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# 1. SARS Surveillance

## A. Goals and Key Concepts

The overall goals of Severe Acute Respiratory Syndrome (SARS) surveillance are to:

- Ensure early detection of cases and clusters of respiratory infections that might signal the global re-emergence of SARS.
- If the re-emergence of SARS is confirmed, maintain prompt and complete identification and reporting of potential cases to facilitate control and management of the outbreak.
- Identify and monitor contacts of SARS cases to enable early detection of illness in persons at greatest risk for disease.

The following are key concepts about SARS surveillance:

- The key to recognizing persons with SARS is identifying an epidemiologic link of exposure to another case of SARS or a setting (e.g., hospital) where SARS-associated coronavirus (SARS-CoV) transmission is occurring.
- Screening criteria for epidemiologic linkages need to reflect 1) the status of SARS globally and the risk of exposure from travel, and 2) the status of SARS activity in the community, at the work site, or in other settings where a patient with SARS-like illness may have been.
- In a setting of extensive SARS-CoV transmission, the possibility of SARS should be considered in all persons with a febrile respiratory illness, even if an epidemiologic link cannot be readily established.

## B. Plan for Surveillance of SARS Cases in New York State

In April 2003, on an emergency basis, SARS was added to the NYS reportable disease list (Section 2.1 of the New York State Sanitary Code). Physicians should immediately report any potential cases (as defined by the reporting criteria below) to the local health department (LHD). SARS reporting criteria will be based on the level of SARS activity worldwide. The two categories of SARS activity are: (a) absence of known SARS activity and (b) presence of SARS activity anywhere in the world. An overview of the SARS reporting criteria is in Appendix 1A.

### 1. Case Surveillance

#### a. **No SARS Activity Anywhere in the World.**

In the absence of SARS activity worldwide, surveillance is aimed at early detection of cases and clusters of respiratory infections among individuals likely to be first affected by the re-emergence of SARS (e.g., travelers to areas previously affected with SARS; healthcare workers).

#### Reporting Criteria

Medical providers should ask all patients being admitted to the hospital with radiographic evidence of pneumonia or acute respiratory distress syndrome (ARDS) of unknown etiology about recent travel, employment history and/or exposure to another person who was recently diagnosed with pneumonia.

Providers should immediately report to the LHD any patient who meets the following clinical and at least one epidemiologic criteria:

- Clinical criteria
  - Radiographic evidence of pneumonia or ARDS of unknown etiology, which warrants hospitalization,
- Epidemiologic criteria (at least one of the following)
  - Travel within 10 days of onset to mainland China, Hong Kong, or Taiwan,  
**OR**
  - Within 10 days of onset, close contact with other ill person(s) who recently traveled to mainland China, Hong Kong, or Taiwan,  
**OR**
  - Employment as a healthcare worker with direct patient contact or a worker in a laboratory which contains live SARS-associated coronavirus (SARS-CoV),  
**OR**
  - Within 10 days of onset, close contact with person(s) with radiographic confirmed pneumonia without an alternative diagnosis.

The NYSDOH SARS Screening Form When There is No SARS Activity Worldwide (Appendix 1B) can be used by LHDs to determine if a patient meets the reporting criteria. If a patient does meet the reporting criteria, the NYDOH SARS Case Report Form (Appendix 1C) should be completed. (Appendix 1C also includes a guide on SARS supplemental data entry fields.)

Additional factors that increase the likelihood of SARS-CoV infection

Additional information should be obtained on patients who meet the above reporting criteria to determine if there are factors that would increase the likelihood of SARS-CoV infection, including,

- While traveling, visited a healthcare setting.
- While traveling, had close contact with a person hospitalized for a respiratory infection.
- Part of a cluster of unexplained pneumonia in which one case is linked to travel to a previously SARS-affected area or to an ill healthcare worker.

If a patient has additional factors that increase the index of suspicion for SARS, consideration should be given for more aggressive isolation precautions and clinical evaluation (See Section 2 for details).

Travel to other areas with SARS-CoV transmission in Spring 2003:  
(Singapore; Toronto, Canada; Hanoi Vietnam)

In the absence of SARS transmission worldwide, it is felt that the most likely sites of SARS recurrence are mainland China and the neighboring locations of Taiwan and Hong Kong. Hospitalized persons with radiographic confirmed pneumonia who have a travel history to other areas with SARS-CoV transmission in Spring

2003- Singapore; Toronto, Canada; and Hanoi, Vietnam- do not need to be reported unless there are factors that increase the likelihood of SARS-CoV infection (see above section).

