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**AAMC Press Teleconference
Coronavirus: A View from the Front Lines
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Participants:

David J. Skorton, MD, AAMC president and CEO
Ross McKinney, Jr., MD, AAMC chief scientific officer
Janis Orłowski, MD, AAMC chief health care officer
Alison Whelan, MD, AAMC chief medical education officer

MODERATOR: The Association of American Medical Colleges is pleased to welcome you to today's online press conference, "Coronavirus: A View from the Frontlines." My name is Sandy, and it's my pleasure to be the facilitator for today's event. Please note, if you are listening to the program over the phone, you are in listen-only mode, so you will not be able to speak.

For the members of the press, please make sure you are viewing this webinar on your laptop or desktop, so you can submit your questions to the AAMC experts. You may submit a question at any time by typing into the chat box at the lower left corner of your screen, and clicking on the "send" button. Your questions will be answered in the order we receive them. It is now my pleasure to introduce Dr. David J. Skorton, MD, President and CEO, Dr. Ross McKinney, Jr., MD, Chief Scientific Officer, Dr. Janis Orłowski, Chief Healthcare Officer, and Dr. Alison Whelan, Chief Medical Education Officer at the AAMC. At this point, I'll turn the conference over to Dr. Skorton.

David Skorton, MD: Thank you, Sandy. And welcome, everyone. This is David J. Skorton, MD. I'm a cardiologist and educator. And before we begin, just a couple of quick administrative notes. We understand there's some buzz about the White House perhaps planning to make an announcement at around 11:00, so we'll keep our formal comments quick so there's more time for your questions. And please bear with us if there's any delays. When we get to the Q&A portion, an operator will read your questions, as was mentioned. And we appreciate your patience. The AAMC is 140+ year-old institution that represents roughly 400 major teaching hospitals throughout the country, all accredited medical schools in the US and Canada, 51 VA hospitals, and over 80 academic societies. These are many of the same institutions that are diagnosing and treating patients with COVID-19. For example, the University of Washington and Mass General Hospital. Our member institution [INAUDIBLE] the most advanced medical facilities, and a significant percentage of the precious intensive care unit beds across the United States, more than 11,000. These are staffed, of course, by

physicians and other healthcare workers trained to care for the most ill, complex patients. Recently, we've been doing all we can to help our member institutions respond to the steadily inexorable mounting challenges of COVID-19. We're in touch with our members daily, sharing any concerns they have with policymakers in Washington. We've also been in direct touch with the administration, met with members of the White House, coronavirus taskforce to help the medical communities respond. And we're providing guidance to medical education communities on how to adjust student education and training at this unprecedented time. Along with the three of my colleagues, I'm going to share our view of what's happening on the frontlines, and then take your questions. First, we'll hear from Dr. Ross McKinney, Jr., MD, Chief Scientific Officer. Ross, it's all yours.

Ross McKinney, Jr., MD, Jr., MD: OK. Well, I'm going to hit some of the high points that people are dealing with from a research point of view. First of all, we are dealing with the increased numbers. The numbers reflect... We're up to 9,415 cases. They reflect the ability to make a diagnosis now because the DNA PCR tests are much more widely available. However, we are continuing to see shortages of reagents and an extreme shortage of swabs. The swabs are made by a company called Copan, C-O-P-A-N. They're located in Northern Italy, and they are specific for doing things like viral diagnosis. At the moment, they are in short supply, and that is limiting our ability to test all the people that we would otherwise like to test. We have unfortunately had our first therapeutic failure, Kaletra, which is an antiretroviral drug. Lopinavir-ritonavir did not work for treatment of coronavirus. There are still studies ongoing of dirunavir, another anti-HIV drug that probably will have the same failing. Chloroquine, which is useful for malaria, and has been proposed for prophylaxis. And perhaps most promising, remdesivir, which is a Gilead Sciences' drug, developed as a nucleoside analog originally for Ebola, where it did not work. We hope that it will work for coronavirus. There are clinical trials underway. Also, showing some promise, there is the monoclonal antibody cocktails being developed by Regeneron that are still in animal model testing. The first vaccine study is underway, Moderna's mRNA vaccine, and the first patients have been enrolled. And finally, there is now a lot of research from the CDC showing what the epidemic looks like in the United States. 38% of US hospitalizations are people 20-54. So, the sort-of rumor on the streets, that this is a mild disease for younger people, does not seem to be the case. Half of the 121 US ICU admission patients in this study were less than 65. It looks like it is a problem for younger people as well as for the elderly, which we already knew. And with that, I'll pass it on to Janis Orlowski for her comments from a clinical point of view.

