



Measles FAQ for General Workplaces

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Questions

Q1. Where can I learn about the symptoms of measles?

Q2. When is a person with measles infectious?

Q3. Can measles be transmitted from surfaces or via an airborne form?

Q4. What does the EEOC say generally about infectious diseases and the ADA?

Q5. Can an employer (outside of healthcare) require a measles vaccination of employees?

Q6. Can a healthcare employer require a measles vaccination?

Q7. Should I identify an employee who has measles to his coworkers?

Q8. Should an employer record a case of employee measles on its OSHA Form 300?

Answers

A1. The [CDC](#) or your state health department. It is wise to educate employees before there is an exposure in the workplace or community, especially if you are located in an outbreak area.

[CDC Tracking](#)

[Flu/Epidemic Articles](#)

A2. A person with measles can infect others from four days before to four days after the rash appears.

A3. Yes, the measles virus is more robust than most influenza strains, HIV, etc. Measles is a highly contagious virus that lives in the nose and throat mucus of an infected person. Measles can survive on surfaces and in the air for two (2) hours. It can spread to others through coughing and sneezing. Measles is so contagious that if one person has it, 90% of the people close to that person who are not immune will also become infected. Learn more about the [transmission](#) of measles from the CDC.

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A4. [EEOC Pandemic Preparedness Facts](#)

EEOC – ADA [Guidance](#) regarding Food Service Workers

EEOC – Healthcare Workers [Facts](#)

An employer must do an individualized analysis of the condition presented and the most current public health guidance in order to determine if vaccination is an essential function of the job or if the employee's condition presents a direct threat to safety. The EEOC guidance tends to err on the side of employees continuing to work in the case of HIV and other infectious diseases, even food service, but ease of transmission, potential harm, and past practice (such as in healthcare settings) will be considered. Under the ADA an employer may exclude an applicant or employee with a disability from a particular position if that individual would pose a direct threat to health or safety. "Direct threat" is defined as a significant risk of substantial harm to the individual or others in the workplace that cannot be reduced or eliminated through reasonable accommodation. The determination that a particular applicant or employee with a disability poses a direct threat must be based on an individualized assessment of the individual's present ability to perform the essential functions of the job safely. Factors to be considered include: (1) the duration of the risk; (2) the nature and severity of the potential harm; (3) the likelihood that the potential harm will occur; and (4) the imminence of the potential harm. A fact-specific inquiry into the nature of the workplace setting and the requirements of a position, as well as the best available objective evidence about a particular individual's disability and its effect on health and safety, is needed to assess whether a "direct threat" exists. Do not make knee jerk decisions. **For workplace Guidance and business planning visit, www.flu.gov. Fisher Phillips Guidance regarding Practical Pandemic preparation.**

FROM the EEOC: Direct threat is an important ADA concept during an influenza pandemic. Whether pandemic influenza rises to the level of a direct threat depends on the severity of the illness. If the CDC or state or local public health authorities determine that the illness is like seasonal influenza or the 2009 spring/summer H1N1 influenza, it would not pose a direct threat or justify disability-related inquiries and medical examinations. By contrast, if the CDC or state or local health authorities determine that pandemic influenza is significantly more severe, it could pose a direct threat. The assessment by the CDC or public health authorities would provide the objective evidence needed for a disability-related inquiry or medical examination.

During a pandemic, employers should rely on the latest CDC and state or local public health assessments. While the EEOC recognizes that public health recommendations may change during a crisis and differ between states, employers are expected to make their best efforts to obtain public health advice that is contemporaneous and appropriate for their location, and to make reasonable assessments of conditions in their workplace based on this information.