#### Pediatric Populations

Based on the limited information available from the Spring 2003 SARS outbreak, the role of pediatric patients in the transmission of SARS-CoV disease is thought to be much less significant than the role of adults. Thus, in the absence of SARS activity anywhere in the world, the screening of persons requiring hospitalization for radiographic evidence of pneumonia or ARDS of unknown etiology should be limited to adults, unless there are special circumstances that make the clinician and public health personnel consider a child to be of potentially high risk for having SARS-CoV disease.

#### **b. Presence of SARS Activity Anywhere in the World**

If the re-emergence of SARS is documented in the United States or abroad, the likelihood that persons with respiratory infections may be infected with SARS will increase significantly. Enhanced surveillance activities should focus on:

- increasing the sensitivity of case detection through use of less specific clinical criteria when screening cases (i.e., expand surveillance to include non-hospitalized persons with fever or respiratory symptoms), and
- evaluating suspicious illnesses regardless of identification of an epidemiologic link (e.g., respiratory illness in healthcare workers; clusters of persons with pneumonia).

#### Reporting Criteria

Medical providers should ask all patients presenting with fever or respiratory symptoms about recent travel history or exposure to someone who may have SARS. Providers should immediately report to the LHD any patient who meets the following reporting criteria:

- Any patient meeting the reporting criteria listed for when there is no SARS activity (e.g., healthcare workers hospitalized with radiographic confirmed pneumonia; clusters of unexplained pneumonia)  
**OR**
- Any patient meeting the following clinical criteria and epidemiologic criteria
  - Clinical criteria (at least one of the following)
    - Fever >38°C (100.4°F)  
**OR**
    - Lower respiratory infection (e.g., cough, shortness of breath, difficulty breathing)
  - Epidemiologic criteria (at least one of the following)
    - Travel within 10 days of illness onset to an area with recent local SARS transmission  
**OR**

- Close contact within 10 days of illness onset with a person with known or suspected SARS infection.
- If SARS transmission that is unlinked to other SARS infections (i.e., the source of infection is unclear) has occurred locally, consider SARS in the differential diagnosis and management of all patients with fever or evidence of lower respiratory infection, regardless of whether the patient has SARS risk factors.

### Hospital-Based Surveillance

In the presence of SARS anywhere in the world, hospitals should implement the following hospital-based surveillance strategies based upon the level of SARS activity:

#### Healthcare facility with no SARS patients:

- Ask all patients presenting with fever or respiratory symptoms about recent travel history or exposure to someone who may have SARS.
- Immediately report any patients meeting the above criteria to the LHD.
- Infection control personnel, occupational health officials, and providers should be alert for clusters of severe, febrile respiratory illness among healthcare workers. Any clusters of severe, febrile respiratory illness among healthcare workers with illness onsets within the same 10-day period should be reported immediately to the LHD.

#### Healthcare facility providing care for SARS patients who acquired infection from the community or from other facilities: no evidence of nosocomially acquired SARS-CoV infections:

- Continue all recommended surveillance plans outlined for the previous category.
- Monitor daily all healthcare workers caring for SARS patients. If the healthcare worker has either fever or respiratory symptoms, begin SARS isolation precautions, notify the LHD and initiate preliminary clinical assessment.
- If SARS-CoV transmission is occurring in the surrounding community, screen **all patients, visitors, and employees** upon entry to the facility for fever, cough, or shortness of breath. Screen symptomatic persons for SARS risk factors. If risk factors are present, the patient should be isolated and evaluated for both alternative respiratory illnesses and SARS-CoV infection.

#### Healthcare facility treating a large number of SARS patients, or facilities with nosocomially acquired SARS cases with clearly identified sources of infection:

- Continue all recommended surveillance plans outlined for the previous category.
- Monitor **all** healthcare workers daily for fever, cough, or shortness of breath. If present, begin SARS isolation precautions, obtain chest X-ray, and initiate preliminary workup.
- Begin inpatient surveillance; monitor daily for new or worsening fever, cough, or shortness of breath. If one or more of these symptoms are found, exposure to known or suspected SARS patients should be investigated; if there is evidence of exposure, the patient should be isolated and tested for alternative respiratory illnesses and SARS-CoV infection.

