

Place: Audio Conference Call via FTS Conferencing. The USA toll-free, dial in number is 1-866-659-0537 and the pass code is 9933701.

Status: Open to the public, but without a public comment period.

Background: The Advisory Board was established under the Energy Employees Occupational Illness Compensation Program Act of 2000 to advise the President on a variety of policy and technical functions required to implement and effectively manage the new compensation program. Key functions of the Advisory Board include providing advice on the development of probability of causation guidelines, which have been promulgated by the Department of Health and Human Services (HHS) as a final rule; advice on methods of dose reconstruction, which have also been promulgated by HHS as a final rule; advice on the scientific validity and quality of dose estimation and reconstruction efforts being performed for purposes of the compensation program; and advice on petitions to add classes of workers to the Special Exposure Cohort (SEC).

In December 2000, the President delegated responsibility for funding, staffing, and operating the Advisory Board to HHS, which subsequently delegated this authority to the CDC. NIOSH implements this responsibility for CDC. The charter was issued on August 3, 2001, renewed at appropriate intervals, most recently, August 3, 2009, and will expire on August 3, 2011.

Purpose: This Advisory Board is charged with: (a) Providing advice to the Secretary, HHS, on the development of guidelines under Executive Order 13179; (b) providing advice to the Secretary, HHS, on the scientific validity and quality of dose reconstruction efforts performed for this program; and (c) upon request by the Secretary, HHS, advising the Secretary on whether there is a class of employees at any Department of Energy facility who were exposed to radiation but for whom it is not feasible to estimate their radiation dose, and on whether there is reasonable likelihood that such radiation doses may have endangered the health of members of this class.

Matters to be Discussed: The agenda for the conference call includes: SEC Petitions for Blockson Chemical, General Electric Company (Ohio), and Chapman Valve; NIOSH 10-Year Review of its Division of Compensation Analysis and Support (DCAS) Program; Review of Public Comments to the Advisory Board during February Meeting; Advisory Board Subcommittee and Work Group Updates; and, DCAS

SEC Petition Evaluations Update for the August 2010 Advisory Board Meeting.

The agenda is subject to change as priorities dictate.

Because there is not a public comment period, written comments may be submitted. Any written comments received will be included in the official record of the meeting and should be submitted to the contact person below in advance of the meeting.

FOR FURTHER INFORMATION CONTACT:

Contact Person For More Information: Theodore M. Katz, M.P.A., Executive Secretary, NIOSH, CDC, 1600 Clifton Rd., NE., Mailstop: E-20, Atlanta, GA 30333, Telephone (513) 533-6800, Toll Free 1-800-CDC-INFO, e-mail ocas@cdc.gov.

The Director, Management Analysis and Services Office, has been delegated the authority to sign **Federal Register** notices pertaining to announcements of meetings and other committee management activities, for both CDC and the Agency for Toxic Substances and Disease Registry.

Dated: June 15, 2010.

Elaine L. Baker, M.P.H.,

Director, Management Analysis and Services Office, Centers for Disease Control and Prevention.

[FR Doc. 2010-15016 Filed 6-21-10; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Updated Guidance: Prevention Strategies for Seasonal Influenza in Healthcare Settings

AGENCY: Centers for Disease Control and Prevention (CDC), Department of Health and Human Services (HHS).

ACTION: Notice with comment period.

SUMMARY: The Centers for Disease Control and Prevention (CDC), located in the Department of Health and Human Services (HHS), seeks public comment on proposed new guidance which will update and replace previous seasonal influenza guidance and the *Interim Guidance on Infection Control Measures for 2009 H1N1 Influenza in Healthcare Settings*.

The updated guidance emphasizes a prevention strategy to be applied across the entire spectrum of healthcare settings, including hospitals, nursing homes, physicians' offices, urgent-care centers, and home health care, but is not intended to apply to settings whose primary purpose is not health care. It

focuses on the importance of vaccination, steps to minimize the potential for exposure such as respiratory hygiene, management of ill healthcare workers, droplet and aerosol-generating procedure precautions, surveillance, and environmental and engineering controls.

CDC will consider the comments received and intends to publish the final guidance prior to the 2010-2011 influenza season.

DATES: Written comments must be received on or before July 22, 2010. Comments received after July 22, 2010 will be considered to the extent possible.

ADDRESSES: You may submit written comments to the following address: Influenza Coordination Unit, Centers for Disease Control and Prevention, U.S. 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.

You may also submit written comments via e-mail to: ICUpubliccomments@cdc.gov.

FOR FURTHER INFORMATION CONTACT: Julie Edelson, Influenza Coordination Unit, Centers for Disease Control and Prevention, 1600 Clifton Road, NE., MS A-20, Atlanta, GA 30333; telephone 404-639-2293.

