

Local Public Health Response to the Multistate Fungal Meningitis Outbreak

Summary for local health departments (LHDs)

This document describes how LHDs have been involved in investigating, responding to, or otherwise impacted by the [multistate fungal meningitis outbreak](#).¹ The content in this document represents information NACCHO collected from LHDs through Oct. 18, 2012 and provides a qualitative snapshot of LHD experiences. NACCHO will update this document as-needed to reflect new information as the outbreak evolves.

Ways in Which LHDs Have Been Involved

- **Contacting healthcare facilities that received products from the New England Compounding Center (NECC) to ensure that facilities stop using these products.**

LHDs have relayed health alerts, CDC guidance, and updates to these facilities. LHDs have been actively engaged with these facilities even if there are currently no confirmed cases in their state. LHDs have helped facilities to determine how many people were potentially exposed to these products and develop messages for contacting and screening people. LHDs have coordinated strategies with facilities, neighboring jurisdictions, and the state health department to locate and notify people who received contaminated product. In addition, some LHDs are working with facilities to actively monitor and continue following up with people until they are no longer at risk for developing an infection.

The following are sample comments:

- “We have been in touch with the facility that received contaminated lots from the company. None of their shipment was ever opened and it was returned in total. We have also contacted the other 16 facilities in the county that received other products once the advisory went out to stop using all products from the company. Everyone was complying with that recommendation.”
- “We received affected lots and the clinic that used them had [a substantial number of] people that received the spinal injection. We coordinated with the clinic and [the state health department] to devise a plan to contact all of these people. We provided the clinic with guidance from the CDC on how to contact these people. The clinic was able to contact all of these people by phone, letter or office visit....Now we are involved with tracking people that might have symptoms and are being followed up with their providers.”
- “[Our LHD] had two facilities that received the implicated lots of contaminated methylprednisolone acetate (MP). Immediate follow-up was initiated by [our LHD communicable disease control program] with the two facilities affected....Coordination with [our LHD communicable disease control program] and district public health nurses was done to conduct site visits to both facilities in [our county] to clarify scripts/messages to use, check for left over medications on site, and review the list of patients reached for screening.”

- **Notifying patients who received contaminated product**

Some LHDs have helped healthcare facilities to contact all people who received contaminated product to ensure they are aware of their potential exposure and know what do to if they develop symptoms. Public health nurses have made home visits to notify people they could not reach by phone. LHDs have also worked with local hospitals to identify additional people who may be connected to the outbreak.



The following are sample comments:

- "...assist[ed] other LHDs in tracking down some of their residents who were affected by the distribution of the medication."
- "[Public health nurses from two LHDs] notified patients who had contaminated epidural injections. Both [nurses] were more than willing to help with phone calls and home visits to ensure all at-risk patients were urgently notified."
- "[Our] county was contacted by the [state health department] in regards to [one of our] county resident[s] who was possibly exposed to the product in question. [Our state health department] was unable to reach the patient so it was passed on to us. [Our state health department]...supplied me with the [contact information and the] most up to date information on the outbreak as well as the "talking points". I immediately reviewed the information and proceeded to contact the patient. I completed the interview and returned the information to [our state health department]."
- "[Our LHD communicable disease control program] has also followed up on all patients that were referred to the hospital emergency departments (EDs) for follow-up lumbar punctures and also followed up on several reported meningitis cases that reportedly received epidural steroid injections to determine their connection to this outbreak. [Our LHD communicable disease control program] public health nurses worked with the hospital infection control providers to obtain hospital records of all patients seen in the ED and [our LHD communicable disease control program] physicians carefully reviewed each record."

- **Communicating professional guidance with medical providers and local hospitals**

Medical providers and local hospitals are responsible for ensuring people receive medical care based on CDC guidance. As such, LHDs have been in close contact with these groups to ensure that they are aware of the latest CDC guidance (which rapidly change as the situation evolves) and of people who may seek diagnostic testing, treatment, and follow-up.

The following are sample comments:

- "... people [are] going to an emergency department for cerebrospinal fluid to be drawn. So we are also speaking with the local hospitals in the county about the proper testing and follow-up based on the CDC guidelines."
 - "We also sent out two "Health Alerts" regarding the meningitis cluster to medical providers in our county. Each contained information from the state epidemiologist. We sent the alerts out via blast fax, e-mail, and posting the information onto a "Provider Only" website that we maintain."
 - "Upon learning of the fungal meningitis outbreak...[our LHD] in coordination with [our state health department] actively drafted and sent out a Health Alert Notice to all healthcare providers, hospital laboratories, and clinical laboratories...[Our LHD communicable disease control] physicians have been taking numerous calls from hospital physicians with various concerns regarding clinical screening, diagnosis, and treatment guidelines for exposed patients reporting some type of [symptoms/signs] of infection post epidural, worried well patients concerned of exposure, and calls from random clinics and medical offices that perform epidurals."
 - "[Our] health department shared information about the outbreak and guidance with medical providers in the county through blast fax early in the event and posted updated information on our website. Staff responds to calls from providers with questions about the event. We have had very few calls (4) related to the outbreak."
- **Disseminating information and responding to concerns and questions from the community and local media**
LHDs have answered numerous calls from the community and local media with questions and concerns about the outbreak. High levels of concern, anxiety, and fear among many of the callers have required LHDs to both share information and counsel people in order to effectively provide reassurance and calm fears. In addition, LHDs have broadly disseminated information to the community through websites, newsletters, and other communication channels.

