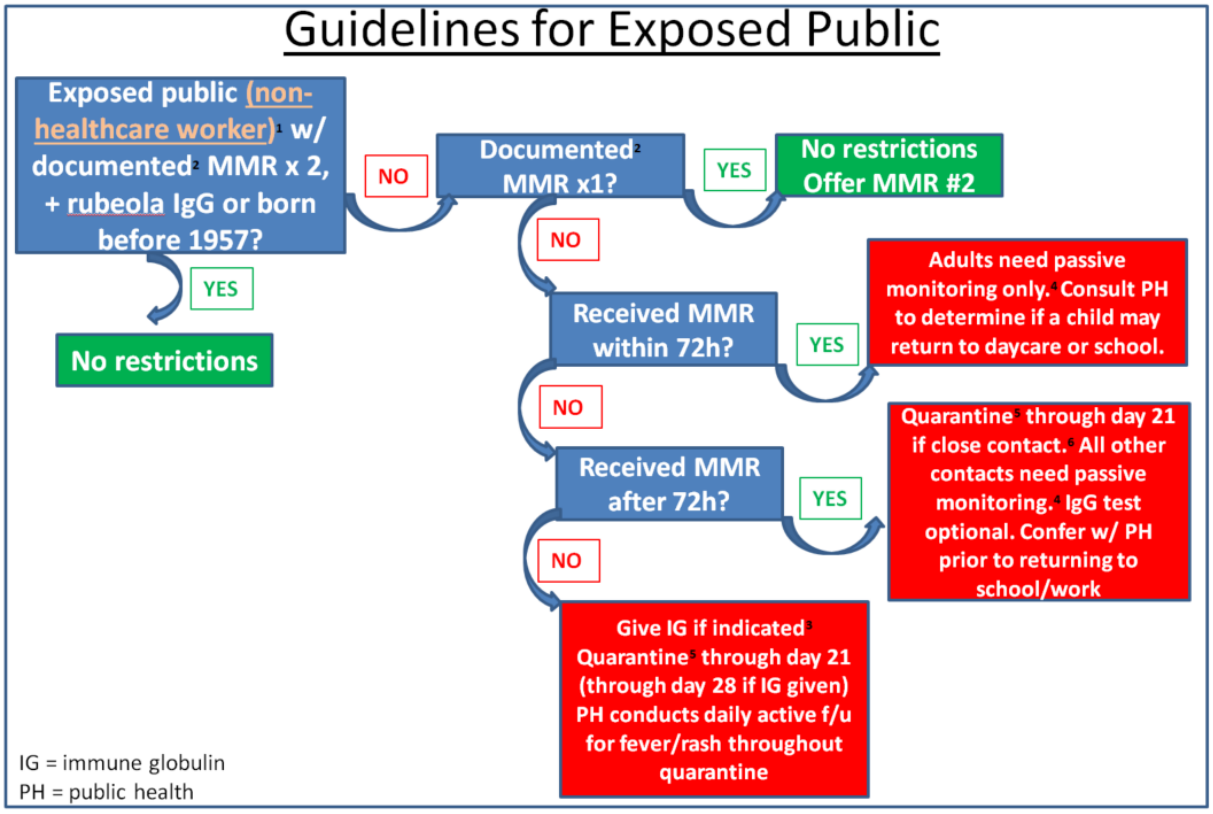
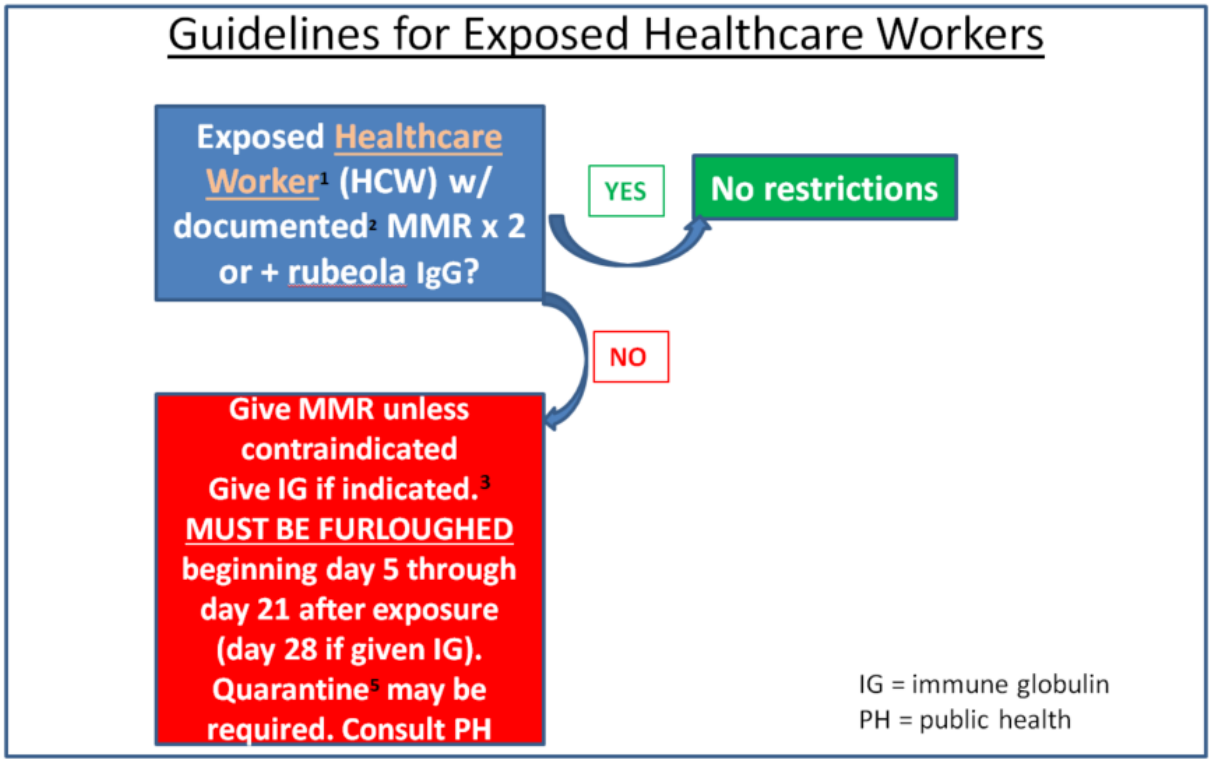
Guidelines for Measles Quarantine/Isolation/Furlough

