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AAMC Press Teleconference

Getting Ahead of the Curve:
What comes next as COVID-19 diagnoses flatten and decline in hot spots

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Participants:
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MODERATOR: The Association of American Medical Colleges is pleased to welcome you to today's press conference, getting ahead of the curve, what comes next as COVID-19 diagnoses flatten and decline in hot spots. My name is Sandy, and it's my pleasure to be the facilitator for today's event. Please note today's call is being recorded. When you want to ask a question, just press star-1 on your telephone keypad to be placed into the phone queue. You will still be able to hear the presentation while you are waiting. When the speakers are ready to take your question, your line will be unmuted. Please announce yourself with your name and media outlet. It's now my pleasure to introduce Dr. David Skorton, president and CEO, who will introduce our other speakers for today.

David Skorton, MD: Thank you very much, Sandy. Welcome to everyone and thank you for joining us. I'm grateful to everyone in the media for continuing your coverage of this pandemic from all different angles for the public and for the good of the policymakers. Very much appreciated. This is the fourth press conference that the AAMC has hosted since the COVID-19 pandemic began. And today we'd like to talk about what the future looks like over the next few months and well beyond.

As you may know, members of the AAMC include roughly 400 major U.S. teaching hospitals that are on the frontlines, including those in emerging hot spot areas for the coronavirus, such an Sanford Medical Center in South Dakota and George Washington University in D.C. Across the country, our members also include institutions such as Rush University Medical Center in Chicago, Thomas Jefferson University Hospital in Philadelphia, University of Texas Southwestern, Cleveland Clinic, Mayo Clinic and many others. We also represent all 155 accredited medical schools in the U.S., 17 in Canada, and 80 academic societies. Since we held

our last press conference two weeks ago today, the number of COVID-19 cases in the U.S. has grown by 173%.

Last week COVID-19 was one of the top two causes of death for the week, second only to heart disease. And I must say with the current underreporting of COVID-19, it may actually be the leading cause of death this last week. Around the world, there are now more than 2.1 million cases and over 145,000 deaths, and the in the U.S., we have more than 670,000 cases and over 33,000 deaths.

Also since we last spoke, there's been a plan to halt funding for the World Health Organization, a development that I find deeply disturbing. Now is actually the time to work together with other nations and to pool our scientific resources. We need the World Health Organization's important work to help us all address what is truly a global pandemic that knows no borders.

Now, before I introduce my colleagues to talk about the latest scientific information and other updates from the frontlines, I'd like to briefly outline my perspective on what steps we as a nation need to take to get ahead of the curve, so to speak, now that we have started to flatten it through social distancing and other mitigation strategies. Our current task is to get through the immediate crisis, including securing adequate and reliable testing options and developing treatments and vaccines.

To that end, the AAMC and our members have been in discussions over the last several weeks with the White House Coronavirus Task Force, HHS, and the FDA to help advance our goal of securing comprehensive testing capabilities, which is required for us to be able to reopen our country in an evidence-based manner. This week we sent a letter to ambassador Dr. Deborah Birx, the White House Coronavirus Task Force coordinator, calling for greater transparency to maximize testing capabilities at academic medical centers, which continue to experience critical shortages of testing supplies. That testing is essential so that we can make evidence-based decisions about reopening our nation. But I also believe we need to do much more than that in the long term. We cannot go back to the old normal in several ways, even though everyone is eager to get back to some kind of normal as soon as possible.

There are, in my view, at least two problems with what our old normal looked like and our experiences with this pandemic have taught us some important lessons:

First, this pandemic has forced us to confront yet again the realities of health inequities in our country. Underserved populations such as people who are homeless, poor, incarcerated, and many others have suffered more severely from this virus. And we've also seen racial disparities. While this virus did not cause these disparities and did not cause these inequities, it reminds us that we cannot return back to the status quo when we get through this initial crisis. Those inequities will still be there and still need to be addressed in an intentional way, more urgently now than ever. And that is why the AAMC and other organizations have called for data collection so we can better track how this pandemic is affecting specific demographics.

