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April 20, 2021

The Honorable Joseph R. Biden, Jr.
President
The White House

The Honorable Nancy Pelosi
Speaker
U.S. House of Representatives

The Honorable Charles Schumer
Majority Leader
U.S. Senate

The Honorable Kevin McCarthy
Minority Leader
U.S. House of Representatives

The Honorable Mitch McConnell
Minority Leader
U.S. Senate

Dear President Biden; Speaker Pelosi; and Leaders Schumer, McConnell, and McCarthy:

On behalf of the AAMC (Association of American Medical Colleges), I write to urge your support for priority areas that contribute to the nation's health care, research, and public health infrastructure, which must be strengthened to improve the health of all and ensure we are prepared for future health challenges. As part of legislation that will shore up the nation's economy and infrastructure, AAMC urges you to support providing research recovery support to mitigate the impact of the pandemic on the research workforce and broader enterprise; increasing investments in the physician workforce; strengthening our public health and health care infrastructure based on lessons learned from the current COVID-19 response to better prepare for future pandemics; and ensuring standardized, valid, inclusive data collection to address pervasive health inequities laid bare by the pandemic's disproportionate impact on communities of color.

We also urge your support for investing in health care physical infrastructure, telehealth capabilities, and health care data capacity. Further, the AAMC applauds long overdue infrastructure investments included the Biden administration's American Jobs Plan that would improve the health and well-being of disadvantaged communities, such as eliminating all lead pipes and service lines and improving public housing and mass transit.

The AAMC (Association of American Medical Colleges) is a not-for-profit association dedicated to transforming health through medical education, health care, medical research, and community collaborations. Its members are all 155 accredited U.S. and 17 accredited Canadian medical schools; more than 400 teaching hospitals and health systems, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools and teaching hospitals and their more than 179,000 full-time faculty members, 92,000 medical students, 140,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences.

As the nexus of medical education, patient care, and medical research, and through critical collaborations with communities, America's medical schools and teaching hospitals are dedicated to improving the health of people everywhere. Essential to this goal is a strong health care system and workforce, robust research enterprise, and bolstered public health infrastructure. As you develop comprehensive legislation to invest in and build a sound foundation for future generations, the AAMC urges you to consider the fundamental role of these pillars in our nation's path forward.

Build Back the Nation's Research Enterprise

In addition to their work on the front lines of patient care, medical schools and teaching hospitals are also leading centers of medical research, with scientists at these institutions conducting over 50 percent of extramural research funded by the National Institutes of Health (NIH). This research commitment has enabled AAMC-member institutions to use their capacity to lead research that resulted in successful vaccines and therapeutic candidates, to develop much-needed tests for COVID-19, and to continue to provide the world's most advanced and expert patient care informed by the latest innovations in fundamental and clinical research. Additionally, federal investments in medical research boost local and regional economies and enhance our national competitiveness. For example, in FY 2020, the federal investment in NIH supported over 536,000 jobs and helped generate $91.4 million in economic activity.

However, the pandemic has resulted in major disruptions to the nation's research enterprise. In response to the COVID-19 emergency, institutions suspended research activities that require access to laboratories and research facilities beyond critical and/or pandemic-related research, leading the vast majority of labs and clinical research nationwide to shut down. While in many cases, the work has resumed, the impact of the pandemic on the research enterprise persists. As you know, research programs cannot start or stop with the flip of a switch. For example, clinical trials and other research involving people has been slower to recover, which ultimately could lead to delays in new treatments for patients. The pandemic also has taken an especially significant toll on the research workforce, including early-stage investigators, scientists with caregiver responsibilities, researchers from underrepresented backgrounds, and, as highlighted in a recent report from the National Academies of Sciences, Engineering, and Medicine, on women in science, technology, engineering, mathematics, and medicine.

Without emergency supplemental funding, NIH and other agencies may be forced to reduce support for new research to free up resources to mitigate the impact of the pandemic. This one-time supplement would help ensure research careers, particularly those of early-stage investigators, are not derailed or halted and allow U.S. medical research to restart the upward trajectory of new discoveries that are critical to patients, communities, and the nation's global economic and scientific innovation leadership. Emergency support to mitigate the disruptions resulting from COVID-19 will help the nation's research enterprise recover as quickly as possible the momentum lost during the pandemic.