Healthcare facility in which nosocomially acquired SARS-CoV infection has occurred and at least some transmission is unlinked to other SARS infections (i. e., source of infection is unclear):

- Continue all recommended surveillance plans outlined for the previous category.
- Expand inpatient surveillance: if new or worsening fever, cough, or shortness of breath is noted, test patient for SARS-CoV regardless of whether an epidemiologic link to another SARS patient is found.
- Consider surveillance for illness and absenteeism among healthcare personnel.

## 2. Case Reporting

### Medical Providers

- Providers should report immediately by telephone to the LHD any patient meeting the reporting criteria.
  - If there are difficulties reaching the LHD, the provider should contact the NYSDOH. During business hours, call 518-473-4436; after hours, call 1-866-881-2809.
  - In New York City, contact the New York City Department of Health and Mental Hygiene through the Provider Access Line at 1-866-NYC-DOH1 (1-866-692-3641). At all other times, call the Poison Control Center at 1-212-764-7667.
- The NYDOH SARS Case Report Form (Appendix 1C) should be completed immediately and forwarded to the LHD.
- After consultation with local/state health department, if SARS testing is indicated the required laboratory testing paperwork should be completed and submitted with the clinical specimens to Wadsworth Center. Three forms are required:
  - Wadsworth Center Virus History Form (Section 4, Appendix 4A),
  - Informed Consent for the RT-PCR assay,
  - Informed Consent for the EIA assay.

The RT-PCR and EIA assays have been released by the Food and Drug Administration (FDA) under an Investigational Device Exemption and are IRB-approved. Use of both assays requires completion of two informed consent documents, one each for the RT-PCR and EIA assays.

The forms are available as Appendices 4B and 4C or at the following websites. <http://www.cdc.gov/ncidod/sars/lab/rtpcr/consent.htm> and <http://www.cdc.gov/ncidod/sars/lab/eia/consent.htm>.

Note: If specimens have been collected prior to informed consent being obtained, the Patient Information Form may be completed instead of the RT-PCR and EIA informed consent forms. This form is available as Appendix 4D and at [www://cdc.gov/ncidod/sars/lab/rtpcr/participant.htm](http://www://cdc.gov/ncidod/sars/lab/rtpcr/participant.htm).

### **Local Health Departments**

- Any patients meeting the reporting criteria should be reported immediately to the NYSDOH Regional Epidemiologist. If the Regional Epidemiologist is not available, call the Bureau of Communicable Disease Control at 518-473-4436 during business hours; after hours, call 1-866-881-2809.
- The NYSDOH SARS Screening Form When there is No SARS Activity Worldwide (Appendix 1B) can be used to determine if the patient meets the reporting criteria. If the patient does meet the reporting criteria, the NYDOH SARS Case Report Form (Appendix 1C) should be completed.
- The report should be initiated on the Health Information Network (HIN) Communicable Disease Electronic Surveillance System (CDESS). If SARS testing is indicated, the HIN identification number generated needs to be included on all paperwork associated with the case, including the lab specimen submission form.

### **NYSDOH**

- If any patients meeting the surveillance criteria are reported by the medical provider directly to NYSDOH, the information will immediately be reported to the appropriate NYSDOH Regional Office and/or LHD.
- If laboratory specimens are received on patients for which there is no HIN ID included with the paperwork, Wadsworth Center will notify NYSDOH BCDC. If the case has not been reported on the HIN, NYSDOH BCDC will notify the appropriate Regional Office and/or LHD for follow-up.
- NYSDOH will report case data to the Centers for Disease Control and Prevention (CDC) through the Secure Digital Network.

### **3. Case Classification**

#### **• SARS Case Definition**

The SARS case definition distinguishes 1) cases of SARS-CoV disease that may be classified as confirmed (i.e., clinically compatible illness that is laboratory confirmed) or probable (i.e., severe respiratory illness with epidemiologic linkage to a laboratory-confirmed case), from 2) other SARS reports under investigation (patients whose illnesses are less severe or whose exposures to SARS-CoV are not definitive). The SARS case definition is provided in Appendix 1D. A summary of the SARS case definition and classification is provided in Appendix 1E.



SARS case definitions may be modified as more clinical and epidemiologic information is obtained. Up-to-date versions of SARS case definitions are available on the NYSDOH HIN or the CDC web site:

<http://www.cdc.gov/ncidod/sars/>.