Second, this pandemic has revealed how unprepared we were as a nation for a public health crisis of this severity. It's a reminder that we must invest in our public health system, in the strategic national stockpile, other measures, as well as medical research for the long term. We shouldn't let our guard down once the current crisis passes. We must also address long-term shortages that have been predicted in the health care work force and bring the private and public sectors together to brainstorm ways collectively to strengthen our preparedness for future public health threats. It's a matter of when, not if, the next crisis will occur, and it's our responsibility, all of us, to learn from our experience and do better next time.

With that, I'd like to introduce four of my colleagues who will share the latest on the frontlines of this crisis. We'll start with Dr. Ross McKinney, the AAMC's Chief Scientific Officer and an infectious disease expert, who will provide an update on lab testing and other research developments. Then my colleague Dr. Janis Orlowski, who's a practicing physician, will talk about how hospitals are responding. Next, Dr. Alison Whelan, the AAMC's Chief Medical Education Officer, will talk about our latest guidance on medical student participation and how students are contributing. Finally, Dr. David Acosta, our Chief Diversity and Inclusion Officer will talk about how we need better data to fully measure the impact of the virus on specific populations. There will be plenty of time for questions. Let's get started, please, with Dr. McKinney. Ross, it's all yours.

Ross McKinney, Jr., MD: Okay. Thank you very much, David. I'm going to talk about three basic topics today. The first is epidemiology. The second is testing. The third is the effect COVID is having on our academic institutions and their research efforts.

In terms of epidemiology, I hope people appreciate how effective our social distancing has been. I was looking earlier this week and saw that there were about 600,000 death -- or 600,000 cases of COVID-19 in the United States and about 25,000 deaths so far. It's increased to 670,000 and 33,000, but at the time, that's what it was. That struck me because the flu in 2009 produced about 60 million cases in the United States. COVID is roughly as contagious as influenza. So if we had had as many cases of COVID-19 as we had influenza in 2009, we would currently have 2.5 million deaths. Two orders of magnitude greater than we've actually got. So I think social distancing has made an enormous difference, and we should pat ourselves on the back for all that we've done. If you look back at Spanish flu, they had 675,000 deaths in the United States, which is 23 times as many deaths as we currently have. So we've done well by social distancing.

The next thing we'll need to maintain that is testing. I think there is some progress being made in the world of testing. We are concerned that there are many labs that cannot get the resources they need to be able to do what they need to do in testing. There's still a shortage of swabs, although there seem to be more swabs becoming available, and it may be that swabs of other types can be used. We hope those sorts of solutions are forthcoming. The other area where there's been a lot of change has been in serology. It will be important to look at it in two ways. First, serology is when people have been infected. So somebody should turn positive. However, that may not actually tell you whether the person is protected or not. And knowing that there are what are called neutralizing antibodies that attach to the virus and keep it from infecting other cells is

absolutely critical because what we really want the antibody to tell us is that this person is protected from being re-infected by the coronavirus. Now, this will be particularly important when we get to vaccines. Because vaccines will want protective antibodies being what we detect, not just experience with some random protein. We want to know that what the person has developed it an antibody that's going to protect them.

The last thing that I think is worth noting that I hope you all are aware of is how much disruption we've seen in the academic laboratories. Most labs are closed that are not working on COVID. And this has been very expensive because people have been maintained in terms of their salaries, but the money that is being spent to keep those labs, those people employed is money that can't be used to complete the projects that were already under way and that often are important things in fields like cancer and heart disease and other important science fields. So several of us organizations, the APLU and the AAMC, have written to Congress requesting money to supplement the budget in order to cover the NIH budget and other science agencies like DOE and NSF to cover the cost of shutting down our laboratories, restarting them, and resuming the projects we had intended to complete when the COVID epidemic arrived. And that will conclude my comments for the moment. Janis?

David Skorton, MD: Thank you very much. Now Dr. Orlowski. Janis, all yours.

Janis Orlowski, MD: Thank you. Good morning, everyone. It continues to be a privilege to have the opportunity to talk with you. I have a couple of comments regarding our patient care areas. I've had the privilege of speaking to many of our teaching hospitals and health systems and physician leaders as well as those on the frontline, and they continue to believe that they are providing immense value and they are very proud of the work they're doing. They're very invigorated by their professional work. We also know, though, and this is something that we've been talking with leaders about, that there are concerns about being able to keep up this sort of relentless 24/7 work.

