

# Pediatric Readiness Program Education Session



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# **Measles, Chickenpox, Pertussis! Oh My!**

## **Quickly Identifying Contagious Patients and Minimizing Exposures**

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# CME Disclosure Statement

None of the planners and faculty for this educational activity have relevant financial relationship(s) to disclose with ineligible companies whose primary business is producing, marketing, selling, reselling, or distributing healthcare products used by or on patients.

# Learning Objectives

- Summarize the concept of syndromic surveillance
- Demonstrate a general knowledge of transmission-based precautions to prevent the spread of infectious diseases
- Recognize the key signs and symptoms to identify patients with measles, chickenpox, and pertussis

“Why is early  
identification  
and isolation  
so important?”

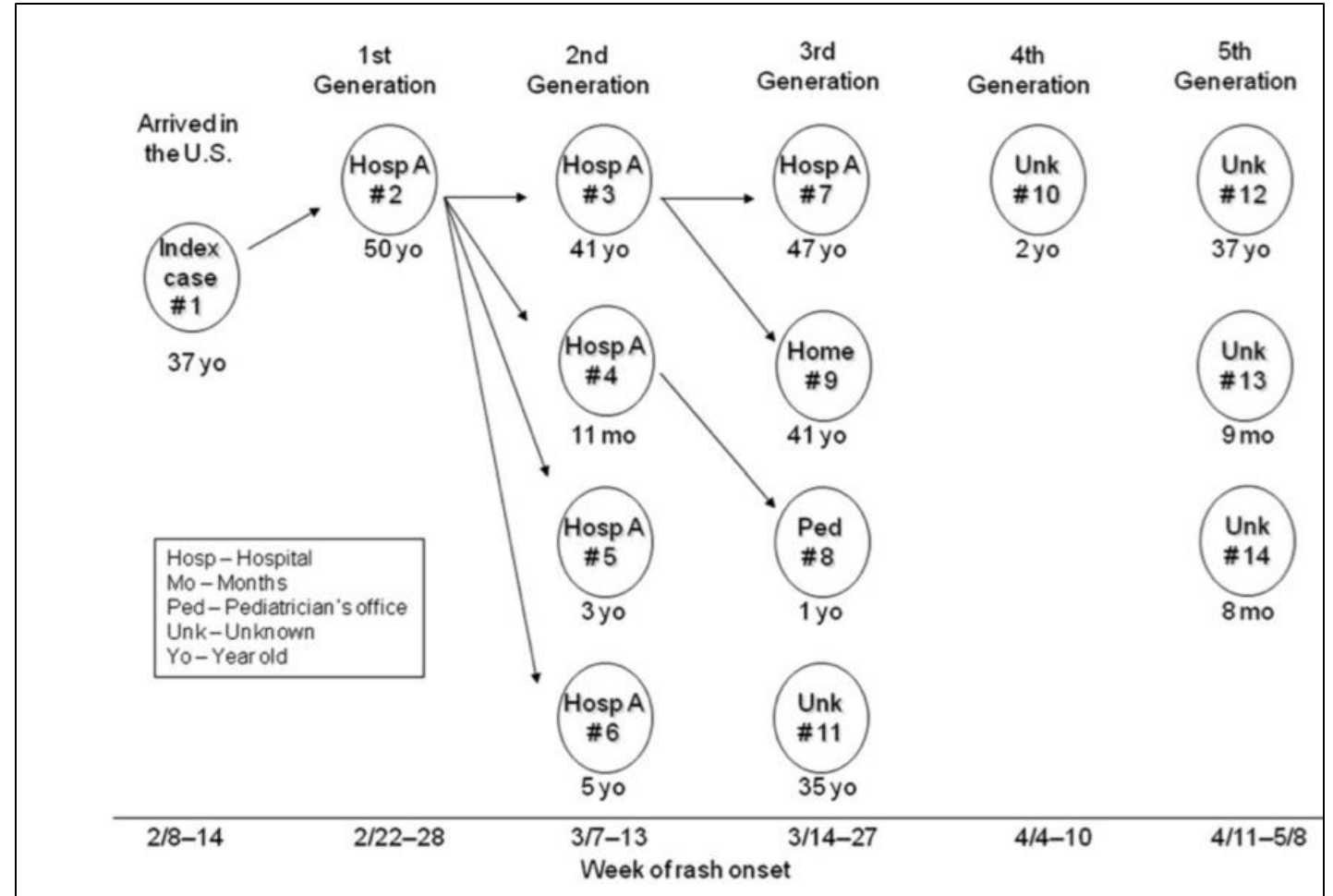
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# Measles outbreak starting in an Arizona ED (2008)

- One unvaccinated Swiss traveler with classic measles visited Emergency Dept in Arizona
  - Two ED visits: She was not isolated either time
- This led to 14 cases of measles... over a 3 month-long outbreak!



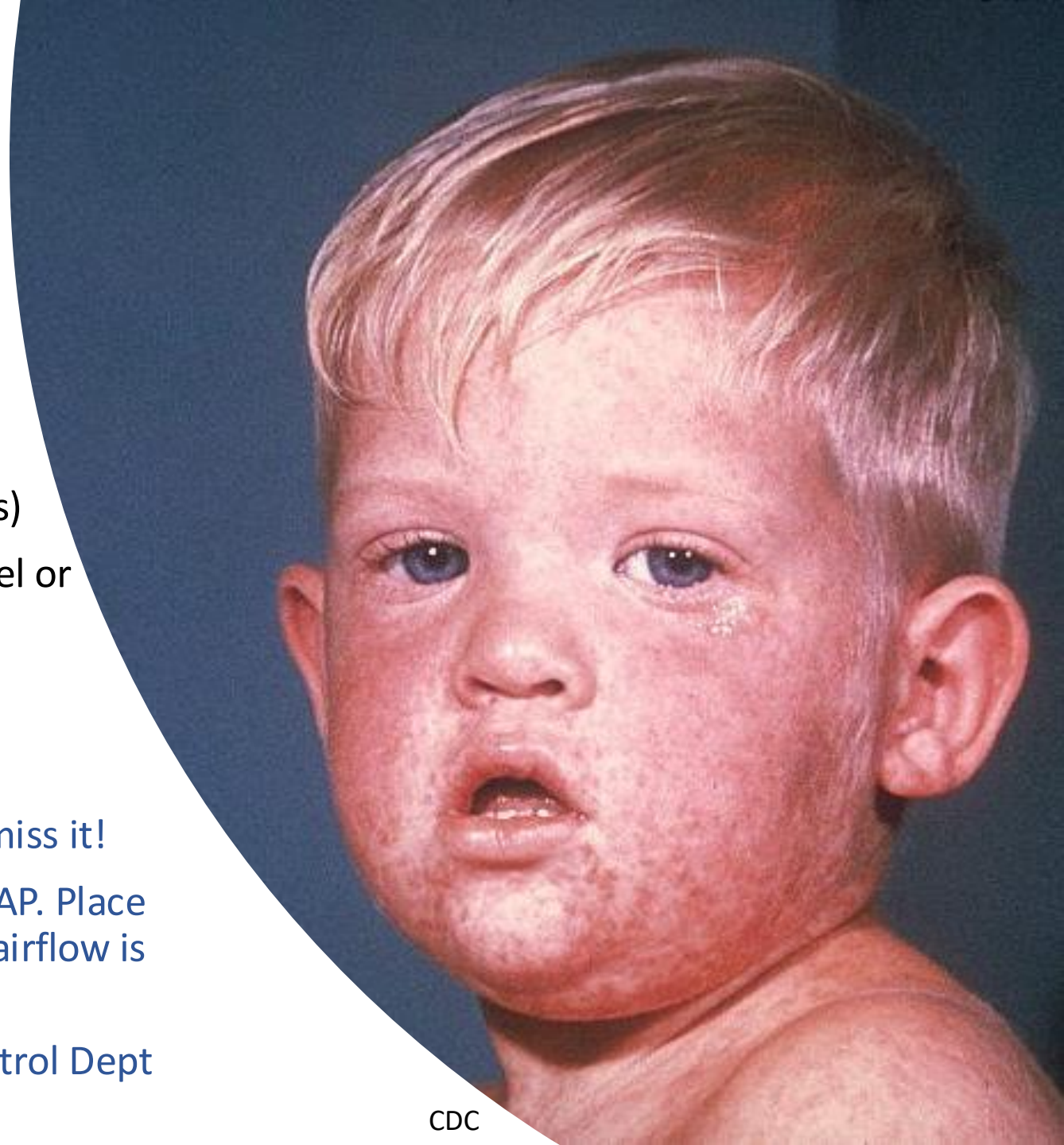
# Measles

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- Highly contagious viral infection
- Cough, coryza (runny nose), conjunctivitis (red eyes)
- Most cases are unvaccinated (MMR) and have travel or known exposure history

## INFECTION CONTROL

- **IDENTIFY:** Be aware of these symptoms, or you'll miss it!
- **ISOLATE:** Put on a mask. Place mask on patient ASAP. Place in AIRBORNE ISOLATION...and confirm the room's airflow is negative pressure
- **INFORM:** Clinic manager, charge RN, Infection Control Dept



Several patients  
were seen in ED  
and were not  
isolated!



