Guidance and responses were provided based on information known on 6.12.25 and may become out of date. Guidance is being updated rapidly; users should look to CDC and NE DHHS guidance for updates.

Long Term Care Webinar Series

June 12, 2025

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

NE ICAP

NEBRASKA INFECTION CONTROL ASSESSMENT AND PROMOTION PROGRAM

Presentation Information

Speaker(s):

Josette McConville, RN, CIC	jmcconville@nebraskamed.com

Panelists:

Dr. Salman Ashraf, MBBS	salman.ashraf@nebraska.gov
Kate Tyner, RN, BSN, CIC	ltyner@nebraskamed.com
Josette McConville, RN, CIC	jmcconville@nebraskamed.com
Chris Cashatt, RN, BSN, CIC	ccashatt@nebraskamed.com
Lacey Pavlovsky, RN, MSN, CIC, LTC-CIP, FAPIC	lacey.pavlovsky@nebraska.gov
Sarah Stream, MPH, CDA, FADAA	sstream@nebraskamed.com
Dr. Juan Teran, ICAP Medical Director	jteranplasencia@unmc.edu
Jenna Preusker, PharmD, BCPS, BCIDP	jepreusker@nebraskamed.com
Daniel Taylor, DHHS	daniel.taylor@nebraska.gov
Larisa Mulroney, DHHS	Larisa.mulroney@nebraska.gov
Becky Wisell, DHHS	becky.wisell@nebraska.gov
Cindy Kadavy, NHCA	cindyk@nehca.org
Kierstin Reed, LeadingAge	kierstin.reed@leadingagene.org
Nurse Planner: Josette McConville, RN, CIC	jmcconville@nebraskamed.com
Moderated by Marissa Chaney	machaney@nebraskamed.com

- Slides and a recording of this presentation will be available on the ICAP website: https://icap.nebraskamed.com/events/webinar-archive/
- Use the Q&A box in the webinar platform to type a question. Questions will be read aloud by the moderator. If your question is not answered during the webinar, please either e-mail NE ICAP or call during our office hours to speak with one of our IPs.

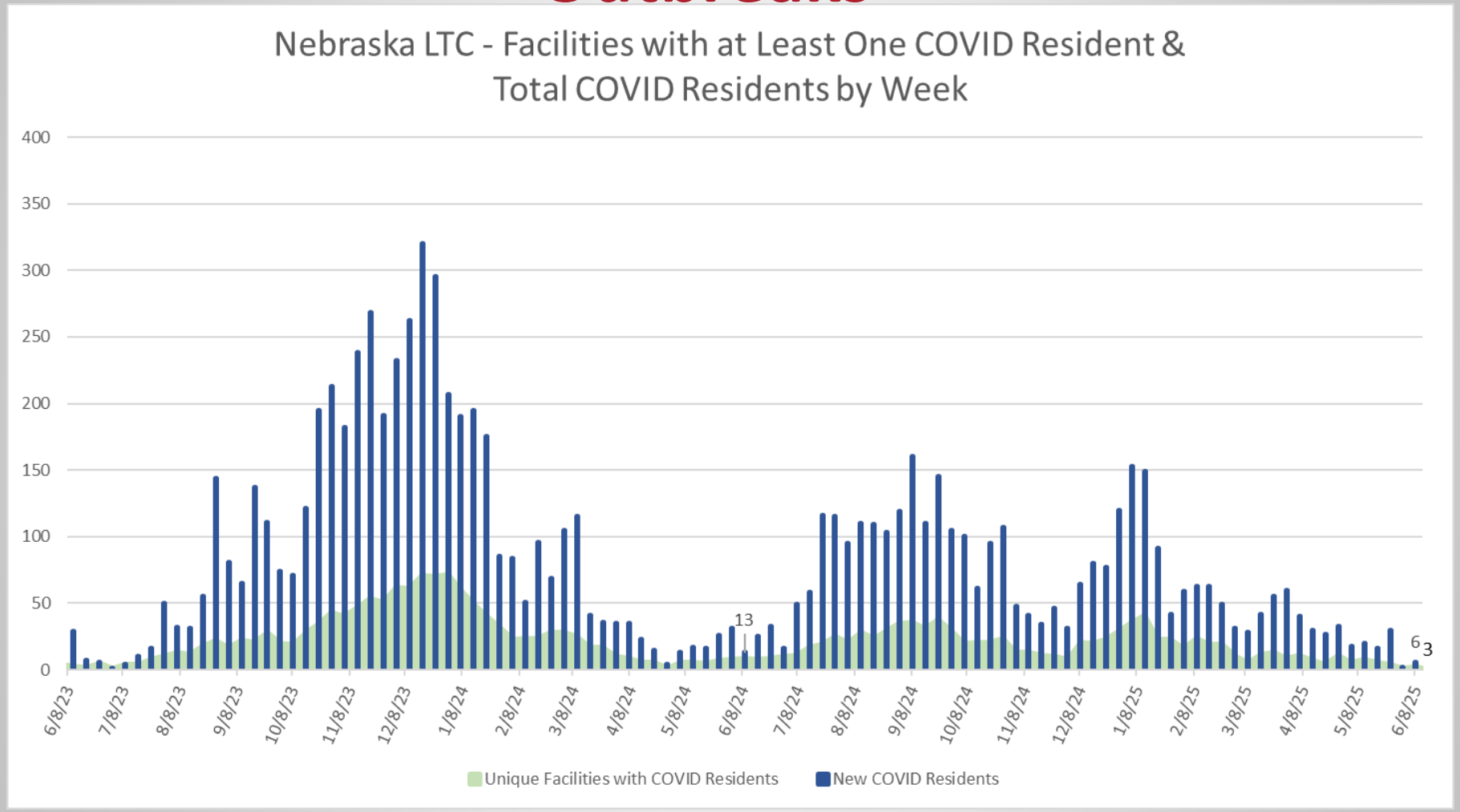
Continuing Education Disclosures

- 1.0 Nursing Contact Hour and 1 NAB Contact Hour is awarded for the LIVE viewing of this webinar
- In order to obtain nursing contact hours, you must attend the entire live activity and complete the post webinar survey
- No relevant financial relationships were identified for any member of the planning committee or any presenter/author of the program content
- This CE is hosted Nebraska ICAP along with Nebraska DHHS
- Nebraska Infection Control Assessment and Promotion Program is approved as a provider of nursing continuing professional development by the Midwest Multistate Division, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation

Nebraska Respiratory Illness Update

NE ICAP

Nebraska LTC Facility COVID-19 Outbreaks

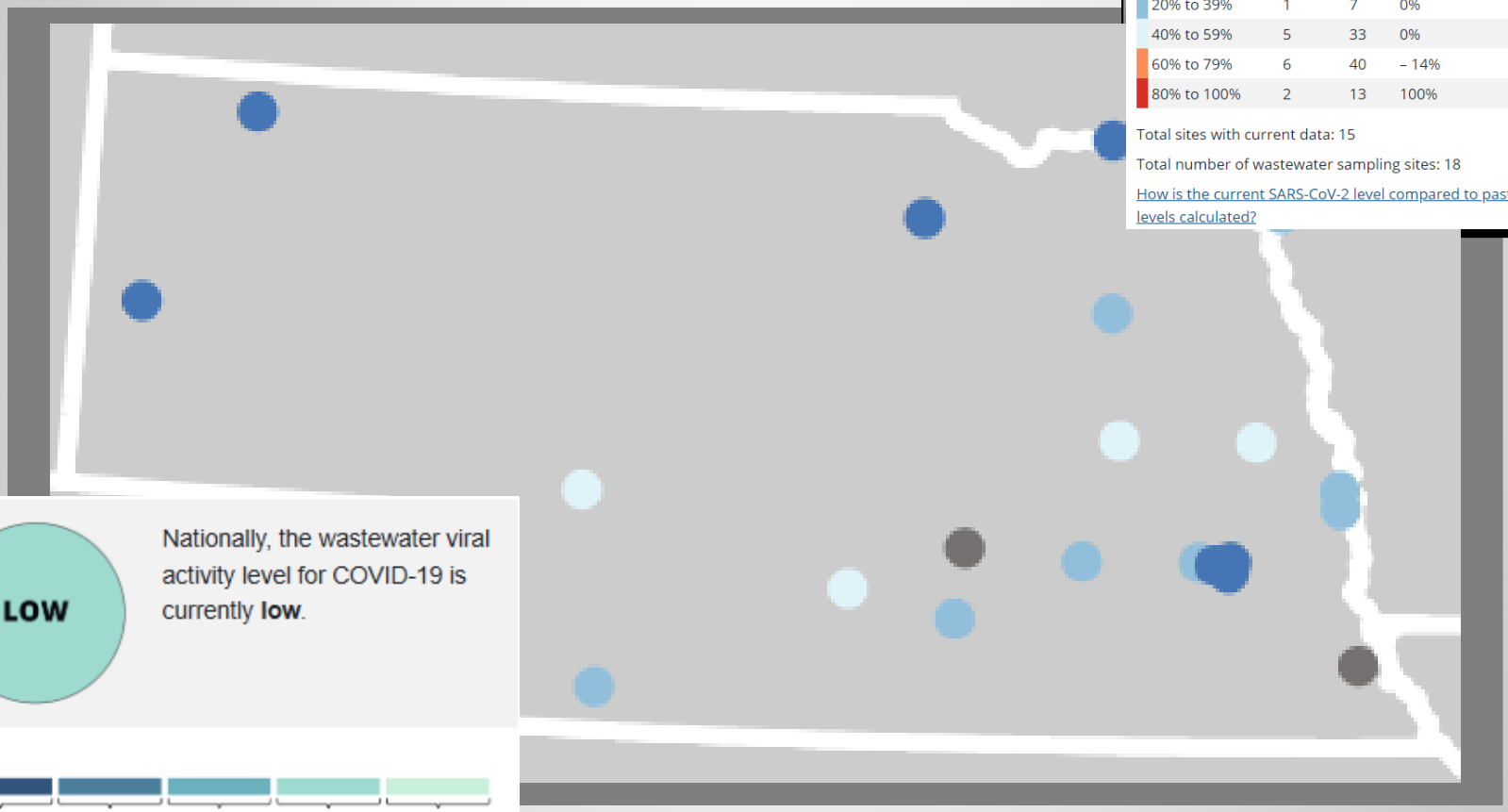


**Updated: 6/9/2025
Source: Unofficial Counts Compiled by Nebraska ICAP based on data reported by facilities and DHHS; Actual numbers may vary.

NE ICAP

Wastewater Surveillance

May 19, 2025 – Jun 02, 2025



Current SARS-CoV-2 virus levels by site, Nebraska

Current virus levels category	Num. sites	% sites	Category change in last 7 days
New Site	1	7	0%
0% to 19%	0	0	N/A**
20% to 39%	1	7	0%
40% to 59%	5	33	0%
60% to 79%	6	40	– 14%
80% to 100%	2	13	100%

Total sites with current data: 15

Total number of wastewater sampling sites: 18

How is the current SARS-CoV-2 level compared to past levels calculated?

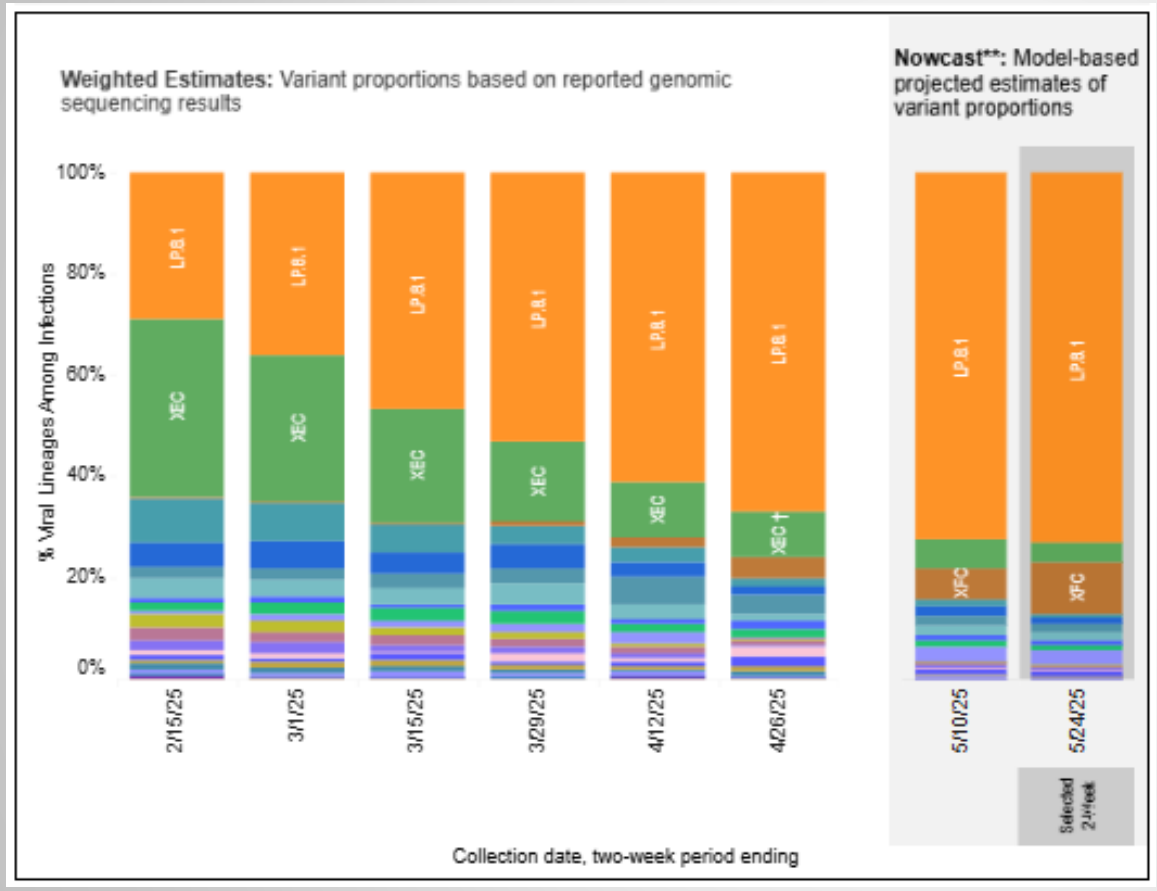
LOW

Nationally, the wastewater viral activity level for COVID-19 is currently **low**.

Very High | High | Moderate | Low | Very Low

[CDC COVID Data Tracker: Wastewater Surveillance]

What's happening with variants?



Weighted and Nowcast Estimates in United States for 2-week Period 5/11/2025 – 5/24/2025

USA

WHO label	Lineage #	%Total	95%PI
Omicron	LP.8.1	73%	69–77%
	XFC	10%	6–17%
	XEC	4%	3–5%
	LF.7.7.2	3%	1–9%
	LF.7	2%	1–3%
	MC.10.1	1%	1–2%
	LB.1.3.1	1%	1–2%
	PA.1	1%	1–2%
	XEC.4	1%	1–2%
	LF.7.7.1	1%	0–2%
	KP.3.1.1	1%	0–1%
	LF.7.2.1	0%	0–1%
	KP.3	0%	0–1%
	XEQ	0%	0–1%
	XEK	0%	0–1%
	MC.1	0%	NA
	JN.1	0%	NA
	MC.19	0%	NA

[CDC COVID Data Tracker: Variant Proportions]

NE ICAP

Stay Prepared to Prevent a Respiratory Illness Outbreak

Ensure everyone is aware of recommended IPC practices in the facility.

- Post visual alerts (e.g., signs, posters) at the entrance and in strategic places (e.g., waiting areas, elevators, cafeterias).
- Include instructions about current IPC recommendations (e.g., when to use source control and perform hand hygiene).
- Dating these alerts can help ensure people know that they reflect current recommendations.

Establish a process to make everyone entering the facility aware of recommended actions to prevent transmission to others if they have a diagnosis or symptoms of communicable illness.

- Visitors with COVID-19 should defer non-urgent in-person visitation until they have met the healthcare criteria to end isolation (10 days).
- Visitors who have had close contact with someone with COVID-19, it is safest to defer non-urgent in-person visitation until 10 days after their close contact.