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A5. Maybe. The employer will have to conduct an individualized analysis to evaluate the threat posed at its specific workplace, the employee's duties, and current public health guidance, as well as employment contracts and union agreements. If the outbreak expands, it is likely that public health

guidance and legislation will more strongly support vaccination demands. **See earlier discussion under Education above.**

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A6. One must analyze the setting and risks but some states require certain vaccines for healthcare workers, and acute care and other healthcare providers have defended MMR requirements for many years. Even if the requirement is defensible under the ADA and Title VII religious discrimination protections, the employer should still examine contracts and union collective bargaining agreements involving the personnel, and ensure that requirements are imposed on a nondiscriminatory basis. **See earlier discussion under Education above.**

CDC [list](#) of state-by-state vaccination requirements for Healthcare Workers.

CDC Specific [Table](#)

This [article](#) deals with mandatory flu vaccinations – one should consider the long history of mandatory MMR vaccinations in healthcare and the greater threat prevented by measles.

** Click on each result to read the abridged text of the state immunization law.

States	Hepatitis B[1]	Influenza[2]	MMR[3]	Varicella[4]	Pneumococcal[5]	Medical(M),Religious(R), or Philosophical(P) Exemptions[6]
AL	No[20]	Ensure[21]	No[22]	No[23]	No[24]	No
AK	Ensure[510]	No	Ensure[26]	No	No	Yes – (M)[27]
AZ	Offer[30]	No	No	No	No	No
AR	Offer[34]	No	No	No	No	No
CA	Offer[41]	Offer[505]	Offer[553]	Offer[554]	No	No
CO	No	Ensure[565]	No	No	No	Yes – (M)[567]
CT	Offer[50]	No	No	No	No	No
DC	No[62]	No[63]	No[64]	No[65]	No[66]	No
DE	No	No	No	No	No	No
FL	No	No	No	No	No	No
GA	No[78]	Offer[569]	No	No	No	No
HI	Offer[82]	No	No	No	No	No
ID	No	No	No	No	No	No
IL	Offer[84]	Offer[85]	Ensure[86]	No[87]	No[88]	No
IN	No	No	No	No	No	No
IA	No	No	No	No	No	No

KS	No	No	No	No	No	No
KY	No	No	No	No	No	No
LA	No	No	No	No	No	No
ME	<u>Ensure[115]</u>	<u>Offer[116]</u>	<u>Ensure[117]</u>	<u>Ensure[118]</u>	No	<u>Yes – (M)[119], (R)[120] & (P)[121]</u>
MD	No	<u>Offer[559]</u>	<u>Ensure[123]</u>	No	No	<u>Yes – (M)[124] & (R)[125]</u>
MA	No	<u>Offer[555]</u>	<u>Ensure[130]</u>	No	No	No
MI	<u>Offer[134]</u>	No	No	No	No	No
MN	<u>Offer[138]</u>	No	No	No	No	No
MS	No	No	No	No	No	No
MO	<u>Offer[139]</u>	No	No	No	No	No
MT	No	No	No	No	No	No
NE	No	<u>Offer[560]</u>	No	No	No	No
NH	No	<u>Ensure[146]</u>	<u>No[147]</u>	No	No	<u>Yes – (M)[148] & (R)[149]</u>
NJ	No	No	<u>Offer[160]</u>	No	No	No
NM	No	No	<u>Ensure[172]</u>	No	No	No
NY	<u>Offer[175]</u>	No	<u>Ensure[176]</u>	No	No	<u>Yes – (M)[177]</u>
NV	<u>No[189]</u>	<u>No[190]</u>	<u>No[191]</u>	<u>No[192]</u>	<u>No[193]</u>	No
NC	No	No	No	No	No	No
ND	No	No	No	No	No	No
OH	No	No	No	No	No	No
OK	<u>Offer[557]</u>	<u>Offer[558]</u>	<u>Ensure[215]</u>	<u>Ensure[216]</u>	No	No
OR	<u>Offer[220]</u>	<u>No[221]</u>	<u>No[222]</u>	<u>No[223]</u>	<u>No[224]</u>	No
PA	No	No	No	No	No	No
RI	<u>Offer[234]</u>	<u>Offer[235]</u>	<u>Ensure[236]</u>	<u>Ensure[511]</u>	No	<u>Yes – (M)[237]</u>
SC	No	No	No	No	No	No
SD	<u>Offer[246]</u>	<u>No[573]</u>	No	No	No	No
TN	No	<u>Offer[512]</u>	No	No	No	No
TX	<u>Offer[256]</u>	<u>No[574]</u>	<u>No[575]</u>	<u>No[576]</u>	<u>No[577]</u>	No
UT	No	No	No	No	No	No
VT	<u>Offer[282]</u>	No	No	No	No	No
VA	<u>No[285]</u>	<u>No[286]</u>	<u>No[287]</u>	<u>No[288]</u>	<u>No[289]</u>	No
WA	<u>Offer[290]</u>	No	No	No	No	No
WV	No	No	No	No	No	No
WI	No	No	<u>Ensure[295]</u>	No	No	No
WY	No	No	No	No	No	No