Using case classification information provided by the LHDs, a statewide list of the number of probable and confirmed SARS cases, by county, will be maintained and posted on the NYSDOH public website. The site will be updated daily (Monday through Friday) at 4pm.

- **Ruling-out SARS-CoV Infection**

The only conclusive rule-out test for SARS-CoV is a negative antibody result on a serum specimen collected >28 days after onset. Thus obtaining a convalescent specimen >28 days after onset will be critical to classify patients whose acute specimens have been negative for SARS-CoV. LHDs should establish a tracking system of SARS cases under investigation to ensure that appropriately-timed convalescent specimens are obtained and submitted to Wadsworth. In all cases, the Virus Reference and Surveillance Laboratory History form (DOH-1795) should be used and informed consent obtained, per laboratory protocol (See Section 4: Laboratory Diagnosis).

#### 4. Roles and Activities for Surveillance of SARS Cases

##### **Healthcare Providers and Facilities: no SARS activity**

- Ask all patients being admitted to the hospital with radiographic evidence of pneumonia or ARDS of unknown etiology about recent travel, employment history and/or exposure to another person who was recently diagnosed with pneumonia.
- Immediately report any patients meeting the reporting criteria to the LHD.
- Infection control personnel, occupational health officials, and providers should be alert for clusters of severe, febrile respiratory illness among healthcare workers. Any clusters of severe, febrile respiratory illness among healthcare workers with illness onsets within the same 10-day period should be reported immediately to the LHD.

##### **Healthcare Providers and Facilities: presence of SARS activity**

- Ask all patients presenting with fever or respiratory symptoms about travel history or exposure to someone who may have SARS.
- Immediately report any patients meeting the reporting criteria to the LHD.
- Implement the hospital-based surveillance strategies based upon the level of SARS activity in the community and facility.

##### **Local Health Departments**

- Conduct active Emergency Department (ED) surveillance for potential SARS cases as recommended by the NYSDOH (e.g., daily phone calls).
- Receive reports from healthcare providers of potential SARS cases.

- Obtain and review information needed to further assess reported cases to determine if there is increased likelihood of SARS-CoV infection, including:
  - Ill travelers who had contact with healthcare settings or persons hospitalized for a respiratory infection while abroad.
  - Clusters of unexplained pneumonia among any group of persons in which one case is linked to travel to a previously affected area or to an ill healthcare worker.
- Report to the NYSDOH any patient who meets the SARS reporting criteria.
- Review reports of persons who meet the reporting criteria to ensure that adequate testing is done to rule out other infectious causes of pneumonia.
- In conjunction with the NYSDOH, ensure that testing for SARS-CoV infection is ordered only when appropriate.

### **NYSDOH**

- Provide guidance to healthcare providers, hospitals, and LHDs regarding SARS surveillance (e.g., issuing health alerts; maintaining SARS sites on the NYSDOH web site, Health Information Network, and Health Provider Network).
- Receive, review and compile reports from LHDs of active ED surveillance.
- Receive reports from LHDs of potential SARS cases, and provide consultation as needed.
- Develop and maintain electronic reporting systems to facilitate the timely reporting of SARS cases and dissemination of surveillance information.
- In conjunction with LHDs, ensure that testing for SARS-CoV infection is ordered only when appropriate.
- Report appropriate cases under investigation to the CDC.

### **C. Plan for Surveillance of Contacts of SARS Cases**

Surveillance of contacts of SARS cases is essential to SARS control efforts. Through rapid identification, evaluation, and monitoring of exposed contacts of possible or known SARS cases, further transmission of disease may be prevented. Contacts who are found to be clinically ill can be quickly isolated to avoid further SARS-CoV transmission. Surveillance of contacts will be conducted by LHDs, with assistance from the NYSDOH as needed. Initiate contact tracing on reports/cases as per the SARS Reporting, Case Testing and Follow-up Table (Appendix 1F).

#### **1. Definitions**

**Close Contact:** A person who cared for or lived with a person with SARS or having a high likelihood of direct contact with respiratory secretion and/or body fluids of a person with SARS (during encounters with the patient or through contact with materials contaminated by the patient), either during the period the person was clinically ill or within 10 days of resolution of fever. Examples of close contact include kissing or embracing, sharing eating or drinking utensils, close conversation (< 3 feet), physical examination, and any other direct physical contact between persons. Close contact does not include activities such as walking by a person or sitting across a waiting room or office for a brief time.

