APIC Virginia Lunch and Learn: Measles Exposure Response: Lessons from Inova

APIC VA
Association for Professionals in Infection Control and Epidemiology

Meet Your 2026 Education Chair

Rebecca Olejer, MPH, CIC

- **Facility:** I am the Infection Prevention Manager for the Bon Secours Richmond Market
- **About me:** I began my public health career with NYSDOH monitoring returning travelers for Ebola and then Zika surveillance and education. I moved to Richmond, VA in 2016 and began working for VDH as an epidemiologist on the Medical Monitoring Project and in 2017 I became the Senior Epidemiologist for Henrico County Health Department where my love for epidemiology and infection prevention really blossomed. During COVID I led the Henrico and Richmond City Health Districts' Long Term Care, Congregate Care, and Correctional Facilities Teams and assisted many facilities across the County and Richmond City in outbreak responses. I joined Bon Secours Mercy Health Infection Prevention Team in Fall of 2021 and became Manager in early 2023. Outside of work, I have two sons (a two-year-old and a 9-month-old) who have changed my whole world in the best way possible. I enjoy going to wineries and going to the beach with my husband and look forward to future beach trips with my boys.

APIC-VA Educational Feedback Survey

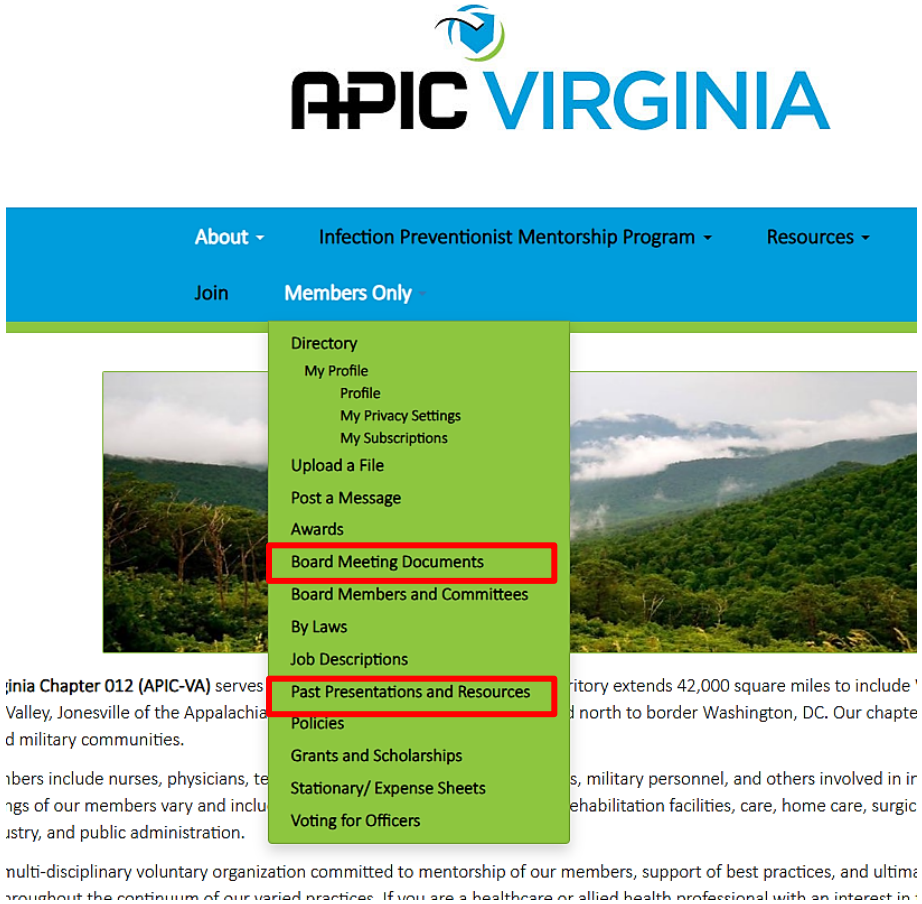
Help shape APIC-VA's lunch and learn and education efforts by taking our **quick survey**:

- 16 questions, approximately 5 minutes
- Confidential responses
- Chance to win one of three $25 gift cards!

