years, experienced localized outbreaks of pertussis and there have been outbreaks of other vaccine-preventable infectious diseases, i.e., measles, on a national level. Vaccine-preventable infectious diseases pose a direct threat to immunocompromised individuals and health care workers. The direct harm posed by communicable diseases is so tangible that students are required to have certain vaccinations in order to attend public school. The Providers have an interest in protecting their patients and staff from illness and death. The Patients have an interest in life and health. The harms – sufficiently pled in the Amended Complaint – presented by contracting or spreading vaccine-preventable illnesses

are real, present, and continuing while MCA 49-2-312 remains in effect. Plaintiffs need not "await the consummation of threatened injury to obtain preventive relief." *Babbitt v. UFW Nat'l Union*, 442 U.S. 289, 298 (1979).

1. MMA has organizational standing.

"[A]n organization may sue to redress its members' injuries, even without a showing of injury to the association itself" because "the association and its members are in every practical sense identical." *United Food & Commer. Workers Union Local 751 v. Brown Grp.*, 517 U.S. 544, 552 (1996) (citations and internal quotation marks omitted). The MMA has sufficiently alleged standing, namely: (a) the organization's members would otherwise have standing to sue in their own right; (b) the interests it seeks to protect are germane to the organization's purpose; (c) based on the MMA's membership, neither the claim asserted, nor the relief requested requires, the participation of individual members in the lawsuit; and (d) in any event, MMA has within its membership physicians employed with FVU, WMC, and PH&S. (Doc. 14 at ¶¶ 12-13); *United Food*, 517 U.S. at 553. This Court has recognized that plaintiff organizations need not identify specific members by name at the pleading stage to satisfy standing requirements. *Mont. Envtl. Info. Ctr. v. Bernhardt*, No. 1:19-cv-00130-SPW-TJC, 2020 U.S. Dist. LEXIS 189477, at *8 (D. Mont. Oct. 13, 2020).

2. Providers have standing.

Without citation to legal authority, Defendants argue medical clinics and hospitals do not have standing unless they admit they are providing subpar medical care. Defendants' argument misconstrues the standard for standing and, if anything, supports the foundation of Plaintiffs' claims. The Providers will continue to provide appropriate medical care within established standards of care, but when doing so runs afoul of the prohibitions of MCA 49-2-312, these clinics and hospitals are exposed to real and tangible legal liability. *See* MCA 49-2-312 (creating an "unlawful discriminatory practice" that, in certain contexts, infringes on physicians' independent medical judgment and potentially violates national standards of care). Providers are not required to allege they currently employ unvaccinated workers. The Amended Complaint alleges the Providers employ and hire employees, yet MCA 49-2-312 forecloses an ability to inquire into vaccination status and properly address it.

Defendants appear to argue that the injury necessary to confer standing can only arise under legal obligations *other than* MCA 49-2-312. This argument is nonsensical. It is the existence of MCA 49-2-312 that creates the real and nonconjectural injury and exposure to legal liability when providers are prohibited from engaging in reasonable steps to protect vulnerable patients and staff from infectious, vaccine-preventable diseases.

Defendants cite professional licensure statutes to argue it is unprofessional conduct for a licensed physician to engage in conduct not meeting "generally accepted standards of practice." (Doc. 21 at 16, n. 5) (citing Mont. Code Ann. § 37-1-316(18)). This only highlights that MCA 49-2-312's infringement on physicians' independent medical judgment and ability to meet generally accepted standards of practice is inconsistent with a host of other federal and state statutes, causing real injury to these licensed physicians. Defendants' argument emphasizes that, in certain circumstances as alleged in the Amended Complaint, medical providers can either comply with established standards of care to deliver safe health care or comply with MCA 49-2-312; they cannot do both.

Defendants fault Plaintiffs for failing to cite medical experts in the Amended Complaint, misconstruing the applicable pleading standard. Nothing in Rule 8(a) or the case law decided thereunder requires a plaintiff to cite expert authority for its factual allegations. *See* Fed. R. Civ. P. 8(a); *Iqbal*, 556 U.S. at 677-79. While Plaintiffs intend to present expert testimony establishing the facts alleged are true, that is not required at the initial pleading phase. *Gould*, at *2 (factual allegations in the complaint are taken as true and the pleadings are construed in the light most favorable to plaintiffs).