Infection Control Guidance: SARS-CoV-2 | COVID-19 | CDC

Managing a COVID-19 Outbreak

CDC Recommendations:

- Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic
  - Infection Control Guidance: SARS-CoV-2 | COVID-19 | CDC
- Interim Guidance for Managing Healthcare Personnel With SARS-CoV-2 Infection or Exposure
  - Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 | COVID-19 | CDC

ICAP Resources:

- ICAP-Summary-of-Recommendations-for-COVID-19-in-a-Long-Term-Care-Facility-5.11.23.pdf
- Zones-and-PPE.pdf

Zone	Resident Masking	Staff PPE	Testing	Notes
Red Zone Isolation (Residents with a positive COVID-19 Test)	Resident isolated to room.	COVID-19 full PPE: Respirator, eye protection, isolation gown, and gloves. Respirator and eye protection may be used according to extended use guidance [if they are not touched]	Repeat testing is not needed to exit isolation unless test-based strategy being used to determine isolation duration for immunocompromised resident.	Room door closed; Communal activity and dining are restricted; and therapy or bathing are preferably performed in the resident room. Designated isolation zone in building with dedicated staff is ideal. Follow relevant regulations that apply to changing resident rooms.
Light Red Zone Isolation (Symptomatic resident with COVID-19 test pending)	Resident isolated to room.	COVID-19 full PPE: Respirator, eye protection, isolation gown, and gloves. Respirator and eye protection may be used according to extended use guidance [if they are not touched]	If using an antigen test, a negative result should be confirmed by either a negative PCR or second negative antigen test taken 48 hours after the first negative test.	Room door closed; Communal activity and dining are restricted; and therapy or bathing are preferably performed in the resident room. Resident should not be moved to a COVID unit until positive status confirmed.
Tan Zone (Facility in outbreak status)	Everyone should mask in communal areas of facility.	Everyone should mask in communal areas of facility. Facility should consider universal use of N95 and protective eyewear for staff when facility is in outbreak, especially when residents unable to use source control or area is poorly ventilated.	Contact tracing approach can be used when facility able to clearly identify exposures (e.g., single resident exposure to a visitor). Broad-based (unit wide) approach is preferred when contacts cannot be identified, or additional cases are identified after contact tracing approach. *Outbreak testing is not recommended for asymptomatic persons with SARS-CoV-2 infection in the prior 30 days.	**Initial Testing:** Perform a series of three tests, 48 hours apart. This will typically be at day 1 (exposure day 0), day 3, day 5. **Follow-up testing if additional cases identified:** Test every 3 days (twice weekly) until 14 days have passed since last known positive test. If concerns exist for outbreak containment (e.g., large number of resident cases, ongoing transmission etc.) facilities should consider using yellow zone instead of Tan Zone
Green Zone (No current outbreak)	Broader use of source control per facility policy, based on risk assessment. Perform risk assessment to identify higher levels of community COVID-19 or other respiratory illness transmission.	Broader use of source control per facility policy, based on risk assessment. Facility should consider universal use of N95 and protective eyewear when there are higher levels of COVID-19 transmission in the community.	No routine testing. Perform test on anyone with even mild symptoms of COVID-19.	Promote core principles of COVID-19 infection prevention: • Hand hygiene • Use of PPE per standard precautions • Respiratory hygiene/cough etiquette • Cleaning and disinfection of environmental surfaces • Instructional signage throughout facility
Gray Zone (New admission or readmission to facility)	Masking is at facility discretion, unless resident reports exposure or symptoms.	Healthcare personnel wear well-fitting source control based on facility policy and outbreak status.	Testing is at facility discretion, unless resident reports exposure or symptoms.	Quarantine not required for gray zone. However, if resident reports symptoms, follow light red zone recommendations

NE ICAP

Source Control During Outbreak

Source control should be recommended for all staff, visitors, and residents until the outbreak is over (e.g., no new cases have been identified for 14 days).

Consider facility policy requiring universal use of N95 respirators and protective eyewear for all staff in affected areas of the facility.

Outbreak Testing

Contact Tracing (use for limited exposure, such as resident exposure to family member)

Broad-based testing (i.e., unit, floor, or entire building) is preferred if all potential contacts cannot be identified or managed with contact tracing. Also use broad-based testing when multiple positive cases have been identified in building.

Initial Testing

- Perform a series of three tests, 48 hours apart. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5
- If no additional cases are identified, outbreak testing ends. If additional cases are identified, initiate broad-based testing.

Follow-up Testing (when outbreak testing has identified additional infections

- Testing is recommended every 3 days (twice weekly) until 14 days have passed since last known positive test.

*Note: Testing is generally not recommended for asymptomatic individuals who have recovered in the **prior 30 days**.*

Isolation Duration – Resident(s)

- At least **10 days** have passed *since symptoms first appeared,* **and** at least 24 hours have passed *since last fever* without the use of fever-reducing medications, **and** symptoms (e.g., cough, shortness of breath) have improved.

- Residents that are moderately to severely immunocompromised or who are identified to have a severe or critical infection, may require up to 20 days of isolation. Consider use of a test-based strategy to discontinue isolation.

Infection Control: Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) | CDC

Infected Staff – Return to Work

Staff diagnosed with COVID-19 need to be restricted from work until at least 7 days have passed since symptoms first appeared (or from the date of positive test if asymptomatic), AND they have resolution of fever and an improvement of symptoms, AND negative viral testing.

- If using an antigen test, staff member should have a negative test obtained on day 5 and again 48 hours later.

- If the staff member tests positive on day 5 - 7 or testing is not performed between day 5-7 then restriction will need to be extended for at least 10 days.

Room Placement

Ideally, residents should be placed in a single-person room.

- If limited single rooms are available, or if numerous residents are simultaneously identified to have known SARS-CoV-2 exposures or symptoms concerning for COVID-19, residents should remain in their current location.

- Facilities will need to follow all relevant regulations that apply to changing resident rooms, including securing consent from resident/families.

If unable to move roommates, consider other measures to prevent further exposure:

- Maintain physical distancing as much as possible.
- Separate residents with privacy curtain.
- Mask resident, as able, if crossing into separate areas of room (i.e., bathroom visit).
- Increase disinfection of surfaces in room and bathroom

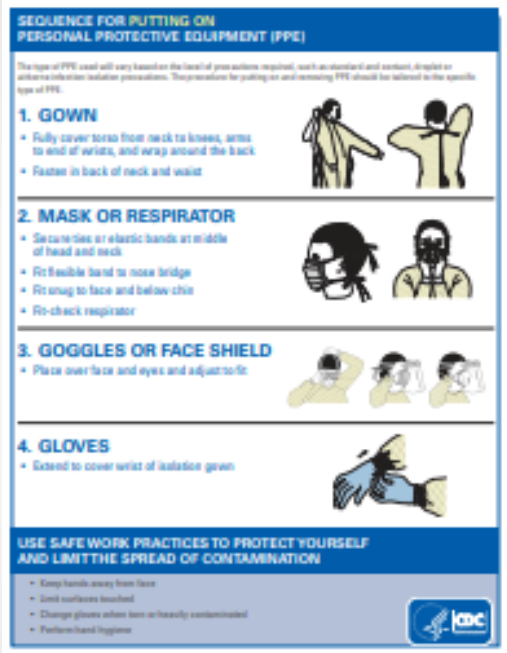
Isolation – PPE Use

Staff entering the room of a resident with COVID-19 should adhere to standard precautions and COVID-19 isolation, with use of respirator (N95), gown, gloves, and eye protection.

- **Standardize isolation signs** to include required PPE. Recommend signage to indicate donning and doffing techniques.

- **Training** – When and how to don and doff PPE
  - Ensure gown and gloves are doffed inside of the resident room, prior to exiting into hallway.

- **Audits** – Provide real time feedback for improvement.



ppe-sequence-p.pdf (cdc.gov)

Yellow Zone

Yellow Zone Transmission-Based Precaution measures should be implemented in the event of ongoing COVID-19 transmission within the facility that is not controlled with initial interventions.

Shift to Yellow Zone Phases instead of Tan Zones when there are concerns related to outbreak containment (e.g., large number of resident cases or ongoing transmission, such as new RESIDENT cases being identified COVID-19 positive in rounds of testing 7 days or more after the first residents(s) identified COVID-19 positive).

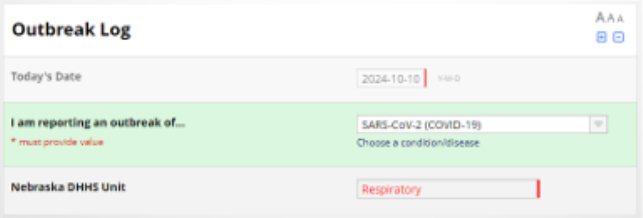
Yellow Zone does **not** need to be considered if facility has only staff positive cases identified during outbreak testing.

Yellow Zone (Uncontrolled COVID-19 outbreak)	**Yellow Zone Phase**	**Staff PPE Use**	**Additional Transmission-Based Precautions Recommended**
	Phase 1	Staff universal use of N95 and eye protection. Respirator and eye protection may be used according to extended use guidance [if they are not touched]	Resident wear source control when outside of room. Restrict communal dining. Small group activities can continue with source control and physical distancing.
	Phase 2	Staff universal use of N95 and eye protection. Respirator and eye protection may be used according to extended use guidance [if they are not touched]	Resident wear source control when outside of room. Restrict dining and group activities.
	Phase 3	COVID-19 full PPE: Respirator, eye protection, isolation gown, and gloves. Respirator and eye protection may be used according to extended use guidance [if they are not touched]	Residents mostly limited to their rooms. Keep resident doors closed. Restrict dining and group activities. Facility can devise a plan for a small number of residents to be outside of their room at any given time with mask use. Facility should ensure physical distancing and could prioritize outdoor visits, dependent on weather.