Janis Orlowski, MD: Thanks very much, Ross. I am Janis Orlowski. I'm the Chief Healthcare Officer, and also a practicing nephrologist. I wanted to make just a couple of comments. First of all, everyone should know that the US hospital and health system has been planning for a respiratory pandemic for years. I personally, prior to coming to the AAMC, was involved in scenario training for a respiratory pandemic virus. And so, you should understand that our hospitals and health systems tried to imagine this day and this time, and so have some

foundational planning for what's going on. Obviously, the extent of the spread and the type of virus is going to make our scenario planning need to change. But there is foundational planning across the US health system.

The second thing is what's going on on the ground. Every clinical institution and leader that I'm talking to states that their clinical needs vary by the intensity of the disease in the area. But everyone is saying, "PPE, PPE, PPE." And what does that mean? Personal protective equipment. That is the number one issue for our health institutions at this time. Secondly, test kits. Ross has discussed some of the issues with the test kits. It's the availability and ability to have test kits.

And then, third, what we're looking forward to, as far as integrity of the US supply chain. And we're particularly looking at the types of medical devices and drugs that are used in intensive care units. Do we have enough in the supply chain? What is our estimate of the use that's going to happen? So, what do we do with these needs? The AAMC really has a role where we talk to teaching hospitals, schools of medicine, and we talk to people who are on the ground, and begin to collect information about what is actually happening, what are some of the concerns, what are some of the issues. And then, in each one of the cases that I mentioned on supply chain, we've been in discussions with ASPR, with CMS, with the FDA.

And I'll give you an example. CMS, we've had extensive discussions on a couple of issues. One is the nuanced guidelines for elective surgery. And I applaud the CMS for the guidelines that they put out yesterday. I think that they're very clear. And as with many things that happen in health systems, you need to have a nuanced understanding for a guideline.

The second issue that we've been asking CMS for greater help and authority is in telehealth and in licensing. ASPR's been having multiple discussions with us about preparedness, about how teaching hospitals and other hospitals can access the national stockpile. And I would say, the final point that I would like to make is a personal experience. I provide clinical care at a teaching hospital. And at that teaching hospital, we take care of not only highly complex care, but we also take care of a vulnerable population, a poorer population, a population that has many comorbid conditions. What we know is that everyone will be affected by the COVID-19 crisis that is going on right now. But we need to understand the severity is likely to be worse in this population that is served by everyone, but in particular, by teaching hospitals.

Yesterday I saw individuals. I would tell you that the ambulatory care is down to just those who need to be seen, and there is a transition to telehealth. And I would tell you that the last patient of the day that I saw was someone who had multiple comorbid events and had a fever and a cough. And so, I found myself not only talking about this over the last couple of days and weeks, but actually having to begin a system of care for that individual to rule out

COVID-19 as a possibility. Those are the points that I wanted to make. I am delighted to turn this over to my colleague Alison Whelan. Alison?

Alison Whelan, MD: Good morning. Thank you. Talking about medical education. Our medical schools are balancing teaching, clinical care, and public safety. That's always been their goal. The challenge is, how do we do that with the rapidly evolving pandemic? The three aspects of COVID that are particularly unique is the rapid spread going on in the community and the national scale, the national shortage of PPE, and the high person-to-person transmission rate.

Right now, the majority of our hospitals and medical schools are really trying to focus on containment and limiting spread. For that reason, they've taken the students off of clinical rotations to preserve PPE, and to limit the total number of people within their buildings to really try to limit spread. These schools are doing a terrific job of redeploying those students in creative ways to really help the strained healthcare systems. Examples are, they have taken them on phone lines to help with telehealth. They're checking with post-op and post-discharge patients. They are calling colleagues and healthcare professionals who have been quarantined to check in on them for their care. Those are all valuable clinical care activities. In addition, they're volunteering in a more general way. For those healthcare professionals who need to be on the frontlines, whose kids are not in school, students have voluntarily created ways to take care of their kids, etc. Those kinds of activities continue to go on.

AAMC is helping by bringing our medical educators together virtually, and collecting resources to share best practices, so we can disseminate these great ways to really use our students effectively. I want to recognize that there are portions of our country that are beyond the containment and are really facing a surge. And we recognize that if there is a surge of cases, potentially combined with limited healthcare professionals who are either quarantined or ill, that there may need to be a rethinking of how to use medical students, bringing them back to the frontline. We are working with our medical schools in developing principles and guidelines for this. The rapidity with which the landscape is changing and with which our medical schools are responding, and how we are assisting them, exceeds anything any of us have experienced. It continues to move the pace. Thank you, and I will turn it back to David.

