



Measles Outbreak in Ohio: Guidance for Healthcare Providers

October 5, 2026

Situation Summary

- The Ohio Department of Health (ODH), local health departments, and state and federal public health partners are continuing to respond to ongoing measles outbreaks and exposures in Ohio.
- As of Oct. 1, ODH had reported 206 cases of measles in 2026, with most cases occurring since mid-July. Cases are primarily unvaccinated residents of rural communities in several counties in eastern Ohio.
- Healthcare providers should take precautions to prevent the spread of measles in their facilities, including administrative procedures to reduce potential exposures in waiting rooms and public areas of healthcare facilities.

Guidance for Healthcare Providers

Diagnosis and Laboratory Testing

- Consider measles as a diagnosis in anyone with a febrile illness and clinically compatible symptoms (e.g., a generalized [maculopapular rash](#) with cough, coryza, or conjunctivitis). A clinical history should include assessment for known contact to someone with measles, recent travel to areas with measles transmission, including international travel or travel to outbreak areas within the U.S., and MMR vaccination status.
- Collection of virologic and serologic specimens is recommended for confirmation of disease. For patients with suspected measles, collect **both** respiratory (oropharyngeal or nasopharyngeal) and serum specimens for testing. Measles testing can be performed by commercial laboratories.
 - Testing for measles virus is also available through the ODH laboratory (ODHL) for [eligible clinical specimens](#). To request approval for testing at ODHL, Healthcare providers should contact the [local health department](#) in which the patient resides for testing approval.

Preventing Measles Exposures

- Patients with suspected measles should be rapidly identified and isolated and should not remain in the waiting room or other common areas of a healthcare facility. Healthcare facilities can consider asking about measles exposures or symptoms during scheduling or triage, using [signage](#) instructing people with measles exposures or symptoms to notify staff before entering the building, directing patients with suspected measles to entry points into

facilities that minimize exposure to common areas, and identifying designated testing areas (e.g., outside testing venues) that minimize exposures when clinically appropriate.

- Individuals with respiratory symptoms, including patients with suspect measles, should be masked at entry into the facility, if tolerated, and respiratory etiquette should be encouraged.
- Patients with suspected measles should be placed in a single-patient airborne infection isolation room (AIIR), or in a private room with a closed door until an AIIR is available.
- To the extent possible, visitors who are not protected against measles should not be allowed into the patient room.
- Examination rooms should not be used for at least two hours after the possibly infectious patient leaves. This duration may be shortened for spaces with a known defined rate of air changes per hour depending on the time required for 99.9% removal efficiency of airborne contaminants per [CDC guidance](#).
- If possible, schedule patients with suspected measles at the end of the day.
- If a patient is referred for additional clinical evaluation or laboratory testing, the receiving facility should be notified so appropriate infection control precautions can be implemented.

Protecting Healthcare Providers

- Adhere to standard and airborne precautions when evaluating confirmed or suspect measles cases, regardless of provider vaccination status.
- Healthcare personnel should wear an N95 or higher-level respirator regardless of presumptive evidence of immunity. A user seal check should be performed each time the respirator is donned.
- Ensure all healthcare providers have [presumptive evidence](#) of immunity to measles.
- During a measles outbreak, two doses of measles virus-containing vaccine are recommended for all healthcare providers, regardless of year of birth.
- Healthcare providers without presumptive evidence of measles immunity who are exposed to measles should be excluded from work from day 5 after the first exposure until day 21 following their last exposure and offered post-exposure prophylaxis, as appropriate.

Exposure Follow-up

- Make note of the staff and other patients who were in the area during the time the patient with suspected measles was in the facility, and for two hours after they left.
- If measles is confirmed, healthcare facilities should work with local public health officials to rapidly notify exposed individuals.
- Measles vaccine given [within 72 hours](#) after first exposure to susceptible contacts may prevent or modify measles disease.
- Immune globulin may be indicated for certain vulnerable contacts with no presumptive immunity and should be administered within six (6) days. Healthcare facilities should educate

applicable staff on processes for immune globulin administration and ensure appropriate staffing readiness. For more information see CDC's [Immune globulin for Measles Post-Exposure Prophylaxis](#).

- Consider ways to identify exposed patients within EMR systems for 21 days after exposure. If an exposed person presents with compatible symptoms, including prodromal symptoms, during the potential incubation period, EMR notifications can ensure rapid implementation of appropriate infection control measures.

Vaccination

- Two doses of the measles, mumps, rubella (MMR) vaccine is the best way to protect against measles. The first dose is routinely recommended at 12-15 months and the second dose at 4-6 years.
- **Vaccine considerations in areas affected by outbreaks**
 - While MMR vaccination is not routinely recommended for children before 12 months of age, it can be safely administered to children as young as 6 months if they are at increased risk of exposure to measles. The Ohio Department of Health, consistent with guidance from the American Academy of Pediatrics (AAP), recommends an early dose of MMR vaccine for children aged 6-11 months who are traveling internationally or **who live in or are traveling to an outbreak area.**
 - Clinicians should weigh the benefit of protection from measles during an outbreak against the risk of decreased immune responses in infants vaccinated with MMR before 12 months of age.
 - Infants younger than 12 months of age are at greatest risk of severe illness. Vaccination of infants aged 6-11 months minimizes the risk of disease and death that could occur in these infants during measles outbreaks.
 - The level of protective antibodies is lower and may remain lower in children vaccinated at younger than 12 months of age than children vaccinated later. Infants who receive one dose of MMR vaccine before their first birthday should receive two more doses according to the routinely recommended schedule (one dose at 12 through 15 months of age and another dose at 4 to 6 years of age or at least 28 days later).
 - For additional information, see the AAP's [Measles Prevention and Control Implementation](#) or CDC's [Clinical Questions about Measles](#).
 - For information on measles activity in Ohio, visit the [Summary of Infectious Diseases in Ohio](#).
 - The dashboard is updated each Thursday afternoon.
 - First, choose the timeframe.

- To find an individual disease or group of diseases, deselect “All” from the “Reportable Condition” dropdown list. For measles, select “Measles- imported from outside Ohio” and “Measles – indigenous to Ohio.”
- Click “Apply.”
- You can select “Epi Curve” or “Demographics” for more details. “Epi curve” will show you the timeline of the onset of illness for each case.
- Consider accelerated dosing for individuals at high risk of repeated exposure. The second dose of MMR can be given as early as 28 days after the first dose if both doses were given after the child’s first birthday.

Reporting

Measles is a Class A disease in Ohio. Any case, suspected case, and/or positive laboratory result should be reported **immediately via telephone** to the [local health department](#) in which the patient resides. If patient residence is unknown, report immediately via telephone to the local public health department in which the reporting healthcare provider or laboratory is located.

Contact Information

For general questions related to measles, healthcare providers and facilities should contact their local health department. Ohio local health departments should contact the ODH Bureau of Infectious Diseases at 614-995-5599 or VPDEpi@odh.ohio.gov.

Resources

- ODH [Collection and Submission of Suspected Measles Specimens](#).
- ODH Infectious Disease Control Manual: [Measles](#).
- ODH [Measles Screening Guide for Healthcare Facilities](#).
- ODH [Measles Screening Checklist for Healthcare Facilities](#).
- ODH Sign: [Steps to Stay Healthy Due to Measles in Community](#).
- ODH Sign: [Steps to Take If You or Your Child Have Been Around Someone with Measles or Have Symptoms](#).
- CDC: [Clinical Overview of Measles](#).
- CDC: [Infection Control in Healthcare Personnel-Measles](#).
- [Dashboard: Summary of Infectious Diseases in Ohio](#).