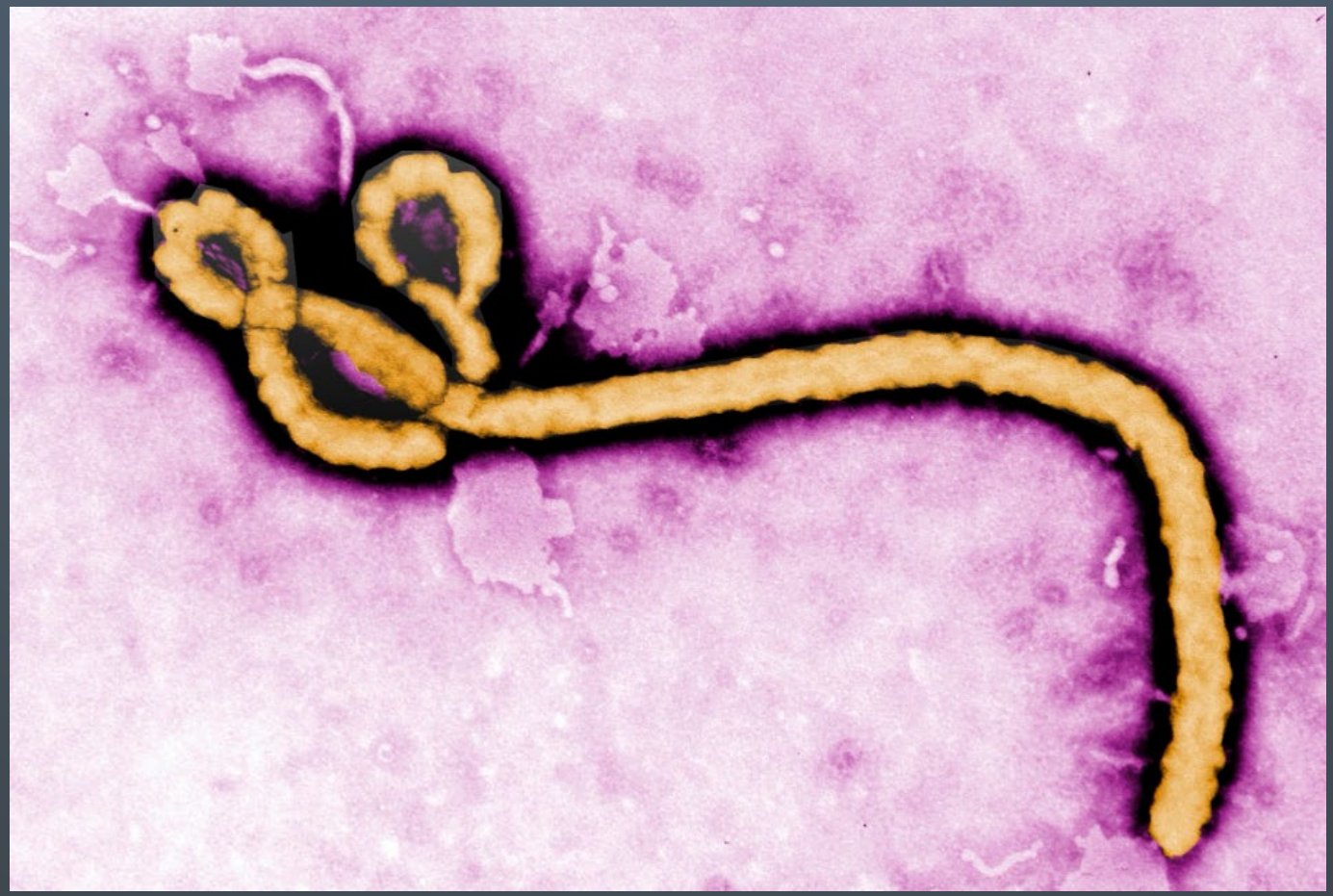


Ebola Bundibugyo Virus Clinical Update

June 11, 2026

Welcome and Opening Remarks

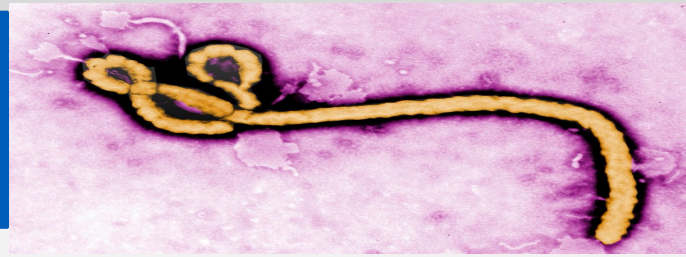
Varun Shetty, MD, MBA, MS
Chief State Epidemiologist
Texas Department of State Health Services

DISCLAIMER

The information presented today is based current preliminary data and on CDC's recent guidance. Information is subject to change.

June 10, 2026

Agenda



1. Overview of Bundibugyo virus disease
   Mehgan Kidd, MD MS
   Infectious Diseases Medical Officer, DSHS
2. Ebola Bundibugyo Virus Situational Update
   Stephen L. White, PhD, MLS(ASCP)^{CM}
   Epidemiologist IV
   High Consequence Infectious Diseases Team Lead, DSHS
3. Laboratory Testing
   Grace Kubin, PhD
   Deputy Commissioner, Public Health Laboratory Division, DSHS
4. Infection Prevention and Control
   Gretchen Rodriguez, PhD, MPH, CIC
   HAI/AR Epidemiology Manager, Healthcare Safety Unit, DSHS
5. Emergency Medical Task Force Infectious Disease Response Unit
   Jeff Hoogheem
   Director
   Center for Health Emergency Preparedness and Response, DSHS

   Sara Jensen
   Deputy Director
   Emergency Medical Task Force
6. Resources
   Saroj Rai, PhD, MPH
   Chief Advisor, DSHS
7. Q&A
8. Closing Remarks
   Varun Shetty, MD, MBA, MS
   Chief State Epidemiologist, DSHS

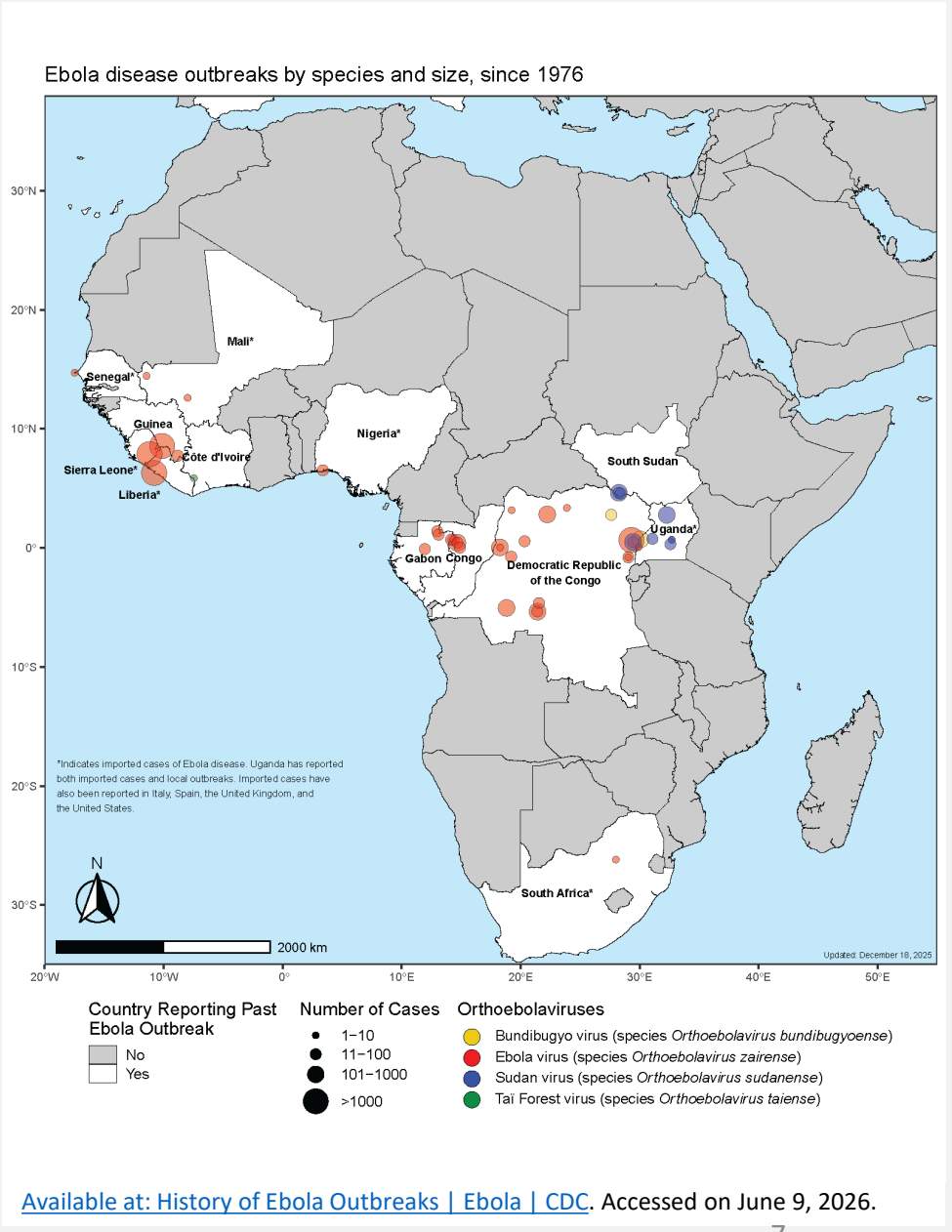
Overview of Bundibugyo Virus Disease (BVD)

Mehgan Kidd, MD, MS
Infectious Diseases Medical Officer
Texas Department of State Health Services

Ebola Disease

- Ebola disease: Umbrella term to describe clinical disease due to infection with any of the 4 viruses within the genus *Orthoebolavirus* that have caused disease in humans:
  - Ebola virus (species *Orthoebolavirus zairense*)
  - Sudan virus (species *Orthoebolavirus sudanense*)
  - Bundibugyo virus (species *Orthoebolavirus bundibugyoense*)
  - Taï Forest virus (species *Orthoebolavirus taiense*)
- Illnesses caused by infection with these viruses are clinically indistinguishable.
- Bundibugyo virus disease (BVD): Term used to describe clinical disease due to infection with Bundibugyo virus.

Available at: COCA Call Ebola Bundibugyo Virus, accessed on June 4, 2026.



Available at: History of Ebola Outbreaks | Ebola | CDC. Accessed on June 9, 2026.

Ebola Disease Background

- Mean incubation period of 8-10 days (Range of 2-21 days).
  - Patients are not infectious during their incubation period, before symptoms develop.
- Most likely reservoir are bats.
- Mortality rate ranges from 25-90% and typically occurs 7-10 days after symptoms onset

Available at: Fruit eating bat: Natural host for Ebola virus disease. | Download Scientific Diagram. Accessed on June 4, 2026.