The following are sample comments:

- “The outbreak also led to an increase in calls from those worried that they may have been affected or those wanting more general information.”
- “The media became involved once they learned that a clinic in [our local jurisdiction] received the product. This led to our public information officer to coordinate messaging with the media.”
- “I was contacted by the media and was able to reassure them. A short article was run in the local paper, including quotes from me reassuring people, explaining the exposures, and referring people to their healthcare providers and [the] CDC website.”
- “We talked about it on our weekly public health radio spot. We [also] sent out information in our "public health" update that we do electronically each week. [In addition], we have received multiple phone calls and questions about the outbreak by the public that we answered.”

Several LHDs noted that they have only been minimally involved to date and have primarily continued to monitor the situation, disseminate information broadly, and provide ongoing updates to healthcare providers.

Successes and Challenges

Good communication and coordination with the state health departments, healthcare facilities, and LHDs in neighboring jurisdictions have been especially critical factors contributing to the success LHDs have had in tracking and investigating this disease, responding to the outbreak, and ensuring that healthcare facilities, pharmacies, and providers are not using NECC products. While some LHDs have indicated no challenges regarding their involvement in outbreak response, others have noted that lack of good communication and coordination have hindered response activities.

Additional challenges include the following:

- **Receiving timely and detailed information and updates.** *(see also: Successes)*
Sample comment: “One issue that comes up time and again is the timely flow of information. Often we hear about updated news from CNN or other newscasts. It often takes some time to validate the information being put out by the news.”
- **Determining which patients received contaminated product.**
Sample comment: “[It was initially] challenging [to] determin[e] exact numbers of exposed patients at both facilities in [our jurisdiction] as they did not document lot numbers. Discrepancies were also discovered between invoices received from NECC and number of medication vials and lot numbers on hand in their clinics.”
- **Locating, notifying, and managing people who receive contaminated product - particularly those who receive healthcare in one jurisdiction but live in another.**
The following are sample comments:
 - “Our county is adjacent to a county where re-called lots were used. Since some affected patients may reside in our county, we must rely on the efforts of the clinician and local health department if the treatment occurred.”
 - “One challenge has been tracking down exposed individuals to make sure they have information on signs and symptoms. If these individuals were not able to be reached by phone or letters we attempted to contact them in person and this was done by LHD staff.”
- **Managing the substantial time needed to: (1) identify, notify, counsel, and track affected people; (2) communicate and coordinate information exchange with the state health department, healthcare facilities, and medical providers; (3) remain informed and stay up to date on the evolving situation and guidance; (4) convey complex**

and rapidly-changing information in a clear and timely manner; and (5) address the concerns and questions from the community and local media.

Sample comment: “Numerous hours have been spent with calls and e-mails between both facilities and [our LHD communicable disease control program] to clarify the scope of the problem, review patient lists, clarify procedures done involving MP, review patient records, review invoice receipts of medications received from NECC, and draft messages for them to use when contacting/screening patients for signs/symptoms of infection.”

- **Lack of staff**

Sample comment: “Not enough staff to make up for time spent working on this investigation which took away from regular responsibilities.”

Additional successes include:

- **Receiving timely and detailed information and updates.** *(see also: Challenges)*

The following are sample comments:

- “[Our state health department] was very responsive to questions and assisted in coordinating information between neighboring counties.”
- “The state supplied me with all pertinent information and I was able to reassure the patient and also offer a website that had specific patient information regarding the outbreak. [Our] county has always had a great working relationship with the state...”
- “[State] Health Alert Network alerts provided frequent updates on the situation.”

- **Cooperation with neighboring jurisdictions, healthcare facilities, and affected people**

The following are sample comments:

- “Partnering with public health and other affected agencies that also serve [our] county residents maximized resources and ensured consistent communication.”
- “Jurisdictions support[ed] each other to successfully carry out investigation responsibilities in a reasonable time frame.”
- “... facilities [that] have been contacted regarding recalled products have been very accommodating in removing the products from use. Overall individuals, both those exposed and healthcare providers, have been very cooperative in helping out during this outbreak.”

- **Rapid and effective information dissemination to healthcare partners and the public**

The following are sample comments:

- “Upon learning of the fungal meningitis outbreak...on [Sept. 27], [our LHD] in coordination with [our state health department] actively drafted and sent out a Health Alert Notice to all healthcare providers, hospital laboratories, and clinical laboratories on [Sept. 28].”
- Quick outreach to [our jurisdiction’s] clinics and medical facilities (from list FDA provided as receiving NECC products) via fax or mail alerting them to follow FDA and CDC recommendations...”
- “Quick activation of public health nurse home visits to screen or locate patients unable to be reached by phone.”
- “Although [tracking exposed individuals] has been a challenge... once we reached them, we found out they were already aware of the situation and knew what to do if they were experiencing sign or symptoms.”

¹Centers for Disease Control and Prevention. (2012). Multistate Fungal Meningitis Outbreak Investigation. Retrieved October 26, 2012 from <http://www.cdc.gov/hai/outbreaks/meningitis.html>.