Characteristic	FLU (-) N = 482[1]	FLU (+) N = 175[1]	p-value[2]
Age, years	71 [67–76]	71 [67–74]	0.2
Female sex	288 (60%)	104 (59%)	>0.9
Male sex	194 (40%)	71 (41%)	—
Race	—	—	0.4
Black	251 (52%)	93 (53%)	—
White	202 (42%)	71 (41%)	—
Other	29 (5%)	10 (5.7%)	—
Fever	149 (32%)	115 (66%)	<0.001
Chills	238 (50%)	122 (71%)	<0.001
Body aches	299 (62%)	128 (74%)	0.006
Any comorbidity	252 (52%)	124 (71%)	<0.001
Baseline EQ-5D	0.92 [0.86–0.96]	0.93 [0.84–0.96]	0.5
Baseline VAS	50 [40–70]	50 [40–75]	0.5
Follow-up EQ-5D	0.87 [0.72–0.96]	0.88 [0.77–1.00]	0.04
Follow-up VAS	75 [50–85]	80 [70–90]	0.005
Characteristic	COVID (-) N = 603[1]	COVID (+) N = 44[1]	p-value[2]
Age, years	71 [67–75]	71 [66.5–74.5]	0.8
Female sex	362 (60%)	22 (50%)	0.2
Male sex	241 (40%)	22 (50%)	—
Race	—	—	0.6
Black	314 (52%)	24 (55%)	—
White	253 (42%)	16 (36%)	—
Other	30 (5.8%)	4 (9%)	—
Shortness of breath	444 (74%)	26 (59%)	0.037
Wheezing	387 (65%)	21 (48%)	0.025
Diarrhea	153 (25%)	18 (41%)	0.024
Fatigue	540 (90%)	35 (80%)	0.046
Any comorbidity	353 (59%)	16 (36%)	0.004
Baseline EQ-5D	0.92 [0.85–0.96]	0.91 [0.87–0.96]	0.6
Baseline VAS	50 [40–70]	50 [25–75]	0.7
Follow-up VAS	75 [60–85]	78 [70–90]	0.13
Characteristic	RSV (-) N = 581[1]	RSV (+) N = 31[1]	p-value2
Age, years	71 [67–75]	70 [66–77]	0.8
Female sex	342 (59%)	17 (55%)	0.7
Male sex	239 (41%)	14 (45%)	—
Race	—	—	0.7
Black	299 (52%)	18 (58%)	—
White	247 (43%)	11 (35%)	—
Other	34 (5.9%)	2 (6.4%)	—
Smell/taste change	126 (22%)	12 (43%)	0.011
Any comorbidity	321 (55%)	18 (58%)	0.8
Baseline VAS	50 [40–75]	50 [20–60]	0.086
Return to normal activities at follow-up	550 (95%)	24 (77%)	0.002

[1]n (%); Median [Q1, Q3]

[2] Pearson's Chi-squared test; Fisher's exact test; Wilcoxon rank sum test; NA

Presentation Type:
Poster Presentation
Subject Category: Respiratory Viruses Other than SARS-CoV-2

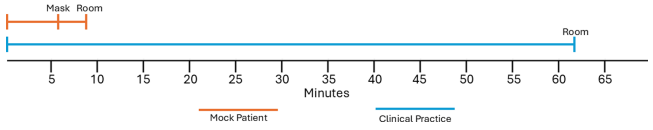
Lessons Learned from Measles Exposure Response[‡]

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Background: During a measles outbreak in the United States in 2025, health care settings were on high alert for patients who may have been exposed to or infected with this disease. When an infection is found, contact tracing investigations are extensive and require significant labor. Identify, Isolate, Inform (III) has become a standard tool for special pathogen preparedness. Our facility implemented an electronic medical record (EMR) alert for patients reporting fever and rash. The objective of this work is to compare and contrast our experience in drill vs clinical practice. **Methods:** Setting. Denver Health is an acute-care safety net hospital with both adult and pediatric emergency departments, sharing a common security checkpoint for entrance, and a check in and arrival space before patients are triaged into individual waiting rooms. Drill. In March 2025, Denver Health conducted a drill to test the III process in the pediatric emergency department and urgent care center (PEDUC) where care was provided for a mock patient with fever, rash, and cough. Time to masking and time to isolation were collected by a drill observer. Clinical practice. In April 2025, an infant with recent international travel presented to the PEDUC with cough, fever, and rash and was subsequently diagnosed with measles by PCR. Time to isolation was collected via time stamps in the EMR. **Results:** During the drill, fever and rash were documented, and the alert fired appropriately. The mock patient was masked within six minutes of entry and roomed in a negative pressure room within nine minutes of entry. During clinical practice, rash was documented, but the patient was afebrile at triage, and the EMR alert did not fire. The patient spent 62 minutes in the waiting room before being roomed. Contact tracing involved individuals in both the adult and pediatric emergency departments due to the shared airspaces. In total, 149 patients were identified as contacts and were notified of the exposure by public health. No transmission was identified. **Conclusions:** Despite a recent successful drill in the PEDUC, when a patient presented with measles, there were challenges with identification and isolation, as well as structural limitations within the facility and gaps with technology aiding the early identification of patients at risk. Having a real-life situation resulted in an extremely large contact investigation and juxtaposed the recent successful drill, highlighting the need to continue performing "no notice drills" and work on improving each facet of preparedness.

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Figure 1. Time between arrival and rooming: mock patient vs. clinical practice



[‡]The abstract titles in this supplement have been corrected since original publication. A notice detailing the changes has been published at https://doi.org/10.1017/ash.2026.10802.

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