Available at: Ebola Disease Basics | Ebola | CDC. Accessed on June 4, 2026.

Person-to-person transmission

- Ebolavirus viral load increases through the patient illness and is highest at the time of death.
- Virus is found **in all body fluids** and is transmitted through:
  - Direct contact with the body fluids of a person who is sick with or has died from Ebola disease
  - Contact with contaminated items (clothes, bedding, needles, or medical equipment)
  - Sexual activity with someone who has recovered from Ebola disease
  - Congenital transmission
  - Through breastfeeding
- **Ebola is not spread through airborne transmission.**
- Virus can persist for several months in some organs that evade the body's immune system including:
  - Semen/testicles (Can be detected in testicles/semen years after infection)
  - Placenta and amniotic fluid
  - Human milk, saliva, cerebrospinal fluid, joints
  - Conjunctivae

Available at: Caring for Ebola Disease Survivors in the U.S. | Ebola | CDC. Accessed on June 2, 2026.

Risk factors for Bundibugyo virus

- Contact with a symptomatic person with a suspected or confirmed Bundibugyo virus or any objects contaminated by their body fluids.
- Experienced a breach in infection prevention and control precautions that result in the potential for contact with body fluids of a patient with suspected or confirmed Bundibugyo virus.
- Contact with semen from a person who has recovered from Bundibugyo virus.
- Participated in the following activities in an outbreak area or where Orthoebolaviruses are endemic:
  - Having contact with someone who was sick or died, or any objects contaminated by their body fluids.
  - Attending/participating in funeral rituals, including preparing bodies for funeral or burial.
  - Working in a healthcare facility or laboratory.
  - Visiting a healthcare facility or traditional healer.
  - Having contact with bats or wild animals.
  - Working or spending time in a mine/cave.

Available at: COCA Call Ebola Bundibugyo Virus, accessed on June 4, 2026.

Clinical presentation

- No sign or symptom is pathognomonic for Ebola disease.
- Fever is not universally present
- Bleeding/bruising not universally present.

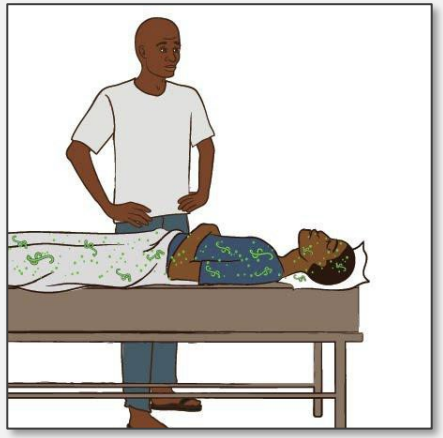
Dry Phase	Wet Phase
Fever	Nausea/vomiting
Fatigue	Dysphagia
Headache	Diarrhea
Sore throat	Unexplained bleeding or bruising
Abdominal pain	Hiccups
Joint pain	Maculopapular rash
Myalgias	Conjunctival injection or subconjunctival hemorrhage
Back pain	

* Includes bleeding from the gums, mouth, nose, bloody vomit, bloody stools, bleeding from injection sites, vaginal bleeding outside of a menstrual cycle

Available at: COCA Call Ebola Bundibugyo Virus, accessed on June 2, 2026.

INFECTION

Infection occurs after exposure to a person who is sick or has died of Ebola.



INCUBATION PERIOD

- It can last from 2-21 days (usually 4-17 days)
- Person feels well and has no symptoms
- **The person cannot transmit the virus**

DRY PHASE

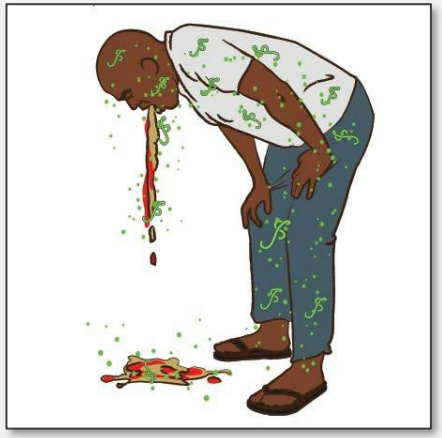
Common signs and symptoms are

- Fever
- Fatigue
- Headache
- Joint pain
- Muscle pain
- Back pain
- Sore throat

WET PHASE

Common signs and symptoms are

- Diarrhea
- Nausea/vomiting
- Bleeding occurs in some cases
- Hiccups
- Eye redness



- The patient becomes more contagious as the disease progresses.
- In fatal cases, death occurs on average 7 to 10 days after the onset of symptoms.
- The amount of Ebola virus is highest at the time of death.

EXPOSURE TO THE VIRUS — NOT CONTAGIOUS — **DAY 0 OF THE DISEASE** — CONTAGIOUS — **DAY 4 OF THE DISEASE** — EVEN MORE CONTAGIOUS — **DAY 7-10 OF THE DISEASE** — THE MOST CONTAGIOUS

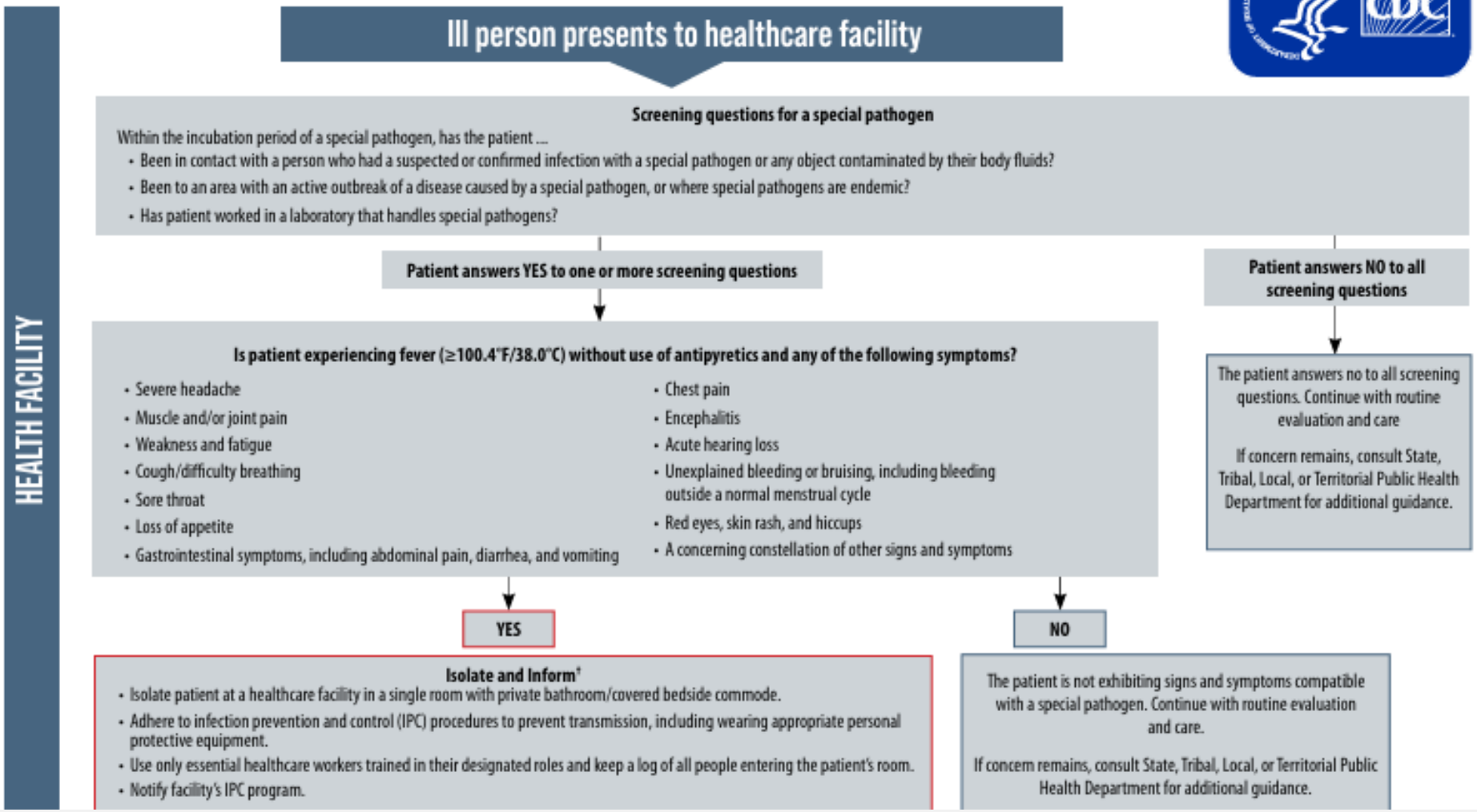
Available at: Clinical Features of Ebola Disease | Ebola | CDC, accessed on June 4, 2026.

Laboratory Findings

- Leukopenia/lymphopenia and elevated neutrophils later in disease
- Thrombocytopenia
- Elevated aspartate aminotransferase (AST) and alanine aminotransferase (ALT)
- Metabolic derangements
  - Hypokalemia
  - Hyponatremia
  - Hypocalcemia
  - Hypomagnesemia
- Disseminated intravascular coagulation
- Increased vascular permeability

Available at: Hemorrhagic Fevers Caused by Filoviruses: Ebola and Marburg | Red Book: 2024–2027 Report of the Committee on Infectious Diseases | Red Book Online | American Academy of Pediatrics. Accessed on June 5, 2026.

Guide for Clinicians Evaluating an Ill Person for a Special Pathogen



Available at: Guide for Clinicians Evaluating an Ill Person for a Special Pathogen Accessed on June 10, 2026.

Diagnosis

- If a clinician suspects a patient may be infected with a VHF, please call your LHD/DSHS to determine if testing is warranted.
- Viral hemorrhagic fever case definition:
  - Suspect case: Signs and symptoms compatible with a VHF **AND** an epidemiological risk factor within 21 days before the onset of symptoms.
  - Confirmed case: Laboratory-confirmed diagnostic evidence of a VHF

- Differential diagnoses to consider depending on place of travel:
  - Malaria – most common cause of fever in a traveler
  - Measles
  - Typhoid fever
  - Meningococcemia
  - Lassa fever
  - Dengue
  - Hepatitis A
  - Influenza
  - COVID-19

Available at: Clinical Screening and Diagnosis for VHFs | Viral Hemorrhagic Fevers (VHFs) | CDC. Accessed on June 3, 2026.

