



# Transforming Nursing Clinical Placements: Standardization and Innovation for Massachusetts

**January 9, 2025**

*Submitted by the Clinical Placements Committee as part of the Nursing Council of Workforce Sustainability*

## **Executive Summary**

To ensure an available and prepared nursing workforce, academic institutions must consistently graduate nurses who are workforce-ready. This requires an academic pipeline that is accessible to students, offers robust support, and minimizes administrative and procedural barriers that could hinder timely progress through their studies.

Clinical experience is a cornerstone of every nursing student's education. Throughout their program, students engage in hands-on learning that culminates in a senior practicum (Price, 2019). These clinical placements typically take place in acute and long-term healthcare organizations, where students collaborate with practicing nurses under the supervision of a clinical instructor.

In Massachusetts, most clinical placements are coordinated through the state's electronic platform, the Massachusetts Centralized Clinical Placement Management System (CCP). In 2023, the Nursing Council on Workforce Sustainability (NCWS) conducted an evaluation of the CCP and published its recommendations in December of that year (Nursing Council on Workforce Sustainability, 2023).

The Clinical Placements Committee of the NCWS subsequently initiated a review of the clinical placement processes in Massachusetts. The committee collaborated with placement coordinators, healthcare organizations, and academic institutions to inform this work. Leveraging the CCP database, the committee also surveyed healthcare organizations to identify the documentation required for students to participate in clinical placements. The survey addressed demographic information, vaccination and health records, compliance processes, and other procedural requirements.

The survey responses revealed a highly fragmented approach to clinical placements, with organizations requiring varying and inconsistent information from students. In response, the committee initiated efforts to standardize these requirements to create a more streamlined process. This standardization will simplify clinical placements, reduce financial and procedural burdens on students, and eliminate unnecessary complexities, ultimately improving accessibility and efficiency.

Standardization also alleviates the administrative burden on academic institutions by reducing the repetitive and time-consuming tasks required to secure student clinical placements.

This recommendation aims to address the current challenges in clinical placement processes and provide clear, evidence-based solutions aligned with nationwide industry practices.

## **Student Requirements**

For clarity, student requirements have been categorized into three key areas: student demographics, compliance, and immunizations.

Before evaluating these recommendations, it is imperative to understand two foundational principles regarding students and clinical placements:

1. Academic institutions maintain comprehensive student records, including demographics, immunizations, and compliance documentation. This recommendation strongly advocates for academic institutions to verify student compliance through attestations to streamline processes and avoid unnecessary duplication. If required for regulatory purposes, institutions will provide copies and verification of compliance to healthcare organizations as needed.
2. Recognizing that students completing clinical rotations in healthcare organizations are not employees is essential. They are supervised learners under the oversight and responsibility of their academic institutions. Students do not engage in unsupervised patient care and are present in facilities only for designated periods as part of their educational program.

## **Continued Technical Challenges in the Massachusetts CCP**

The current electronic CCP system presents significant challenges for both students and academic professionals. Notably, the CCP lacks HIPAA-compliant servers, preventing the storage of sensitive student information, such as demographics and immunization records. Ideally, a fully functional clinical placement system would enable student information to be securely attached to electronic profiles, providing healthcare organizations with seamless and secure access.

Currently, the process is cumbersome and largely manual, often relying on exchanging information through unsecured spreadsheets sent via email. Furthermore, students are unable to complete forms electronically within the system. While electronic signatures are supported, forms require manual completion and then must be uploaded separately, adding additional complexity and inefficiency.

This technology and other user-friendly features are already integrated into clinical placement systems used nationwide. These systems are readily available from companies specializing in creating, developing, and overseeing clinical placement systems. Massachusetts is strongly encouraged to evaluate the current state and future sustainability of maintaining its own CCP with the challenges of advancing technology and cyber threats.

