Recent Legal Decisions: AAP vs. Kennedy

Nava Yeganeh, MD MPH

Background of the lawsuit and key allegations

Lawsuit Filing

AAP and other medical groups filed a lawsuit against the HHS Secretary in July 2025 challenging government actions.

Allegations Against HHS

The lawsuit alleges:

- arbitrary decision-making
- procedural violations
- interference with advisory panels by HHS.

Amended complaints

Multiple Amendments

The lawsuit was amended multiple times due to evolving vaccine recommendations.

Disputed Vaccine Recommendations

AAP challenged the vaccine recommendations as lacking scientific evidence.

January 2026 Update

Complaint was updated after HHS revised the child vaccination recommendations via memo released on January 5, 2026.

Judge’s Rulings

Court's Temporary Block

The court temporarily blocked three major actions pending a full trial, ensuring a pause on changes.

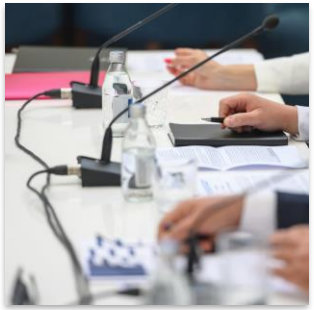
- A January 2026 memo proposed reducing child vaccination recommendations from 17 vaccines to 11.
- Recent ACIP member appointments without appropriate vetting
- All ACIP votes

Impact of the Stay

The stay prevents immediate implementation of the reduced vaccination schedule until trial conclusion.

Legal rationale:

CDC and ACIP procedural issues

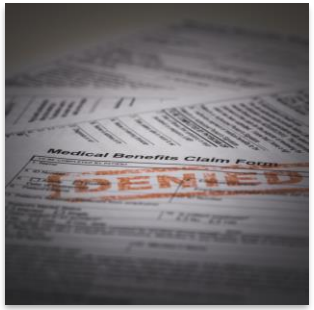


CDC Bypassing ACIP

Federal laws require the CDC Director to involve ACIP before changing immunization schedules. CDC bypassed this protocol.

Unbalanced ACIP Composition

The new ACIP was not fairly balanced as mandated by the Federal Advisory Committee Act, violating procedural fairness.



Arbitrary and Capricious Changes

The procedural changes made were arbitrary and capricious, lacking proper justification and adherence to rules.

Implications for ACIP

Effects of ACIP meeting cancellation and lack of guidance

Meeting Cancellation

The March 2026 ACIP meeting was cancelled due to majority member participation issues caused by a ruling.

Lack of Guidance

No clear guidance has been issued yet, creating uncertainty about the ACIP's next steps.

Key Adviser Quits Federal Vaccine Panel

Dr. Robert Malone, vice chair of the committee, was appointed by Robert F. Kennedy Jr. after a purge of the previous advisers.

Listen · 3:18 min

Share full article

Dr. Robert Malone, the vice chair of the Advisory Committee on Immunization Practices, during a meeting at the C.D.C. in Atlanta in December. Alyssa Pointer/Reuters

By Apoorva Mandavilli

March 24, 2026

Revision of ACIP Charter

- On April 6th, 2026, HHS secretary ”re-oriented ACIP’s focus”
  - Removed requirement that members “have expertise in the use of vaccines and other immuno-biologic agents in clinical practice or preventative medicine, have expertise with clinical or laboratory vaccine research or have expertise in assessment of vaccine efficacy and safety. “
  - Changed to “necessary expertise” and “fairly balanced”
  - Added in “identifying gaps in vaccine safety research, including adverse effects following vaccination.”
  - Added in new liaison members for groups critical of vaccines:
    - Independent Medical Alliance
    - Physicians for Informed Consent
    - Association of American Physicians and Surgeons,

Public Opinion/Midterms

With Vaccines Widely Popular, Kennedy Changes Tone, but Maybe Not His Plans

Several moves suggest Health Secretary Robert F. Kennedy Jr. could revive his campaign to question the safety and effectiveness of the shots after the midterm elections.

Listen · 9:10 min

Share full article

14

Trump to Nominate Doctor Who Has Publicly Supported Vaccines as C.D.C. Director

Dr. Erica Schwartz is seen as a highly q
and tapping her is the strongest signal y
is veering away from vaccine skepticism

Listen · 7:31 min

Questions

HPV Vaccination in 2026: Challenges and Opportunities

Peter G. Szilagyi, MD, MPH

Distinguished Professor & Executive Vice-Chair

Department of Pediatrics

UCLA Mattel Children's Hospital

Pediatric Immunization Information Session
April 23, 2026

David Geffen School of Medicine

UCLA Mattel Children's Hospital

Children's Discovery & Innovation Institute

Disclosure

- In compliance with ACCME Standards for Commercial Support of CME activities
- I have no relevant financial relationships to disclose
- Several slides were provided by the California HPV Vaccination Roundtable Data Workgroup (noted during the presentation)
- No one involved in the planning or presentation of this activity has any relevant financial relationships with a commercial interest to disclose

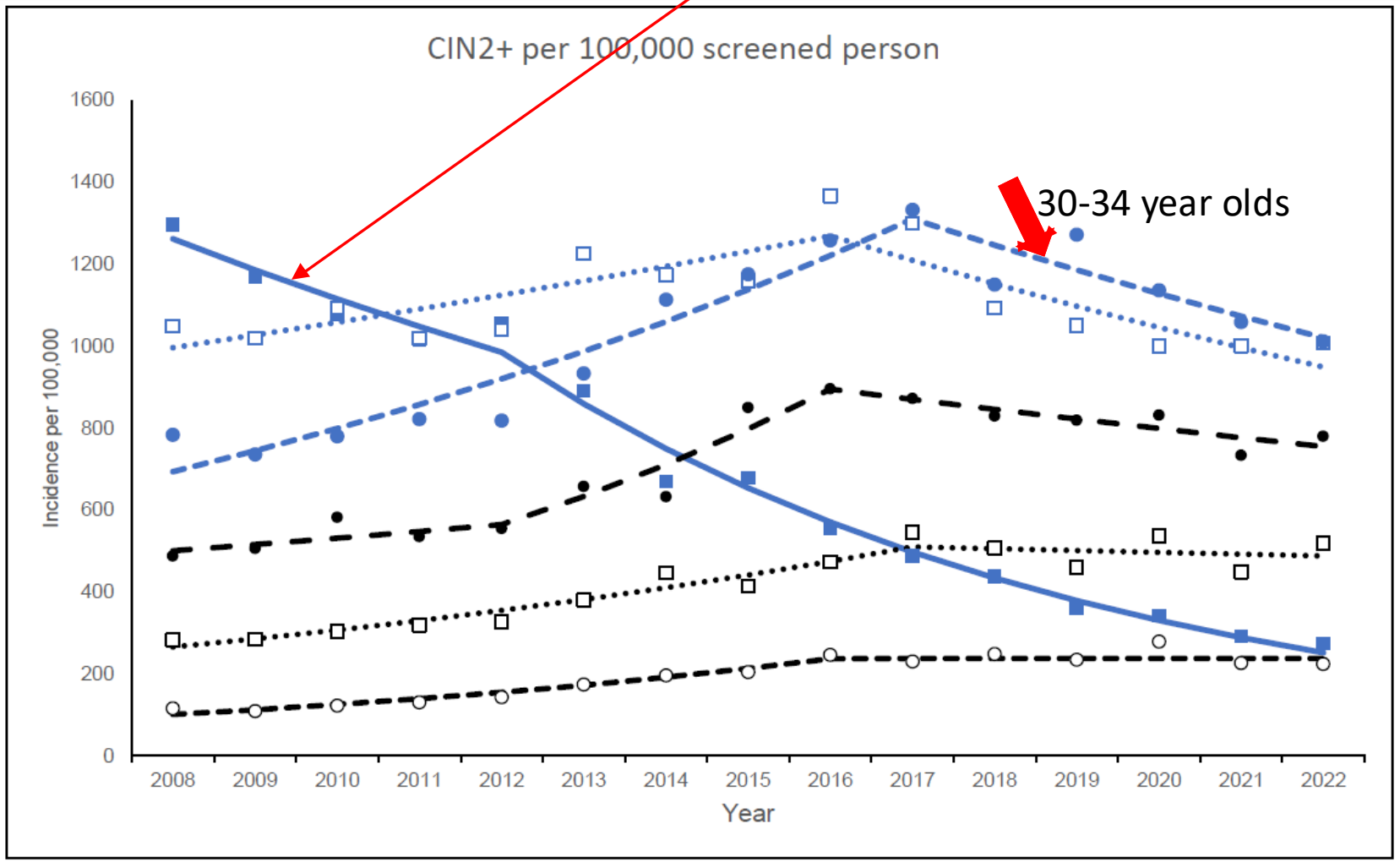
Learning Objectives

1. Impact of HPV Vaccination
2. Latest HPV vaccination uptake data (NIS Teen and CAIR data)
3. How to raise HPV vaccination rates within pediatric practices
    - Improve Communication
    - Improve workflows
4. The HPV Early Intervention Trial (9-10)

HPV vaccine has been shown to be very effective!

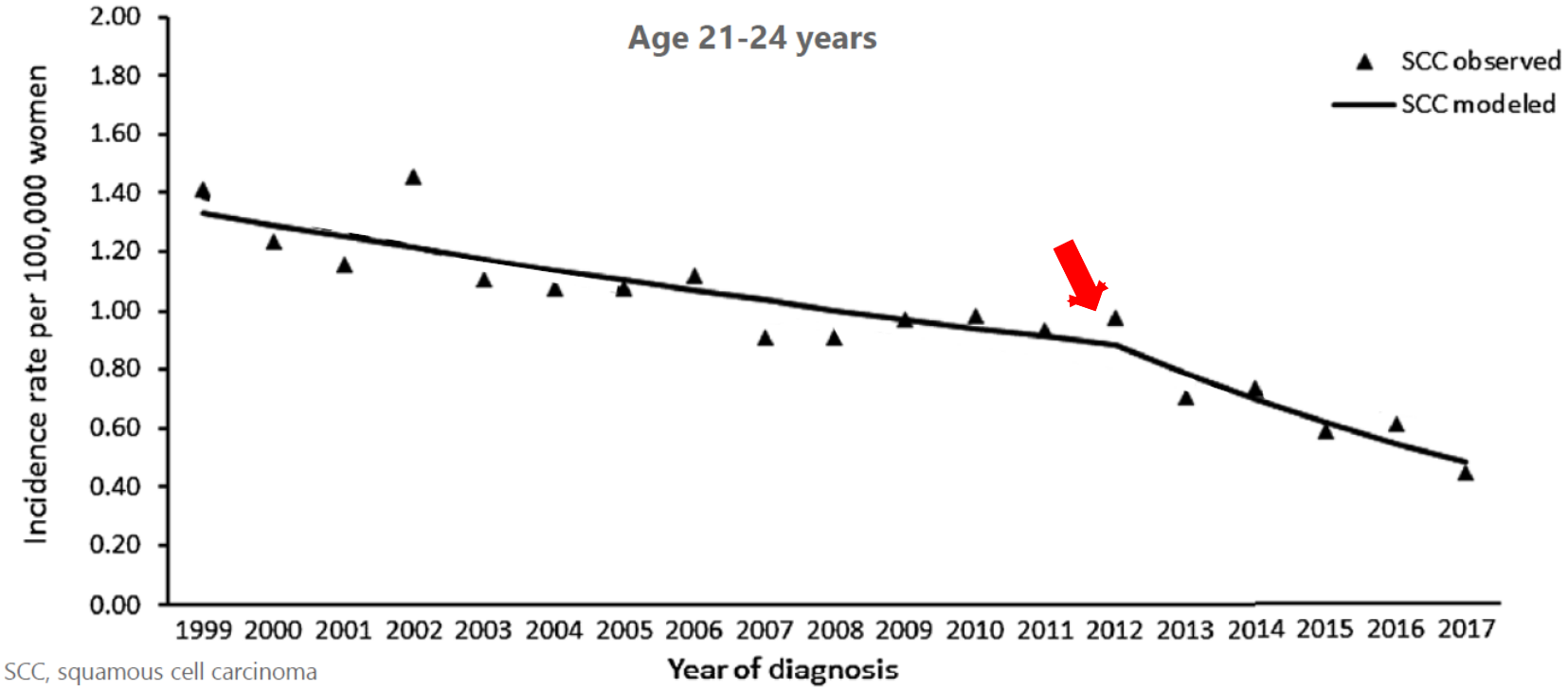
92% of HPV-Attributable cancers can be prevented by HPV vaccination

79% decline in pre-cancerous cervical lesions in 20-24yr olds – eligible for HPV vaccine. No decline among older women.



Gargano et al
MMWR Feb 2025

Cervical cancer trends, United States Cancer Statistics



SCC, squamous cell carcinoma
Mix et al, *Cancer Epidemiol Biomarks Prev*, 2020

29

You only need to vaccinate ≈200 adolescents (compared to not vaccinated) to prevent 1 case of cancer!

Anogenital Warts Prevalence

Flagg et al. Am J Public Health 2017

Impact of HPV Vaccination on Outcomes

- Reduced genital HPV (in both vaccinated and unvaccinated)
- Cervical precancer incidence has declined in young women
- Seeing early impact on invasive cancer
- Unclear about oropharyngeal cancer (early hints of impact)

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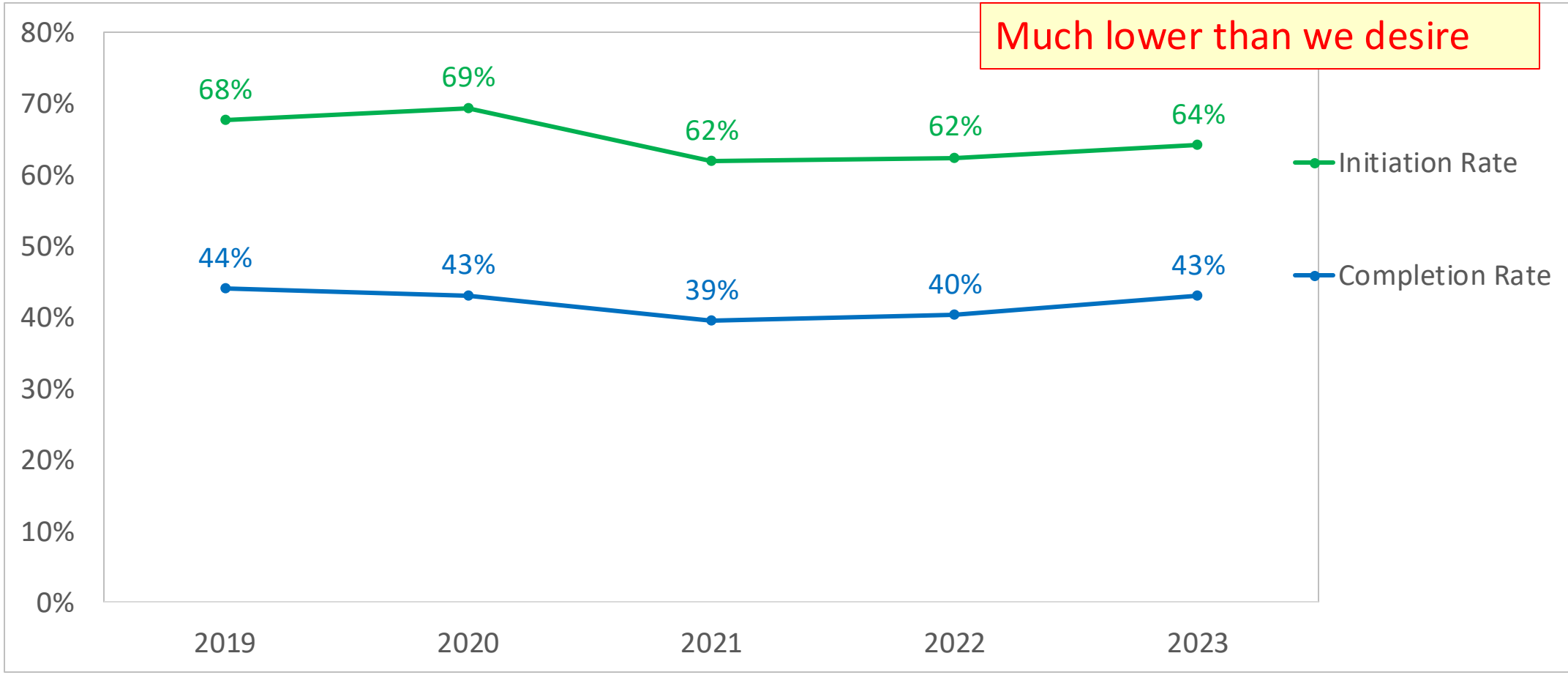
Thank -you!!