David J. Skorton, MD: Thanks very much, colleagues. And now we're going to open it up for your questions, reminding you that because of the webinar setup, an operator will read your question for you, and we'll answer everything in the order they were received. In case there are questions we don't get time for, or if you have a question after the webinar, please send them to us by email at press@aamc.org. [Press@aamc.org](mailto:press@aamc.org). OK, Sandy, we're ready for questions.

MODERATOR: OK, very good. Thanks, Dr. Skorton. The first one is, are medical students, pre-graduation, being recruited and prepared to help overburdened healthcare workers? Or is that planned? If so, please provide details on where and how many, etc.

Alison Whelan, MD: I think I answered that question, doing it in two ways. Nearly all of our schools are deploying students in the not-frontlines to really help with connecting with patients, through phone calls, medical records, etc. And the schools that are on the frontlines with more surge are beginning to gear up. And I believe we will have a guideline out soon. And I suspect schools will be dealing with this in the next couple of days of this rapidly-moving pandemic. Thank you.

MODERATOR: OK. The next one is, what are the one or two most important research studies happening now that have not been widely reported?

Ross McKinney, Jr., MD: That's hard to say because you would like to know what--For example, one that might be important is, there might be studies of vaccines that have been in progress for a while. Looking, for example, at SARS, the original SARS, and that some of those vaccine studies may actually turn out to be translatable into this stage of the SARS-CoV-2 epidemic. Those might be studies that are of particular importance. But otherwise, it's hard to know because if they're below the threshold, they're below the threshold.

David J. Skorton, MD: I wanted to add just one quick thing to that answer, and that is, as the days go forward now, we will probably get some more information. And so, again, if you have follow-up questions, or if something comes up two, three days from now, we're at your service, press@aamc.org. Please feel free to contact us and we'll get you to the right person very quickly.

MODERATOR: OK, great. The next one has to do with telehealth. I'm wondering how teaching hospitals are using telehealth, especially considering the steps the administration took to relax those requirements. Could you give us some context on how that's going, how doctors are using telehealth now, and did the steps from CMS help? Could the administration do more? All about telehealth.

David J. Skorton, MD: Janis, if you'd take that one. And please, also, if you would, speak up about the issue of state-by-state licensing relevant to telehealth. Janis?

Janis Orlowski, MD: Yes, thank you, David. Is telehealth important? Absolutely.

How has telehealth been employed in this area? I think the first thing that we're seeing is that multiple institutions have instituted telehealth for screening. So, they don't want everyone to come to the primary care office or the emergency room. What they're saying is, "Here's a

number. We will have a medical professional who will talk with you." So, one of the very first telehealth screenings that I was aware of in the country was at UCLA. I spoke with Dr. saying is, "Here's a number. We will have a medical professional who will talk with you." So, one of the very first telehealth screenings that I was aware of in the country was at UCLA. I spoke with Dr. Cherry, the Chief Medical Officer, and that was their way to begin to screen a number of people who had symptoms, or who had questions or concerns.

The second way that telehealth can and is being used is that there's a number of people who have chronic illnesses that need to have regular appointments, not only with primary care doctors, but with their specialist. And what we saw is that Yale began to transition as much as 50% of their ambulatory physician visits to a telehealth platform. Now, this depends on a couple of things. First of all, at Yale, the healthcare institution has the platform, but it also requires the patient to have some platform that can be used. That is being worked on right now on the fly, so to speak.

Let's talk about the administration's work with telehealth. I would say, we've had multiple conversations with CMS about telehealth. They came out with an advisory last Friday that talked about Medicare and Medicaid paying for telehealth. We spoke to them over the weekend about the issues of licensure, about the issues of broadening the use of telehealth. And the guidelines that came out yesterday were very helpful, and were along the lines of much of the recommendations that we had made, as well as others had made to the government.

The issue that David brought up regarding licensing is that at the current time, physicians cannot, in many places, cannot practice telehealth unless they have a license in the state in which the patient is receiving their healthcare. So, if a patient is calling from Connecticut, and they're calling to a doctor in Massachusetts, the doctor in Massachusetts has to have a license in Connecticut. That all changed yesterday, and is evolving as we speak.

First of all, the president in federal issues have said that if you are a physician who has a license who has a practice ongoing and a license in good standing, you can practice anywhere in the United States. We are asking CMS to clarify that this goes to telehealth. And the third thing that we're looking for clarification is that we can begin to expand the workforce, and it's not just doctors, but it would be medical residents and other individuals. So, I'll stop at that point. Thank you.