## Student Demographics

The type and volume of student demographics collected by healthcare organizations across the commonwealth vary significantly. In addition to basic demographic information, many organizations also require students' social security numbers, which presents both a security risk and unnecessary challenges. Currently, these sensitive numbers are often transmitted in spreadsheets via standard email, which lacks encryption. Most academic institutions do not have the capability to send encrypted emails or files, and some healthcare organizations report being unable to receive encrypted messages, making standard email the default method of transmission.

***The committee strongly recommends immediately ceasing the practice of requiring organizations to release a student's social security number for clinical placement.*** This practice poses a security risk to students and creates a potential liability for academic institutions. While the necessity of collecting a student's social security number is widely debated, the responsibility for obtaining this information—if deemed necessary—should be transferred to the healthcare organization. The healthcare organization must be responsible for collecting this information from the student directly via a secure method.

In lieu of requiring social security numbers, other less concerning data methods can be provided. For example, the last four digits of a student's social security number and their mother's maiden name can often be easily supplied.

Additionally, the committee assessed the essential information required for placing a student in a clinical setting. The recommended process and the necessary details are outlined in Attachment A. Healthcare organizations are encouraged to evaluate and adopt these requirements for student demographics.

Current processes and requirements of varying and inconsistent information from organization to organization require that academic institutions complete multiple sets of duplicative paperwork. For example, suppose a student is presented to three hospitals for a potential clinical placement. In that case, it is quite possible that three completely different packets of demographic information must be completed based on the facility. This requires a significant investment of time from clinical instructors. The committee recommends that this time be better invested in instructing future nursing students. Duplicative and administratively burdensome processes must be abandoned for a simpler, streamlined approach.

## Student Compliance

Compliance is a critical priority for both academic institutions and healthcare organizations, underscoring the need for careful and thoughtful management of compliance issues. Many

organizations interviewed during this process raised concerns about meeting the requirements of regulatory bodies like the Joint Commission. To address these concerns, the Clinical Placements Committee conducted in-depth research on regulatory standards, consulted with subject matter experts, and, when possible, engaged directly with regulatory agencies to ensure a clear understanding of expectations.

Regulatory agencies unanimously emphasized a key principle regarding student placements in healthcare facilities: compliance is measured based on the facility's adherence to its policies on student placements. Consequently, there is no universal list of requirements for clinical nursing students; instead, agencies focus on evaluating whether facilities follow their established guidelines.

Building on this understanding, the committee analyzed various aspects of student compliance, resulting in the recommendations detailed in Attachment B.

## **CORI Compliance**

Organizations use Criminal Offender Record Information (CORI) checks to determine whether individuals have been charged with crimes in Massachusetts courts (Commonwealth of Massachusetts, 2024). Typically, students are required to complete a CORI check annually. However, many organizations mandate a CORI check within three months of beginning clinical, potentially requiring students to undergo up to three CORI checks in a single year.

The financial burden of these repeated checks falls on students, creating unnecessary costs. The committee recommends conducting a single CORI check annually for each student and shared with healthcare organizations as needed and requested.

## **Fit Testing**

Fit testing emerged as another requirement presenting significant challenges. The committee received scores of concerning feedback from multiple academic institutions and individuals regarding fit testing. The fit testing process, commonly conducted for new hospital employees and students, determines the appropriate N-95 mask size and type for the individual.

N-95 masks are essential for protecting healthcare workers from exposure to airborne illnesses such as COVID-19, tuberculosis (TB), and chickenpox. Historically, most institutions included fit testing as part of their onboarding procedures.

The fit testing process is relatively time-intensive, requiring specialized equipment, trained personnel, and approximately 15 minutes per individual (Occupational Health and Safety Administration, 2004). Moreover, fit testing is brand-specific, meaning it must be conducted using a specific N-95 mask brand. Since mask brands often vary not only within facilities but also between them, this presents a significant challenge.