HPV Vaccination Data

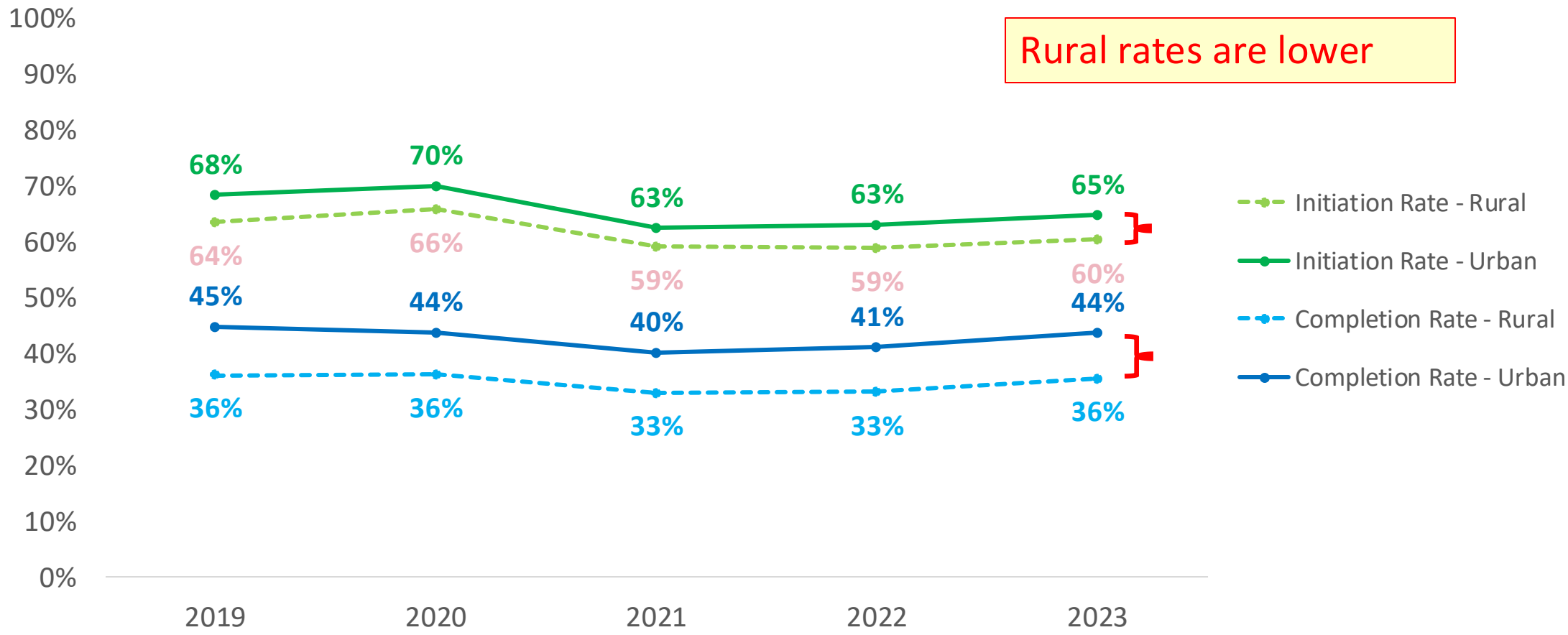
California 2023

Slides provided by CA HPV Vaccination Roundtable's Data Workgroup with collaboration from the CDPH Immunization Branch

Proportion of 13-year-olds initiating and completing HPV vaccine series, CA, 2019-2023 (Source: CAIR)



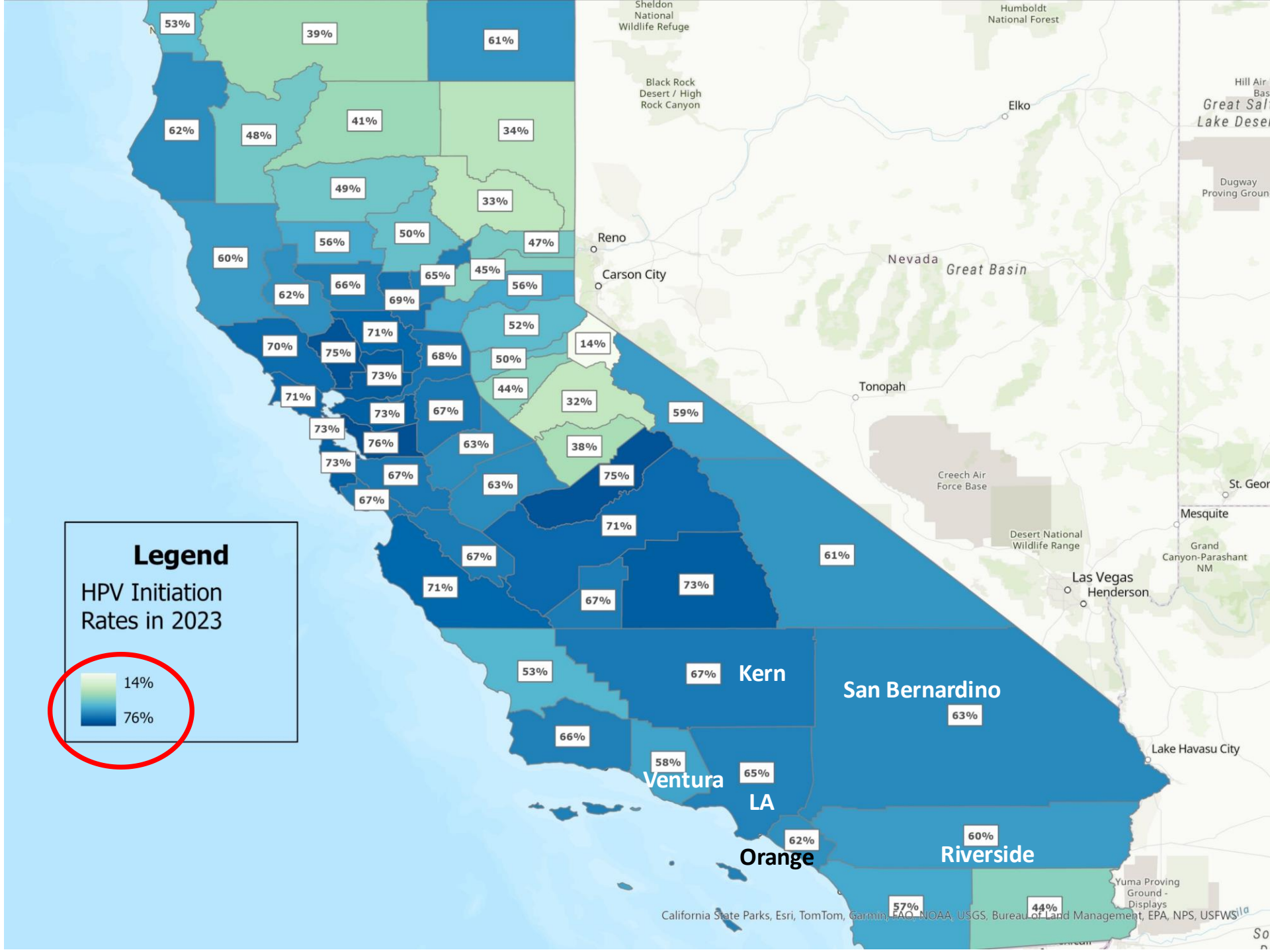
Proportion of 13-year-olds who initiated and completed the HPV vaccine series by urbanicity*, CA, 2019-2023 (Source: CAIR)



*RUCA Codes 1-3 Urban, 4-10 Rural

Proportion of 13-year-olds initiating HPV vaccine series by county, CA, 2023 (Source: CAIR)

Enormous variation by urban/rural
Rural rates are much lower



Summary of HPV Vaccination Data: California

- Rates dipped during COVID-19 but have risen since the pandemic
- Rates are lowest for:
  - Rural areas
  - White adolescents vs other groups
- Rates by age 13 years are much lower than desired
- We need to keep working to raise coverage!

RAISING THE BAR

Learning Objectives

1. Impact of HPV Vaccination
2. The current climate
3. Latest HPV vaccination uptake data (NIS Teen and CAIR data)
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   - Improve Communication
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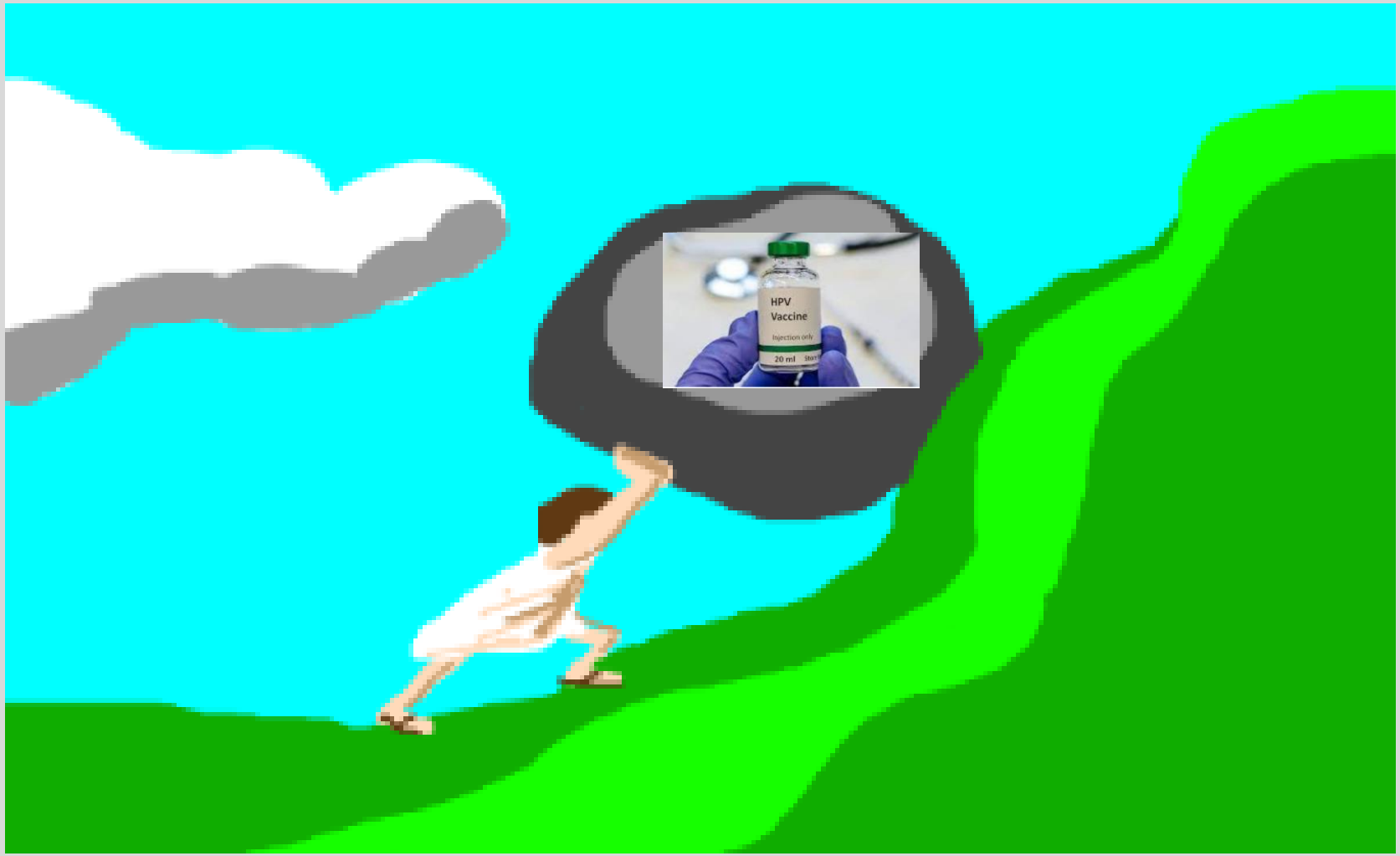
HPV Vaccination



Immunization Barriers Model

Barriers in 2000

Parent/Patient

- Lack of knowledge
- Poor access, costs
- Perceived disease risk
- Vaccine confidence / hesitancy

Clinicians/Staff

- Suboptimal vaccine communication
- Missed vaccination opportunities
- Unaware of low vaccination rates

Health System

- Poor access (costs, convenience)
- No reminders to patients
- No feedback for clinicians

Immunization Barriers Model

Barriers in 2000

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Clinicians/Staff
- Suboptimal vaccine communication
- Missed vaccination opportunities
- Unaware of low vaccination rates

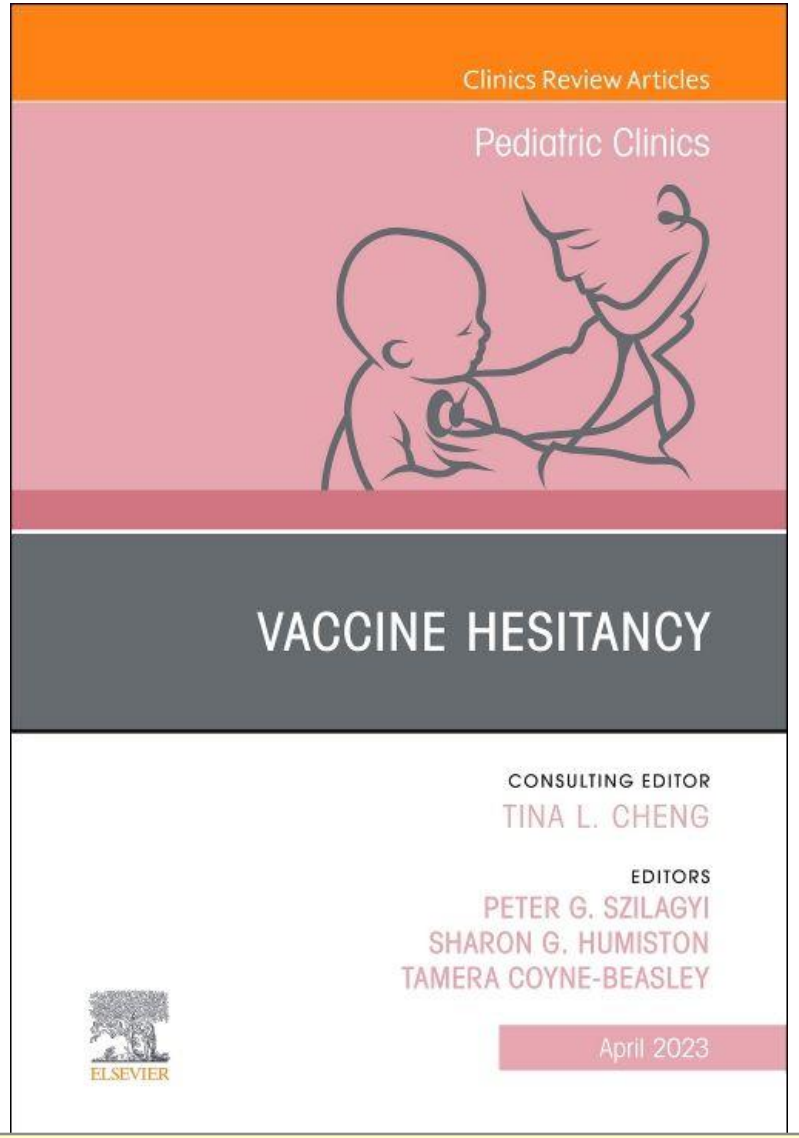
Health System
- Poor access (costs, convenience)
- No reminders to patients
- No feedback for clinicians

Major Barriers Today

Parent/Patient
- Vaccine hesitancy

Clinicians/Staff
- Suboptimal vaccine communication
- Missed vaccination opportunities

Health System
- No/poor feedback for clinicians



14 articles
Available through your institutions for free
Book can be purchased (I do <u>not</u> receive royalties)

Preface

Addressing Vaccine Hesitancy for Child and Adolescent Vaccines: The Next Big Challenge


Peter G. Szilagyi, MD, MPH


Sharon G. Humiston, MD, MPH, FAAP


Tamera Coyne-Beasley, MD

Editors

When safe and effective COVID-19 vaccines were developed, it was easy to imagine that we were at the beginning of an era when everyone would recognize the stunning power of immunization to prevent illness and death from infections and to reduce societal costs. Vaccine hesitancy would be replaced by tickertape parades for everyone essential to vaccination—from the scientists who develop vaccines to the health care providers in public health, medical offices, and pharmacies who translate the scientific developments to practical protection. Antivaccine forces would lose their power as people recognized that COVID-19 vaccination saved millions of lives worldwide in the first year of use, just as smallpox, polio, measles, influenza, and pneumococcal vaccines, to specify a few, have drastically reduced morbidity and mortality from these scourges.