Emergency supplemental funding would allow federal agencies to provide several things, including:

- Research grant and contract supplements (i.e., cost extensions) for expenses arising from COVID-19 related impacts;
- Emergency relief to sustain research support personnel and some base operating costs for core research facilities and user-funded research services; and

- Support for additional graduate student and postdoc fellowships, traineeships, and research assistantships to allow early career scientists to complete degrees and enter the workforce – rather than leave science and engineering altogether.

The AAMC, along with more than 300 organizations, including the Chamber of Commerce, Google, other higher education associations, patient groups, and others, strongly supports the emergency funding outlined in the *Research Investment to Spark the Economy (RISE) Act* (H.R. 869/ S. 289). This bill, which has bipartisan support and has been introduced in both the House and Senate, would support approximately $25 billion in emergency funding for federal research agencies, including $10 billion for NIH, to mitigate the impact of the pandemic on the research enterprise. While past COVID relief packages considered by Congress have proposed some research relief funding for NIH, such funding has yet to be finalized in any of the packages that have been enacted to date. Additionally, funding provided in past COVID packages to institutions and students through other mechanisms, such as the Higher Education Emergency Relief Fund (HEERF), would not fully address the challenges that research agencies are facing.

Research and innovation played a major role in developing COVID-19 vaccines ready for distribution less than a year after the first cases were discovered in the United States and will play a major role in health care well into the future. To ensure medical research continues to improve the lives of all and to restore then nation's research and innovation capacity, the AAMC strongly urges the inclusion of the RISE Act and supplemental emergency funding for federal research agencies in the infrastructure package.

Physician Workforce and Graduate Medical Education

The COVID-19 pandemic has demonstrated that physicians are a critical component of our nation's health care infrastructure, and we must train more to meet both the current and future needs of our nation. At the same time, the pandemic also exposed the significant barriers to care that patients face and highlighted rising concerns of physician burnout and retirement. Additionally, as our population grows and ages, the demand for physicians continues to grow faster than the supply, resulting in an estimated shortfall of between 54,100 and 139,000 primary care and specialty physicians by 2033.[1]

A broad bipartisan coalition of members of Congress representing diverse districts, states, and communities worked together last year to provide, 1,000 new Medicare-supported graduate medical education (GME) positions in the Consolidated Appropriations Act, 2021– the first increase of its kind in nearly 25 years. This increase in residency positions was an important initial investment and first step, but more is needed to help ensure a diverse physician workforce and that patients throughout the country can access the primary and specialty care they need.

To help meet this growing need, bipartisan health care leaders in the House and Senate recently reintroduced the *Resident Physician Shortage Reduction Act of 2021* (S.834/H.R. 2256), which would gradually raise the number of Medicare-supported GME positions by 2,000 per year for seven years, for a total of 14,000 new positions. Much like the 2020 year-end package, these positions would be targeted to hospitals with diverse needs including hospitals in rural areas, hospitals serving

[1] *The Complexities of Physician Supply and Demand: Projections from 2018-2033*, Association of American Medical Colleges: https://www.aamc.org/news-insights/press-releases/new-aamc-report-confirms-growing-physician-shortage

patients from health professional shortage areas, hospitals in states with new medical schools or branch campuses, and hospitals already training over their Medicare caps.

Another critical component to rebuilding the nation's health care infrastructure is an expansion of health care workforce programs that will be integral to addressing health care equity and training a more diverse, culturally competent physician workforce. While existing pipeline programs play a crucial role in cultivating a more diverse workforce, more must be done to increase physician diversity. The *Resident Physician Shortage Reduction Act of 2021* takes an important step in addressing this challenge by commissioning a report to specifically look at ways to create a more diverse clinical workforce.

Access issues persist in rural and underserved communities, and it is paramount that we are able to direct resources where they are needed most. Additional Medicare-supported GME positions allow hospitals training over their caps to expand their training programs and can help teaching hospitals take advantage of programs that diversify the resident experience, such as Rural Training Track programs, which rotate residents training in urban hospitals into rural hospitals.

The physician workforce mirrors our aging society and, in 2019, nearly 45 percent of active physicians in the United States were age 55 or over.[2] As the country recovers from the COVID-19 pandemic and begins to prepare for planned (and unplanned) physician retirements and long-term health care impacts of the pandemic, it is evident that investments in the physician workforce infrastructure are vital to the country's health. The *Resident Physician Shortage Reduction Act of 2021* would help alleviate the physician shortage, ensure that patients have access to the care they need, take steps towards diversifying the physician workforce, and better prepare the nation to tackle future health care crises. It is imperative that this legislation be included in the infrastructure package so that the nation can bolster this critical part of our health care infrastructure.