Note: Facility can choose to initiate yellow zone precautions with any of the three phases listed above depending on their assessment of outbreak (e.g., nature of exposure, ability of residents to follow instructions, ventilation in the building, number of staff and resident cases etc.). However, if facility continues to see resident cases 7 days after implementing a lower-level phase, then proceed to a higher-level phase. If already on phase 3 and still seeing new cases 7 days later, reassess infection control practices and consider reaching out to Nebraska ICAP to discuss additional infection control measures.

Outbreak Reporting Requirements

- **Long-term care facilities** that are CMS certified are required to report to NHSN. NHSN reporting satisfies the requirement to report the COVID, influenza and/or RSV outbreaks to the state (DHHS).
    - CDC | NHSN Recent Trainings
- **Assisted living facilities** can meet the requirement to report outbreak through completion of Redcap survey:
    - https://epi-dhhs.ne.gov/redcap/surveys/?s=HFDCEHEYT844R8C8



- Note: Also inform local health department of outbreak, depending on specific local health department expectation.

Measles

Josette McConville, RN, CIC

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

NE ICAP

NEBRASKA INFECTION CONTROL ASSESSMENT AND PROMOTION PROGRAM

Nebraska Department of Health and Human Services

Health Alert Network

Update

June 4, 2025

Measles Detected in Nebraska

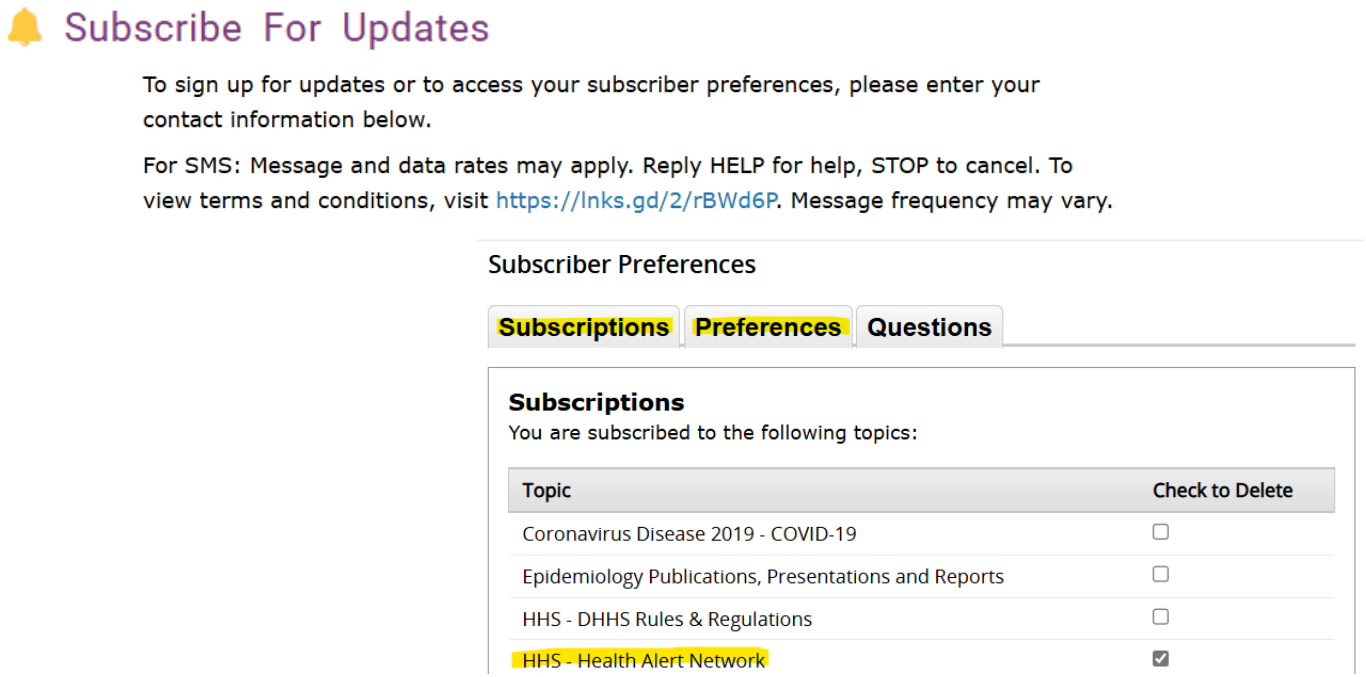
Summary

On May 27, 2025, the Nebraska Department of Health and Human Services reported the first measles case in Nebraska since 2017. Panhandle Public Health District identified a confirmed case of measles in an age-appropriately vaccinated child that had not had any recent out-of-state travel history, indicating potential spread within the community. Locations of potential public measles exposure can be found here. The symptom monitoring period for most contacts of this case will end June 11, 2025.

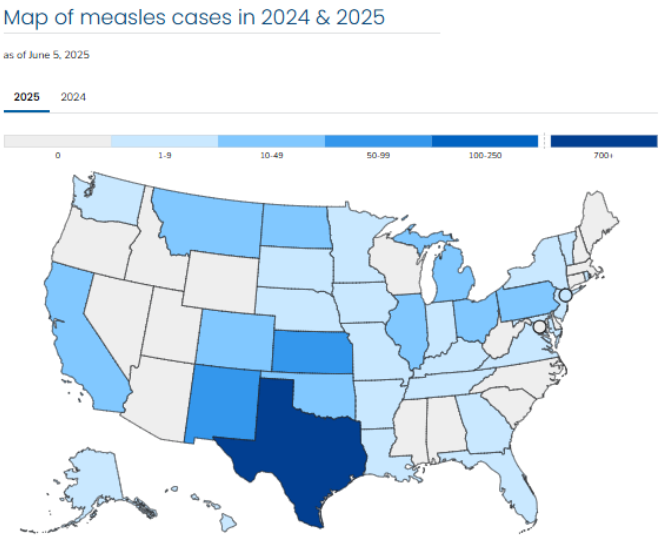
https://dhhs.ne.gov/han%20Documents/UPDATE06042025.pdf

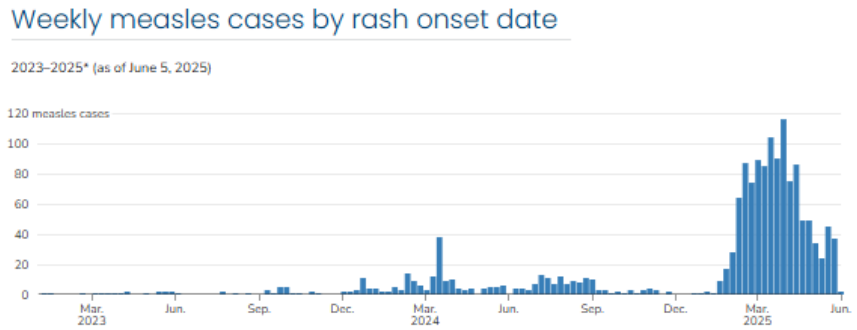
Options for Nebraska Health Alert Network (HAN) Communications

When subscribing to the Nebraska HAN, select type (e.g. email, text) and daily frequency.
https://dhhs.ne.gov/Pages/Health-Alert-Network.aspx



CDC Measles Cases and Outbreaks





U.S. Cases in 2025
Total cases
1168

89% of confirmed cases are outbreak related.

Age
Under 5 years: **339 (29%)**
5-19 years: **439 (38%)**
20+ years: **381 (33%)**
Age unknown: **9 (1%)**

Vaccination Status
Unvaccinated or Unknown: **95%**
One MMR dose: **2%**
Two MMR doses: **3%**

U.S. Hospitalizations in 2025
12% of cases hospitalized

U.S. Deaths in 2025
3

Measles Cases and Outbreaks | Measles (Rubeola) | CDC

Measles Infection

- An acute, highly infectious, respiratory viral disease
- Pre-vaccines, childhood infection was a nearly universal occurrence
- Measles vaccinations in the US available since 1963
  - Current strain (Edmonston-Enders) since 1968
  - Combined MMR since 1971
  - Combined MMR-Varicella since 2005
- Measles was declared ‘eliminated’ in the US in 2000
- Due to global prevalence of measles and unimmunized populations, cases and outbreaks in the US still occur

Measles is an acute respiratory viral illness

Initial Symptoms

- Fever (may spike to more than 104° F)
- Malaise (overall feeling of illness and discomfort)
- Cough
- Coryza (runny nose)
- Conjunctivitis (red watery eyes)

} the 3 “C”s

[Clinical Overview of Measles]

[CDC About Measles]

[CDC Measles Symptoms and Complications]

2 – 3 days after symptoms begin, Koplik's spots can appear

Koplik's spots are tiny white macular (flat) spots that may appear inside the mouth including hard and soft palate – especially opposite lower premolars.