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	Age	Vaccination status	Measles exposure	Past medical history	Symptoms	Medical care (date)	Clinical diagnosis/laboratory testing <sup>a</sup>	Isolated (date)
1	37 years	Unvaccinated	Imported	Thalassemia	Fever, cough, coryza, sore throat, myalgia	ED (12 February)	Acute bronchitis	No
					Fever, cough, coryza, sore throat, rash, dehydration	ED (13 February), admitted (13–18 February)	Acute viral illness, measles; positive IgM and PCR results; D5 genotype	Yes (15 February)
2	50 years	Unknown	ED	Chronic obstructive pulmonary disease	Fever, shortness of breath, difficulty breathing	ED (24 February), admitted (24–26 February)	Asthma exacerbation	No
					Rash, conjunctivitis, cough, pneumonia	ED (28 February), admitted (28 February–3 March)	Allergic drug reaction, pneumonia, measles; positive IgM and PCR results, D5 genotype	Yes (28 February)
3	41 years <sup>b</sup>	Unknown	Hospital	Asthma	Fever, cough, coryza, conjunctivitis, shortness of breath	ED (7 March)	Upper respiratory infection	No
					Rash, fever, cough, coryza, koplik spots, conjunctivitis	ED (9 March)	Measles; positive IgM and PCR results, D5 genotype	Yes (9 March)
4	11 months	Unvaccinated	ED	None	Fever, cough, coryza, diarrhea	Pediatrician (7 March)	Otitis media	No
					Fever, cough, coryza, diarrhea	Pediatrician (10 March)	Upper respiratory infection	No
6	5 years <sup>c</sup>	Unvaccinated (PBE)	Hospital	None	Fever, cough, coryza, rash, koplik spots	Pediatrician (10 March)	Measles; positive IgM result, PCR not performed	No
7	47 years	Unknown	ED	Hypertension, pyelonephritis, cholecystitis	Fever, cough, coryza, conjunctivitis, dehydration	ED (19 March)	Urinary tract infection	No
					Rash, diarrhea, cough, pneumonia, thrush, conjunctivitis	ED (22 March), ICU (22–25 March)	Pneumonia, measles; positive IgM and PCR results, D5 genotype	Yes (24 March)
8	1 year <sup>d</sup>	Unvaccinated	Pediatrician	None	Fever, coryza, rash, earache, diarrhea	No	Measles IgM testing not performed, negative PCR results	-
9	41 years <sup>d</sup>	Unknown	Home	Brain cancer	Rash, fever, cough, coryza, conjunctivitis	No	Positive measles IgM result, PCR not performed	-
10	2 years	Unvaccinated	Unknown	Unknown	Fever, seizures, rash	ED (3 April), ICU (3–8 April)	Generalized complex seizures, measles; positive IgM and PCR results	No
11	35 years	Unknown (SR)	Unknown	Unknown	Fever, diarrhea, rash, cough, conjunctivitis	No	Positive measles IgM results, PCR not performed	...
12	37 years	Unknown (SR)	Unknown	MDS, Down syndrome	Rash, fever, cough, coryza, dehydration, conjunctivitis, photophobia, diarrhea, sore throat	Oncology (7, 11, and 15 April)	Measles; negative measles IgM and positive PCR results	...
13	9 months	Unvaccinated	Unknown	None	Fever, coryza, rash, earache	ED (3 May)	Otitis media, measles; positive IgM results, PCR not performed	No



# Measles



## Measles (Rubeola)

EXPLORE TOPICS ▾

SEARCH

APRIL 18, 2025 [ESPAÑOL](#)

## Measles Cases and Outbreaks

### WHAT TO KNOW

- Updated on April 18, 2025. The data on this page reflects confirmed measles cases reported to CDC as of noon on Thursdays.
- Starting 2/21/25, CDC will update this page every Friday.



## Measles cases in 2025

### For Healthcare Providers

Learn what to do if you suspect your patient has measles or was exposed to measles.

[Healthcare Providers: Stay Alert for Measles Cases](#)

As of April 17, 2025, a total of 800 confirmed\* measles cases were reported by 25 jurisdictions: Alaska, Arkansas, California, Colorado, Florida, Georgia, Hawaii, Indiana, Kansas, Kentucky, Maryland, Michigan, Minnesota, New Jersey, New Mexico, New York City, New York State, Ohio, Oklahoma, Pennsylvania, Rhode Island, Tennessee, Texas, Vermont, and Washington.

### ON THIS PAGE

[Measles cases in 2025](#)

[Measles cases in 2024](#)

[What to know about measles](#)

[Weekly measles cases by rash onset date](#)

[Map of measles cases in 2024 & 2025](#)

[Yearly measles cases](#)

[History of measles cases](#)

[MMR vaccine coverage for kindergarteners ...](#)

Adobe Acrobat

# Pertussis



## Two as ca

By Neha Mukhe  
5 minute read



Oregon Health Authority  
Public Health Division  
Center for Public Health Practice

### MEMENTO MORBI A Monthly Communicable Disease Surveillance Report

Data are updated through March 2025

Data are current as of April 8, 2025.  
This report contains several dashboards that allow you to explore monthly trends in communicable disease in Oregon over the past 10 years. Click on the different icons below to view data tables and charts by demographic group or county.

This report is an early source of infectious disease surveillance data for Oregon. These data are important for monitoring early trends of infectious diseases and for targeting prevention and control efforts. Data are provisional and subject to change upon the completion of ongoing disease investigations.



Submit feedback.



Data by demographic group



Data charts



Data tables



Data by County



Data charts

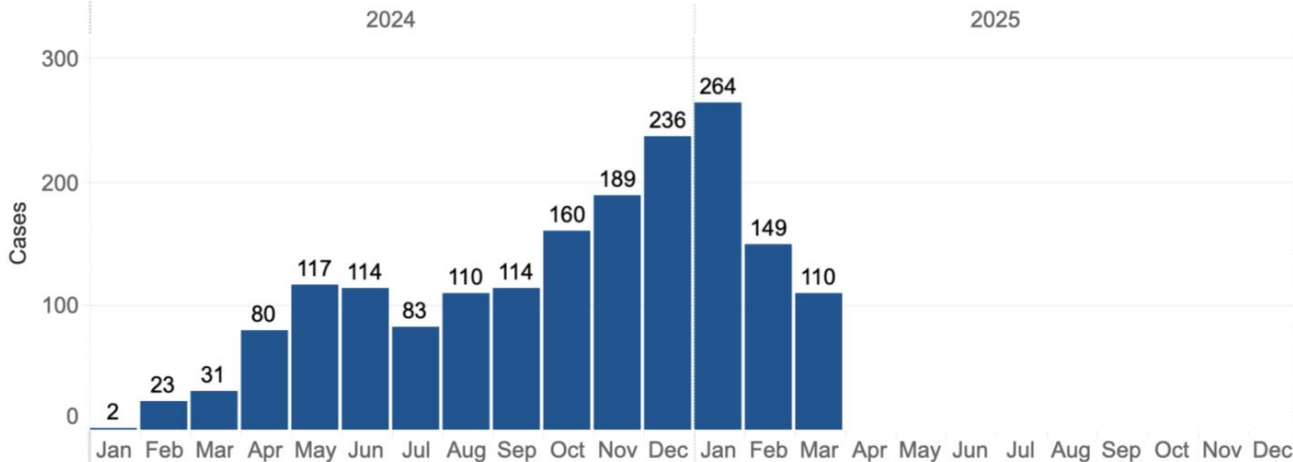


Data tables

Case counts of Pertussis  
by Month: Oregon, 2024 & 2025

Select a disease to view

Pertussis



Additional tables:

Ten years of communicable disease data presented by month, county of residence and year.



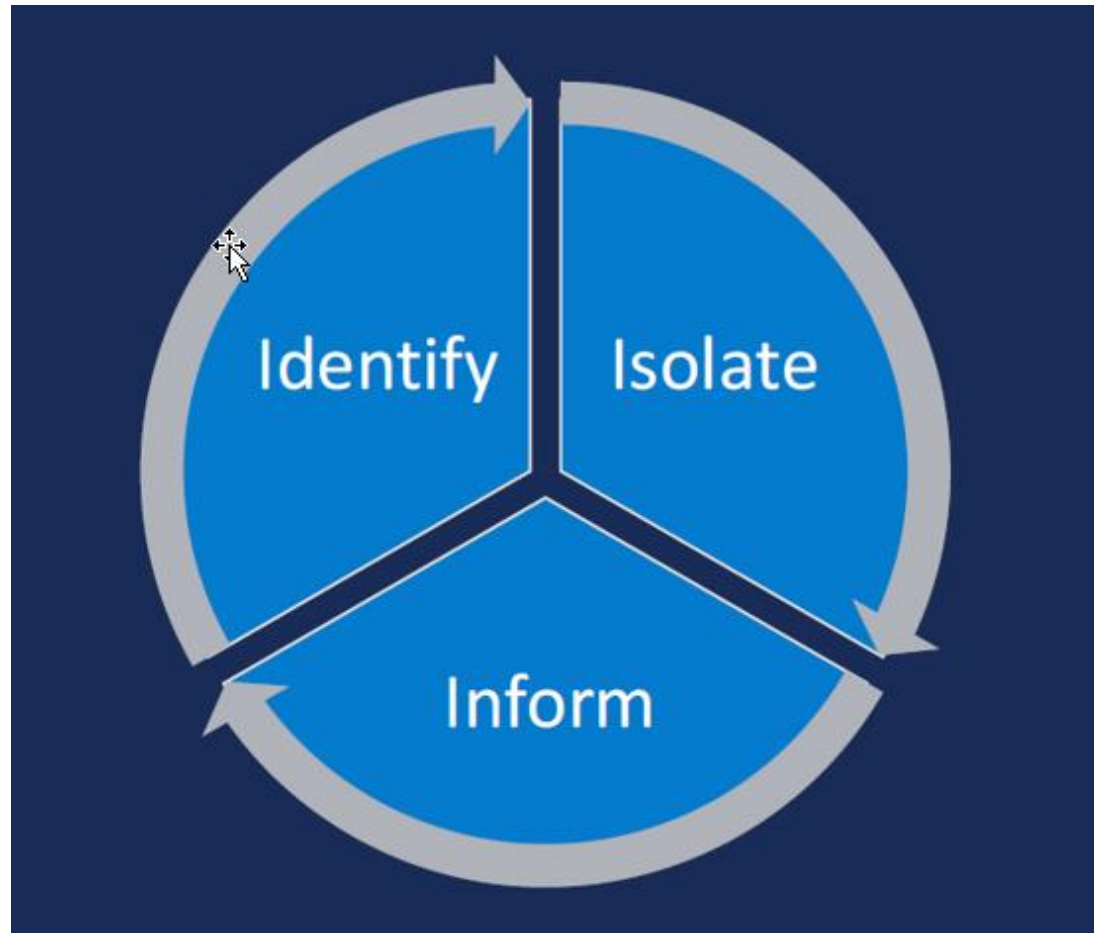
# Identify, Isolate and Inform:

