

September 28, 2005

**ASSOCIATION OF OCCUPATIONAL HEALTH PROFESSIONALS IN HEALTHCARE  
POSITION STATEMENT ON INFLUENZA VACCINE**

**HISTORICAL/BACKGROUND**

Influenza continues to be a major cause of death and disease, spread by respiratory droplets both in the community and healthcare facilities. Both healthcare workers and their patients are at risk of infection from exposure to each other.

Every year in the United States, on average:

- 5% to 20% of the population gets the flu;
- more than 200,000 people are hospitalized from flu complications, and;
- about 36,000 people die from flu.

Some people, such as older people, young children, and people with certain health conditions, are at high risk for serious flu complications. (1)

Influenza vaccine has been found to be the most helpful tool available to prevent the development and spread of the illness in the community at large and between patients and healthcare staff. The activity of the vaccine is most optimal with measurable results on an annual basis and prior to the start of the influenza season.

National vaccination rates for health care workers have been about 40%, even during years when there has been an ample supply of vaccine. Creative, comprehensive plans to increase compliance have been successful – as demonstrated in California and Minnesota – through incentives, mass vaccination clinics, peer vaccination programs, and creative marketing, with a rise in compliance at one facility from 42 to 76 percent over the span of two years. (2) There is also a facility in South Dakota that maintained an acceptance rate of the vaccine from 69-72% for several years with a similar program. (3)

**CONTROL STRATEGIES**

An influenza control program needs to consist of more than the use of the influenza vaccine, which is only one piece of a multi-faceted approach to infection control. Employees must also adhere to appropriate use of handwashing and personal protective equipment, and they should exercise proper respiratory etiquette in the work-place and self-removal from work when experiencing symptoms of a communicable respiratory illness. Influenza vaccine itself has variable effectiveness, as low as 47 and as high as 90 percent, depending on the match between antigens in the vaccine and circulating virus. (4) There are also antiviral medications

which have comparable efficacy to vaccination when taken as prophylaxis and can shorten the duration of illness and transmissibility when taken within 48 hours of onset of symptoms.

Reliance on employee vaccination alone for prevention and control of influenza in the health care environment offers a false sense of security and ignores some of the more practical and effective means of minimizing nosocomial transmission. Patients will continue to be exposed to influenza in the community because of the nature of the disease. In general, patients have much less contact to healthcare workers than they have to family and friends.

## **PROPOSED CHANGES TO HEALTHCARE INFLUENZA VACCINE**

It has come to the attention of AOHP that a recommendation is pending that will require every healthcare worker to sign a declination statement if they choose not to accept influenza vaccination or prophylactic medication. Implementing such a recommendation will present employers with some very difficult decisions. A breach of sanitary precautions should lead to corrective action, but refusal to take prophylactic measures that may affect the worker's personal health, i.e., live intranasal vaccine, injected inactivated vaccine or oral medication, raises significant ethical issues. An unvaccinated employee does not pose an immediate threat to patients if he/she has no respiratory symptoms. Even with such symptoms, the other measures (hand washing, etc.) mentioned above can greatly reduce the risk of transmission to patients and other staff members.

The rights of the patient must be weighed against the rights of employees. There may be work settings, such as an organ transplant unit, in which the patients are so immunocompromised that any risk of nosocomial transmission warrants administrative action. In such a setting, the unvaccinated employee might be offered temporary reassignment during the influenza season, but such action could not be justified in all health care settings.

## **AOHP'S POSITION**

AOHP agrees with the immunization of the general population emphasizing high-risk groups and with a tiered approach for healthcare workers depending on availability of the vaccine. These are both appropriate public health measures and strategies.

AOHP endorses a multifaceted influenza control program in all health care facilities and strongly encourages health care organizations to facilitate participation by providing influenza vaccine and/or prophylactic medication at no expense to the employee.

AOHP discourages generalized policies requiring mandatory compliance with employee vaccination or prophylactic medication. It has been suggested that healthcare organizations should require employees who refuse vaccination to sign declination forms. There is no evidence to suggest that such programs will increase compliance, and the burden of requiring compliance from those who have already chosen not to participate would place additional burdens on employee occupational health resources that could otherwise be devoted to positive reinforcement for compliance. Influenza control can be successful with creative programs while respecting the rights of both patients and employees.

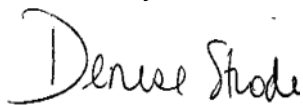
This position statement applies to seasonal influenza and does not necessarily apply during a pandemic situation.

We thank you for this opportunity to communicate our comments and look forward to an opportunity to provide additional information or assist you further. Please contact Sandra Prickitt at (415) 492-4790 or [prickis@sutterhealth.org](mailto:prickis@sutterhealth.org) for additional information. .

AOHP, a national association of approximately 1000 members, is dedicated to promoting the health and safety of workers in healthcare. This is accomplished through:

- A**dvocating for employee health and safety
- O**ccupational health education and networking opportunities
- H**ealth and safety advancement through best practice and research
- P**artnering with employers, regulatory agencies and related associations.

Sincerely,



## **REFERENCES**

1. CDC. Key Facts About Influenza and Influenza Vaccine. September 7, 2005.
2. CDC. Interventions to increase influenza vaccination of health-care workers – California and Minnesota. *MMWR*. 2005;54(08):196-199.
3. Boersam B, Rhames T, Keegan JM. Additional Cost Savings of an Effective Employee Influenza Program on Prevention of Nosocomial Influenza. *American Journal of Infection Control*. 1999; 27: 177-8.
4. CDC. Preliminary assessment of the effectiveness of the 2003-2004 inactivated influenza vaccine – Colorado, December 2003. *MMWR*. 2004;53:8-11
5. Raad I, Abbas J, Whimbey E. Infection control of nosocomial respiratory viral disease in the immunocompromised host. *Am J Med*. 1997;102(3A):48-52; discussion 53-4.
6. Morens DM, Rash VM. Lessons from a nursing home outbreak of influenza A. *Infect Control Hosp Epidemiol*. 1995;16(5):275-80.
7. CUPE Press Release. Paramedics get charter challenge 'booster', as workers' right to refuse flu shot upheld. April 24, 2002. [www.cupe.ca/www/News/3089](http://www.cupe.ca/www/News/3089).
8. Infectious Disease Society of America's Statement by Andrew T. Pavia, MD, concerning pandemic influenza, presented before the Committee on Energy and Commerce Subcommittee on Health, United States House of Representatives, May 26, 2005.

9. Nichol, Kristin and Hauge, Meri. Influenza Vaccination of Healthcare Workers. *Infection Control and Hospital Epidemiology*. 1997;18(3): 189-194.