Responsibility for fit testing has largely shifted to academic institutions, placing the burden on nursing schools to acquire fit testing equipment, train staff, and allocate time to fit test all students. Schools are also expected to maintain a stock of N-95 masks, but the extensive variation in mask types and brands makes this expectation impossible to meet effectively. To be

compliant, academic institutions would need to know the brand of N-95 used at every healthcare organization in Massachusetts and keep an adequate stock of those masks on hand.

The committee conducted an in-depth review of the fit testing process and its requirements, evaluating them against evidence-based practices. Discussions also focused heavily on the return on investment of fit testing, which allows students to care for a specific subset of the patient population. Questions concerned whether it provides any tangible educational benefits for students.

The committee also explored potential interventions the commonwealth could implement to ease the fit testing burden on nursing schools. Options considered included offering training programs and investing in quantitative fit testing technology. Unlike traditional qualitative methods, quantitative fit testing uses a machine to measure mask fit, providing more reliable results. This method also significantly reduces the time required, cutting it to approximately five minutes per individual.

Implementing this approach would require an initial investment of \$5,000 to \$10,000 per machine and additional staff training costs. However, this solution does not address the persistent issue of facilities using different mask brands, leaving schools responsible for maintaining a stock of various masks. Once again, the central question remains: what is the actual return on investment, and how does it benefit the student?

After extensive discussion, the committee proposed eliminating the fit testing requirement for nursing students in clinical placements. This would exclude students from caring for patients with conditions such as TB, COVID-19, measles, or chickenpox, but the impact on their overall learning experience was considered minimal to negligible. Additionally, it was acknowledged that some facilities, such as those with obstetric or pediatric units, may require fit testing. In such cases, the committee recommends that these facilities take responsibility for conducting the necessary fit testing themselves. The responsibility for fit testing must not remain with academic institutions.

Recognizing that eliminating fit testing for students marks a significant departure from long-standing tradition, the committee thoroughly vetted this idea through discussions with academic institutions and healthcare organizations across the commonwealth. The response was overwhelmingly supportive, with near-unanimous agreement that removing the fit testing requirement would provide substantial financial and time savings for academic institutions while posing no risk to students' health or learning experience.

Based on these findings, the committee recommends eliminating the fit testing requirement for all nursing students. This proposal acknowledges that students would not provide care for certain patient populations. Additionally, for specialty areas requiring fit testing, it is recommended that healthcare organizations take responsibility for the testing.

## **Student Immunizations**

Students are frequently required to meet varying vaccination and testing requirements across multiple facilities, often resulting in out-of-pocket expenses exceeding \$400.

The committee consulted with the Massachusetts Department of Public Health (DPH) to promote both compliance and a standardized approach to vaccination requirements. In collaboration with the Centers for Disease Control and Prevention (CDC), DPH has developed a set of standardized vaccination guidelines, which are outlined in Attachment D (Advisory Committee on Immunization Practices, 2024).

The committee recommends that healthcare organizations adopt the DPH and CDC guidelines as the standard for student immunization requirements. Special consideration was also given to flu vaccinations, COVID-19 vaccinations, and TB testing.

The committee recommends setting an annual deadline of October 31 for both flu and COVID vaccinations. This provides flexibility for the timing of vaccine availability, which can vary from year to year, and allows students sufficient time to complete the requirements. Some organizations currently set deadlines at the end of September, which often cannot be reasonably met year after year, especially considering the varying availability of vaccinations.

## **TB Testing**

TB testing emerged as the requirement with the most variation and the highest cost to students. While many healthcare organizations require initial TB testing upon hire, annual testing is no longer standard. Instead, many have transitioned to annual symptom reviews, conducting tests only on a "for cause" basis, such as when symptoms or exposure are present.

There are three standard methods for testing tuberculosis (TB): the two-step PPD test, the QuantiFERON Gold lab test, and the T-SPOT lab test. A chest X-ray is typically the preferred screening method for individuals who are high-risk or exhibit symptoms. The CDC comprehensively overviews TB screening methods and criteria (Centers for Disease Control, 2024).