Share your feedback by March 27th

Lunch and Learns

- Stay tuned for future lunch and learns
- Until then, check out previous webinars on the APIC Virginia website
  - Located under Member's Only tab (requires APIC login)
    - Past Presentations and Resources - Virginia and
    - Board Meeting Documents (lunch and learns that are part of the open board meeting)



Resources:

- VDH measles webpage - general info and 2026 case counts
- VDH measles information for healthcare providers webpage - laboratory testing, reporting, infection prevention measures, vaccination, and postexposure prophylaxis.
- VDH measles toolkit -print resources to help educate about measles and vaccination.
- CDC website – healthcare measles preparedness and response resources

Education Support Reminders!

The APIC VA education grants--$615 for Virtual registration, or $2000 towards expenses for In-person attendance, deadline 3/23/26 apply here: National APIC Education Support Application 2026 – Fill out form

Other opportunities:

PDI-- $1100 toward expenses , deadline 3/15/26 2026 PDI Education APIC Form | PDI Healthcare

Vitalacy --$1000 toward expenses, deadline 4/3/26 APIC Scholarship - Vitalacy, Inc.

CS Medical—Amount covers airfare, hotel, and registration, deadline 4/10/26 2026 APIC Scholarship Application-CS Medical

Symmetry—One conference registration fee, deadline 4/30/26 Symmetry APIC Scholarship - Symmetry Hand Hygiene

All the links posted on the APIC Virginia member website

March 13, 2026

Measles Exposure Response: Lessons from Our Hospital's Experience

Becky Lapian, MPH, CIC, CLSGB

Inova™

Measles

Background

- Highly contagious; airborne droplets linger up to 2 hours
- Symptoms: fever (up to 105°F), cough, runny nose, pink eye
- Morbilliform rash: starts on forehead → spreads down
- Contagious 4 days before to 4 days after rash onset

When to Suspect Measles

- Unvaccinated, recent international/domestic travel, or known exposure
- Fever and rash AND Cough, runny nose, OR conjunctivitis
- Rash: maculopapular, starts on head → spreads down, including palms/soles

Action: Isolate Immediately

- Place suspected cases on airborne isolation in a negative pressure room
- If no negative pressure room (ambulatory/outpatient): mask patient, escort to private room, keep masked
- Notify Infection Prevention immediately

Next Steps as an IP

- Consult ID and notify the local health department right away
- Coordinate evaluation and testing with ID/IP and the health department
  - Discharge with strict home isolation, or
  - Admit to a negative pressure room if needed
- Measles testing requires health department approval and is decided case-by-case

Patient instructions:

- Give clear instructions for patients awaiting results or confirmed positive
- Call ahead if the patient needs additional care or transfer

Case Presentation

8 Jan.

15-month-old unvaccinated male returns from Pakistan on January 8

10 Jan.

Onset of fever and cough with worsening diarrhea

12 Jan.

Development of conjunctivitis

13 Jan.

PM Pediatrics

Ongoing fever, conjunctivitis, and erythematous papules around mouth; atopic dermatitis noted on trunk and extremities

15 Jan.

Fairfax ED

Persistent high fevers, bilateral conjunctivitis, bilateral otitis media, and gingivostomatitis with discrete oral lesions

16 Jan.

Fairfax ED

Worsening respiratory distress with stridor, right upper lobe pneumonia on chest radiograph; required admission with high-flow nasal cannula oxygen

17 Jan.

Continued stridor, fever, cough; development of periorbital edema with mild erythema

18 Jan.

Worsening rash spreading from face to trunk; transferred to negative pressure isolation; measles testing sent

19 Jan.

Measles confirmed by health department testing

Determining Measles Exposure Window & Location

Establish Source Case Timeline

- Identify rash onset date and prodrome symptoms (fever, cough, coryza, conjunctivitis)
- Contagious 4 days before rash onset through 4 days after rash onset

Define the Exposure Window

- Start: 4 days before rash onset
  - Partner with Infectious Disease
- End: When airborne isolation is initiated, plus 2 hours after the patient leaves the area

Identify Potential Exposure Locations

- Determine where the patient spent time while contagious:
  - Waiting rooms, inpatient units, outpatient clinics, public areas

Consider Airborne Spread

- Account for 2 hours after the patient leaves
- Include shared airspaces, even without direct contact
- Partner with Engineering/ Facilities

