Good Morning Mr. Chairman and members of the Subcommittee, and thank you for the opportunity to appear before the Senate Permanent Subcommittee on Investigations.

My name is Rodney Huebbers and I am President and CEO of Loudoun Healthcare, a community non-profit healthcare organization serving as Loudoun County, Virginia's principal healthcare services provider. At Loudoun Hospital Center, a 145-bed acute-care facility, we have provided quality healthcare to the Loudoun Community since 1912 by offering state-of-the-art healthcare services with 60 specialties, 454 providers and 1400 employees lending support.

Loudoun County, Virginia is the second fastest growing county in the United States. We are bordered on the east by Dulles International Airport, to the north by the Potomac River, and to the west by the Blue Ridge Mountains and the Shenandoah River. It is home to a diverse business and residential population, from high tech companies to a thriving rural economy. Loudoun is also home to the FAA's center for the National Capital Region and is a major emergency evacuation route from the District of Columbia.

Loudoun Hospital Center's role in relation to these county dynamics is, of course, to provide first-line acute healthcare whether it be in the realm of preventative medicine, elective procedures, emergency response or rehabilitative services. Given the Subcommittee's specific interest in SARS – both our response as well as assistance from state and federal authorities – I

will limit my formal testimony to our emergency response protocols and observations as requested by Mr. Kennedy, General Counsel for the Subcommittee.

I have provided in our formal filing with the Subcommittee supplemental information including the Virginia Department of Health's original press release with respect to Loudoun Hospital Center's treatment response to the first probable case of SARS in the United States as well as several pages of questions and answers as have been documented by our staff.

With respect to our SARS experience, at the time of presentation in our ER "Severe Acute Respiratory Syndrome" had not yet been identified nor clinically defined with respect to symptoms or treatment. On February 17, 2003 a woman who had recently traveled to Guangdong Province in China presented in our ER with pneumonia-like symptoms. We obtained the personal history of the patient, including her recent travel itinerary, which included a report of unusual pneumonias being seen in Guangdong Province. While symptoms did mirror pneumonia, an atypical dry cough and respiratory distress proved an unknown prompting the patient's isolation in a negative pressure room as a means of infection control.

Subsequently, the hospital's infection control chief and the Loudoun County Health Department were notified as part of our infectious disease notification algorithm. In turn, the Virginia Department of Health and the Centers for Disease Control and Prevention were also notified.

Prior to this SARS presentation, it is important to note that before 9/11 our hospital had a specific disaster plan in place that included coordination with county, state and federal authorities. Following 9/11 and with the advent of nuclear, biological or chemical terrorism threats, our disaster protocols were further refined on paper as well in practice. Loudoun County

has been confronted with a variety of communicable disease issues including anthrax, Virginia's first human death from West Nile virus as well as three locally acquired cases of malaria. Hence, we have practical experience from which to draw conclusions as to our own protocol evolution and the quality of assistance from regulatory offices.

As to the performance of Loudoun Hospital's ER, triage training as well as the development of infection protocols combined to serve us well on February 17th. The documentation of symptoms along with pre-determined history including a travel inquiry, information volunteered by the patient's family, and consultation with the Loudoun County Health Department proved critical in the initial decision to isolate and contact infection control. From there, the notification algorithm worked as designed.

However, while the patient herself was of great concern, so too were the clinical and non-clinical staff who had either incidental or clinical contact with the patient. Again, SARS was not known at this time, but given the symptomatic issues identified it was obvious that infection was a distinct possibility. Our Emergency Response team, including ER, Infection Control, HR, Communications and County and Regional Health Department staff, began the process of identifying those with whom the patient had had contact during the admission process. Within hours we had a list of individuals and began contacting and testing.

At the time of the SARS presentation, the hospital's most notable infection control protocol in place was for tuberculosis. Now, of course, we have a SARS protocol, which, based upon information supplied by various authorities, has been amended in keeping with clinical findings.

As for staff reaction during and following our SARS presentation, I would characterize it as informed and collaborative. Given the unknown symptoms of SARS at the time, common sense,

admission information and proper infection protocols combined for an adequate medical response on behalf of patient and staff alike. The hospital's existing emergency preparedness committee, lecture series on emerging diseases and bio-terrorism threats, evolving policies and algorithms related to infection control, and improved communication with regional Northern Virginia hospitals via a dedicated rapid notification radio frequency continue to provide threat mitigation.

With respect to response of county, state and federal medical authorities, Loudoun County's Health Department was responsive and of great assistance in consultation and collection of samples as directed by the CDC. Thanks to a federal bio-terrorism grant permitting the addition of the Health Department's epidemiological expert, our case was thoroughly investigated with adequate consultation with counterparts at the Virginia Department of Health and the Centers for Disease Control and Prevention in Atlanta. In addition, the investigation and testing of any employees with patient contact was initiated and resulted in the finding that no other person had contracted SARS as a result of incidental or clinical contact.

There were some gaps identified during our review that, in this case, did not impact patient care. They include:

- Insufficient testing materials pre-placed in Northern Virginia for all the individuals we needed to test. Fortunately, the county health department received these materials by courier from Richmond.

- There were procedures in place to transport specimens quickly to the Virginia state's lab, but the procedures for quickly shipping these specimens to Atlanta during a weekend were lacking.

- In this particular case multiple agencies were involved, which at times pitted patient care against regulatory expectations. Specifically, the hospital staff was, at times, torn between specimen collection and delivery, symptomatic consultation with multiple agencies and actually caring for the patient as well as possible others infected. Streamlining information dissemination should prove a priority.

- In our particular case, the SARS patient spoke only Chinese. Had it not been for a family member accompanying the patient, vital information impacting patient care and subsequent infection control would have not been communicated easily.

- At our hospital, we have provided additional instruction in the taking of samples and chain-of-custody procedures to accelerate the diagnostic process.

- A genuine concern of ours continuous to be multiple isolation patients requiring negative pressure rooms.

Three elements played a key role in the successful outcome of this case with respect to the patient and infection prevention:

- Plans were in place in the emergency room to isolate the patient and notify key personnel.

- Effective communication patterns pre-established throughout the public health sector, from hospital to federal authorities, worked well.

- Positive working relationship between the hospital and the local public health office proved critical in diagnosis and containment.

In conclusion, the single largest gap experienced between our hospital and expectations of state and federal health authorities, as well as the public to whom we are dedicated, is the additional cost associated with clinical education, supplies, and ultimately prevention of a local, regional or national infectious disease issue. Local hospitals, like Loudoun Hospital Center, have spent considerable time, man-hours and capital in emergency preparedness for all levels of trauma and infection associated with accidental or intentional hazard situations. It has taxed us heavily and, while we carry the burden and meet expectation, assistance by way of appropriated dollars would certainly provide the means to assure a successful rapid response by your front-line healthcare providers.

Appropriated funds would be allocated initially to deal with surge-capacity issues, including facilitation of critically ill patients requiring respirators as well as building and equipping more isolation rooms with negative pressure capability.

I thank the Subcommittee again for both invitation and very kind attention.