However, these standards do not apply to students. Many healthcare organizations require students to have a negative TB test within three months of starting clinical placements, regardless of prior negative screenings within the past year, the absence of symptoms, or whether the student is in a high-risk category. For instance, a student who has had a negative QuantiFERON Gold test within the last year may still be required to undergo another test to meet healthcare facility requirements. This results in additional costs for the student, who must obtain a provider's order and pay out-of-pocket for the test—often totaling around \$400 since most insurance plans only cover annual employment screenings.

A student who completes multiple clinical rotations at different healthcare organizations each year may be required to undergo several TB screenings despite having a negative test result and no symptoms.

This disparity needs to be addressed. The committee recommends that students initially undergo a negative TB screening and then complete an annual symptom review. The committee also supports the option of a yearly TB screening. If any symptoms or exposure occur, the student should follow the CDC's guidelines for testing and follow-up.

## Recommendations

The Clinical Placements Committee of the NCWS conducted a comprehensive review of the processes governing nursing student placements in clinical learning settings within healthcare organizations. The requirements and procedures were found to be fragmented and inconsistent. However, throughout the research process, committee members reached a consensus on the need for a standardized approach to clinical placement processes.

Standardizing clinical placement processes offers numerous benefits without compromising patient health and safety. These benefits include, but are not limited to:

- a. A streamlined, more efficient pathway for healthcare organizations, reducing unnecessary administrative burdens.
- b. There are fewer administrative barriers for academic institutions, reducing faculty time spent on repetitive and unnecessary tasks.
- c. Lower costs and reduced burdens on students pursuing their nursing education.

The committee presents the following recommendations to improve nursing student clinical placements within the commonwealth.

### **1. Optimize the current Massachusetts Centralized Clinical Placement Management System**

The current system does not utilize HIPAA-compliant servers, resulting in a manual clinical placement process that places the burden on academic institutions. Additionally, students are unable to complete electronic forms or access key features of the system from their mobile devices.

Improved technology, already in use in other states, is available. We strongly recommend investing in updated systems to address these shortcomings. For more information on the CCP, please refer to the NCWS recommendation from December 2023 ([clinical-placements-recommendations--addendum-final-3-18-24.pdf](#)).

### **2. Standardize Basic Student Demographic Data and Eliminate The Transmission of Student Social Security Numbers via Unsecure Methods**

Academic institutions maintain comprehensive student records, and given the temporary and limited nature of clinical nursing students, a more streamlined approach to managing student information is both feasible and efficient. The committee recommends that demographic information adhere to the standardized format outlined in Attachment A.

Additionally, we urge healthcare organizations to reassess the necessity of collecting students' Social Security numbers. The practice of sending student lists with Social Security numbers is unsafe and should be discontinued. Most academic institutions lack the capability to send encrypted emails, creating a significant cybersecurity risk for students.

If healthcare organizations determine that a student's Social Security number is absolutely necessary, they must implement a secure method for collecting this information.

### **3. Adopt a Standardized Approach to Compliance Requirements for Students**

Before beginning their academic journeys, students must meet various compliance requirements, which are crucial for ensuring that the healthcare workforce is properly prepared and capable of providing safe patient care. As such, compliance is a fundamental aspect of the clinical placement process.

However, there is an opportunity to streamline these requirements, ensuring that standards are upheld while eliminating unnecessary repetition.

The committee recommends adopting the processes outlined in the Student Compliance Flowsheet in Attachment B. This recommendation also includes eliminating the fit testing requirement for students. Removing fit testing as a standard practice will save substantial time and money without negatively affecting student health, patient safety, or the quality of student learning.