That, however, is not what happened. Vaccine hesitancy ...

We have studied two types of interventions to raise HPV vaccination rates

Address vaccine hesitancy- by training clinicians and nurses on optimal communication

Since pediatricians and nurses are the most trusted sources of vaccine information

Optimize workflows within the practice

Since most HPV vaccinations are given in pediatric practices

Four sequential Interventions

Each intervention was 6-months duration

Intervention #2 Interrupted by pandemic

Funded by NIH

All 4 improved HPV vaccination to some extent!

1. Online Communication Skills Training (RCT)
2. Performance Feedback Reports (RCT)
3. Nurse and EHR Prompts (RCT)
4. Bundle: 3 interventions implemented together (Pre-post plus 48 comparison practices)

Addressed Vaccine hesitancy

Addressed workflow and office procedures

All 4 interventions also included weekly quick tips delivered via text or email

Grand Summary
Impact of the 4 interventions

Intervention	Impact on Captured Opportunities for HPV Vaccination		Journal
	At WCC Visits	Acute and Chronic Visits	
Communication Training			
Covid-19 Pandemic			
Performance Feedback			
Prompts			
Bundle			

Grand Summary
Impact of the 4 interventions

Interventions #1 - #4	Impact on Captured Opportunities for HPV Vaccination		Journal
	At WCC Visits	Acute and Chronic Visits	
Communication Training	+6.8% points for HPV vax initiation +2.5% points for subsequent (NS)	No impact (initial or subsequent)	*JAMA Peds* 2021
Covid-19 Pandemic			
Performance Feedback			
Prompts			
Bundle			

Grand Summary
Impact of the 4 interventions

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	At WCC Visits	Acute and Chronic Visits	
Communication Training	+6.8% points for initiation +2.5% points for subsequent (NS)	No impact (initial or subsequent)	*JAMA Peds* 2021
Covid-19 Pandemic			
Performance Feedback	Backsliding in WCC initiation (-4.2%) No impact on WCC subsequent	No impact (initial) +3.5% point for subsequent	*Acad Peds* 2023
Prompts			
Bundle			

Grand Summary
Impact of the 4 interventions

Intervention #1 - #4	Impact on Captured Opportunities for HPV Vaccination		Journal
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Prompts	+4.5% points for initiation No impact on WCC subsequent	No impact (initial or subsequent)	*Acad Peds* 2023
Bundle			

Grand Summary: STOP-HPV Impact of the 4 interventions

Intervention #1 - #4	Impact on Captured Opportunities for HPV Vaccination		Journal
	At WCC Visits	Acute and Chronic Visits	
Communication Training 2019	+6.8% points for initiation +2.5% points for subsequent (NS)	No impact (initial or subsequent)	*JAMA Peds* 2021
Covid-19 Pandemic			
Performance Feedback 2021	Backsliding in WCC initiation (-4.2%) No impact on WCC subsequent	No impact (initial) +3.5% point for subsequent	*Acad Peds* 2023
Prompts 2021	+4.5% points for initiation No impact on WCC subsequent	No impact (initial or subsequent)	*Acad Peds* 2024
Bundle 2022	+4.8% points for initiation +2.2% points for subsequent (borderline significance)	No impact (initial or subsequent)	*Pediatrics* 2025

More parental hesitancy by this time

Summary (so far)

- HPV vaccine is incredibly effective, but vaccination rates are low
- The three major causes are:
  - Parental vaccine hesitancy
  - Suboptimal provider workflows
  - Systems not providing actionable feedback
- We have shown that several interventions work to raise HPV vaccination rates, and are feasible and relatively low cost to implement:
  - Communication training
  - Feedback to clinicians
  - Prompts for nurses/MAs
  - A bundle
- Do “something”

Learning Objectives

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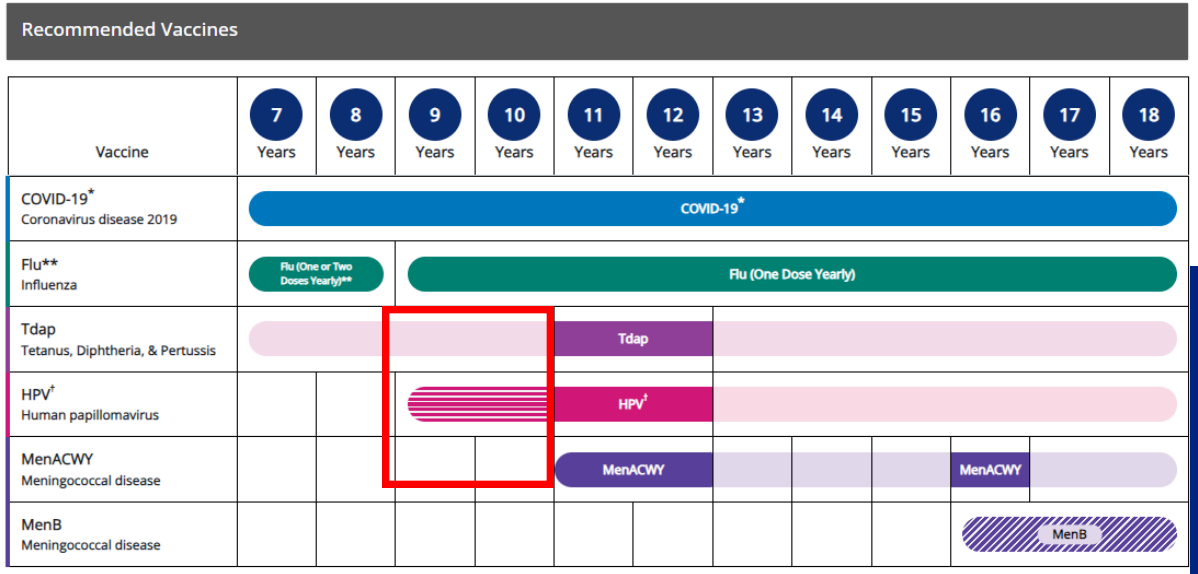
ACIP & AAP Recommendations for HPV Vaccine (ACS Recommendations on next slide)

ACIP



CDC recommends routine vaccination of preteens at ages 11 or 12 years. The vaccination series can be started at age 9 years.

AAP

"…all adolescents starting between age 9 and 12 years, at an age that the provider deems optimal for acceptance and completion of the vaccination series"

AAP Recommendations

The AAP recommends routine HPV vaccination for all adolescents starting between age 9 and 12 years, at an age that the provider deems optimal for acceptance and completion of the vaccination series.

- AAP News: **Why AAP recommends initiating HPV vaccination at age 9 through 12 years**
- AAP Red Book Chapter: **Human Papillomaviruses**
- Clinical Report: **The Need to Optimize Adolescent Immunization**

The difference between ACIP and AAP is nuanced

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HPV Vaccination Starting at Age 9

Created 17 Feb 2023 | Updated 19 Dec 2023 | 22 articles

Share

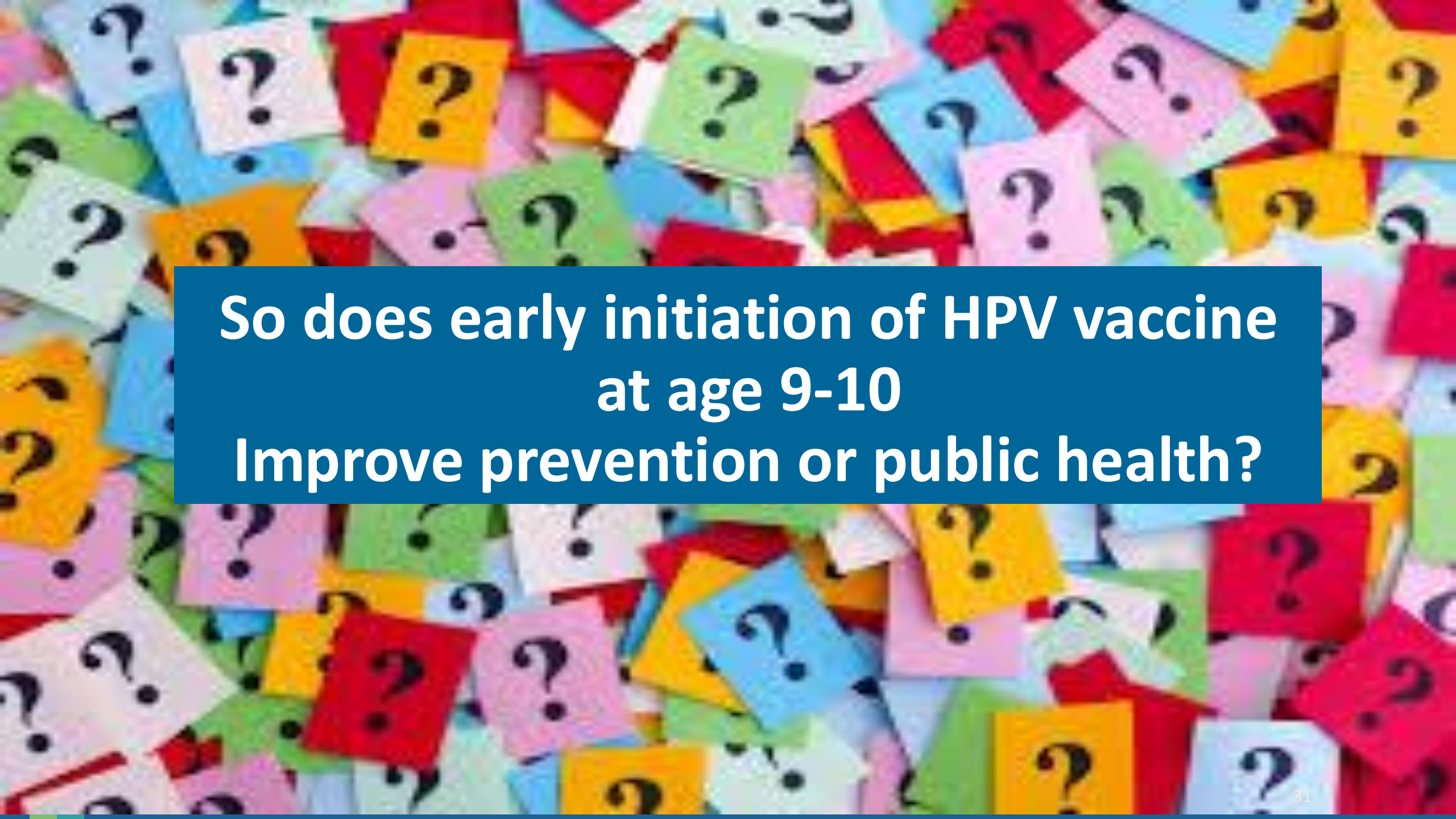
HPV vaccination has the potential to dramatically reduce rates of cervical, oropharyngeal, vaginal, vulvar, anal, and penile cancers. However, HPV vaccination rates in the US lag behind other countries, and HPV vaccine has lower coverage than other adolescent vaccines. Initiation of the vaccine series at ages 9-10 has been suggested as a way to improve vaccination utilization and increase the number of adolescents who complete their series on time. This Collection presents original research on the impact of initiating HPV vaccination at ages 9-10, including population studies and quality improvement projects, as well as commentaries from medical organizations and leading experts in the field.

Edited by

Rebecca Perkins *(Boston University Chobanian and Avedisian School of Medicine/ Boston Medical Center)*

Kristin Oliver *(Departments of Environmental Medicine & Public Health, Pediatrics Icahn School of Medicine at Mount Sinai)*

Sharon Humiston *(Department of Pediatrics, Division of Urgent Care, Children's Mercy Kansas City; Professor of Pediatrics, UMKC)*


So does early initiation of HPV vaccine
at age 9-10
Improve prevention or public health?

Reasons to recommend HPV vaccine at age 9-10

- Vaccination coverage remains suboptimal
- More opportunities to vaccinate by age 13 or before exposure
- Spreads out # shots (fewer at age 11…Tdap, MenACWY, HPV, Influenza)
- Missed vaccinations at 11-12yrs are usually HPV or influenza vaccine
- Immune response is robust by ages 9-12
- Antibody levels appear to plateau for a long time (some think forever)

ACCORDS

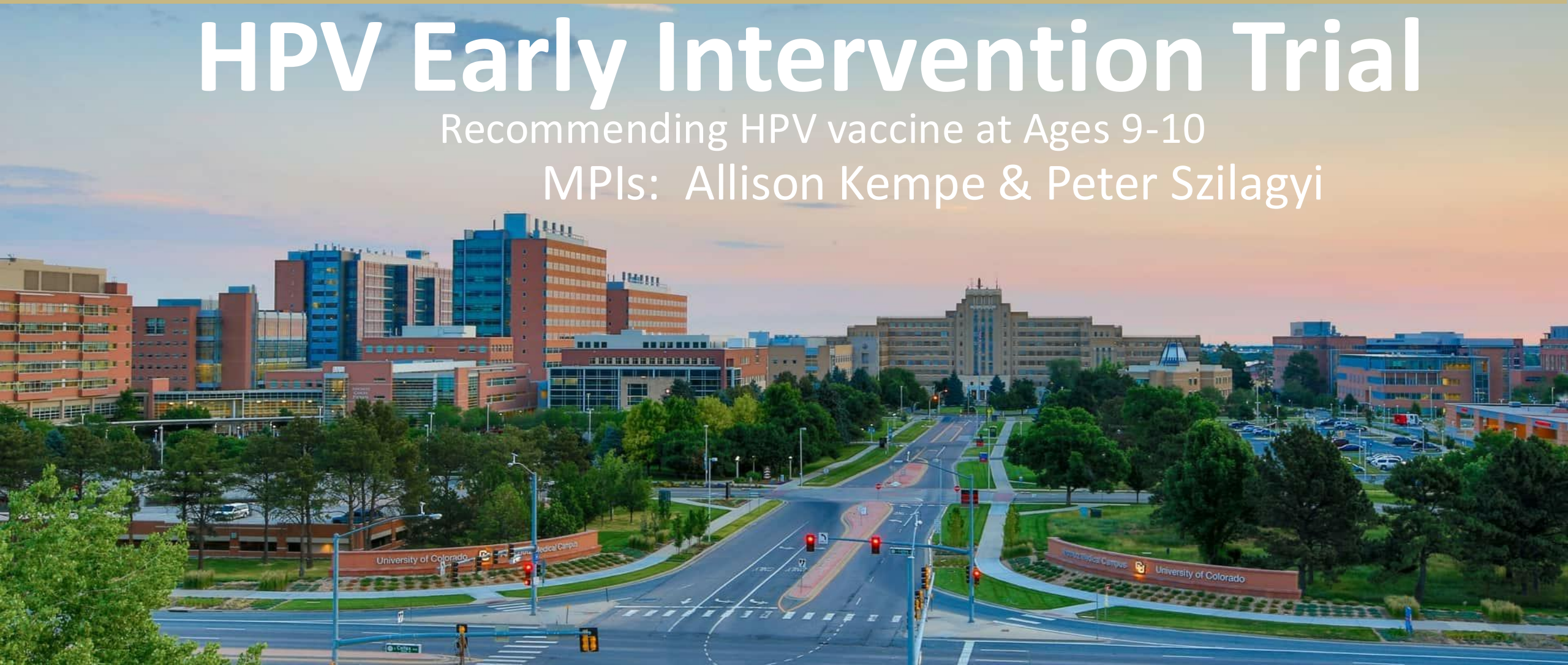
ADULT AND CHILD CENTER FOR OUTCOMES RESEARCH AND DELIVERY SCIENCE

UNIVERSITY OF COLORADO
CHILDREN'S HOSPITAL COLORADO

HPV Early Intervention Trial

Recommending HPV vaccine at Ages 9-10

MPIs: Allison Kempe & Peter Szilagyi



Specific Aims

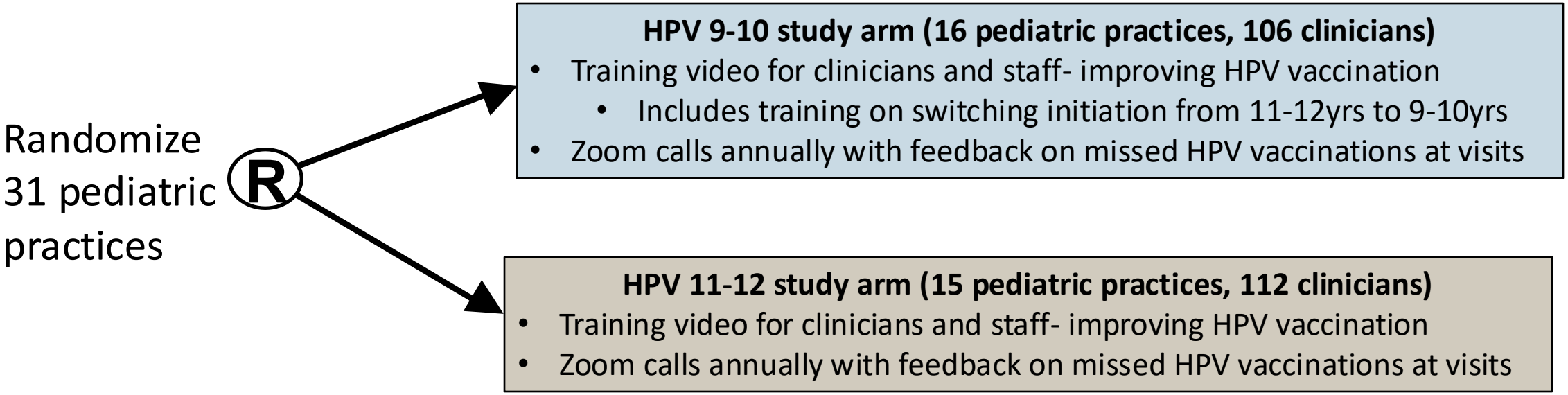
1. Recruit representative practices in Colorado and California, randomize to initiation at 9-10yrs or 11-12yrs, and provide training on improving HPV vaccination