SUPPLEMENTARY INFORMATION: In 2009, CDC posted on its Web site *Interim Guidance on Infection Control Measures for 2009 H1N1 Influenza in Healthcare Settings, Including Protection of Healthcare Personnel*. At the time it was posted, uncertainties existed regarding the novel H1N1 influenza strain, and the vaccine was not yet widely available. As stated in that document, CDC planned to update the guidance when new information became available. Since then, circumstances have changed. A safe and effective vaccine has become widely available, and is being included in the 2010-2011 seasonal influenza vaccine. Further, we now have information about the number of cases of disease, hospitalizations, and deaths caused by 2009 H1N1, which can be compared to historical seasonal influenza data. At this point, an update of the guidance to address current circumstances is warranted.

Additionally, recommendations for prevention of seasonal influenza in healthcare facilities are currently found throughout the influenza section of the CDC Web site. By posting this proposed guidance, CDC will consolidate a range of evidence-based strategies into a comprehensive, easily-accessible document.

Proposed Updated Guidance

CDC proposes to update and replace previous seasonal influenza guidance and the *Interim Guidance on Infection Control Measures for 2009 H1N1 Influenza in Healthcare Settings, Including Protection of Healthcare Personnel*, as follows below.

Dated: June 16, 2010.

Tanja Popovic,

Deputy Associate Director for Science,
Centers for Disease Control and Prevention.

Prevention Strategies for Seasonal Influenza in Healthcare Settings

This guidance supersedes previous CDC guidance for both seasonal influenza and the Interim Guidance on Infection Control Measures for 2009 H1N1 Influenza in Healthcare Settings, which was written to apply uniquely to the special circumstances of the 2009 H1N1 pandemic as they existed in October 2009. As stated in that document, CDC planned to update the guidance as new information became available. In particular, one major change from the spring and fall of 2009 is the widespread availability of a safe and effective vaccine for the 2009 H1N1 influenza virus. Second, the overall risk of hospitalization and death among people infected with this strain, while uncertain in spring and fall of 2009 is now known to be substantially lower than pre-pandemic assumptions. The current circumstances and new information justify an update of the recommendations. This updated guidance continues to emphasize the importance of a comprehensive influenza prevention strategy that can be applied across the entire spectrum of healthcare settings. CDC will continue to evaluate new information as it becomes available and will update or expand this guidance as needed. Additional information on influenza prevention, treatment, and control can be found on CDC's influenza Web site: www.cdc.gov/flu.

Definition of Healthcare Settings

For the purposes of this guidance, healthcare settings include, but are not limited to, acute-care hospitals; long-term care facilities, such as nursing homes and skilled nursing facilities; physicians' offices; urgent-care centers, outpatient clinics; and home healthcare. This guidance is not intended to apply to other settings whose primary purpose is not healthcare, such as schools or worksites, because many of the aspects of the populations and feasible countermeasures will differ substantially across settings. However, elements of this guidance may be

applicable to specific sites within non-healthcare settings where care is routinely delivered (e.g., a medical clinic embedded within a workplace or school).

Definition of Healthcare Personnel

For the purposes of this guidance, the 2008 Department of Health and Human Services definition of Healthcare Personnel (HCP) will be used [<http://www.hhs.gov/ophsp/programs/initiatives/vacctoolkit/definition.html>]. Specifically, HCP refers to all persons, paid and unpaid, working in healthcare settings who have the potential for exposure to patients and/or to infectious materials, including body substances, contaminated medical supplies and equipment, contaminated environmental surfaces, or contaminated air. HCP include but are not limited to physicians, nurses, nursing assistants, therapists, technicians, emergency medical service personnel, dental personnel, pharmacists, laboratory personnel, autopsy personnel, students and trainees, contractual personnel, home healthcare personnel, and persons not directly involved in patient care (e.g., clerical, dietary, housekeeping, laundry, security, maintenance, billing, chaplains, and volunteers) but potentially exposed to infectious agents that can be transmitted to and from HCP and patients. This guidance is not intended to apply to persons outside of healthcare settings for reasons discussed in the previous section.

Introduction

Influenza is primarily a community-based infection that is transmitted in households and community settings. Each year, 5% to 20% of U.S. residents acquire an influenza virus infection, and many will seek medical care in ambulatory healthcare settings (e.g., pediatricians' offices, urgent-care clinics). In addition, more than 200,000 persons, on average, are hospitalized each year for influenza-related complications [<http://www.cdc.gov/flu/keyfacts.htm>]. Healthcare-associated influenza infections can occur in any healthcare setting and are most common when influenza is also circulating in the community. Therefore, the influenza prevention measures outlined in this guidance should be implemented in all healthcare settings. Supplemental measures may need to be implemented during influenza season if outbreaks of healthcare-associated influenza occur within certain facilities, such as long-term care facilities and hospitals [refs: Infection Control Guidance for the Prevention and Control of Influenza in

Acute-care Settings: <http://www.cdc.gov/flu/professionals/infectioncontrol/healthcarefacilities.htm>; Infection Control Measures for Preventing and Controlling Influenza Transmission in Long-Term Care Facilities: <http://www.cdc.gov/flu/professionals/infectioncontrol/longtermcare.htm>].