### **4. Standardize Immunization Requirements to Meet Massachusetts Department of Health and Centers for Disease Control Guidelines**

The Massachusetts Department of Public Health (DPH) and the CDC provide clear guidelines on immunization requirements, including TB testing. However, the current approach to student clinical health requirements does not align with DPH or CDC standards and imposes unnecessary process and financial burdens on students.

Drawing on the DPH and CDC guidelines, the committee developed a Student Immunization Flowsheet, which also recommends a more evidence-based approach to student TB testing.

The committee recommends adopting this Student Immunization Flowsheet as the standard for nursing students entering clinical rotations.

### **5. Remove the Fit Testing Requirements for Clinical Nursing Students**

Current fit testing requirements place an undue burden upon schools of nursing to complete. Additionally, there is no measurable benefit to the nursing student's education in being able to care for the subset of the patient population that requires an N-95 mask.

The committee recommends eliminating the fit testing requirement for all nursing students based on research, current broken processes, and feedback from healthcare organizations and academic institutions. This proposal acknowledges that students would not provide care for certain patient populations. Additionally, for specialty areas requiring fit testing, it is recommended that healthcare organizations take responsibility for the testing.



## Closing

The clinical component of nursing education is a foundational and essential experience for students. To ensure its success, it is critical to have a clinical placement process free from unnecessary administrative burdens. Streamlining these processes benefits all parties involved, and standardizing them makes it easier to onboard new healthcare organizations, particularly in the long-term care sector, such as clinical placement sites.

The committee acknowledges and appreciates healthcare organizations' valuable role and will continue to play in nursing education. We recognize that standardization may require re-evaluating organizational policies and potentially revising affiliation agreements. However, this process is necessary as we work to expand clinical placement opportunities for the next generation of healthcare professionals.

**The *Clinical Placements Process Recommendation* was proposed by the Clinical Placements Committee and presented to the full NCWS on January 09, 2025. The NCWS voted to support the recommendation and passed unanimously.**

## References

Advisory Committee on Immunization Requirements (2024). Adult occupational immunizations Massachusetts recommendations and requirements. <https://www.mass.gov/doc/adult-occupational-immunizations-massachusetts-recommendations-and-requirements/download>

Centers for Disease Control (2024). Testing for tuberculosis. [Testing for Tuberculosis | Tuberculosis \(TB\) | CDC](#)

Commonwealth of Massachusetts (2024). Massachusetts Criminal Offender Record Information (CORI). [Massachusetts Criminal Offender Record Information \(CORI\) | Mass.gov](#)

Nursing Council on Workforce Sustainability (2023). [Clinical Placements Committee Proposal for the Massachusetts Centralized Clinical Placement Management System and Clinical Placement Processes. clinical-placements-recommendations--addendum-final-3-18-24.pdf](#)

Occupational Safety and Health Administration (2004). 1910.134 App A - Fit Testing Procedures (Mandatory). [1910.134 App A - Fit Testing Procedures \(Mandatory\). | Occupational Safety and Health Administration](#)

Price B. Improving nursing students' experience of clinical placements. Nurs Stand. 2019 Jun 10. doi: 10.7748/ns.2019.e11328. Epub ahead of print. PMID: 31468866.

# Attachment A

## Student Demographic Information

Process
The academic institution will collect student demographics and load it into the electronic clinical placement system. This information will be accessible by the healthcare organizations.
Student Data
<ul style="list-style-type: none"><li>• Name</li><li>• Birthdate</li><li>• Email</li><li>• Cell phone</li><li>• List of healthcare organizations which are current and former employers</li><li>• Last four digits of the social security number</li><li>• Clinical/Placement Coordinator name/contact information</li></ul>