**Infectious Period:** Period of time from the onset symptoms to up to 10 days after the resolution of fever and improving respiratory illness.

## 2. Case Interview

### a. Pre-interview Preparation

A successful interviewing session is the product of numerous factors, including thorough preparation. Disease intervention opportunities depend on the Interview and Contact Tracing team (ICCT) knowing and skillfully using pertinent, available facts. Preparation is important for each priority interviewing/counseling session.

Before the original interview/counseling session, the ICCT should review/analyze:

- Existing case report information;
- Other medical information, such as a medical record if available;
- Available historical information pertinent to the current infection;
- Existing case interview and investigative records for evidence of relationships to other known cases.

### b. Case Interview Session

Successful disease intervention requires that diagnosed patients are isolated during the infectious period and that all contacts are promptly identified, monitored for signs of infection, and referred for appropriate medical attention if indicated.

- To achieve maximum disease intervention, the ICCT should conduct interviewing sessions without delay after the case comes to program attention.
- In conducting each interview session an ICCT should:
  - Communicate at the patient's level;
  - Confirm known information supplied by the patient:
    - Complete home address and phone number (including cell phone, email address, and fax number if pertinent);
    - Emergency locating information;
    - Work address and phone number;
    - Symptom history including date of onset, type of symptoms, and date of resolution;
    - Likely source of infection (e.g. epidemiologic risk factors).
  - Explain that all work is performed in the strictest confidence.
  - Explain the purpose of the session, which is to assist with management of this infection.
  - Emphasize contact tracing;
  - Persist tactfully to ensure all contacts are identified;
  - Pursue detailed information during the patient's infectious period to identify and locate known individual contacts by:

- Obtaining travel, work and social history relevant to the infectious period (from the date of first symptom onset to 10 days following resolution). If the source of the infection is not known, the interview period should also include the 10 days prior to onset. Information should include dates, times, modes of transportation and supervisor/organizer of the following activities:
  - Work;
  - Social settings (e.g., theater, restaurants, recreational events, etc.);
  - Hospitalizations and/or visits to health care facilities.
- Obtaining for known contacts:
  - Identifying and demographic information:
    - Name(s) (including nicknames);
    - Address (including apartment numbers);
    - Telephone number(s);
    - Employer and work telephone number(s);
    - Age/Race/Sex/Marital Status;
    - Physical description;
    - Other locating information;
    - Information regarding safety and other procedural concerns about the partner's domicile, acquaintances, and demeanor.
  - Nature of contact (i.e., household, health care worker, community);
  - Exposure history
    - First and last date of exposure,
    - Frequency and duration of exposure, and whether the exposure is ongoing;
    - If other than household, determine the approximate distance and details of the contact.
    - Timing relative to infectious period of the index patient.

**c. Post-Interview Session and Analysis**

- Review and reinforce with case:
  - All components of the monitoring plan and infection control procedures;
  - Commitment to communicate information;
  - Potential need for re-interview.
- Evaluate:
  - Any remaining patient concerns, needs;
  - Compliance regarding isolation of case;
  - Potential difficulties with contact identification and symptom monitoring;
  - Potential for ongoing exposure and risk for household or other contacts.
- Investigative activity should be documented on the SARS Interview Record and SARS Contact Record.

**3. Contact Tracing**

- All close contacts should be located and contacted within 12 hours of the case/contact report.

- Use work and school contact numbers, telephone directories, voting lists, neighborhood interviews, site visits, etc. to trace contacts when information is unknown or incomplete.
- If having difficulty locating a contact, consult with STD, TB, HIV/AIDS staff who have contact tracing experience.
- If the contact can not be located, other sources of notification, such as the media, may have to be considered.
- If the contact has left the county and/or state, notify the NYSDOH Regional Epidemiologist.

#### **4. Contact Evaluation**

- Notify contacts of their potential exposure to SARS.
- Verify exposures.
  - Verify exposure to index case during the period of infectiousness.
  - Verify the type of exposure.
- If initial contact is made through a home or workplace visit, the appropriate personal protective equipment (PPE) should be utilized since the contact's health status is unknown.
- Evaluate contact's health status using the SARS Contact Record Form.
- Identify any additional contacts who may not have been listed by the index case.
- Enter data from the SARS Contact Record Form on the HIN.

