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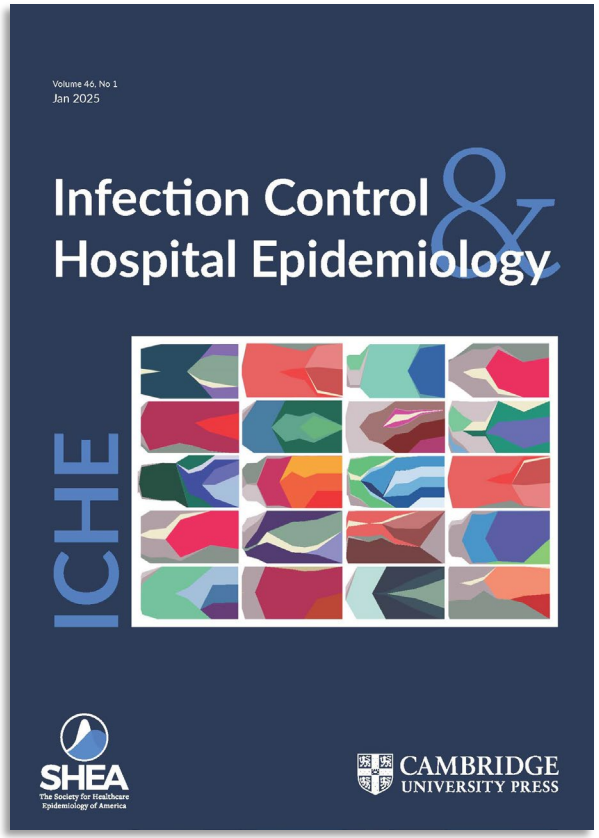

Infection Control & Hospital Epidemiology publishes scientifically authoritative, clinically applicable, peer-reviewed research on control and evaluation of the transmission of pathogens in healthcare institutions and on the use of epidemiological principles and methods to evaluate and improve the delivery of care. Major topics covered include infection control practices, surveillance, antimicrobial stewardship, cost-benefit analyses, resource use, occupational health, and regulatory issues.

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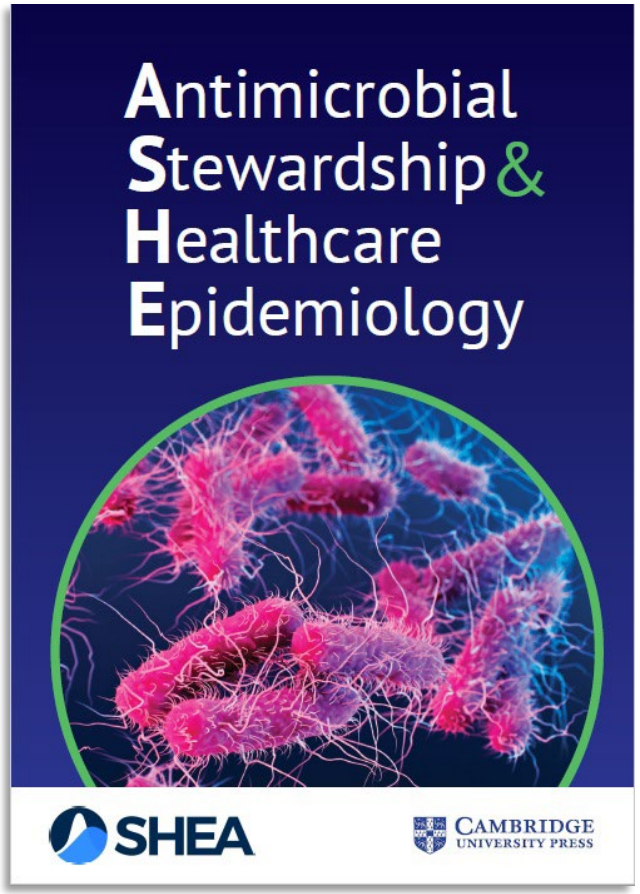

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Primer on Healthcare Epidemiology, Infection Control & Antimicrobial Stewardship

SCAN TO LEARN MORE

NEW!

SHEA Members Open Forum

Get ready for real discussion! This is a peer-driven, discussion-based program designed for SHEA members to connect, share experiences, and talk through real-world challenges.

June 24th at 4:00 – 5:00 pm ET

Topic: Varicella Identification, Isolation & Testing Workflow

Moderator: Harjot K. Singh, MD, ScM

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You Can Help!

Improving Antibiotic Stewardship and Infection Prevention in Nursing Homes

eLearning Course


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SHEA Webinar

Town Hall 2026

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Housekeeping

- Technical difficulties? Visit: https://support.zoom.us
- Webinar recording, PowerPoint presentation, and references available on learningce.shea-online.org
- Streaming Live on SHEA's Facebook page
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June Town Hall Panelists:

Dr. Katie Passaretti
Advocate Health

Dr. Chris Nyquist
Children's Hospital Colorado

Dr. Tom Talbot
Vanderbilt University

Invited Panelist:

Justin Chan, MD, MPH
NYU Grossman School of Medicine

Current Emerging Pathogens - Preparedness and Lessons Learned

June 2026 Town Hall

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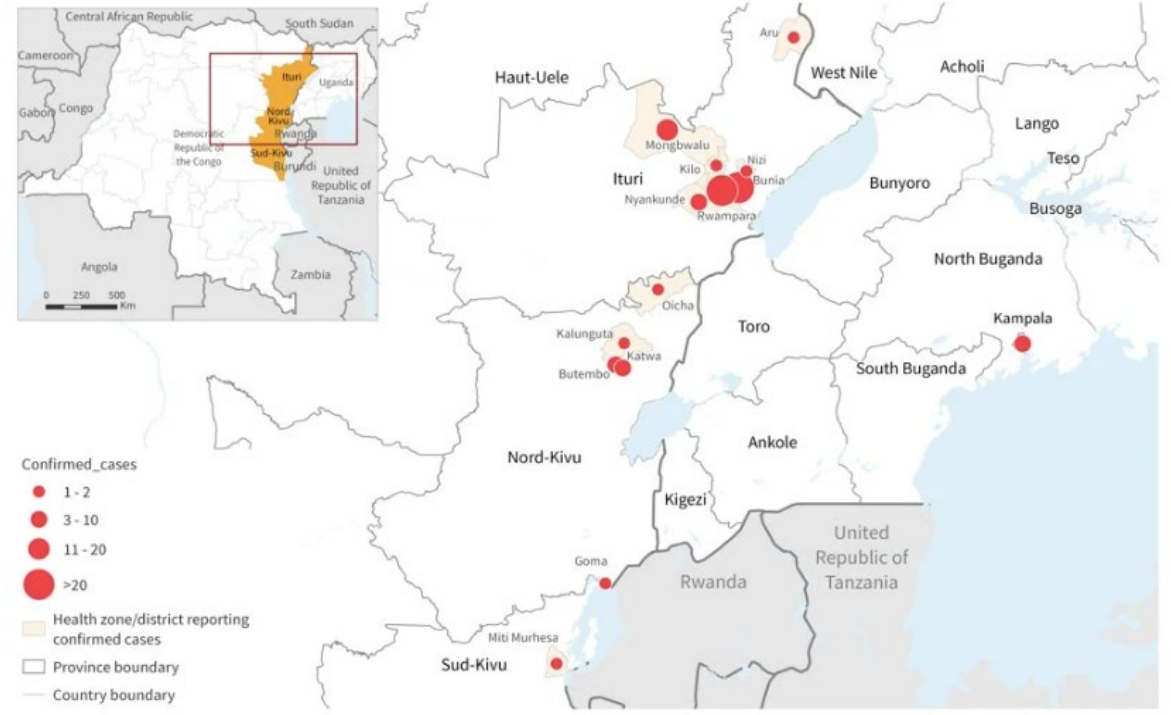
Ebola Virus Disease (Bundibugyo virus)