## Attachment B

### Student Compliance

Process
<p>The academic institution will hold responsibility for ensuring that students remain compliant with the below measures. Additionally, each institution can load required compliance forms into a form bank within the electronic clinical placement system. The student will then be required to electronically sign the forms via the electronic clinical placement system.</p> <p>All students will sign an attestation that the below requirements have been met. This attestation will be verified by the academic institution.</p>
Student Compliance
<b>CORI</b> <ul style="list-style-type: none"><li>• Completed annually</li><li>• Additional criminal background checks required by facilities should be completed by the facilities</li></ul>
<b>Fingerprinting</b> <ul style="list-style-type: none"><li>• Facility specific; responsibility lies with the facility to complete</li></ul>
<b>BLS</b> <ul style="list-style-type: none"><li>• Valid American Heart Association BLS certification</li></ul>
<b>Fit Testing</b> <ul style="list-style-type: none"><li>• No longer require fit testing for students with the understanding that certain specialty areas may require it. In this situation it would be the facility's responsibility to complete the fit testing.</li></ul>
<b>Drug Testing</b> <ul style="list-style-type: none"><li>• Gold standard is to perform for cause drug testing</li><li>• Follow school policy</li><li>• Unique drug testing by facilities should be covered by the healthcare organization</li></ul>

# Attachment C

## Student Immunizations

Process
<p>The academic institution will hold responsibility for ensuring that students remain compliant with immunizations and will hold all available records in their possession. The academic institution will be able to provide this information to the healthcare organization upon request.</p> <p>All students will sign an attestation that the below requirements have been met. This attestation will be verified by the academic institution. The academic institution can also verify these requirements via an attestation if needed by the healthcare organization.</p>
Student Compliance
<b>MMR</b> <ul style="list-style-type: none"><li>• Two doses and/or a titer</li></ul>
<b>Varicella</b> <ul style="list-style-type: none"><li>• Two doses and/or a titer</li></ul>
<b>Hep B series and titer</b> <ul style="list-style-type: none"><li>• Documentation from provider required for non-converters</li><li>• Titer</li><li>• Waiver if indicated</li></ul>
<b>Tdap</b> <ul style="list-style-type: none"><li>• One dose within the last 10 years</li></ul>
<b>Meningococcal</b> <ul style="list-style-type: none"><li>• 1 dose received on or after the student's 16<sup>th</sup> birthday</li><li>• Student may decline with a waiver</li></ul>
<b>Flu or flu exemption</b> <ul style="list-style-type: none"><li>• Provided yearly; Deadline is 10/31</li></ul>
<b>COVID or COVID exemption</b> <ul style="list-style-type: none"><li>• Provided yearly</li><li>• Deadline is 10/31</li></ul>
<b>TB</b> <ul style="list-style-type: none"><li>• Provided yearly then upon any exposure events</li><li>• Two step or QuantiFERON gold are acceptable</li><li>• T-spot is also an acceptable method of testing</li></ul>

