Date: August 2003

To: Patrick McConnor, CSTE Executive Director

From: Kathleen F. Gensheimer, State Epidemiologist, Maine

RE: SARS Preparedness Planning Meeting, August 12-13, 2003

The purpose of the meeting was to invite partners from key public health and health care infection control organizations to share their experiences in response to the recent SARS outbreak in the United States, to describe their anticipated needs in preparation for the possible re-emergence of SARS later this fall, to discuss SARS preparedness plans currently under development, and to outline priority areas and roles of various partners in ensuring adequate preparedness at the national, state, and local level in the event of the possible resurgence of SARS.

The meeting included CDC scientists and representatives from the Council and State Epidemiologists (CSTE), Association of State and Territorial Health Officials (ASTHO), National Association of County & City Health Officials (NACCHO), Association of Public Health Laboratories (APHL), Society for HealthCare Epidemiology of America (SHEA), Healthcare Infection Control Practices Advisory Committee (HICPAC), Infectious Disease Society of America (IDSA), and the Association for Professionals in Infection Control and Epidemiology (APIC). In addition, representatives from public health institutions involved in responding to the SARS outbreak in Canada and from the World Health Organization were invited to participate in the meeting.

The meeting convened on August 12th with presentations that outlined the goals and objectives of the meeting, summarized the current understanding of SARS, described the public health response and lessons learned during the SARS outbreak in the United States and Canada, and outlined key issues and needs in preparedness for the possible re-emergence of SARS at the national, state, and local level. The meeting continued with small working groups that discussed and formulated SARS preparedness plans covering specific topic areas of surveillance, infection control, quarantine, communication and education efforts, and laboratory response. The working groups presented a summary of their discussions. It is clear that much remains to be done

prior to October 1 if states and local health agencies are in an optimal custom to prepare and respond to the possible re-emergence of SARS this coming respiratory season. The many significant questions that remain, include how to coordinate local, regional and national responses; improve global communications; strengthen ties between hospitals and health departments; define cases; develop appropriate precautions; integrate SARS planning with other emergency preparedness planning; establish guidelines on lab testing; and define optimal therapy.

Because I participated in the health care preparedness work group, I will include a summary of the deliberations.

- Need to modify the approach taken for patients with undiagnosed respiratory infections. This would include placing masks on patients (and visitors) in waiting rooms, etc., who have coughs or respiratory symptoms, and placing all patients with undiagnosed pneumonia on droplet precautions. It was pointed out that this is actually consistent with current guidelines, in that existing guidelines recommend placing a number of respiratory illnesses (e.g., mycoplasma, influenza) on droplet precautions. Until a definite diagnosis is established one could argue that prudence would dictate droplet precautions for all patients (just as patients with possible bacterial meningitis are placed on droplet precautions until the etiology is determined). There was actually fairly uniform agreement that this should be done (one participant suggested the phrase "respiratory hygiene" to complement "hand hygiene";(i.e., covering one's mouth/nose when sneezing/coughing, etc.)

- Need surveillance for detecting SARS in the community quickly. There were comments that an astute clinician may well detect the first case. However, given the predilection for HCWs in this year's epidemic, some form of surveillance of HCWs with pneumonia would likely be helpful. This led to a number of suggestions. As hospitals are developing "care paths", etc., for community-acquired pneumonia for Joint Commission on Accreditation of Healthcare Organization Core Measures, ensuring that epidemiologic information (travel history, occupation) was routinely collected could be incorporated into such plans. Hospitals could report HCWs hospitalized with pneumonia to local health departments. In that way, the health department might recognize a cluster of ill HCWs from one facility (even if the HCWs themselves were scattered among different hospitals). In addition, hospitals could collect information about employee absences and the reasons therefore.

- Hospitals need to strengthen ties with local health departments. In many communities this is already being done because of BT/smallpox planning. Cross training so that hospital infection control personnel and health department personnel have better understanding of each other's working environment would be helpful.

- Need to develop surge capacity for infection control within hospitals. Some hospitals already have the foundation for such a system in "IC liaison nurse" programs.

Unresolved issues:

- Need for droplet vs. airborne precautions. This engendered a lot of discussion. It clearly feeds into hospital planning to what degree do hospitals need to be able to generate large numbers of negative pressure rooms? What should a SARS unit look like? What PPE was really required? CDC is looking at information gathered in various locations to try and sort this out. There was a general feeling that CDC probably would not be able to say definitively. This led into a number of ancillary issues. For hospitals with some negative pressure rooms scattered around, and a modest number of SARS patients, would it be better to place patients in the available isolation rooms, or to cohort the patients on one nursing unit (in private rooms-not cohorted together within rooms) so that a limited number of staff could become proficient at appropriate procedures? The notion of having designated SARS hospitals was quickly dismissed as not possible. No hospital would be likely to volunteer. Even if a hospital were forced by government mandate to take this role, the fact that patients may show up anywhere and need to be dealt with was felt to be a more significant practical matter, leading to the conclusion that essentially all hospitals would need to be able to deal with at least some SARS patients.

- The need to integrate SARS planning with other planning was discussed with this group as well. The sense from CDC representatives was that while they agreed, tackling that was beyond their scope at this point, and that they needed to get out information on how to deal with SARS right now, and as time passed the integration issues could be addressed.

- Need to get information disseminated widely, not only to infection control/ID, but also to primary care providers and emergency departments. My take from the meeting is that there remains much to be done, in a small amount of time. I think that the meeting was very valuable in pinpointing some of the many issues where there is not general consensus, but their remain many other issues where I think there could be some clear guidelines established. Because I know that many states are grappling with some of these issues on their own, I think it would make sense to provide a framework where a minimum set of standards, whether it be surveillance; laboratory testing; infection control etc could be laid out, versus having States struggle with some of these many issues on their own. I feel that the threat of SARS is greater than smallpox ever was and we certainly spent considerable time and resources dealing with smallpox preparedness. One of the most valuable meetings was held in December 2001, where States were pulled together on short notice to provide them a basic grounding in smallpox preparedness issues. A similar meeting should be considered for SARS preparedness, inviting State with big city epidemiologist, laboratorians, and bioterrorism coordinators. I think that States would welcome the guidance, while at the same time, laying out some minimum expectations. Of critical importance would be some sense of consistency across State borders as we all grapple together with yet another emerging infectious disease.

KFG/CEB