David J. Skorton, MD: Thanks, Janis. Sandy, we're ready for the next question. Sandy, we're ready if you are.

MODERATOR: How are medical schools responding to match day tomorrow? Are most schools doing virtual match days?

Alison Whelan, MD: Yes. Match is typically a massive celebration of family, friends, and faculty. And all of our schools are not having a group activity. Some are letting students celebrate alone. Most are creating a virtual experience with some creative ways of connecting students, asking for selfies, and really encouraging students to gather with their closest small group of people, and then share back virtually. And we are delighted to be welcoming this new group of healthcare providers to our community.

MODERATOR: OK. The next question is, are schools continuing lessons virtually? If so, do schools have previous experience doing this, or is this new?

Alison Whelan, MD: Yeah, again, it's a little bit mixed. Yes, they are all continuing their lectures and small-group learning virtually. That has been a pretty seamless transition because most of them had capabilities and were using that kind of teaching in one way or another. A challenge that will come up is those things that really need to be face to face. You probably know we use standardized patients for teaching communication skills, and those kinds of things. Those have been put on hold. And if the pandemic continues, we'll need to come up with new and creative solutions to continue to meet the learning objectives as we continue to protect public safety. Thank you.

MODERATOR: Next question, OK. Are you worried that the shortages of PPE are endangering healthcare providers and patients in your affiliated hospitals?

David J. Skorton, MD: Well, we're certainly worried about this shortage for those reasons and for others. Janis, would you like to comment further?

Janis Orlowski, MD: I have to say, that has been the major discussion and ongoing with ASPR about the shortage. We are, in multiple areas, being very careful to conserve PPE. And there will come a time where there will be a reuse of PPE. I would say that we are glad that the national stockpile is being distributed. We are very pleased that the Pentagon has released PPE. But we are going to really have to push to get more PPE into the hands of our healthcare workers. Are we worried about this? Yes, we are.

David J. Skorton, MD: Janis, could you also comment on a possible tactic of keeping patients with known or suspected coronavirus in a cohort, in a group, so that perhaps the physician doesn't need to change the entire PPE between patients?

Janis Orlowski, MD: Sure, David. What Dr. Skorton is referring to is that, if a physician is making rounds and the physician can somehow geographically locate--the patients can be located, the physician could use PPE in examining those individuals, without having to take them off and go back on, put PPE back on. I think the other thing that our teaching hospitals,

what we see, and this came very early, is a restriction in the number of individuals who are going into the room. So, team care is the care of the day. Many teams have not only attending physicians, residents, medical students, but ethicists, pharmacists, multiple others. And what institutions are doing is basically keeping the individuals to a real minimum, that need to go in and do an actual, physical examination or interaction with the patient. I think that there have been many creative ways to try and be very conservative in the use of PPE.

MODERATOR: OK. Still on the topic of PPE, can you give specific examples of products that are running out or being reused, or institutions having to come up for some kind of a replacement for those depleted items?

Janis Orłowski, MD: We did a, I would say, a rough survey, talking with our institutions, about what they're running out of. And principally, it's masks, it's the shield to the eyes, it's the gowns. Those are the big items, and then it sort of went down the list to include gloves, shoe coverings, the hand sanitizers that are used at institutions. So, what are these institutions doing? First of all, they're going through all the conservation methods that we just talked about. Then, in concert with their state, the national supply is being distributed in a pro rata fashion to states. So, there has been contact with the states. We also have encouraged ASPR to see if there are other industries that use PPE that we could, at this time, emergently transfer those PPEs to us. And then, we actually have been talking about what would people do if they needed to go without PPE. Probably, everyone needs to have a mask, that goes in to see a patient. Soap and water can be used, obviously, to clean your hands. And then the question is, if there aren't gowns, do you wear some type of clothing that you then dispose of? Or do you get out of those clothes and into other clothes once you're done examining the COVID-19? Many discussions about what we can do. I should also mention that we have had discussions with the CDC, and they, in concert with CMS and the White House, made the decision to close the dental offices and the elective surgery places, again, to draw PPE to those areas that are needed.

MODERATOR: OK. Are there any policies that could be changed to help with workforce issues on the frontlines?