## Applies to “An All-Hazards” Approach

**1. IDENTIFY**  
the contagious  
patient *as quickly  
as possible!*



Getty Images/iStockphoto



**2. ISOLATE** the patient, to  
minimize spread to other  
people

**3. INFORM** the appropriate  
team members, so that the  
patient receives the best  
care, and the patient is  
isolated appropriately!

# #1 IDENTIFY....how?

- **Evaluate each patient for signs and symptoms** of contagious diseases....for example, if pt has respiratory illness, give patient a mask! And put on a mask!
  - > **If YES: Ask if patient has been exposed** to anyone who has a known contagious disease. This can give you clues about additional isolation needs
- **Ask for travel history** to geographic areas where contagious diseases are common, or where an outbreak is occurring. This helps to identify **high-risk** diseases (TB, measles, chickenpox)!



**Patient Arrives at  
Check-In Desk or  
Triage.**

**1. Ask about Symptoms:** Have you had a fever? Have you had respiratory illness, severe headache, rash, vomiting, or diarrhea?

***If yes, ask:***

- Have you been in close contact with someone who recently traveled outside the US or Oregon and became sick, or has a contagious disease?

**2. Ask About Travel:**

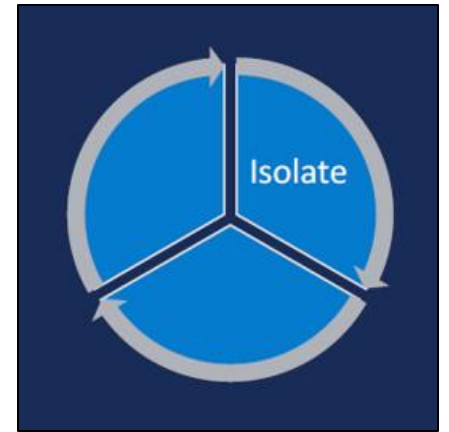
- Have you traveled outside of the United States or Oregon in the last 30 days?
- Have you been in close contact with someone who became sick after travel outside the US or Oregon?



# #2 ISOLATE....how?



- **Administrative Controls:**
  - > Isolation precautions signs
  - > Know your facility's infection control policies!
- **Environmental Controls:**
  - > Airborne isolation (negative pressure) rooms
  - > Make sure the airflow is truly negative pressure!
- **Physical Controls (Standard Precautions):**
  - > Hand hygiene
  - > Cleaning and disinfection of environment and equipment
  - > Personal protective equipment (PPE)



CDC/ Kimberly Smith, Christine Ford



# Personal Protective Equipment (PPE)

## PPE Goals:

1. Protect healthcare personnel from exposure
2. Limit spread of contamination

## How it Works:

1. Think about the exposure risks before you start a task
2. Choose and put on your PPE components
3. Do your task...you are protected from exposure!
4. Remove PPE without contaminating yourself
5. Clean your hands

## HOW TO SAFELY REMOVE PERSONAL PROTECTIVE EQUIPMENT (PPE) EXAMPLE 1

There are a variety of ways to safely remove PPE without contaminating your clothing, skin, or mucous membranes with potentially infectious materials. Here is one example. **Remove all PPE before exiting the patient room** except a respirator, if worn. Remove the respirator **after** leaving the patient room and closing the door. Remove PPE in the following sequence:

### 1. GLOVES

- Outside of gloves are contaminated!
- If your hands get contaminated during glove removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Using a gloved hand, grasp the palm area of the other gloved hand and peel off first glove
- Hold removed glove in gloved hand
- Slide fingers of ungloved hand under remaining glove at wrist and peel off second glove over first glove
- Discard gloves in a waste container



### 2. GOGGLES OR FACE SHIELD

- Outside of goggles or face shield are contaminated!
- If your hands get contaminated during goggle or face shield removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Remove goggles or face shield from the back by lifting head band or ear pieces
- If the item is reusable, place in designated receptacle for reprocessing. Otherwise, discard in a waste container



### 3. GOWN

- Gown front and sleeves are contaminated!
- If your hands get contaminated during gown removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Unfasten gown ties, taking care that sleeves don't contact your body when reaching for ties
- Pull gown away from neck and shoulders, touching inside of gown only
- Turn gown inside out
- Fold or roll into a bundle and discard in a waste container

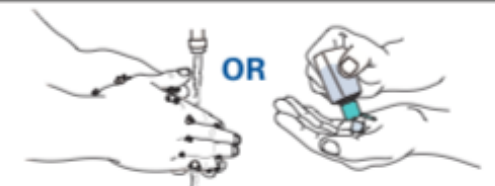


### 4. MASK OR RESPIRATOR

- Front of mask/respirator is contaminated — **DO NOT TOUCH!**
- If your hands get contaminated during mask/respirator removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Grasp bottom ties or elastics of the mask/respirator, then the ones at the top, and remove without touching the front
- Discard in a waste container



### 5. WASH HANDS OR USE AN ALCOHOL-BASED HAND SANITIZER IMMEDIATELY AFTER REMOVING ALL PPE



# Specific Isolation Precaution Categories



Category	PPE Components	Examples
CONTACT precautions	Disposable gloves and gown	C difficile diarrhea

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DROPLET precautions	Disposable procedure or surgical mask	Pertussis (Whooping Cough)



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DROPLET precautions	Disposable procedure or surgical mask	Pertussis (Whooping Cough)
AIRBORNE precautions	N-95 or powered air-purifying respirator (PAPR)	Pulmonary tuberculosis, measles
COMBO (e.g. Contact + Droplet)	Disposable gloves + gown + mask	Infant bronchiolitis

# “Standard Precautions”

## A 3 Step Decision-Making Process

**#1 What does the patient have, and  
What is my exposure risk?**

**#2 What is your planned task?**

**#3 How do you protect yourself?**

# “Standard Precautions”

## A 3 Step Decision-Making Process

### #1: What does the patient have, and What is my exposure risk?

**Patient:** A large, open, infected wound with purulent drainage

**Risk:** The drainage could be loaded with bacteria (e.g., Staph aureus)

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<p><b>Patient:</b> Cough, sneezing, fever</p> <p><b>Risk:</b> I could get coughed on. This could be influenza or another respiratory virus!</p>	Check the patients blood pressure	<ul style="list-style-type: none"> <li>• Disposable facemask</li> <li>• Clean your hands before and after patient contact</li> <li>• Wipe down the cuff, if re-usable</li> <li>• Follow <b>Droplet Precautions</b></li> </ul>

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<p><b>Patient:</b> Cough with any of the following: hemoptysis, weight loss, night sweats, and born/traveled to TB-endemic areas</p> <p><b>Risk:</b> This could be TB. The cough makes it highly contagious</p>	Perform an initial triage evaluation	<ul style="list-style-type: none"> <li>• Patient: facemask ASAP</li> <li>• You: N-95 respirator or PAPR (regular facemask is better than none)</li> <li>• Place patient in private room, move to Airborne Isolation room ASAP</li> <li>• <b>Follow Airborne Precautions</b></li> </ul>

## #2 ISOLATE...which isolation category?




### **More Patient Examples**

- If a patient with a left-sided rash has vesicles that are blisters or draining and/or a rash involving one dermatome on his body or face:
  - > Contact Precautions
- If an unvaccinated child with a rash has fluid-filled vesicles and her school is in midst of a chickenpox outbreak:
  - > Contact + Airborne Precautions
- If a patient has had three or more watery stools in the last 24 hours, or acute onset of vomiting and/or diarrhea:
  - > Contact Precautions