Post Exposure Prophylaxis (PEP) Recommendations

- PEP depends on timing, immunity status, and patient risk factors
  - ≤ 72 hours of exposure:
    - Give MMR vaccine to eligible non-immune individuals ≥6 months old
  - > 72 hours to 6 days after exposure:
    - Immunoglobulin (IG) may be given to these groups:
      - Infants <6 months (non-immune)
      - 6-11 months, not severely immunocompromised (non-immune)
      - ≥12 months, not pregnant, not severely immunocompromised (non-immune or unknown)
      - Pregnant individuals without immunity (non-immune or unknown)
      - Severely immunocompromised persons (non-immune or unknown)
- If immune: No PEP needed; monitor for symptoms for 21 days after exposure.

Monitoring & Quarantine

- No Quarantine:
  - If immune: Monitor for symptoms for 21 days after exposure
  - MMR Received: Monitor for symptoms for 21 days after last exposure
- Quarantine:
  - Non-immune, no MMR received or no immunoglobulin (IG) received: Quarantine 21 days after last exposure
  - Immunoglobulin received: Quarantine 28 days after last exposure due to prolonged incubation

Exposure Details, PEP & Quarantine

Exposure Window and Locations

- Inova Children's Emergency Department Waiting Room
  - January 15 7:30 p.m. – 10 p.m.
  - January 16 8:30 p.m. – 11 p.m.
- Inova Fairfax Hospital Women's & Children's Building, Floors 2-10
  - January 17 2:30 a.m. – January 18 5 p.m.

PEP Deadline

- MMR: Within 72 hours (3 days) of exposure
  - January 20 2:30 a.m.
- Immunoglobulin: Within 6 days of exposure
  - January 23 2:30 a.m.

Quarantine Starts & Ends

- 21 days: Day 5 after first exposure through Day 21 after last exposure
  - January 22 2:30 a.m. – February 8 5 p.m.
- 28 days: Extend monitoring/exclusion through Day 28 after last exposure
  - January 22 2:30 a.m. – February 15 5 p.m.

Make your Electronic Health Record (EHR) work for you!

Implement ED Communicable Disease Screening to flag fever + rash + recent international/domestic travel for measles risk

Use census snapshot reports to identify exposure by shared air-handler zones, not just room proximity

Pre-pull all needed data once- avoid rework (contact info, address, discharge date, PCP, etc.) and store in a central, accessible location

Use EHR mass-flagging to quickly identify exposed patients needing monitoring or quarantine