- 1°: Democratic Republic of the Congo
- Few cases in Uganda
- Bundibugyo species of Ebola
  - No vaccine or specific treatment

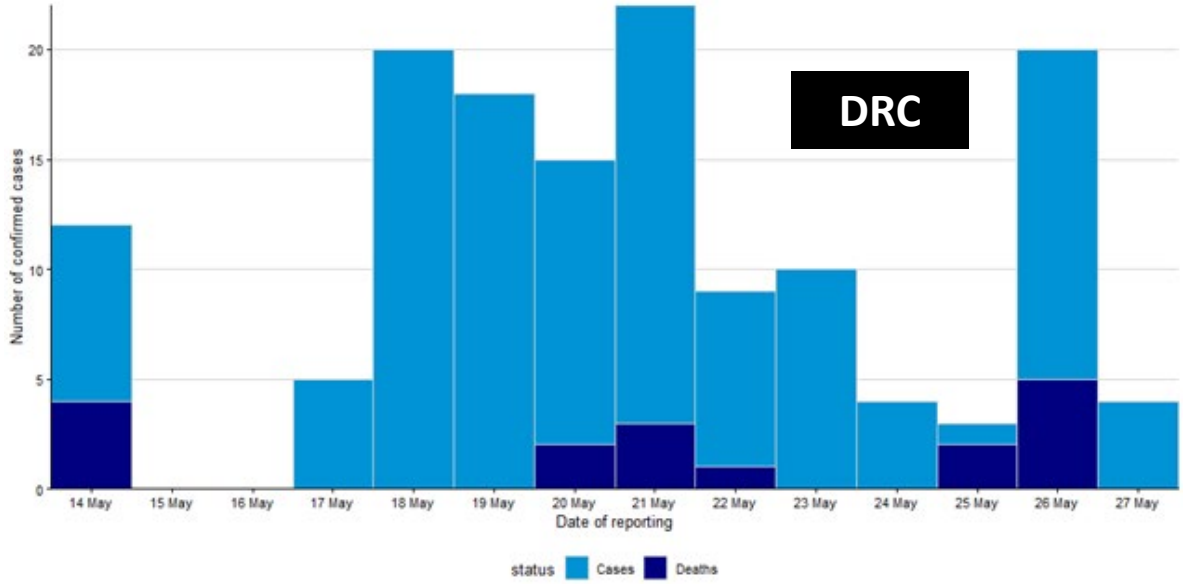
Affected countries	Suspected cases	Confirmed cases	Confirmed deaths	Probable deaths	CFR (%) confirmed	Recovered
Data as of 07 June 2026						
Democratic Republic of the Congo#	94	550	101	-	18%	19
Data as of 08 June 2026*						
Uganda	-	19	2	1	11%	5
Total	**94**	**569**	**103**	**1**	**18%**	**24**

Figure 1. Distribution of suspected and confirmed cases of Bundibugyo virus disease in Democratic Republic of the Congo and Uganda, as of 29 May 2026

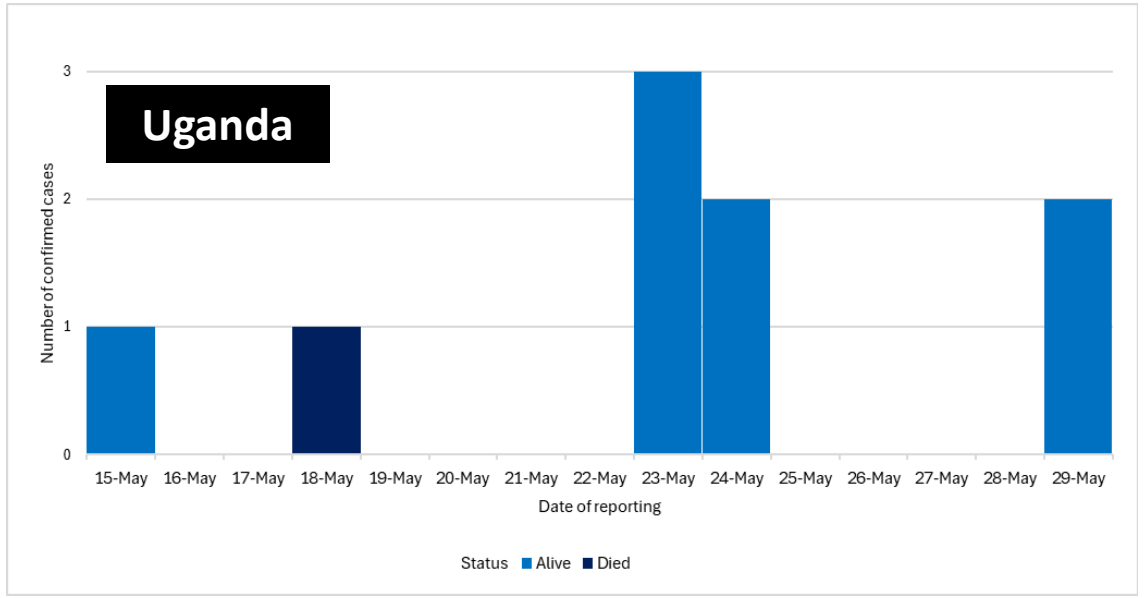


Data as of June 7, 2026

Ebola Virus Disease (Bundibugyo virus)