## #3 INFORM....who?



- **Who should be informed of suspected/confirmed infection?**
  - **Inpatient:** Any units receiving the patient from the ED (e.g., radiology, inpt unit)
  - **Outpatient:** Clinic managers for high-risk infections (e.g., poss measles)
  - **If you are transferring pt to another facility:** Inform them of infection, even if not yet confirmed!
  - **ED:** Charge Nurse for high-risk infections (e.g., possible measles, Ebola, TB)
- **Who is responsible for informing these individuals?**
  - Be sure you know the Chain of Command for relaying information.
  - Keep your hospital colleagues, visitors, patients, and other facilities safe. They cannot isolate the patient if they don't know the risk.
- **Who else must be informed?**
  - **Infection Prevention & Control** will help to ensure correct isolation and decrease transmission risks
  - **Infectious Diseases** is the clinical team to ensure the patient receives the correct infection treatment
  - **Local Public Health Department** if a reportable disease or concern for outbreak

**Local health department information**  
 For a list of local health department phone numbers  
 go to [www.health Oregon.org/publicinfo](http://www.health Oregon.org/publicinfo)

# OREGON PUBLIC HEALTH DIVISION REPORTING FOR CLINICIANS

**B**y law, Oregon clinicians must report diagnosis of the specified infectious, diseases and conditions listed on this poster. Both lab-confirmed and clinically suspected cases are reportable. The parallel system of lab reporting does not override the clinician's obligation to report. Some conditions (e.g., unknown illness of public health significance, aneurysm, hemolytic uremic syndrome (HUS), petechiae/purpura disease outbreaks) are rarely, if ever, identified by labs. We depend on clinicians to report.

Reports to the division are made to the patient's local health department of residence and include at least the patient's name, home address, phone number, date of birth, sex, diagnosis and date of specimen receipt. Most reports should be made within one working day of the diagnosis, but there are several important exceptions — please refer to the list on this poster.

Disease reporting enables appropriate public health follow-up for your patients, helps identify outbreaks, provides a better understanding of morbidity patterns, and may even save lives. Remember that HIPAA does not prohibit you from reporting protected health information to public health authorities for the purpose of preventing or controlling diseases, including public health surveillance and investigations.\*

**CIVIL PENALTIES FOR VIOLATIONS OF OREGON REPORTING LAW**

A civil penalty may be imposed against a person or entity for a violation of any provision in ORS Chapter 233, Division 18 or 19. These regulations include the requirement to report the diseases listed on this poster, along with related duties, and to cooperate with local and state public health authorities in their investigation and control of reportable diseases. Civil penalties shall be imposed as follows:

- First violation \$500, second violation \$200, third or subsequent violation \$500;
- Each day of non-compliance will be considered a new violation.

**Safe Injection Practices\***

Outbreaks and unknown illnesses (any known or suspected common-source outbreak, any uncommon illness of potential public health significance)

**Public Health Division**  
 Oregon Health Division  
 Oregon Department of Health  
 815 NE Oregon Street  
 Portland, Oregon 97232-3100  
 503-946-1500 (toll free)  
 503-946-1501 (fax)  
[www.health Oregon.org](http://www.health Oregon.org)

**New reportables are highlighted.**

**IMMEDIATELY**

**Anthrax** (*Bacillus anthracis*)

**Botulism** (*Clostridium botulinum*)

**Brucellosis** (*Brucella abortus*)

**Cholera** (*Vibrio cholerae*)

**Or, ORS, or foreign**

**Diphtheria** (*Corynebacterium diphtheriae*)

**Exanthem** (any exanthematous disease)

**Haemolytic uremic syndrome** (HUS)

**Hemorrhagic fever** caused by viruses of the (flavivirus (e.g., Ebola, Marburg) or arenavirus (e.g., Lassa, Mayaro)) families

**Influenza (new?)**

**Measles** (infectious disease caused by measles microorganisms or their byproducts) i.e., paralytic distal limb paresthesia, dermatitis, alopecia, angitis, scleritis, etc.)

**Meningitis** (*Streptococcus pneumoniae*)

**Plague** (*Yersinia pestis*)

**Poliomyelitis**

**Q fever** (*Coxiella burnetii*)

**Rabies** (human)

**Rubella**

**WITHIN 24 HOURS**  
(including weekends and holidays)

- **Hepatitis A** (*Hepatitis A virus*)
- **Hepatitis B** (*Hepatitis B virus*)
- **Hepatitis C** (*Hepatitis C virus*)
- **Hepatitis D** (*Hepatitis D virus*)
- **Hepatitis E** (*Hepatitis E virus*)
- **Hepatitis F** (*Hepatitis F virus*)
- **Hepatitis G** (*Hepatitis G virus*)
- **Hepatitis H** (*Hepatitis H virus*)
- **Hepatitis I** (*Hepatitis I virus*)
- **Hepatitis J** (*Hepatitis J virus*)
- **Hepatitis K** (*Hepatitis K virus*)
- **Hepatitis L** (*Hepatitis L virus*)
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- **Hepatitis P** (*Hepatitis P virus*)
- **Hepatitis Q** (*Hepatitis Q virus*)
- **Hepatitis R** (*Hepatitis R virus*)
- **Hepatitis S** (*Hepatitis S virus*)
- **Hepatitis T** (*Hepatitis T virus*)
- **Hepatitis U** (*Hepatitis U virus*)
- **Hepatitis V** (*Hepatitis V virus*)
- **Hepatitis W** (*Hepatitis W virus*)
- **Hepatitis X** (*Hepatitis X virus*)
- **Hepatitis Y** (*Hepatitis Y virus*)
- **Hepatitis Z** (*Hepatitis Z virus*)
- **Hepatitis AA** (*Hepatitis AA virus*)
- **Hepatitis AB** (*Hepatitis AB virus*)
- **Hepatitis AC** (*Hepatitis AC virus*)
- **Hepatitis AD** (*Hepatitis AD virus*)
- **Hepatitis AE** (*Hepatitis AE virus*)
- **Hepatitis AF** (*Hepatitis AF virus*)
- **Hepatitis AG** (*Hepatitis AG virus*)
- **Hepatitis AH** (*Hepatitis AH virus*)
- **Hepatitis AI** (*Hepatitis AI virus*)
- **Hepatitis AJ** (*Hepatitis AJ virus*)
- **Hepatitis AK** (*Hepatitis AK virus*)
- **Hepatitis AL** (*Hepatitis AL virus*)
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- **Hepatitis AP** (*Hepatitis AP virus*)
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- **Hepatitis BZ** (*Hepatitis BZ virus*)
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- **Hepatitis CB** (*Hepatitis CB virus*)
- **Hepatitis CC** (*Hepatitis CC virus*)
- **Hepatitis CD** (*Hepatitis CD virus*)
- **Hepatitis CE** (*Hepatitis CE virus*)
- **Hepatitis CF** (*Hepatitis CF virus*)
- **Hepatitis CG** (*Hepatitis CG virus*)
- **Hepatitis CH** (*Hepatitis CH virus*)
- **Hepatitis CI** (*Hepatitis CI virus*)
- **Hepatitis CJ** (*Hepatitis CJ virus*)
- **Hepatitis CK** (*Hepatitis CK virus*)
- **Hepatitis CL** (*Hepatitis CL virus*)
- **Hepatitis CM** (*Hepatitis CM virus*)
- **Hepatitis CN** (*Hepatitis CN virus*)
- **Hepatitis CO** (*Hepatitis CO virus*)
- **Hepatitis CP** (*Hepatitis CP virus*)

**These helpful reference posters are free from OHA**

**Local health department information**  
For a list of local health department phone numbers  
go to [www.healthreporting.org/forHealthcity](http://www.healthreporting.org/forHealthcity)

# OREGON PUBLIC HEALTH DIVISION REPORTING FOR LABORATORIES

**B**elow: Oregon laboratories must report all human test results "indicative of and specific for" the following diseases, infections, microorganisms and conditions listed in the accompanying table. These results include microbiological culture, isolation or identification; assays for specific antibodies and identification of specific antigens; toxins or nucleic acid sequences.

In general, reports must be made to the patient's local public health department of residence within one working day of the initial test report.<sup>1</sup>

Laboratories should also familiarize themselves with select biological agents and toxins that have potential to pose severe threats.<sup>2</sup> Reports must include the patient's name, date of birth, county of residence, specimen type and specimen source (site, collection date, test, result, and contact information for the ordering clinician and the lab.<sup>3</sup>)

If possible, patient sex and street address should also be submitted.

