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Measles Outbreak in a Child Care Facility — Lubbock, Texas, March–April 2025

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Abstract

During 2025, the United States recorded the highest number of measles cases since measles elimination was declared in 2000. On March 21, 2025, Lubbock Public Health (LPH) in Texas received a report of a child care attendee aged 3 years, with fever, rash, cough, coryza, conjunctivitis, otitis media, and diarrhea who received a positive test result for measles by real-time reverse transcription–polymerase chain reaction (RT-PCR). Six additional children who attended the same child care facility and the grandfather of one of the children were confirmed by RT-PCR testing to have measles. None of the patients was reported to have traveled. LPH contacted the pediatric patients' caregivers to conduct case investigations and provided recommendations to the child care facility for home isolation, vaccination, and testing. LPH also communicated with caregivers, other child care facilities in the area, and the public to raise awareness. The child care facility implemented measures to minimize transmission, including separating children who were not yet eligible for the measles, mumps, and rubella vaccine; minimizing the use of shared spaces; and monitoring signs and symptoms. Collaboration between public health and community partners such as child care facilities can facilitate a rapid response and control of infectious disease outbreaks.

Investigation and Results

Index Case

On March 21, 2025, Lubbock Public Health (LPH) in Texas was notified of a suspected measles case in a child aged 3 years (index patient, patient A) who had fever, rash, cough, coryza, conjunctivitis, otitis media, and diarrhea. The child had fever onset on March 15 and rash onset on March 20; the infectious period was estimated to be March 16–24 (4 days before and 4 days after rash onset). The child had no travel history during the exposure period but attended a child care facility that had 48 employees and 287 enrolled children, ranging from infants to prekindergarten children; 39 (13.6%) of the children were aged <12 months. Real-time reverse transcription–polymerase chain reaction (RT-PCR) testing detected measles virus. The child had not received the measles, mumps, and rubella (MMR) vaccine and had a vaccination exemption on file with the child care center. The child's caregivers reported that they had each received the MMR vaccine; neither developed symptoms of measles. An investigation was conducted by LPH. This activity was reviewed by CDC, deemed not research, and conducted consistent with applicable federal law and CDC policy.*

Patient A attended the child care facility while infectious until March 17 (2 days after symptom onset and 3 days before rash onset). The child received testing for *Streptococcus* infection at a drive-through health care clinic on the morning of March 21. Later that same day, the child visited an emergency department and received measles RT-PCR testing. The positive measles laboratory result was available 3 days later (March 24), and the child care facility was informed the next day (March 25).

Additional Cases Associated with the Child Care Facility

During March 25–29, LPH was notified of two additional suspected measles cases (patients B and C); both cases occurred

*45 C.F.R. part 46, 21 C.F.R. part 56; 42 U.S.C. Sect. 241(d); 5 U.S.C. Sect. 552a; 44 U.S.C. Sect. 3501 et seq.

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in children who attended the same child care facility as the index patient, including a child in the same classroom as the index patient (patient B) and a sibling of the index patient (patient C) who was exposed at home (Table). During April 1–15, four additional suspected measles cases among children who attended the same facility but were not in the same classroom as the index patient (patients D, E, F, and G) were reported to LPH. All six additional cases identified after the index case were confirmed by RT-PCR. On April 16, LPH was notified that a man aged 41 years with unknown vaccination status (patient H, the grandfather of patient D), developed measles symptoms. The diagnosis was later confirmed by RT-PCR.

Age and Vaccination Status of Children with Measles

Among the seven total confirmed pediatric measles cases, three occurred among children aged <12 months. The index patient (aged 3 years) was unvaccinated and hospitalized for 1 day. One patient aged 7 months received 1 MMR vaccine dose as postexposure prophylaxis after being exposed to a child with confirmed measles at the child care facility during this outbreak. The patient received the vaccine 3 days before symptom onset. All patients recovered.

