Good Morning. My name is Colleen Conway-Welch. I am the Dean of the School of Nursing at Vanderbilt University, and currently hold the Nancy and Hilliard Travis Chair of Nursing. I have worked every day as a nurse for over 43 years in both nursing service and nursing education. My goal during the last 4 decades has been to ensure sufficient quality health care for our population, no matter the situation. Over the last decade, I have taken a special interest in the area of emergency preparedness.

While disaster preparedness and community symptom surveillance have always been present in nursing curriculum either formally or informally, in 2000, at the urging of and with funding from the Office of Emergency Preparedness of HHS, I founded The International Nursing Coalition for Emergency Preparedness, now known as Nursing Emergency Preparedness Education Coalition. It is a network of organizations that uses technology to serve as a clearing house for emergency preparedness nursing education, competencies, and curriculum. In 2004-2005, I received funding from DHHS to start a Middle Tennessee Medical Reserve Corps, which is housed at the Vanderbilt School of Nursing, along with our National Center for Emergency Preparedness. I was named to Secretary Thompson's Secretary's Advisory Committee on Public Health Preparedness in 2002 – 2006 and presently serve on the Institute of Medicine's Committee that is preparing a Workshop this summer on Medical Preparedness for a Nuclear Explosion.

I am here today to describe the likely consequences to hospital emergency preparedness if three of the proposed seven cuts in Medicaid occur on May 26, to make the link between the consequences of reduced Medicaid funding and the level of emergency preparedness and to urge the committee to recommend a moratorium on these actions until at least March 2009.

Specifically, implementation of the following three changes:

1. Limiting Medicaid payment to public providers only
2. Dropping Medicaid funding for Graduate Medical Education (or GME)
3. Limiting Medicaid dollars for services in outpatient settings

Will have a devastating effect on emergency preparedness and our ability to respond to the terrible toll that disasters take on our nation's citizens. It will severely curtail the response of personnel and medical facilities that depend on Medicaid dollars.

If the changes anticipated for May 26 occur, it will be virtually impossible to "fix" these rules legislatively in a rushed and piece-meal manner and HHS will be hard pressed to effectively respond to HSPD21 which directs the department to look at regulations that impact emergency preparedness, especially emergency departments and Level I Trauma Centers. If Medicaid dollars are reduced in these three areas, a reduction in personnel and readiness will occur in our hospitals and emergency departments across this country; even worse, it will occur in the midst of a serious and intractable nursing shortage that will have a significant negative impact on readiness of our hospitals and emergency rooms to respond to a disaster, particularly a blast/explosive injury with significant burn injuries, which frankly, can and do occur in our communities on a regular basis, let alone as a terrorist event. The red impact of these regulations is to remove billions of dollars from an already stressed system. It is also reasonable to assume that states, including Tennessee, will <u>not</u> hold the providers harmless if federal matching funds are lost. There would be no easy way to redirect money to those who are losing it, such as the Medical Schools and the Safety Net Providers. Even if the State was able to redirect state dollars to areas eligible for Federal match those fully matched funds would most likely be distributed to the Managed Care Organizations in Tennessee on a per member per month (PMPM) basis and then be part of the payment structure for all hospitals. There is simply no easy way to redirect money to the providers. For example, across Tennessee, we have only forty-eight burn unit beds and in the eight state southern regions we have just

240. This is to serve a population of fifty-eight million. Of even greater concern, if something happened tomorrow, we really only have a limited percentage of hospital beds available for use, because the rest are filled with complex patients that simply cannot be moved without quality of their care in jeopardy.

To better present the impact of these proposed changes, I want to speak specifically to the three proposed changes in the Medicaid program:

Proposal 1:

Limiting payment only to providers who are a unit of government puts our rural, community, private and 501(c)3 hospitals at an even greater risk, since they already must pick up the slack of escalating numbers of uncompensated care and are tied to a public health infrastructure that is increasingly unfunded, unavailable, and marginally functional. In Tennessee, this would result in only one hospital, Nashville Metro General, being included. The TennCare program would lose over $200 million per year in matching funds. TennCare would likely need to reduce rates, limit benefits and change eligibility criteria to reduce the number of TennCare eligibles. This will put all the hospitals in Tennessee in the position of cost shifting and services reductions as well as limiting access even further. The safety net hospitals, which play an even bigger role in emergency preparedness, would need to make difficult decisions to cut services and limit access. While I am discussing Tennessee, these are issues that would occur in every hospital in the country, many of which are more financially vulnerable. All disasters are local, and conventional explosive attacks are especially local. The casualties are immediate, and nobody should expect help for at least twenty-four hours. Medical experts tell us that the most critical time is already over by then. Only a system of local functional emergency departments can address the casualties of the most probable form of attack. On the battlefield, it used to be the “golden hour”, then “the golden fifteen minutes”; it is now the “golden five minutes”.

