Breaking Through the Status Quo: Improving Influenza Vaccination Coverage Among Health-Care Personnel

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No one wants to be admitted to a health-care facility, but when it is necessary, every patient expects to receive the highest quality care possible. Too often, however, admission leads to harm, not health. At any given time, one out of every 20 patients has an infection related to their hospital stay.¹ Such has been the case for far too long. The passage of the Patient Protection and Affordable Care Act of 2010 has brought not only a heightened commitment to better systems of health-care infection prevention, but also new tools and resources to improve quality of care and protect patients.²

Preventing the spread of seasonal influenza in health-care settings is an important element of any effort to improve patient safety. While influenza infections in patients and health-care personnel (HCP) often go undiagnosed or underreported,³ we know that influenza can spread from HCP to patients, from patients to HCP, and from HCP to HCP.^{4–7} In fact, evidence shows that HCP are at a greater risk of influenza infection than other healthy adults.⁸ For vulnerable patients, these transmissions can result in severe complications and sometimes even death.

Fortunately, improving policies for HCP influenza vaccination can substantially increase coverage and help reduce the likelihood that providers become infected or serve as vectors for infection.^{9–11} Although HCP influenza vaccination coverage rates have risen to nearly 67% in recent seasons,¹² they remain well below the 90% Healthy People 2020 goal.^{13,14} Notably, coverage rates differ by health-care setting. HCP influenza vaccination rates (for the 2011–2012 influenza season) reached 76.9% within hospital settings but only 52.4% within long-term care facilities,¹² where patients are at the highest risk of complications and death from influenza.^{15,16}

VACCINATION BARRIERS AND MISPERCEPTIONS

Known barriers to HCP vaccination primarily relate to misperceptions (i.e., knowledge and attitudes about influenza and the vaccine) and organizational challenges (i.e., availability and access).^{17–19} For example, HCP, like many others,

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may not perceive influenza as a significant risk or may have misconceptions about vaccine safety and efficacy. The extent to which these barriers influence HCP decisions differs among occupation, age, and racial/ethnic groups^{18,19} and may contribute to coverage disparities observed among different types of health-care settings.

Studies in long-term care facilities have shown that vaccinating HCP reduces overall patient mortality, highlighting the potential benefits of such efforts in these settings.^{20–24} However, a systematic review of the literature found that the available evidence was insufficient to conclude that HCP vaccination impacts patient outcomes.²⁵ Clearly, continued research is warranted to evaluate the role of HCP vaccination in patient safety improvement efforts. In the meantime, complacency is not an acceptable alternative; vaccination is our most effective intervention in preventing influenza infections in HCP and in patients.

IMPROVING VACCINATION COVERAGE

So, how do we best improve HCP vaccination coverage? This question has triggered the interest of major health groups nationwide, including patient advocacy groups, professional associations, public health organizations, labor organizations, and employers. Debate surrounds the question of how best to make progress toward a goal that has been endorsed by all—based on our shared commitment to patient safety—even in the face of less-than-perfect evidence.

The Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) has outlined key components for a comprehensive HCP influenza vaccination program.²⁶ Essential elements include educating HCP on the benefits and risks of influenza vaccination, making the vaccine accessible and available at the worksite at convenient times and at no cost, and reporting coverage as a quality measure. However, many facilities have found that such a comprehensive program is necessary, but not sufficient, for success. Additional measures are needed.²⁷

Four major developments are accelerating the momentum for progress. First, in this issue of *Public Health Reports*, the U.S. Department of Health and Human Services (HHS) National Vaccine Advisory Committee (NVAC) presents evidence-based recommendations to improve HCP vaccination rates. The tiered approach, incorporating proven interventions, represents a call to action. The recommendations, which align with ACIP guidelines, include (1) implementing influenza prevention programs that highlight

vaccination as an integral component of infection control, (2) managing influenza vaccination programs for HCP that address barriers to coverage, and (3) measuring and reporting HCP vaccination coverage as a mechanism to achieve target goals and improve existing programs. As these issues affect working conditions and personal choices, policies need to incorporate ethical considerations for patient care, employee rights, and individual autonomy.

Second, the NVAC recommendations add depth and detail to the HHS 2008 “National Action Plan to Prevent Healthcare-Associated Infections,” a comprehensive roadmap for hospitals and other health-care settings.²⁸ An updated version of the Action Plan, which was anticipated to be released in late 2012, specifically emphasizes the need to improve HCP influenza vaccination, particularly in long-term care settings.

Third, the Joint Commission recently strengthened its standard for influenza vaccination of licensed independent practitioners and staff. This standard now states that by July 2013, all facilities seeking accreditation are required to develop influenza vaccination programs that meet defined elements of performance. These elements include setting incremental targets that stimulate commitment toward achieving national goals and then demonstrating progress toward meeting them.²⁹ Incorporating influenza vaccination of HCP into formal accreditation standards can generate momentum and progress in hospitals across the country. All of these efforts remind us that the most successful public health interventions create new social norms and raise the expectations for what constitutes quality.

Fourth, starting in January 2013, the Centers for Medicare & Medicaid Services will require most acute care hospitals to report seasonal influenza vaccination coverage among HCP using CDC’s National Healthcare Safety Network as part of the Hospital Inpatient Quality Reporting program. Hospitals that fail to report will be subject to a 2% reduction in the annual payment increase under the hospital Inpatient Prospective Payment System.³⁰ Data will be made publicly available on the www.hospitalcompare.hhs.gov website beginning in the 2013–2014 season. The measure, endorsed by the National Quality Forum, will help consumers make health-care decisions based on quality and will encourage acute care hospitals to improve integration of HCP influenza vaccination into infection-control programs. New data on annual vaccination rates among different health-care facilities will highlight high performers and could help to identify best practices for stimulating further improvements.

CONCLUSION

In short, heightened attention to maximizing HCP influenza vaccination rates can create safer working environments. We must break through the status quo and increase HCP influenza vaccination coverage rates, which have been low for far too long. The time has come for all of us to work together to determine not if, but how improving HCP influenza vaccination rates can create the higher standards for quality and safety that everyone deserves.

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