Influenza Modes of Transmission

Traditionally, influenza viruses have been thought to spread from person to person primarily through large-particle respiratory droplet transmission (e.g., when an infected person coughs or sneezes near a susceptible person) [<http://www.cdc.gov/flu/professionals/acip/clinical.htm>]. Transmission via large-particle droplets requires close contact between source and recipient persons, because droplets generally travel only short distances (approximately 6 feet or less) through the air. Indirect contact transmission via hand transfer of influenza virus from virus-contaminated surfaces or objects to mucosal surfaces of the face (e.g., nose, mouth, eyes) may be possible. Airborne transmission via small particle aerosols in the vicinity of the infectious individual may also occur; however, the relative contribution of the different modes of influenza transmission is unclear. Airborne transmission over longer distances, such as from one patient room to another has not been documented and is thought not to occur. All respiratory secretions and bodily fluids, including diarrheal stools, of patients with influenza are considered to be potentially infectious; however, the risk may vary by strain. Detection of influenza virus in blood or stool in influenza infected patients is very uncommon.

Fundamental Elements To Prevent Influenza Transmission

Preventing transmission of influenza virus and other infectious agents within healthcare settings requires a multi-faceted approach. Spread of influenza virus can occur among patients, HCP, and visitors; in addition, HCP may acquire influenza from persons in their household or community. The core prevention strategies include:

- Administration of influenza vaccine.
- Implementation of respiratory hygiene and cough etiquette.
- Appropriate management of ill HCP.
- Adherence to infection control precautions for all patient-care activities and aerosol-generating procedures.
- Implementing environmental and engineering infection control measures.

Successful implementation of many if not all of these strategies is dependent on the presence of clear administrative policies and organizational leadership that promote and facilitate adherence to these recommendations among the various people within the healthcare setting, including patients, visitors, and HCP. These administrative measures are included within each recommendation where appropriate. Furthermore, this guidance should be implemented in the context of a comprehensive infection prevention program to prevent transmission of all infectious agents among patients and HCP.

Specific Recommendations

1. Promote and Administer Seasonal Influenza Vaccine

Annual vaccination is the most important measure to prevent seasonal influenza infection. Achieving high influenza vaccination rates of HCP and patients is a critical step in preventing healthcare transmission of influenza from HCP to patients and from patients to HCP. According to current national guidelines, unless contraindicated, vaccinate all people aged 6 months and older, including HCP, patients and residents of long-term care facilities [refs: <http://www.cdc.gov/flu/professionals/vaccination/> and <http://www.cdc.gov/vaccines/recs/provisional/downloads/flu-vac-mar-2010-508.pdf>].

Strategies to improve HCP vaccination rates include providing incentives, providing vaccine at no cost to HCP, improving access (e.g., offering vaccination at work and during work hours), and requiring personnel to sign declination forms to acknowledge that they have been educated about the benefits and risks of vaccination. While some have mandated influenza vaccination for all HCP who do not have a contraindication, it should be noted that mandatory vaccination of HCP remains a controversial issue. Tracking influenza vaccination coverage among HCP can be an important component of a systematic approach to protecting patients and HCP. Regardless of the strategy used, strong organizational leadership and an infrastructure for clear and timely communication and education, and for program implementation, have been common elements in successful programs. More information on different HCP vaccination strategies can be found in the Appendix: Influenza Vaccination Strategies.

2. Take Steps To Minimize Potential Exposures

A range of administrative policies and practices can be used to minimize influenza exposures before arrival, upon arrival, and throughout the duration of the visit to the healthcare setting. Measures include screening and triage of symptomatic patients and implementation of respiratory hygiene and cough etiquette. Respiratory hygiene and cough etiquette are measures designed to minimize potential exposures of all respiratory pathogens, including influenza virus, in healthcare settings and should be adhered to by everyone—patients, visitors, and HCP—upon entry and continued for the entire duration of stay in healthcare settings [<http://www.cdc.gov/flu/professionals/infectioncontrol/resphygiene.htm>].

Before Arrival to a Healthcare Setting

- When scheduling appointments, instruct patients and persons who accompany them to inform HCP upon arrival if they have symptoms of any respiratory infection (e.g., cough, runny nose, fever) and to take appropriate preventive actions (e.g., wear a facemask upon entry, follow triage procedure).
- During periods of increased influenza activity:
 - Take steps to minimize elective visits by patients with suspected or confirmed influenza. For example, consider establishing procedures to minimize visits by patients seeking care for mild influenza-like illness who are not at increased risk for complications from influenza (e.g., provide telephone consultation to patients with mild respiratory illness to determine if there is a medical need to visit the facility).

