American Hospital Association

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July 22, 2010

Julie Edelson
Influenza Coordination Unit
Centers for Disease Control and Prevention
Department of Health and Human Services
Attn: Prevention Strategies for Seasonal
Influenza in Healthcare Settings
1600 Clifton Road, NE., MS A–20
Atlanta, GA 30333

RE: Centers for Disease Control and Prevention (CDC); Updated Guidance: Prevention Strategies for Seasonal Influenza in Healthcare Settings (Vol. 75, No. 119), June 22, 2010

Dear Ms. Edelson:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our 40,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the *CDC's Updated Guidance on Prevention Strategies for Seasonal Influenza in Healthcare Settings*.

The AHA strongly supports the revisions made to the influenza prevention guidance document, particularly the emphasis on annual vaccination as the most important measure to prevent seasonal influenza infection, thus protecting health care personnel, visitors and patients. Hospitals use many strategies to maximize the vaccination rate among their workforce, such as providing incentives and making access to vaccination at work more convenient. A growing number of hospitals have been successful in implementing a mandatory vaccination policy for their workforce, although, as the CDC notes, this strategy remains controversial and can be difficult to implement. The AHA is committed to working with the CDC to improve hospital health care personnel influenza vaccination rates.

We also agree that to improve influenza vaccination rates, hospital and health systems need strong internal leadership that supports annual vaccinations and provides clear, fact-based and timely education and communication initiatives. But strong hospital leadership is only part of the equation for improving vaccination rates among health care workers. Hospitals frequently have found that certain unions representing health care workers have sought to delay or block the implementation of employee vaccination programs. Vaccination rates of health care workers could be improved with union support of hospitals' vaccination policies and programs. The AHA urges the CDC to encourage unions representing health care workers both to support the need for all health care personnel (unless contraindicated) to be vaccinated annually in order to protect fellow workers and patients and to provide clear, fact-based and timely education on vaccinations.

The AHA also supports the CDC's decision to return to the recommendation for standard and droplet precautions for seasonal influenza and H1N1 virus infection, including the use of facemasks for direct patient contact. We believe that the evidence to support this change has been in place for nearly a year. We understand why the CDC initially took a conservative posture in the early phase of the H1N1 pandemic, recommending modified airborne transmission precautions, such as suggesting the use of particulate respirators, e.g., N95 respirators, for the care of known or suspected H1N1 patients. In the interest of extra caution in addressing an unknown and novel type of influenza, this approach was understandable.

However, it quickly became clear that H1N1 influenza transmitted in much the same way as seasonal influenza, primarily through large-particle respiratory droplet transmission and to a lesser extent through indirect contact transmission from virus-contaminated hands or surfaces to mucosal surfaces of the face. Airborne transmission of H1N1 influenza infection via small particle aerosols from room to room has not been demonstrated, as the CDC noted in this updated guidance. By late July 2009, the CDC's own Healthcare Infection Control Practices Advisory Committee (HICPAC) had recommended a return to use of precautions based on droplet and contact transmission of H1N1. However, the CDC's three-pronged consultative strategy for updating its infection control guidance significantly delayed the final decision on how best to protect against the spread of H1N1 in health care settings.

The CDC needs to be able to respond in a timelier manner when science and clinical experience demonstrates and supports updated recommendations. The delay in deciding to follow the seasonal influenza approach for H1N1, i.e., standard and droplet precautions, caused unnecessary strain on hospitals and other health care facilities. They had to continually scramble to obtain adequate supplies of N95 respirators and ensure fit-testing for all staff who would be expected to come into contact with known or suspected H1N1 patients. This was a costly and burdensome process that occurred at a time of increased stress on the health care system due to patient volume. Unnecessary fit-testing of health care personnel and the use of respirators against a large droplet and contact spread disease is a waste of resources that could have been better used for direct patient care.

Again, we are pleased that the CDC has updated the influenza guidance. In order to better understand the transmission dynamics of influenza, the AHA encourages the agency to direct additional funding to laboratory and translational clinical research and epidemiological surveillance studies. We also support research into and the development of better fitting respirators that do not have to be fit-tested.

If you have any questions, please contact me or Roslyne Schulman, director for policy development, at (202) 626-2273 or rschulman@aha.org.

Sincerely,

Rick Pollack
Executive Vice President