from vaccination policies that include use of a declination statement.[2,3]

Distinguishing between the 2 policies would have strengthened the article and made it more useful for organizations considering employee vaccination policies. We were struck by the fact that the use of declination forms was not separately included among the factors evaluated for their relative influence on influenza vaccine compliance within and between the 2 healthcare worker (HCW) groups. We would be interested to know whether the term "mandatory vaccination policies," as used by authors, included the declination process and, if so, precisely how it was accounted for in the design and execution of their study.

The use of declination forms has been reported in the literature to improve HCW influenza vaccine uptake.[4-6] These sources suggest that, to be effective, a declination policy needs to be combined with other vaccination strategies and include consequences for HCWs who decline vaccination and do not sign a declination form.

We believe that there would have been an added benefit to the study if the authors had (*a*) clearly defined the terms "declination" and "mandatory vaccination" at the outset and then treated them as separate, distinct factors when presenting the study methods, results, and conclusions and (*b*) investigated the effectiveness of a declination policy compared with a more extreme policy, such as making influenza vaccination a condition of continued employment for all HCWs except those with exemptions (eg, medical and religious).

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Reply to Soyemi et al

To the Editor—We appreciate the interest of Soyemi et al[1] in our article and study. Our instrument did differentiate between a mandatory vaccination policy and the use of declination statements. In addition to being asked about having a mandatory vaccination policy or use of declination forms, subjects were asked (*a*) if nonvaccinated staff had to wear a mask during patient care activities, (*b*) if nonvaccinated staff were fired for noncompliance, (*c*) if nonvaccinated staff had their paycheck held until they complied with the policy, and (*d*) if nonvaccinated staff had to attend a mandatory counseling/educational influenza transmission session. In this way, we were able to assess the extent to which the mandatory vaccination policy was enforced and/or documented; these results were included in our article.

In our regression, we assessed vaccination using the following categories: mandated, highly encouraged, informed, and nothing. Declination forms could have been a separate category (mandatory policy that excuses only medically contraindicated individuals or those with religious opposition versus mandatory policy consisting of written declination forms that also allow for opting out for personal reasons). However, statistically we could not separate these groups because of a corresponding cell count of 0 that caused a very high standard error in the regression model. We collapsed those categories, which solved the statistical problem. This approach also reinforced our pilot study findings that subjects had difficulty differentiating between mandatory vaccination and the use of declination forms. Pilot study participants indicated that they interpreted declination statements as a form of mandatory vaccination, albeit one in which healthcare personnel could still opt out of vaccination as long as they signed a statement indicating their religious or philosophical reason for not wanting the vaccine. Perhaps this is reflective of the current mandatory vaccination policies that exist in the Saint Louis region, where both the pilot testing and the full study were conducted. Differentiating between a declination policy and mandatory vaccination may be ben-

eficial for future studies that assess a different sample of healthcare personnel. These issues were not addressed in the article because of journal word-count limitations.

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