This was a patient who presented with Koplik's spots on palate due to pre-eruptive measles on day three of the illness.
Source: CDC/PHIL

This patient presented on the third pre-eruptive day with "Koplik spots" indicative of the beginning onset of measles.
Source: CDC/PHIL

CDC Photos of Measles

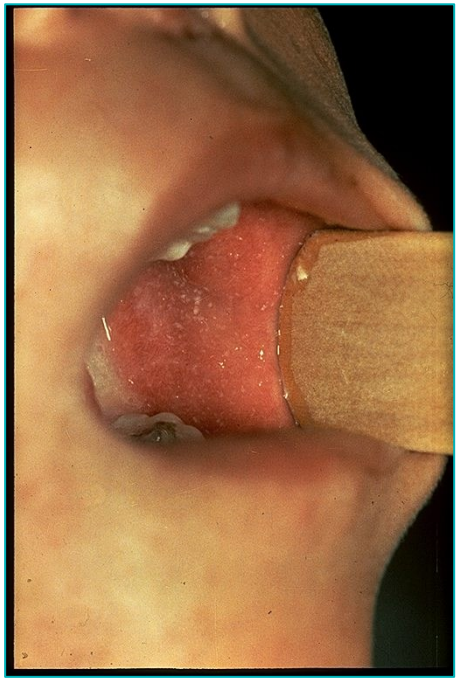


Photo Courtesy of vaccineinformation.org

Approximately 2 – 4 days after symptoms begin: Maculopapular rash appears

Maculopapular rash usually appears 14 days after exposure

- Spreads from head to trunk to lower extremities
- It usually begins as flat red spots that appear on the face at the hairline.
- Spreads downward to the neck, trunk, arms, legs, and feet.
- Small raised bumps may also appear on top of the flat red spots.

Eyes of a child with measles
Source: CDC/PHIL

Face of boy after three days with measles rash.
Source: CDC/PHIL

Child with a classic measles rash after four days.
Source: CDC/PHIL

CDC Photos of Measles

Complications of Measles Infection

- About 1 in 5 people who get measles in the US are hospitalized
- Children <5years old and adults are more likely to suffer complications

- Common Complications
  - Diarrhea and vomiting
  - Otitis media
  - Croup
  - Pneumonia
- Severe Complications
  - Acute encephalitis
  - Pregnancy complications
  - Death
  - Subacute sclerosing panencephalitis
  - Immune suppression

Incubation period

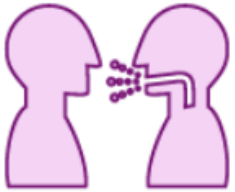
- Incubation period is the term that refers to the time between exposure to an infectious disease and the start of symptoms
- The incubation period for measles is 7 to 21 days with an average of 11 to 12 days to symptom onset and 14 days to rash onset
  - Influences work restrictions for non-immune healthcare personnel

Infectious period

- 4 days before through 4 days after rash appearance

Transmission

- Airborne spread when an infectious person coughs, sneezes, or breathes
- Measles remains infectious in the air for up to two hours after an infected person leaves an area
- Direct contact with infectious droplets



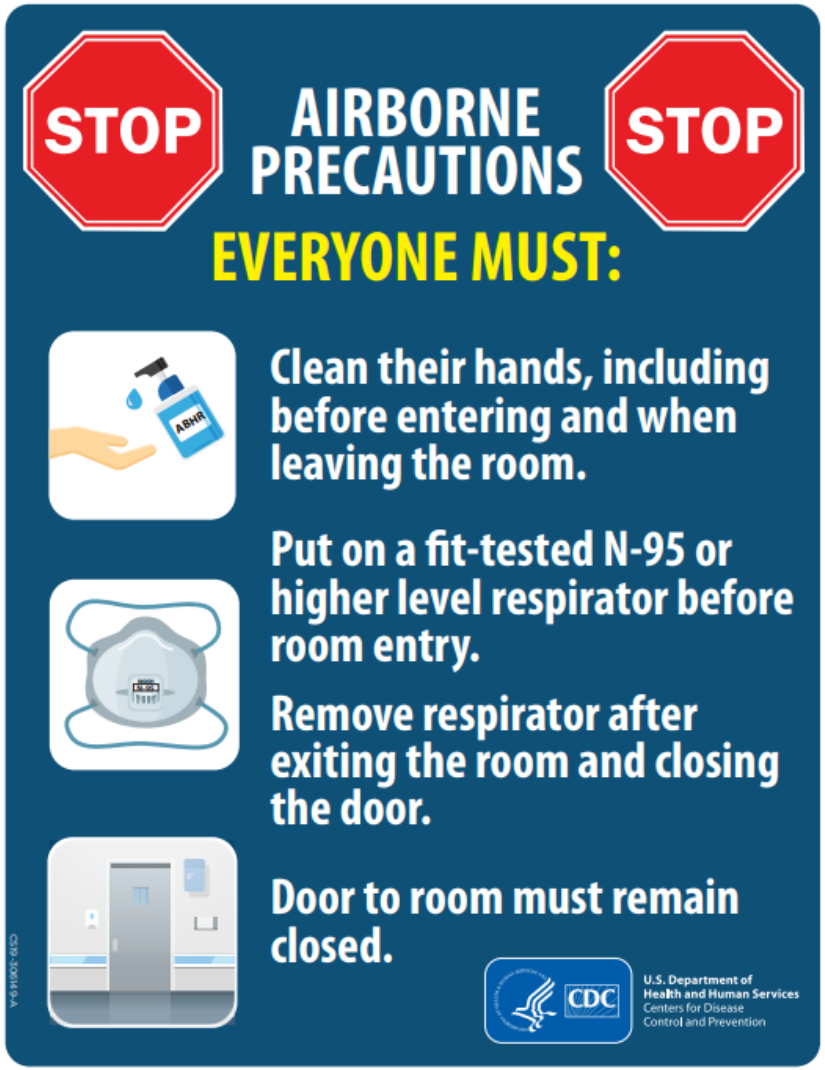
It spreads when an infected person coughs or sneezes.

The virus can live for up to two hours in an airspace.

Clinical Overview of Measles

Isolate Immediately

Isolate patients with suspected measles immediately, ideally in a single-patient airborne infection isolation room (AIIR) if available, or in a private room with a closed door until an AIIR is available. Healthcare providers should be adequately protected against measles and should adhere to standard and airborne precautions when evaluating suspect cases, regardless of their vaccination status.



Transmission-Based Precautions | Infection Control | CDC

Measles Resources for Long-Term Care

Post-acute and Long-term Care Medical Association (PALTmed) Measles Statement

- https://paltmed.org/news-media/paltmed-measles-statement

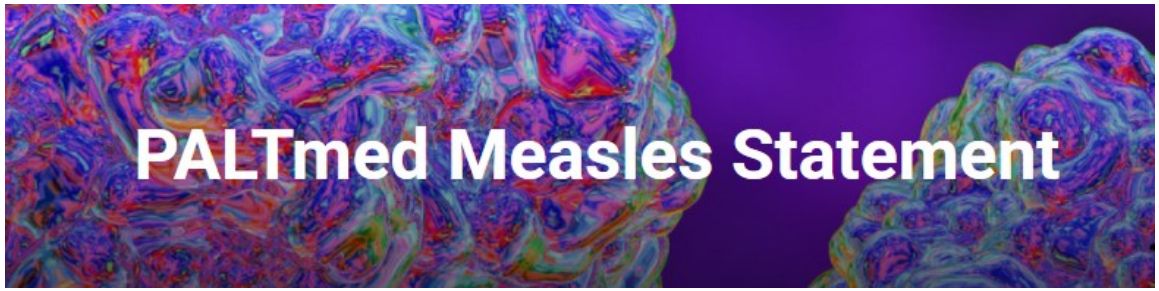
AHCA/NCAL Infection Preventionist Hot Topic Brief, Measles Risk in the Long-term Care Setting

- https://www.ahcancal.org/Quality/Clinical-Practice/Documents/Hot%20Topic%20Brief_Measles%20Risk%20in%20the%20Long-Term%20Care%20Setting.pdf

CDC Interim Infection Prevention and Control Recommendations for Measles in Healthcare Settings

- https://www.cdc.gov/infection-control/hcp/measles/?CDC_AAref_Val=https://www.cdc.gov/infectioncontrol/guidelines/measles/index.html

PALTmed
POST-ACUTE AND LONG-TERM CARE MEDICAL ASSOCIATION



In a non-outbreak regions

The focus of the Medical Director should be on prevention and readiness by:

- Verifying immunity of staff.
- Reviewing screening and isolation/work exclusion protocols and Personnel Protective Equipment (PPE) supplies.
- Educating staff about signs and symptoms of measles.
  - Early signs and symptoms of measles include fever, cough, coryza and red, watery eyes (conjunctivitis)
  - Measles rash appears 3 to 5 days after the first symptoms. It usually begins on the face and then spread downward to the neck, trunk, arms, legs, and feet.
- Discussing measles containment response plans with infection prevention and control team.