3. Patients have standing.

Defendants advance the baseless argument that the Patients are not harmed by MCA 49-2-312 because they are already required to take steps to protect themselves during the current COVID-19 pandemic. This slim argument not only improperly minimizes the very real threat these vulnerable individuals face, it flatly ignores that the Patients are also exposed to vaccine-preventable diseases other than COVID-19. Patients need to be treated by physicians and staff who are vaccinated against COVID-19 *and* other infectious diseases. (*See* Doc. 14 at ¶¶ 23-26). The Patients are harmed by MCA 49-2-312 because they need to seek health care from vaccinated providers or from clinic spaces that otherwise reduce the risk of contraction of a disease – similar to the students in *E.T.* who needed to attend school in an environment that reduced risk of COVID-19 transmission through masking policies.

B. All claims state viable causes of action and are sufficiently pled.

Defendants' arguments against the substance of Plaintiffs' claims systemically fail in several fundamental ways. First, Defendants fail to acknowledge MCA 49-2-312 provides no exception or exemption for physician offices. The statute draws a limited – and insufficient – exception for a "health care facility," which is defined to specifically exclude "offices of private physicians, dentists, or other physical or mental health care workers regulated

under Title 37, including licensed addiction counselors." Mont. Code Ann. § 50-5-101(26)(b). To the extent Defendants argue Plaintiffs' claims are usurped by the exception expressed in MCA 49-2-312(3)(b), Defendants' position unequivocally fails.

Second, Defendants' entire argument relates only to COVID-19, failing to acknowledge MCA 49-2-312's prohibitions apply to all diseases and vaccines, both known and unknown. While Plaintiffs are undoubtedly harmed by MCA 49-2-312's prohibitions against addressing COVID-19, Plaintiffs are additionally harmed by its application to all diseases, including pertussis, measles, mumps, rubella, shingles, hepatitis, and more. Despite Plaintiffs raising this fundamental flaw in a prior filing, Defendants offer no argument countering the very real and detrimental impact MCA 49-2-312 has on the prevention of these other diseases.

Third, throughout Defendants' brief, Defendants argue that a vaccinated individual is just as likely to carry and spread COVID-19 as an unvaccinated individual – insinuating the COVID-19 vaccine is meaningless and therefore MCA 49-2-312 does not harm the medical community. This argument is belied by Defendants' reliance on CDC Science Briefs, which establish the effectiveness of the COVID vaccine. The degree to which an unvaccinated individual is more likely to both contract and spread disease and the standards of care applicable to a clinical environment are matters appropriately addressed through expert testimony.

Defendants' argument not only fails to address all of the other vaccine-preventable diseases implicated in a clinical environment, it is based upon snippets of articles, taken out of context, without considering the scientific data as a whole or the source of the information. As such, it is wholly insufficient to defeat Plaintiffs' claims on a motion to dismiss.

Fourth, Defendants repeatedly argue the public health policies of Montana support their argument. But MCA 50-1-105 expresses the policy of the state of Montana to protect and promote the health of the public. MCA 50-1-105(1). Montana's public health system does this by, among other things, (1) "promoting conditions in which people can be healthy;" (2) "investigating and diagnosing health problems and health hazards in the community;" (3) "implementing and enforcing laws and regulations that protect health and ensure safety;" (4) seeking "innovative solutions to health problems;" and (5) "striving to ensure that public health services and functions are provided and public health powers are used based upon the best available scientific evidence[.]" MCA 50-1-105(2). Defendants do not, and cannot, contend that MCA 49-2-312 promotes and protects public health – by its very nature this statute is antagonistic to public health.

1. Plaintiffs' claims pertaining to preemption by the Americans with Disabilities Act's ("ADA") are legally viable.

The Supremacy Clause "invalidates state laws that 'interfere with, or are

contrary to,' federal law." *Hillsborough Cty. v. Auto. Med. Labs., Inc.*, 471 U.S. 707, 713 (1985) (citation omitted). "Even where Congress has not completely displaced state regulation in a specific area, state law is nullified to the extent that it actually conflicts with federal law." *Id.* Such a conflict arises when "'compliance with both federal and state regulations is a physical impossibility,'" or when state law "'stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress[.]'" *Id.* (citations omitted). State laws may be preempted by federal regulations as well as by federal statutes. *Id.*; *Williamson v. Mazda Motor of Am., Inc.*, 562 U.S. 323, 330 (2011).