- Most Uganda cases in HCP



Woman treated after health scare at Mt. Juliet gas station

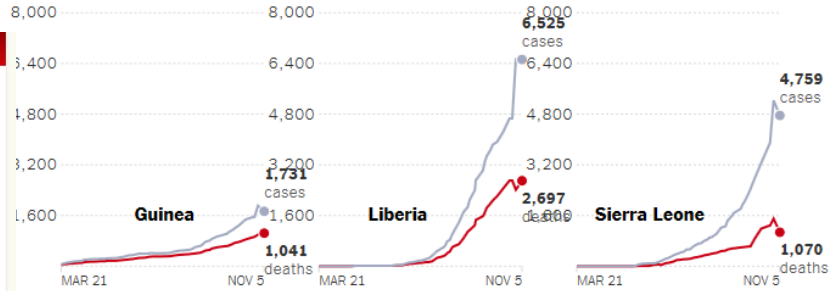
Posted: Oct 12, 2014 6:36 AM CDT
Updated: Oct 13, 2014 11:23 AM

Conservative Columnist: Is The Government Orchestrating The Ebola Crisis To Confiscate Guns?

How Many People Have Been Infected in Africa? UPDATED NOV. 5

More than 13,000 people in Guinea, Liberia, Mali, Nigeria, Senegal and Sierra Leone have contracted ıe World Health Organization, making this the biggest outbreak on ıve died.

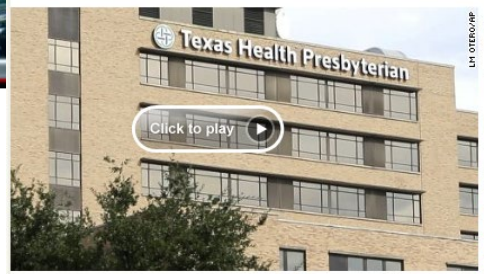
ks in Nigeria and Senegal were over. The two countries registered a combined 21 contracted cases and eight deaths.



Note: The number of deaths and cases reported by the World Health Organization sometimes decreases because of data revisions.

BREAKING NEWS

New Ebola case in Dallas



Worker tended to Thomas Eric Duncan

Duncan should have been moved to either Emory University Hospital in Atlanta or Nebraska Medical Center in Omaha, an official says. FULL STORY

- Nurses slam hospital | Fear spreads
- Texas doc gets testy on live TV
- Get up to speed | WHO on outbreak
- Gov.'s Ebola myth: Water kills it

Ebola Test Is Positive in Second Texas Health Worker

AKING NEWS

'We are deeply sorry'

Texas hospital apologizes for Ebola mistakes

Several policy changes have occurred since Thomas Eric Duncan's case, a hospital official says. FULL STORY

- Q&A: How did this happen?
- Spanish nurse is improving
- Nurses slam hospital | Fear spreads
- Who's who | Obama on Ebola
- Liberia overwhelmed | Photos: Gear

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SHEA Press Statement

In response to the recent Ebola quarantines, SHEA has released the following press statement. If you have any questions or comments, please contact kweinshel@shea-online.org.

SHEA Supports Evidence-Based Measures to Prevent Ebola Transmission, Opposes Mandatory Quarantine for Healthcare Personnel

Ebola Virus Disease

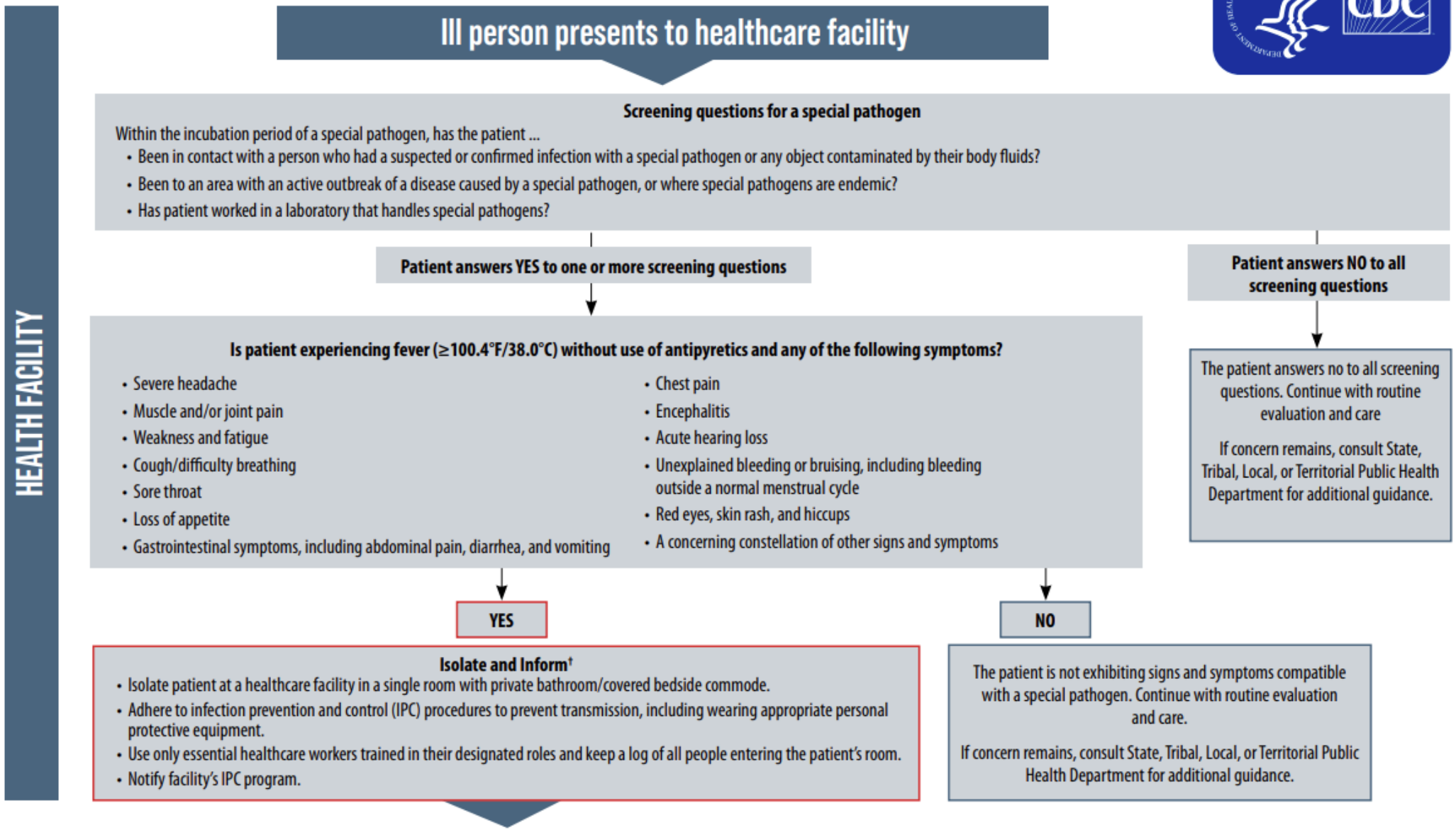
- May 18: CDC/HHS announce enhanced travel screening, entry restrictions:
  - Affected air passengers from DRC, South Sudan, and Uganda will have their air travel re-routed to arrive at Washington-Dulles International Airport (IAD), Atlanta Hartsfield-Jackson International Airport (ATL), George Bush Intercontinental Airport (IAH), or John F. Kennedy International Airport (JFK). Airlines will work directly with affected travelers to rebook flights.