PALTmed Measles Statement | PALTmed

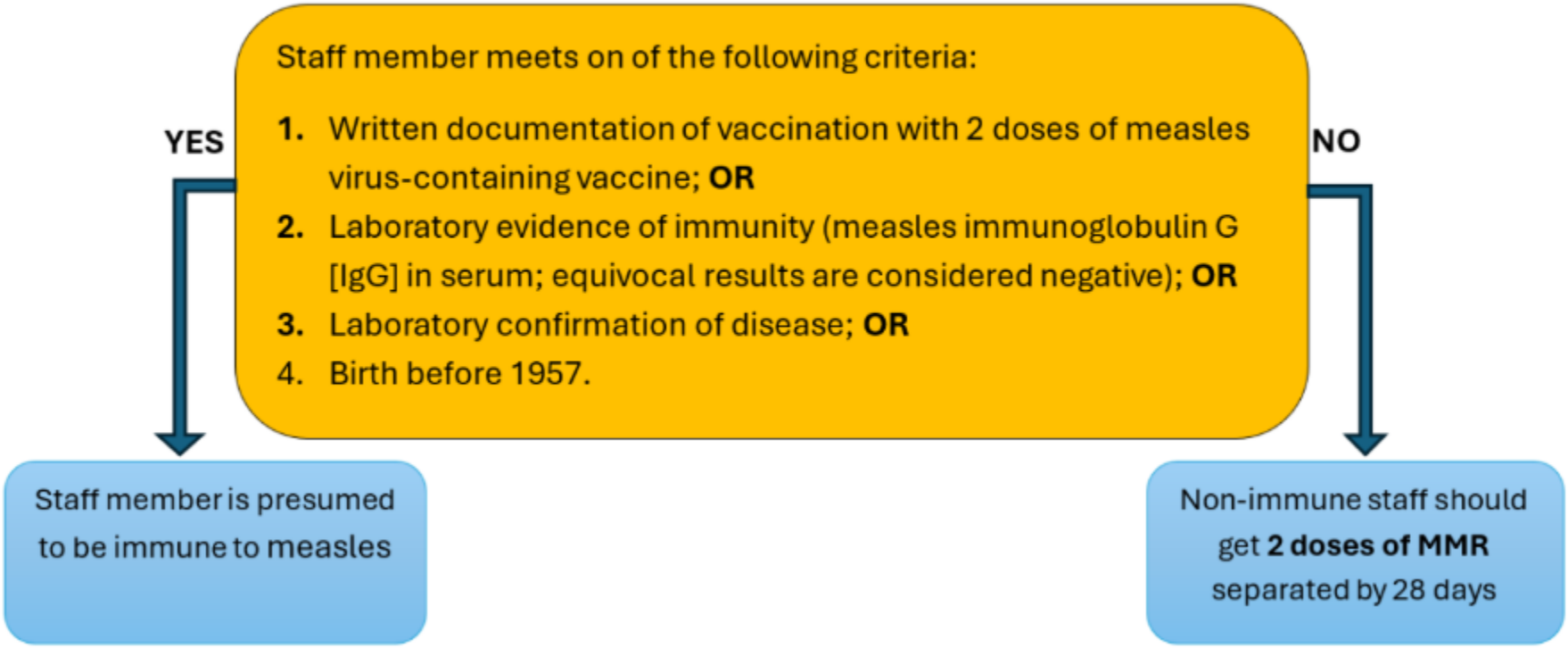
PALTmed
POST-ACUTE AND LONG-TERM CARE MEDICAL ASSOCIATION

Non-Outbreak Settings

- [ ] Verify immunity of staff
- [ ] Review screening and isolation/work exclusion protocols using CDC guidance as a reference
- [ ] Review personal protective equipment (PPE) supplies
- [ ] Educate staff about early signs and symptoms of measles using CDC guidance as a reference
- [ ] Discuss measles containment response plans with infection prevention and control team using CDC guidance as a reference

PALTmed Measles Statement | PALTmed

Confirm Healthcare Personnel Immunity



PALTmed Measles Statement | PALTmed
Interim Infection Prevention and Control Recommendations for Measles in Healthcare Settings | Infection Control | CDC
Prevention of Measles, Rubella, Congenital Rubella Syndrome, and Mumps, 2013

In areas experiencing measles outbreaks

The Medical Director should:

- Monitor state and CDC health alerts and follow state and local public health guidance.
- **Proactively review and document** immunity of all staff.
- Educate staff and residents about signs and symptoms of measles.
- Implement enhanced entry screening for rash/fever.
- Inform healthcare personnel on infection control protocols for management of exposed healthcare personnel and those infected with measles.
- Be prepared to implement cohorting or quarantine strategies, if needed.
- Establish a communication plan for rapidly informing public health officials and families if a case is suspected.

PALTmed Measles Statement | PALTmed

In areas experiencing measles outbreaks

1. **For healthcare personnel:**

- During a measles outbreak: **2 doses** of measles virus-containing vaccine are recommended for all HCP, **regardless of year of birth**.
- If there is a suspected or confirmed measles case in the facility, work with public health to assess the need for **post-exposure prophylaxis (PEP), symptoms monitoring** and **work exclusions**.
- PEP is recommended for individuals without evidence of immunity against measles.
- PEP should be provided, as soon as possible after exposure, either with MMR vaccine (within 72 hours) or immunoglobulin (within 6 days). The choice of PEP is based on elapsed time from exposure or medical contraindications to vaccination (e.g. pregnancy or immunocompromised status).
- HCP without evidence of immunity against measles are recommended to be excluded from work from the 5th day after their first exposure through the 21st day after their last exposure, regardless of receipt of post-exposure prophylaxis.

2. **Residents:**

- If there is a suspected or confirmed measles case in the facility, work with public health to assess need for *post-exposure prophylaxis* and *immune status evaluation*.

PALTmed Measles Statement | PALTmed

Outbreak Settings

PALTmed
POST-ACUTE AND LONG-TERM CARE MEDICAL ASSOCIATION

	Follow any state and local public health guidance
☐	Monitor state and CDC health alerts • Sign up for CDC's Health Alert Network here • Visit your state health department's website to sign up for health alerts
☐	Proactively review and document immunity of all staff • During a measles outbreak: **2 doses** of measles virus-containing vaccine are recommended for all HCP, **regardless of year of birth**
☐	Educate staff and residents about signs and symptoms of measles using CDC guidance as a reference
☐	Inform healthcare personnel on infection control protocols for management of exposed healthcare personnel and those infected with measles
☐	Prepare to implement cohorting or quarantine strategies, if needed
☐	Establish a communication plan for rapidly informing public health officials and families if a case is suspected
☐	If suspected or confirmed measles case in the facility: work with public health to assess needs for immune status evaluation of residents, post-exposure prophylaxis for staff and residents, symptoms monitoring for exposed staff and work exclusions

PALTmed Measles Statement | PALTmed

HCP Work Restrictions After Measles Exposure

For asymptomatic healthcare personnel ***with*** presumptive evidence of immunity to measles who have an exposure to measles:

- Postexposure prophylaxis is not necessary.
- Work restrictions are not necessary.
- Implement daily monitoring for signs and symptoms of measles from the 5th day after their first exposure through the 21st day after their last exposure.

Measles | Infection Control | CDC

HCP Work Restrictions After Measles Exposure

For asymptomatic healthcare personnel ***without*** presumptive evidence of immunity to measles who have an exposure to measles:

- Administer postexposure prophylaxis in accordance with CDC and ACIP recommendations.
- Exclude from work from the 5th day after their first exposure through the 21st day after their last exposure, regardless of receipt of postexposure prophylaxis.
- Work restrictions are not necessary for healthcare personnel who received the first dose of MMR vaccine prior to exposure:
  - They should receive their second dose of MMR vaccine as soon as possible (at least 28 days after their first dose).
  - Implement daily monitoring for signs and symptoms of measles from the 5th day after their first exposure through the 21st day after their last exposure.