"'[T]he ADA must be construed broadly in order to effectively implement the ADA's fundamental purpose of providing a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities.'" *McGary v. City of Portland*, 386 F.3d 1259, 1268 (9th Cir. 2004) (citation omitted). The ADA provides that no individual may be discriminated against on the basis of a disability in employment or "in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation[.]" 42 U.S.C. §§ 12182(a), 12112 (2021).

MCA 49-2-312 conflicts with the ADA. First, patients with compromised immune systems, comorbidities, or extraordinary sensitivity to vaccine-preventable

diseases require individualized treatment from vaccinated individuals. As a public accommodation, physician offices and hospitals are required to reasonably accommodate these types of patients with disabilities under the ADA.

Contrary to Defendants' mischaracterizations, Plaintiffs are not claiming that the ADA compels termination of unvaccinated staff members. Instead, the ADA requires physician offices and hospitals to provide reasonable accommodations to disabled patients, which can include disclosing vaccination status, altering terms or conditions of employment such that a disabled patient is not treated by an unvaccinated individual, requiring unvaccinated individuals to wear additional personal protective equipment ("PPE"), or other appropriate measures to provide reasonable accommodation. To provide a safe environment for disabled individuals to receive care, a provider needs to be able to screen and reasonably require vaccination of staff for vaccine-preventable infectious diseases or alter the conditions of the nonvaccinated individuals' employment to appropriately mitigate the risk they pose to patients. This requires providers identifying and distinguishing between vaccinated and unvaccinated employees or risk excluding individuals with disabilities from receiving care. MCA 49-2-312 prevents physician offices from employing these accommodations to disabled patients who should not be treated by unvaccinated individuals, thus directly conflicting with the ADA.

Similarly, as an employer, physician offices and hospitals are required to reasonably accommodate employees with disabilities. An employee with a compromised immune system likewise may require – as a reasonable accommodation – identification of and separation from coworkers who are not vaccinated against certain diseases. MCA 49-2-312 offers no liability exception for physician offices, and prohibits segregation of employees or any other changes in working conditions based upon vaccination/immunity status.

For hospitals, the limited exception for licensed facilities is insufficient. The exception requires hospitals to accommodate an unvaccinated individual in a manner that protects others from communicable diseases. Mont. Code Ann. § 39-2-312(3)(b).[2] But it is the unvaccinated individual that poses the threat to a disabled/immunocompromised patient/employee, who is the individual entitled to accommodation under the ADA. Moreover, given certain vaccine-preventable diseases are not airborne, simple masking would be ineffective in protecting employees exposed to bloodborne or contact-communicable diseases. Thus, there would not be any reasonable accommodation available to provide to an unvaccinated employee for bloodborne diseases and the limited exception would not apply. Additionally, masking may not be a reasonable accommodation for

[2] It should be noted that this exception impliedly recognizes the threat nonvaccinated people present to the safety and health of others.

airborne illnesses as it is not, necessarily, equally effective to vaccination and may not eliminate the direct threat posed to disabled employees/patients. *See* Mont. Admin. R. § 24.9.613(1). Moreover, requiring full or additional PPE or segregating employees whose vaccination status has not been volunteered (whether the employee is unvaccinated, or vaccinated and immunocompromised) would constitute "discrimination" in terms and conditions of employment, again running afoul of MCA 49-2-312. Appropriately incentivizing vaccination through bonuses would likewise constitute "discrimination." The perfunctory exception articulated in MCA 49-2-312(3)(b) does not save the statute from ADA preemption.

Observance of MCA 49-2-312's prohibitions requires providers to ignore their mandate to reasonably accommodate immunocompromised patients and employees with disabilities in direct violation of the ADA. MCA 49-2-312 requires these vulnerable patients/employees to risk their safety or forego employment or care by otherwise available and capable Montana providers. "Even where an individual 'is not wholly precluded from participating in [a] service, if he is at risk of incurring serious injuries each time he attempts to take advantage of [the service], surely he is being denied the *benefits* of this service." *E.T.*, Doc. 82 at 26-27 (citation omitted).