Upon Entry and During Visit to a Healthcare Setting

- Take steps to ensure all persons with symptoms of a respiratory infection adhere to respiratory hygiene, cough etiquette, hand hygiene, and triage procedures throughout the duration of the visit. These might include:
 - Posting visual alerts (e.g., signs, posters) at the entrance and in strategic places (e.g., waiting areas, elevators, cafeterias) to provide patients and HCP with instructions (in appropriate languages) about respiratory hygiene and cough etiquette, especially during periods when influenza virus is circulating in the community. Instructions should include:
 - How to use facemasks or tissues to cover nose and mouth when coughing or sneezing and to dispose of

contaminated items in waste receptacles.

- How and when to perform hand hygiene.
 - Implementing procedures during patient registration that facilitate adherence to appropriate precautions (e.g., at the time of patient check-in, inquire about presence of symptoms of a respiratory infection, and if present, provide instructions).
 - Provide facemasks (*See* definition of facemask in Appendix) to patients with signs and symptoms of respiratory infection and supplies to perform hand hygiene to all patients upon arrival to facility (e.g., at entrances of facility, waiting rooms, at patient check-in) and throughout the entire duration of the visit to the healthcare setting.
 - Provide space and encourage persons with symptoms of respiratory infections to sit as far away from others as possible (at least three feet but preferably six feet away from others, if feasible). If available, facilities may wish to place these patients in a separate area while waiting for care.
 - During periods of increased community influenza activity, facilities should consider setting up triage stations that facilitate rapid screening of patients for symptoms of influenza and separation from other patients.

3. Monitor and Manage Ill Healthcare Personnel

HCP who develop fever and respiratory symptoms should be:

- Instructed not to report to work, or if at work, to stop patient-care activities, don a facemask, and promptly notify their supervisor and infection control personnel/occupational health before leaving work.
 - Excluded from work until at least 24 hours after they no longer have a fever, without the use of fever-reducing medicines such as acetaminophen.
 - Considered for temporary reassignment or exclusion from work for 7 days from symptom onset or until the resolution of symptoms, whichever is longer, if returning to care for patients in a Protective Environment (PE) such as hematopoietic stem cell transplant patients (HSCT) [<http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf>].
 - HCP recovering from a respiratory illness may return to work with PE patients sooner if absence of influenza viral RNA in respiratory secretions is documented by real-time reverse transcriptase polymerase chain reaction (rRT-PCR).
 - Patients in these environments are severely immunocompromised, and infection with influenza virus can lead to severe disease. Furthermore, once

infected, these patients can have prolonged viral shedding despite antiviral treatment and expose other patients to influenza virus infection. Prolonged shedding also increases the chance of developing and spreading antiviral-resistant influenza strains; clusters of influenza antiviral resistance cases have been found among severely immunocompromised persons exposed to a common source or healthcare setting.

- Reminded that adherence to respiratory hygiene and cough etiquette after returning to work remains important because viral shedding may occur for several days after resolution of fever. If symptoms such as cough and sneezing are still present, HCP should wear a facemask during patient-care activities. The importance of performing frequent hand hygiene (especially before and after each patient contact and contact with respiratory secretions) should be reinforced.

- HCP with influenza or many other infections may have fever alone as an initial symptom or sign. Thus, it can be very difficult to distinguish influenza from many other causes, especially early in a person's illness. HCP with fever alone should follow workplace policy for HCP with fever until a more specific cause of fever is identified or until fever resolves.

HCP who develop acute respiratory symptoms without fever may still have influenza infection but should be:

- Allowed to continue or return to work unless assigned to care for patients requiring a PE such as HSCT [<http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf>]; these HCP should be considered for temporary reassignment or excluded from work for 7 days from symptom onset or until the resolution of all non-cough symptoms, whichever is longer. HCP recovering from a respiratory illness may return to work with patients in PE sooner if absence of influenza viral RNA in respiratory secretions is documented by rRT-PCR.

- Reminded that adherence to respiratory hygiene and cough etiquette after returning to work remains important because viral shedding may occur for several days following an acute respiratory illness. If symptoms such as cough and sneezing are still present, HCP should wear a facemask during patient care activities. The importance of performing frequent hand hygiene (especially before and after each patient contact) should be reinforced.

Facilities and organizations providing healthcare services should:

- Develop sick leave policies for HCP that are non-punitive, flexible and consistent with public health guidance

to allow and encourage HCP with suspected or confirmed influenza to stay home.

- Policies and procedures should enhance exclusion of HCPs who develop a fever and respiratory symptoms from work for at least 24 hours after they no longer have a fever, without the use of fever-reducing medicines.

- Ensure that all HCP, including staff who are not directly employed by the healthcare facility but provide essential daily services, are aware of the sick leave policies.

- Employee health services should establish procedures for tracking absences; reviewing job tasks and ensuring that personnel known to be at higher risk for exposure to those with suspected or confirmed influenza are given priority for vaccination; ensuring that employees have access via telephone to medical consultation and, if necessary, early treatment; and promptly identifying individuals with possible influenza. HCP should self-assess for symptoms of febrile respiratory illness. In most cases, decisions about work restrictions and assignments for personnel with respiratory illness should be guided by clinical signs and symptoms rather than by laboratory testing for influenza because laboratory testing may result in delays in diagnosis, false negative test results, or both.