Public Health Response

Notifying Caregivers of Children

Once notified of the first measles case on March 25, 2025, the child care facility director telephoned caregivers of all enrolled children. Communications were sent from the child care facility to all caregivers through email and text message on March 26. Staff members at the child care facility were informed in person and through email and text message. On March 28, 2025, LPH sent a letter to caregivers, providing information about measles, advice for contacting providers if they or their children experienced symptoms, and recommendations for MMR vaccination, available at LPH.

Reviewing Vaccination Status of Children and Staff Members and Offering Postexposure Prophylaxis

The child care facility reviewed the vaccination status of all enrolled children and reported 96% vaccination coverage with ≥1 MMR vaccine dose each among the 248 children aged ≥12 months. Ten children aged 6 months–6 years at the facility who were eligible for MMR vaccination had vaccine exemption forms on file with the child care facility and had not received any MMR vaccine dose; three of these children had measles during this outbreak. All staff members reported that they had received MMR vaccine; however, their vaccination status was not verified. No measles cases occurred among staff members. LPH offered MMR vaccine as postexposure prophylaxis to all persons who were exposed to measles at the child care facility. Immunoglobulin was offered as postexposure prophylaxis at local hospital facilities.

Separating Infants Aged <6 Months and Excluding Unvaccinated Children from Attendance

Starting April 3, 2025, six infants aged <6 months[†] were grouped into a single classroom with a separate entrance and were

[†] Infants aged <6 months are not eligible for MMR vaccination.

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TABLE. Characteristics of patients with measles linked to a single child care facility — Lubbock, Texas, March–April 2025

Patient	Date of LPH notification	Age	No. of MMR vaccine doses received	Signs and symptoms	Date of fever onset	Date of rash onset	Clinical complications	UC or ED visit	Hospitalized	Epidemiologic link*	Classroom
A (index)	Mar 21	3 yrs	0	Fever, rash, cough, coryza, and conjunctivitis	Mar 15	Mar 20	Otitis media, diarrhea	ED	Yes (1 day)	NA	A
B	Mar 25	2 yrs	1†	Fever, rash, cough, coryza, and conjunctivitis	Mar 22	Mar 29	Diarrhea	UC	No	Same classroom as patient A	A
C	Mar 29	5 mos	Not age eligible	Fever, cough, coryza, and conjunctivitis	Mar 27	No rash reported	NA	NA	No	Sibling of patient A	B
D	Apr 1	2 yrs	1†	Fever, rash, coryza, and Koplik spots	Mar 27	Mar 29	NA	UC and ED	No	NA	C
E	Apr 2	4 yrs	0	Fever, rash, and coryza	Mar 28	Apr 2	Pneumonia	ED	No	NA	D
F	Apr 2	7 mos	1§	Fever, rash, cough, coryza, and conjunctivitis	Mar 31	Mar 31	Diarrhea	UC	No	NA	B
G	Apr 15	8 mos	0¶	Fever, rash, cough, coryza, and conjunctivitis	Apr 10	Apr 13	NA	UC	No	NA	B
H	Apr 16	41 yrs	Unknown	Fever, rash, cough, and coryza	Apr 13	Apr 16	NA	ED	No	Grandfather of patient D	NA

Abbreviations: ED = emergency department; LPH = Lubbock Public Health; MMR = measles, mumps, and rubella; NA = not applicable; UC = urgent care.
* The epidemiologic link indicates potential contacts or relationships with another patient with measles. Patients A–G were enrolled at the child care facility.
† Patients B and D received the age-appropriate first dose of MMR vaccine.
§ Patient F received 1 dose of MMR vaccine as postexposure prophylaxis 3 days before symptom onset.
¶ Patient G was considered unvaccinated at the time of the outbreak. On April 7, 2025, Lubbock was added to the list of outbreak areas in Texas, and an early dose of MMR vaccine was recommended for infants aged 6–11 months.

cared for by two designated staff members. All children and staff members remained in their assigned classrooms (15–20 students in each classroom) to minimize cross-classroom transmission; use of shared spaces, including the cafeteria, was suspended. LPH staff members contacted caregivers of the children aged <6 months to inform them of the separation of children and two staff members in a single classroom and to discuss risks and benefits for continued attendance at the facility. On April 3, 2025, LPH sent a letter to caregivers of unvaccinated children informing them their child could not return to the facility until 21 days had elapsed since their last measles exposure and recommending MMR vaccination for future protection.