Treatment and Prevention

- Early initiation of management is important in improving outcomes.
- Mainstay of treatment is supportive care including:
  - Fluid and electrolyte repletion
  - Hemodynamic support
  - Blood products
  - Symptom management
    - Oxygen
    - Nutritional support
    - Antiemetics
    - Analgesics
- Antimalarial and antimicrobial medications when coinfections are suspected or confirmed

Available at: Clinical Guidance for Ebola Disease | Ebola | CDC. Accessed on June 5, 2026

Treatment and Prevention

- There are currently no FDA-approved treatments for the Bundibugyo virus (BDBV).

Ebola virus species involved in outbreak	Vaccines	Therapeutics
Ebola virus (*Orthoebolavirus zairense*)	• ERVEBO • Zabdeno/ Mvabea	• Ebanga • Inmazeb
Sudan virus (*Orthoebolavirus sudanense*)	No licensed vaccine	No licensed therapeutics
Taï Forest virus (*Orthoebolavirus taiense*)	No licensed vaccine	No licensed therapeutics
Bundibugyo virus (*Orthoebolavirus bundibugyoense*)*	No licensed vaccine	No licensed therapeutics

Available at: Clinical Guidance for Ebola Disease | Ebola | CDC. Accessed on June 11, 2026.

Treatment and Prevention

- Remdesivir (manufactured by Gilead Sciences)
  - FDA approved for treatment of SARS-CoV-2
  - In the PRISM trial, Remdesivir monotherapy was shown to be inferior to monoclonal antibodies for human treatment of Ebola virus.
  - Remdesivir has shown mortality benefit in non-human primate studies and when administered in combination with monoclonal antibodies for treatment of Sudan virus infection.
- MBP134 (manufactured by Mapp Biopharmaceuticals)
  - Investigational two monoclonal antibody cocktail
  - Targets all Orthoebolaviruses
  - It has shown improved mortality and decreased viral loads in non-human primate trials against Ebola, Sudan, and Bundibugyo virus.
- If a provider requests clinical consultation, please call your LHE/DSHS or our DSHS epidemiologist on-call at 1-800-705-8868.

Available at: A Randomized, Controlled Trial of Ebola Virus Disease Therapeutics. Accessed on June 10, 2026.

Available at: Experts convened by WHO advise on candidate treatments and vaccines for Ebola disease caused by Bundibugyo virus. Accessed on June 5, 2026.

Treatment and Prevention

- Currently, there are no approved vaccines for Bundibugyo virus.
- Three candidate vaccines in development:
  - Single-dose rVSV Bundibugyo vaccine (developed by the International AIDS Vaccine Initiative or IAVI)
  - ChAdOx1 Bundibugyo (developed by Oxford University/Serum Institute of India)
  - Bundibugyo virus vaccine candidate (Moderna)

Available at: CEPI fast-tracks three Bundibugyo ebolavirus vaccine candidates. Accessed on June 10, 2026.

Ebola Bundibugyo Virus Situational Update

Stephen L. White, PhD, MLS(ASCP)^{CM}

Epidemiologist IV, High Consequence Infectious Diseases Team Lead

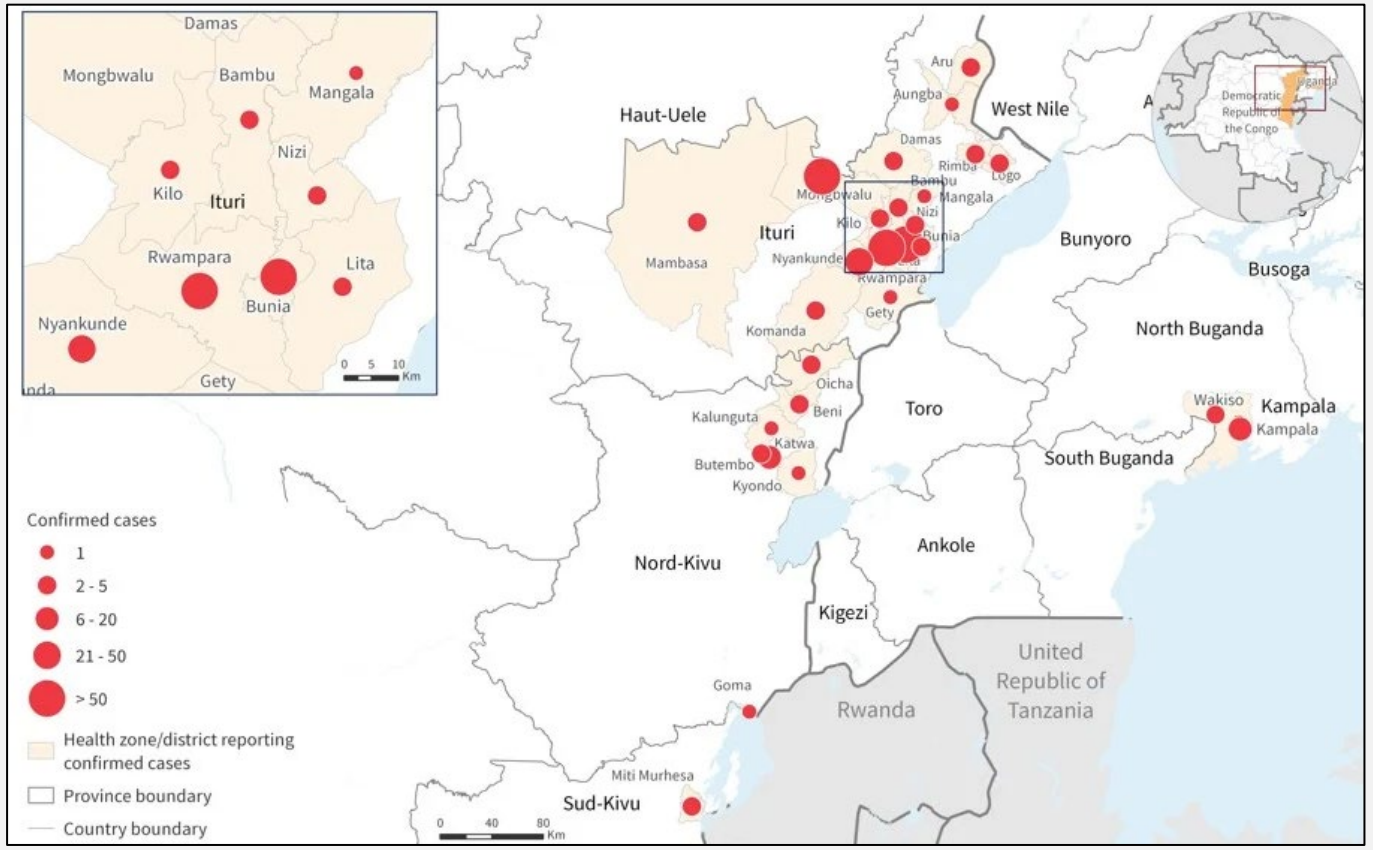
Texas Department of State Health Services

Current Situation

- On April 24, 2026, the first known suspected case of Ebola disease was reported in a nurse in Ituri Province, Democratic Republic of the Congo (DRC)
  - Retrospective investigations have identified suspect cases in March 2026, suggesting prolonged undetected transmission
- Initial testing of suspect cases was negative because the test was not designed to detect Bundibugyo virus
- Bundibugyo virus was confirmed at the DRC's Institut National de la Recherche Biomédicale in mid-May
- This is the 17th outbreak of Ebola disease in the DRC and the third outbreak caused by Bundibugyo virus

Current Situation

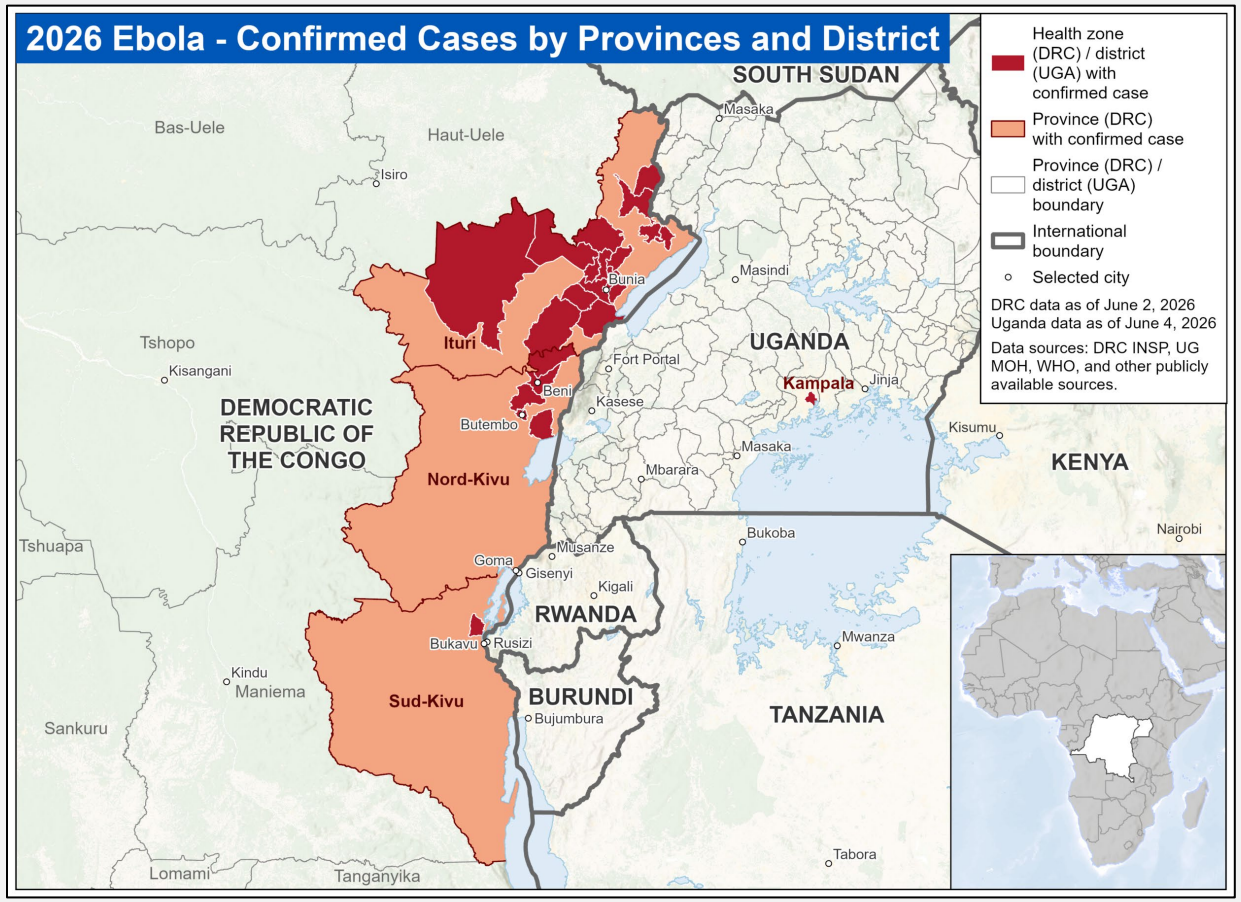
- As of 6/9/2026, DRC had reported:
  - 635 confirmed cases
  - 127 confirmed deaths
- As of 6/8/2026, Uganda had reported:
  - 19 confirmed cases
  - 2 confirmed deaths
  - 1 probable case
  - 1 probable death



Available at: https://www.who.int/emergencies/disease-outbreak-news/item/2026-DON606, accessed on June 9, 2026.