Good 2014 paper on vaccinations and the law: <http://fas.org/sgp/crs/misc/RS21414.pdf>

Other Resources: 38 Megan C. Lindley et al., *Assessing State Immunization Requirements for Healthcare Workers and Patients*, 2 AM. J. PREVENTIVE MEDICINE, 459-465 (2007). 39 The CDC maintains a continuously updated online database of state laws pertaining to vaccination requirements for health care workers. See CENTERS FOR DISEASE CONTROL AND PREVENTION, STATE IMMUNIZATION LAWS FOR HEALTHCARE WORKERS AND PATIENTS (current as of December 2013). See generally Abigale L. Ottenberg, Joel T. Wu, and Gregory A. Poland, et al., *Vaccinating Health Care Workers Against Influenza: The Ethical and Legal Rationale for a Mandate*, 101 Am. J. P. Health 212-216 (2011).

CDC Current Vaccination recommendations for Healthcare Workers

2011 CDC Guidance

Example from 2011 CDC Recommendations:

Vaccination

All persons who work in health-care facilities should have presumptive evidence of immunity to measles. This information should be documented and readily available at the work location. Recently vaccinated HCP do not require any restriction in their work activities.

Presumptive evidence of immunity to measles for persons who work in health-care facilities includes any of the following:

- written documentation of vaccination with 2 doses of live measles or MMR vaccine administered at least 28 days apart,[†]
- laboratory evidence of immunity,
- laboratory confirmation of disease, or
- birth before 1957.

Prevaccination Testing

Prevaccination antibody screening before MMR vaccination for an employee who does not have adequate presumptive evidence of immunity is not necessary unless the medical facility considers it cost effective (134,170--172) although no recent studies have been conducted. For HCP who have 2 documented doses of MMR vaccine or other acceptable evidence of immunity to measles, serologic testing for immunity is not recommended. In the event that a HCP who has 2 documented doses of MMR vaccine is tested serologically and determined to have negative or equivocal measles titer results, it is not recommended that the person receive an additional dose of MMR vaccine. Such persons should be considered to have presumptive evidence of measles immunity. Documented age-appropriate

vaccination supersedes the results of subsequent serologic testing. Because rapid vaccination is necessary to halt disease transmission, during outbreaks of measles, serologic screening before vaccination is not recommended.

Use of Vaccine and Immune Globulin for Treating Exposed Persons and Controlling Outbreaks

Following airborne infection--control precautions and implementing other infection-control measures are important to control the spread of measles but might fail to prevent all nosocomial transmission, because transmission to other susceptible persons might occur before illness is recognized. Persons infected with measles are infectious 4 days before rash onset through 4 days after rash onset.

When a person who is suspected of having measles visits a health-care facility, airborne infection--control precautions should be followed stringently. The patient should be asked immediately to wear a medical mask and should be placed in an airborne-infection isolation room (i.e., a negative air-pressure room) as soon as possible. If an airborne-infection isolation room is not available, the patient should be placed in a private room with the door closed and be asked to wear a mask. If possible, only staff with presumptive evidence of immunity should enter the room of a person with suspect or confirmed measles.

