

Testimony of Dr. Daniel Varga

**HOUSE ENERGY AND COMMERCE COMMITTEE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS**

“EXAMINING THE U.S. PUBLIC HEALTH RESPONSE TO THE EBOLA OUTBREAK”

OCTOBER 16, 2014

INTRODUCTION

Good afternoon, Chairman Murphy, Vice Chair Burgess, Ranking Member DeGette and members of the committee.

My name is Dr. Daniel Varga. I am the Chief Clinical Officer and Senior Executive Vice President for Texas Health Resources. I am board certified in internal medicine and have more than 24 years of combined experience in patient practice, medical education and health care administration.

I'm sorry I couldn't be with you in person today. I appreciate the Committee's understanding of our situation and how important it is for me to be here in Dallas during this very challenging and sensitive time.

Texas Health Presbyterian Hospital Dallas (THD) is one of 13 wholly-owned, acute-care hospitals in the Texas Health Resources system. It is an 898-bed hospital treating some of the most complicated cases in North Texas. Texas Health Dallas is recognized as a Magnet-designated facility for excellence in nursing services by the American Nurses Credentialing Center, the nation's leading nursing credentialing organization.

Texas Health Resources is one of the largest faith-based, nonprofit healthcare systems in the U.S., and the largest in North Texas in terms of patients served. Our mission is to improve the health of the people in the communities we serve, and we care for all patients regardless of their ability to pay. We serve diverse communities, and as such we provide one standard of care for all, regardless of race or country of origin.

OVERVIEW

As the first hospital in the country to both diagnose and treat a patient with Ebola, we are committed to using our experience to help other hospitals and healthcare providers protect public health against this insidious virus.

It's hard for me to put into words how we felt when our patient Thomas Eric Duncan lost his struggle with Ebola on October 8. It was devastating to the nurses, doctors, and team who tried so hard to save his life. We keep his family in our thoughts and prayers.

Unfortunately, in our initial treatment of Mr. Duncan, despite our best intentions and a highly skilled medical team, we made mistakes. We did not correctly diagnose his symptoms as those of Ebola. We are deeply sorry.

Also, in our effort to communicate to the public quickly and transparently, we inadvertently provided some information that was inaccurate and had to be corrected. No doubt that was

unsettling to a community that was already concerned and confused, and we have learned from that experience as well.

Last weekend, nurse Nina Pham, a member of our hospital family who courageously cared for Mr. Duncan, was also diagnosed with Ebola. Our team is doing everything possible to help her win the fight, and on Tuesday her condition was upgraded to “good,” so we are all very hopeful. I can tell you that the prayers of the entire Texas Health system are with her. Yesterday, we identified a second caregiver with EVD. I can also tell you that our thoughts and prayers are with her and her family as well.

A lot is being said about what may or may not have occurred to cause Ms. Pham to contract Ebola. She is known as an extremely skilled nurse, and she was using full protective measures under the CDC protocols, so we don't yet know precisely how or when she was infected. But it's clear there was an exposure somewhere, sometime. We are poring over records and observations, and doing all we can to find the answers.

SEQUENCE OF EVENTS

You have asked about the sequence of events with regard to our preparedness for Ebola and our treatment of Mr. Duncan. Key events from our preparation timeline are attached to our submitted statement, but here is a brief overview:

As the Ebola epidemic in Africa worsened over the summer, Texas Health hospitals and facilities began educating our physicians, nurses and other staff on the symptoms and risk factors associated with the virus.

- On July 28, an Infection Prevention Nurse Specialist at Texas Health received the [first Centers for Disease Control and Prevention \(CDC\) Health Advisory about Ebola Virus Disease \(also known as EVD\)](#) and began sharing it with other Texas Health personnel. The Healthcare Advisory encouraged all healthcare providers in the US to consider EVD in the diagnosis of febrile illness – in other words, a fever -- in persons who had recently traveled to affected countries.

The CDC advisory was also sent to all directors of our Emergency Departments (our EDs) and signage was also posted in the EDs.

- On August 1, Texas Health leaders, including all regional and hospital leaders and the ED leaders across our system, received an e-mail directing that all hospitals have a hospital Epidemiologic Emergency Policy in place to address how to care for patients with Ebola-like symptoms. The email also drew attention to the fact that our Electronic Health Record documentation in EDs included a question about travel history to be completed on every patient. Attachments to the e-mail included:
 - Draft THR Epidemiologic Emergencies Policy that specifically addresses EVD.
 - CDC based poster to be posted in ED admissions and other appropriate locations.
 - CDC advisory from 7/28/14.
- The August 1 CDC *Guidelines and Evaluation of US Patients Suspected of Having Ebola Virus Disease* ([CDCHAN-00364](#)) was distributed to staff, including physicians, nurses, and other frontline caregivers on August 1 and August 4.

Over the last two months, the Dallas County Health and Human Services Department communicated with us frequently as plans and preparatory work were put in place for a possible case of Ebola. We have also provided the August 27, 2014 Dallas County Health Department algorithm and screening questionnaire.

At 10:30pm on September 25, Mr. Duncan presented to the Texas Health Dallas Emergency Department with a fever of 100.1°F, abdominal pain, dizziness, nausea, and headache—symptoms that could be associated with many other illnesses. He was examined and underwent numerous tests over a period of four hours.