For these reasons, MCA 49-2-312 is in direct, irreconcilable conflict with the ADA, rendering compliance with both impossible. *See Mary Jo C. v. N.Y.*

State & Local Ret. Sys., 707 F.3d 144, 164 (2d Cir. 2013) (The ADA preempts inconsistent state law when appropriate and necessary to effectuate a reasonable accommodation); *E.T.*, Doc. 82 at 18 (ADA preempts Texas ban on mask mandates in schools because the ban conflicts with school's obligation under the ADA to reasonably accommodate immunocompromised students). At a minimum, MCA 49-2-312 stands as a direct obstacle to the accomplishment of the full objectives of the ADA. *See Crowder v. Kitagawa*, 81 F.3d 1480, 1484 (9th Cir. 1996) (finding enforcement of a facially-neutral Hawaii quarantine requirement for individuals with dogs improperly burdened visually-impaired persons, further discussing the court's role in enforcing the anti-discrimination application of the ADA).

2. Plaintiffs' claims pertaining to preemption by Occupational Safety and Health Administration ("OSHA") regulations are legally viable.

Through OSHA, "Congress endeavored 'to assure so far as possible every working man and woman in the Nation safe and healthful working conditions.'" *Gade v. Nat'l Solid Wastes Mgmt. Ass'n*, 505 U.S. 88, 96 (1992) (quoting 29 U.S.C. § 651(b)). "To that end, Congress authorized the Secretary of Labor to set mandatory occupational safety and health standards applicable to all businesses affecting interstate commerce[.]" *Id.* (citing 29 U.S.C. § 651(b)(3)). When a federal standard has been implemented, OSHA conflict preemption applies to state

statutes that stand as an obstacle to the accomplishment and execution of OSHA's full purposes and objectives. *Gade*, 505 U.S. at 98.

OSHA requires employers to furnish all employees a place of employment "free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees[.]" 29 U.S.C. § 654(a). OSHA may implement Emergency Temporary Standards ("ETS") when it determines that "employees are exposed to grave danger from exposure to substances or agents determined to be toxic or physically harmful or from new hazards," and that such emergency standard "is necessary to protect employees from such danger." 29 U.S.C. § 655(c)(1).

Plaintiffs sufficiently pled the COVID-19 virus, Hepatitis B, pertussis and other communicable diseases are "recognized hazards" that are causing, or likely to cause, death or serious physical harm. (Doc. 14 at ¶ 47). Health care providers are particularly exposed to these recognized hazards, with increased risk in certain clinical settings and when performing certain medical procedures. MCA 49-2-312 prohibits health care providers from mandating certain infectious disease protocols (including vaccination programs and other alterations to terms and conditions of employment) to address these hazards.

Specifically, 29 C.F.R. § 1910.502 recognizes COVID-19 as a workplace hazard and requires health care employers to "develop and implement a COVID-19

plan," which must include "policies and procedures to . . . [m]inimize the risk of transmission of COVID-19 for each employee." MCA 49-2-312 effectively prohibits employers from enforcing policy or procedure that minimizes transmission of COVID-19 in the workplace – whether through appropriate vaccine mandates or other changes to terms or conditions of employment, such as quarantines, additional PPE or testing for nonvaccinated individuals, or other measures based upon vaccination status. In complying with OSHA requirements, physician offices and hospitals subject themselves to liability under MCA 49-2-312. Having a purely voluntary program that merely recommends a vaccine or other voluntary PPE protocols, without any ability to compel or incentivize compliance, does not effectively minimize transmission of COVID-19 in the workplace. Moreover, MCA 49-2-312 strips a health care provider's ability to avail itself of the exemptions applicable when the employer has a fully vaccinated staff. *See* 29 C.F.R. §§ 1910.502(a)(2)(iv), 1910.502(a)(4), 1910.502(c)(5). Under MCA 49-2-312, physician offices cannot implement policies or procedures to either achieve a fully vaccinated workforce or otherwise meaningfully reduce the transmission of COVID-19. This clearly frustrates OSHA's clear and unambiguous objective of preventing transmission of communicable diseases. *See E.T.*, Doc. 82 at 20-22 (ban on mask mandates conflicted with ARPA in that it

frustrated the ability of the school to develop its own plan to comply with the funding requirements).

Defendants' citation to the November OSHA ETS is inapplicable here, as that ETS specifically does not apply to health care providers covered by § 1910.502. 29 C.F.R. § 1910.501(b)(2)(ii).[3]

3. Plaintiffs' claims under Montanans' Constitutional Right to a Safe and Healthy Environment are legally viable.

Article II, section 3 of the Montana Constitution establishes the inalienable "right to a clean and healthful environment" including "seeking [] safety, health and happiness in all lawful ways." Mont. Const. art. II, § 3. MCA 49-2-312 violates Patients' right to "seek health" by jeopardizing their ability to obtain medical treatment. MCA 49-2-312 prevents the Patients from seeking medical care without placing themselves at unnecessary risk for contracting a communicable disease from an unvaccinated medical worker. The statute further obstructs the Providers' ability to maintain a healthful environment for their patients and staff.