4. Adhere to Standard Precautions

During the care of any patient, all HCP in every healthcare setting should adhere to standard precautions, which are the foundation for preventing transmission of infectious agents in all healthcare settings. Standard precautions assume that every person is potentially infected or colonized with a pathogen that could be transmitted in the healthcare setting. Elements of standard precautions that apply to patients with respiratory infections, including those caused by the influenza virus, are summarized below. Additional details about these recommendations can be found in the CDC Healthcare Infection Control Practices Advisory Committee (HICPAC) guideline titled *Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings and Guidelines for Preventing Healthcare-Associated Pneumonia* [http://www.cdc.gov/hicpac/2007IP/2007ip_part4.html#4; <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5303a1.htm>].

Hand Hygiene

- HCP should perform hand hygiene frequently, including before and after all patient contact, contact with potentially infectious material, and before putting on and upon removal of personal protective equipment, including gloves. Washing with soap and water or using alcohol-based hand rubs can be used in healthcare settings. If hands are visibly soiled, use soap and water, not alcohol-based hand rubs.

- Healthcare facilities should ensure that supplies for performing hand hygiene are available.

Gloves

- Wear gloves for any contact with potentially infectious material. Remove gloves after contact, followed by hand hygiene. Do not wear the same pair of gloves for care of more than one patient. Do not wash gloves for the purpose of reuse.

Gowns

- Wear gowns for any patient-care activity when contact with blood, body fluids, secretions (including respiratory), or excretions is anticipated.

5. Adhere to Droplet Precautions

- Droplet precautions should be implemented for patients with suspected or confirmed influenza for 7 days after illness onset or until 24 hours after the resolution of fever and respiratory symptoms, whichever is longer, while a patient is in a healthcare facility. In some cases, facilities may choose to apply droplet precautions for longer periods based on clinical judgment, such as in the case of young children or severely immunocompromised patients, who may shed influenza virus for longer periods of time [http://www.cdc.gov/hicpac/2007IP/2007ip_part4.html#5].

- Place patients with suspected or confirmed influenza in a private room or area. When a single patient room is not available, consultation with infection control personnel is recommended to assess the risks associated with other patient placement options (e.g., cohorting [*i.e.*, grouping patients infected with the same infectious agents together to confine their care to one area and prevent contact with susceptible patients], keeping the patient with an existing roommate). For more information about making decisions on patient placement for droplet precautions, see CDC HICPAC *Guidelines for Isolation Precautions* [section V.C.2: http://www.cdc.gov/hicpac/2007IP/2007ip_part4.html#5].

- HCP should don a facemask when entering the room of a patient with suspected or confirmed influenza. Remove the facemask when leaving the patient's room, dispose of the facemask in a waste container, and perform hand hygiene.

- Based on their local needs, facilities and organizations may opt to provide employees with alternative personal protective equipment as long as it offers the same protection of the nose and mouth from splashes and sprays provided by facemasks (e.g., face shields and N95 respirators or powered air purifying respirators which would also protect against inhaling airborne particles).

- If a patient under droplet precautions requires movement or transport outside of the room:

- Have the patient wear a facemask, if possible, and follow respiratory hygiene and cough etiquette and hand hygiene.

- Communicate information about patients with suspected, probable, or confirmed influenza to appropriate personnel before transferring them to other departments in the facility (e.g., radiology, laboratory) or to other facilities.

- Patients under droplet precautions should be discharged from medical care when clinically appropriate, not based on the period of potential virus shedding or recommended duration of droplet precautions. Before discharge, communicate the patient's diagnosis and current precautions with post-hospital care providers (e.g., home-healthcare agencies, long-term care facilities) as well as transporting personnel.

6. Use Caution When Performing Aerosol-Generating Procedures

Some procedures performed on patients with suspected or confirmed influenza infection may be more likely to generate higher concentrations of infectious respiratory aerosols than coughing, sneezing, talking, or breathing. These procedures potentially put HCP at an increased risk for influenza exposure. Although there are limited data available on influenza transmission related to such aerosols, many authorities [refs: WHO, <http://www.who.int/csr/resources/publications/aidememoireepidemicpandemid/en/index.html>] recommend that additional precautions be used for the following procedures: Bronchoscopy; sputum induction; endotracheal intubation and extubation; open suctioning of airways; cardiopulmonary resuscitation; autopsies. A combination of measures

should be used to reduce exposures from these aerosol-generating procedures performed on patients with suspected or confirmed influenza, including:

- Only performing these procedures on patients with suspected or confirmed influenza if they are medically necessary and cannot be postponed.

- Limiting the number of HCP present during the procedure to only those essential for patient care and support. All HCP that are required to perform or be present during these procedures should receive influenza vaccination.