#### **5. Ill Contacts**

- If the contact is symptomatic with fever and/or respiratory symptoms, make arrangements for a medical evaluation by a healthcare provider.
  - Ensure the facility is prepared to handle a suspect SARS case.
  - Ensure the facility and staff are aware that the patient may have been exposed to SARS.
  - Ensure the contact does not take public transportation, or any other type of transportation that may expose others, enroute to their medical evaluation.
  - Advise the contact to remain at home until they are evaluated by a healthcare provider.
- Ill contacts should be counseled, interviewed, and reported as a suspected SARS case using the appropriate surveillance definitions, SARS Case Report Form, and his/her contacts should be identified.

## 6. Well Contacts

- Initiate plans for ongoing symptom monitoring for 10 days after their last exposure to a SARS case. Monitoring of contacts may be active (e.g., regular workplace body temperature monitoring) or passive (e.g., contact monitors their own symptoms and is contact by the local health department at least once a day).
  - Determine the time period in which the contact must be monitored (10 days after last exposure or 20 days after that last day of fever in the index case for those contacts with ongoing exposures).
  - Provide thermometers to any contacts who do not have one or would be willing to purchase one.
  - Provide contact with a daily temperature/symptom log.
  - Enter contact monitoring/symptom data on the HIN.
  - A copy of the SARS Contact Daily Temperature Log Tracking Sheet is provided (Appendix 1J) if the information collected cannot be immediately entered on the HIN.
- Develop a plan for locating contacts who are lost to follow-up during the monitoring period.
- Provide information on seeking medical care should the contact develop fever and/or respiratory symptoms while they are being monitored.
  - Seek medical evaluation by a healthcare provider.
  - Notify the local health department.
  - Ensure the facility is equipped to handle a suspect SARS case.
  - Ensure the facility and staff are aware that the patient may have been exposed to SARS.
  - Ensure the contact does not take public transportation, or any other type of transportation that may expose others, enroute to their medical evaluation.
  - Advise the contact to remain at home until they are evaluated by a healthcare provider.
  - Ill contacts should be counseled, interviewed, and reported as a suspected SARS case using the appropriate surveillance definitions, SARS Case Report Form, and his/her contacts should be identified.

## 7. Healthcare Workers

- Exposed healthcare workers should be located, evaluated, counseled, and educated.
- The healthcare worker's employer should be notified of the SARS exposure.

- Healthcare workers who are ill should be interviewed, and reported as a suspected SARS case using the appropriate surveillance definitions, SARS Case Reporting Form, and his/her contacts should be identified.
- If the healthcare worker had an unprotected high-risk exposure (e.g., the healthcare worker is in the same room as a probable or confirmed SARS case during a high-risk aerosol-generating procedure), they should be excluded from duty for 10 days following the last high-risk exposure.
- Well healthcare workers, who did not have any unprotected high-risk exposures, should be monitored for 10 days after their last exposure.
- Initiate plans for ongoing symptom monitoring:
  - Determine the time period in which the contact must be monitored (10 days after last exposure or 20 days after that last day of fever in the index case for those contacts with ongoing exposures).
  - Daily monitoring of the healthcare worker will be coordinated by the local health department and the healthcare facility.
  - The healthcare worker's employer may wish to institute procedures to evaluate their employee's health each day at the beginning of their shift.
  - Provide them with a daily temperature/symptom log.
  - Update contact monitoring/symptom data on the HIN.
  - A copy of the SARS Contact Daily Temperature Log Tracking Sheet is provided (Appendix 1J) if the information collected cannot be immediately entered on the HIN.
  - Develop a plan for locating contacts who are lost to follow-up during the monitoring period.
- Provide information on seeking medical care should they develop fever and/or respiratory symptoms while they are being monitored.
  - Seek medical evaluation by a healthcare provider.
  - Notify the local health department.
  - Ensure the facility is equipped to handle a suspect SARS case.
  - Ensure the facility and staff are aware that the patient may have been exposed to SARS.
  - Ensure the contact does not take public transportation, or any other type of transportation that may expose others, enroute to their medical evaluation.
  - Advise the contact to remain at home until they are evaluated by a healthcare provider.
  - Ill contacts/healthcare workers should be counseled, interviewed, and reported as a suspected SARS case using the appropriate surveillance

definitions, SARS Case Report Form, and his/her contacts should be identified.