Experts criticise plan for American-only Ebola quarantine centre in Kenya

Plan departs from policy of bringing CDC staff back to US for treatment and offering support to all health workers


Rebel attacks in eastern DRC kill 30 people and hamper Ebola response

Guide for Clinicians Evaluating an Ill Person for a Special Pathogen



https://www.cdc.gov/viral-hemorrhagic-fevers/hcp/diagnosis-testing/index.html

Hantavirus (Andes Virus)

- May 2: Reports of cluster of cases among passengers on Dutch ship MV Hondius (Argentina → Cape Verde)
  - First case sx start April 6
- Andes virus can spread person-to-person
- 18 people repatriated to U of Nebraska Medical Center (13 remain)

Data as of June 4, 2026

Data as of 04 June 2026, 17:00

World Health Organization

Status	Confirmed	Probable	Suspected	Inconclusive	Total
Alive	9	1	0	0	**10**
Dead	2	1	0	0	**3**
Total	**11**	**2**	**0**	**0**	**13**

The previously inconclusive case was subsequently confirmed negative following further laboratory testing and has been removed from the total count.

Interim Guidance for Public Health Assessment and Management of People with Potential Exposure to Andes Virus

Contacts with high-risk exposure:

- Being on board the M/V Hondius at any time from April 6 (date of symptom onset for the index case-patient) through the date of disembarkation of the exposed passenger cohort; or
- Answering "yes" to **any** of the exposure questions in Section 1.2 of the questionnaire (Appendix 1) PDF; or
- Being on an aircraft with a symptomatic case-patient and sitting within two seats in any direction*
    - If the exact seat number of the case-patient is not known, the zone will be expanded to include the same row as, two rows in front of and two rows behind the case-patient.

**Aircraft crew members and anyone who provided direct assistance to the case-patient on board the aircraft should be individually assessed for high-risk exposures.*

Hantavirus pulmonary syndrome (See Andes virus-specific guidance under Andes virus)	Standard		Not transmitted from person to person.
Andes virus ⚠ Andes virus [September 2024] Update: New precaution recommendations for Andes virus.	See comments	Duration of precautions should be determined on a case-by-case basis, in conjunction with local, state, and federal health authorities. Factors that should be considered include, but are not limited to, presence of symptoms, date symptoms resolved, other conditions that would require specific precautions (e.g. tuberculosis, *Clostridium difficile*) and available laboratory information.	Patient Placement: AIIR PPE: Gown, gloves, eye protection, N95® respirator or higher

Measles

U.S. Cases

	2026 To date	2025 Full year
Total Cases	**1,983**	**2,288**
Age		
Under 5 years	417 (21%)	584 (26%)
5-19 years	1,006 (51%)	1,016 (44%)
20+ years	554 (28%)	675 (30%)
Age unknown	6 (0%)	13 (1%)
Vaccination Status		
Unvaccinated or Unknown	92%	93%
One MMR dose	4%	3%
Two MMR doses	4%	4%

U.S. Hospitalizations

	2026	2025
Total Hospitalized	**6%** (124 of 1,983 cases)	**11%** (243 of 2,288 cases)
Percent of Age Group Hospitalized		
Under 5 years	10% (42 of 417)	18% (106 of 584)
5-19 years	3% (33 of 1,006)	6% (58 of 1,016)
20+ years	9% (49 of 554)	12% (79 of 675)
Age unknown	0% (0 of 6)	0% (0 of 13)

U.S. Deaths

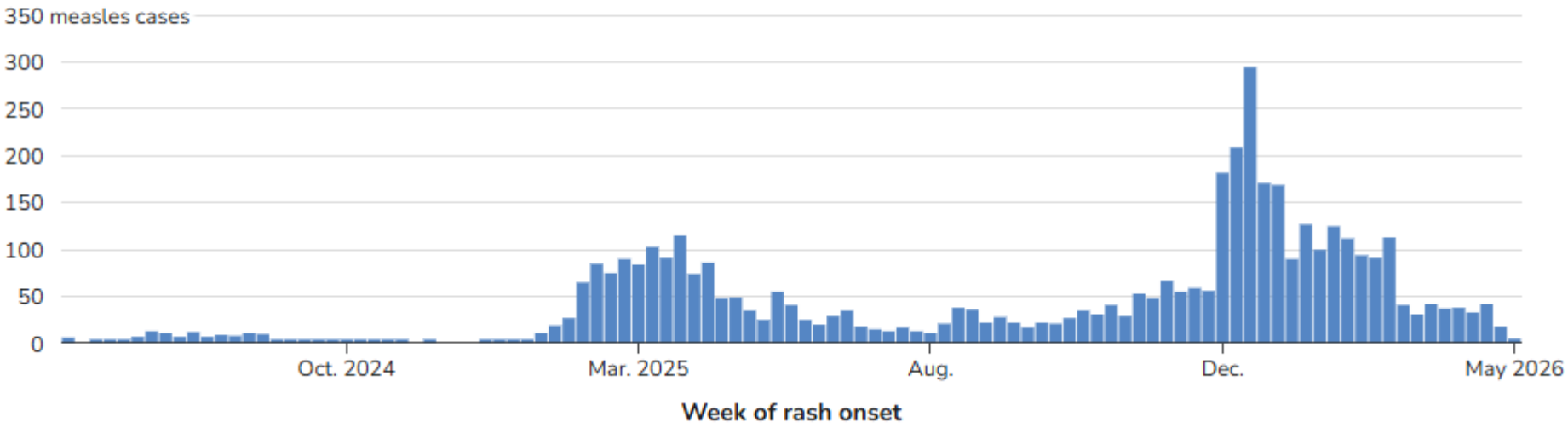
	2026	2025
Total Deaths	**0**	**3**

Data as of May 29, 2026

Measles

Weekly measles cases by rash onset date

2022–2026* (as of May 28, 2026)