- Conducting the procedures in an airborne infection isolation room (AIIR) when feasible. Such rooms are designed to reduce the concentration of infectious aerosols and prevent their escape into adjacent areas using controlled air exchanges and directional airflow. They are single patient rooms at negative pressure relative to the surrounding areas, and with a minimum of 6 air changes per hour (12 air changes per hour are recommended for new construction or renovation). Air from these rooms should be exhausted directly to the outside or be filtered through a high-efficiency particulate air (HEPA) filter before recirculation. Room doors should be kept closed except when entering or leaving the room, and entry and exit should be minimized during and shortly after the procedure. Facilities should monitor and document the proper negative-pressure function of these rooms. [<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5417a1.htm>]

- Considering use of portable HEPA filtration units to further reduce the concentration of contaminants in the air. Some of these units can connect to local exhaust ventilation systems (e.g., hoods, booths, tents) or have inlet designs that allow close placement to the patient to assist with source control; however, these units do not eliminate the need for respiratory protection for individuals entering the room because they may not entrain all of the room air. Information on air flow/air entrainment performance should be evaluated for such devices.

- HCP should adhere to standard precautions [http://www.cdc.gov/hicpac/2007IP/2007ip_part4.html#4], including wearing gloves, a gown, and either a face shield that fully covers the front and sides of the face or goggles.

- HCP should wear respiratory protection equivalent to a fitted N95 filtering facepiece respirator (i.e., N95 respirator) or higher level of protection (e.g., powered air purifying respirator) during aerosol-generating procedures (See definition of respirator in

Appendix). When respiratory protection is required in an occupational setting, respirators must be used in the context of a comprehensive respiratory protection program that includes fit-testing and training as required under OSHA's Respiratory Protection standard (29 CFR 1910.134) [http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=12716].

- Unprotected HCP should not be allowed in a room where an aerosol-generating procedure has been conducted until sufficient time has elapsed to remove potentially infectious particles. More information on clearance rates under differing ventilation conditions is available [<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5210a1.htm#tab1>].

- Conduct environmental surface cleaning following procedures (see section on environmental infection control).

7. Manage Visitor Access and Movement Within the Facility

Limit visitors for patients in isolation for influenza to persons who are necessary for the patient's emotional well-being and care. Visitors who have been in contact with the patient before and during hospitalization are a possible source of influenza for other patients, visitors, and staff.

For persons with acute respiratory symptoms, facilities should consider developing visitor restriction policies that consider location of patient being visited (e.g., oncology units) and circumstances, such as end-of-life situations, where exemptions to the restriction may be considered at the discretion of the facility. Regardless of restriction policy, all visitors should follow precautions listed in the respiratory hygiene and cough etiquette section. Visits to patients in isolation for influenza should be scheduled and controlled to allow for:

- Screening visitors for symptoms of acute respiratory illness before entering the hospital.

- Facilities should provide instruction, before visitors enter patients' rooms, on hand hygiene, limiting surfaces touched, and use of personal protective equipment (PPE) according to current facility policy while in the patient's room.

- Visitors should not be present during aerosol-generating procedures.

- Visitors should be instructed to limit their movement within the facility.

- If consistent with facility policy, visitors can be advised to contact their healthcare provider for information about influenza vaccination.

8. Monitor Influenza Activity

Healthcare settings should establish mechanisms and policies by which HCP are promptly alerted about increased influenza activity in the community or if an outbreak occurs within the facility and when collection of clinical specimens for viral culture may help to inform public health efforts. Close communication and collaboration with local and state health authorities is recommended. Policies should include designations of specific persons within the hospital who are responsible for communication with public health officials and dissemination of information to HCP.

9. Implement Environmental Infection Control

Standard cleaning and disinfection procedures (e.g., using cleaners and water to preclean surfaces prior to applying disinfectants to frequently touched surfaces or objects for indicated contact times) are adequate for influenza virus environmental control in all settings within the healthcare facility, including those patient-care areas in which aerosol-generating procedures are performed. Management of laundry, food service utensils, and medical waste should also be performed in accordance with standard procedures. There are no data suggesting these items are associated with influenza virus transmission when these items are properly managed. Laundry and food service utensils should first be cleaned, then sanitized as appropriate. Some medical waste may be designated as regulated or biohazardous waste and require special handling and disposal methods approved by the State authorities. Detailed information on environmental cleaning in healthcare settings can be found in CDC's *Guidelines for Environmental Infection Control in Health-Care Facilities* [<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5210a1.htm>] and *Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings* [section IV.F. Care of the environment: http://www.cdc.gov/hicpac/2007IP/2007ip_part4.html].

10. Implement Engineering Controls

Consider designing and installing engineering controls to reduce or eliminate exposures by shielding HCP and other patients from infected individuals. Examples of engineering controls include installing physical barriers such as partitions in triage areas or curtains that are drawn between patients in shared areas. Engineering

controls may also be important to reduce exposures related to specific procedures such as using closed suctioning systems for airways suction in intubated patients. Another important engineering control is ensuring that appropriate air-handling systems are installed and maintained in healthcare facilities [<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5210a1.htm>].