Janis Orłowski, MD: Sure. I think that initially some of the discussions that we had had to do with licensing, had to do with the use of telehealth. Those are all being addressed right now. The other--This doesn't require regulatory change, but the other issue that we've been talking about is making sure that all professionals are practicing at the top of their license. And then, the next thing, and this is something that Alison had mentioned, the question is, how do we bring in other workforce individuals? What is the role of the residents? What is the role of students? And how we begin to pace what is going to be a very long, likely 8-10-week course during the spring, and then prepare ourselves for the fall? As far as other regulatory issues, one of the things that we're going to need to look at is, healthcare institutions are not doing elective

cases, which tend to be the areas where their principal higher earnings come in. Those have stopped. And so, there are discussions with both Congress, as well as federal agencies, about how to get an appropriate amount of dollars back to the institutions at this time. David?

David J. Skorton, MD: I'd like to just add--Thank you very much, Janis. Just to add a couple quick comments. One of the things that we're learning in a time of great stress like this is that the problems that are long-standing tend to come out in bold relief at a time where the system is stressed even more. And we've been concerned for some years that there's a shortage of physicians in the United States, and that there will be more of a shortage as time goes on. I'm a baby boomer. I have an active medical license in both the District of Columbia and New York state. And when my cohort of physicians retires and are no longer available, that shortage will be exacerbated. So, we think that one particular area that would be terrific is, once medical school is done, as you all know, the doctor will move into a residency training, which is postdoctoral training, in either a general practice discipline, primary care discipline, and/or a specialist discipline.

And so, one of the roadblocks for us, dealing with the doctor shortage, is the lack of graduate medical education slots, payments for them, at the great teaching hospitals around the country. There's something we've been concerned about for some time. And I'm more concerned about it now for many of the reasons that were brought up. So, those are just a few thoughts. Sandy, ready for the next question.

Janis Orłowski, MD: David, if I could just quickly add on to your thoughts. The other thing that I would say is that, as we take a look at funding of the healthcare system, we have to take a look at what should be the true cost or expense, not just for day to day, but how do we make sure that we invest in research, in education, and invest in expansion capacity? And I think those are issues that we can't forget the lessons of this pandemic.

MODERATOR: OK, very good. Are medical school faculty helping or being asked to help in hospitals with doctor shortages?

David J. Skorton, MD: Alison, why don't you take a comment on that one, and then Janis may want to add, or Ross. Alison?

Alison Whelan, MD: Yeah, just to clarify, medical school faculty who are physicians typically are part of the workforce of their affiliated or partner hospitals, so that they often have a foot in both worlds. And what we see is those faculty who are educators have ramped up their work on both sides. The answer is, that's what they always do, they're just doing more of it now. Thank you.

David J. Skorton, MD: And if I could just add, if I were a member of the press, I would think about this as an interesting story, perhaps. Most faculty include not only M.D.s, clinicians working in various areas, but they also include PhD faculty who are doing research. Whether it is the faculty working on some of the antiviral treatments that Ross talked about earlier in this press conference, or whether it's actually participating in direct patient care, we're depending on these faculty, not only to get us through this particular problem, but to make progress in the research arena and the organization of clinical care arena, to make sure that the next time this happens, and there will be a next time, that we're better situated to deal with it. Sandy, ready for the next question if you have one.

MODERATOR: Yes, you have a lot of questions standing by. If people are diagnosed, how long does the virus last? And how long are they contagious? And are they immune once they've had it?

Ross McKinney, Jr., MD: Yes. OK, the understanding is that they are infectious from shortly before they become symptomatic until about day 8 to 10 of symptoms, at which point it begins to abate. There are some reports that people may shed considerably after they have completed all of their symptoms. But the numbers, it looks like it probably goes down significantly. So really, the contagiousness peaks in the first few days of symptoms and right before somebody becomes symptomatic. And that right before is what makes this so difficult to control. And what was the second part of that question?

MODERATOR: I'm sorry. The second part is, are they immune once they've had it?

Ross McKinney, Jr., MD: And the answer to that is, as best we can tell, yes.

MODERATOR: All right. What look like the most promising drugs to combat COVID-19 right now? I know the malaria drug was mentioned, and the antibody serum.

Ross McKinney, Jr., MD: I think, actually, as I--So you're just getting one person's read--I probably have the most hope in the monoclonal antibody cocktails. They worked for Ebola. They were the most effective drugs there. And there's reason to think that you could be able to put together a cocktail that would work for coronaviruses. Remdesivir has the advantage of being a drug that's been considered for other conditions, so there's a lot of preclinical information. We can get testing of it going quickly. And in fact, a clinical trial is enrolling. So, those are probably the two drugs that I hold the highest promise for. Chloroquine has shown in-vitro, in the test tube, activity before, and failed in patient situations, in regard to viral diseases. So, I am skeptical that the Chloroquine is actually going to be effective when we do controlled studies.