Prior to the COVID-19 crisis, we were co-members with the National Academy of Medicine on the action collaborative on resilience. What we're seeing right now is probably greater workplace hardships. We're seeing more moral dilemmas that our physicians and other providers are faced with, and we're seeing exacerbations of tension between professional and personal responsibilities. Quite frankly, we're seeing fatigue. So we are working with our partners at the National Academy of Medicine to continue to have tools and appropriate ways that we can work with our work force to make sure that they are taking care of themselves.

The next topic that I want to talk about is financial strain on the institutions. For many institutions, the stay at home, decrease your elective cases occurred somewhere around the beginning of March. We're now at April 17th. Institutions have taken a look at their 30-day run rate. I had mentioned to you that we have had numerous conversations and had an initial dollar figure that folks were losing between 2 million and 8 million a day. We know for a number of institutions, particularly in New York and Detroit, those dollar figures have gone up because of the cost of being a hot spot and the number of cases that they're seeing and the fact that they are

staffing beds outside of their walls of their hospital. So those institutions are reporting losses of between $10 million and $15 million a day. This is tremendous financial strain.

So what institutions are looking at is how we belt tighten, where can we have furloughs, and where do we decrease our individual compensation models. So it's a very stressful time for everyone because just as we are looking at the peak of the COVID-19 -- we believe this is the peak time -- we are having to take a look and saying, you know, what do we do for people's salaries, what do we do for furloughs, how can we make financial decisions at this particular time.

So it's a very, very tough time to be looking at those decisions while the work continues. I can tell you that I've had conversations, and we are taking a look at when and how elective cases can be returned. I would just re-emphasize that we're not doing that now, but people are looking at how we return to normal, and they have a checklist of items such as adequate PPE.

Also on that checklist is adequate testing. We are talking about the need to have adequate testing for anyone who would come into our institutions for an elective procedure as well as ongoing testing for the work force, and finally ongoing testing for the public. So I would just underscore Dr. McKinney's comments regarding the need for more testing.

And finally, the issue of residents and fellows has come up. Residents and fellows are individuals who are in a time of their training when they are in an apprenticeship, where they have hands-on training. We are proud and continue to be very impressed with the work that residents and fellows have done across the country. We're also concerned about their well-being, and we are continuing to emphasize the need for supervision, for resources, and for them to be working in areas where their skill and education are appropriate. Folks have said our residency is going to start on July 1st.

Although I can't promise you they'll start everywhere on July 1st, our institutions are making plans for the new residents and fellows to come to the institution. That planning requires that a resident and fellow be introduced to the institution in a very structured, very careful way where they understand the quality and safety procedures for the institution, where they're introduced to the team, where they learn about the electronic health record. It is a very structured input of these new, highly qualified individuals into our institutions.

Many of our institutions are looking at last week of June, first couple weeks of July. It's not going to be a crisp start date. There will be local decisions that are made, but the question that has arisen is will we be starting new classes in the middle of the summer and the answer is definitely, we will be. And at this point, I'm going to turn to my colleague, Dr. Alison Whelan.

Alison Whelan, MD: Good morning, everyone. So medical schools continue to deliver education remotely and virtually and doing a fabulous job. They're also continuing to identify new and meaningful ways for students to engage in meaningful clinical work for credit without

having direct patient contact. And the amount of creative ways students are contributing continues to expand as well.

Now we're looking ahead. Although as Ross pointed out, most of the country, if not all the country, remains with sufficient community spread and insufficient PPE and testing, that we continue to recommend that direct patient contact not be allowed for students. There are hopeful signs in the future.

So our guidelines released this week include the areas to consider as schools develop their plans to bring students back to direct patient contact. Again, it emphasizes what needs to be in place to ensure safety for the students, safety for the patients for whom they're caring, and safety for the community in which they're working. It also re-emphasizes those aspects of the educational infrastructure that needs to be in place so they can have meaningful educational experiences that move them towards their degree requirements.

The other area all of our schools are looking at is the next set of our work force. So recruiting the next set of medical students to enter medical school and for our final year students, their process towards selecting and getting into residencies. For both our undergraduates interested in medical school and for medical schools applying to residency, their spring courses have been massively disrupted, important exams have been delayed. Sorting out how to move this forward and how to appropriately communicate that to the schools is something the whole community is looking at.