South Carolina's measles outbreak is over. But more are brewing around the country

APRIL 27, 2026 · 7:17 PM ET

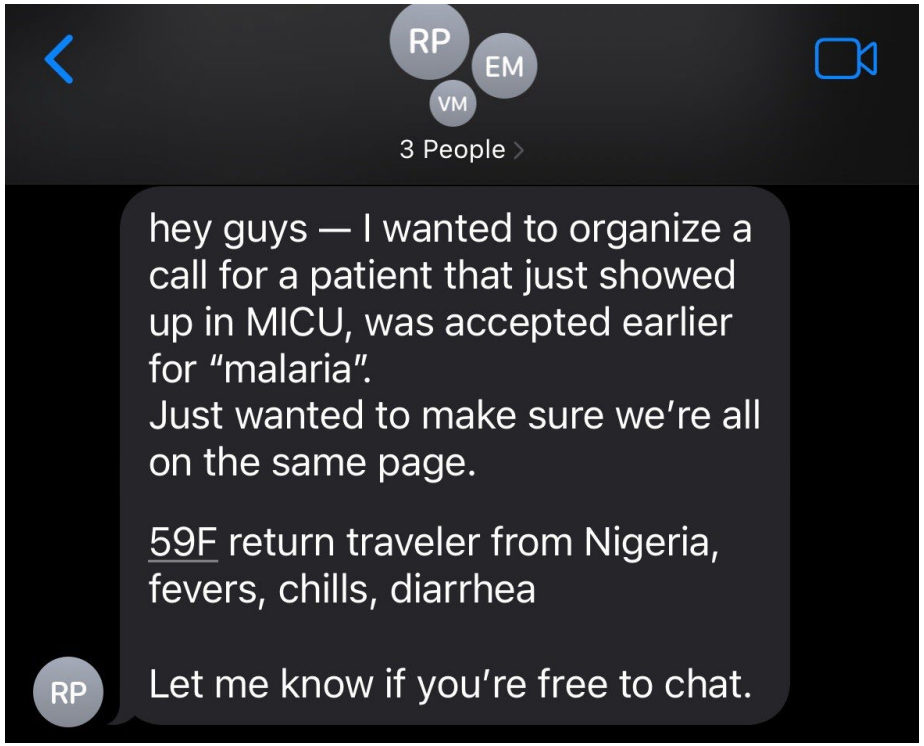
After SC measles outbreak declined, a new case is found in a new part of the state

By **Bristow Marchant**

June 3, 2026 3:39 PM

Data as of May 29, 2026

Text from a colleague



TJC Requirements for Infection Prevention and Control for Critical Access Hospitals and Hospitals

Requirement

Standard IC.07.01.01 The hospital implements processes to support preparedness for high-consequence infectious diseases or special pathogens.

EP 1. The hospital develops and implements protocols for high-consequence infectious diseases or special pathogens. The protocols are readily available for use at the point of care and address the following:

- Identify: Procedures for screening at the points of entry to the hospital for respiratory symptoms, fever, rash, and travel history to identify or initiate evaluation for high-consequence infectious diseases or special pathogens

Note: Points of entry may include the emergency department, urgent care, and ambulatory clinics.

- Isolate: Procedures for transmission-based precautions
- Inform: Procedures for informing public health authorities and key hospital staff
- Required personal protective equipment and proper donning and doffing techniques
- Infection control procedures to support continued and safe provision of care while the patient is in isolation and to reduce exposure among staff, patients, and visitors using the hierarchy of controls

Note: See the Glossary for a definition of hierarchy of controls.

- Procedures for waste management and cleaning and disinfecting patient care spaces, surfaces, and equipment

(See also EC.02.02.01; EC.02.05.01, EP 15)

https://digitalassets.jointcommission.org/api/public/content/01f83448fbb54ba7b9225048834e7247?v=4e3fcba2

Challenges associated with initial management of emerging pathogens and other high consequence infectious diseases (HCIDs)

1. Clinical findings are non-specific
2. Travel history and risk factors may not be reliably elicited
3. Rare infections are often not endemic to a traveler's destination country and not familiar to clinicians

All can lead to delays in clinical recognition, initial isolation, and diagnosis.

#1 Maintain situational awareness: Selected Resources to Track Global and Domestic Outbreaks

Public health authority sources

- Centers for Disease Control and Prevention (CDC) health alerts
- State and local health department alerts
- World Health Organization (WHO) disease outbreak news
- United Kingdom National Health Service HCID Report

Curated news aggregators

- Biothreats Emergence, Analysis, and Communications Network (BEACON)
- The Program for Monitoring Emerging Diseases (ProMED)
- HealthMap (https://www.healthmap.org/en/)

Center for Infectious Disease Research and Policy (CIDRAP)

HHS Region 2 RESPTC Outbreak Resources:
https://www.r2resptc.org/tools.php

#2 Partner with your Regional Emerging Special Pathogen Treatment Center (RESTPC) for preparedness

Find Your Regional Contacts

Find contact information below for each of our Regional Treatment Centers, including local and state health partners; physician, nursing, and operations leadership; and pediatric contacts.

→ Contact Your RESPTC

https://netec.org/about-netec/partners-regional-contacts/#regional-contacts

Identify, Isolate, Inform

STEP 1. **Identify** potentially infectious patient

Primary Assessment:

Signs and symptoms (fever, rash, conjunctivitis, respiratory symptoms, vomiting, diarrhea)

+

Travel history relative to symptom onset

Guided by current HCID outbreaks

STEP 2. **Isolate** patient, then perform Secondary Assessment:

Subnational travel itinerary

Exposures (sick contacts, animals, insects, food, recreational and occupational activities)

STEP 3. Formulate differential diagnosis.