11. Train and Educate Healthcare Personnel

Healthcare administrators should ensure that all HCP receive job- or task-specific education and training on preventing transmission of infectious agents, including influenza, associated with healthcare during orientation to the healthcare setting. This information should be updated periodically during ongoing education and training programs. Competency should be documented initially and repeatedly, as appropriate, for the specific staff positions. A system should be in place to ensure that HCP employed by outside employers meet these education and training requirements through programs offered by the outside employer or by participation in the healthcare facility's program [http://www.cdc.gov/hicpac/2007IP/2007ip_part4.html#1].

- Key aspects of influenza and its prevention that should be emphasized to all HCP include:
 - Influenza signs, symptoms, complications, and risk factors for complications. HCP should be made aware that, if they have conditions that place them at higher risk of complications, they should inform their healthcare provider immediately if they become ill with an influenza-like illness so they can receive early treatment if indicated.
 - Central role of administrative controls such as vaccination, respiratory hygiene and cough etiquette, sick policies, and precautions during aerosol-generating procedures.
 - Appropriate use of personal protective equipment including respirator fit testing and fit checks.
 - Use of engineering controls and work practices including infection control procedures to reduce exposure.

12. Administer Antiviral Treatment and Chemoprophylaxis of Patients and Healthcare Personnel When Appropriate

Refer to the CDC Web site for the most current recommendations on the use of antiviral agents for treatment and chemoprophylaxis. Both HCP and patients should be reminded that persons treated with influenza antiviral

medications continue to shed influenza virus while on treatment. Thus, hand hygiene, respiratory hygiene and cough etiquette practices should continue while on treatment <http://www.cdc.gov/flu/professionals/antivirals/index.htm>.

13. Considerations for Healthcare Personnel at Higher Risk for Complications of Influenza

HCP at higher risk for complications from influenza infection include pregnant women and women up to 2 weeks postpartum, persons 65 years old and older, and persons with chronic diseases such as asthma, heart disease, diabetes, diseases that suppress the immune system, certain other chronic medical conditions, and possibly morbid obesity [www.cdc.gov/hn1flu/highrisk.htm]. Vaccination and early treatment with antiviral medications are very important for HCP at higher risk for influenza complications because they can decrease the risk of hospitalizations and deaths. HCP at higher risk for complications should check with their healthcare provider if they become ill so that they can receive early treatment. For HCP who identify themselves as being at higher risk of complications, consider offering work accommodations to avoid potentially high-risk exposure scenarios, such as performing or assisting with aerosol-generating procedures on patients with suspected or confirmed influenza.¹

Appendix: Additional Information About Influenza

Information about Facemasks:

- www.cdc.gov/Features/MasksRespirators/
- www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/GeneralHospitalDevicesandSupplies/PersonalProtectiveEquipment/ucm055977.htm
- A facemask is a loose-fitting, disposable device that creates a physical barrier between the mouth and nose of the wearer and potential contaminants in the immediate environment. Facemasks may be labeled as surgical, laser, isolation, dental or medical procedure masks. They may come with or without a face shield. If worn properly, a facemask is meant to help block large-particle droplets, splashes, sprays or splatter that may contain germs (viruses and bacteria) from

¹ In considering this guidance, employers should familiarize themselves with the *Americans with Disabilities Act of 1990 (Pub. L. 101-336) (ADA), as amended*, which may impact how they implement this guidance. Details specific to the ADA and influenza preparedness are provided on the U.S. Equal Employment Opportunity Commission Web site [http://www.eeoc.gov/facts/pandemic_flu.html].

reaching your mouth and nose. Facemasks may also help reduce exposure of your saliva and respiratory secretions to others. While a facemask may be effective in blocking splashes and large-particle droplets, a facemask, by design, does not filter or block very small particles in the air that may be transmitted by coughs, sneezes or certain medical procedures.

- Facemasks are cleared by the U.S. Food and Drug Administration (FDA) for use as medical devices. Facemasks should be used once and then thrown away in the trash.

Information about Respirators:

- www.cdc.gov/Features/MasksRespirators/

- www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/GeneralHospitalDevicesandSupplies/PersonalProtectiveEquipment/ucm055977.htm

- www.cdc.gov/niosh/npptl/topics/respirators/disp_part/RespSource3.html#e

- A respirator is a personal protective device that is worn on the face, covers at least the nose and mouth, and is used to reduce the wearer's risk of inhaling hazardous airborne particles (including dust particles and infectious agents), gases, or vapors. Respirators are certified by the National Institute for Occupational Safety and Health (NIOSH), CDC. A commonly used respirator is a filtering facepiece respirator (often referred to as an N95).

- To work properly, respirators must be specially fitted for each person who wears one (this is called "fit-testing" and is usually done in a workplace where respirators are used).

- OSHA Respiratory Protection eTool: <https://www.osha.gov/SLTC/etools/respiratory/index.html>.