As you look ahead towards the interview process, both for applying medical students and those applying to residency, it typically includes multiple day-long visits to multiple sites, both for interviews but also to get a sense of the community and the school of residency in which they're applying. So our medical schools and residencies are looking carefully about how can we assure to really support these future physicians in making their decision while still emphasizing safety now and safety throughout the year when we don't know what the pandemic is going to be looking like.

I've been very impressed with both the work the individual schools are doing, how they're working together, and how the residency programs individually are thinking creatively within specialties or thinking creatively in the cross-talk that's going on between them and also with the other associations involved in the medical education community. So I'm confident although it will be a very different year that we will be recruiting a fabulous class of medical students to all of our medical schools and that we will support and assist our graduating medical students, the upcoming class, as they make their residency selections also. Thank you, and I will turn it over to my colleague, David Acosta.

David Acosta, MD: Thank you, Alison. Well, COVID-19 has clearly illuminated the historical impact that racism in our health care system has had in the past, and it's very similar to what we're seeing today in our communities of color and other most vulnerable population groups. The impact from the racial inequities during this pandemic is unprecedented, especially when we

begin reviewing the data as we've been talking about on testing, prevention, treatment, and continue of care in these communities of color.

Over the past week or so, the media coverage of race inequities finally emerged. I want to applaud those efforts.

Some of the data reported are data such as in the state of Louisiana, where African-Americans comprise 30% of the population, African-Americans make up 70% of the COVID-19 deaths in the state.

In Michigan, where African-Americans make up 14% of the population, 33% are infected with COVID-19 and represent 40% of the deaths that have occurred in the state. If we narrow it down to Detroit, some reports have talked about Detroit as an example. That is made up of 79% of the population as black. But African-Americans account for 26% of the total Michigan infections and 25% of the death rate in that state.

Chicago, in a like manner, we have found that African-Americans represent 52% of the cases of COVID-19 and are responsible for 72% of the deaths there.

Some have even called the racial inequities a crisis within a crisis, and I can't agree more. I think this underscores the impact of the lack of data transparency with population groups who have been disproportionately affected by these illnesses. There's a biotech data firm that's Boston based that basically looked at billing codes for those populations that were able to access care and even found when they were able to access care that African-Americans and Latina patients able to access these patients with a cough and a fever to the most common initial symptoms they present with were far less likely to be given testing.

An associate professor and researcher from Drexel University found that in Philadelphia, as another example, that the neighborhoods with a higher number of unemployed or uninsured people that there was less testing. Per capita, zip codes with a lower proportion of minorities and a higher income group, there were a higher number of tests. He also found that higher income neighborhoods are being tested six times more in Philadelphia than in lower income areas. Positive tests were higher in poor neighborhoods. No difference in Memphis.

I also found the distribution of testing sites also demonstrated the disparity of access, most screening happening in white, well-off suburbs, not the majority of black neighborhoods. Unfortunately, we've relied on the CDC to collect the data from local and state public health departments, but we find data is very underreported and very incomplete. For example, the total number of cases reported today, only 76% of data had missing race information and 78% of the data are missing ethnicity data.

Dr. Skorton emphasized in his remarks on April 10th there's a sense of urgency to create a standardized data collection system. Research also tells us that unconscious bias, assumptions, stereotypes, stigma, discrimination peaked during times of high stress, fear, and anxiety. And for

this reason, our hospitals need to be vigilant to ensure that the care that's being provided is equitable and that any disparities and care that is found must be immediately addressed.

Several weeks ago, as many of you are aware, the Office of Civil Rights sent out a reminder to all hospitals about this. This also underscores the importance of why medical education today includes teaching and skill-building techniques on not only how to learn about how to diagnose and treat a variety of acute and chronic illnesses but also learning about the injustice of associating these diseases and the delivery of health care today and how they vary from one population group to another.

These are just reminders that are meant to help policymakers and outside partners to achieve a much better understanding of how different segments of the population are being affected and how this information should drive where resources are needed the most. This is also reminder that it is time that we have the courage and begin to learn how to have dialogue about racism because we cannot afford not to. Working with our local communities as true partners and bringing their voices to the table, understanding their true experiences is critical to the development of target interventions for those that are most vulnerable.

This not only should be addressed to ensure equitable access of testing and equitable access to care but also removing any barriers to maintain health such as the need for nutritious foods in neighborhoods, good clean water, housing, and employment. With that, I'll turn it back to Dr. Skorton.