2. Conduct a cluster randomized trial, comparing HPV 9-10 vs HPV 11-12 initiation. Assess (by EHR):
   - Series Completion (1°)
   - Series initiation (2°)
   - Completion by 13 years (2°)

3. Assess implementation outcomes (by Surveys every 6 months, also interviews after 1yr)
   - Fidelity to the intervention
   - HPV vaccine discussion times and content
   - Feasibility and acceptability
   - Effect on parental acceptance

Earliest Date for outcomes: Interviews and Surveys (completed)
EHR analyses -completion by 13yrs- Summer 2026

Study Design



Training (by online video):
Improving clinician communication (value of vaccination, answering common questions)
Workflow enhancements (nurse prompts for vaccination, vaccinating at acute visits)
Annual training boosters for new clinicians and office staff
Posters for waiting room or exam room- Adolescent vaccination schedule (either 11-12 or 9-10yrs)

Training times were the same for both study arms
The only difference was asking 9-10 arm practices to initiate HPV vaccination at ages 9-10

Timeline for Outcomes

Now (from Surveys & Interviews)

- Feasibility and Acceptability
- Discussion time and content
- Ability to convince parents

Summer/Fall of 2026

- Impact on completion/initiation by 13 yrs
- Average age of completion/initiation

Interviews of clinicians

Methods:

- Interviews of the HPV 9-10 study arm
- 18 clinicians, 17 office staff
- 3 months following start of study

Findings:

- Many parents were receptive to vaccination at 9-10yrs
- Pushback often stemmed from expectation of shot-free visit
- Discussions at 9-10 appeared shorter (sexual activity not as salient)
- Spaced out vaccinations

Feasibility and Acceptability of Recommending HPV Vaccine at Ages 9–10 Years *Pediatrics, 2025*

Caroline K. Tietbohl, PhD,[1,2] Dennis Gurfinkel, MPH,[1] Danielle Duran, MA,[1] Alison Saville, MSPH, MSW,[1] Emma Clark, MSc,[3] Sean O'Leary, MD, MPH,[1,4] Christina Albertin, BSN, MPH,[3] Brenda Beaty, MSPH,[1] Sitaram Vangala, MS,[3] Peter G. Szilagyi, MD, MPH,[3,5] Allison Kempe, MD, MPH[1,4]

Surveys of clinicians

Methods

- Email survey of all clinicians in both study arms (HPV 9-10 and HPV 11-12)
- At 1, 6, 12, 16, 24 , 30 and 36 months
- Questions about:
  - -Age of initiation (fidelity to study arm)
  - -Reasons if initiation not per protocol
  - -Factors affecting HPV vaccination
  - -Changes in factors at 9-10 (for that arm)
  - -Discussion of sexual activity
  - -Parental hesitancy
  - -Discussion time

Findings

- Almost all HPV 9-10 study arm clinicians switched rapidly from 11-12 to 9-10
- Parental concerns, questions, pushback, hesitancy, and adherence did not differ between study arms
- Parents still raised sexual activity at age 9-10
- Similar rate of ability to convince parents
- Discussion times were shorter for HPV 9-10

Clinician Perceptions of the Acceptability of Switching HPV Vaccine Initiation to Ages 9-10

Pediatrics, 2026

Peter G Szilagyi, MD MPH,[1*] Dennis Gurfinkel, MPH,[1,2] Emma Clark, MSc,[1] Christina Albertin, BSN MPH,[1] Alison Saville, MSPH MSW,[1,3] Sean T. O'Leary, MD MPH,[2,3] Brenda Beaty, MSPH[1], Sitaram Vangala, MS,[4] Heide Woo MD,[1] Charles Golden DO,[5] Jasjit Singh MD,[5] Allison Kempe, MD MPH[2,3*]

At what age do you routinely initiate HPV vaccination?

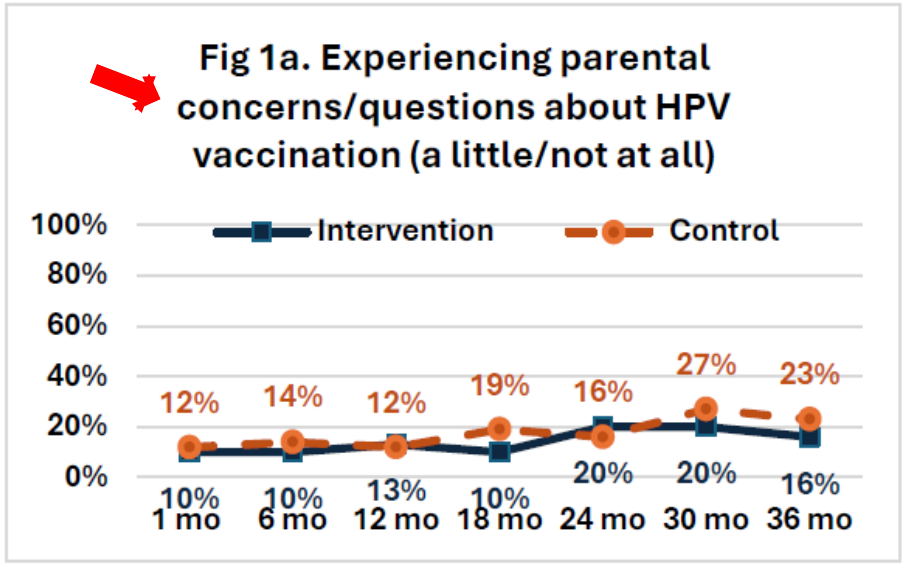
Age at which clinicians begin routinely recommending the first dose of HPV vaccine							
Survey	**1 month**	**6 months**	**12 months**	**18 months**	**24 Months**	**30 months**	**36 months**
Intervention Arm (HPV 9-10)							
N (Response %)	**106/117 (91%)**	**101/117 (86%)**	**103/114 (90%)**	**106/117 (91%)**	**98/116 (84%)**	**105/115 (91%)**	**104/117 (89%)**
9 years	84 (79%)	91 (90%)	95 (92%)	98 (92%)	92 (94%)	100 (95%)	99 (95%)
10 years	5 (5%)	6 (6%)	4 (4%)	5 (5%)	4 (4%)	3 (3%)	5 (5%)
11 years	17 (16%)	4 (4%)	4 (4%)	3 (3%)	2 (2%)	2 (2%)	0
12 years	0	0	0	0	0	0	0
13 years	0	0	0	0	0	0	0
Control Arm (HPV 11-12)							
N (Response %)	**113/131 (86%)**	**109/131 (83%)**	**100/127 (79%)**	**116/129 (90%)**	**118/137 (86%)**	**121/136 (89%)**	**128/138 (93%)**
9 years	1 (1%)	1 (1%)	1 (1%)	1 (1%)	4 (3%)	3 (2%)	5 (4%)
10 years	2 (2%)	1 (1%)	4 (4%)	1 (1%)	5 (4%)	3 (2%)	6 (5%)
11 years	105 (93%)	101 (93%)	94 (94%)	111 (96%)	107 (91%)	111 (92%)	113 (88%)
12 years	5 (4%)	6 (6%)	1 (1%)	3 (3%)	2 (2%)	3 (2%)	4 (3%)
13 years	0	0	0	0	0	1 (%)	0

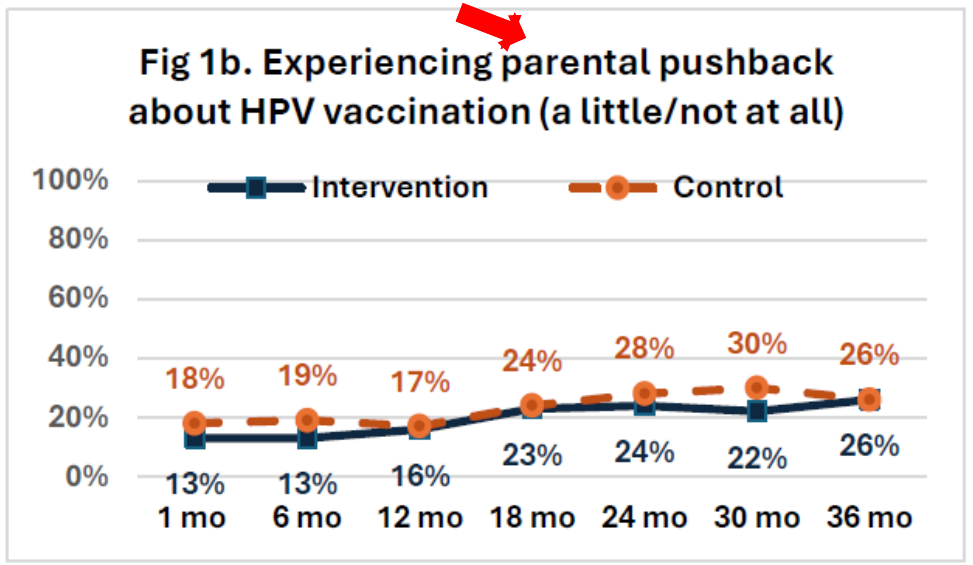
Almost all clinicians switched within 1 month to 9-10yrs

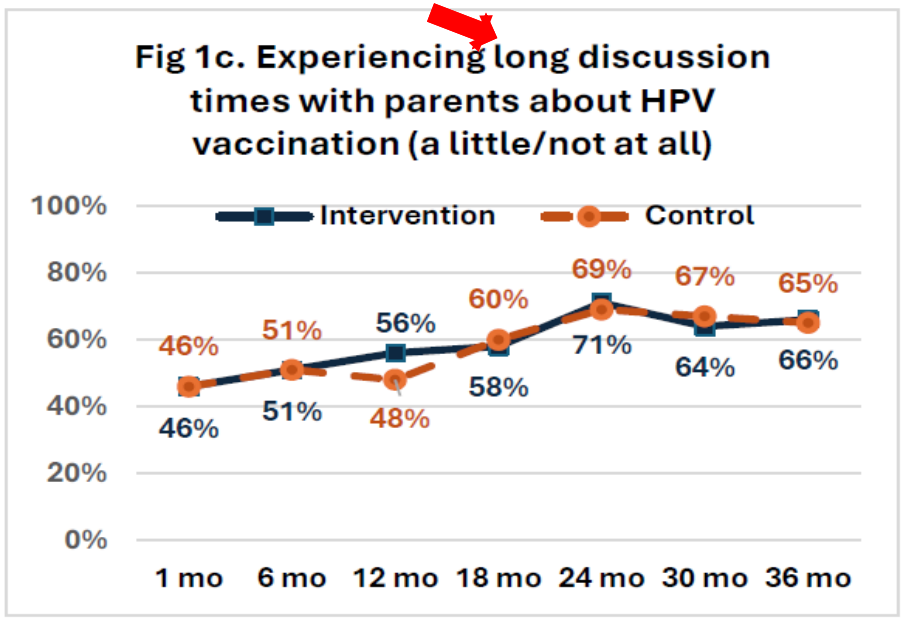
So switching to 9-10 can be done quickly

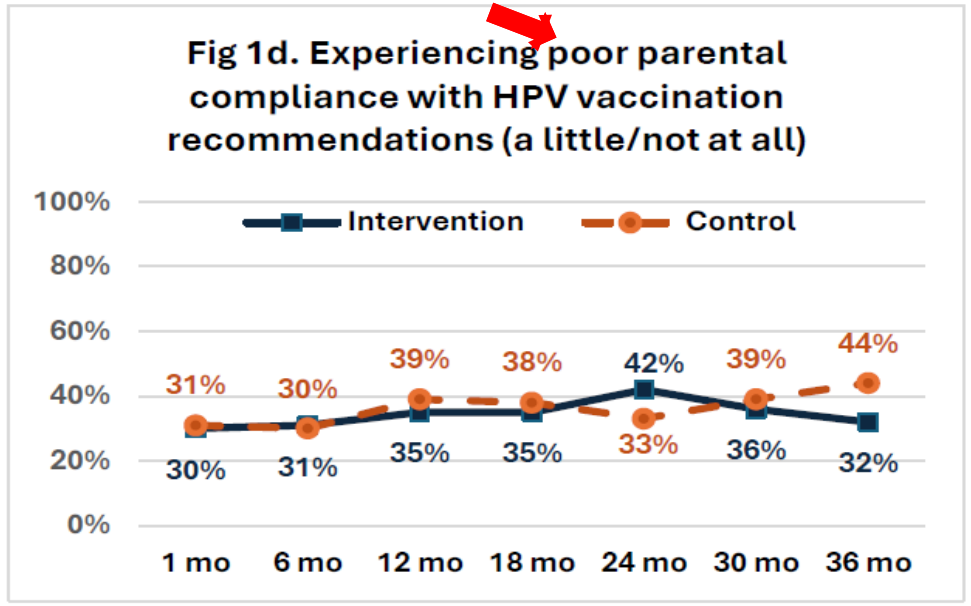
Almost all control clinicians remained at 11-12 yrs

Factors affecting HPV vaccine initiation





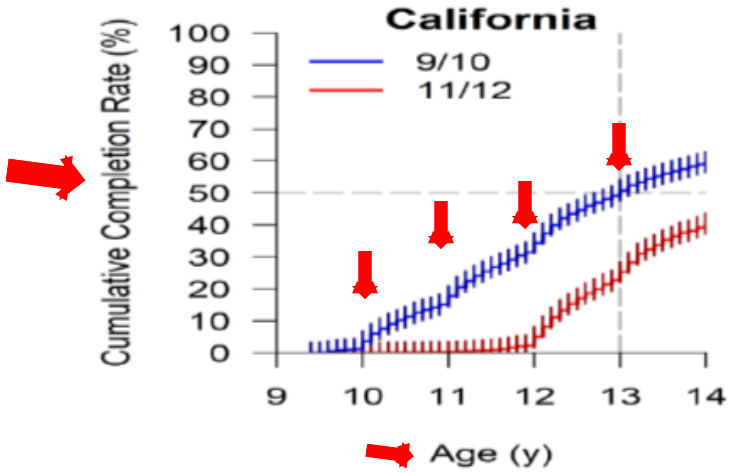




Findings are the same In both arms

So hesitancy may not be different at ages 9-10 versus 11-12

PRELIMINARY findings
Not to be Shared (only partial data)