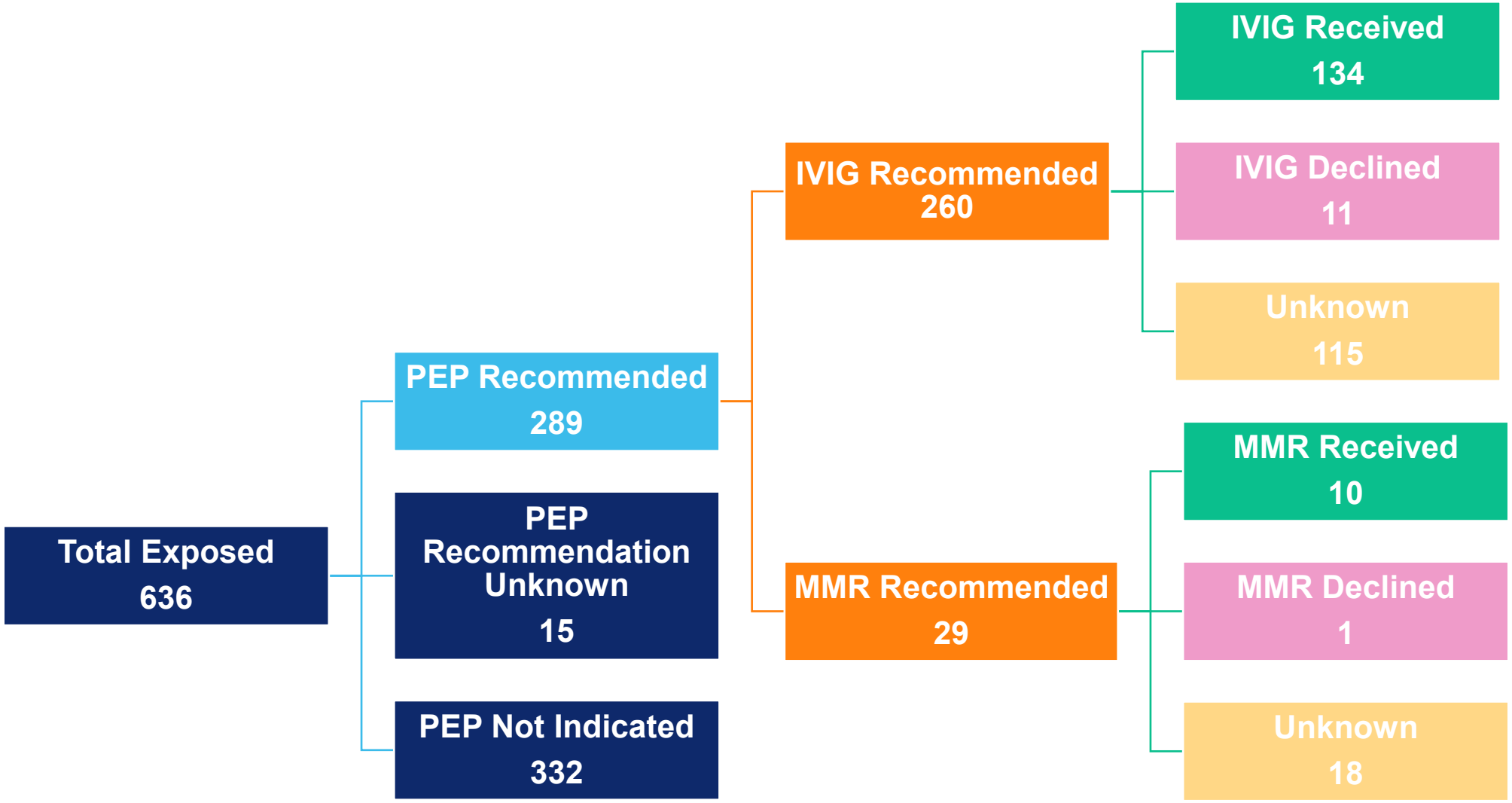
Activate a measles PEP order panel to standardize and streamline MMR/IG decision-making

Run upcoming-appointment reports to identify exposed patients who need rescheduling, isolation routing, or pre-arrival symptom screening

Use standardized SmartPhrases in AVS to give exposed patients clear instructions on monitoring, quarantine, and when to seek care

Use MyChart/ patient portal messaging to notify exposed patients about risk, monitoring steps, immunity guidance, quarantine, and when to seek care

Summary of Potentially Exposed



Healthcare Worker Management

- Leverage existing immunization policy, if applicable:
  - If MMR or Rubeola titers are required, identify non-immune workers and check whether they were in the exposure area during the exposure window
- Define which healthcare workers fall under Employee Health vs. which groups do not (e.g., contractors, vendors, agency staff)
- Establish documentation (proof of immunity) routes:
  - Employee Health provides immunity records for employed staff
  - Contractor liaison/vendor manager provides records for non-employees
- Provide PEP as indicated based on immunity status and exposure timing

Anticipating Operational Impact

Laboratory

Issue: Need reliable specimen collection, courier coordination, and chain-of-custody accuracy

Response: Standardize workflows for collection, pick-up, and documentation to prevent delays or errors

IP Mental Preparedness

Issue: Surge in inquiries overwhelmed IP capacity and required rapid, consistent guidance

Response: Implement structured triage, rapid documentation, and extended IP coverage to support real-time decision-making

Billing

Issue: Billing exposed patients for prophylaxis or for care that shifted from outpatient to inpatient due to exposure-related precautions

Response: Flag exposed patients in the system and ensure accurate billing and appropriate room-charge documentation

Clinical Operations (ED & Inpatient)

Issue: High numbers of exposed patients re-presenting before immunity was verified; limited airborne isolation rooms

Response: Develop a plan with the ED and inpatient teams to prioritize and plan for when negative-pressure rooms unavailable

Capacity, Isolation & Room Holds

Issue: System-wide strain managing negative-pressure rooms during concurrent respiratory-season demands.