[3] *But see* COVID-19 Vaccination and Testing; Emergency Temporary Standard, 86 Fed. Reg. 61,402 (Nov. 5, 2021) ("Regardless of viral loads in vaccinated and unvaccinated individuals, the fact remains clear that unvaccinated people pose a higher risk of transmission to others than vaccinated people, simply because they are much more likely to get COVID-19 in the first place.").

Article IX, section 1 of the Montana Constitution requires the state and each person to "maintain and improve a clean and healthful environment in Montana for present and future generations" tasking the legislature to "provide for the administration and enforcement of this duty." MCA 49-2-312 does exactly the opposite, prohibiting the Providers from maintaining, and the Patients from enjoying, a clean and healthful environment to seek safe medical care.

These claims, taking the allegations as true, are sufficiently pled to survive dismissal. Infectious diseases are spread through airborne particles, blood borne pathogens, and pathogens carried through surface contact, which contaminate the environment. Vaccines slow down and help prevent the spread of these particles and pathogens, leading to a cleaner and more healthful environment. MCA 49-2-312 prevents the health care community from taking appropriate measures to promote a clean and healthful environment in a setting where infectious viruses are particularly prominent and spread through air, bodily fluids, and surfaces. For purposes of the instant claims, there is no material difference between airborne pollutants, such as asbestos or arsenic, that cause disease and airborne viruses that cause disease. Both affect the "natural environment" the framers sought to maintain.

These constitutional provisions were intended to be broad, read together in conjunction with the preamble to the Montana Constitution, and implemented in a

manner that provides "protections which are both anticipatory and preventative." *Mont. Envtl. Info. Ctr. v. Dep't of Envtl. Quality*, 1999 MT 248, ¶ 77, 296 Mont. 207, 988 P.2d 1236. The Montana Supreme Court has embraced these constitutional provisions in the context of an individual's fundamental right to "seek health." *See, e.g.*, *Mont. Cannabis Indus. Ass'n v. State*, 2012 MT 201, ¶ 23, 366 Mont. 224, 286 P.3d 1161 ("In pursuing one's own health, an individual has a fundamental right to obtain and reject medical treatment.") (citing *Wiser v. State*, 2006 MT 20, ¶ 17, 331 Mont. 28, 129 P.3d 133).

While the Montana Supreme Court has applied these constitutional provisions in the toxic tort and pollution contexts, Defendants cite no authority specifically limiting these constitutional protections to these types of matters. The fact that the Montana Supreme Court has not yet applied this provision in the context of vaccines does not doom Plaintiffs' claims. Rather, it reflects that, until recent attacks on evidence-based science, it was a foregone conclusion that vaccines contribute to the clean and healthful environment enjoyed by Montanans. Indeed, MCA 49-2-312 represents an unprecedented assault on the health care community's ability to address vaccine-preventable diseases.

Interestingly, Defendants continue their reliance on the police powers of the State, citing the concurrence in *South Bay United Pentecostal Church v. Newsom*, 140 S. Ct. 1613, 1613-14 (2020), to claim state officials are granted broad latitude

to "guard and protect" the "safety and the health of the people." (Doc. 21 at 34). *Newsom* does not support Defendants' argument. The *Newsom* Court denied injunctive relief against California's Executive Order limiting public gatherings in furtherance of public health, given the COVID-19 pandemic. The Supreme Court deferred to California's ability to guard and protect public health, even though such measures had an arguably undue impact on the religious community, allowing the Executive Order to stand.

In contrast, MCA 49-2-312 is not an instance of the state exercising its police powers to protect public health in degradation to individual liberty – it is the opposite. MCA 49-2-312 is an exercise of legislative power against public health, in the, albeit misconstrued, name of individual privacy. MCA 49-2-312 undisputedly does not protect public health. Instead, it places barriers upon physicians from protecting public health and utilizing public health tools, such as vaccines, to ensure a healthful environment. It further prevents physicians' offices from utilizing other public health protocols, such as increased PPE for nonvaccinated individuals, segregating nonvaccinated individuals from high-risk populations, and incentivizing employees to become vaccinated, by prohibiting physicians' offices from treating employees differently based upon vaccination status. Defendants' reliance on the police power of the state does nothing to defeat Plaintiffs' claims.