Pandemic and Public Health Preparedness

As the nation and world continues to combat the coronavirus pandemic, the AAMC urges Congress and the administration to support efforts to strengthen our public health and health care infrastructure based on lessons learned from the COVID-19 response, as well as from previous public health and national disaster emergencies, such as measles, Ebola, H1N1, and Hurricanes Katrina and Maria.

To ensure the public's health and assure businesses and consumers that it is safe to resume some level of pre-COVID-19 operations, the appropriate infrastructure must be in place to contain the current outbreak and prevent and/or quickly detect and respond to its potential recurrence. As part of these efforts, state and local health departments must be equipped to establish and implement robust testing, surveillance, contact tracing, and other key public health plans with federal support and guidance, and the AAMC supports the public health community's recommendations to fund and sustain these efforts and to take the necessary steps to reverse the chronic underfunding of public health. For example, the AAMC supports the *Public Health Infrastructure Saves Lives Act* (S. 674), which would help create a sustained funding stream to support core public health functions.

[2] *2020 Physician Specialty Data Report*, Association of American Medical Colleges: https://www.aamc.org/data-reports/workforce/interactive-data/active-physicians-age-and-specialty-2019

To serve their communities and support their public health colleagues, medical schools and teaching hospitals are also engaged in these efforts. For example, academic medical centers have described conducting diagnostic and serological testing, developing contact tracing processes and training protocols used by the state, offering data and analytic support, launching surveillance studies, promoting public education campaigns, extending outreach to marginalized and under-resourced populations, and engaging in community-partnered research and surveillance, among other efforts. Ideally, these activities would be aligned between the academic medical centers and the health departments, social service agencies, and local community groups that all are working toward the same mutual goal. However, the pre-existing relationships among these entities varies greatly, and there is currently no federal funding available to explicitly support this purpose.

To this end, the AAMC proposes the creation of a new network of U.S. academic medical centers to be designated as pandemic centers. These centers would promote greater and stronger collaborations between academic medical centers and their local public health and community organizations in support of the local and national response to the pandemic in both the near-term and the long-term. Specifically, these new pandemic centers could act as regional hubs with enhanced capabilities to respond quickly to potential pandemics, including, for example, informing strategies to secure sufficient stockpiles of medical equipment and PPE and leveraging staff who have received additional training and who regularly participate in pandemic preparedness drills.

Additionally, providing support on an ongoing basis for a number of academic medical centers to develop and deepen a research agenda on pandemic planning, including activities such as data collection and dissemination, disease modeling, and conducting training for contact tracers, will help ensure that the health care community has a strong evidence base to pull from in developing preparedness and response strategies. Designating and funding select hospitals and academic medical centers across the country with enhanced preparedness capabilities will allow the country to more quickly respond to infectious disease pandemics affecting the United States.

Valid, Inclusive Data Collection

Over the past year, the COVID-19 pandemic's disproportionate impact on communities of color has laid bare pervasive health inequities, exposing the structures, systems, and policies that create social and economic conditions that lead to health disparities, poor health outcomes, and lower life expectancy. Race and ethnicity represent only small part of the data collection needed to ensure coronavirus vaccinations are administered equitably. Indeed, neither race nor ethnicity are modifiable risk factors. Rather, they are poor proxies for the social risks and social determinants to which communities of color and the residents who live within them are exposed.

Beyond sociodemographic data, we need standardized, valid, inclusive data collection on the social needs and social determinants most likely to correlate with increased exposure, susceptibility, and severity of infectious diseases. Fortunately, those data points are known. The Centers for Disease Control and Prevention (CDC) released a Social Vulnerability Index (SVI) in 2011 and noted that a "number of factors including poverty, lack of access to transportation, and crowded housing may weaken a community's ability to prevent human suffering and financial loss in a disaster" (CDC 2011). Unfortunately, the SVI have not been incorporated into national COVID-19 response activities to date.

