Measles Prevention Strategies and Best Practices for FQHCs

This document is a compilation of state and federal CDC guidelines, with input from Maine’s FQHC network clinical teams. It is not intended to be a comprehensive plan. Please review the web-based resources for ongoing updates, and work with your CHC’s EP team to adopt and appropriate plan for your setting.

Report all Measles cases to State Public Health Authorities
Maine CDC -- 1-800-821-5821

Community vaccination is the main prevention strategy for ALL settings

Children and Adolescents – One dose at 12 –15 months of age and a second dose at 4 –6 years of age
Adults without evidence of measles immunity – Most adults need one dose –Two doses for high risk adults, at least 28 days apart

Adult Immunization schedule: http://www.cdc.gov/vaccines/schedules/hcp/adult.html

Proactively ensure that HCP have presumptive evidence of immunity

Presumptive Evidence of Immunity - Birth before 1957 - Laboratory evidence of immunity - Laboratory confirmation of disease

- They are considered immune if born before 1957
- They are considered immune if born between 1957 and 1989 if they had 1 MMR vaccine
- They are considered immune if born after 1989 and had 2 MMR vaccines
- MMR vaccines can be given at age 12 months and 4 years old.
  - All patients can catch up anyone if they want a vaccine if they have not had one
- Infants between 6-11 months who are traveling outside the US should get 1 vaccine before travel and then get 2 more vaccines at ages noted above
- If patients do not know if they had vaccine and born after 1957 they can have a titer drawn to prove immunity
- Adults having 1 documented vaccine do not need a booster per guidelines
- After 1 vaccine children are 93% effective and 2 are 97% effective in measles prevention.

Rapidly identify and isolate measles patients (known or suspected)

Establish protocol for triage team to identify signs/symptoms of Measles, and communication strategy for care team (charting).

Provide instructions for patient about arrival at clinic. Post visual alerts at entry points. Patient with known or suspected Measles should not wait in waiting room. Use alternative entrance and/or bypass
common areas; have patient and family wait in vehicle until staff brings them in. The evidence base suggests that facemasks help contain respiratory secretions in patients with respiratory viruses.

Establish lab testing protocol – on-site or with the facility you will refer to. Nasopharyngeal swab for PCR and a blood sample should be obtained for IgM. Testing is extremely important for measles as a case cannot be confirmed based on clinical presentation alone.

**Adhere to Standard and Airborne precautions**

Establish protocol for rooming Measles patients in your clinic. Immediately place patient in AIIR (negative pressure) room if available. If not available, place masked patient in room with door closed and transfer to isolation as soon as possible.

All HCP should use N95 masks if available – regular mask if not.

Protocol remains in place for 4 days after rash onset.

Standard precautions for cleaning – consider leaving door closed 3.5 hours after patient leaves before cleaning. Measles virus remains viable for 2 hours.

**Appropriately manage exposed and ill HCP**

Offer post-exposure prophylaxis to people who cannot readily show that they have evidence of immunity against measles [https://www.cdc.gov/measles/hcp/index.html#prophylaxis](https://www.cdc.gov/measles/hcp/index.html#prophylaxis)

For HCP without evidence of immunity, MMR within 72 hrs or IG within 6 days, and exclude from duty from day 5 after first exposure to day 21 after last exposure regardless of post-exposure vaccine

Do not administer MMR + IG simultaneously; invalidates vaccine

**Report – to all transferring facilities**