4. Plaintiffs' claims under the Equal Protection Clauses of the Montana and United States Constitutions are legally viable.

Both the Fourteenth Amendment to the United States Constitution and article II, section 4 of the Montana Constitution provide that no person shall be denied the equal protection of the laws. "The Equal Protection Clause of the Fourteenth Amendment commands that no State shall deny to any person within its jurisdiction the equal protection of the laws, which is essentially a direction that all persons similarly situated should be treated alike." *Gallinger v. Becerra*, 898 F.3d 1012, 1016 (9th Cir. 2018) (citation and internal quotation marks omitted). Montana's equal protection guarantee likewise embodies "a fundamental principle of fairness: that the law must treat similarly-situated individuals in a similar manner." *McDermott v. State Dep't of Corr.*, 2001 MT 134, ¶ 30, 305 Mont. 462, 29 P.3d 992. Its function "'is to measure the validity of classifications created by state laws.'" *ISC Distribs. v. Trevor*, 273 Mont. 185, 195, 903 P.2d 170, 176 (1995) (citation omitted). "[T]he principal purpose of Montana's Equal Protection Clause is to ensure that Montana's citizens are not subject to arbitrary and discriminatory state action." *Powell v. State Comp. Ins. Fund*, 2000 MT 321, ¶ 16, 302 Mont. 518, 15 P.3d 877 (citation omitted). Equal protection claims require a showing "that the state has adopted a classification that affects two or more

similarly situated groups in an unequal manner." *Powell*, ¶ 22; *Gallinger*, 898 F.3d at 1016.

Defendants challenge the viability of Plaintiffs' equal protection claims based on whether Plaintiffs have identified similarly situated classes. Contrary to Defendants' arguments, MCA 49-2-312 draws arbitrary classifications of similarly situated groups and treats them in an unequal, unconstitutional manner.

First, the statute discriminates against offices of private physicians as compared to other, similarly situated health care providers. By affording no exception or exemption to physician offices, MCA 49-2-312 denies equal protection under the law to providers in these care settings. Physicians treat patients in clinic settings (i.e., private physician offices) in the same manner they treat patients in a licensed facility such as a hospital, nursing home, long-term care facility, or assisted living facility. Physician offices are the "front line" in both primary care and specialty services. Physicians work and treat patients in all settings – physicians with the same specialty can treat the same types of patients in a physician office, hospital, nursing home, long-term care facility, or assisted living facility. Montana Code Annotated § 50-5-101(31) requires Hospitals to provide medical care "by or under the supervision of licensed physicians." The Centers for Medicare and Medicaid Services ("CMS") Conditions of Participation require hospitals to administer care through a medical staff comprised of

physicians. 45 C.F.R. § 482.22(a). Physicians treat patient populations with similar medical conditions in a physician office in the same manner they would treat such a patient in a hospital or other clinical setting within a licensed facility. Private physician offices represent a class similarly situated to hospitals and other licensed facilities.

Despite this, physician offices are not exempted from MCA 49-2-312 like nursing homes, long-term care facilities, and assisted living facilities (*see* Montana Code Annotated § 49-2-313), nor are they afforded the – albeit insufficient – exception in MCA 49-2-312(3)(b). Immunocompromised patients and patients infected with communicable diseases seek care from physician offices in the same way they seek care in other settings; yet physician offices are afforded no relief from MCA 49-2-312's detrimental effect on infectious disease prevention.

Second, and relatedly, the statute treats physician offices and hospitals more harshly than nursing homes, assisted living facilities, and long-term care facilities. Montana Code Annotated § 49-2-313 exempts nursing homes, long-term care facilities, and assisted living facilities from compliance with MCA 49-2-312 when compliance would violate "regulations or guidance" issued by the CMS or CDC. The Court should reject Defendants' conclusory argument that these facilities "are different" and therefore this unequal treatment is legally permissible. The very definition of "health care facilities" cited by MCA 49-2-312 and Defendants in