The laboratory reporting the result to the clinician is responsible for reporting to public health, regardless of which lab actually performs the test. Reports on out-of-state residents should be made directly to that state's health department, or to the Public Health Division of the Oregon Health Authority. Document these reports in a log. Oregon law requires laboratories that report an average of >30 records per month to submit the data electronically according to the standards in the Oregon Health Authority's Manual for Mandatory Electronic Laboratory Reporting (ELR)<sup>4</sup>

- Please contact us at 877-673-1111 for ELR initiation, assistance and approval.
- Laboratories required to report via ELR shall have a state-approved continuity of operations plan to maintain reporting in emergency situations. At least two alternate methodologies should be incorporated, such as electronic, mail or courier service.
- A licensed laboratory required to report data electronically shall participate fully in Oregon's Data Quality Control program, as specified in the Oregon Health Authority's Manual for Mandatory Electronic Laboratory Reporting<sup>5</sup>
- Electronically submitted reports shall meet relevant reporting timelines.<sup>6</sup>

*Streptococcus pneumoniae*

REPORTABLE DISEASES, INFECTIONS, MICROORGANISMS AND CONDITIONS	TESTS
<i>Escherichia coli</i> , enterohemorrhagic	Culture
<i>Escherichia coli</i> , Shiga toxin-producing	Culture, toxin
<i>Escherichia coli</i> , O157 and other serotypes	Culture, toxin
<i>Escherichia coli</i> , enterohemorrhagic	Culture, toxin
<i>Escherichia coli</i> , Shiga toxin-producing	Culture, toxin
<i>Escherichia coli</i> , O157 and other serotypes	Culture, toxin
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<i>Escherichia coli</i> , Shiga toxin-producing	Culture, toxin
<i>Escherichia coli</i> , O157 and other serotypes	Culture, toxin
<i>Escherichia coli</i> , enterohemorrhagic	



# Identify, Isolate and Inform:

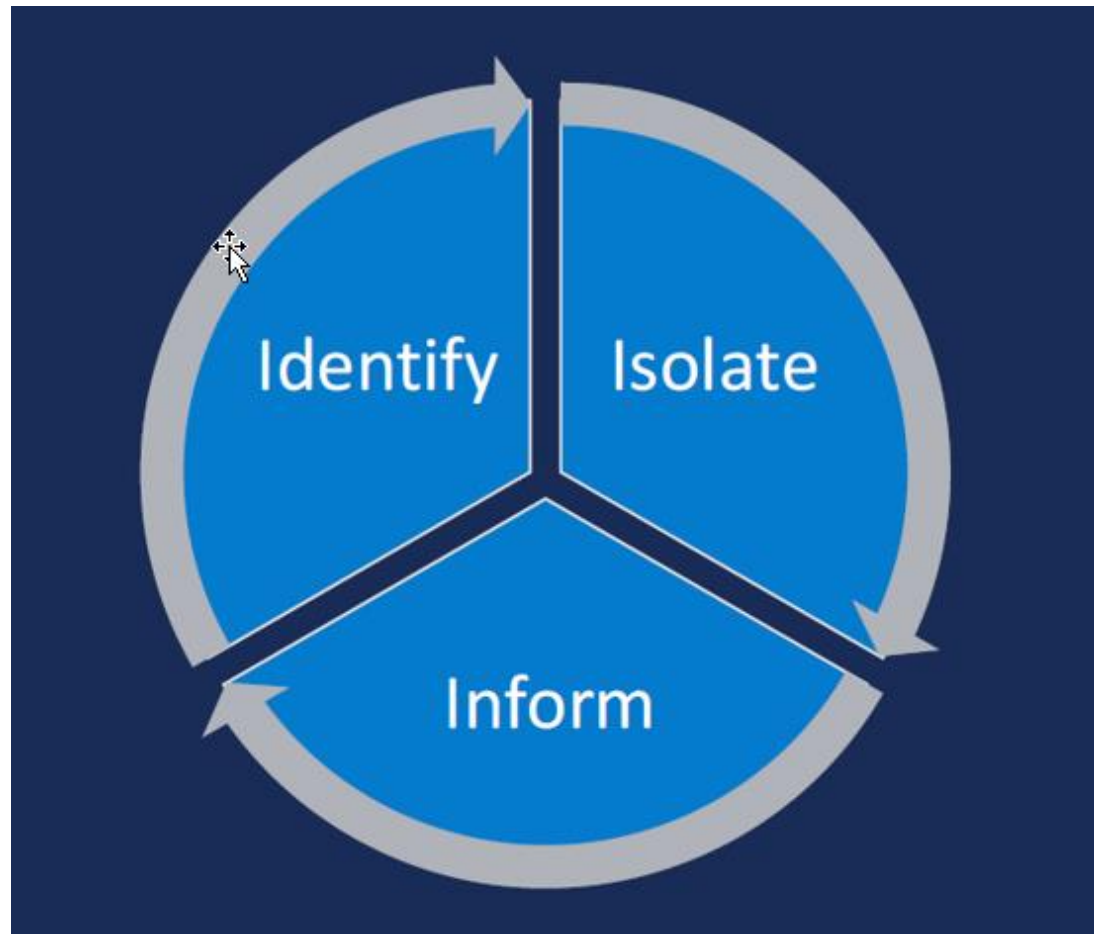
*Rapid assessment should happen with every patient you see in triage!*

## 1. IDENTIFY

the contagious patient *as quickly as possible!*



Getty Images/iStockphoto



**2. ISOLATE** the patient, to minimize spread to other people

**3. INFORM** the appropriate team members, so that the patient receives the best care, and the patient is isolated appropriately!



# Identifying measles

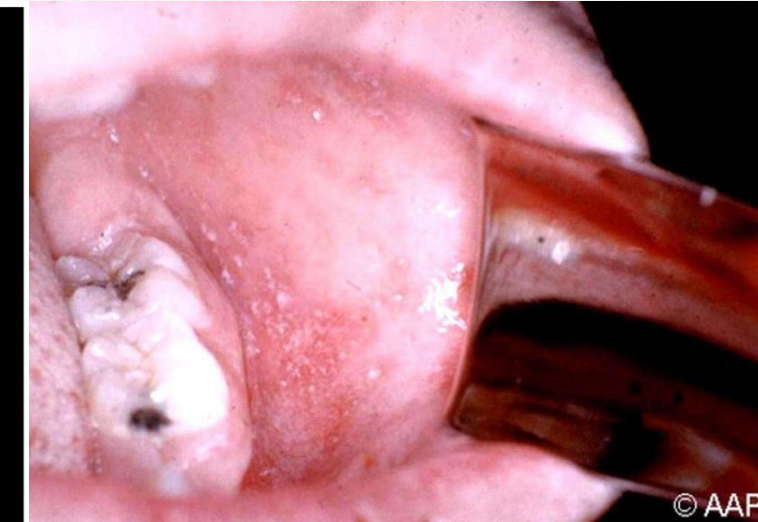
A prodrome of fever (as high as 105°F), malaise, and cough, coryza, and conjunctivitis (three "C"s)

A pathognomonic enanthema (Koplik spots)

Followed by a maculopapular rash

The rash usually appears about 14 days after a person is exposed. The rash spreads **from the head to the trunk to the lower extremities**

Patients are considered to be contagious from 4 days before to 4 days after the rash appears



# Identifying chickenpox

The classic sign of chickenpox is a rash that turns into itchy, fluid-filled blisters which eventually become scabs

The rash may first appear on the chest, back, and face. The rash can then spread over the entire body, including inside the mouth, eyelids, or genital area

About 1-2 days before the rash, people will have fever, tiredness, poor appetite, and fatigue

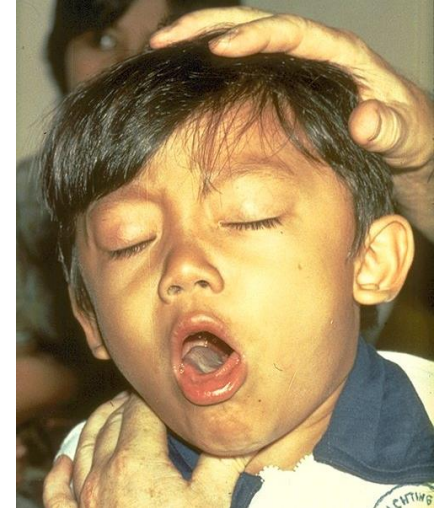
Patients are considered to be contagious from 1-2 days before rash onset until all lesions have dried & crusted





# Identifying pertussis (whooping cough)

- Incubation period: 7-10 days (range 4-21)
- Three clinical stages
  1. **Catarrhal:** Rhinorrhea, sneezing, low-grade fever, mild cough  
This is the most contagious period!
  2. **Paroxysmal:** severe spasms of cough, thick mucous, classic “whoop,” vomiting, exhaustion
  3. **Convalescent:** gradual slow recovery with less frequent & less severe coughing...it’s called “the 100-day cough”



# Stay Alert! Protect Yourself & Others!



## **TRAVEL HISTORY**

MAY BE THE ONLY DISTINGUISHER  
BETWEEN MEASLES, EBOLA AND  
EVERYTHING ELSE SEEN EVERY  
DAY!



## **WHEN IN DOUBT, ADD PRECAUTIONS. YOU CAN ALWAYS DISCONTINUE THEM LATER.**

YOU ARE RESPONSIBLE FOR THE  
SAFETY OF YOUR COWORKERS,  
TOO!