Response: Prioritize airborne isolation for measles, other airborne illnesses, IG recipients, and immunocompromised patients. Use EMR reminders for room holds

Anticipating Operational Impact

Pharmacy

Issue: Need for immunoglobulin, dispensing, documentation

Response: Verify IG inventory at various sites, workflows, and documentation to ensure the right patient receives the right product within the required exposure window (order panel)

Supply Chain

Issue: High demand for N95s and respiratory fit testing during airborne-precaution surges.

Response: Allocate N95s and PAPRs strategically and expand fit-testing capacity, including contingency planning for large volumes of patients needing airborne precautions

Outpatient Sites

Issue: Unclear guidance on whether exposed patients should be seen, rescheduled, routed to telehealth, or directed to an airborne-capable site.

Response: Implement standardized workflows guiding rescheduling, telehealth conversion, or routing based on exposure timing, immunity status, and PEP received

Community Providers

Issue: Variable awareness among community clinicians leading to unnecessary ED visits and inconsistent evaluation pathways.

Response: Align with pediatricians and community providers to enable consistent messaging, safe evaluation pathways, and appropriate routing of symptomatic or exposed patients

Key Takeaways

- **ED vigilance:** know what to look out for, what to ask, establish processes to act quickly
- **All-hands-on-deck approach:** quickly convene key stakeholders to align on roles, workflow, and next steps before beginning response activities. Use collaboration tools to share resources.
- **Communication with key stakeholders:** regularly provide updates, share new information, and ensure alignment as the situation evolves
- **Anticipate re-presentation of exposed patients** (inpatient or outpatient): prepare clinical teams and identify appropriate locations and isolation processes in advance
- **Strong partnership with the local health department:** critical for timely guidance, contact tracing, and coordinated response

FAIRFAX COUNTY HEALTH DEPARTMENT

Measles Response: Lessons from Local Health Department

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Fairfax County Health Department
March 13, 2026
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Measles Response: Public Health Case and Contact Investigation

- Goals and Priorities:
  - Ensure rapid case identification, smooth specimen collection and testing process, proper precautions in-place, and early/often/effective communication.
  - Interview case and gather information on close contacts and exposure history.
  - Identify contacts & assess immunity.
  - Coordinate and deliver post-exposure prophylaxis during specified time windows.
  - Quarantine and monitor susceptible individuals.
  - Provide public information and alerts to healthcare providers and the general public.

Measles Investigations in Northern Virginia, January – March 12, 2026

- **Northern VA**: 9 cases; with 2 out-of-state cases (FL) with significant exposures in the region
- 1,007+ contacts assessed *(does not include occupational exposures/assessments conducted by Occ Health/Employee Health and contacts transferred to their home jurisdiction for follow-up)*
- 2026 year-to-date Fairfax County Health Department (FCHD) has provided:
  - 30 contacts received IMIG
  - 2 contacts received MMR vaccines
  - 5 titers drawn (HCP with non-occupational exposures and no documentation of immunity).
- No sustained community transmission or local outbreaks identified at this time
- Over 20 exposure locations year-to-date
  - Exposure settings: healthcare (urgent care, ED, hospital), travel related (airports, train) and community exposures (church, school, apartment building, businesses)

Public Health Contact Investigation Strategies

Strategy 1: Active Contact Tracing

- Request contact lists from facilities.
- Contact individuals, assess immunity, provide prophylaxis/ public health guidance.
- Commonly used in healthcare exposures.
- Resource intensive- high response rate.
  - 88% Contact success rate for Fairfax contacts after receiving list (887/1007)

Strategy #2- Passive Contact Tracing

- Press release and/or notification through exposure location (sign posted; letter provided for distribution).
- Instructs contacts to call HCP or LHD.
- Commonly used in public location exposures.
- Resource light-low(er) response rate.