During his time in the ED, his temperature spiked to 103°F, but later dropped to 101.2. He was discharged early on the morning of September 26. We have provided a timeline on the notable elements of Mr. Duncan's initial emergency department visit.

On September 28, Mr. Duncan was transported to the hospital by ambulance. Once he arrived at the hospital, he met several of the criteria of the Ebola algorithm. At that time, the CDC was notified.

The hospital followed all CDC and Texas Department of State Health Services recommendations in an effort to ensure the safety of all patients, hospital staff, volunteers, nurses, physicians and visitors. Protective equipment included water impermeable gowns, surgical masks, eye protection and gloves. Since the patient was having diarrhea, shoe covers were added shortly thereafter.

We notified the Dallas County Health and Human Services Department, and their infectious disease specialists arrived on site shortly thereafter. On September 30, lab testing confirmed the first case of the Ebola Virus Disease diagnosed in the United States at Texas Health Dallas. Later that same day, CDC officials were notified, and they arrived on campus October 1.

The physicians, nurses and other caregivers at Texas Health Dallas worked diligently to provide compassionate, intensive care to Mr. Duncan. He was treated with the most appropriate and available medical interventions, including the investigative antiviral drug Brincidofovir. Mr. Duncan was the first Ebola patient to receive this drug. Mr. Duncan did not receive a serum transfusion because his blood type was not compatible with the serum donor.

REVIEW OF EVENTS IN OCTOBER

The treating personnel at Texas Health Dallas followed the CDC protocols included in the [CDC checklist](#) for patients being evaluated for EVD, including use of personal protective equipment (PPE).

Unfortunately, THD has since learned that there was an exposure during Mr. Duncan's care resulting in two of his healthcare workers testing positive for the virus. The CDC and THD are doing a thorough analysis of how this exposure occurred. We also plan to share the results of this analysis with other hospitals and providers to increase awareness in an effort to reduce the potential for future exposure of health care workers.

Today, every person at Texas Health Dallas who has had contact with a known Ebola patient is under active monitoring for 21 days after their last contact with the patient. This includes taking a temperature and assessing symptoms twice a day. We created the monitoring program based on three categories of risk as prescribed by the CDC:

- High-risk exposure;
- Low-risk exposure; and,
- No-known exposure.

All individuals in the high-risk exposure category are undergoing active monitoring by the Dallas County Health Department, are on work furlough, and are required to remain in their county of residence.

Anyone in the low-risk category is undergoing active monitoring, are able to work and have no travel restrictions.

Even those in the “no known exposure” group – those who have virtually no risk – are part of the program and are in active monitoring without work and travel restrictions.

Of note, the two caregivers who unfortunately contracted Ebola were part of this monitoring program, and as a result, were promptly and successfully isolated and diagnosed.

LESSONS LEARNED AND STEPS TAKEN

I want to emphasize that we have made a number of changes based on the preliminary lessons learned from our experience with EVD over the last two weeks:

1. Diagnosing Ebola is very different from treating Ebola

THD was and remains well prepared and equipped based upon the best available information to treat patients already identified as having EVD. Where we fell short initially was in our ability to detect and diagnose EVD, as evidenced by Mr. Duncan’s first visit to the ED.

As a result, following Mr. Duncan’s initial admission, we have changed our screening process in the ED to capture the patient’s travel history at the first point of contact with ED staff. This process change makes the travel history available to all caregivers from the beginning of the patient’s visit in the ED.

Additionally, we have modified our Electronic Health Record in multiple ways to increase the visibility and documentation of information related to travel history and infectious exposures related to EVD. These include:

- Better placement/title of the screening tool
- Expanded screening questions, which include:
 - Exposure to persons known or suspected to have EVD
 - High-risk activities for persons who have traveled to Ebola endemic areas such as: “have you touched a dead animal or helped carry someone sick”;
 - A pop up identifying the patient as high-risk for Ebola with explicit instructions for next steps if the answer to any of the screening questions is positive

2. Communication is Critical but it is No Substitute for Training

Despite the communications regarding EVD preparedness that occurred between August 1 and October 1, we realized a need for more proactive, intensive, and focused training for frontline responders in the diagnosis of EVD. Therefore an Emergency Department (ED) refresher course was provided to THD ED nurses. Additionally, an “in-service” face-to-face training was provided starting with the night shift and continued at

the start of every shift for a number of days. The education included screening of suspected patients, documenting response to travel questions in the Electronic Health Record and proper donning and doffing of PPE.

3. Ebola Extends Beyond the Walls of the Hospital

In a crisis like this, a hospital's focus needs to be on providing exceptional care. Coordination and collaboration with federal, state, and local agencies is critical to limiting the perimeter of Ebola, managing contact identification interviews, and establishing community confidence. We have been blessed with exceptional support and leadership from all of the above agencies.

CONCLUSION

In conclusion, I would like to underscore that we have taken all of these steps to maximize the safety of our workers, patients and community, and we will continue to make changes as new learnings emerge. Moreover, we are determined to be an agent for change across the U.S. healthcare system by helping our peers benefit from our experience.

Texas Health Resources is an organization with a long history of excellence, and a commitment to caring for our patients and communities. Our mission and our ministry will continue, and we will emerge from these trying times stronger than ever.

Thank you for the opportunity to testify. I would be glad to answer any questions from Committee members.