David Skorton, MD: Thanks very much, Dr. Acosta. Now we're going to shift to the Q&A portion. We have a good half hour for questions. We may be joined by a few additional colleagues. As always, if there are questions we don't get time for, please send them to me at press@AAMC.org. That's press@AAMC.org. Sandy, we're ready for questions.

MODERATOR: Excellent. Thank you, Dr. Skorton. Just a reminder to our participants, when you want to ask a question, press star-1 on your telephone keypad to be placed into the phone queue. You will still be able to hear the presentation while you're waiting. When the speakers are ready to take your question, your line will be unmuted. Please do announce yourself with your name and media outlet. And the questions will be taken in the order that we receive them. So our first question today is from Peter Sullivan from The Hill. Peter, go ahead.

REPORTER: Hi, thanks. I wanted to ask about Deborah Birx said yesterday at the White House that she thinks there are about a million tests or testing capacity that's going unused right now. I know you addressed some of this in your letter, but is it still the case that, you know, even if this excess capacity exists, it maybe doesn't really exist because you don't have the supplies for it? Is that accurate? And if that's true, what do you need from the federal government to fix that problem? Do you need them to direct companies to make more swabs and that kind of thing? I mean, what do you need from them? Thanks.

David Skorton, MD: Thanks very much for a very pertinent question. Ross, would you like to

answer that? I'm not sure if Dr. Pierce is with us.

Ross McKinney, Jr., MD: Heather is with us. Actually, I would like to defer this question to Heather Pierce, who's the regulatory attorney for us who's been working on this specific issue. Heather?

Heather Pierce, JD, MPH: Thank you very much, Ross. I think it's a good question and one that we're hearing from many of our members.

As you noted and as we put forth in the letter, there are a number of components that are required for every single test, and a failure to have sufficient quantities of any one of those components means that test does not happen.

We also have heard that the number that there are a million tests that are not happening, and we believe those were specific to a single testing platform, the M-2000 machine created by Abbott. We know those machines exist throughout the country and existed previous to this. It is an RNA extraction machine that is used for other purposes. So simply understanding that a machine exists at an institution or a laboratory does not necessarily tell you what the capacity for that machine and that situation is.

In addition to the highly specialized reagents that are needed to operate the test for that machine, each machine has their own specialized equipment such as the tubes that enter into the machine, as well as the shortages that we've heard across the country in swabs, in the media that have needed to transport the swabs, the biological samples to the machine, and realizing these are complex tests to run and every set of tests in a more high throughput machine requires a trained technician that must be able to run these tests in the particular lab.

Many academic labs and independent labs are running tests on many different platforms, including those they've developed themselves, in part to address the shortages of different types of components. So there are limits in personnel who need to be running these tests but also need the protective gear to protect their health in dealing with these potentially infectious materials.

David Skorton, MD: Thanks very much, Heather. Peter, the one other thing I would add is in the letter we sent to Dr. Birx, we indicated three actions that we hope the federal government will take. The first one is to establish a web portal so that there can be one place where we can go to figure out these shortages that Heather was talking about. The second is to become more active and actually recognizing and managing some aspects of the supply chain so that we can bring some of these supplies where they need to be. And the need for them is nonuniform. Then thirdly, to increase even more the transparency of where we do have shortages. So Heather, I don't know if you want to comment further on those in terms of Peter's question about what should the federal government do.

Heather Pierce, JD, MPH: Yes, so three key steps they need to take. We will note in the transparent communication that we really have focused on both having an input so that labs can

quickly tell the government what it is they need and which of those components are missing, but also a way for the government to indicate to labs if there are certain types of components or materials that are being sent preferentially to certain hot spots or areas that labs across the country can understand that so they know where they're able to maximize their own capacity given the national need.

MODERATOR: So the next question comes from Lauren Clason with CQ Roll Call.

REPORTER: Hi. Thanks for doing the call. I just wanted to build off Peter's question. The government has done a few things to sort of address the testing issue. They've increased reimbursements for high-capacity tests. Yesterday the FDA approved polyester swabs for testing. Democrats are also calling on the administration to use the Defense Production Act to increase supplies. I just wanted to get your perspective on those actions and if there's one that is more effective than the other and what else can be done in those areas.