April 23, 2019





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[1]**"Healthcare worker"** includes anyone working or volunteering (employee, student, contract, LIP, EMS) in a healthcare-related facility (hospital, lab, clinic, etc) who would have exposure to an infectious individual.

[2]**Valid dose of measles vaccine**: written documentation of the date of a dose administered after the first birthday and (if documented) 2nd dose at least 28 days after the first. For healthcare workers, **ONLY WRITTEN** documentation of 2 doses of MMR or measles vaccine or **WRITTEN** documentation of a rubeola IgG showing immunity is acceptable for presumptive immunity. There are **NO** exceptions to these criteria for healthcare workers. **DO NOT** draw serology on healthcare workers who have 2 documented doses of MMR or documentation of a prior positive rubeola IgG.

Note IgG may be negative despite adequate immunity
2 documented MMR and negative IgG = immune
1 documented MMR and negative IgG = susceptible-- Give MMR x 1. Do NOT recheck IgG
0 documented MMR and negative IgG = susceptible-- Give MMR x 2, 28d apart. Do NOT recheck IgG
0 documented MMR and positive IgG = immune

[3]**Immune Globulin (IG)** is indicated for infants <12 months of age, pregnant women, and those who are severely immune compromised (HIV/AIDS, cancer chemotherapy, immunosuppressant medications) **IF it can be given within 6 days of exposure**. For infants ages 6-12 months, MMR vaccine is preferred to IG if vaccine can be administered within 72h of exposure. Advise parents that receipt of IG impacts the ability to receive additional immunizations according to the CDC-recommended schedule. Consult CDC guidance for specific timing of subsequent immunizations. Contacts weighing >30kg must be given IG intravenously and under observation. Those <30kg may be able to receive IG intramuscularly– consult public health (PH). Severely immune compromised require PH consultation. Those requiring IG MAY require quarantine and should be discussed on a case-by-case basis with public health. Note that IgG testing may NOT be done after IGIV or IGIM administration.

Types of exclusion for contacts:

[4]**Passive monitoring**– contact is considered to be low-risk for infection and advised to immediately isolate and notify public health if ANY prodromal symptoms (fever >100.4, cough, runny nose, conjunctivitis, rash beginning on the face and spreading to trunk and then extremities) develop within 21 days (28 days if received IG) of exposure. Contact should avoid

high risk environments during the monitoring period (see [6] below) but may visit low risk settings.

[5]**Quarantine**– for individuals who have known exposure, are susceptible, and who are asymptomatic. Includes close contacts receiving MMR >72h after first exposure or who received IG. If possible, rubeola IgG should be obtained to allow likely-immune adults out of quarantine after lab confirmation of immunity (do not obtain serology after IG is given). Those without immunity and who have had close contact[5] with an infectious person should remain at home and away from susceptible individuals and the public, without exception, for 21 days from the date of last contact. Public health will make daily calls to assess for compliance and onset of symptoms. If a quarantined individual does not respond to attempts to contact within a 24 hour period (2 phone calls and texts to any available phone number), a home visit is warranted. If a quarantined individual cannot be located or is uncooperative at a home visit, a public health directive may be issued.

Isolation– for individuals who have known or suspected exposure and who are symptomatic. Maintain isolation until 5 days after onset of rash. Contact should remain at home and away from susceptible individuals and the public, without exception. Public health will make daily calls to assess for compliance and progression of symptoms. If isolated individual does not respond to attempts to contact within a 24 hour period (2 phone calls and texts to any available phone number), a home visit is warranted. If an isolated individual cannot be located or is uncooperative at a home visit, a public health directive may be issued. If no rash develops patient was likely symptomatic from another etiology but may need to remain isolated (except in the case of someone who is severely immunocompromised, in which case measles rash may not develop). Consult with a TDH physician (615-741-7247).

[6]**Close contact** applies to those with direct exposure to infectious persons or those with anything but brief exposure to shared airspace within two hours of the infectious person's presence.

[7]**High Risk Settings** include healthcare facilities, congregate settings (public worship, concerts, restaurants), or childcare facilities with children under 1 year of age. Contacts being passively monitored should avoid high-risk settings.

Low Risk Settings include schools with high immunization rates and where there is risk to a child being excluded from school for a prolonged period. Unvaccinated students MAY be able to return to K-12 settings, if healthy, as soon as the first MMR is given (even if >72h post-exposure), depending upon the vaccination status of school contacts. This will be decided on a

case-by-case basis in consultation with public health. Students who received MMR PEP would be excluded at first sign of fever.

Testing of Suspect Cases:

! Isolate

! Call public health

! Obtain pharyngeal specimen with synthetic swab for PCR. Notify State Public Health and send to State Public Health Lab. Note PCR may be falsely negative prior to onset of rash. PCR may be positive with vaccine strain if patient recently received MMR vaccine and may require whole genome sequencing to determine if virus is vaccine or wild strain. Obtain serum for rubeola IgM if patient has not received MMR vaccine or immune globulin (IG) within the past 60 days. Obtain serum for rubeola IgG if establishing immunity would eliminate need for quarantine.

Contact SHOC.DACO@tn.gov or call 615-741-7247 with questions or for clinical consultation

Guidance adapted from CDC VPD Surveillance Manual, Measles: Chapter 7.1