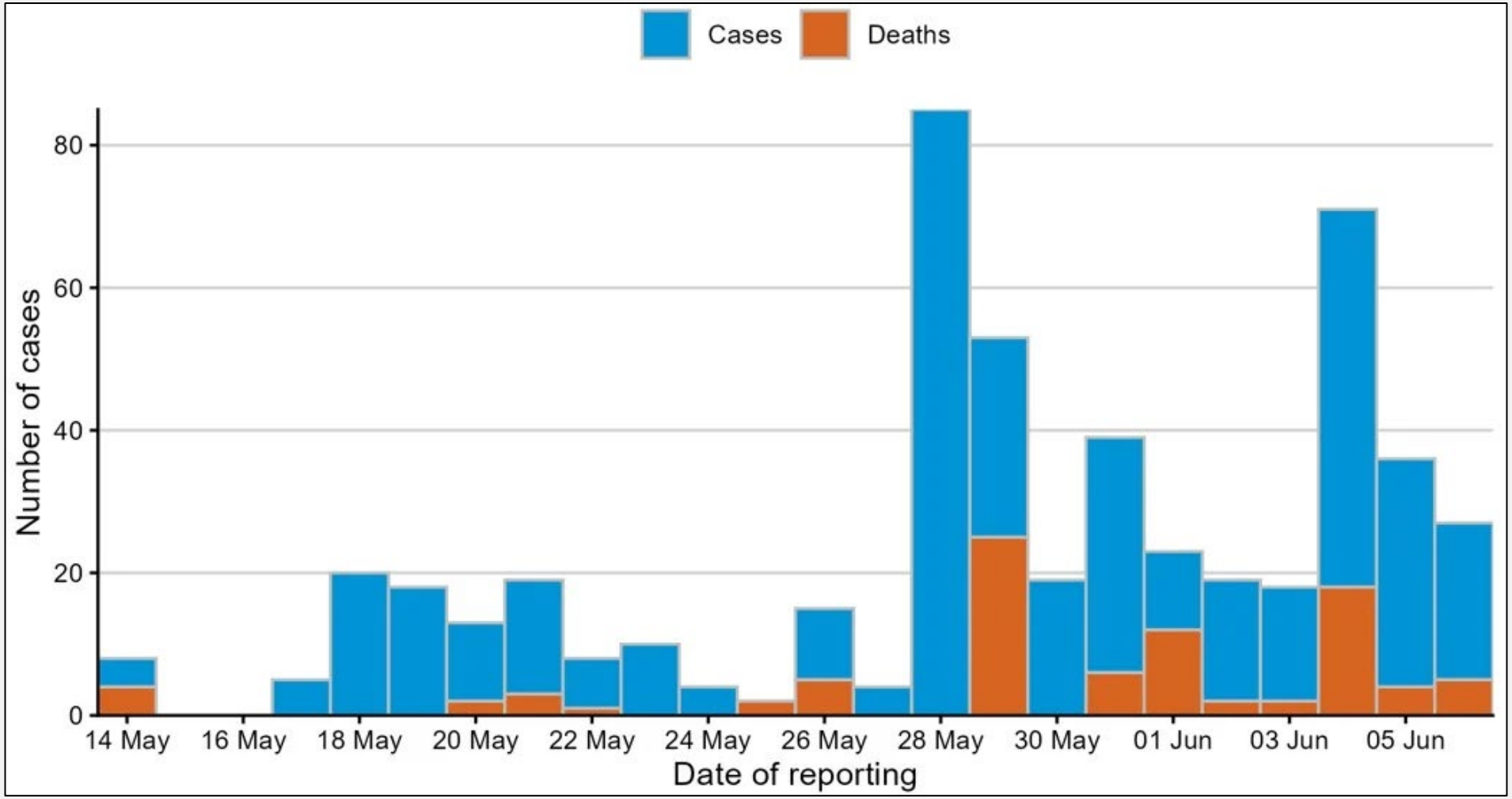
Current Situation

- DRC
  - Cases have been reported in 3 provinces
  - 94% of cases have been reported in Ituri Province
  - 5,040 contacts have been identified
  - The security situation in this area of the DRC has continued to affect the public health response
- Uganda
  - 2 districts affected
  - All cases have been linked to travelers from the DRC
  - 668 contacts have been identified



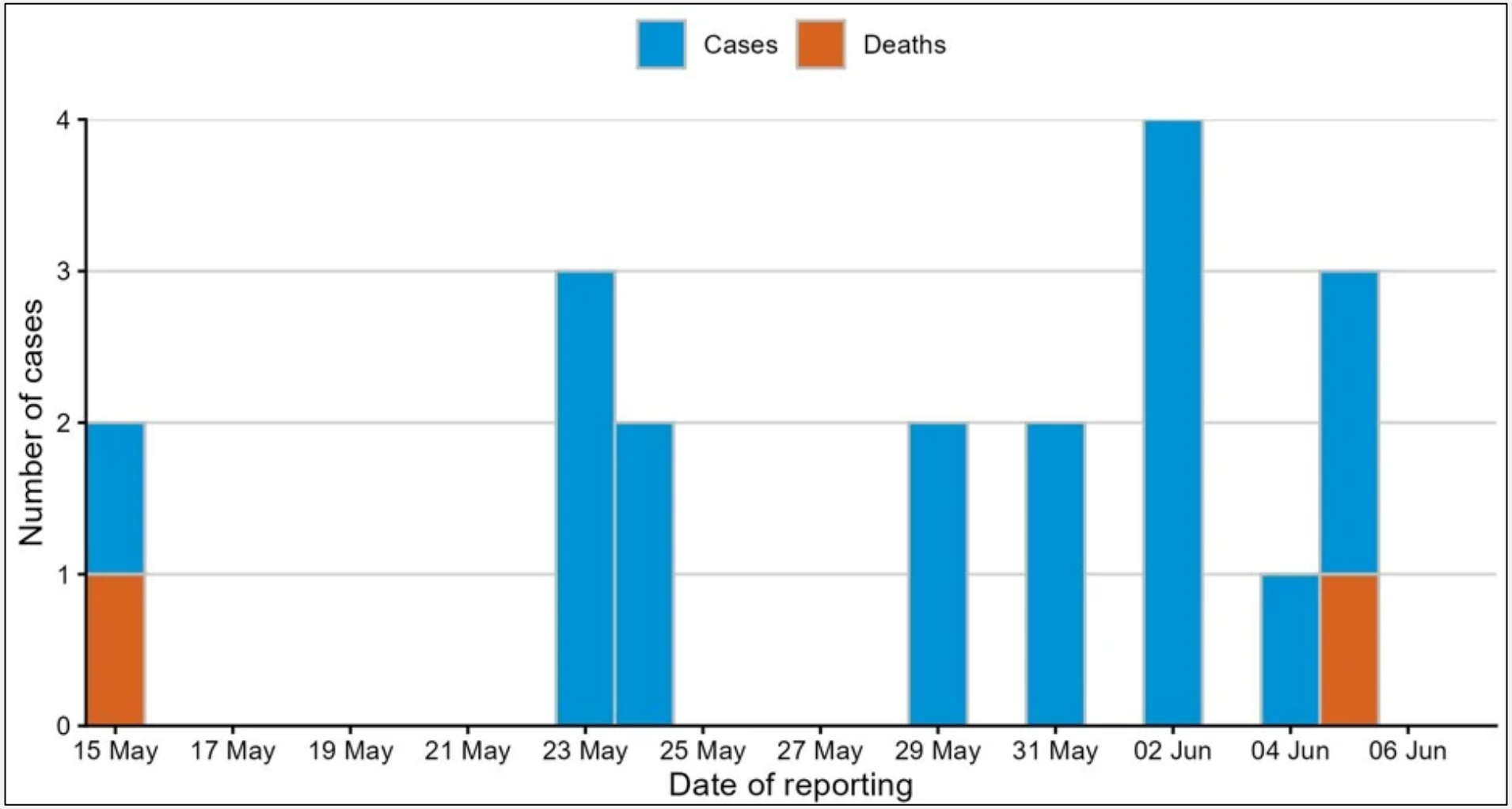
Available at: https://www.cdc.gov/ebola/situation-summary/index.html, accessed on June 10, 2026.

DRC Outbreak Epi Curve



Available at: https://www.who.int/emergencies/disease-outbreak-news/item/2026-DON606, accessed on June 9, 2026.

Uganda Outbreak Epi Curve



Available at: https://www.who.int/emergencies/disease-outbreak-news/item/2026-DON606, accessed on June 9, 2026.

CDC Assessment of Risk

- CDC assesses the risk of infection in the United States population to be extremely low at this time.
  - Limited population movement from the affected areas.
  - Minimal secondary transmission *if* there were a case in the United States.
- The impact of infection within the United States was assessed to be high.
  - Severity of disease and lack of medical countermeasures.
  - Increased amount of resources required to respond.
- Overall risk is **low.**

Available at: https://www.cdc.gov/mmwr/volumes/75/wr/mm7522e2.htm?s_cid=OS_mm7522e2_w, accessed on June 9, 2026.

Public Health Response

- CDC staff have deployed to the affected countries to provide strategic and technical assistance.
- CDC has also activated its Domestic Readiness Task Force.
- A federal order was implemented suspending entry most non-U.S. citizens and nationals from entering the country following travel to an affected country within the previous 21 days.
- For those allowed to enter the US, enhanced screening for individuals who recently traveled to an affected country was implemented on 5/22/2026.
- Travelers are routed through 4 designated airports where they are screened before traveling on with a plan for monitoring.
- CDC has travel health notices in place for DRC and Uganda to help Americans planning travel to either country in the near future learn how to keep themselves safe from Ebola
- CDC published a health advisory on 5/19/2026

Available at: https://www.cdc.gov/ebola/situation-summary/what-cdc-is-doing.html, accessed on June 9, 2026.

Public Health Response

- DSHS is coordinating traveler monitoring with the CDC, local health departments (LHDs) and public health regions (PHRs) .
  - Travelers are monitored for signs and symptoms of Ebola disease.
  - Travelers are monitored for 21 days following departure from an affected country.
- DSHS is working with PHRs and LHDs to assist with epidemiologic. readiness and to support investigations into suspect cases.
- DSHS is actively updating guidance and other resources.
- The DSHS Laboratory has procured additional tests for Ebola.