Recommendation for Vaccination of Infants Aged 6–11 Months and Completion of MMR Vaccination Series

On April 7, 2025, the Texas Department of State Health Services (DSHS) issued a recommendation for an early dose of MMR vaccine for infants aged 6–11 months in an expanded list of outbreak areas, including Lubbock County and nine other counties. Children aged ≥6 months were required under the Texas school and child care attendance criteria to receive the first MMR vaccine dose if they were not vaccinated or to quarantine at home for 21 days after exposure, even in the absence of symptoms (*1*). Five unvaccinated children from four families had not received the vaccine and were quarantined at home. Children aged ≥6 months who had documentation of 1 MMR vaccine dose were encouraged to be vaccinated with the second dose ≥28 days after the first dose but were still allowed to attend the child care facility.

Ongoing Monitoring, Quarantine, and Return to the Child Care Facility

The child care facility instructed caregivers to keep children who received positive measles RT-PCR results at home; they were allowed to return to the child care facility after 4 days had elapsed since rash onset, if no other signs or symptoms (e.g., fever, vomiting, or diarrhea) were present. The facility continued to monitor children in attendance for fever, cough, coryza, and conjunctivitis. Children with symptoms were sent home immediately and required to remain home for 21 days or provide a negative RT-PCR test result to return. No staff members reported symptoms.

Summary

What is already known about this topic?

Measles is a highly contagious, vaccine-preventable disease. In recent years, U.S. measles outbreaks have occurred in communities with low vaccination coverage.

What is added by this report?

During March–April 2025, eight confirmed measles cases linked to a child care facility were reported in Lubbock, Texas. The index case occurred in an unvaccinated child aged 3 years. Multiple mitigation measures were implemented, including exclusion of unvaccinated children who had been exposed; separating children too young for measles, mumps, and rubella (MMR) vaccination; minimizing use of shared spaces; encouraging MMR vaccination; home isolation of patients; and communication with the public and child care facilities.

What are the implications for public health practice?

Vaccination, collaboration, and rapid public health actions are needed to prevent measles transmission in congregate settings.

Increasing Community Awareness of the Outbreak

On April 11, 2025, a meeting with CDC (including members from the National Institute for Occupational Safety and Health), LPH, and DSHS was held to discuss potential approaches to continue to reduce transmission within the child care facility. CDC shared guidance on topics such as preventing infection in education settings, national standards on health and safety from Caring for Our Children (*2*), a set of voluntary safety standards for early care and education programs, and facility ventilation guidelines. A representative from LPH and the child care facility administrator were interviewed on television to inform the community about the outbreak. LPH also contacted 117 child care facilities in the area. None of these facilities reported measles cases.

Discussion

The response to a measles outbreak in this child care facility highlights the importance of vaccination and rapid response in accordance with public health guidance. CDC recommends 1 routinely administered MMR vaccine dose for children aged 12–15 months and a second dose at age 4–6 years (*3*). In 2024, coverage with ≥1 MMR vaccine dose among children aged 1–3 years and 4–5 years in Lubbock County was 82% and 90%, respectively. In child care settings, Texas law requires receipt of ≥1 MMR vaccine dose by age 16 months or serologic evidence of immunity from previous infection unless the child has a documented vaccination exemption for medical reasons or reasons of conscience (*4*). The proportion of children with a conscientious exemption has been increasing in Texas and Lubbock County. During the 2024–25 school year, 3.95% of kindergarten children in Texas and 4.49% in Lubbock County had a conscientious exemption, compared with 2.14% in Texas and 2.04% in Lubbock County during the 2020–21 school year (*5*). Because a person with measles can infect 90% of nonimmune persons with whom they come into contact, maintaining community vaccination coverage of >95% is the most effective means for preventing measles transmission (*6*). Two doses of MMR vaccine are 97% effective in preventing measles (*3*). In addition, herd immunity, achieved through high community vaccination coverage, protects children who are not yet eligible for MMR vaccination and other persons who cannot receive the vaccine for medical reasons.