## **ROUTINE INFECTION PREVENTION PRACTICES**

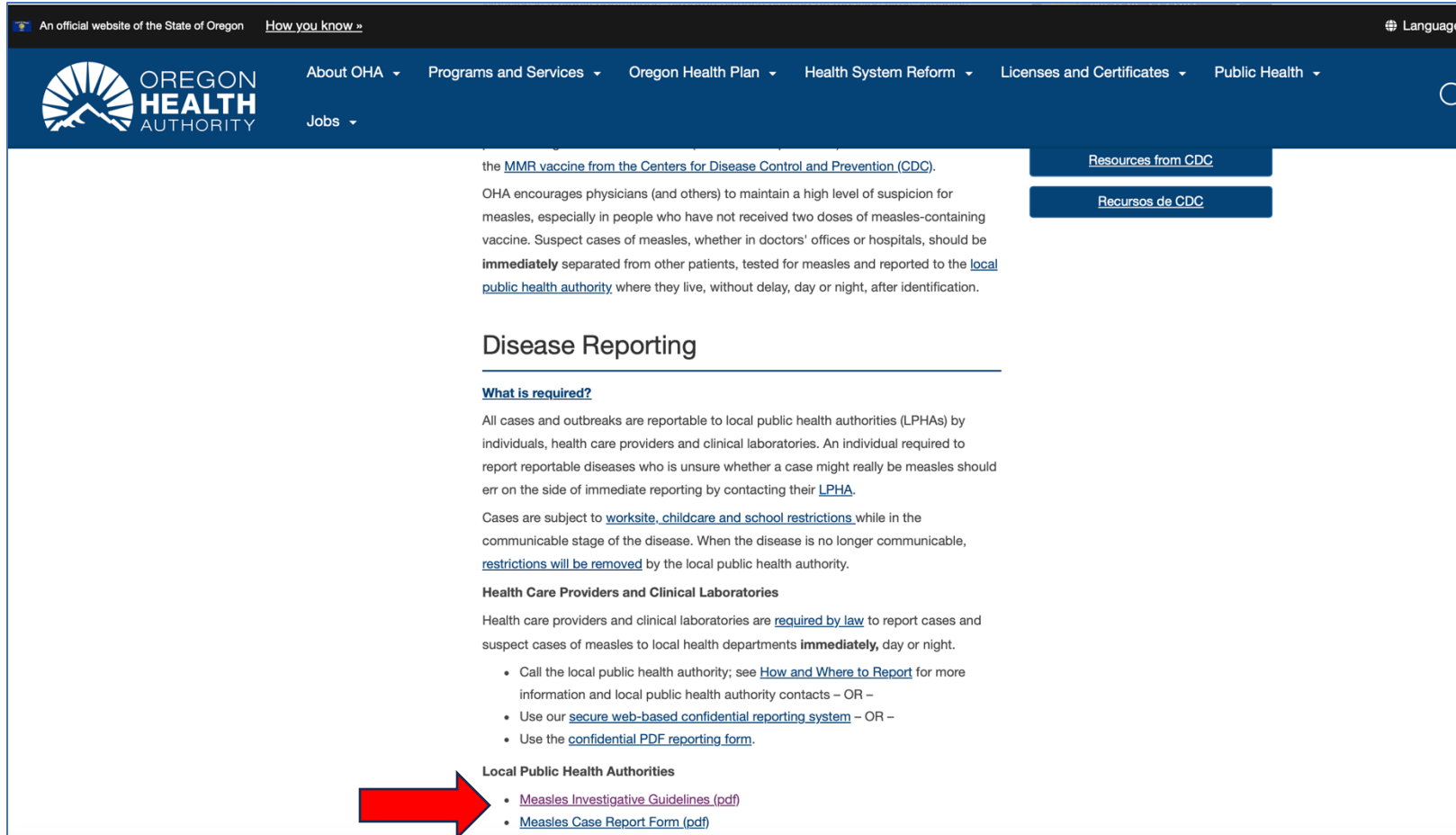
CAN STOP THE SPREAD OF  
INFECTIONS FROM THE PATIENT  
TO OTHER PATIENTS, YOU, AND  
YOUR FAMILY.



Getty Images/iStockphoto

# Suggested Resources

# Measles Resources: OHA



The screenshot shows the Oregon Health Authority (OHA) website. The header includes the OHA logo, navigation links (About OHA, Programs and Services, Oregon Health Plan, Health System Reform, Licenses and Certificates, Public Health, Jobs), and a search icon. The main content area is titled "Measles Resources" and includes a section on "Disease Reporting". A red arrow points to the "Local Public Health Authorities" section, which lists links for "Measles Investigative Guidelines (pdf)" and "Measles Case Report Form (pdf)".

An official website of the State of Oregon [How you know »](#) Languages

**OREGON HEALTH AUTHORITY**

About OHA ▾ Programs and Services ▾ Oregon Health Plan ▾ Health System Reform ▾ Licenses and Certificates ▾ Public Health ▾ Jobs ▾

the [MMR vaccine from the Centers for Disease Control and Prevention \(CDC\)](#).

OHA encourages physicians (and others) to maintain a high level of suspicion for measles, especially in people who have not received two doses of measles-containing vaccine. Suspect cases of measles, whether in doctors' offices or hospitals, should be **immediately** separated from other patients, tested for measles and reported to the [local public health authority](#) where they live, without delay, day or night, after identification.

[Resources from CDC](#)

[Recursos de CDC](#)

## Disease Reporting

[What is required?](#)

All cases and outbreaks are reportable to local public health authorities (LPHAs) by individuals, health care providers and clinical laboratories. An individual required to report reportable diseases who is unsure whether a case might really be measles should err on the side of immediate reporting by contacting their [LPHA](#).

Cases are subject to [worksite, childcare and school restrictions](#) while in the communicable stage of the disease. When the disease is no longer communicable, [restrictions will be removed](#) by the local public health authority.

### Health Care Providers and Clinical Laboratories

Health care providers and clinical laboratories are [required by law](#) to report cases and suspect cases of measles to local health departments **immediately**, day or night.

- Call the local public health authority; see [How and Where to Report](#) for more information and local public health authority contacts – OR –
- Use our [secure web-based confidential reporting system](#) – OR –
- Use the [confidential PDF reporting form](#).

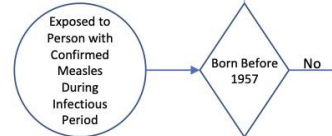
### Local Public Health Authorities

- [Measles Investigative Guidelines \(pdf\)](#)
- [Measles Case Report Form \(pdf\)](#)

<https://www.oregon.gov/oha/ph/diseasesconditions/diseasesaz/pages/measles.aspx>

# OHA Measles Exposure Algorithm

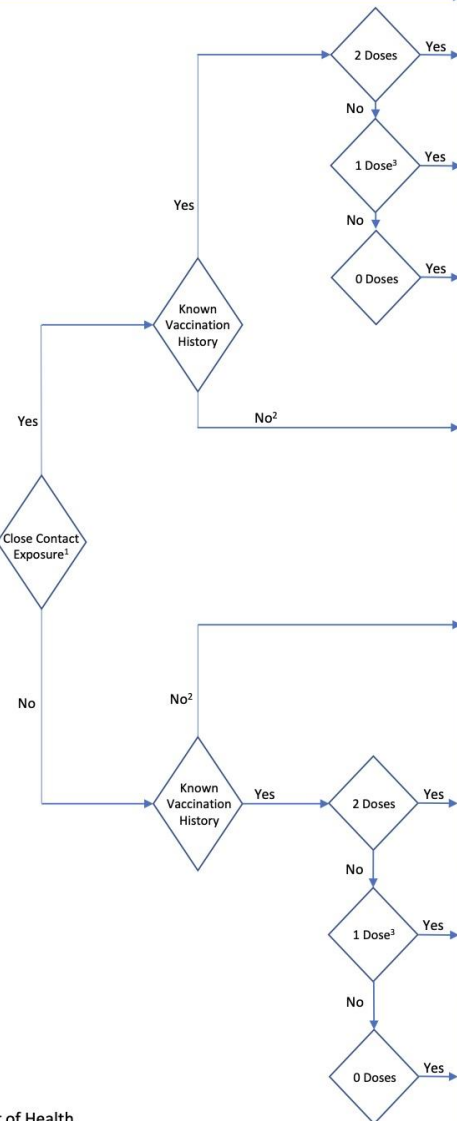
## Algorithm for Assessment of People Exposed to Measles



ACDP: Acute and Communicable Disease Prevention Section, Oregon Health Authority  
 HC: Health Care  
 HCF: Health Care Facility  
 IG: Immune Globulin  
 IgG: Immunoglobulin G  
 OSPHL: Oregon State Public Health Laboratory  
 PH: Public Health



Last Revised: February 2019  
 Adapted from Washington State Department of Health