Monitoring in Texas

Public Health Region (Data as of 6/10/2026, 4:15pm)	Current PUMs	% of PUMs
PHR 1	4	1.8%
PHR 2/3	118	52.9%
PHR 4/5N	14	6.3%
PHR 6/5S	48	21.5%
PHR 7	21	9.4%
PHR 8	13	5.8%
PHR 9/10	2	0.9%
PHR 11	3	1.3%
Pending/Unknown	0	0.0%
Grand Total	**223***	**100.0%**

*223 PUMs under active monitoring in Texas

Laboratory Testing

Grace Kubin, PhD
Deputy Commissioner
Public Health Laboratory Division
Texas Department of State Health Services

Lab Preparedness for Testing Patients

- OSHA standard, Bloodborne Pathogens Standard (29 CFR 1910.1030), provides guidance for reducing personnel exposure to bloodborne pathogens
- Laboratories should conduct a site-specific risk assessment to minimize the exposure risk for personnel
- Identifying and implementing engineering controls, work practice controls and use of PPE will help mitigate exposure risks
- Guidance on Performing Routine Diagnostic Testing for Patients with Suspected VHFs or Other High-Consequence Disease | Viral Hemorrhagic Fevers (VHFs) | CDC has useful tips and suggestions for conducting the risk assessment and considerations for handling and processing of specimens

Patient Assessment

- CDC recommends collecting a complete travel history and any risk factors for patients presenting with BVD symptoms
- Patient should be assessed for other causes of the symptoms, (i.e., malaria)
- If other diseases or conditions are not found to be the cause of the symptoms and the patient has traveled from an affected area, reach out to local or state public health
- Consult with public health to determine whether testing is warranted and what the next steps would be

Malaria Testing for Patients with Suspected BVD

- Microscopic examination of thick and thin blood smears is the gold standard diagnostic test for malaria
- Modified thin smear protocol to inactivate orthoebolaviruses:
  - Fix thin smears for 15-30 minutes in 100% methanol. Allow to dry.
  - Prepare 40 ml of working Giemsa stain. Add 2 drops of 5% Triton X-100 and mix. Stain thin smears for 45 minutes.
  - Measure 40ml of working Giemsa buffer for rinsing. Add 2 drops of 5% Triton X-100. Rinse thin smears for a few seconds with agitation to remove excess stain.
  - Allow smears to air-dry (do not use a hair dryer or fan) before examination.
- Apply coverslips with rapid drying mounting medium before viewing

Available at: Guidance for Malaria Diagnosis in Patients with Suspected Orthoebolavirus or Orthomarburgvirus Infection in the United States, Accessed on Jun 10, 2026.

CDC Consultation

- Public health will work to set up a consultation call with CDC to determine the best course of action for the patient
- Consultation will include discussion of the patient's travel history, epidemiologic risk factors, clinical course, diagnostic tests performed, and infection control measures in place
- If the decision to test is made, then instructions will be provided for collecting, packaging, and shipping of specimens to the closest Laboratory Response Network site or the CDC, or both

Collecting Specimens

- Only presumptive testing is available at LRN labs (Austin or Houston)
- Whole blood EDTA specimens submitted to LRN laboratories should be refrigerated (2-8°C) and shipped on cold packs
- Confirmatory testing is only available at CDC
- Whole blood EDTA specimens submitted to CDC for testing must be frozen (<-20°C) and shipped on dry ice
- Collect two 4 mL tubes of whole blood in plastic blood tubes preserved with EDTA; no glass tubes

Available at: VHF Specimen Collection | Viral Hemorrhagic Fevers (VHFs) | CDC, Accessed on Jun 10, 2026.

Packaging & Shipping Specimens

- All specimens collected from patients with suspected Ebola disease must be shipped Category A as a non-select agent
- Shipping must adhere with the DOT's Hazardous Materials Regulations (HMR) Title 49 Code of Federal Regulations (CFR) 173.196
- Coordinate with the CDC and/or LRN laboratory to ensure proper specimen submission form is completed and that the specimen is delivered to the appropriate site

Available at: VHF Specimen Collection | Viral Hemorrhagic Fevers (VHFs) | CDC, Accessed on Jun 10, 2026.

Testing Limitations

- Symptom onset date is critical to interpreting RT-PCR results in a symptomatic patient
- A negative RT-PCR test result from a blood specimen collected less than 72 hours after symptom onset does not rule out Ebola disease
- BVD testing at LRN laboratories provides only presumptive results and any presumptive positives must be confirmed by CDC

Infection Prevention and Control

Gretchen Rodriguez, PhD, MPH, CIC

Healthcare Safety Unit

Texas Department of State Health Services

Ebola Healthcare Transmission

- Ebola is transmitted through direct contact with:
  - Body fluids
  - Contaminated equipment and surfaces
- Healthcare settings present higher risk of exposure, especially with:
  - Mucous membrane exposure (eyes, nose, mouth)
  - Aerosol-generating procedures (e.g., intubation, suctioning)
- Effective prevention requires:
  - Proper screening and supply availability
  - Consistent use of policies, training, and infection control precautions

Available at https://www.cdc.gov/viral-hemorrhagic-fevers/hcp/infection-control/index.html; accessed 06/10/26.

Patient Placement and Access

- Room requirements
  - Single-patient room with private bathroom and door closed
  - Designate separate spaces for donning and doffing personal protective equipment (PPE) to prevent cross-contamination, away from patient care area
- Access control
  - Limit number of healthcare personnel providing care
  - Maintain a log of all individuals entering and exiting the room

Available at https://www.cdc.gov/viral-hemorrhagic-fevers/hcp/infection-control/index.html; accessed 06/10/26.

PPE Principles

- Training and competency
  - Train, practice, and demonstrate competency before providing patient care
  - Only designated trained personnel should provide care
- Supervision and oversight
  - Onsite manager and trained observer required
  - Trained observer must monitor each step of PPE including during donning, patient care, and doffing
- PPE protection
  - Must fully cover skin and mucous membranes
  - Depends on patient status (confirmed or suspected, unstable or stable)

Available at https://www.cdc.gov/viral-hemorrhagic-fevers/hcp/guidance/ppe-clinically-unstable.html; accessed 06/10/26.

Patient Status

- Suspected clinically unstable patient (Wet)
  - A person who is suspected to have Ebola and is
    - Exhibiting bleeding, vomiting, or diarrhea; OR
    - Clinically unstable; AND/OR
    - Will require invasive or aerosol-generating procedures
- Suspected clinically stable patient (Dry)
  - A person who is suspected to have Ebola and is
    - Not exhibiting obvious bleeding, vomiting, or diarrhea; AND
    - Clinically stable and will not require invasive or aerosol-generating procedures
- Confirmed

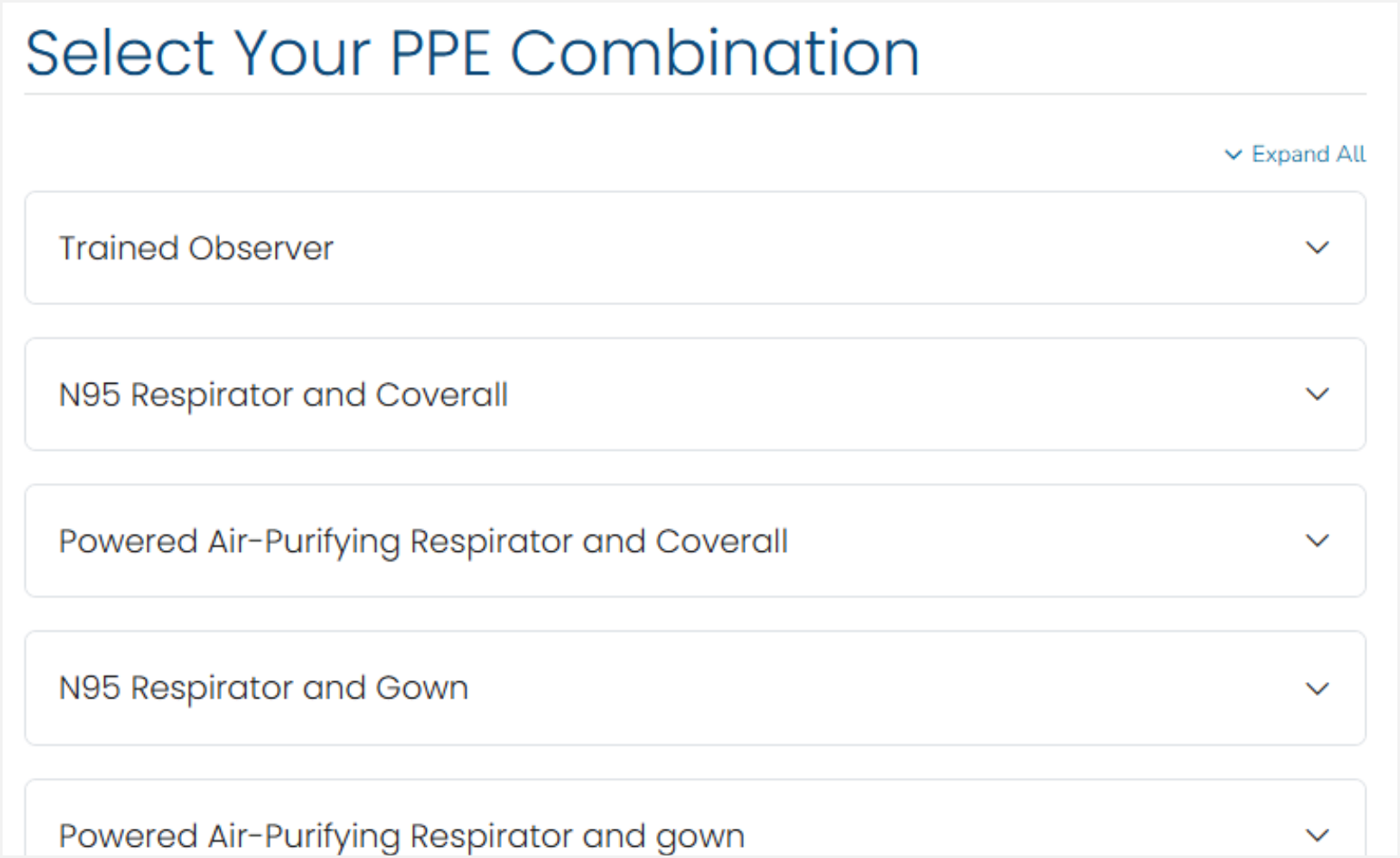
Available at https://www.cdc.gov/viral-hemorrhagic-fevers/hcp/guidance/index.html; accessed 06/10/26.