Determining the exposure timeframe

- Persons present in the same airspace **from the time the infectious patient entered the area until 2 hours after they left the space or were placed in an AIIR** are considered exposed.
- <u>Items to consider:</u>

Facility airflow	Patient volume	Movement through shares spaces	Non-patient contacts
• Do multiple units share the same air-handling system? • Are areas such as the ED waiting room and patient rooms connected?	• How busy was the waiting room or ED during the exposure time?	• Include patients who **entered and left** the airspace during the window. • Do not limit review to patients who checked in at the same time.	•Contractors •Visitors •Staff •Other guests in the area

Public health communications

- VDH press release reporting exposure locations and times
- FCHD website
  - Key information from the VDH press release
  - What to do if you have been exposed
  - General measles information
- Social media
  - 1/11/26 Facebook post viewed by 274,100
  - Comments and questions used to develop Q & As posted on the website

Active Exposure Sites:

Location	Date and Time	Last Day of Symptom Watch
Inova-GoHealth Urgent Care – Lorton Marketplace 9427 Lorton Market St. Lorton, VA	Friday, Feb. 13 9:30 a.m. - 1:30 p.m.	March 6, 2026
Harris Teeter 10060 Market Circle Manassas, VA	Friday, Feb. 13 5 p.m. - 7:30 p.m.	March 6, 2026
Walmart 9401 Liberia Avenue Manassas, VA	Friday, Feb. 13 5:30 p.m. - 8:00 p.m.	March 6, 2026
Marco's Pizza 9223 Sudley Road Manassas, VA	Friday, Feb. 13 6 p.m. - 8:30 p.m.	March 6, 2026
Inova HealthPlex Lorton Emergency Room 9321 Sanger St. Lorton, VA	Saturday, Feb. 14 10 a.m. - 12:30 p.m.	March 7, 2026
Bull Run Unitarian Universalists 9350 Main Street Manassas, VA	Saturday, Feb. 14 7:30 a.m. - 11:30 a.m.	March 7, 2026

RECENTLY ASKED QUESTIONS TO OUR SOCIAL MEDIA

- I got my measles vaccine as a child. I'm in my 50s now. Am I still protected? +
- What is a titer? +
- Follow up question: Who needs a titer drawn? +
- I'm worried I may not be protected against measles. How do I get my titers checked? +
- Should everyone traveling internationally get a measles vaccine now? +
- Should everyone with young children under age 4 get their children immunized against measles? +
- Do doctors treat measles with Vitamin A? +

