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ATTN: Healthcare Personnel Influenza Vaccination

To Whom It May Concern:

The Infectious Diseases Society of America (IDSA), the Pediatric Infectious Diseases Society (PIDS), and the Society for Healthcare Epidemiology of America (SHEA) are pleased to have the opportunity to comment on the National Vaccine Advisory Committee's (NVAC) Health Care Personnel Influenza Vaccination Subgroup's (HCPIVS) recommendations for improving Health Care Personnel (HCP) vaccination rates to reach the Healthy People 2020 annual goal of 90% influenza vaccine coverage.

IDSA, PIDS, and SHEA appreciate that the NVAC Adult Immunization Working Group established the HCPIVS to develop recommendations and strategies for addressing the gap between current HCP influenza immunization rates and the Healthy People 2020 goal of 90% vaccine coverage. The five recommendations from the HCPIVS encompass a tiered set of strategies for health care employers (HCE) and facilities, beginning with implementation of influenza infection prevention programs and vaccination programs, and progressing to consideration of employer mandates for HCP vaccination if the facility cannot achieve the targeted goal with other programs. While our Societies welcome recommendations that recognize the role of employer mandates, we regret that the draft NVAC recommendations do not provide much stronger support for employer requirements, as outlined in the 2010 SHEA position paper on influenza vaccination of HCP, endorsed by IDSA¹.

IDSA, PIDS, and SHEA urge the NVAC to strengthen its draft recommendations to strongly recommend policies for mandatory influenza vaccination of all health care personnel, unless valid medical contraindications exist, as the most efficient and reliable way of achieving targeted immunization rates. We maintain that it is difficult for health care facilities to achieve high HCP vaccination rates without employer mandate, and therefore the tiered recommendations will only result in delays in achieving higher vaccination rates and may result in failures if HCE and facilities merely "consider" an employer requirement and do not

¹ Talbot, TR et al., Revised SHEA Position Paper: Influenza Vaccination of Healthcare Personnel, *Infect Control Hosp Epidemiol*, 2010; **31**(10): 987-995.

implement one. There are numerous examples, many cited in the draft report, that demonstrate that organizations with a mandatory vaccination policy in place have a much higher immunization rate than those who have a voluntary program or no program at all. Facilities such as Virginia Mason Medical Center² and the Hospital Corporation of America³ have demonstrated the effectiveness of these policies by achieving and maintaining vaccination rates of 98% and 96%, respectively, compared to rates of 54% and 58%, respectively, prior to implementation of requirements. The Centers for Disease Control and Prevention (CDC) found that during the 2010-11 influenza season, vaccination coverage was 98.1% among HCE that required vaccination as a condition of employment, compared to 58.3% among those without a requirement⁴. While data cited in the draft HCPIVS report suggest that 90% vaccination rates can be achieved through comprehensive programs without a mandate, both the St. Jude Children's Research Hospital and the Iowa Health care Collaborative examples contain important caveats (elements such as an especially vulnerable patient population and strong leadership dedicated to this issue) that do not exist in all health care facilities.

Some critics have argued that employer mandates will lead to a false sense of security and decreased adherence to infection prevention programs. There are no data to support this argument, and it is contradicted by observations that multiple infection prevention strategies (including mandate programs) often synergize to reduce healthcare-associated infections (HAIs) (e.g., requiring operating room attire along with adherence to sterile technique and Surgical Care Improvement Project (SCIP) measures). If a false sense of security is a concern, it could arise both from an employer mandate as well as voluntary achievement of high vaccination rates. Regardless, our Societies strongly support comprehensive influenza educational efforts for HCP and continuation of comprehensive infection prevention and control programs, in addition to employer mandates. Such programs would include identification and isolation of infected patients, adherence to hand hygiene and cough etiquette, the appropriate use of personal protective equipment, and restriction of ill healthcare workers and visitors in the facility.

While HCP vaccination rates have risen in the last couple of years since the 2009 H1N1 pandemic, they are still well below the targeted goal of 90%. As the CDC data referenced in the report shows, 61.9% of HCP were vaccinated in the 2009-10 influenza season and 63.5% in the 2010-11 season. Universal vaccination of HCP is the cornerstone to a comprehensive national effort to prevent the spread of influenza in health care facilities during a seasonal influenza outbreak or a pandemic. In addition to the arguments raised above, the rationale behind our position on mandatory influenza vaccination of HCP is as follows:

- Several studies demonstrate that immunizing HCP against influenza reduces the risk of patients acquiring the virus from HCP, reducing both morbidity and mortality^{5,6,7,8,9,10,11,12,13}. Thus, universal immunization of HCP against seasonal influenza

² Rakita, R, et al., Mandatory influenza vaccination of healthcare workers: A 5-year study. *Infect Control Hosp Epidemiol*, 2010; **31**(9): 881-889.

³ Septimus, E, et al., A multifaceted mandatory patient safety program and seasonal influenza vaccination of healthcare workers in community hospitals, *JAMA*, 2011; **305**(10):999-1000.

⁴ CDC, Influenza Vaccination Coverage Among Health-Care Personnel—United States, 2010–11 Influenza Season, *MMWR Morb Mortal Wkly Rep*, 2011; **60**(32):1073-1077.

⁵ Potter J et al., Influenza vaccination of health care workers in long-term care hospitals reduces the mortality of elderly patients, *J Infect Dis*, 1997; **175**:1-6.

is a critical patient safety issue.