PPE Requirements

Status	Gown or Coverall	Respiratory	Gloves	Other
Confirmed **or** Suspected Clinically Unstable Patient	Single-use (disposable): • Impermeable gown extending to at least mid-calf **or** coveralls; **AND** • Apron that covers the torso	• Powered air-purifying respirator (PAPR); **OR** • NIOSH-approved, fit-tested N-95 respirator with single-use surgical hood and full-face shield	• Two pairs of single-use (disposable) gloves with extended cuffs	• Single-use boot covers
Suspected Clinically Stable Patient	Single-use (disposable): • Fluid-resistant gown extending to at least mid-calf; **OR** • Fluid-resistant coveralls without integrated hood	Single-use (disposable): • Full face shield; **AND** • Facemask	• Two pairs of single-use (disposable) gloves with extended cuffs	• None

Available at https://www.cdc.gov/viral-hemorrhagic-fevers/hcp/guidance/; accessed 06/10/26.

PPE Training Videos



Available at https://www.cdc.gov/viral-hemorrhagic-fevers/hcp/guidance; accessed 06/10/26.

Patient Care Considerations

- Perform frequent hand hygiene
- Use dedicated equipment and supplies (prefer disposable)
- Limit sharps, non-essential procedures and visitors
- Follow safe injection practices
- Avoid aerosol-generating procedures when possible

Available at https://www.cdc.gov/viral-hemorrhagic-fevers/hcp/infection-control/index.html and https://www.cdc.gov/viral-hemorrhagic-fevers/hcp/infection-control/environmental-infection-control-hospitals.html; accessed 06/10/26.

Environmental Cleaning & Disinfection

- Facility must maintain strict routine cleaning and disinfection protocols in patient care and doffing areas
- Trained healthcare workers wearing appropriate PPE must conduct routine protocols and immediately clean and disinfect any visible contamination
- Use Environmental Protection Agency (EPA)-registered disinfectant lists
  - List L - EPA's Registered Antimicrobial Products Effective Against Ebola Virus | US EPA
  - List Q - Disinfectants for Emerging Viral Pathogens (EVPs) | US EPA
  - Numerous products available on both lists (L & Q) with varying contact time for effectiveness; consider selecting a product with short contact time

Available at https://www.epa.gov/pesticide-registration/selected-epa-registered-disinfectants and https://www.cdc.gov/viral-hemorrhagic-fevers/hcp/infection-control/environmental-infection-control-hospitals.html; accessed 06/10/26.

Infection Control Precautions Duration

- Determined case-by-case
  - In coordination with local, state, and federal health authorities
- Key factors to consider
  - Presence of symptoms
  - Date symptoms resolved
  - Other conditions requiring precautions
  - Available laboratory information

Available at https://www.cdc.gov/viral-hemorrhagic-fevers/hcp/infection-control/index.html; accessed 06/10/26.

Healthcare Personnel Exposure Management

Exposure	Symptoms?	Symptom Monitoring	Restrictions
High-risk exposure*	No	• Daily monitoring by health department or occupation health (with daily temperature check) for 21 days after last exposure	• Exclude from work • Quarantine • Restrict commercial travel
	Yes	• Initiate immediate medical evaluation	• Stop work immediately
Not high-risk exposure	No	• Self-monitor for 21 days after last exposure • Conduct daily temperature measurements prior to shift	• Generally, no work restriction
	Yes	• Initiate medical evaluation	• Stop work immediately

*High-risk exposure = blood or body fluid exposure, direct contact without PPE or PPE breach

Available at https://www.cdc.gov/viral-hemorrhagic-fevers/hcp/infection-control/; https://www.cdc.gov/ebola/php/emergency-guidance/index.html; accessed 06/10/26.

Key Takeaways

- Healthcare personnel must receive comprehensive training and demonstrate competency in performing Ebola-related infection control practices and procedures
- PPE must be selected based on patient status and be used with strict training and oversight
- Appropriate PPE donning and doffing is critical to prevent transmission

Emergency Medical Taks Force Infectious Disease Response Unit (IDRU)

Jeff Hoogheem

Director

Center for Health Emergency Preparedness and Response, DSHS

Texas Department of State Health Services

EMS Guidance

- **Patient Assessment**
  - Screen for symptoms and risk factors before arrival
- **Safety and PPE**
  - Choose PPE based on patient status (unstable vs. stable)
  - Don PPE before entering scene and wear until no longer in contact with patient
  - Limit the number of personnel who care for patient
- **Transport**
  - Isolate the driver from the patient compartment
  - Disinfect vehicle after completing transport with EPA-registered disinfectant (List L or List Q)

Available at https://www.cdc.gov/viral-hemorrhagic-fevers/hcp/emergency-guidance/ems-911.html; accessed 06/02/26.

Waste Management

Classification

- Category A infectious waste
- Includes PPE, sharps, linens, equipment

Containment

- Package at point of generation
- Wear appropriate PPE
- Double-bag
- Do not reopen

Handling

- Limit handling
- Use designated carts
- Transport per DOT regulation
- Store securely

Inactivation

- Autoclave/ incineration onsite OR
- Transport for offsite inactivation
- No longer infectious after

Available at: https://www.cdc.gov/viral-hemorrhagic-fevers/hcp/infection-control/handling-vhf-associated-waste.html; accessed 06/02/26

Postmortem Management

- Wear recommended PPE during body preparation and transport.
- Do not wash, clean, embalm the body, or remove inserted medical equipment.
- Perform autopsies only when necessary and in consultation with public health.
- Coordinate all transportation, including local transport for mortuary care or burial, with relevant local and state authorities in advance.
- Cremate remains; if not possible, bury using standard metal casket.

Available at https://www.cdc.gov/viral-hemorrhagic-fevers/hcp/infection-control/guidance-for-safe-handling-of-human-remains-of-vhf-patients-in-u-s-hospitals-and-mortuaries.html; accessed 06/02/26.

Scenarios for Discussion

Scenarios for a Person Under Monitoring Developing Symptoms

- Acute care need such as a heart attack, or other condition that needs to go to the emergency department.
- Early onset symptoms: fever, aches/pains, headache.
- Major wet symptoms such as vomiting, diarrhea, etc.

Expectations for Hospitals

- Texas does not have designated hospitals for triage of viral hemorrhagic fever suspects.
- Hospitals must assess the patient and look for other causes of the symptoms, (ie: malaria).
- If other conditions are ruled out, physicians can request testing at a Laboratory Response Network site (Austin or Houston).
- Consultation is required with DSHS and CDC to receive approval to run Ebola test.
- Patient transport/transfer to the UTMB Biocontainment Unit requires approval by DSHS.

If Symptoms Develop

- Assessment occurs at home and local hospital.
- LHD, DSHS, Hospital, and CDC quickly convene consultation call considering:
  - High risk patient?
  - Patients' condition
  - Initial lab results (other conditions ruled out)
  - Decision to conduct Ebola test
- Determination of high likelihood or positive lab test
- Simultaneously Alert IDRU and UTMB that transport might be needed
- Convene conference call with LHD, Hospital, DSHS, CDC, IDRU, EMTF SCO, and UTMB – decision & alert partners
- IDRU transport to Biocontainment unit at UTMB, Galveston

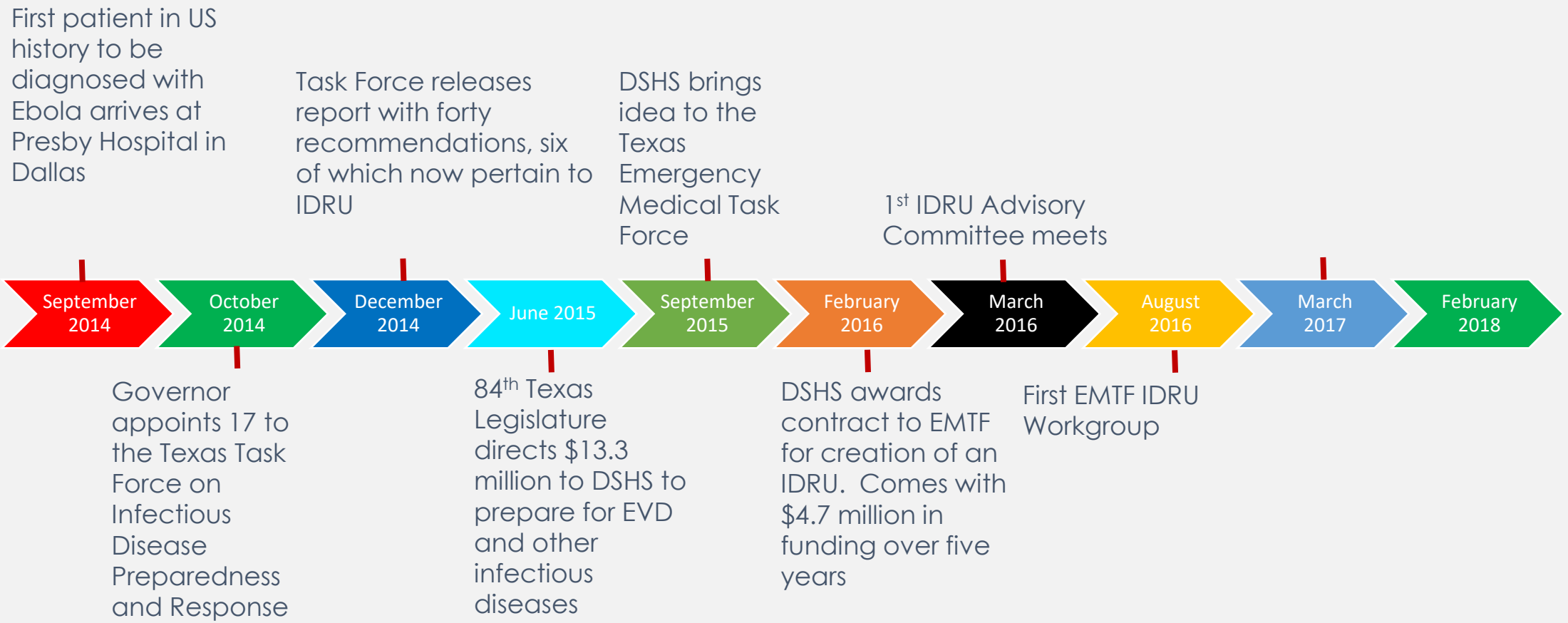
Emergency Medical Task Force Infectious Disease Response Unit (EMTF IDRU) Program Overview