David J. Skorton, MD: Ross, could you help our colleagues by reminding everybody about the differentiation in the time it takes to get something available to the public of brand new approaches, brand new antivirals, brand new drugs, and those that are currently on the market that might be used in so-called off-label use? Can you just remind us about those differences in when something might be available?

Ross McKinney, Jr., MD: OK. Well, if something is being used off label, for example Chloroquine, which is a well-established, long-known anti-malarial, you can begin doing testing almost immediately. And in fact, you can use it off label, you can use it for patients on a prescription basis. Although, we are better off if we put people into studies so that we learn something in the process. Kaletra was another drug that could be used off label because it's a licensed drug. It didn't work, so because the study was completed, we now know it didn't have any effect, and people might have taken it, with its considerable side effects, in hopes that it was going to do something. And now we know it did not.

It's important to do good studies of drugs like Chloroquine. So, it'll take a little bit of time for those studies to be complete, even though the drug is well-known. The monoclonal antibodies have the advantage of being similar to other monoclonal antibodies that have been used for Ebola. So, in fact, there is the kind of preclinical information that needs to be developed, what does it do, how much of the drug, where is it distributed? That needs to be done before you can begin using a drug in people for a disease. And fortunately, we're farther along because of previous experience. And remdesivir, the same thing is true. It was used in a clinical trial of Ebola. So, we know what its pharmacology is. We know basically what its toxicology is. So, it's a drug that can be put into a clinical trial immediately, and is in one.

MODERATOR: OK. Is the anticipated forecast of the peak of this still targeted for the first week of April? And what happens after the peak?

Ross McKinney, Jr., MD: That's very complicated. And we are in guesswork land. The projection is that sometime in the next month or so, we'll get a peak. But you don't know if you're going to develop other hotspots, like you've had in New York and Boston and Seattle. We hope that the social distancing that we are doing will lead to us to begin to see, in a few weeks, some decrement in the rate of spread of the infection. Our hope is that early in April we will start to see a decline in the number of new cases. Once we get out of--If we can get to the point that China is now, where there were no reported new cases in China that weren't imported, if we can get to that point, we still have to worry that this virus will, like influenza, go through a hemispheric flip-flop where it is present in the winter in one hemisphere, and present in what would be their winter in the other hemisphere, as the seasons flip. That's true of influenza. And we worry that that could be true of coronavirus. That's what happened with Spanish influenza. There was a small blip in the spring of 1918 that became a huge epidemic in the fall. And most of the deaths occurred in the fall. So, we worry that where we're seeing

disease now, that it could in fact come back again. We could see another wave. And we don't know whether the next wave will be larger or smaller.

MODERATOR: OK. How much worse would it have to be for some of your hospitals to run out of ventilators, or need retired doctors or nurses to come back to work?

David J. Skorton, MD: Janis, would you like to speculate on that?

Janis Orlowski, MD: Sure. I would--Like Ross said, we're going to see what happens over the next couple of weeks. There's been wide discussion. Dr. [INDSCERNIBLE] has continued to talk about all of the social distancing to try and flatten the curve. Right now, what we know is, across all states, there are fewer than one intensive care bed per thousand people, age 60 or older. We know right now that we have a large capacity, if you look at the numbers. But if you look at the ratio, that ratio of ICU beds is small, compared to others. We also know that there are certain hospital rooms that can be flipped from a general med surg to an ICU-type level. So, those numbers could go up.

The other thing that I would tell you is that we, in our scenario plannings for a respiratory pandemic, we talked about having a mash-type tents that would be outside of hospitals. There are plans underway. And this is going on at the University of Washington. It's also going on in Massachusetts, where hospital officials are beginning to use buildings that have not recently been used for acute care. So, we're trying to use as much as possible.

We also, since 9/11, we have had not only the ventilators that have been in day-to-day use, but we've had additional ventilators that have been stored for mass casualty or mass crisis events. Those will come. And the Pentagon will provide ventilators. So, there are multiple sources. But if we get to the point where we run out, then there will need to be a decision about how we will strategically use those.

Specifically, in regards to your question regarding, do you bring retired doctors and nurses back in? We have had that discussion with a number of federal agencies. And the problem with bringing retired physicians and nurses back in is that, first of all, they are at an age where the morbidity and mortality of this disease is higher. And they may not have recent training. So, the question is, how can we bring people up to speed and bring them in? And likely, what they will do is they will backfill in areas where it's not direct patient care.