Regardless of presumptive immunity status, all staff entering the room should use respiratory protection consistent with airborne infection--control precautions (i.e., use of an N95 respirator or a respirator with similar effectiveness in preventing airborne transmission) (3,150).

Because of the possibility, albeit low (~1%), of measles vaccine failure in HCP exposed to infected patients (173), all HCP should observe airborne precautions in caring for patients with measles. HCP in whom measles occurs should be excluded from work until ≥ 4 days following rash onset. Contacts with measles-compatible symptoms should be isolated, and appropriate infection-control measures (e.g., rapid vaccination of susceptible contacts) should be implemented to prevent further spread (174).

If measles exposures occur in a health-care facility, all contacts should be evaluated immediately for presumptive evidence of measles immunity. HCP without evidence of immunity should be offered the first dose of MMR vaccine and excluded from work from day 5--21 following exposure (135). HCP without evidence of immunity who are not vaccinated after exposure should be removed from all patient contact and excluded from the facility from day 5 after their first exposure through day 21 after the last exposure, even if they have received postexposure intramuscular immune globulin of 0.25 mL/kg (40 mg IgG/kg) (135). Those with documentation of 1 vaccine dose may remain at work and should receive the second dose.

Case-patient contacts who do not have presumptive evidence of measles immunity should be vaccinated, offered intramuscular immune globulin of 0.25 mL/kg (40 mg IgG/kg), which is the standard dosage for nonimmunocompromised persons (135), or quarantined until 21 days after their exposure to the case-patient. Contacts with measles-compatible symptoms should be isolated, and appropriate infection-control measures should be implemented to prevent further spread. If immune globulin is administered to an exposed person,

observations should continue for signs and symptoms of measles for 28 days after exposure because immune globulin might prolong the incubation period.

Available data suggest that live virus measles vaccine, if administered within 72 hours of measles exposure, will prevent, or modify disease (134). Even if it is too late to provide effective postexposure prophylaxis by administering MMR, the vaccine can provide protection against future exposure to all three infections. Identifying persons who lack evidence of measles immunity during contact investigations provides a good opportunity to offer MMR vaccine to protect against measles as well as mumps and rubella, not only for HCP who are part of an organization's vaccination program, but also for patients and visitors. If an exposed person is already incubating measles, MMR vaccination will not exacerbate symptoms. In these circumstances, persons should be advised that a measles-like illness occurring shortly after vaccination could be attributable either to natural infection or to the vaccine strain. In such circumstances, specimens should be submitted for viral strain identification.

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A7. Follow Public Health Guidance, which differs from disease to disease. Even if the fact of infection is not protected medical records under the ADA, one must still consider common law invasion of privacy and other claims. Weigh the gain versus the degree of intrusion. Because measles, unlike most influenzas, is easily transmitted and can survive in the air or on surfaces for two hours, it would be near impossible to determine coworkers who were or were not exposed, and the coworkers' actions to monitor themselves for symptoms or consult a medical provider would be the same regardless of whether they knew "who" may have exposed them.

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A8. Different rules apply to healthcare setting where the employee may be exposed expressly as part of their duties, but normally routine infectious diseases are not treated as recordable workplace illnesses or as those that must be "Reported" to OSHA if overnight hospitalization is required for more than observation. However, in the case of certain Influenza Pandemics, OSHA liberalized the exclusion. See OSHA discussion. OSHA's definition of work-related for Recordkeeping purposes.

1904.5(b) You are not required to record injuries and illnesses if ...

(2)

At the time of the injury or illness, the employee was present in the work environment as a member of the general public rather than as an employee.

(i)

The injury or illness involves signs or symptoms that surface at work but result solely from a non-work-related event or exposure that occurs outside the work environment.

(ii)

(viii)

The illness is the common cold or flu (Note: contagious diseases such as tuberculosis, brucellosis, hepatitis A, or plague are considered work-related if the employee is infected at work).