Risk Assessment	Prophylaxis	Recommendations	Symptom Watch	Work/School Exclusion	Quarantine at Home	Testing at OSPHL
Presumed immune	None	No recommendations or restrictions	Yes: Discuss date of exposure and symptom watch times.	None unless symptoms develop	No	If rash develops
93% effective	MMR within 72 hours of exposure	Second MMR recommended if needed per ACIP recommendations even if >72 hours after exposure (but MMR within 72 hours preferred)	Yes: Discuss date of exposure and symptom watch times. Explain what to do if symptoms arise: i.e., stay home, call PH/HC provider before going to HCF. Counsel on adverse events <sup>4</sup>	None unless symptoms develop or in a high-risk setting/occupation <sup>3</sup>	No	If rash develops
Susceptible!	MMR within 72 hours of exposure or consider IG (if indicated <sup>9</sup> ) within 6 days of exposure <sup>6</sup> (not both)	MMR recommended even if MMR not given within 72 hours of exposure <sup>7</sup>	Yes: Discuss date of exposure and symptom watch times. Consider active monitoring if possible, with check-in every 1-2 days. Explain what to do if symptoms arise: i.e., stay home, call PH/HC provider before going to HCF. Counsel on adverse events <sup>4</sup>	Yes <sup>8</sup> until 21 days after exposure, whether or not given MMR or IG <sup>9</sup> .	Yes <sup>8</sup> and no non-immune visitors	If symptoms develop, discuss with ACDP Epi
Presume susceptible	MMR within 72 hours of exposure or consider IG (if indicated <sup>9</sup> ) within 6 days of exposure <sup>6</sup> (not both)	If asymptomatic, encourage IgG titer and then give a dose of MMR through HC provider (in special situations PH can support testing)	Yes: Discuss date of exposure and symptom watch times. Consider active monitoring if possible, with check-in every 1-2 days. Explain what to do if symptoms arise: i.e., stay home, call PH/HC provider before going to HCF. Counsel on adverse events <sup>4</sup>	If titer negative or not done: Yes <sup>8</sup> for 21 days after exposure. <sup>9</sup> If titer positive: no further restrictions; no MMR needed.	Yes, stay home from day 7 after exposure until titer results available. If titer negative or not done: Isolate for 21 days after exposure. <sup>9</sup>	If symptoms develop, discuss with ACDP Epi
Presume susceptible	MMR within 72 hours of exposure or consider IG (if indicated <sup>9</sup> ) within 6 days of exposure <sup>6</sup> (not both)	If asymptomatic, encourage IgG titer or dose of MMR through HC provider	Yes: Discuss date of exposure and symptom watch times. Explain what to do if symptoms arise: i.e., stay home, call PH/HC provider before going to HCF. Counsel on adverse events <sup>4</sup>	None unless symptoms develop or in a high-risk setting/occupation <sup>3</sup>	No, unless symptoms develop. If symptomatic during the 21 days after exposure, isolate <sup>8</sup> and test for measles if rash develops. If titer positive: no further restrictions. If titer negative or not done: Isolate for 21 days after exposure. <sup>9</sup>	If rash develops
Presumed immune	None	No recommendations or restrictions	Yes: Discuss date of exposure and symptom watch times.	None unless symptoms develop.	No	Clinical measles <sup>10</sup>
93% effective	MMR within 72 hours of exposure	Second MMR recommended even if >72 hours after exposure (but MMR within 72 hours preferred)	Yes: Discuss date of exposure and symptom watch times. Explain what to do if symptoms arise: i.e., stay home, call PH/HC provider before going to HCF. Counsel on adverse events <sup>4</sup>	None unless symptoms develop or in a high-risk setting/occupation <sup>3</sup>	No	Clinical measles <sup>10</sup>
Susceptible!	MMR within 72 hours of exposure or consider IG (if indicated <sup>9</sup> ) within 6 days of exposure <sup>6</sup> (not both)	If asymptomatic, encourage HC provider give a dose of MMR	Yes: Discuss date of exposure and symptom watch times. Explain what to do if symptoms arise: i.e., stay home, call PH/HC provider before going to HCF. Counsel on adverse events <sup>4</sup>	None unless symptoms develop or in a high-risk setting/occupation <sup>3</sup>	No, unless symptoms develop. If symptomatic during the 21 days after exposure, isolate <sup>8</sup> and test for measles if rash develops.	If rash develops

## 6.2 Case in a Medical Setting

Control efforts in medical settings should focus on reviewing existing immunization policies, employee immunization records, and patient isolation practices.

Healthcare workers (volunteers, trainees, nurses, physicians, technicians, receptionists and other clinical support staff) should be immunized before exposure. Documentation of immunity should be easily and readily available.

When a person suspected of measles visits a healthcare facility, airborne isolation precautions should be followed stringently. The patient should wear a mask (procedure or surgical mask) until isolated in a negative air pressure isolation room, also known as airborne infection isolation (AII) or airborne

March 2025

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### 1. DISEASE REPORTING

#### 1.1 Purpose of Reporting

1. To identify
2. To prevent
3. To identify

#### 1.2 Laboratory and Testing

Physicians should  
immediately  
IgM, virus  
[018-0018](#),  
Laboratory  
forwarded

#### 1.3 Local Public Health

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day or  
night.
2. Begin the  
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### Measles

infection isolation room (AIIR). If an AIIR is not available, the patient should be placed in a private room with the door closed and be asked to wear a surgical or procedure mask. Only staff with presumptive evidence of immunity should enter the room of a person with suspect or confirmed measles. Ideally, for individuals for whom measles is a distinct possibility, the LHD will facilitate a plan for entry into the evaluating health care facility in a way that minimizes the likelihood of exposing others.

If a case with measles in any stage of communicability was treated at a healthcare facility, identify potentially exposed healthcare workers (see §4.2

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page 12 of 19



# **Acquiring state-supplied immune globulin, vaccine, and other medications**

## **Investigative Guidelines**

### **June 2024**

#### **1. PURPOSE**

The purpose of this guidance is to advise public health staff on the process of acquiring immune globulin and vaccine from the Oregon Immunization Program (OIP) during an outbreak, acute event, or in situations where the needed prophylaxis is not otherwise available to the Local Public Health Authority (LPHA). This document is not intended to replace the guidance on general prophylaxis of contacts outlined in the Investigative Guidelines for those conditions that require postexposure prophylaxis (PEP) of contacts. Immune globulin products available through OIP's Vaccine Supply & Access Team (VSAT) include IG (for hepatitis A and measles prophylaxis) and HBIG (for hepatitis B prophylaxis).

#### **2. CONTACTING ACUTE AND COMMUNICABLE DISEASE PREVENTION**

When contacts are identified that may need immune globulin or vaccine that is not currently accessible by LPHAs, the LPHA should contact the Acute and Communicable Disease Prevention section (ACDP) on-call epidemiologist at 971-673-1111. The on-call epidemiologist and the LPHA will review the contact history and determine whether immune globulin or vaccine is indicated for each contact. After this determination, the on-call epidemiologist will contact OIP with the relevant information. OIP will then coordinate obtaining the indicated immune globulin or vaccine with the LPHA (detailed below). OIP cannot release immune globulin, or vaccine until ACDP has approved the request. The LPHA must provide OIP with the quantity of product requested and delivery instructions. All other OIP rules and regulations regarding vaccine management and accountability apply.

#### **3. PROPHYLAXIS RECOMMENDATIONS**

# Varicella Resources: OHA

PUBLIC HEALTH DIVISION  
Acute and Communicable Disease Prevention



## **GUIDELINES FOR PREVENTION OF VARICELLA TRANSMISSION IN OREGON SCHOOLS AND CHILDREN'S FACILITIES**

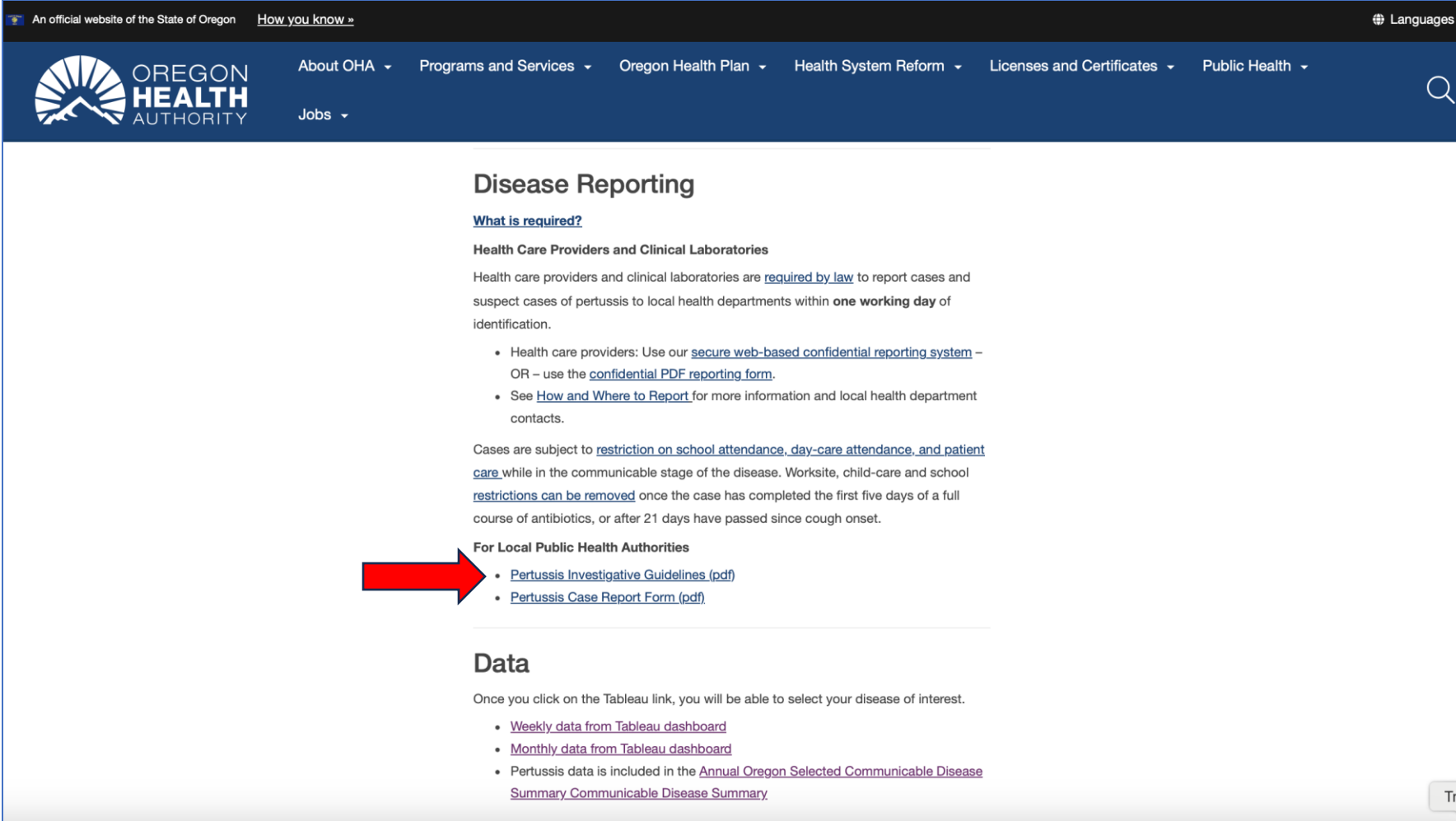
### **BACKGROUND**

In September 2000, vaccination against varicella (chickenpox) was required of susceptible children in Oregon children's facilities, and a similar requirement for children in grades K–12 was phased in during 2000–2006. Four percent of school-age children have a non-medical exemption to varicella vaccination. Those who are not immunized may drive or prolong school outbreaks.