MODERATOR: OK. Are any of your hospitals deploying their own homebrew COVID tests? And have you gotten any data indicating if some COVID tests work better than others?

Ross McKinney, Jr., MD: The answer is yes. We're seeing some labs come up with their own diagnostic tests. I don't know that we have yet documentation of comparative effectiveness.

This has been moving so fast that I don't think that the degree of precision of any of the tests is that well worked out. The FDA expects you to give them data, after 15 business days of using your new test, on how well it's working in comparison to some other laboratory as a standard. So, we will be seeing, in the near future, whether, in fact, these laboratory-developed tests are being effective.

MODERATOR: OK. The next question is, do we know if, in fact, the virus lives on surfaces? And if so, which surfaces, and for how long?

Ross McKinney, Jr., MD: Yes. We know that the virus--It doesn't exactly live, because these are viruses. They don't replicate, so they may be stable. And they are stable on metal surfaces for a few hours, on paper surfaces, it may be for a few days. However, it is very difficult to-- You have to get a certain level of virus exposure in order to be infected. So, we do not yet know, even though you can, through laboratory techniques, find the virus on paper 72 hours after the infection, we don't know if you're picking up an envelope, and then immediately licking your tongue or your hand where the envelope was, would give you the infection, because it requires a certain inoculum size to infect somebody. So, I would say that we are aware that it will stick to surfaces for a period of up to days on porous surfaces. But we don't yet know what that means in terms of infectiousness through what are called fomites or objects in the environment.

MODERATOR: OK. The next question: Has the AAMC cited a need to conserve PPE as one reason to pull medical students from clinical settings? When do you anticipate that a need for more healthcare workers on the frontlines will outweigh the need to conserve PPE?

David J. Skorton, MD: I think that's going to be a tough call, and would have to be made locally. But Alison, can you give us more expert thoughts on that?

Alison Whelan, MD: I would echo what David just said. It will definitely be a local decision. As we've talked to our colleagues across the country, it's very clear that what circumstances they're dealing with varies depending on the local prevalence of what they're experiencing. We do believe that working together with our colleagues, understanding what the surge is, that we can make rational decisions in an otherwise crazy pandemic. It will be individual and will really be based on balancing the basic principles that we always balance, which is clinical care, public health safety, and the individual safety of the healthcare providers. It's a tough equation that I think--Thinking about all those things in a really thoughtful, principled way is the way we will get through this.

MODERATOR: OK. Please give more details on how students are helping with telehealth and checking in on patients. Do you mean COVID-19 patients or others? And if you could please give some examples.

Alison Whelan, MD: Yep. A couple of specific examples. Post-op patients typically get a call from their physician. Some schools are having the medical students do the follow-up calls to free up physicians, and actually nurse practitioner time, as well. Many hospitals have call-in numbers for people seeking information or wondering if they should be seen. So, some hospitals are having students staff those lines with physician backup to answer those questions to have an informed public. And then, third, nearly every hospital has seen patients or triaged them by phone for COVID. And they may have tested positive and be well, or they may have not been able to have testing because tests weren't available, and they've been asked to go home and self-quarantine. So, some schools are having students call these individuals and do a telephone health check on them. Those are three specific examples. And our schools are continuing to evolve and develop new, really meaningful ways for our students to contribute. Thank you.

MODERATOR: OK, also on the subject of telemedicine. If someone has a doctor and the person has a relevant chronic illness and would like to do telemedicine from home, but can't because of HIPAA, so the person is wondering if this is something that you're trying to get HHS to wave.

Janis Orlowski, MD: A patient can speak with a doctor, and there should not be any HIPAA violation during that. I guess the question--And recall, too, that a patient can waive. So, if they want to have a family member or someone else who's with them, they can waive and include their family members in on a discussion with a physician. I'm not sure if there was another meaning to your question. But HIPAA should not be an issue in telehealth.

David J. Skorton, MD: And that's not just related to COVID. That's a statement that Janis could have said two months ago, as well. Sandy, other questions?

MODERATOR: OK. Oh, yes. Are you concerned the grant money now being sent on salaries will leave PIs without the funds to complete their research? And if so, how would you like government agencies to address this potential problem?

David J. Skorton, MD: We're very, very concerned about disruption in the research pipeline for those and other reasons. And Ross, would you like to comment on that? It's a very big concern.