David Skorton, MD: Thank you. Very important question as well. Either Ross or Heather, if you'd like to --

Ross McKinney, Jr., MD: I'll take it this time. I think those are constructive actions. We're pleased, for example, to see the studies that show that other types of swabs and greater availability of swabs because we've been dependent largely on a factory in Northern Italy for most of the swabs we've used. So it's good to start seeing other swabs become available. The serology testing is another category. It will be good to have more serology testing available. That's what I was expecting you to get to. The second question you raised was --

REPORTER: I'm sort of just asking about testing in general. I think most of those I mentioned were aimed at diagnostic tests.

Ross McKinney, Jr., MD: So the two areas of diagnostic tests, it's important for people to keep straight. There's the PCR, it detects the genes of the virus. That tells you when somebody is infected and infectious. Serology becomes positive typically ten days after somebody's symptoms started. So it's a late phenomena. It's part of how we physically clear the virus. So it's a way of knowing who had the virus and potentially who might be protected from getting the virus again. So there's two different kinds of tests. We need them both if we're going to have a complete ability to do the kind of surveillance that we need to know where there are hot spots starting to develop.

David Skorton, MD: Thank you, Ross. And thank you for the question. Sandy, ready for the next one, please.

MODERATOR: Excellent. The next question is from Joyce Frieden with MedPage Today.

REPORTER: Thanks for taking my question. I was wondering, several people have alluded to the plan released last night by the White House about opening up the country in phases, and I

wanted to get your comments on the plan, especially with regard to whether any place in the U.S. is at the point with testing where they would need to be to go through any of the phases.

David Skorton, MD: I'll take a first try at this, and then I would appreciate anybody else, Ross or Janis, if you'd like to pitch in. I think that the White House suggested plan has some good elements. It's a step AAMC in the right direction to think about a phased approach and an approach that is based on local evidence. My read of it, what I could garner from the information available so far, leaves me with some details unclear. So I can't give you a more specific answer as to whether this is everything that we need. Certainly, the point you raise about testing is critical. Not only testing of those suspected to have it but surveillance testing so we get a sample of the population to find out what the overall burden is in any given population. I don't think we're there yet. So I'm quite concerned that we're not ready today to open up any areas despite what may look like a lower burden of coronavirus because of the need to be able to detect what's happening in the community and to follow it along. Because the virus is still out there, even in areas that have few cases. They still have cases. Ross, you may want to add.

Ross McKinney, Jr., MD: Yeah, I think the notions that are in the plan are good. The specifics are still lacking. If you look, for example, at phase one, it says elective surgeries can resume when appropriate. Well, you're still going to want to test every single patient who comes in to the hospital for an elective surgery, both for their own well-being and for the well-being of those who are providing care to them. That testing will have to be a PCR test that can be turned around within a day. So it's going to be critical that we have a lot more testing available. And they don't specify that, but that's going to be critical. When it says restaurants and theaters, places of worship can reopen if they observe social distancing, that's going to require considerable change in their normal operating procedures. Restaurants are built on the model of packing as many people in a small space as possible and turning them over as quickly as possible. Well, that's not going to work. It's going to be wide spacing of groups between. So it's going to require considerable social adjustment if we're going to go through this process of reopening. And I hope people are ready to go through. The other thing is that we really need to get into a model of track and trace. What you basically do is go out and find the infected individuals, find who they were in contact with. You do so either using the traditional means of individual trackers or using an electronic system. Then you have to test those people very quickly. They may have to go into quarantine. If they have to go into quarantine, you should provide for them financial support so that their time in quarantine doesn't hinder them and allows people to not run away from the quarantine process because they're economically protected.

David Skorton, MD: And just one more comment. I believe Dr. McKinney would agree. It's in all of our interests to make sure that a plan like the White House has proposed, a phased plan, it's in all of our interests to make it work. What we need to do that is to dig into some more details and particularly have this capacity for testing and make sure that we don't get out ahead of where the evidence is, that is what the testing is showing us. So I do want to say it's in our interests to make sure something like this works. We just have to go slowly, and as always, be evidence based.

MODERATOR: Okay. The next question comes from Emma Court with Bloomberg News.

REPORTER: Hi. Thank you so much for taking my call. I wanted to kind of follow up on sort of some of the commentary at the beginning of the call around sort of some of the bottlenecks for testing that have eased up a bit. I'm just hoping you can sort of state plainly where we are in terms of testing right now and what are the challenges we'll continue to face as we move forward?