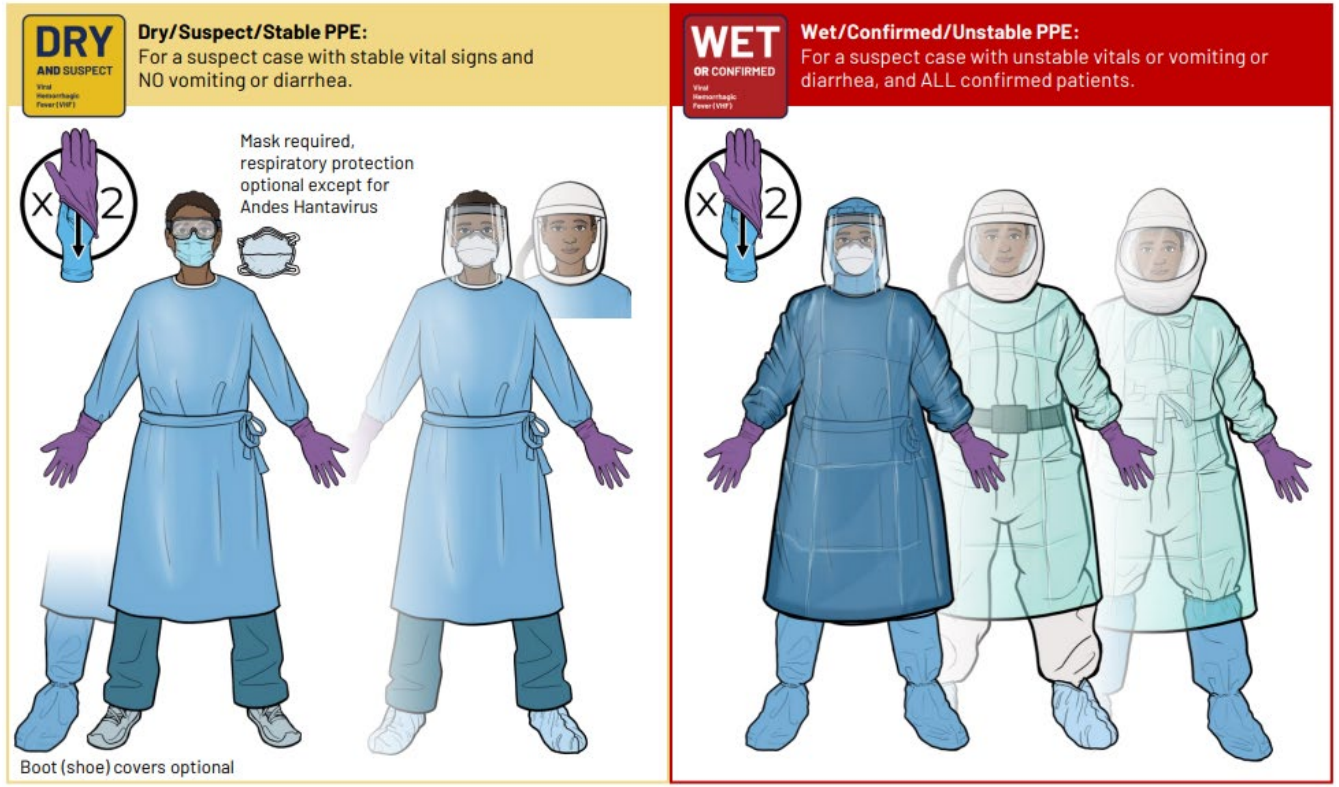
If HCID suspected, **inform** relevant stakeholders (infection prevention and control department, public health department, hospital leadership)

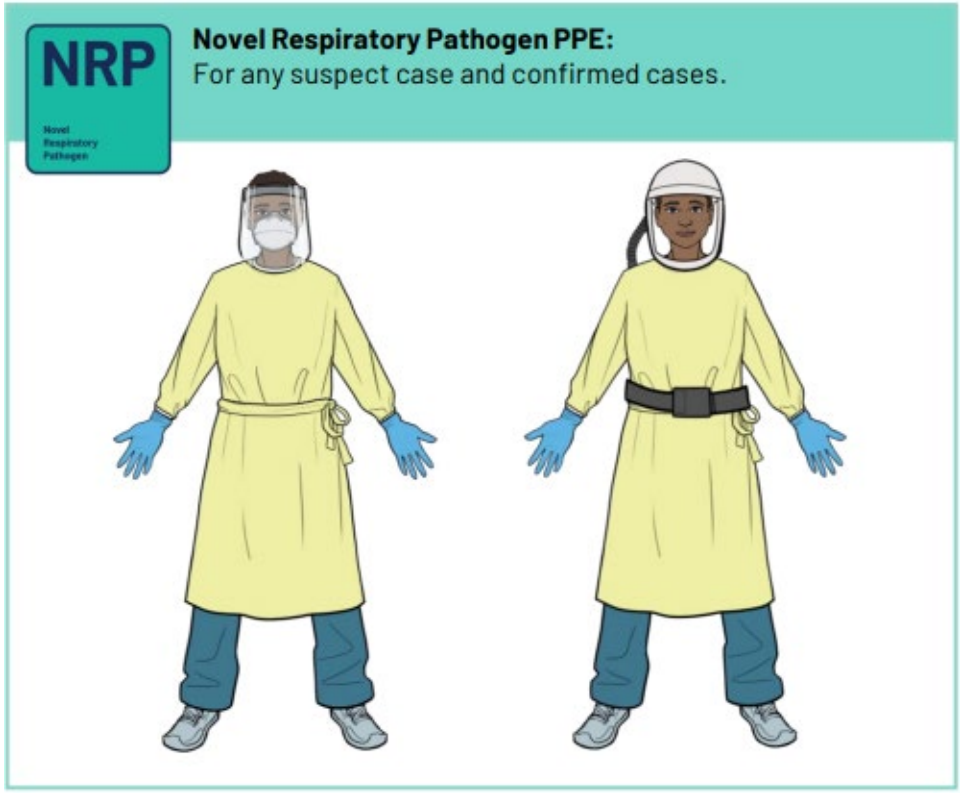
Lazarus JE et al. Antimicrob Steward Healthc Epidemiol. 2025 Sep 1;5(1):e192.

Establish plans for PPE supplies and training for emerging pathogens and high consequence infectious diseases (HCIDs)

Consider:

- Known or suspected pathogen
- Transmission pathways, when known
- Patient condition
- Facility and role risk assessment





NETEC PPE Work Group, & NETEC. (2026). PPE Matrix for High-Consequence Infectious Diseases. NETEC Resource Library. Retrieved 2026-06-05, from https://repository.netecweb.org/items/show/1693

Safe provision of care while the patient is in isolation

What routine labs can be safely done for a patient with suspected Ebola at your hospital?