Ross McKinney, Jr., MD: Yes. We are very concerned for a variety of reasons. One, we want to make sure that our staff are able to get by in between because if you aren't doing research, should you be paid for doing research? And then, if you expend the funds to keep people whole during this break, then how are you going to complete the project? There will be several levels of expenses that need to sustain the funding so that people are able to get back to work and do the job. There will be the startup and shutdown costs because you have to close down

all the experiments, many of which have been going on for months. Some, like in agriculture, not in medical, but agriculture, it's seasonal, and you may not be able to do your research. There are a lot of expenses that come with the delays and with the shutdown and startup that occurs. And we would hope that the federal government could provide some support to enable institutions to sustain the research that we think is very important for people's health.

MODERATOR: Thank you. Have there been any cases where healthcare providers contracted COVID-19 from working the frontlines, despite having protective gear? And if yes, how common is this?

Janis Orłowski, MD: Sure. I spoke with the CDC yesterday regarding that. And for the healthcare workers who have become positive, they are actually just at the start of doing an investigation of whether they caught the illness with that or not. As far as healthcare workers in the United States, too early to provide that information. Ross, I think you might know a little bit more about the Chinese experience?

Ross McKinney, Jr., MD: The Chinese experience, what was interesting was that a lot of the cases that were originally suspected to be tied to failures of PPE turned out to be home exposures and clusters that came through the home. That was what WHO found when they inspected. It's a mix of other exposures and perhaps breakdowns of PPE. But I'm not aware of specific details about the rate of failures of PPE. I don't think it's very high.

MODERATOR: OK. Another question. You talked about how long the virus lives on surfaces, a question came in, how long does it live in the air? Can people go outside? If they're not close to people, can they take walks outside?

Ross McKinney, Jr., MD: The answer there is yes. The radius of when--An asymptomatic person probably sheds the virus for about a six-foot circle. And it does not waft like measles wafts. Now, you can generate aerosols. If you're doing a procedure like a bronchoscopy, where somebody is washing out somebody's lung, and that will generate small particles, aerosols, that could, I'd say waft, and spread to people farther away than six feet from the source of the infection, the individual who is the source of infection. But in general, the infected person doesn't generate aerosols like that. While you could technically do it, it looks like most of the spread continues to be droplet-type transmission, like influenza, which typically occurs two people who are within six feet of the infected individual.

MODERATOR: OK. When you talk about getting doctors to practice at the top of their license, does this mean less time on the computer? Less EHR time? And how do you get around that?

David J. Skorton, MD: I think what Janis was referring to was other healthcare workers to practice at the top of their license, advance practice nurses, physician assistants. Janis, do you want to clarify that?

Janis Orlowski, MD: Yes, you're right, David. And I would say, I was not thinking about the documentation issue. I was thinking about bringing in all the other healthcare workers, pharmacists, dietitians, social workers, who can help with aspects of healthcare delivery. Although, you bring up a very important point. Many of you have seen the studies that documentation eats up a good part of a physician's time, and in some cases, up to 50% of the time that they're doing it. I think that we are going to understand that as people are taking care of individuals, the documentation that is required for what I would say regulatory issues is likely to be less, or likely to be missing.

People are going to need to just document to provide information to others who are also providing care on sort of a need-to-know. And we're going to, quite frankly, be away from all the documentation that's required for regulatory issues. One thing of interest, we did talk to CMS a couple of days ago about their quality indicators. And they, right now, although they have a high degree of interest of certainly maintaining high quality and infection control in hospitals, what they're looking at is how they can decrease the burden of regulatory documentation. So, we look for further changes from CMS in that regard.

David J. Skorton, MD: A couple quick comments I want to make. I want to take a second just to personally thank the media for your coverage of this pandemic. It's been incredibly important, and it's been very reassuring for us, just as citizens, not as specialists, to get the knowledge that you bring to us every day. So, I thank you for your terrific coverage. We want to be helpful. We're going to have more virtual press conferences, and we'll announce soon. We're going to do our best to answer any of the questions still in the queue, since we're wrapping up. Please let us help you in two other ways. If you have other questions that come up after this first virtual press conference, send them to us at press@aamc.org. And if we can help connect you with specialist physicians, researchers, leaders at academic health centers, you can also write us at that same address, and we're glad to work with you to get you connected to the right people for the coverage that you're seeking. I want to thank my three colleagues for their answers, and thank the media for terrific questions. And Sandy, turn it over to you to close.

MODERATOR: OK. Thank you, Dr. Skorton. With that, we will conclude today's program. This session has been recorded, and AAMC Media Relations will post the link to the recording on the AAMC website within the hour. On behalf of the Association of American Medical Colleges, thank you and have a great day. You may now disconnect.

End of Webinar