## Attachment D

### Massachusetts Department of Public Health Adult Occupational Immunizations

#### Adult Occupational Immunizations Massachusetts Recommendations and Requirements

Recommended Immunizations for Health Care Personnel (HCP)	
Vaccine	Recommendations in Brief
<b>Influenza</b>	1 dose of flu vaccine every flu season. All HCP should receive annual flu vaccine.
<b>Tdap/Td</b> (Tetanus, diphtheria, pertussis)	1 dose of Tdap if not previously received, then 1 booster dose of either Td or Tdap every 10 years. All HCP, regardless of age, should receive a single dose of Tdap as soon as feasible if they have not previously received Tdap, and regardless of the interval since last Td dose.
<b>MMR</b> (Measles, mumps, rubella)	2 doses of MMR, $\geq$ 28 days apart or presumptive evidence of immunity to measles <b>and</b> mumps <b>and</b> rubella. Presumptive evidence of immunity includes: a) 2 doses of MMR on or after the 1 <sup>st</sup> birthday and at least 1 month apart; or b) laboratory evidence of immunity to measles <b>and</b> mumps <b>and</b> rubella or laboratory confirmation of each disease (Consider HCP with "indeterminate" or "equivocal" immunity as susceptible).
<b>Varicella</b>	2 doses of varicella vaccine $\geq$ 4 weeks apart, or laboratory evidence of immunity, or laboratory confirmation of disease, or reliable history of varicella disease (chickenpox or herpes zoster) by a health-care provider, including school or occupational health nurse.
<b>Hepatitis B</b>	HCP should receive either 3 doses of the Engerix-B or Recombivax-HB formulations of the hepatitis B vaccine on a 0, 1, and 6 month schedule, or 2 doses of the Hcpisav-B formulation on a 0 and 1 month schedule. To test for hepatitis B surface antibody (anti-HBs), do so 1–2 months after the final dose in the series to document immunity.  For guidance about health care providers who received routine hepatitis B (HepB) vaccination during childhood, prevaccination testing, and revaccination, see CDC guidance for Prevention of Hepatitis B Virus Infection in the United States: Recommendations of the Advisory Committee on Immunization Practices <a href="https://www.cdc.gov/mmwr/volumes/67/rr/pdfs/rr6701-H.PDF">https://www.cdc.gov/mmwr/volumes/67/rr/pdfs/rr6701-H.PDF</a>
<b>Meningococcal Vaccines</b>	For microbiologists:  To protect against serogroups ACWY: Quadrivalent meningococcal conjugate vaccine (MenACWY) is recommended for microbiologists who are routinely exposed to <i>N. meningitidis</i> isolates. Microbiologists of all ages who remain at risk should be revaccinated every 5 years with MenACWY vaccine.  To protect against serogroup B: In addition to quadrivalent conjugate meningococcal vaccine, microbiologists routinely exposed to <i>N. meningitidis</i> should receive a meningococcal B series. Bexsero: 2 doses on a 0 and 1-6 month schedule, or Trumenba: 3 doses on a 0, 1-2 and 6 month schedule. If risk remains, administer 1 MenB booster dose 1 year after primary series and then every 2-3 years.
<b>COVID-19</b>	Appropriate number of doses to be up to date with COVID-19 vaccines. <a href="https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html">https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html</a>

**Health care personnel (HCP)** include full- and part-time staff with or without direct patient contact, including physicians, students, and volunteers who work in inpatient, outpatient and home-care settings. See Immunization of Health-Care Personnel - Recommendations of the ACIP. [www.cdc.gov/mmwr/pdf/rr/rr6007.pdf](http://www.cdc.gov/mmwr/pdf/rr/rr6007.pdf)

These guidelines are based on the recommendations of the Advisory Committee on Immunization Practices (ACIP). For specific ACIP recommendations, refer to the full statements at [www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/index.html](http://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/index.html); visit the MDPH website at [www.mass.gov/dph/imm](http://www.mass.gov/dph/imm); or call MDPH 617-983-6800.

#### Information on Vaccines for Travelers

Visit [www.cdc.gov/travel/default.aspx](http://www.cdc.gov/travel/default.aspx) or call the CDC Travel Hotline at 877-394-8747.

Vaccine	Recommendations in Brief
<b>MMR</b> (Measles, Mumps, Rubella)	2 doses, 4 weeks apart, for adults born $\geq$ 1957. 1 dose for adults born outside of the U.S. < 1957. Adults born in the U.S. < 1957 are considered immune. Evidence of immunity to measles, mumps and rubella is <b>required</b> for staff of licensed group and family day care centers (see table below) and <b>recommended</b> for teachers and staff in other school settings.
<b>Varicella</b>	2 doses, 4 weeks apart, for adults born in the U.S. $\geq$ 1980, or born outside the U.S. regardless of year of birth. Adults born < 1980 in the U.S. are considered immune. Laboratory evidence of immunity, laboratory confirmation of disease, or a reliable history of varicella disease (MD diagnosis or personal recall) is acceptable.
<b>Hepatitis B</b>	3 doses of the Engerix-B or Recombivax-HB formulations of the hepatitis B vaccine, or 2 doses of the Heplisav-B formulation. Laboratory evidence of immunity is acceptable. Federal OSHA regulations require some employers to offer hepatitis B vaccine to childcare staff whose responsibilities include first aid.
<b>Td/Tdap</b> (Tetanus, diphtheria, pertussis)	1 dose of Tdap if not previously received, then 1 booster dose of either Td or Tdap every 10 years. There is no minimum interval between Tdap and a previous dose of Td.
<b>Influenza</b>	1 dose of flu vaccine every flu season.
<b>COVID-19</b>	Appropriate number of doses to be up to date with COVID-19 vaccines. <a href="https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html">https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html</a>