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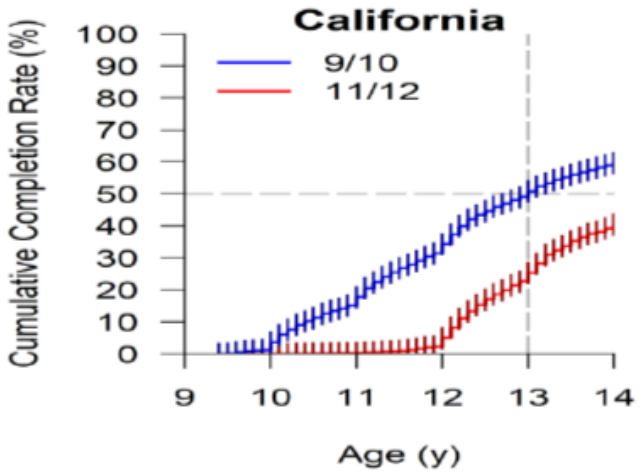

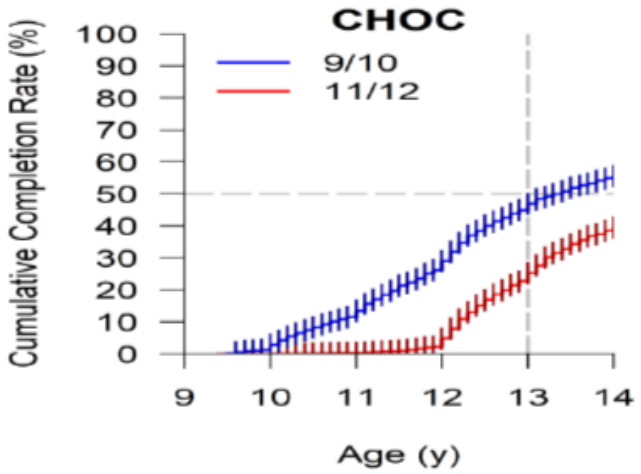

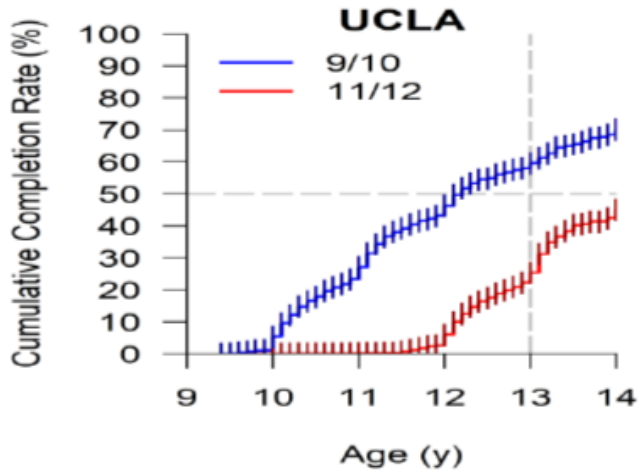

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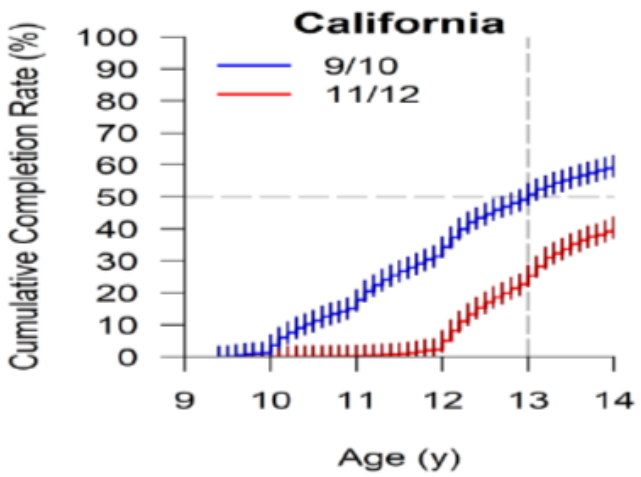

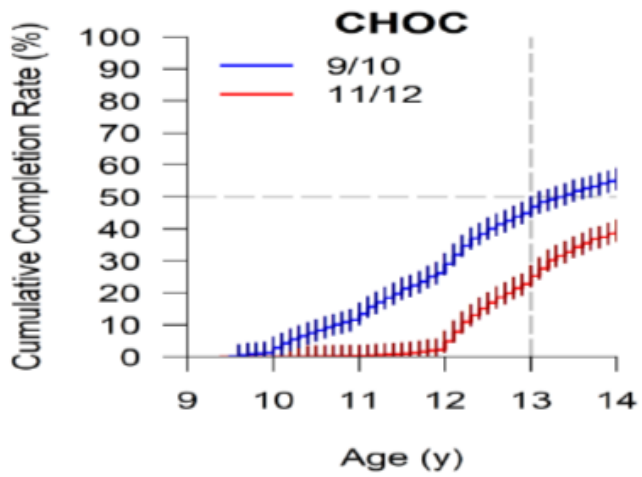

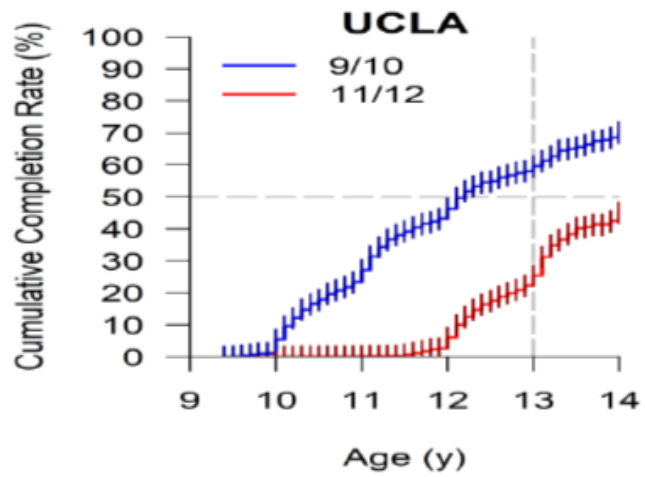

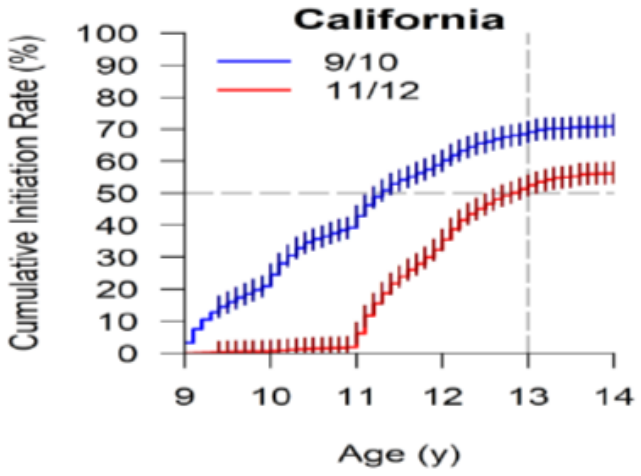

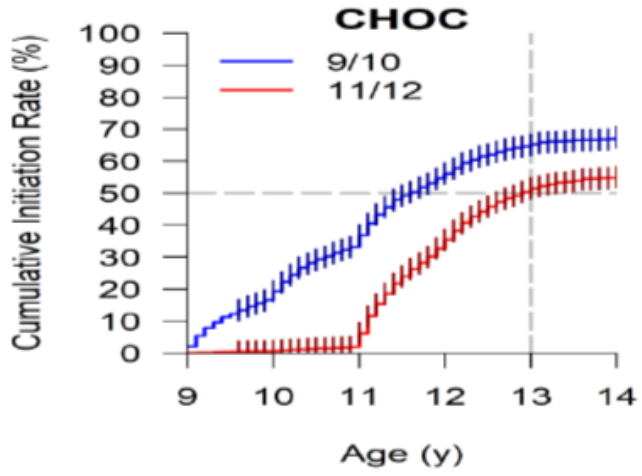

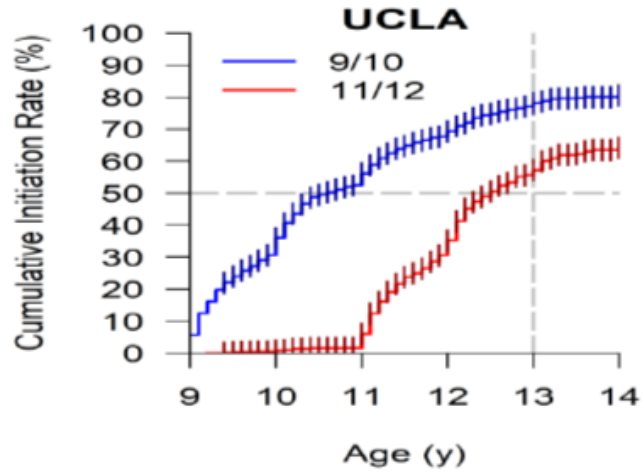

Summary of Findings: The HPV Early Intervention Trial (9-10)

SUMMARY

- Parents are receptive to initiation at ages 9-10
- Parental concerns, questions, pushback, hesitancy, adherence are not different
- Parents still raise sexual activity during discussions at ages 9-10

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- Early initiation does not change clinician perceptions of - able to convince parents
- Discussion times were shorter when initiating at 9-10 versus at 11-12yrs
- If switching to early initiation, we need to prepare parents and staff
- Early initiation does not change the patient-provider relationship

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- Discussion times were shorter when initiating at 9-10 versus at 11-12yrs
- If switching to early initiation, we need to prepare parents and staff
- Early initiation does not change the patient-provider relationship
- PRELIMINARY findings from California- Early initiation improves:
    - Initiation by age 13
    - Completion by age 13

We need to wait till mid-2026 for final results

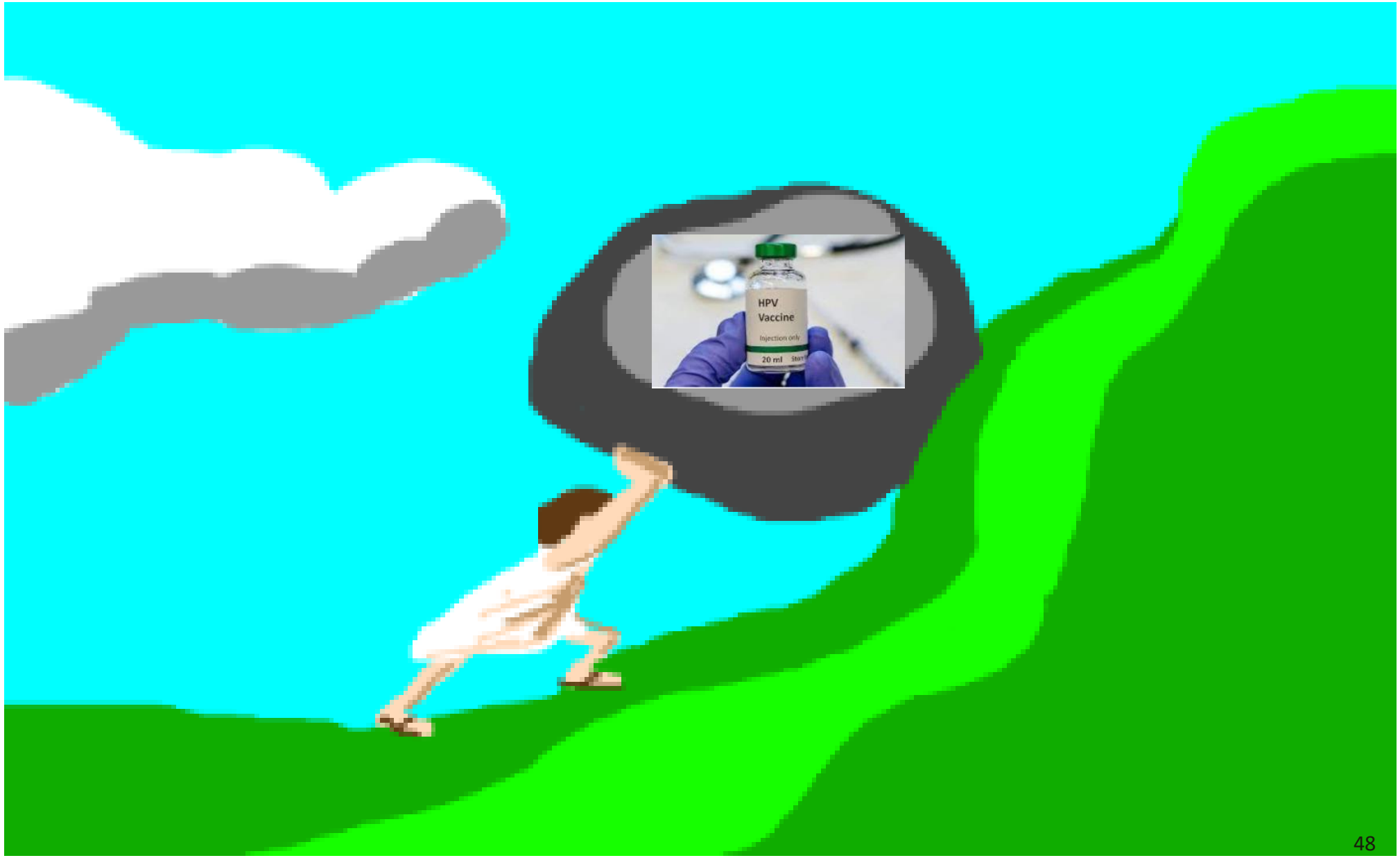
Grand Summary – 10 Points

1) HPV infection remains a major public health threat
2) The current federal climate is concerning, ACIP has changed-so it's up to us!
3) HPV vaccination rates are high but still suboptimal in CA
4) Disparities exist in HPV vaccine coverage (especially rural/urban)
5) HPV vaccine hesitancy is a big threat to optimal rates
6) Two office strategies can work… (a) Communication and (b) Workflows
7) Multi-component interventions may be the most effective
8) HPV 9-10 initiation is promising- doesn't change parental concerns or pushbacks or Dr.-Pt. relationship but shortens vaccine discussion times
9) Findings on impact of HPV 9-10 will come soon

Wait– this was only 9 updates!!!

Point #10

HPV Vaccination can feel like this



Point #10

Measles Situational Update & Preparing for Measles in the Pediatric Setting

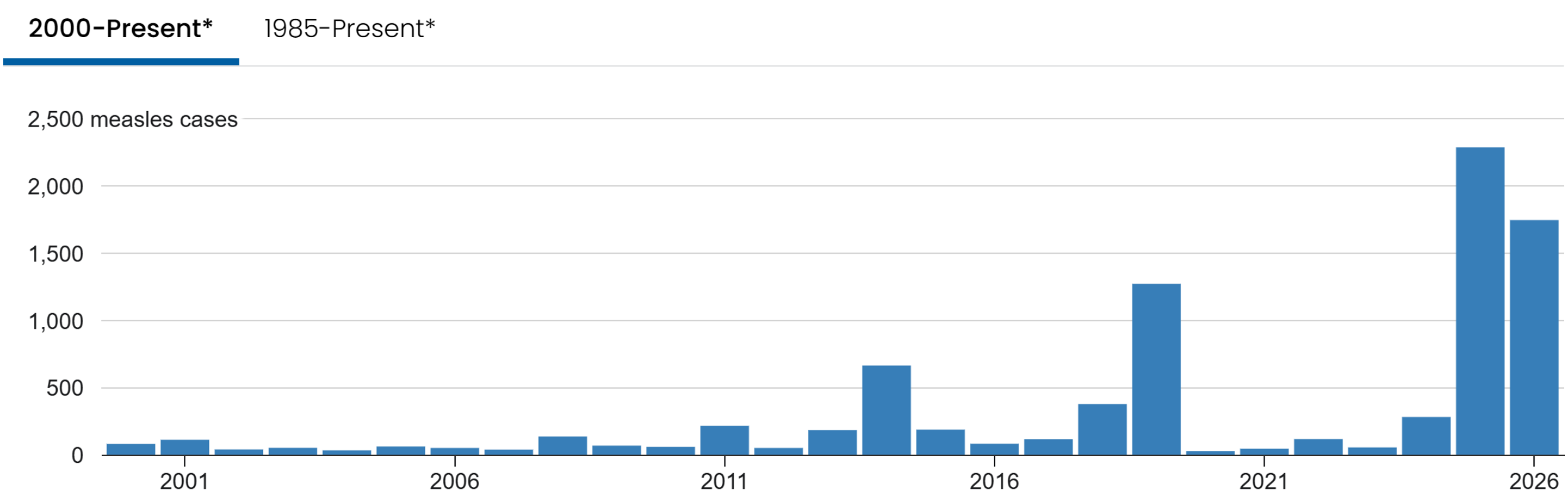
Faith Washburn, MPH
Vaccine Preventable Disease Control Program

Outline

- Measles Situational Update
- Measles Clinical Summary
- Preparing Your Pediatric Facility for Measles
- Our Patient was Confirmed, What Now?