Key Facts about Influenza: <http://www.cdc.gov/flu/keyfacts.htm> Clinical Information (signs and symptoms, modes of transmission, viral shedding): <http://www.cdc.gov/flu/professionals/acip/clinical.htm>

World Health Organization (WHO). Epidemic- and pandemic-prone acute respiratory diseases—Infection prevention and control in health care: <http://www.who.int/csr/resources/publications/aidememoireepidemicpandemid/en/index.html>

Control of Influenza Outbreaks in Acute-care Settings: <http://www.cdc.gov/flu/professionals/infectioncontrol/healthcarefacilities.htm>

Infection Control Measures for Preventing and Controlling Influenza Transmission in Long-Term Care Facilities: <http://www.cdc.gov/flu/>

[professionals/infectioncontrol/longtermcare.htm](http://www.cdc.gov/flu/professionals/infectioncontrol/longtermcare.htm)

Preventing Opportunistic Infections in HSCT/Bone Marrow Transplant Recipients (p. 18): <http://www.cdc.gov/mmwr/PDF/rr/rr4910.pdf>

Seasonal Influenza Vaccination Resources for Health Professionals: <http://www.cdc.gov/flu/professionals/vaccination/#patient>

Guidance for Prevention and Control of Influenza in the Peri- and Postpartum Settings: <http://www.cdc.gov/flu/professionals/infectioncontrol/peri-post-settings.htm>

Clinical Description & Lab Diagnosis of Influenza: <http://www.cdc.gov/flu/professionals/diagnosis/>

Treatment (Antiviral Drugs): <http://www.cdc.gov/H1N1flu/antivirals/> Influenza Vaccination Strategies: Health and Human Services Toolkit to Improve Vaccination among Healthcare Personnel: <http://www.hhs.gov/ophsp/programs/initiatives/vac toolkit/index.html>

Veterans Health Administration Influenza Manual: http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1978

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DEPARTMENT OF THE INTERIOR

Fish and Wildlife Service

[FWS-R3-ES-2010-N121; 30120-1113-0000-F6]

Endangered and Threatened Wildlife and Plants; Permit Applications

AGENCY: Fish and Wildlife Service, Interior.

ACTION: Notice of availability of permit applications; request for comments.

SUMMARY: We, the U.S. Fish and Wildlife Service, invite the public to comment on the following applications to conduct certain activities with endangered species. With some exceptions, the Endangered Species Act (Act) prohibits activities with endangered and threatened species unless a Federal permit allows such activity. The Act requires that we invite public comment before issuing these permits.

DATES: We must receive any written comments on or before July 22, 2010.

ADDRESSES: Send written comments by U.S. mail to the Regional Director, Attn: Peter Fasbender, U.S. Fish and Wildlife Service, Ecological Services, 1 Federal Drive, Fort Snelling, MN 55111-4056; or by electronic mail to permitsR3ES@fws.gov.

FOR FURTHER INFORMATION CONTACT:

Peter Fasbender, (612) 713-5343.

Background

We invite public comment on the following permit applications for certain activities with endangered species authorized by section 10(a)(1)(A) of the Act (16 U.S.C. 1531 *et seq.*) and our regulations governing the taking of endangered species in the Code of Federal Regulations (CFR) at 50 CFR 17. Submit your written data, comments, or request for a copy of the complete application to the address shown in **ADDRESSES**.

Permit Applications

Permit Application Number: TE805269

Applicant: Daniel A. Soluk, Univ. of South Dakota, Vermillion, SD.

The applicant requests a permit renewal to take (capture and release, collect eggs, larvae, and exuviae) the Hine's Emerald Dragonfly (*Somatochlora hineana*) in the States of Alabama, Illinois, Michigan, Missouri, Ohio, and Wisconsin. Proposed activities are aimed at enhancement of survival of the species in the wild.

Permit Application Number: TE15027A

Applicant: Stantec Consulting Services, Inc., Columbus, OH.

The applicant requests a permit renewal to take (capture, radio-tag, and release) Indiana bats (*Myotis sodalis*) and gray bats (*Myotis grisescens*), and to take Hine's emerald dragonflies, American burying beetles (*Nicrophorus americanus*), and Mitchell's satyr butterflies (*Neonympha mitchellii mitchellii*) (capture and release). The applicant would carry out these activities in the States of Illinois, Indiana, Michigan, Missouri, New Jersey, Ohio, Pennsylvania, and Wisconsin, in order to document presence/absence and distribution of the species and to conduct habitat use assessments. Proposed activities are aimed at enhancement of survival of the species in the wild.

Permit Application Number: TE15057A

Applicant: Brent M. McClane, McClane Environmental Services, St. Louis, MO.

The applicant requests a permit renewal to take (capture and release) fat pocketbook (*Potamilus capax*), Higgin's eye pearlymussel (*Lampsilis higginsii*), Curtis' pearlymussel (*Epioblasma florentina curtisi*), pink mucket pearlymussel (*Lampsilis abrupta*), orangefoot pimpleback (*Plethobasus cooperianus*), clubshell (*Pluerobema clava*) white wartyback pearlymussel