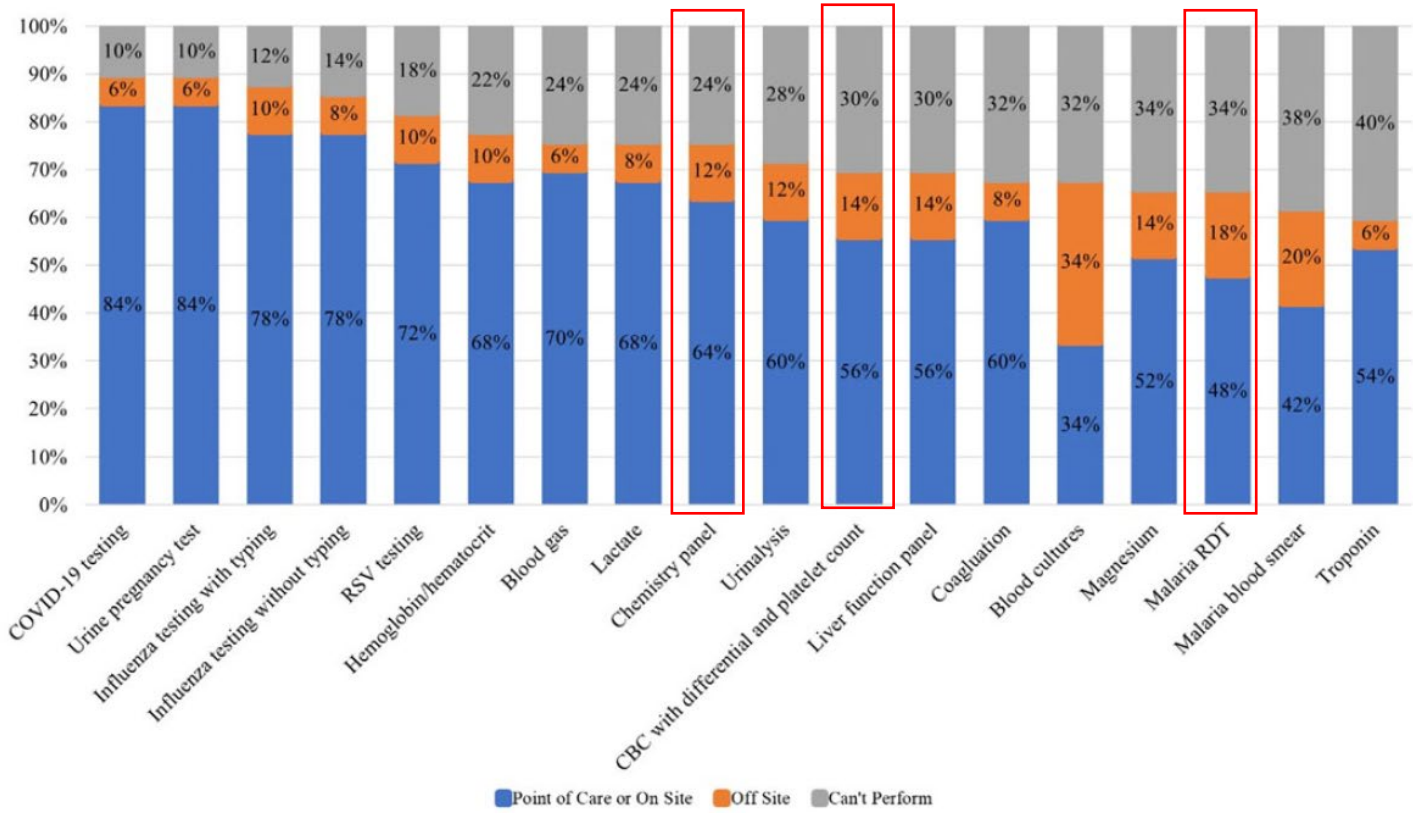


Figure 1. Which of the following best describes your institution's current ability to safely perform this test for a suspected or confirmed high consequence infectious diseas (HCID) patient?. Stacked bar graph representing the ability of hospitals to safely perform 18 routine laboratory tests on a suspect HCID patient. Blue bars indicate hospitals tha can perform the test at the point of care or at an on-site core laboratory. Orange bars indicate hospitals that can collect a specimen and send it to an off-site laboratory. Gray bar indicate hospitals that cannot perform the laboratory test.

Figure 3. Assembled Laboratory "Go Kit" Cart.

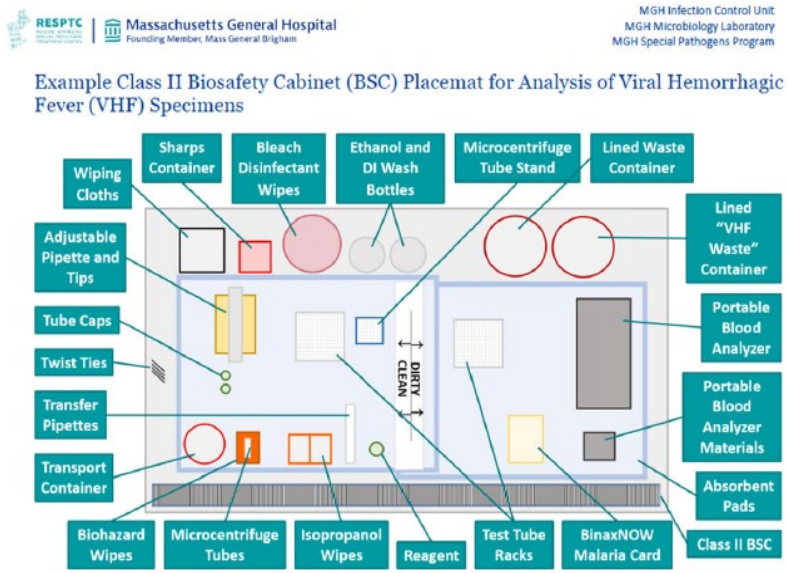


Figure 4. Picture map of class II biosafety cabinet placement for analysis of viral hemorrhagic fever specimens.

DiLorenzo MA et al. Infect Control Hosp Epidemiol 2026. doi: 10.1017/ice.2026.10465

Turbett SE et al. Infect Control Hosp Epidemiol 2024;45:1–7.