Measles Situational Update

Annual Measles Cases in the United States



Source: https://www.cdc.gov/measles/data-research/index.html
Accessed 04/21/26

Measles Cases are on the rise

Total U.S. measles cases in 2025: 2,288

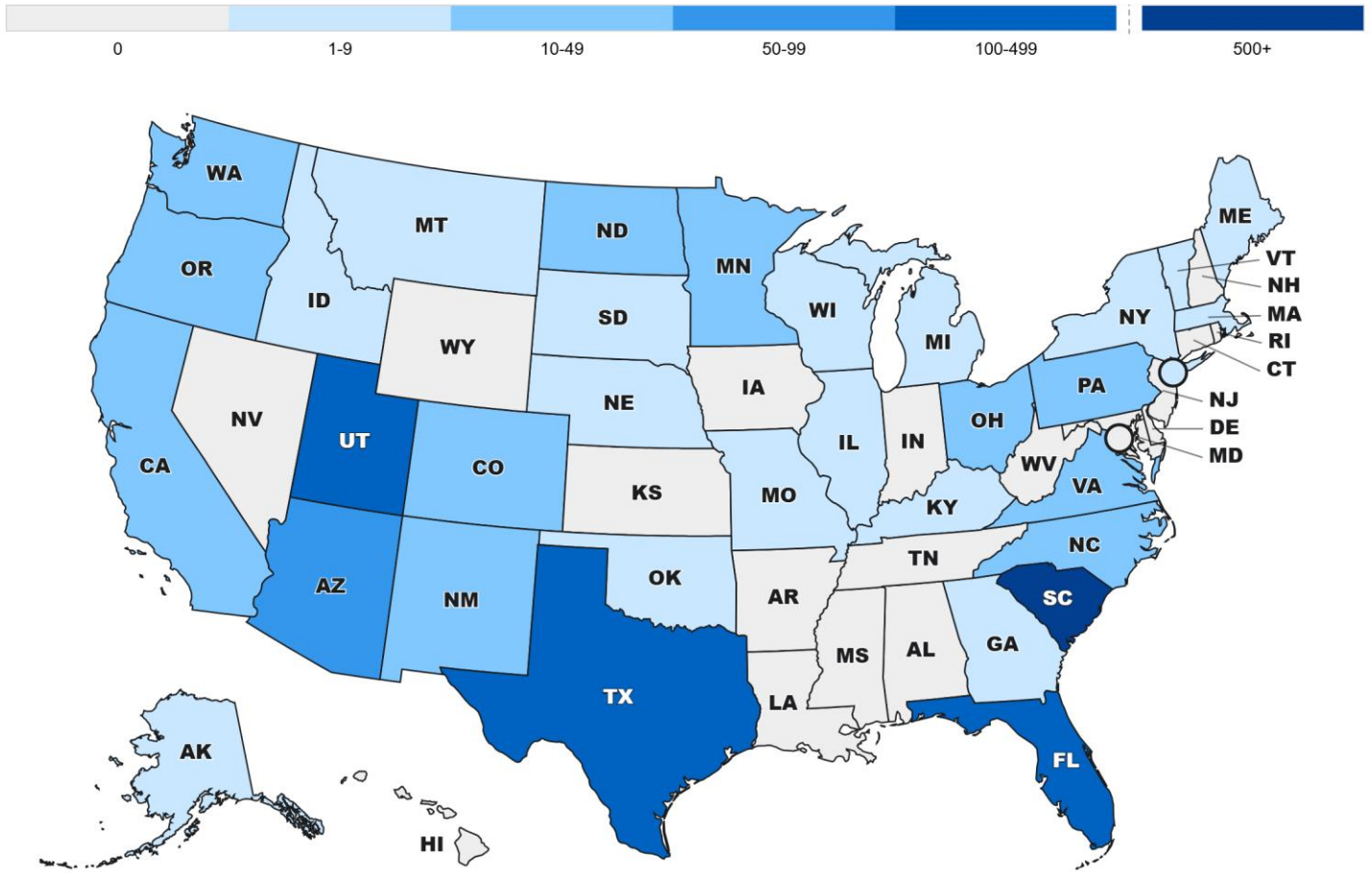
U.S. measles cases by mid-April 2026: 1,748

Source: https://www.cdc.gov/measles/data-research/index.html
Accessed 04/21/26

Map of measles cases among U.S. residents

as of April 16, 2026

2026 | 2025 | 2024



Source: https://www.cdc.gov/measles/data-research/index.html
Accessed 04/21/26

Measles Cases in California and Los Angeles County

- **2025: 25 confirmed** cases in CA
  - **7** LA County cases
- **Jan-Apr 2026: 43 confirmed** cases in CA
  - **4** LA County cases

NEWS RELEASE

313 N. Figueroa Street, Room 806 | Los A

media@ph.lacounty.gov

For Immediate Release:

January 30, 2026

Public Health Confirms First 2026 Measles Cas - Community urged to ensure immunity before

The Los Angeles County Department of Public Health has confirmed a case of measles in internationally. This is the first confirmed case of measles in 2026 among Los Angeles Co

There are no identified public exposure locations in Los Angeles County outside of a hea fac

January 31, 2026

had **Public Health Confirms Second 2026 Measles**

The Los Angeles County Department of Public Health is investigating a confirmed case who was infectious while traveling through Los Angeles International Airport (LAX), at l healthcare settings in Los Angeles County.

This traveler arrived on Viva Aerobus Flight #518 at the Tom Bradley International Airpo

Individuals who were at Terminal B from 10:45 p.m. on January 26 to 1 a.m. on January

In collaboration with the Centers for Disease Control and Prevention (CDC), passengers seated near the infected traveler will be notifie by their respective local health departments. The CDC and local public health departments routinely work together to investigate communicable disease exposures on international flights to the United States.

Additionally, individuals who were at the following location on the specified dates and times may be at risk of developing measles due to exposure to this case:

- January 30, 2026 - Dunkin' Donuts, 22020 Ventura Blvd., Woodland Hills, 91364, 3 p.m. to 4:45 p.m.

February 19, 2026

Public Health Confirms Measles Case in LA County - Public Advised to Take Preventive Steps and Ensure Measles Protection

The Los Angeles County Department of Public Health is investigating a confirmed case of measles in a resident who recently traveled internationally and visited several LA County public locations while infectious. This is the **fourth case** of measles reported by Public Health in 2026.

precautions

The Los Angeles County Department of Public Health is investigating a confirmed case of measles in a resident who recently traveled internationally and visited at least one public location in LA County while infectious. This is the **third case** of measles reported by Public Health in the past week; the cases are not related.

As measles outbreaks continue to occur both in the United States and internationally, Public Health urges everyone in LA County to ensure they are fully protected from measles before traveling and take recommended precautions.

Individuals who were at the following location on the specified date and time may be at risk of developing measles due to exposure to this case:

· January 24, 2026 - Mardi Gras Tuesday restaurant, 14543 Ventura Blvd., Sherman Oaks, CA 91403, 11:30 a.m. to 2:30 p.m.

People who were at this location during the date and time listed above may be at risk of developing measles from 7 to 21 days after being exposed. These individuals should confirm their protection against measles. Those who have had measles in the past or received the recommended measles vaccine are likely protected, but should still monitor for symptoms. People who are unimmunized or have unknown measles immunization status are at higher risk and should monitor for symptoms closely. Anyone who remains symptom-free for more than 21 days after being exposed is no longer considered at risk.

· For those exposed at Mardi Gras Tuesday, the last day to monitor for symptoms is February 14.

Affected healthcare facilities are directly notifying patients and staff who may have been exposed.

Source:
https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Immunization/measles.aspx
Accessed 04/21/26

Measles Clinical Summary

Measles is HIGHLY contagious

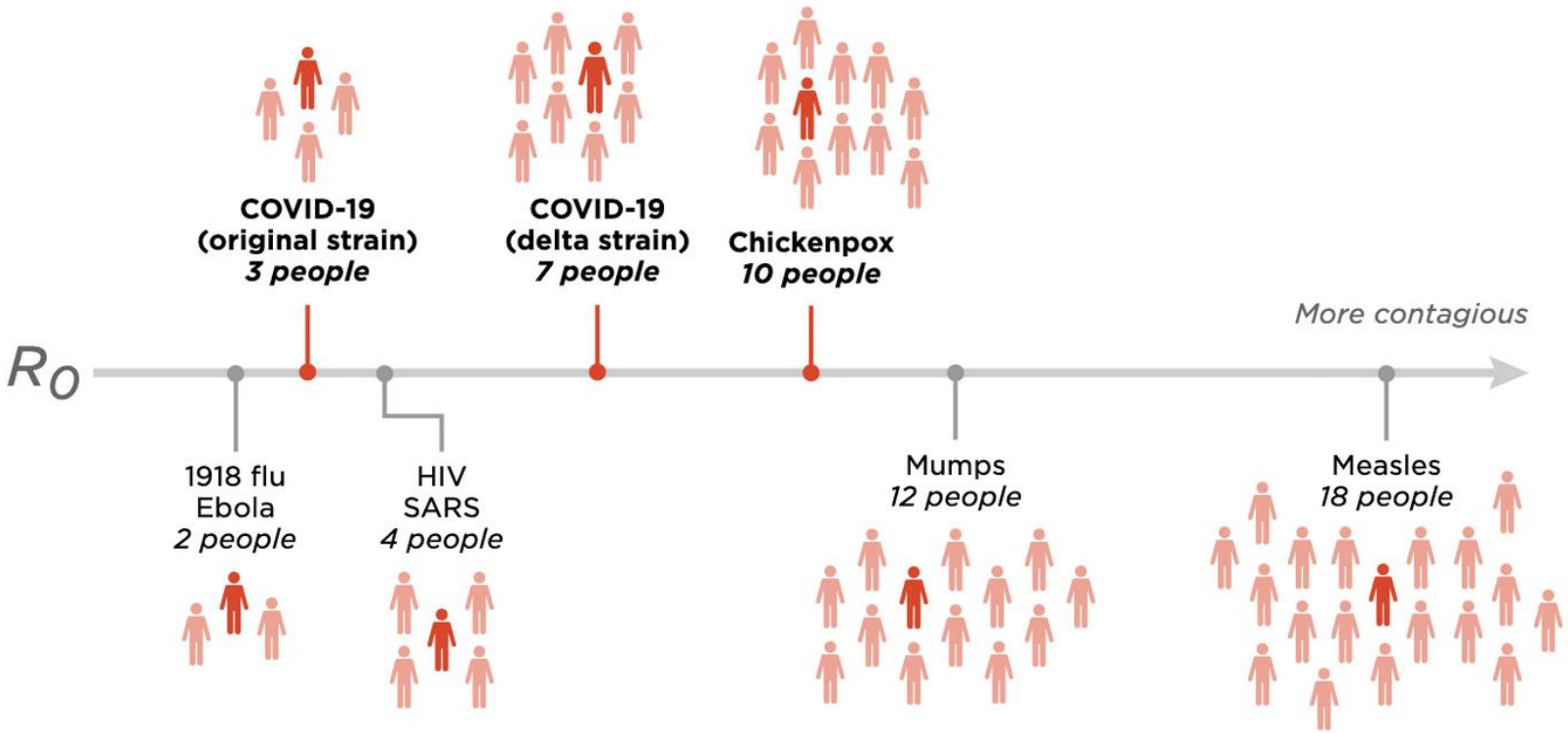
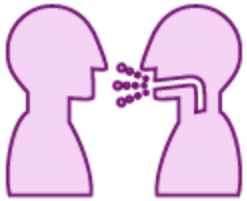


Image: https://media.npr.org/assets/img/2021/08/11/seamus-contagiousness-3-20210810_wide-778cb0a01c02994046f726426d7ed0251a37a54f.png?s=1400&c=100&f=png

Measles Transmission



Spreads through air when infected person talks, breathes, coughs, or sneezes

Can stay in the air and live on surfaces for a full hour after case has left

90% chance of becoming infected if exposed and not vaccinated

Images: https://www.cdc.gov/measles/transmission.html

Classical Measles Presentation

Fever & 3 C's

- Cough
- Conjunctivitis
- Coryza
- Fever starts low grade and progresses to high

2-3 days after initial sx onset

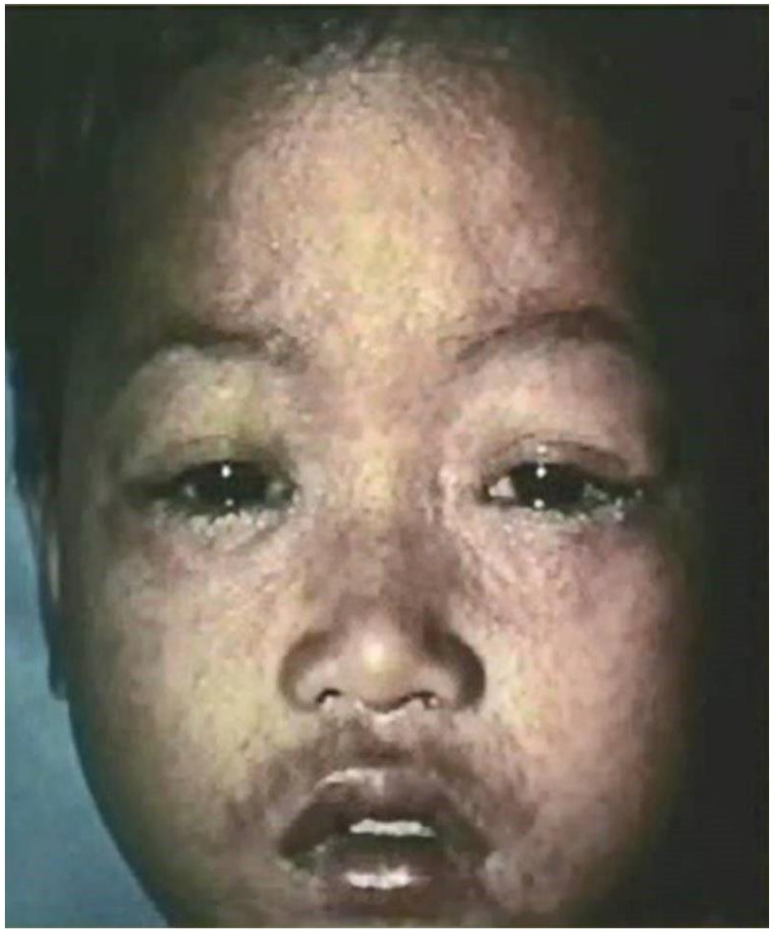
Koplik Spots

- Tiny white spots in mouth

3-5 days after initial sx onset

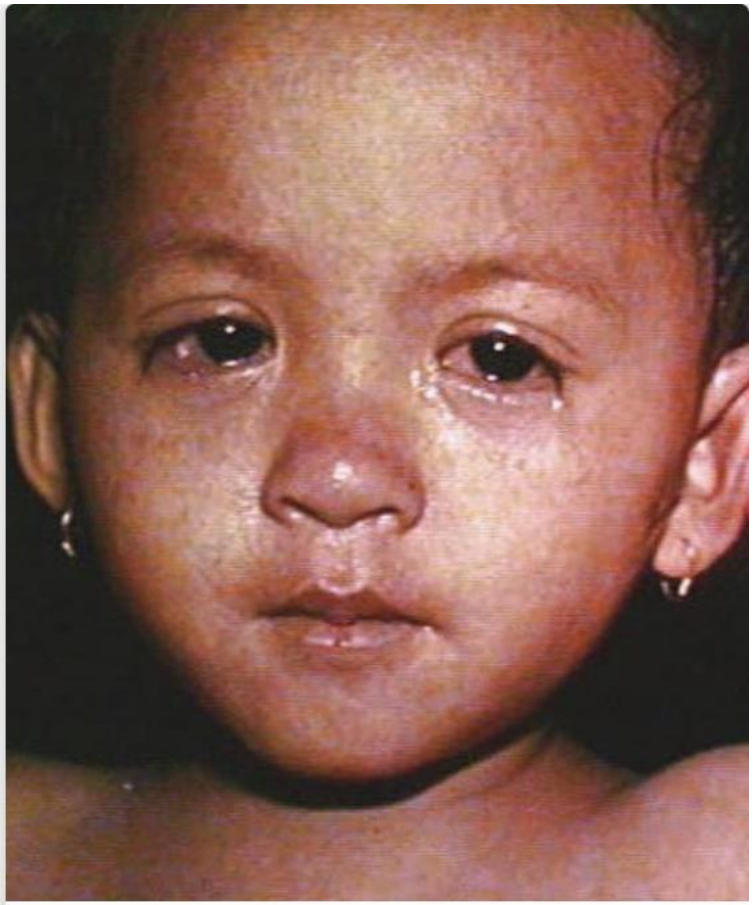
Maculopapular Rash

- Starts on face/hairline
- Spreads downward to neck, trunk extremities
- Not itchy
- Small raised bumps may also appear on top of the flat red spots.
- Maculopapular - The spots may become joined together as they spread from the head to the rest of the body



Young, dark-skinned child with watery eyes, runny nose, and raised rash.