Varicella is not reportable in Oregon, and Oregon Administrative Rule 333-019-0010 regarding school-restrictable diseases makes no provision for exclusion of susceptible contacts of non-reportable diseases. In schools where varicella has been identified, parents of susceptible children should be notified, informed of the risks to their children, and, absent medical contraindications, strongly advised to have their children vaccinated.

Parents should be advised that children who lack immunity and continue to attend school are

# Pertussis Resources: OHA



The screenshot shows the Oregon Health Authority website. The header includes the OHA logo, navigation links (About OHA, Programs and Services, Oregon Health Plan, Health System Reform, Licenses and Certificates, Public Health, Jobs), and a search icon. The main content area is titled "Disease Reporting" and includes a link for "What is required?". Under "Health Care Providers and Clinical Laboratories", it states that health care providers are required by law to report cases and suspect cases of pertussis to local health departments within one working day of identification. It lists two options: using a secure web-based confidential reporting system or a confidential PDF reporting form. It also mentions that cases are subject to restrictions on school attendance, day-care attendance, and patient care while in the communicable stage of the disease. A red arrow points to the "For Local Public Health Authorities" section, which lists links for "Pertussis Investigative Guidelines (pdf)" and "Pertussis Case Report Form (pdf)". Below this is a "Data" section with links for "Weekly data from Tableau dashboard", "Monthly data from Tableau dashboard", and "Annual Oregon Selected Communicable Disease Summary Communicable Disease Summary".

An official website of the State of Oregon [How you know »](#) Languages

**OREGON HEALTH AUTHORITY**

About OHA ▾ Programs and Services ▾ Oregon Health Plan ▾ Health System Reform ▾ Licenses and Certificates ▾ Public Health ▾ Jobs ▾

## Disease Reporting

[What is required?](#)

**Health Care Providers and Clinical Laboratories**

Health care providers and clinical laboratories are [required by law](#) to report cases and suspect cases of pertussis to local health departments within **one working day** of identification.

- Health care providers: Use our [secure web-based confidential reporting system](#) – OR – use the [confidential PDF reporting form](#).
- See [How and Where to Report](#) for more information and local health department contacts.

Cases are subject to [restriction on school attendance, day-care attendance, and patient care](#) while in the communicable stage of the disease. Worksite, child-care and school [restrictions can be removed](#) once the case has completed the first five days of a full course of antibiotics, or after 21 days have passed since cough onset.

**For Local Public Health Authorities**

- [Pertussis Investigative Guidelines \(pdf\)](#)
- [Pertussis Case Report Form \(pdf\)](#)

## Data

Once you click on the Tableau link, you will be able to select your disease of interest.

- [Weekly data from Tableau dashboard](#)
- [Monthly data from Tableau dashboard](#)
- Pertussis data is included in the [Annual Oregon Selected Communicable Disease Summary Communicable Disease Summary](#).

<https://www.oregon.gov/oha/ph/diseasesconditions/diseasesaz/pages/pertussis.aspx>

# Pertussis

## Investigative Guidelines

March 2025

### 1. DISEASE REPORTING

#### 1.1 Purpose of Reporting and Surveillance

1. To prevent illness and death among exposed, high-risk persons.
2. To vaccinate exposed, under-immunized children.
3. To educate exposed persons about the signs and symptoms of pertussis in order to facilitate prompt diagnosis and treatment and prevent further spread.
4. To monitor the epidemiology of pertussis in Oregon.

#### 1.2 Laboratory and Physician Reporting Requirements

Physicians are required to report cases (including suspect cases) within one working day (OAR 333-018- 0015). Clinical labs must similarly report within one working day of identification or initial positive test report to the requesting physician (OAR 333-018-0015).

#### 1.3 Local Public Health Authority Reporting and Follow-Up Responsibilities

1. Begin routine case investigation within one working day.
2. Identify and evaluate contacts; educate and recommend measures to prevent further spread.
3. Report all confirmed and presumptive (but not suspect) cases to the Acute and Communicable Disease Prevention section (ACDP) as soon as possible, but no later than the end of the calendar week of the initial physician or laboratory report. Submit all case data electronically.

### 2. THE DISEASE AND ITS EPIDEMIOLOGY

#### 2.1 Etiologic Agent

*Bordetella pertussis*, a fastidious pleomorphic Gram-negative bacillus.

#### 2.2 Description of Illness

Classic pertussis, whooping cough, is characterized by spasms of severe

**3.1 Close Contacts**

Close contacts are defined to include immediate family members (those who spend many hours together or sleep under the same roof) and anyone who had direct contact with respiratory secretions. Although obviously these are somewhat arbitrary distinctions, “close contacts” should also include those who shared confined space (within ~6 feet) for >1 hour during the communicable period. These might include, for example, close friends and other social contacts in childcare, school, or work settings; co-participants in certain extra-curricular activities or outings; and healthcare workers caring for a case without wearing a mask. Schoolchildren sitting within ~3 feet of a case (i.e., adjacent seating) can also be included.

High-risk close contacts comprise infants (<1-year-old) and pregnant women in the third trimester.

**3.2 Confirmed Case Definition**

- Acute cough illness of any duration, with

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**Pertussis**

- Isolation of *B. pertussis* from a clinical specimen  
OR
  - Polymerase chain reaction (PCR) test positive for *B. pertussis*
- Note that a positive test result in the absence of cough (ouch!) is not considered confirmatory.

**3.3 Presumptive Case Definition**

- In the absence of a more likely diagnosis, a cough illness lasting at least 14 days with any of the following: paroxysms of coughing, inspiratory “whoop,” post-tussive vomiting or apnea (with or without cyanosis).

OR

- Illness with cough of any duration, with
  - At least one of the following signs or symptoms:
    - Paroxysms of coughing;
    - Inspiratory whoop;
    - Post-tussive vomiting; or
    - Apnea (with or without cyanosis)

AND

- Contact with a laboratory-confirmed case (epidemiologic linkage)

Consider getting specimens for confirmation of presumptive cases; the results will affect the classification of their symptomatic contacts.

**3.4 Suspect Case Definition**

## 5.2 Protection of Contacts

### Active Immunization

Exposed children who received their third dose of DTaP 6 months or more before exposure to pertussis should be given a 4th dose at this time. Children who received all four primary doses before their fourth birthday should receive a fifth (booster) dose of DTaP before entering school. Persons 7–9 years of age who have not been fully immunized against pertussis should receive Tdap now. Those  $\geq 10$  (including persons  $\geq 65$ ) years of age who have not received Tdap or who received it as part of the primary series catch-up schedule should get it at this time. There is no need to observe any minimum interval between doses of Td and Tdap. A dose of Tdap vaccine should be administered during each pregnancy irrespective of the patient's prior history of receiving Tdap. Optimal timing for Tdap administration in pregnant women is at 27–36 weeks' gestation. If Tdap is not administered during pregnancy, Tdap should be administered immediately post-partum. The postpartum dose is only recommended for women who have not previously received Tdap.

### Chemoprophylaxis

Most pertussis in adults and adolescents is neither diagnosed nor reported and antibiotic prophylaxis does not control the transmission of pertussis when it is widespread in the community. The effort to provide antibiotic prophylaxis for pertussis must focus on infants <1 year of age since serious complications and death are limited to this group. Recommend prompt antibiotic prophylaxis within 21 days of exposure for close contacts of confirmed, presumptive, and suspect cases who are:

- Infants;
- Pregnant women in the 3rd trimester (since they will soon have contact with an infant);
- All household contacts of a case if there is an infant or a pregnant woman in the 3rd trimester in the household, even if the infant in the household is the case;
- All those attending or working in a childcare setting (i.e., same room) of a case if there is an infant or one of those same third trimester women in the setting;
- Other contacts at the discretion of the local health department (e.g. pediatric healthcare workers, unimmunized contacts, other pregnant women, high-risk contacts of suspect cases).

# Acknowledgements

Oregon Health Authority HAI Program

*Questions?*



# Thank you!



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