Proposal 2:

Eliminating federal support for Graduate Medical Education or GME programs in and across the country will result in a reduction in medical residents in a wide variety of settings, including emergency departments; Trauma, Burn, and Intensive care Units. They will also not have the support of many skilled trauma nurses since these numbers will be reduced as well. As an example, what this would mean in Tennessee, the four medical schools in the state will lose $32M annually. These schools also serve as the safety net providers and will be forced to reduce their numbers of students. Even more important, this is done in the face of an impending MD shortage and will result in even fewer MDs to respond to disasters.

Proposal 3:

Limiting the amount and scope of Medicaid payment for outpatient services will result in our hospitals experiencing even greater incapacity and gridlock. It is absurd to think about evacuating hospitals in a time of disaster with the high acuity level we maintain on a day-to-day basis. At Vanderbilt Medical Center, for example, the Burn Unit and ICUs are already at capacity. This typical of almost every major community in the country. Health Care Providers will need to be dispatched to surrounding clinics to help them care for patients with serious injuries who cannot be transported or accommodated by hospitals. As clinics reduce services and personnel, commensurate with reduced Medicaid dollars, their ability to provide vital triage and care to patients injured in a disaster will be reduced and they will have fewer resources available. Of even greater concern, this will not be limited to only disaster and surge, but will affect every aspect of care.

To many health care professionals of both political parties in the field of emergency preparedness, it appears that HHS and DHS do not have a mechanism

for accountability to assess and monitor the extent to which states and major cities have the capability and game plan in place to respond to a disaster such as a blast explosion. In fact, DHS and HHS have not been able to provide guidance on which to base these state plans. The current array of fifteen scenarios, while mesmerizing reading, fails to provide even rudimentary guidance and readiness. While I understand that this is not seen as a federal responsibility, we have learned from Katrina that citizens turn to the federal government in expectation of a responsive coordinating role. I understand that there are territorial and political issues, but there is no one place anywhere in our nation, or at any level of government, where one can go and receive reliable information on how many burn beds there are in Tennessee – or how many ICU beds in Nevada, etc. States may well have that information in a variety of offices, but there is no "one-stop shop" that can answer this on a federal level and disasters are frequently not limited to one state, so regional statistics and information are needed. For example, Tennessee has forty-eight burn unit beds, twenty of which are at Vanderbilt and the eight states in the southeast region have a total of 240. I had to go to the American Burn Association to get these statistics.

I am encouraging a moratorium on these changes as an opportunity to enhance coordination between and among the various federal, state, and local entities and achieve a "double whammy", namely improving emergency preparedness response while improving the public health infrastructure, which will be desperately needed in an emergency. For example, the public health infrastructure was virtually paralyzed after Katrina in New Orleans after years of underfunding and neglect.

It is important to be clear that continued cuts to providers ultimately negatively impacts every service hospitals provide, including emergency preparedness as well the level and quality of care to patients. Vanderbilt Medical Center has historically absorbed these reductions and looked for alternative revenue sources. This has been relatively successful so far but in the world of increasing regulation, it becomes more and more difficult. Vanderbilt will be forced like everyone else to downsize or eliminate programs that generate no margin. It is too difficult to

speculate what those might be but logical candidates would be helicopter transport, HIV/AIDs program, and certain medical and surgical specialties.

As Vanderbilt Medical Center is forced to make these difficult choices, it will also need to look at its role in Emergency Preparedness. Vanderbilt supports this program in a very robust way now but we would need to limit our participation in regional drills and internal administrative planning in preparation for a regional or national emergency as well as to reduce or eliminate our commitment to stockpiling of medical supplies and equipment that are crucial in a national emergency.

In conclusion, please extend the moratorium into next year and charge HHS and DHS to thoughtfully work together to address the declining public health infrastructure from the perspective of improving our emergency preparedness or even better, urge that these rules be withdrawn since Congress did not direct their propagation. It is vital that the very critical issues identified in this testimony be addressed. The problems are real; a simple and immediate cut in Medicaid funding to these three areas is not a thoughtful solution, will not work and will have a devastating effect on the ability of our hospitals and providers to respond to a disaster. In the final analysis, if these rules are enacted as proposed, when our citizens need us most, we will not be able to be there.