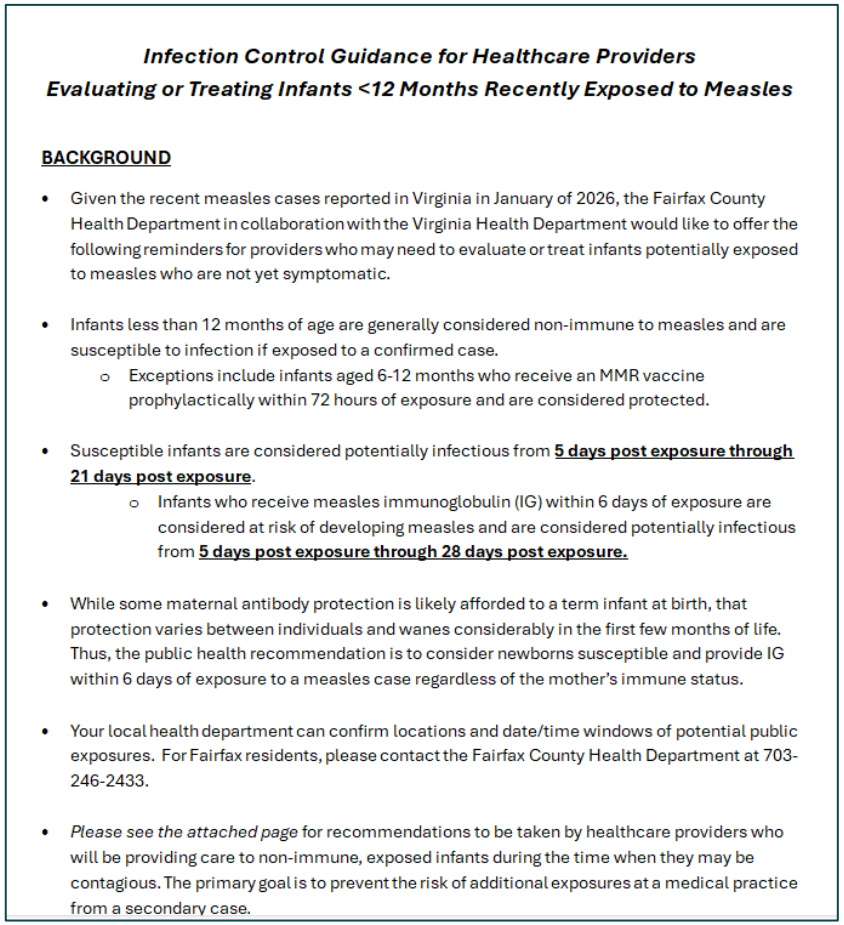
Amplifying the message

During the response

- FCHD issued Health Advisories to notify healthcare partners of the case and exposure locations.
- Hospital partners shared messaging with their network providers.
- Providers contacted the health department, which led to development of materials.

Prevention messaging

- Spring break travel messaging distributed by FCHD to schools (public, private, and childcare centers).



Infection Control Guidance for Healthcare Providers
Evaluating or Treating Infants <12 Months Recently Exposed to Measles

BACKGROUND

- Given the recent measles cases reported in Virginia in January of 2026, the Fairfax County Health Department in collaboration with the Virginia Health Department would like to offer the following reminders for providers who may need to evaluate or treat infants potentially exposed to measles who are not yet symptomatic.
- Infants less than 12 months of age are generally considered non-immune to measles and are susceptible to infection if exposed to a confirmed case.
  - Exceptions include infants aged 6-12 months who receive an MMR vaccine prophylactically within 72 hours of exposure and are considered protected.
- Susceptible infants are considered potentially infectious from **5 days post exposure through 21 days post exposure**.
  - Infants who receive measles immunoglobulin (IG) within 6 days of exposure are considered at risk of developing measles and are considered potentially infectious from **5 days post exposure through 28 days post exposure.**
- While some maternal antibody protection is likely afforded to a term infant at birth, that protection varies between individuals and wanes considerably in the first few months of life. Thus, the public health recommendation is to consider newborns susceptible and provide IG within 6 days of exposure to a measles case regardless of the mother's immune status.
- Your local health department can confirm locations and date/time windows of potential public exposures. For Fairfax residents, please contact the Fairfax County Health Department at 703-246-2433.
- *Please see the attached page* for recommendations to be taken by healthcare providers who will be providing care to non-immune, exposed infants during the time when they may be contagious. The primary goal is to prevent the risk of additional exposures at a medical practice from a secondary case.

Incident Command Structure (ICS) Considerations

- Measles investigations require extensive workforce.
  - 2026: Case investigation #1 (200+ contacts in an ED), FCHD estimates for time spent was equal to a total of 410 staff hours.

HD Program Area	Estimated hours spent on response
Epidemiology/Communicable Disease	300
Emergency Preparedness and Response (ICS support)	40
IT	35
Pharmacy/Health Services (IMIG/MMR administration: 3 families seen)	20
Communications	15

- Atypical ICS response- needs are more geared towards trained CD staff (call center), data systems, and template letters/notifications (rather than majority medical supplies)

What this response reinforced

- Hold regular coordination calls during the initial response phase
- Establish clear points of contact and after-hours response plans
- Develop processes to minimize additional exposures within healthcare settings
- Partner with healthcare systems on post-exposure prophylaxis (PEP) workflows
- Coordinate information sharing and outcome reporting (immunity assessments)

Preparedness recommendations

- **Get to know your local health department point of contact**
  - How do you contact your local health district afterhours/weekend/holidays?
- **Specimen collection and transport**
  - Confirm you have what needs to be collected and appropriate shipping container.
- **Loop in facilities/engineering**: Air flow: are multiple units on the same air handling system?
- **Know your immunizations and have your record**

Remember you are not alone!

Public health is here to support you and provide guidance.

Resources

- Virginia Department of Health (VDH): https://www.vdh.virginia.gov/measles/
- VDH Measles Information for Healthcare Providers: https://www.vdh.virginia.gov/measles/hcp/
- Fairfax County Health Department Measles: https://www.fairfaxcounty.gov/health/measles
- Request Immunization Record: https://www.vdh.virginia.gov/immunization/request-immunization-record/
- HCP instructions for measles specimen collection: https://www.vdh.virginia.gov/content/uploads/sites/207/2021/09/HCP-Instructions-for-Measles-Specimen-Collection.pdf

Questions?