David Skorton, MD: I'll give you a general answer, and then please, Ross, Heather, or Janis, jump in as you wish. We're not where we need to be because of the inhibitors that Heather Pierce had brought up earlier. I refer you as well to the letter that we sent to Dr. Birx, which lays out basically, I would say, a few different things that are causing us to not be where we want to be. One is the lack of supplies. It was very important as made in that letter, it's not a uniform phenomenon. So different labs in different areas have different needs, which is why we've called for a web portal and for some more active federal management of the supply chain so that we know, you know, who needs this or that component more quickly than others.

Secondly, it is very important to know when test results occur, especially during the phase of reopening the country, one of the things that Dr. McKinney mentioned was tracing. To do that work requires training of a pretty substantial work force. So we need to be ready to stand up that work force because it's methodical work, time-consuming work to do that kind of tracing.

Then thirdly, just to underscore something Heather Pierce already said, the personnel to run the tests, we need to have the folks available. They need to be trained, especially on newer procedures, and as Heather Pierce mentioned, they need to be protected because they're handling potentially infectious material with every test. So they need personal protective equipment just as much as anyone on the front lines of health care. So Heather, Ross, or Janis, please add to that if you wish.

Janis Orlowski, MD: I was going to say, for the points that my colleagues have made, we are talking about when can we open up hospitals, when we can move forward in one of the phases, but quite frankly, we are many, many weeks off. We have to have enough PPE equipment. We have to have testing, and there's not adequate testing right now. We have to have the ability to do tracer studies.

Then quite frankly, I'd mentioned our work force. We've got to make sure our work force is rested and able to turn their attention not just to the continuing COVID cases that they're seeing but also to any new ones. So although we are discussing when we can open up, I see this as several weeks of preparation and the need for these supplies and the need for these people and the need for the tests all have to be worked on and have to be maximized in the next couple weeks.

David Skorton, MD: Thank you very much. And thanks for the question. Sandy, ready for the next question.

MODERATOR: Our next one comes from Robert King with Fierce Health Care.

REPORTER: Hi. Thanks for taking my question. I'm wondering if I can get more details from you about resuming -- when facilities can resume elective procedures. One, what's the timeline that you think elective procedures can come back? And two, could you tell me a little bit about how would the testing for patients that are getting elective procedures work in light of the struggle that you guys have been talking about on this call with testing capacity?

David Skorton, MD: Dr. Orlowski, would you take that one, please?

Janis Orlowski, MD: Sure. So in a discussion that I had just yesterday afternoon with a number of institutions, we talked about what we would need to be able to restart testing. So again, just to go through, there's kind of a long list of PPE and adequate testing and the ability to do tracer testing. But the other thing that I would tell you is that the ability to come back will be variable.

I'll give you a specific example. Our institutions down in Miami are really having a significant number of cases. I talked to our institution in Tampa, and they actually have less than 20 COVID cases within their institution. So what you see is sort of this local variance in overall burden. What we will need to see is the ability to have all of these components ready, testing, PPE, a rested work force, and an assessment of whether their local conditions are increasing or if they've been decreasing for a couple of weeks. Then working with state public health departments and with state officials, decisions will be made about reopening.

I can only say a couple weeks, but it will be variable. You'll see some institutions being able to open in a couple weeks. You'll see others that are months away from being able to open elective surgeries.

Ross McKinney, Jr., MD: Can I add one thing to that, Janis? It's an interesting observation. You would think that this might be by big regions, but you can see at the moment super hot spots occurring in places that you wouldn't have expected like Minnehaha county in South Dakota, which has had 1,065 cases in spite of having only 193,000 people. That's more than nine states in a city that holds Sioux Falls. In Dougherty County, Georgia, it has less than 100,000 people. So hospitals will have to be doing regular testing, even if they're in areas that look like they should be low incidence because they may be places where patients come in and you get the effect like a nursing home where there's rapid spread in the institution.

David Skorton, MD: Just one other quick comment I would make to our colleague. In general, opening up parts of the country -- and again, it's in all of our interests for a plan like the White House's to succeed. We have to remember that America is an especially mobile culture. We love to jump in the car and drive somewhere, get on a train. When things are different, jump on a plane.