Measles | Infection Control | CDC

AHCA/NCAL Infection Preventionist Hot Topic Brief

Measles Risk in the Long-Term Care Setting

Focal Problem or Issue

Measles is a highly infectious disease that is preventable with vaccination. We have recently seen an increase in measles outbreaks in the US. The CDC alert issued on January 25, 2024, contained specific recommendations for healthcare settings regarding these types of outbreaks. The risk of being exposed to individuals who are contagious with measles in a long-term care setting is less likely than in health clinics or schools due to the differences in populations served. However, there is potential of exposure and spread in any setting when susceptible individuals are exposed to those who are contagious, so by applying the information contained in this Brief, the LTC Infection Preventionist (IP) can reduce the risk of measles transmission in their facility.

The LTC IP can assure that their facility is prepared by verifying:

- The HCP at the facility understand that the goal for measles prevention including:
  - Everyone being immune to measles which includes having the disease as a child or being fully vaccinated against measles unless contraindicated.
  - If there is a suspected case of measles among healthcare workers or a LTC resident, that it is quickly identified and appropriate infection prevention precautions are taken (e.g., use of Airborne Precautions for residents or furlough for staff/personnel) to limit potential for transmission.
- Their facility has processes in place to recognize signs and symptoms of measles including recognizing the red or reddish-brown maculopapular rash.
- An effective process is in place to check measles immunity status for residents as well as for all healthcare workers (HCW).
- Those responsible for resident health and for HCP occupational health requirements understand specifically how to verify immunity to measles in residents and HCP.
- Their facility has processes in place to recognize signs and symptoms of measles including recognizing a maculopapular rash that begins with the hairline spreading downwards and outwards. Staff are aware of the need to inform the Occupational Health or IP regarding any staff with signs or symptoms of measles themselves or in their immediate family.
- A process for contacting and notifying the local health department regarding suspected cases among healthcare workers or residents is in place and ready for activation when needed.

AHCA/NCAL NATIONAL INFECTION PREVENTION FORUM

Background and Scope

Measles, also known as "rubeola," is one of the most highly infectious diseases that can be prevented with vaccination. Measles spreads when a person with the infection coughs or sneezes and exposes a susceptible individual to the measle virus which can travel through the air. The virus can linger in the air for extended periods of time and remains infectious to susceptible individuals in the vicinity. A person who is susceptible can contract measles simply by walking into a room and breathing the air an hour or even longer after a person with an active case of measles has been treated in the same room.

Assessing for Evidence of Immunity

According to CDC, acceptable presumptive evidence of immunity against measles includes **at least ONE** of the following:

- Written documentation of vaccination with 2 doses of measles virus-containing vaccine (the first dose administered at age ≥12 months; the second dose no earlier than 28 days after the first dose); OR
- Laboratory evidence of immunity (measles immunoglobulin G [IgG] in serum; equivocal results are considered negative); OR
- Laboratory confirmation of disease; OR
- Birth before 1957.
  - Consider vaccinating HCP born before 1957 who do not have other evidence of immunity to measles.

Two doses of measles virus-containing vaccine are recommended for all HCP, regardless of year of birth. Recommendations on immunization of HCP for measles are maintained by CDC and ACIP.

What may contribute to lack of measles immunity or measles transmission in LTC settings?

- Inadequate process at the facility for assessing each resident and HCP for immunity status and taking appropriate measures when measles non-immune individuals are identified
- HCP and residents may have received less than the number of measles doses of vaccine as noted above in "assessing for evidence of immunity" which places them at risk of contracting measles and exposing other non-immune people to the disease
- Failure of immunized HCP to follow Standard and Airborne Precautions when caring for people with measles.
- Inadequate facility policies on vaccinations for healthcare personnel. Occupational Health Programs should have specific policies in place that include immunity assessment and vaccination requirements for HCP for vaccine preventable communicable diseases including measles, mumps, rubella, pertussis, varicella, influenza and Covid-19 and others per state or national recommendations.
- Failure to rapidly identify and isolate someone with suspected measles infection.

AHCA/NCAL NATIONAL INFECTION PREVENTION FORUM

Hot Topic Brief_Measles Risk in the Long-Term Care Setting.pdf

Measles Clinical Features

Incubation period 11–12 days
- Exposure to rash onset averages 14 days (range 7–21 days)

Prodrome lasts 2–4 days
- Stepwise increase in fever to 103–105° F
- Cough, coryza (i.e. runny nose) and conjunctivitis
- Koplik spots (often seen in the prodromal or beginning stages, one of the signs of the onset of measles. Koplik spots are classically described as being bright red spots with white or bluish-white centers that may resemble grains of sand.)

Rash (maculopapular)
- Persists 5–6 days
- Begins at hairline, then involves face and upper neck
- Proceeds downward and outward to hands and feet
- Severe areas peel off in scales
- Fades in order of appearance

People at high risk for severe illness and complications from measles include*:
- Infants and children aged <5 years
- Adults aged >20 years
- Pregnant women
- People with compromised immune systems, such as from leukemia and HIV infection

*Measles Complications | CDC

Key Reminders for Infection Prevention and Control in Healthcare Settings
- Residents with signs and symptoms of measles (e.g. febrile rash) should be placed in Airborne Precautions upon suspicion of infectious illness as noted in CDC recommendations.
- Visitors and staff suspected of having measles should not be permitted in the healthcare facility until they are no longer considered contagious per CDC criteria or guidance from your local or state health agency.
  - If there are people with measles in your community, consider screening visitors for signs and symptoms of measles before entering the facility.
  - Visitors without acceptable presumptive evidence of immunity should not enter the room of a patient with known or suspected measles.

Key Reminders for Infection Prevention and Control in Healthcare Settings (cont.)
  - Limit visitors to patients with known or suspected measles to those who are necessary for the patient's well-being and care.
- If HCP with presumptive evidence of immunity to measles are exposed to measles in their home (i.e., they live with a child that has measles), they should not be restricted from work, should not receive post-exposure prophylaxis, but should monitor for symptoms until 21 days after the last exposure (i.e., the end of the cases infectious period).
- When transporting suspected residents or patients with suspected or confirmed measles outside of an airborne isolation precautions room, place a standard surgical mask (not N-95 respirator) over their mouth/nose to prevent the spread of measles.
  - This should only be for necessary transport, ideally with a route that is coordinated to limit potential for exposure.
  - Example: following a back route or semi-private hall and not through major traffic areas
- Refer to the CDC's Interim Infection Prevention and Control Recommendations for Measles in Healthcare Settings for more information

