TESTIMONY BY ADAM WILLMANN IN FAVOR OF SB 6

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Hello, my name is Adam Willmann. I am the President and CEO of Goodall-Witcher Healthcare in Clifton, Texas. I am testifying in favor of SB 6.

Goodall-Witcher is a 25-bed critical access hospital. We are located 35 miles northwest of Waco on Highway 6 in Bosque County. We operate two rural health clinics and serve a population of about 21,000 people. Like many rural hospitals, we have an emergency department but lack the capability of providing ICU care.

Traditionally, we stabilize and then transfer acute care patients needing ICU level care to hospitals that can provide a higher level of care. When COVID hit, receiving hospitals filled to or beyond capacity. So, it became increasingly difficult to transfer any patient, both those with and without COVID. Consequently, we had to keep patients in the emergency department longer, often hours and sometimes days longer.

In one instance, we called 40 hospitals—some as far away as Oklahoma, Colorado, and New Mexico—looking for an open ICU bed. This middle-aged patient presented with severe pneumonia, with a high probability of COVID. Unable to effectuate a transfer, we spent the next 10 hours providing this woman with ICU level care on a Med-Surg floor in a facility without ICU level resources, training, or staffing. We did the very best we could and pulled nurses from other departments, leaving them short-staffed, to accommodate the needed staffing levels. Sadly, this patient passed three days after transfer. Just three hours into this episode, another COVID patient appeared at the ED and the balancing act of care and transfer began anew as we continued to draw down available nurses.

In another instance, a patient presented to the Emergency Department with shortness of breath and fever and tested positive for COVID. We immediately attempted transfer and then intubated this patient. Six hours later, we found a receiving hospital. All the while, we had to pull nurses from other departments to backfill as this Emergency Department nurse worked the phone trying to find a transfer. A similar scenario happened seemingly every day.

Elsewhere, because so many ICU beds were converted to COVID ICU beds, it became increasingly difficult to transfer patients for any medical need. An elderly patient presented to the Emergency Department in septic shock. She did NOT have COVID. We resuscitated her and placed her on a vasopressor drip to maintain blood pressure in accordance with sepsis guidelines. We couldn't successfully transfer her for 30 hours. All the while, we provided ICU level care without ICU capabilities. This patient ultimately spent seven days in an Intensive Care Unit in a big city hospital before being transferred back to our facility for a 13-day lower-level inpatient stay. Ultimately, she was discharged to a nursing facility.

Throughout much of the pandemic, we've worked short-staffed as doctors and nurses either became infected with COVID or self-isolated after their direct contact with a COVID-positive individual.

During this pandemic year, our staff has delivered care above and beyond what you would reasonably expect because we've had to. Our physicians cover our clinics, round on hospital patients, and staff our ER. We've been all hands-on deck for the past year.

Our doctors and nurses have been asked to do more during COVID-19, and they have done it without complaint while putting themselves in harm's way. And we will continue to go above and beyond until this pandemic is over. We believe we should be granted additional liability protections for efforts made in a good faith attempt to take care of people as long as we are forced to perform beyond our capabilities, training, and resources.