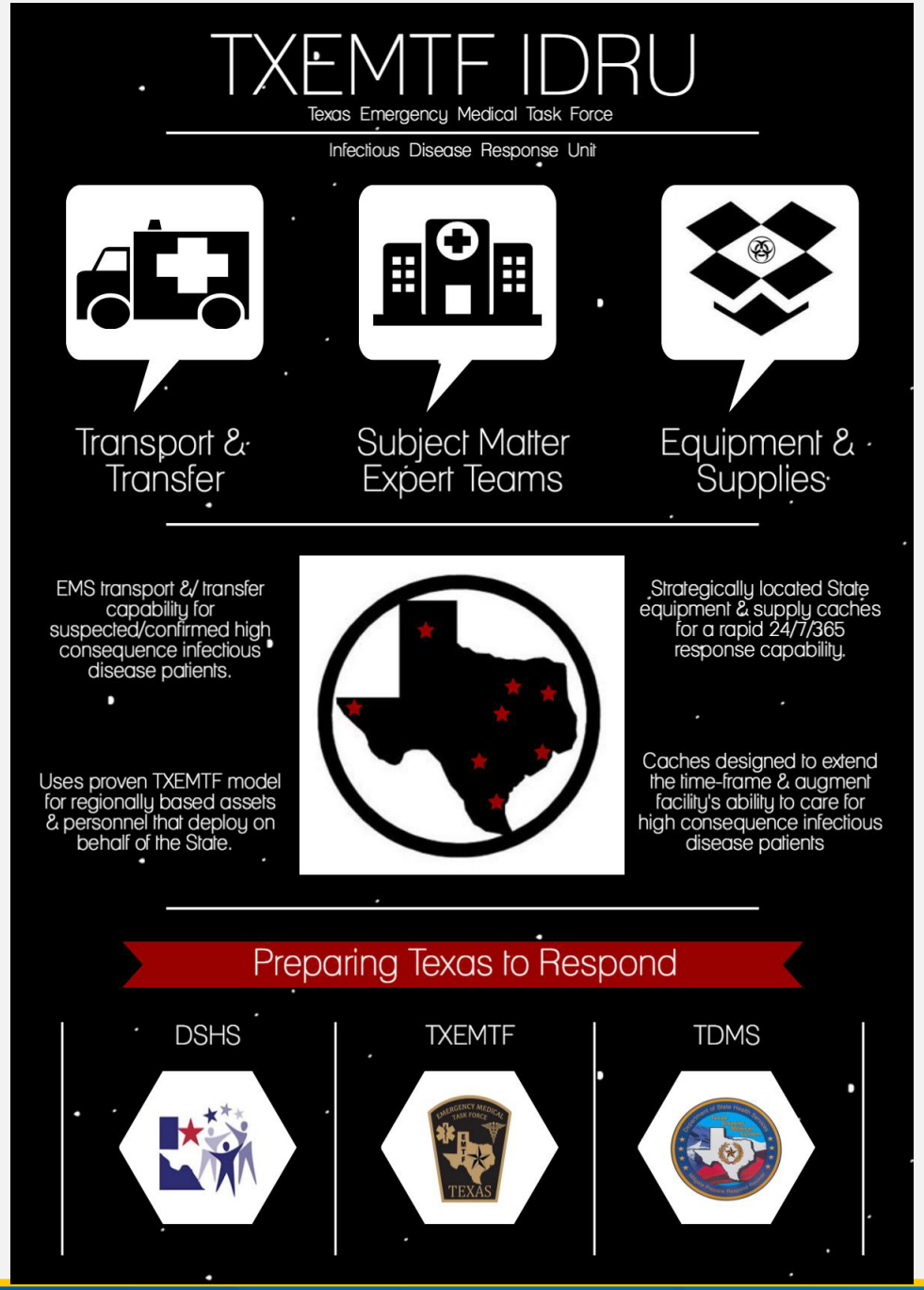
Sara Jensen

Deputy Director

Emergency Medical Task Force

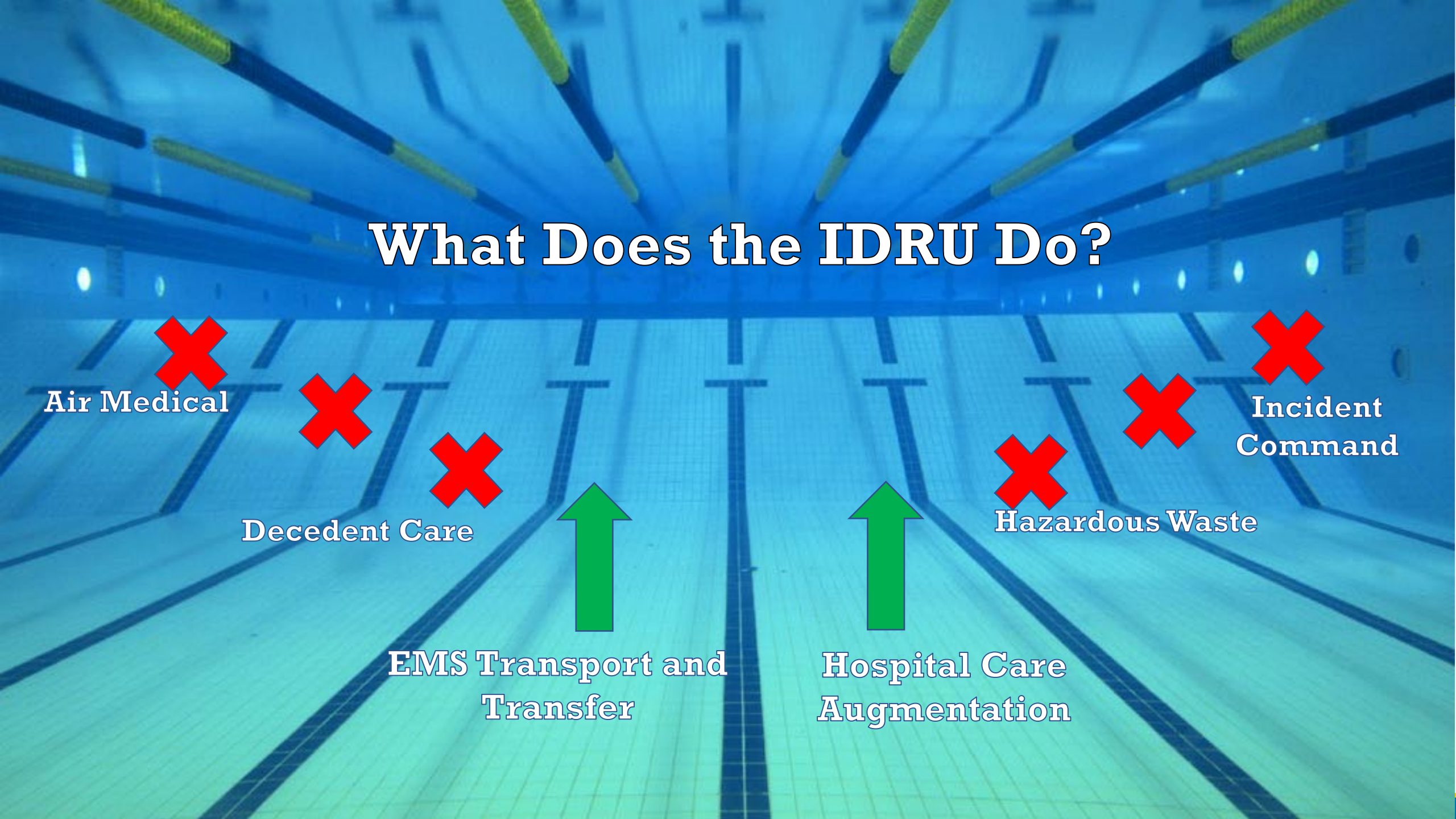
How Did IDRU Get Here?





- Coordinated development of a Statewide HCID response capability augmenting regional efforts
- EMS Transport & Transfer Support Teams & Caches
- Hospital Support Teams & Caches

What Does the IDRU Do?



Cache Locations and Deployment

- Personal protective equipment & supplies support for the care of high consequence infectious disease patients are strategically located throughout the state

★ 24 Hour IDRU Hospital/Pre-Hospital PPE Support Caches located in each of the **eight EMTF** regions

★ 72 Hour IDRU Hospital PPE Support Caches located in **four EMTF** regions

★ 7-10 Day IDRU Hospital PPE Support Cache located with the TX EMTF SCO

★ Caches designed to support hospital PPE & supply needs for caring for a HCID patient

IDRU Typing

RESOURCE: Infectious Disease Response Unit				
CATEGORY: Public Health & Medical (ESF #8)				
MINIMUM CAPABILITIES: Component	Metric	Hospital Augmentation Team	Hospital Augmentation Logistics Team	Pre-hospital Team
Overall Function		Augmentation of a hospital's capabilities to care for a patient with a/suspected high-consequence infectious disease.	Delivery, training, and management of IDRU personal protective equipment caches, independent of a hospital augmentation team.	Transport of a patient with a confirmed or suspected high-consequence infectious disease by ground emergency medical services.
Mobilization	Availability	<6 Hours		
	Operationally Capable	2 hours upon arrival at the site		Upon arrival
Personnel	Number of Personnel	16	6	14
	Team Composition[1]	(2) Group Supervisors (2) MIST (2) Physicians or appropriately trained Licensed Independent Practitioners (8) Registered Nurses [or - 6/7 RN & up to 2 Paramedics - total 8] (2) Logistics Specialists *(1) Respiratory Therapist rostered on 'ALERT' *(1) Infectious Disease Physician on call	(2) MIST Personnel (2) Logistics Technician (2) Safety Officer (specific to cache type: EMS/Hospital)	(1) Group Supervisor (2) MIST Personnel (1) Physician or appropriately trained Licensed Independent Practitioners (2) AST Units with (3) DSHS Certified Providers per Unit [Minimum of 2 Paramedics credentialed by Agency Medical Director to practice at ALS level per unit] (4) Hazardous Materials Technicians *(1) Respiratory Therapist rostered on 'ALERT' *Law Enforcement escort per request
Equipment	Equipment Cache	IDRU 24 Hour, 72 Hour or 7 to 10 Day Cache		IDRU Pre-Hospital Cache

[1] Team composition will be based on a consensus plan involving EMTF Medical Director, member agency Medical Director, member agency, DSHS, all hospitals involved in patient care, DSHS, EMTF SCO and any other local, State or Federal parties involved in patient care.