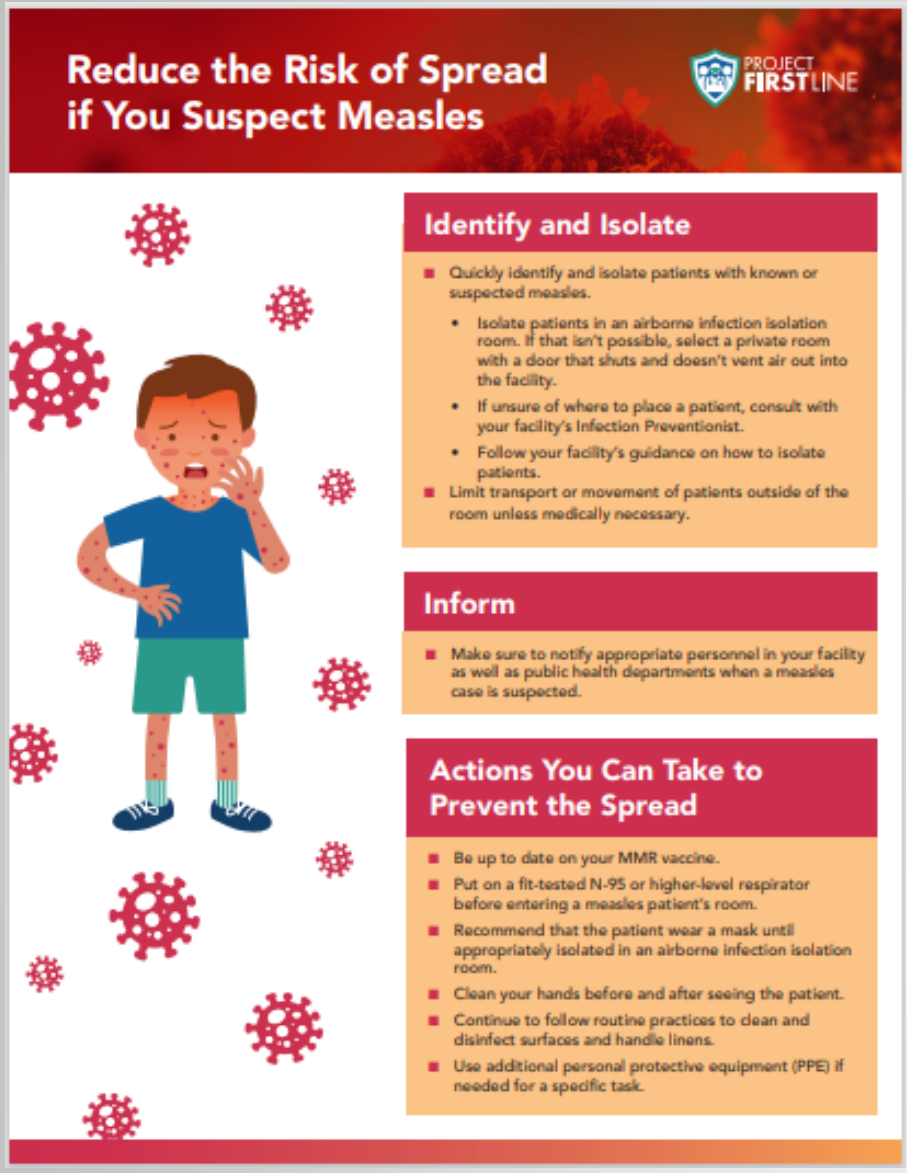
Resources/Sources

1. "Stay Alert for Measles Cases" COCA Now; January 25, 2024
2. Interim Infection Prevention and Control Recommendations for Measles in Healthcare Settings
3. CDC Pink Book
4. CDC Measles (Rubeola)
5. Immunization of Health-Care Personnel Recommendations of the Advisory Committee on Immunization Practices (ACIP) MMWR November 21, 2011

Interested in joining the National Infection Prevention Forum?

LEARN MORE

Hot Topic Brief_Measles Risk in the Long-Term Care Setting.pdf



PROJECT FIRSTLINE

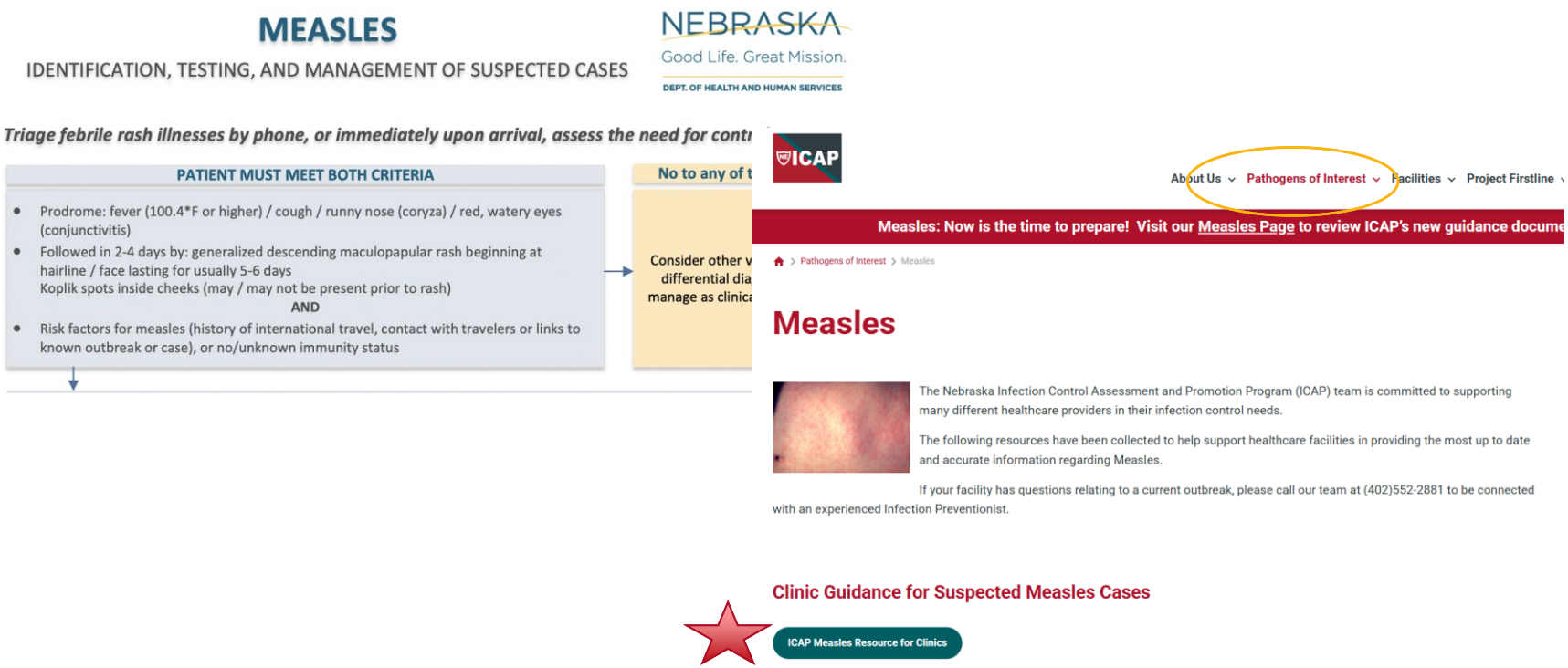
About Micro-Learns: The Project Firstline Infection Control Micro-Learns are a series of guided infection control discussions that provide brief, on-the-job educational opportunities. Healthcare workers can easily apply the key points to their daily work and perform the recommended actions to keep germs from spreading.

The micro-learns can be incorporated into existing opportunities where groups of healthcare workers gather, such as pre-shift "huddles" or team meetings. The sessions should be led or facilitated by an experienced team member with infection control expertise.

Measles Micro-Learn

NE ICAP

Additional Resources, Not Specific to LTC



- Measles – ICAP
- icap.nebraskamed.com/wp-content/uploads/sites/2/2024/03/ICAP-Measles-Resource-for-Clinics_3.4.2024.pdf
- https://dhhs.ne.gov/Pages/Measles-Provider-Guidance.aspx

In Closing

NE ICAP

APIC NEBRASKA

Nebraska Infection Control Network

NEBRASKA METHODIST COLLEGE
THE JOSIE HARPER CAMPUS
PROFESSIONAL DEVELOPMENT

The NICN and APIC NE Symposium: 45 Years of Progress: Advancing Infection Prevention and Control Together

Time CST	Topic/Title/Speaker/Contact Hours Awarded
7:00 am – 8:15 am	Registration/Breakfast
8:15 am – 8:30 am	Welcome: Dr. Richard Starlin (0.25 CH)
8:30 am – 9:15 am	Future of Infection Prevention: Dr. Gonzalo Bearman (0.75 CH)
9:15 am – 10:00 am	Leadership Development & Influencing Change: Dr. Hilary Babcock (0.75 CH)
10:00 am – 10:30 am	Break/Vendors
10:30 am – 11:30 am	Vaccination Promotion: Dr. Peter Hotez (presenting remotely 0.0 CH)
11:30 am – 12:30 pm	Lunch (Provided) and Vendors
12:30 pm – 1:30 pm	Track 1: TBD: LTC Guideline Updates (1.0 CH)
12:30 pm – 1:30 pm	Track 2: Vascular Access Related Infection Prevention and Management/Preventative Technology: Barb Nickel (1.0 CH)
1:30 pm – 2:00 pm	Break/Vendors
2:00 pm – 2:45 pm	MDRO in Animals: Stephen Cole (0.75 CH)
2:45 pm – 3:30 pm	How to Interact with Media and Art of Communication: Cathy Wyatt (0.75 CH)
3:30 pm – 3:45 pm	Closing (0.25 CH)

Join NICN and APIC NE for their 45th anniversary symposium. Join us for an engaging and informative workshop dedicated to infection prevention and control in all healthcare settings

- Friday, August 29, 2025
- 8:00 AM to 3:15 PM
- The Holland Center, Omaha, NE 68102

NICN APIC Nebraska Symposium Registration

NE ICAP

Join Us - Upcoming ICAP Webinars

July 10th, 2025

- 12:00 – 1:00 PM (CST), Environmental Rounding for Infection Prevention and Control

Webinar CE Process

1 Nursing Contact Hour is offered for attending this LIVE webinar.

Individual surveys must be completed for each attendee.

Questions? Contact us at:

nebraskaicap@nebraskamed.com 402-552-2881

Nursing Contact Hours:

- Completion of survey is required.
  - The survey must be specific to the individual obtaining credit. (i.e.: 2 people cannot be listed on the same survey)
- One certificate is issued quarterly for all webinars attended
- Certificate comes directly from ICAP via email

Infection Prevention and Control Hotline Number:

Call 402-552-2881

Office Hours are Monday – Friday

8:00 AM - 4:00 PM Central Time

On-call hours are available for <u>emergencies only</u>

Weekends and Holidays from 10:00 AM- 4:00 PM

*Messages left outside of Office or On-call hours will be answered the next business day.

**Please call the main hotline number to ensure the quickest response.