During this outbreak, the child care facility followed guidance from state and local health departments regarding MMR vaccination and child care attendance. According to state guidance, children who are unvaccinated and do not receive an MMR vaccine dose within 72 hours of exposure to measles, including those with medical or other exemptions, should not return to school for 21 days after their last exposure. However, LPH recognized that asking families to quarantine their children at home is disruptive, especially in families lacking financial or social safety nets who might not have the means to keep their children at home.

Because of concerns that some families might seek out other facilities for child care, LPH determined that not allowing children aged <6 months to attend the child care facility might inadvertently accelerate the spread of measles across the community. This guided their decision to group infants aged ≤6 months into a single classroom and permit their continued attendance.

Effective communication was vital during this response. Proactive engagement between public health staff members and community partners, such as child care administrators and caregivers, was important for implementing timely public health measures. To maintain readiness for potential future outbreaks, public health departments need to draw on staff member expertise to implement rapid, clear, and tailored infection prevention and control measures and raise community awareness. Vaccination remains the most effective public health intervention to prevent measles and measles outbreaks. Few measles outbreaks in child care settings have been recently reported (*7*,*8*). This report highlights the challenges and lessons learned to guide future measles outbreak responses in these settings.

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Notes from the Field

Borrelia mayonii Lyme Disease — New York, 2025

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Introduction

On July 8, 2025, the New York State Department of Health (NYSDOH) was notified by a commercial laboratory that a Herkimer County resident had received a positive test result via real-time polymerase chain reaction (PCR) testing for *Borrelia mayonii,* a less common bacterial cause of Lyme disease than *B. burgdorferi* (Lyme disease bacterium); *B. mayonii* is transmitted by blacklegged ticks (*Ixodes scapularis*) and has previously been reported only in Minnesota and Wisconsin (*1*). The patient sought medical care with onset of symptoms consistent with a tickborne infection in late June and was coinfected with *Anaplasma phagocytophilum* (anaplasmosis bacterium). The patient was treated with doxycycline and made a full recovery (Treatment of Anaplasmosis | Anaplasmosis | CDC). The patient had spent time outdoors but had no history of travel, transplant, or transfusion, prompting a public health investigation to determine the etiology of the *B. mayonii* infection.

Investigation and Outcomes

On July 22, 2025, NYSDOH Vector Ecology Laboratory staff members collected 147 *I. scapularis* nymphs along hiking trails through the wooded property surrounding the residence of the patient with *B. mayonii* infection and 22 from a nearby forest. Ticks were tested for *B. mayonii* using a real-time PCR assay based on previously published primers and probe and validated by the Wadsworth Center Bacteriology Laboratory to detect *B. mayonii* in ticks collected during NYSDOH's routine pathogen surveillance and case investigation efforts (*2*). The limit of detection for this assay was 34 genome copies for *B. mayonii* with 100% specificity. This project represents public health practice by NYSDOH, and institutional review board review was not required

One nymph (0.7%) from the patient's yard was positive for *B. mayonii*. The positive nymph was co-infected with *B. burgdorferi* and *A. phagocytophilum*. NYSDOH investigators returned on October 29, 2025, and collected 305 adult ticks from these two locations, detecting nine additional *B. mayonii*–positive ticks from the patient's property (nine of 229; 3.9%), four of which were co-infected with *B. burgdorferi.*