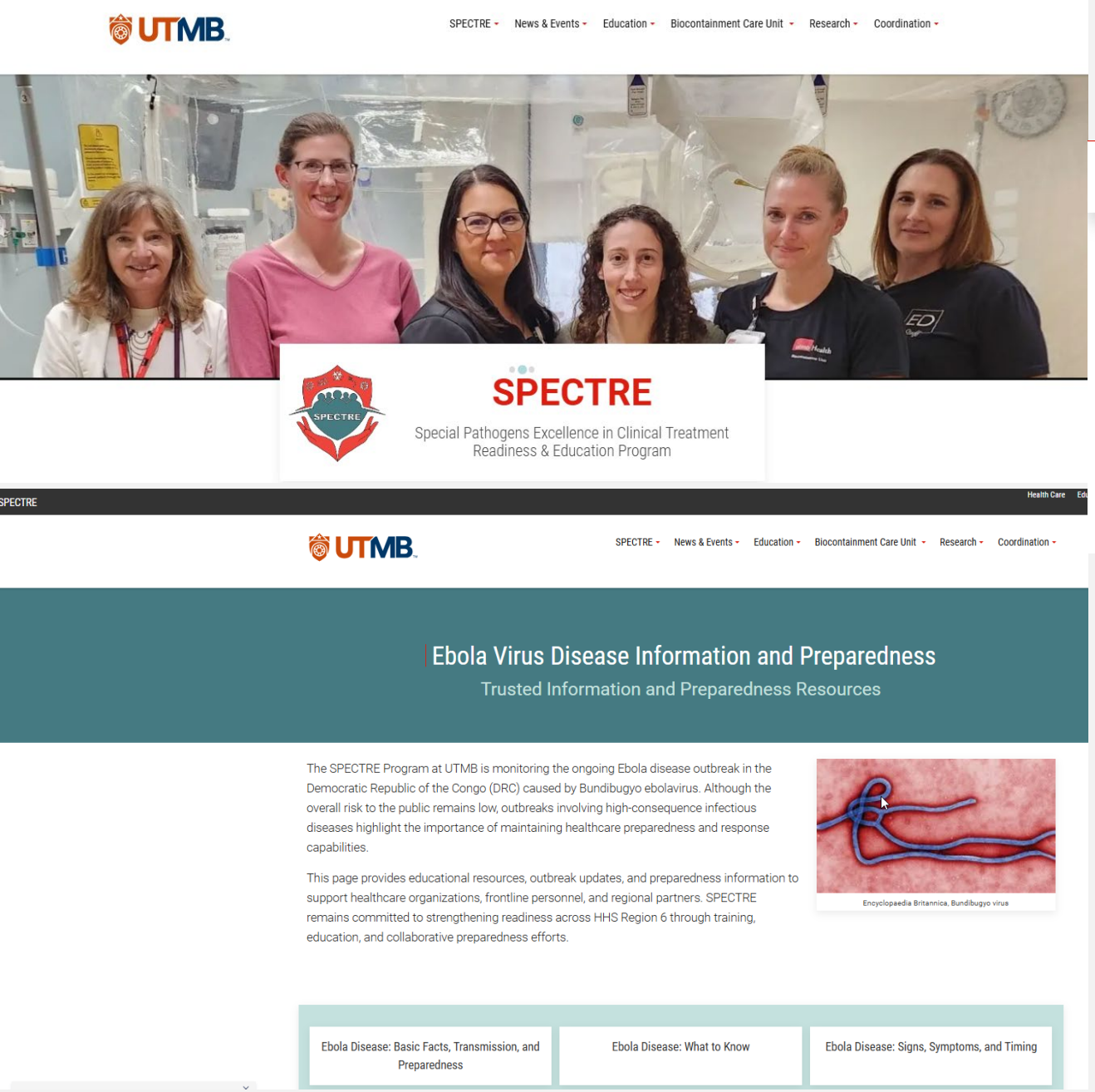
TEXAS Health and Human Services

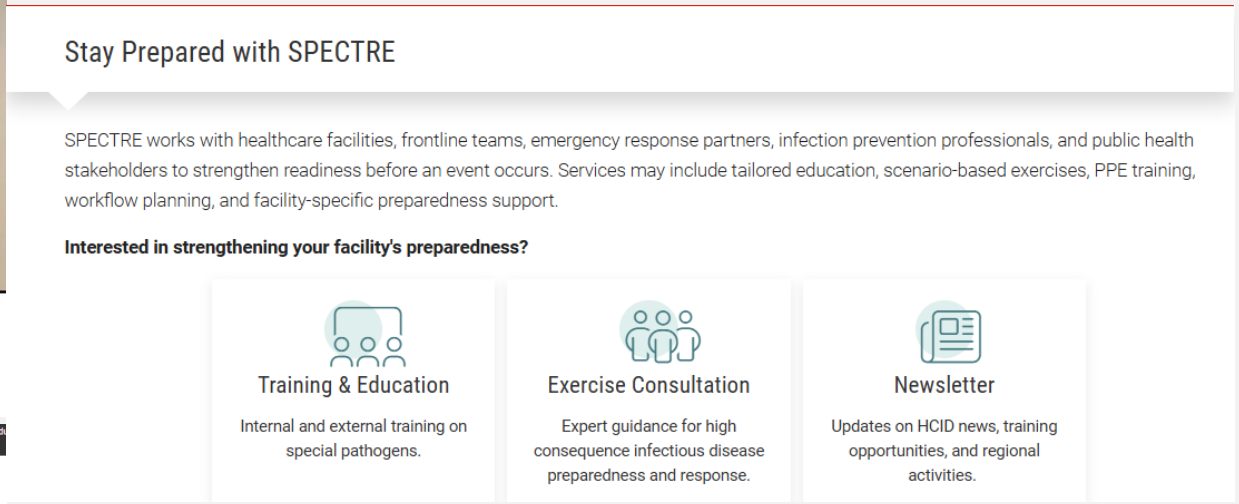
Texas Department of State Health Services

Resources

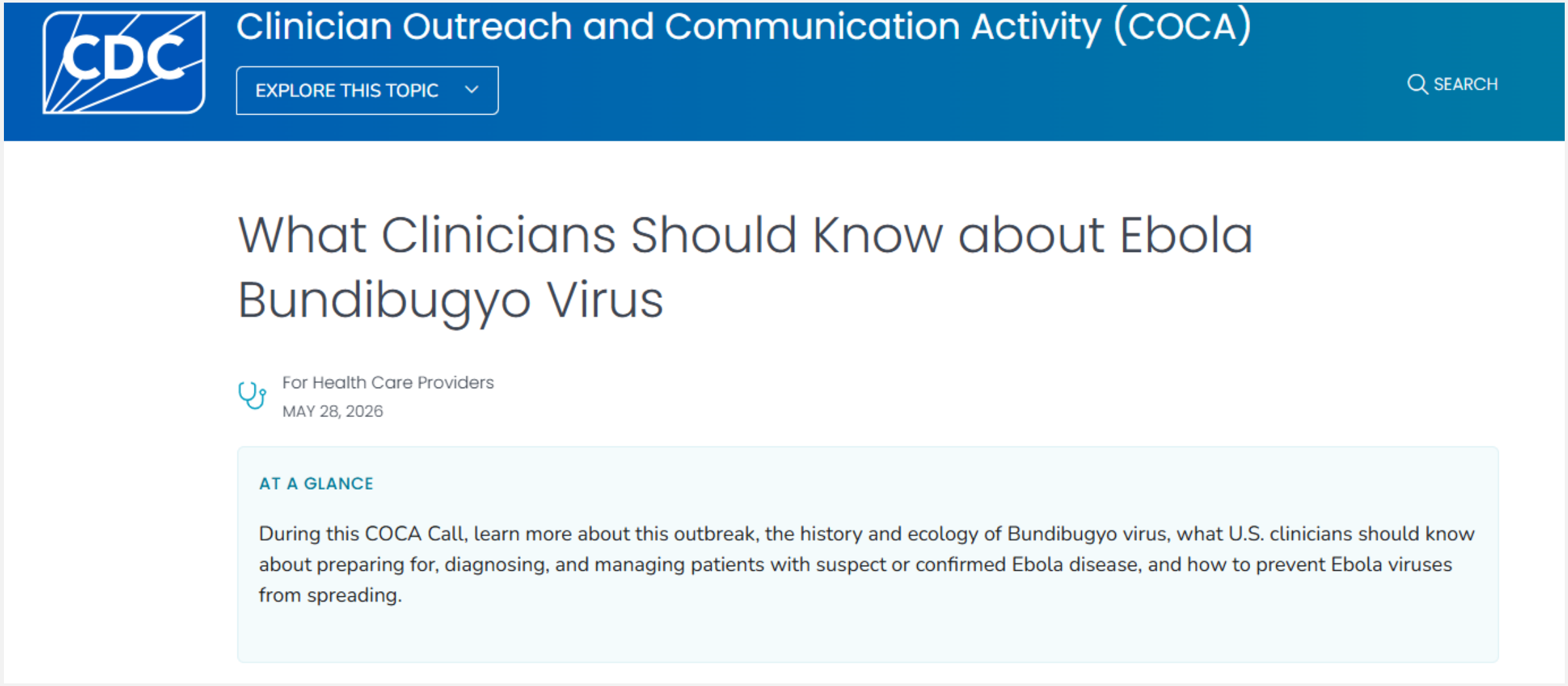
Saroj Rai, PhD, MPH

Texas Department of State Health Services





Available at: SPECTRE - SPECTRE – UTMB, accessed on June 9, 2026



Available at: What Clinicians Should Know about Ebola Bundibugyo Virus | COCA | CDC, accessed on June 9, 2026

Notes from the Field: Outbreak of Ebola Disease Caused by Bundibugyo Virus — Democratic Republic of the Congo and Uganda, May 2026

Available at: Notes from the Field: Outbreak of Ebola Disease Caused by Bundibugyo Virus — Democratic Republic of the Congo and Uganda, May 2026 | MMWR, accessed on June 9, 2026

Assessment of Risk to the U.S. Population from the Ebola Disease Outbreak Caused by Bundibugyo Virus, 2026

Early Release / June 5, 2026 / 75

Available at: Assessment of Risk to the U.S. Population from the Ebola Disease Outbreak Caused by Bundibugyo Virus, 2026 | MMWR, accessed on June 9, 2026

Modeled Scenario Projections for the Ebola Disease Outbreak Caused by Bundibugyo Virus, 2026

Early Release / June 5, 2026 / 75

Available at: Modeled Scenario Projections for the Ebola Disease Outbreak Caused by Bundibugyo Virus, 2026 | MMWR, accessed on June 9, 2026

Ebola Virus Resources

- Ebola Outbreak: Current Situation | Ebola | CDC
- Ebola Disease Outbreak in the Democratic Republic of the Congo and Uganda | HAN | CDC
- What Clinicians Should Know about Ebola Bundibugyo Virus | COCA | CDC
- Public Health Guidance for Ebola Disease | Ebola | CDC
- Information for Travelers Returning from Ebola-Affected Areas | Ebola | CDC
- About the Current Ebola Outbreak | Ebola | CDC
- Signs and Symptoms of Ebola Disease | Ebola | CDC
- How Ebola Disease Spreads | Ebola | CDC
- Ebola and Bundibugyo Virus Frequently Asked Questions | Ebola | CDC
- Ebola: What to Do After Travel | Ebola | CDC

Q&A

Closing Remarks

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Texas Department of State Health Services

Questions

Please send any questions to EAIDUMonitoring@dshs.texas.gov

Thank You