Child with a classic measles rash after four days.



Eyes of a child with measles

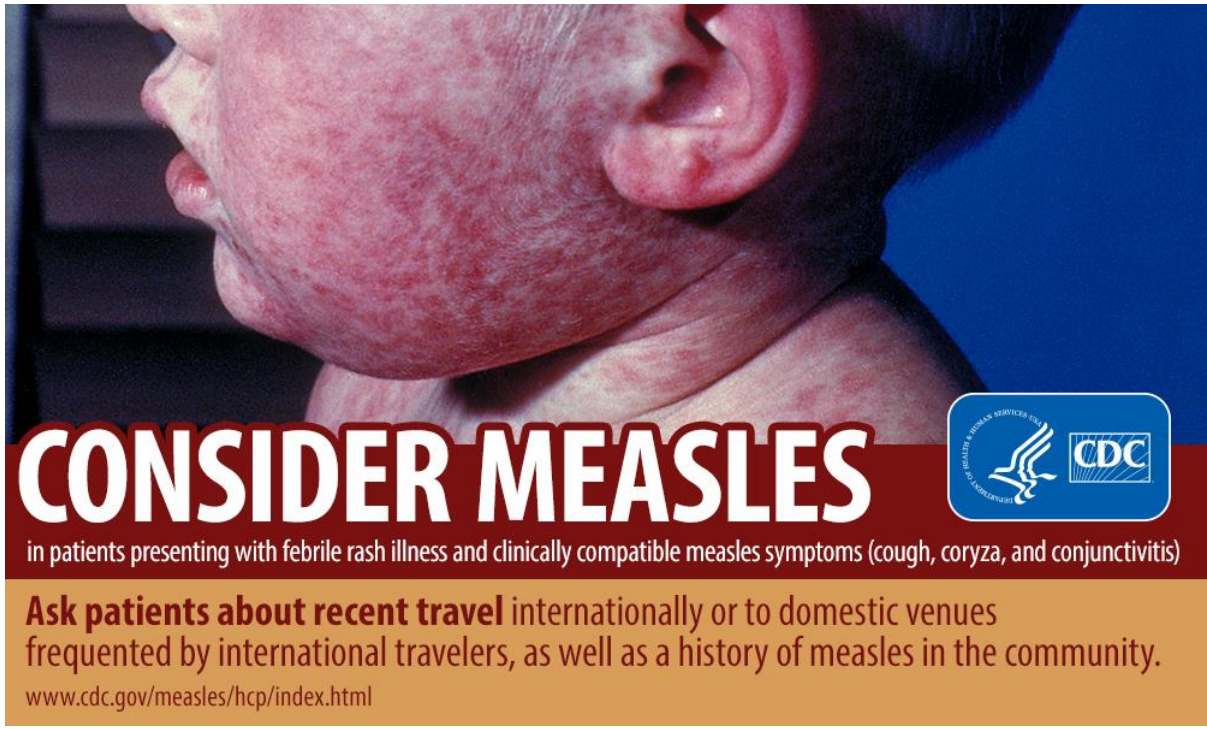
https://www.cdc.gov/measles/symptoms/photos.html

When to Suspect Measles

- Consider measles in any patient with
  - febrile rash
  - clinically compatible symptoms (cough, coryza, conjunctivitis, Koplik spots)

  especially if they are unvaccinated or under-vaccinated or have any of the following risk factors in the past 4 weeks:
  - **Travel**, especially international or through an international airport, or to a US area experiencing an outbreak
  - Contact with someone with a **febrile rash illness**
  - Exposure to a **known or possible measles case**

If you suspect measles, contact VPDC right away at 213-351-7800 – don't wait for labs!



Preparing Your Pediatric Practice for Measles

Pre-Case Preparation: Maintain Staff Immunity Records

- Obtain documentation of measles immunity when hiring or ASAP afterward
  - Consider offering IgG testing for any worker unable to provide documentation
  - Consider offering MMR for any non-immune workers
- Use increasing case counts to re-engage staff regarding immunity testing or receiving MMR vaccine

Pre-Case Preparation: Communicate and Educate

- Consider the following preparations:
  - Post measles warning outside of your facility
  - Educate triage to ID potential cases upon entry and divert these individuals to appropriate isolated areas
  - Ensure good adherence to cough etiquette and hygiene among staff
  - Consider screening visitors prior to entry if cases have been detected in the area

Suspect Measles On Site: Triage to Prevent Infection

If you have an airborne infection isolation room (AIIR), **use it** – isolate patient immediately upon arrival.

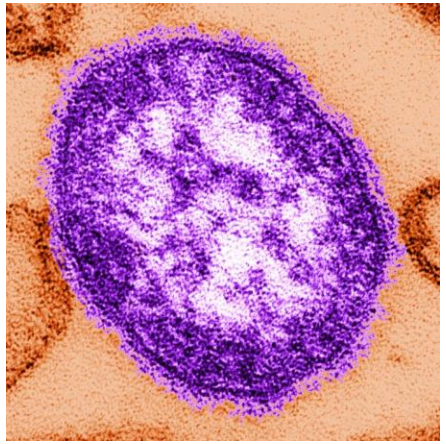
If you **don't** have an AAIR:

- Immediately give facemasks to patients 2+ years old and their caregivers
  - If patient is under 2 or can't tolerate a mask, have caregiver(s) tent the patient with a blanket or towel when entering the facility or assess patient in the vehicle
  - No other children should accompany the patient
  - Patient and caregiver(s) should leave facemasks on for the entire visit
- Isolate the patient and caregiver(s) to a private room with a closed door

Source: https://www.aap.org/en/patient-care/measles/measles-frequently-asked-questions/
Accessed 04/21/26

Suspect Measles On Site: Report to Public Health

- After isolating the patient, please call DPH **immediately** to help facilitate testing and to receive additional guidance!
  - Weekdays 8:30 am – 5:00 pm: Call **213-351-7800** - Investigator on Duty
  - Non-business hours/weekends: Call **213-974-1234** option **8** - Administrative Officer on Duty



Suspect Measles On Site: Collect Specimens for Diagnosis

- Ideal specimens to test for measles are
  - **Nasopharyngeal (NP) or throat swab,**
  - **Urine, and**
  - **Serum**
- RT-PCR performed on NP or throat swab and urine
  - Most sensitive within 3 days of rash onset; collect up to 2 weeks after rash onset
- IgG and IgM performed on serum
  - IgG can be used to measure immunity, usually available before PCR results
  - IgM is positive for 6-8 weeks after infection but false positives are possible
- If VPDC approved testing, fill out PHL forms (one per specimen); if not, you can send to a commercial laboratory

Suspect Measles on Site: Traffic Control

- Limit suspect case's transportation outside of their room – use for essential diagnostic and therapeutic procedures only
  - Patient should **always be wearing facemask during transport**
  - Transport route and process should include minimal contact with person's not essential to patient's care
- Limit suspect case's visitors to those who are both necessary for the patient's well-being and have presumptive evidence of immunity

Suspect Measles On Site: Cleaning and Disinfection

- Do not use the room for an hour after the patient was in it
- Standard cleaning and disinfection procedures are appropriate for measles virus environmental control in all healthcare settings
- Use an EPA-registered disinfectant for healthcare settings, per manufacturer's instructions
- No special management of measles waste is required – follow standard federal, state, local regulations for regulated medical waste

Source: https://www.cdc.gov/infection-control/hcp/measles/index.html

Our Patient was Confirmed, What Now?

Exposure Management: Health Care Facility Responsibilities

1) ID all staff, patient, and visitor contacts

2) Determine risk level and immune status of all exposed contacts

3) Offer IgG testing and/or PEP for all contacts without proof of immunity

4) Exclude staff as appropriate

Exposure Management Step 1: **Identify Exposed Contacts**

- **Contact:** Anyone who occupied a shared airspace with the case while the case was present and up to 1 hour after the case's departure from that space
- Use the measles healthcare contact line list to fill out available information on exposed contacts
  - Prioritize pregnant, immunocompromised, infant contacts (higher risk of severe measles)
- Send line list to VPDC@ph.lacounty.gov via secure email

Exposure Management Step 2: Determine Risk Level and Immune Status

High-Risk Contacts:

- Pregnant persons without proof of immunity
- Infants <12 months of age
- Severely immunocompromised persons
- Household contacts
- Persons with prolonged exposure (e.g., rideshare driver of the case)
- Persons who work in high-risk settings

High-Risk Measles Immunity Criteria (24 hours to provide):

- Documentation of **two** doses of measles vaccine given in 1968 or later, separated by at least 28 days, with the first dose on or after the first birthday
- A documented IgG positive test for measles
- Laboratory confirmation of previous disease

Exposure Management Step 2: Determine Risk Level and Immune Status

Low-Risk Contacts:

- Immunocompetent
- 12+ months of age
- Not pregnant
- No prolonged exposure to case
- Does not work in a high-risk setting

Low-Risk Measles Immunity Criteria (48 hours to provide):

- Any high-risk immunity criteria, OR
- Born prior to 1957
- Born in 1976 or later AND attended a U.S. primary or secondary school
- Have at least one dose of measles-containing vaccine given on or after their first birthday in 1968 or later
- Served in the U.S. Armed Forces
- Entered the U.S. as a Permanent U.S. Resident or became a Permanent U.S. Resident in 1996 or later (i.e., have a “green card”)

Exposure Management Step 3: IgG Testing and Post-Exposure Prophylaxis (PEP)

If immunity not met: Collect serum for IgG titers and advise contacts to quarantine while pending results

PEP within the target window may provide measles protection or modify the clinical course of disease among susceptible people

MMR

- Should be given within 72 hours (3 days) of initial measles exposure
- Vaccination can be given after this window, but would only be expected to protect from future exposures and is not considered "adequate PEP"

Immunoglobulin

- Needs to be given within 6 days of initial exposure
- Can be given intramuscularly (IMIG) or intravenously (IVIG)
  - IVIG should be prioritized for adults at high risk of severe disease

Exposure Management Step 4: **Exclusion vs Quarantine**

- Quarantine: Non-immune contacts who have not received PEP stay home
  - If quarantine is implemented, it should begin on day 7 after the date of first exposure through day 21 after the date of last exposure
- Exclusion for healthcare workers
  - Should begin on **day 5** after the date of *first* exposure through **day 21** after the date of last exposure (day of exposure is day 0)
  - Exclusion is required for anyone without 2 documented MMRs or serologic evidence of immunity, even if they received PEP

In Summary

- Fever + Generalized maculopapular rash + 1 or more of the 3 C's = ***think measles!***
  - Recent travel or un-/under-immunized or sick contacts = **even higher chance**
- If a suspect measles patient enters your facility, mask and isolate **ASAP**
  - Call VPDC Weekdays 8:30 am – 5:00 pm: **213-351-7800** - Epidemiologist on Duty
  - Non-business hours/weekends: **213-974-1234** option 8 - Administrative Officer on Duty
- **Before** you get a suspect measles patient, assess your staff's immunity (2 MMR doses or positive IgG test)
- Visit our measles B73 website for everything you want to know about measles investigations in LA County: http://publichealth.lacounty.gov/ip/b73/measlesindex.htm
- Sign up for our LA Health Alert Network: http://publichealth.lacounty.gov/lahan/

Questions?

Contact: VPDC@ph.lacounty.gov
213-351-7800

Faith Washburn, MPH
Lead Epidemiologist, LA County DPH
Vaccine Preventable Disease Investigations & Response
Fwashburn@ph.lacounty.gov

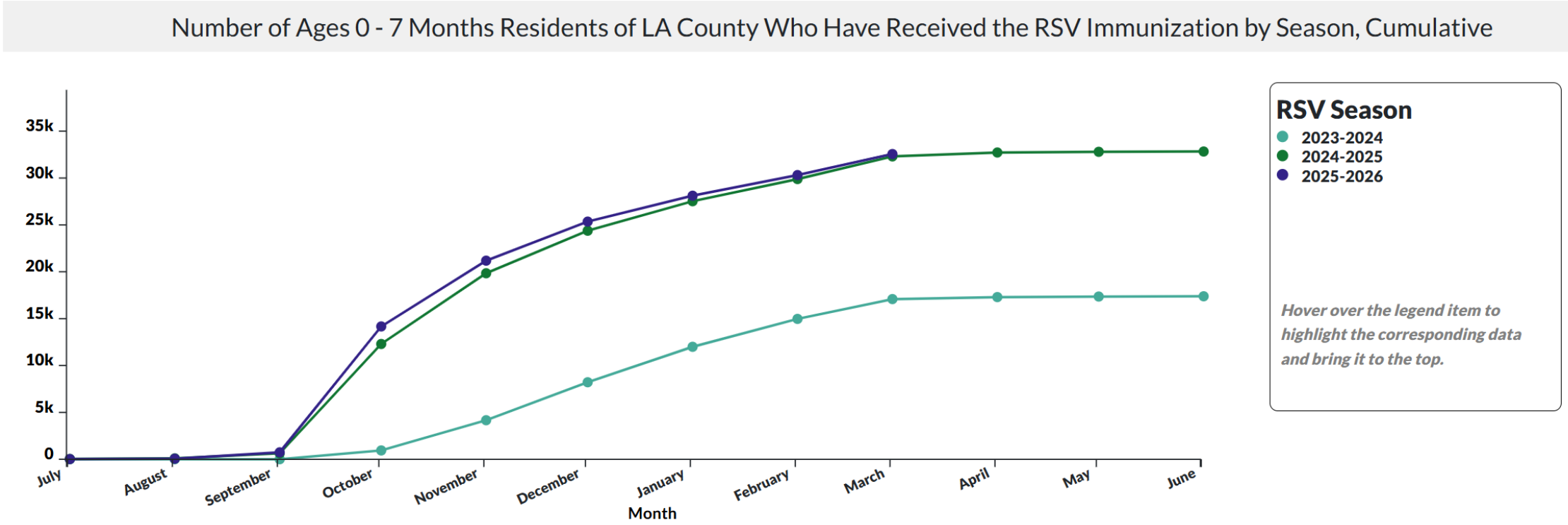
Infant RSV Immunization Trends in Los Angeles County