To determine whether *B. mayonii*–positive ticks were present elsewhere in New York or before this investigation, 1,309 additional ticks collected during 2021–2025 from 23 other New York counties (1,044 collected and tested for *B. mayonii* by NYSDOH using the assay described previously, and 265 collected by NYSDOH and screened for pathogenic *Borrelia* species, including *B. mayonii*, by CDC using the assay described as part of a separate investigation) (*3*); all were negative for *B. mayonii*. Overall, 1,518 individual ticks, (1,437 *I. scapularis* and 81 *Dermacentor variabilis* [American dog ticks]), collected by standardized dragging surveys from 24 New York counties were screened by NYSDOH (Figure), including 474 *I. scapularis* from the patient's residence and nearby forest collected as part of this investigation. The only ticks that tested positive for *B. mayonii* were collected in 2025 from the Herkimer County case property.

Preliminary Findings and Conclusions

The findings of this investigation indicate local peridomestic tickborne transmission of *B. mayonii*. The overall prevalence of *B. mayonii* among nymphs and adults tested by NYSDOH statewide during the study period was 0.2% (one of 627) and 1.0% (nine of 891), respectively. The higher prevalence of *B. mayonii* observed in adult ticks (3.9%) compared with nymphs (0.7%) collected from the same location (the patient's property) and year suggests the presence of a competent local vertebrate reservoir, such as mice or squirrels, and an established focus of enzootic transmission as opposed to incidental introductions of bird-dispersed infected immature ticks originating from the Midwest.

This study provides the first evidence of *B. mayonii* presence in New York ticks and locally acquired *B. mayonii* infection in a New York resident. Further characterization using next-generation sequencing is necessary to assess the genomic relatedness of New York *B. mayonii* isolates to the original reference strain. Continued entomological, molecular, and human tickborne disease surveillance are critical for understanding the distribution and public health significance of emerging tickborne pathogens in New York.

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[*] These authors contributed equally to this report.

Summary

What is already known about this topic?

Borrelia mayonii is a pathogen that has been indicated as a causative agent of Lyme disease and identified in humans and ticks in Minnesota and Wisconsin.

What is added by this report?

In July 2025, a New York resident with no reported travel received a positive *B. mayonii* test result. One *Ixodes scapularis* nymph collected from the patient's property was positive for *B. mayonii* by novel polymerase chain reaction assay. Subsequent targeted sampling identified nine additional *B. mayonii*–positive ticks from this property, indicating local transmission.

What are the implications for public health practice?

These findings represent the first detection of *B. mayonii* in the state of New York. The distribution of newly emerging tickborne pathogens can be used to evaluate risk and guide targeted prevention strategies.

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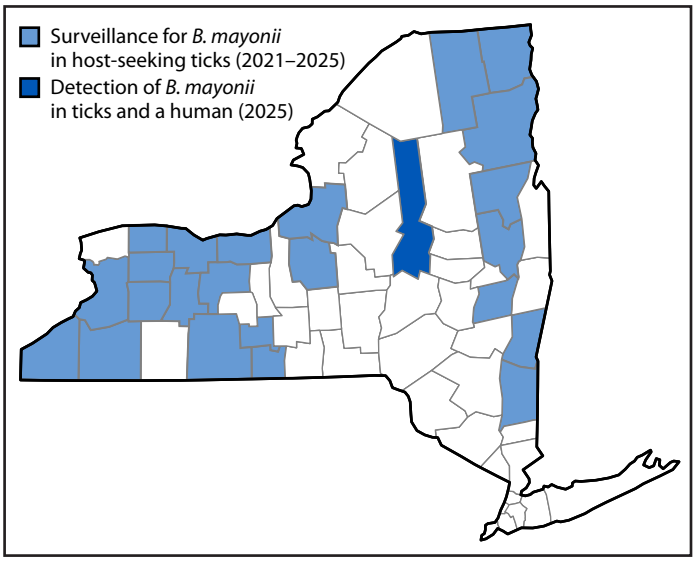
FIGURE. *Borrelia mayonii* surveillance and detections, by county — New York, 2021–2025



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