It's not only a matter of what the situation is in one particular area. The fact that people move around and could of course take the virus with them. I suppose it's obvious, but I just wanted to

state that. So a very important question. Ready for another one.

MODERATOR: Okay. So just a reminder to everyone, if you want to ask a question, just press star-1 on your telephone keypad to be placed into the phone queue. We do have another question here from Samantha Liss with Health Care Dive. Samantha?

REPORTER: Hi. Dr. Acosta, as you said, this pandemic has laid bare inequities in this country. So what role or responsibilities will your institutions have in addressing those after this pandemic? And what role have your facilities played in contributing to these inequities?

David Acosta, MD: Thanks for that question, Samantha. So I think, you know, our role as the organization is really to assist our medical schools and teaching hospitals in, you know, building their skill capacity, building their knowledge base with regards to the learners that are there, the residents that are in training, our medical students in training.

One of the things that Alison Whelan and her group in medical education had strongly advocated for, working very closely with my unit, is diversity policy in programs, is really working with constituents to develop competencies along with milestones and how to address these as future physicians. You know, what sorts of competencies do you need to build to begin having interracial dialogues in a safe manner, along with not only each other but also with communities and how to develop leadership skills to be at the table when you have that opportunity to be able to discuss health inequities, health disparities, and have that chance to try to reverse what is being done but also contribute to what we can do in the future.

AAMC has been really strong in being able to be a convener in bringing many of our medical school, medical educators together who are doing some excellent work in how they've developed curriculum and skill-based training, you know, around how to mitt game some of these and address them using not only just a medical model but also a public health model, which I think is really critical, especially during this time as well. We also help out in developing some of the curriculum, you know, even under emergencies and pandemics as well. But I think that's really our largest role with that.

In addition to that, we also assist our schools in keeping very close to the accreditation standards that do call out, that we do teach our future work force about cultural competency, about health disparities and social determinants of health, about public health. So we assist them in how best to accomplish that. A lot of that is through partnerships with other people doing the work. Alison, would you like to also contribute to that?

Alison Whelan, MD: I think you covered it really well. Thank you.

David Skorton, MD: If I could add one thing, Dr. Acosta. Our colleague was also asking, have we contributed to the structural racism, our types of institutions over the years and generations. I think as an observer and admirer of Dr. Acosta's work and the work of his colleagues around the country, their work is based on the recognition that, yes, we have contributed to this. Perhaps in some active ways and some ways because we've allowed inequities to occur. I would say that in

terms of health inequities, all of us in the United States who are in positions of responsibility bear some responsibility for the fact that we still have many uninsured people in the country. I don't know, David, if you want to comment any further on that aspect.

David Acosta, MD: Thank you, David. No, I think you made an excellent second point. I apologize for not answering that second question. You know, historically if you go back, academic medicine, medicine in general, have unfortunately had a strong history of racism that has been practiced over the years.

As you go through the history itself, there's been quite a bit of a racial divide up and until after the Civil Rights Act of 1964. That essentially really forced all medical schools and teaching hospitals to really consider, reconsider desegregation and how important that was. But we all have a history with that, and it's nothing that we need to be proud of but at least when this happened in the early '70s, we have finally recognized that and are trying to reconcile it in the best way that we can.

It's also a reminder to us that historically over the years, that we can't be ahistorical. We need to understand how that history, you know, shapes our future moving forward. And yeah, we did play a role in that. I think we're doing everything we can at this point in order to reconcile that. So thank you, David, for bringing that back.

David Skorton, MD: Thanks very much. Sandy, do we have time for one more quick question?

MODERATOR: At the moment, there are no more questions in the queue.

David Skorton, MD: Okay. Well, that's very timely. If I'm not mistaken, we're just about out of time. I want to thank all of our colleagues in the media for two things. For being with us today and for the coverage you're giving this very, very extraordinary time. We all appreciate it. Reminding you if further questions arise, whether it's ten minutes from now or tomorrow or any time, please contact us at press@AAMC.org. Please stay tuned. We'll be having more opportunities for you to interact with us. Thanks very much, everyone. Sandy, turning it back to you to close.

MODERATOR: 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 this afternoon. On behalf of the Association of American Medical Colleges, thank you, and you may now disconnect.

End of Webinar