<sup>1</sup> All full- and part-time teachers, student teachers, and staff.

Massachusetts Immunization Requirements for Select Occupational Groups <sup>1</sup>		
Group and Regulation	Requirement	Vaccination/Evidence of Immunity
Health care personnel assigned to maternal-newborn areas (105 CMR 130.626) (Circular letter: DHQ 11-90-300)	Immunity to measles and rubella	At least 1 dose of vaccine on or after 12 months of age; serologic evidence of immunity to rubella and measles. DPH no longer accepts physician-diagnosed disease as acceptable evidence of immunity.
Employees of licensed health care facilities [105 CMR 130.325; 105 CMR 140.150; 105 CMR 150.002 (D)(8)]	Annual influenza vaccination	Licensed health care facilities shall offer influenza vaccine at no cost to all employees and ensure that an employee who declines vaccination signs a statement declining vaccination and affirming that s/he received information about the risks and benefits of vaccination.
All personnel at rest homes, Assisted Living Residences, hospice programs, home care workers providing in-home, direct care services under a state contract or state program, and nursing home personnel [G.L. c. 111, § 73; 105 CMR 153.024(C)]	COVID-19 vaccination	Appropriate number of doses to be up to date with COVID-19 vaccines.
Staff of licensed group and family day cares and programs for school age children [606 CMR 7.09(11)]	Immunity to measles, mumps, and rubella	Those born in or after 1957, regardless of country of birth: 2 doses of MMR (or 2 doses of measles-containing vaccine) and 1 dose each of mumps and rubella vaccine at $\geq$ 12 months of age; or serologic evidence of immunity to measles, mumps and rubella. Those born before 1957 in the U.S. are considered immune. Those born before 1957 in countries other than the U.S.: 1 dose of MMR; or serologic evidence of immunity to measles, mumps, and rubella. Physician-diagnosed disease is <u>not</u> acceptable evidence of immunity.
Camp staff age 18 years and older (CMR 430.152)	Vaccination according to MDPH schedules	MMR: 2 doses, anyone born in or after 1957. 1 dose, anyone born before 1957 outside the U.S. Anyone born before 1957 in the U.S. is considered immune. Laboratory evidence of immunity to measles, mumps, and rubella is acceptable. Varicella: 2 doses, anyone born in or after 1980 in the U.S., and anyone born outside the U.S. Anyone born before 1980 in the U.S. is considered immune. A reliable history of chickenpox or laboratory evidence of immunity is acceptable. Tdap: 1 dose. Then Td or Tdap every 10 years. Hepatitis B: For staff with first aid responsibilities, 3 doses of the Engerix-B or Recombivax-HB formulations of the hepatitis B vaccine, or 2 doses of the Heplisav-B formulation. Laboratory evidence of immunity is acceptable.
Workers exposed to sewage [314 CMR 12.05(10)]		Workers exposed to sewage, as all other adults, should be vaccinated against diphtheria and tetanus, including a single dose of Tdap; and then 1 booster dose of either Td or Tdap every 10 years. Polio, typhoid, hepatitis A and hepatitis B vaccines are not routinely recommended for this group.

<sup>1</sup>Federal Occupational Safety and Health Administration (OSHA) regulations may include other immunization requirements for workers in certain occupational settings.