- Immunizing HCP against influenza also protects the individual HCP (and his/her family) from falling ill, thus both protecting the HCP from potentially serious illness while maintaining an adequate workforce, which further protects patients.
- Decades of scientific data demonstrate U.S. Food and Drug Administration (FDA)-approved influenza vaccines to be safe, effective, and cost-saving.
- Educational programs, declination policies and easy access to influenza immunization have resulted in modest improvements in coverage in many health care systems in recent years, but generally have not achieved acceptable levels of coverage. Despite extensive and sophisticated efforts, most successful educational programs still average only 40 to 70 percent rates of influenza vaccine coverage.
- Other professional societies such as the American College of Physicians, Association of Professionals in Infection Control, National Patient Safety Foundation, the American Academy of Pediatrics, the American Public Health Association, the National Foundation for Infectious Diseases, the American Medical Directors Association, the American Hospital Association, as well as the Department of Defense, many large health care systems and individual hospitals have adopted policies supporting mandatory influenza immunization. Many of these policies have resulted in vaccination rates greater than 95 percent.
- Physicians and other health care providers should adhere to their ethical and moral obligation to prevent transmission of infectious diseases to their patients and must have these special objectives in mind when treating patients: “to do good or to do no harm” (Hippocratic Corpus in *Epidemics*: Bk. I, Sect. 5, trans. Adams).

Our primary goal continues to be the effective delivery of patient care while protecting both patients and HCP from acquiring infections, including influenza, in health care settings. The best preventive measure against influenza is the use of a safe and effective influenza vaccine. Our Societies believe that the NVAC is taking an important step with these draft recommendations, but we once again urge you to consider strongly recommending that an employer mandate be a part of every comprehensive influenza prevention program, instead of

⁶ Carman WF et al., Effects of influenza vaccination of health-care workers on mortality of elderly people in long-term care: a randomised controlled trial, *Lancet* 2000; **355**:93-7.

⁷ Salgado CD et al., Preventing nosocomial influenza by improving the vaccine acceptance rate of clinicians, *Infect Control Hosp Epidemiol*, 2004; **25**(11):923-8.

⁸ Hayward AC et al., Effectiveness of an influenza vaccine programme for care home staff to prevent death, morbidity, and health service use among residents: cluster randomised controlled trial, *BMJ*, 2006; **333**(7581):1241-6.

⁹ Shugarman LR et al., The influence of staff and resident immunization rates on influenza-like illness outbreaks in nursing homes, *J Am Med Dir Assoc* 2006; **7**(9):562-7.

¹⁰ van den Dool C et al., The effects of influenza vaccination of health care workers in nursing homes: insights from a mathematical model, *PLoS Medicine*, 2008; **5**:1453-1460.

¹¹ Lemaitre M et al., Effect of influenza vaccination of nursing home staff on mortality of residents: a cluster-randomized trial, *J Am Geriatr Soc* 2009; **57**(9):1580-6.

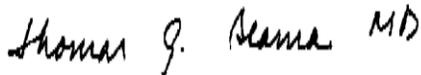
¹² van den Dool C et al., Modeling the effects of influenza vaccination of health care workers in hospital departments, *Vaccine*, 2009; **27**:6261-7.

¹³ Hayward AC and Watson J, Effectiveness of influenza vaccination of staff on morbidity, and mortality of residents of long term care facilities for the elderly, *Vaccine* 2011; **29**(13): 2357-8.

only being considered if other measures fail, as the best way to protect the health of both patients and HCP.

IDSA, PIDS and SHEA greatly appreciate the opportunity to comment on these draft recommendations. Should you have any questions, please do not hesitate to contact Audrey Jackson, PhD, IDSA's Senior Program Officer for Science and Research at ajackson@idsociety.org or 703.299.1216.

Sincerely,



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About Our Organizations:

Infectious Diseases Society of America (IDSA)

IDSA represents nearly 10,000 infectious diseases physicians and scientists devoted to patient care, prevention, public health, education, and research in the area of infectious diseases (ID). The Society's members focus on the epidemiology, diagnosis, investigation, prevention and treatment of infectious diseases in the United States and abroad. Our members care for patients of all ages with serious infections, including influenza, meningitis, pneumonia, tuberculosis, surgical infections, other life-threatening infections caused by unusual or drug-resistant microorganisms, and new and emerging infections, such as severe acute respiratory syndrome (SARS) and H1N1 influenza.

Pediatric Infectious Diseases Society (PIDS)

PIDS is a membership organization of over 1,000 specialists in pediatric infectious diseases, covering areas from basic and clinical research to patient care. PIDS' mission is to enhance the health of infants, children, and adolescents by promoting excellence in diagnosis, management, and prevention of infectious diseases through clinical care, education, research, and advocacy. PIDS represents the leading practitioners, policy-makers, and researchers who work with children's infectious diseases.

The Society for Healthcare Epidemiology of America (SHEA)

SHEA is a professional society representing more than 2,000 physicians and other healthcare professionals around the world with expertise in healthcare epidemiology and infection prevention and control. SHEA's mission is to prevent and control healthcare-associated infections and advance the field of healthcare epidemiology. The Society leads this field by promoting science and research and providing high-quality education and training in epidemiologic methods and prevention strategies. SHEA upholds the value and critical contributions of healthcare epidemiology to improving patient care and healthcare worker safety in all healthcare settings.