their brief, groups hospitals and long-term care facilities together. *See* Mont. Code Ann. § 50-5-101(26) ("The term includes . . . hospitals, . . . long-term care facilities . . . ."). Hospitals and physician offices participate in Medicare and Medicaid, often receiving the majority of their reimbursement from these federal payers – in the same way as nursing homes and long-term care facilities. Hospitals and physician offices are also subject to CMS regulations.[4] Likewise, hospitals and physician offices treat patients in accordance with CDC guidance and recommendations on infectious disease prevention. Hospitals and physician offices should be allowed to follow CMS regulations and CDC recommendations in the same manner as other facilities without liability under MCA 49-3-312. Additionally, these providers treat the same high-risk patient populations as nursing homes, long-term care facilities, and assisted living facilities. MCA 49-2-312's unequal treatment of these facilities deprives hospitals and physician offices equal protection of the law.

[4] The newly-issued CMS Conditions of Participation require the implementation of vaccine mandates, impacting hospitals such as PH&S and other licensed facilities. 86 Fed. Reg. 61,555 (Nov. 5, 2021). MCA 49-2-312 discriminates against hospitals' ability to abide by these regulations, drawing the arbitrary distinction between these care settings and those of nursing homes, long-term care facilities, and assisted living facilities, further evincing the equal protection issues.

Third, MCA 49-2-312 discriminates against Montana patients seeking health care. It discriminates against those patients with compromised immune systems and it discriminates against patients treated in different care settings. Patients require frequent care from physician offices, are especially susceptible to acquiring an infectious disease, must avoid the risk of acquiring a contagious disease, and thereby must avoid establishments that employ unvaccinated workers or are unable to take necessary measures to protect against preventable diseases. (Doc. 14 at ¶¶ 23-25). Defendants acknowledge that the Patients are required to take particular precautious when seeking health care, given the pandemic and heightened risk to these patients, yet non-immunocompromised patients are not. (Doc. 21 at 20) (observing that these risks predated the current COVID-19 pandemic). Again, Defendants focus on COVID-19, but this also applies to other communicable diseases. MCA 49-2-312 infringes upon these immunocompromised patients' ability to seek safe health care from physician offices, denying them equal protection under the law. Similarly, MCA 49-2-312 allows patients receiving care in a nursing home or long-term care setting to receive care in a different, and in certain cases safer, manner as compared with similarly situated patients receiving care in a hospital or physician office.

Because these equal protection claims implicate a fundamental right to both a clean and healthful environment and to seek health under the Montana

Constitution, strict scrutiny applies. *Farrier v. Teacher's Ret. Bd.*, 2005 MT 229, ¶ 16, 328 Mont. 375, 120 P.3d 390 ("Strict scrutiny applies if a statute implicates a suspect class or fundamental right." (citation omitted)). Regardless of the applicable level of scrutiny, the classes drawn by MCA 49-2-312 and 49-2-313 fail even a rational basis test. There is no legitimate governmental interest in drawing distinctions between medical care delivered in different types of health care settings, placing patients and care givers in physician offices and hospitals at greater risk of harm. Creation of an overly broad and novel protected class based on vaccination/immunity status is not rationally related to the claimed government interest, particularly in light of the disproportionate harms caused by MCA 49-2-312. MCA 49-2-312 is internally inconsistent, recognizing the need for schools, daycare facilities, nursing homes, long-term care facilities, and assisted living facilities to be able to respond to an individual's immunity status, yet failing to treat physician offices and hospitals in a similar manner. The fact that MCA 49-2-312 creates an exception for "health care facilities" that, by its own definition, specifically excludes physician offices evidences intentional discrimination against physician offices and their patients with no rational basis for doing so.

Accordingly, Plaintiffs have sufficiently pled all of their claims and Defendants' Motion should be denied.

IV. CONCLUSION

For the reasons set forth above, Defendants' Motion should be denied.

DATED this 17th day of November, 2021.

/s/ Justin K. Cole
Attorneys for Plaintiffs

CERTIFICATE OF COMPLIANCE

Pursuant to Local Rule 7.1(d)(2)(E), I certify that this **Plaintiffs' Brief in Opposition to Second Motion to Dismiss Under Fed. R. Civ. P. 12** is printed with proportionately spaced Times New Roman text typeface of 14 points; is double-spaced; and the word count, calculated by Microsoft Word for Microsoft 365 MSO, is 6,490 words long, excluding Caption, Certificate of Service and Certificate of Compliance.

/s/ Justin K. Cole
Attorneys for Plaintiffs