Common infections are common… and many can mimic HCIDs

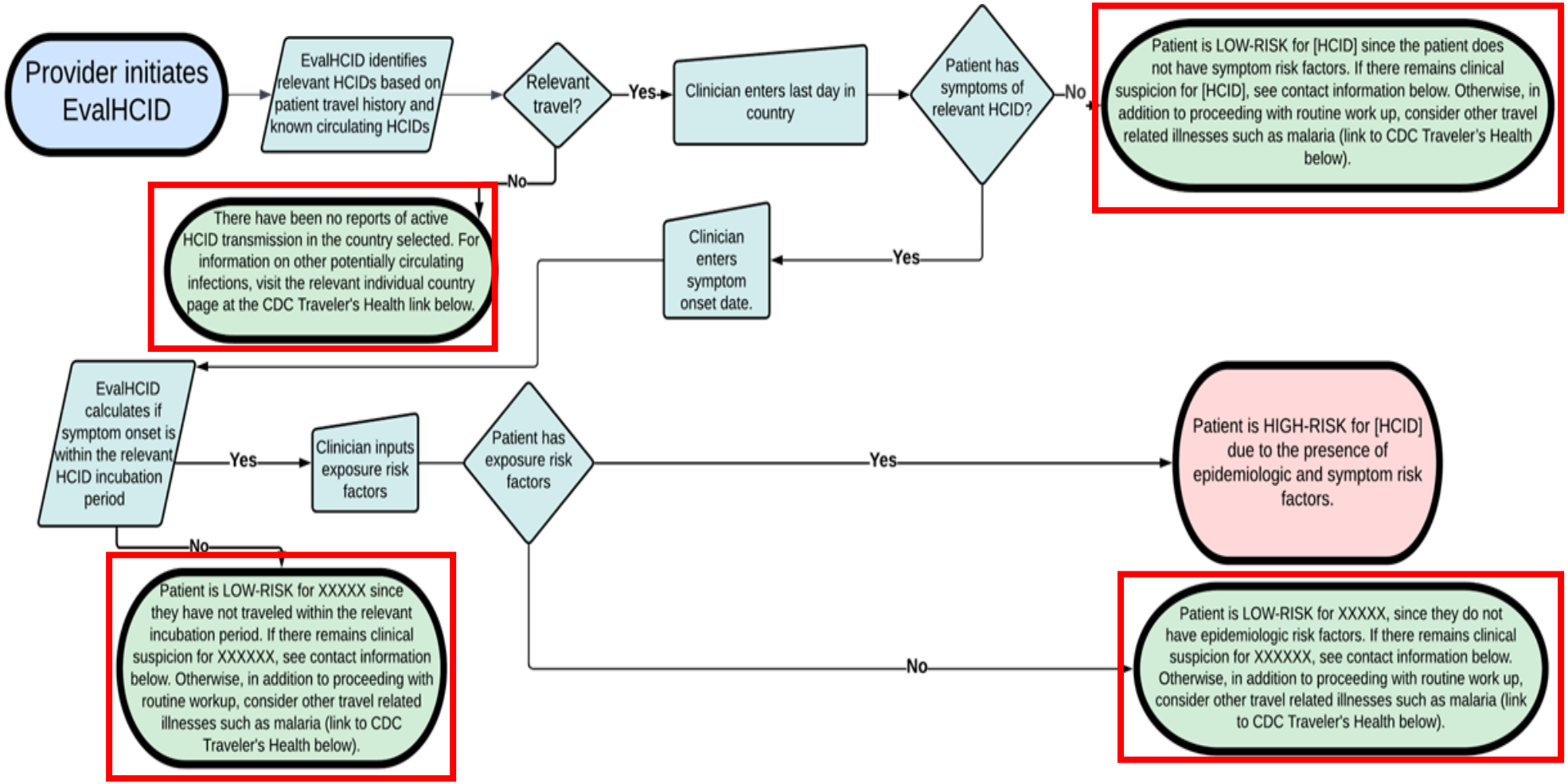
Table 1. Top 10 infectious disease considerations at mass gatherings for sporting events in 2026

Method of transmission	Pathogen	Mean incubation period	Reason for concern	Type of precautions
Food and beverages 	Hepatitis A ^*PEP available	28 days (range 15–50 days)	Foodborne outbreaks are common	Contact precautions
	Norovirus	12–48 hours	Outbreaks ARE common	Contact precautions
	E. Coli	3–4 days (range 3–8 days) *E. coli* O157:H7 : 3–4 days (range 1–10 days) ETEC: 6–48 hrs	Potential for different strains of E. coli based on visiting traveler countries.	Contact precautions
Airborne (aerosol and droplet) 	Measles ^*PEP available	11–12 days	Increased rates in the USA and Canada in past years. Increased rates in some participating visitors' countries	Airborne precautions
	COVID-19 ^	Varied based on prior variants : median incubation period of 3–4 days	Seasonality of COVID-19 is still uncertain with potential for increased transmission	Droplet precautions
	Influenza ^ and other respiratory viruses	Influenza: 1 to 4 days RSV: 4 to 6 days	Potential for increased transmission	Droplet precautions
	Tuberculosis	Detected an average of 8–10 weeks after infection	Increased incidence likely in countries of participating visitors	Airborne precautions
Contact (skin and infectious bodily fluids) 	Mpox ^*PEP available	Range 3–17 days	Relatively new emerging pathogen as of 2024 with evolving epidemiology	Contact precautions
	HIV and other sexually transmitted infections *PEP available for HIV and STIs	HIV: flu-like symptoms within 2 to 4 weeks after infection	Sexually transmitted infections can increase at these type of world events	Standard precautions
Contact (other pathogens) 	Multi-drug resistant bacteria such metallo-B lactamases and *C. auris*		Not likely an acute problem; however, over time introduction could lead to gradual emergence in host cities	Contact precautions

**Please refer to the CDC reports of outbreaks in the USA and international settings.
***This table does not include agents of bioterrorism.
****Abbreviations: ETEC (*Escherichia coli* - Enterotoxigenic), HIV (Human immunodeficiency virus).
^Vaccine Preventable Disease.

Mehrotra P. Antimicrob Steward Healthc Epidemiol 2026. doi: 10.1017/ash.2026.10319

Pathways for de-escalation are important



Source: Lazarus JE et al. Antimicrob Steward Healthc Epidemiol 2025;5(1):e192.

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Mehrotra P, Mathew T, Trulik KG, et al. Sports fever! Getting the ball rolling to prevent infections at the World Cup™ and beyond. Antimicrob Steward Healthc Epidemiol 2026. doi: 10.1017/ash.2026.10319

Turbett SE, Lazarus JE, Nardini MA, et al. Enabling laboratory readiness and preparedness for the evaluation of suspected viral hemorrhagic fevers: development of a laboratory toolkit. Infect Control Hosp Epidemiol 2024;45:1–7. https://doi.org/10.1017/ice.2024.143

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