Vaccine Preventable Disease Control Program

Los Angeles County Department of Public Health

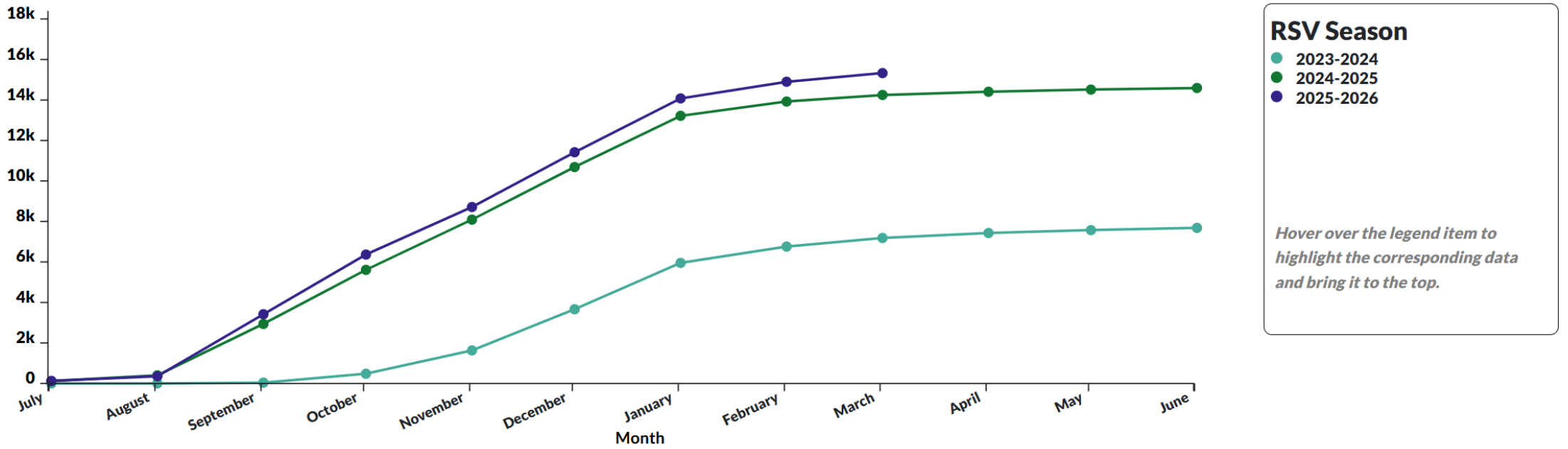
April 23, 2026

Nirsevimab Administration Data from CAIR



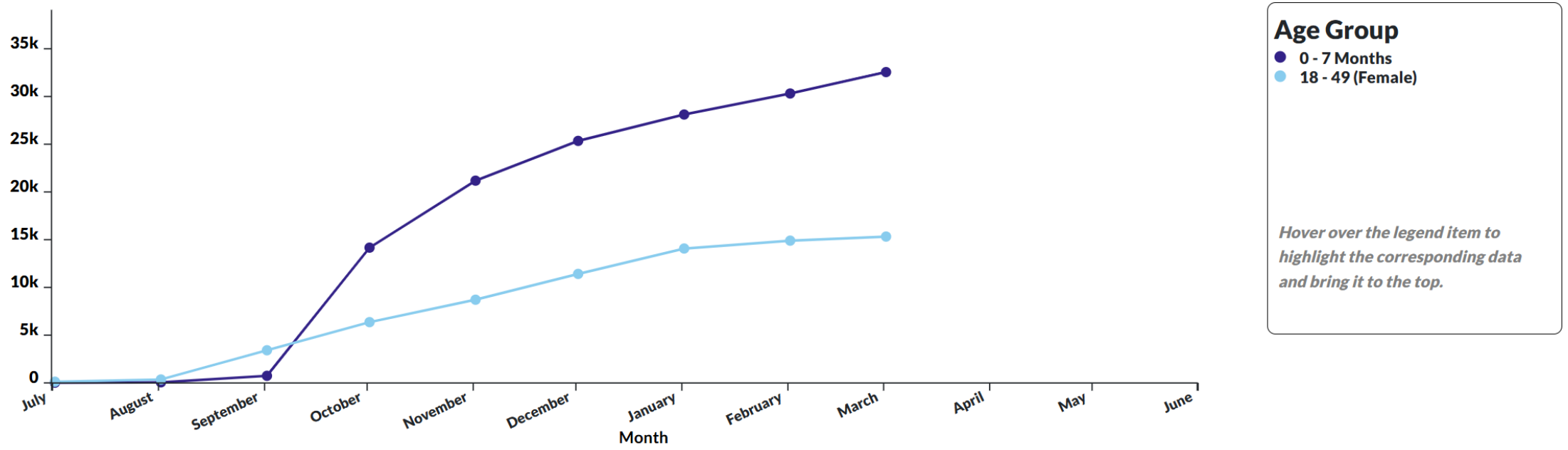
Abrysvo Administration Data from CAIR

Number of Ages 18 - 49 (Female) Residents of LA County Who Have Received the RSV Immunization by Season, Cumulative



Nirsevimab vs. Abrysvo Utilization

Number of LA County Residents Who Have Received the
RSV Immunization During the 2025-2026 Season by Age Group, Cumulative



Birth Cohort Analysis

- Linked birth registry data with CAIR records to better estimate infant immunization coverage
- Examined two cohorts:
  - Apr 2023-Mar 2024 for the first RSV season with product availability
  - Apr-Dec 2024 for the second RSV season (2025 birth records not available)
- Constructed mother-infant pairs to look at protection by either product
- Calculated infant immunization coverage by maternal characteristics

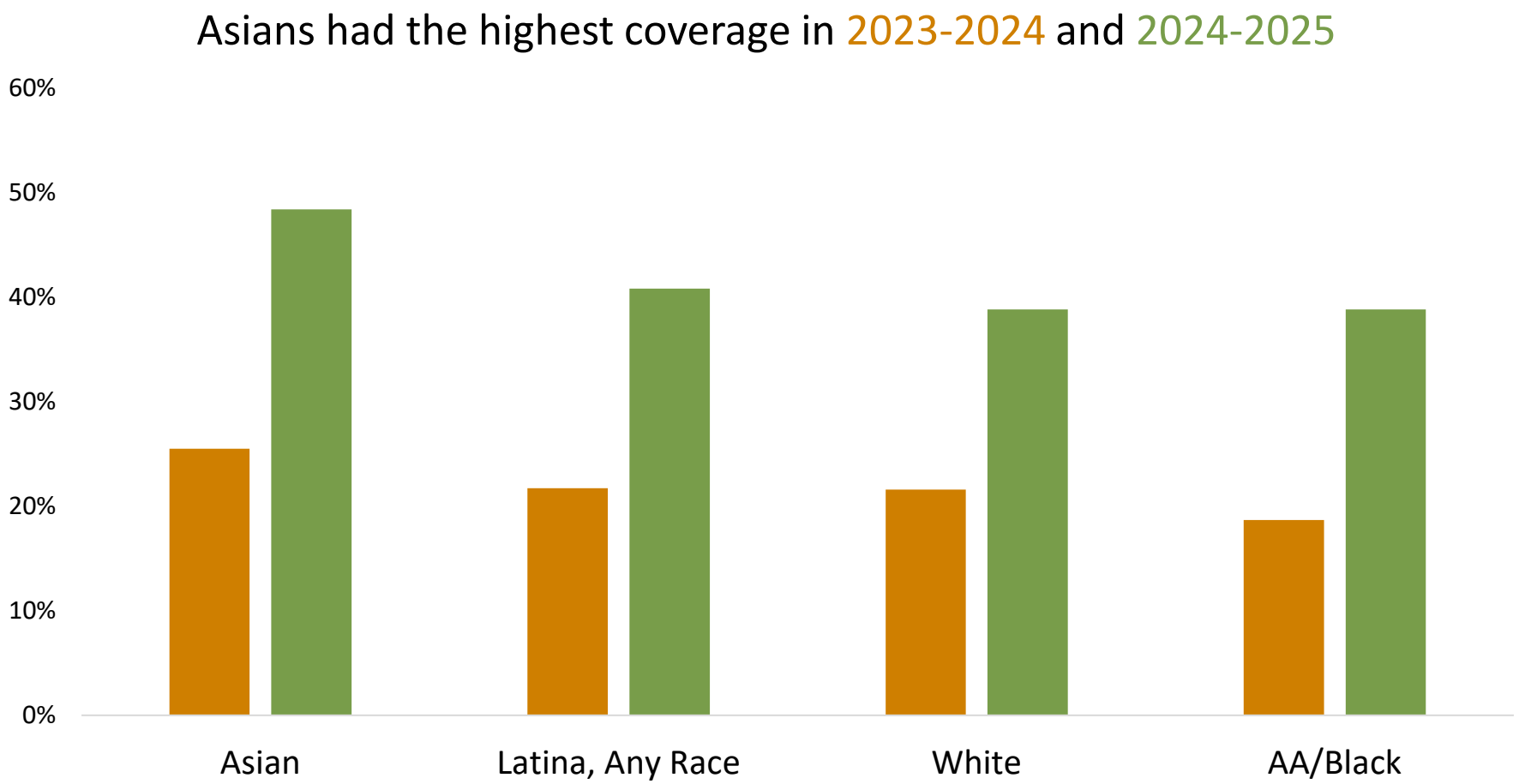
Birth Cohort Analysis – Overall Coverage

Proportion of infants protected through maternal vaccination or nirsevimab **increased 2x** from **2023-2024** to **2024-2025** season:

22% → 41%

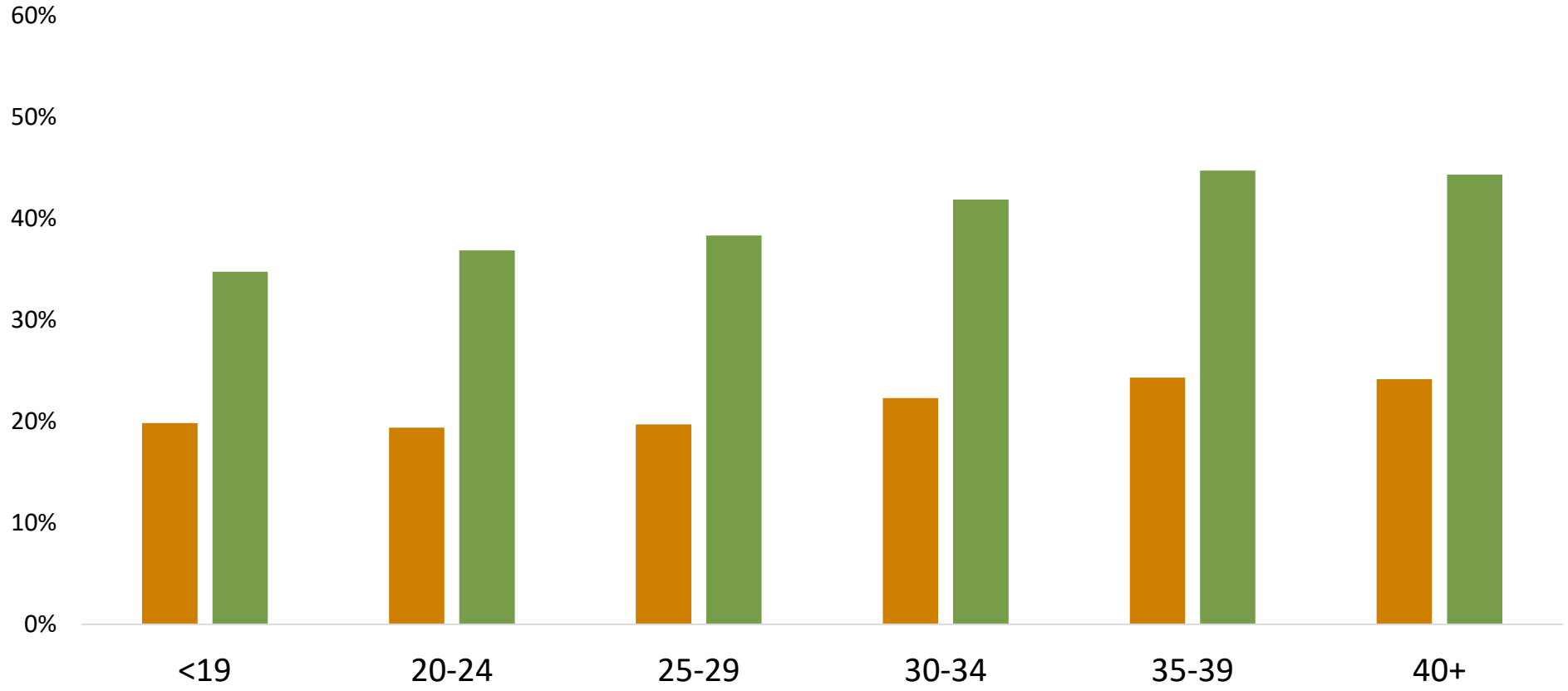
Maternal vaccination increased from 5% to 8% (out of births) while nirsevimab increased from 18% to 34%.

Birth Cohort Analysis – Maternal Race/Ethnicity

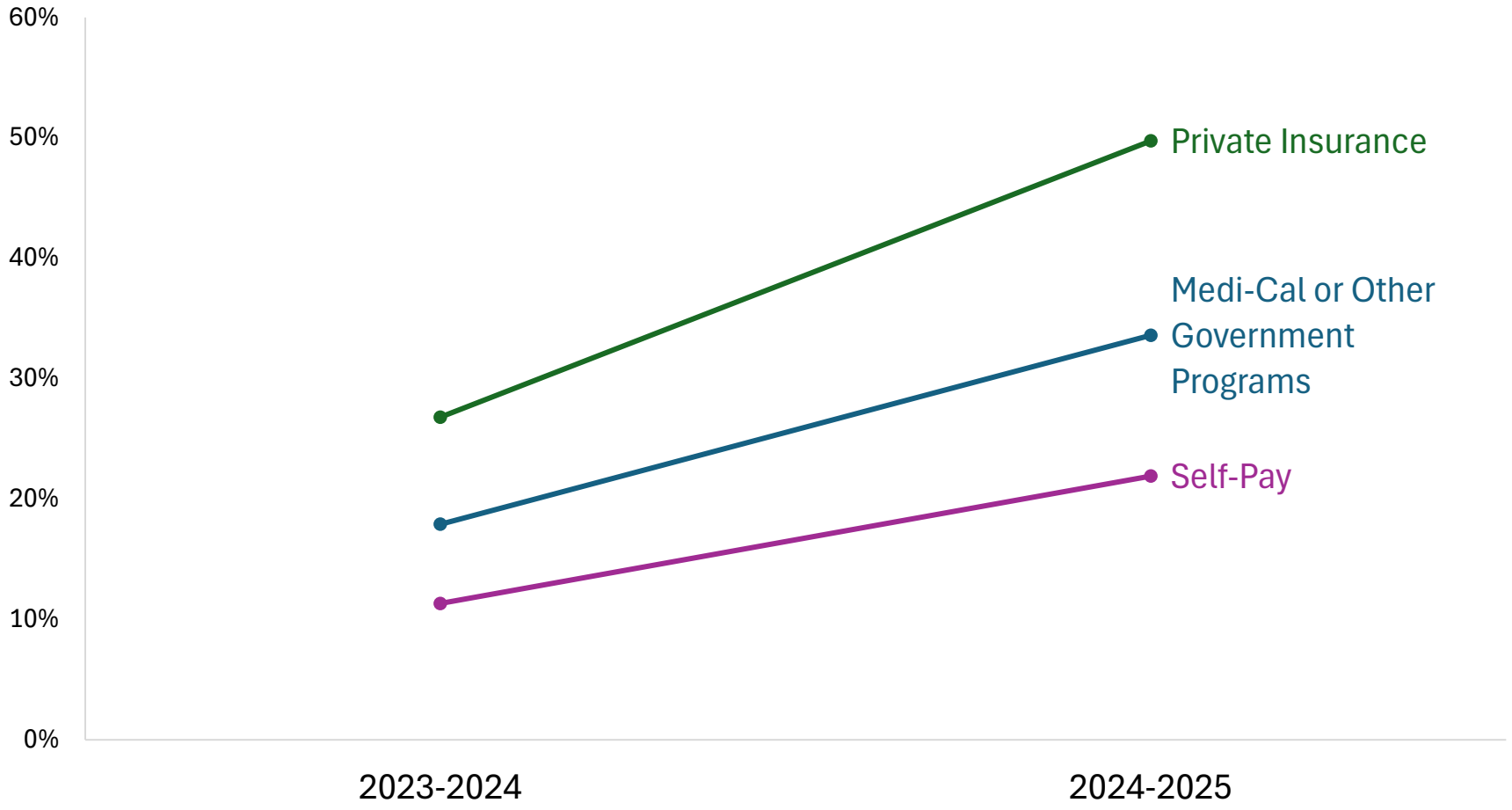


Birth Cohort Analysis – Maternal Age

Coverage generally increased with age in 2023-2024 and 2024-2025



Birth Cohort Analysis – Payment for Prenatal Care



Resources

- VPDC homepage: http://www.publichealth.lacounty.gov/ip/
- LAC respiratory vaccines dashboard: http://ph.lacounty.gov/media/RespiratorySeason/vaccine/#/rsv_infants
- LAC RESPWatch: http://publichealth.lacounty.gov/acd/RespWatch/index.htm