To successfully promote health equity, surveillance system data must:

- Include standardized, core measures that all relevant sectors (health care, public health, social services, etc.) agree to use.
- Allow for data sharing across those sectors while protecting individuals' information.
- Relate to and complement other crucial data collections (such as using formal ICD-10 Z codes to identify social needs in clinical settings, or vital statistics reporting for public health departments).
- Capture macrolevel data on the social determinants of health geocoded to home addresses when possible, at units of geography that correspond to meaningful, locally defined neighborhoods (i.e., census block, not 5-digit zip code).
- Capture self-reported social needs and vulnerabilities and sociodemographic data including race and ethnicity in ways that allow for the valid, non-stigmatizing collection of potentially sensitive personal information.

Investing in Physical Infrastructure

The COVID-19 pandemic has exposed the critical need to support the modernization of many of our nation's hospital and health facilities. Hospitals across the country are struggling to regain their financial stability, which has meant delaying or even canceling improvement and modernization projects. Additionally, there continues to be the challenge of the growing and aging U.S. population, which has stressed a system that is already grappling with an increased demand for care. It is more critical now than ever to modernize our hospitals and health care facilities to keep pace with the demand for health care services and ensure high-quality care. The pandemic has also exposed the need to update clinical laboratory infrastructure so that labs are able to both develop and process tests efficiently and accurately.

As hospitals continue to provide quality health care to all and respond to the pandemic, it is crucial that any infrastructure package provide access to resources and funds that allow hospitals to ensure that their facilities are up to the task of providing high quality patient care. The AAMC urges the Biden Administration and Congress to provide financial support and access to capital for these efforts.

Essential to ensuring a strong R&D infrastructure is the renovation of laboratories to foster state-of-the-art research. AAMC-member institutions are in nearly every state across the U.S. and conduct a disproportionate share of both basic and medical research to understand the foundational underpinnings of medical science and clinical and translational research that improve the patient care activities provided on their campuses. They often work closely with their partners in the physical, computational, and other sciences to push the boundaries of discovery and improve the human condition. This work requires physical facilities that are well-equipped to advance these goals. To continue producing cutting-edge and adaptive medical research discoveries, the AAMC recommends that Congress invest in physical infrastructure to support the U.S. research enterprise and maintain its global competitiveness, recognizing that developing physical infrastructure where such research can take place requires complicated construction that takes many months or years to develop and build.

Telehealth, Broadband, and Health Care Data Security

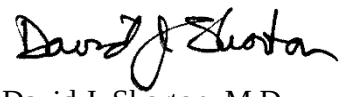
Teaching hospitals and their faculty physicians have responded to the pandemic by rapidly implementing telehealth in their settings and practices to provide continued access to medical care for their patients. Telehealth provides many benefits to patients, such as expanding care for the frail or elderly, for whom travel to a provider or facility is risky or difficult and providing specialty care to patients in rural and other areas without access in their communities. Also, physicians use telehealth to monitor the care of patients with chronic conditions, such as diabetes and heart conditions, reducing their risk of hospital admissions, and to protect patients from exposure to infectious diseases, including COVID-19 and the seasonal flu.

Ensuring the effective development of telehealth capabilities requires investing significant resources in technology, training, and infrastructure. In many parts of the country, providers and their patients have limited access to broadband connectivity, which has been a major barrier to the use of telehealth. This is particularly true for rural areas and underserved communities. The Federal Communications Commission has reported that 30 percent of rural residents lack broadband services. Also, racial and ethnic minorities, older adults, and those with lower levels of socioeconomic status are less likely to have broadband access. To help ensure health equity and the delivery of quality care to all patients, the AAMC urges Congress to increase funding for broadband access and infrastructure development to enable expansion of telehealth services for all patients.

As patients and providers rely more on telehealth and digital health care, hospitals face unprecedented challenges as they try to protect patient data and other sensitive health care information from cyber-attacks. U.S. intelligence agencies have warned that cyber-attacks that include ransomware attacks and theft of patient data are increasing. These attacks are also particularly detrimental because of their propensity to disrupt health care delivery by shutting down hospital IT systems for extended periods of time. While systems are down, hospital operations grind to a halt and jeopardize the critical, life-saving services that hospitals provide. The AAMC urges Congress to include investments in cybersecurity as part of the plan to improve health care infrastructure.

The past year has presented immense challenges for our communities, our patients, and our nation and underscored the need for critical investments in our nation's health care infrastructure. The AAMC looks forward to working with you to advance legislation that will build back and strengthen the nation's economy, health, and well-being.

Sincerely,



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