



**Association of  
American Medical Colleges**  
655 K Street, NW, Suite 100, Washington, DC 20001-2399  
T 202 828 0460 E [djskorton@aamc.org](mailto:djskorton@aamc.org)  
[aamc.org](http://aamc.org)

**David J. Skorton, MD**  
President and Chief Executive Officer

July 1, 2020

The Honorable James Clyburn  
Chair  
Select Subcommittee on the  
Coronavirus Crisis  
Committee on Oversight and Reform  
U.S. House of Representatives  
Washington, DC 20515

The Honorable Steve Scalise  
Ranking Member  
Select Subcommittee on the  
Coronavirus Crisis  
Committee on Oversight and Reform  
U.S. House of Representatives  
Washington, DC 20515

Dear Chairman Clyburn and Ranking Member Scalise:

On behalf of the Association of American Medical Colleges (AAMC), thank you for the opportunity to share our perspectives on the impact of shortages of personal protective equipment (PPE) and other critical supplies on the nation's medical schools, teaching hospitals, and the patients they serve.

The AAMC is a not-for-profit association dedicated to transforming health care through innovative medical education, cutting-edge patient care, and groundbreaking medical research. Its members are all 155 accredited U.S. medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and more than 80 academic societies. Through these institutions and organizations, the AAMC serves the leaders of America's medical schools and teaching hospitals and their more than 173,000 full-time faculty members, 89,000 medical students, 129,000 resident physicians, and more than 60,000 graduate students and postdoctoral researchers in the biomedical sciences.

***Academic Medicine's Role in the Nation's COVID-19 Response***

In partnership with their physician faculty from affiliated medical schools, AAMC-member teaching hospitals are critical institutions for delivering patient care, providing 25% of the nation's medical and surgical intensive care beds, 36% of cardiac intensive care beds, 61% of pediatric intensive care beds, and 69% of all Level 1 Trauma Centers. Their emergency rooms are open to anyone in need, with experts in medical specialties available 24/7. Our members provide the world's most advanced and expert patient care informed by the latest innovations in fundamental and clinical research.

Major teaching hospitals are well-established and respected regional referral centers and centers for tertiary care, and they invest consistently to maintain a heightened level of preparedness to engage rapidly in response to any event at any time. They have years of experience in mobilizing resources during times of crisis and often lead regional responses in collaboration with their state and local departments of health, regional emergency management systems, and all other major

The Honorable James Clyburn  
The Honorable Steve Scalise  
July 1, 2020  
Page Two

players in emergency response. This unique proficiency helped to lead the nation's response to past public health emergencies and disease outbreaks such as measles, Ebola, and H1N1, and now is a key asset in combatting COVID-19.

Major teaching hospitals, medical schools, and teaching physicians have mobilized on all fronts to contain and mitigate COVID-19. As we have heard from our members and seen on national news reports, COVID-19 patients tend to be sicker and require prolonged hospitalizations, including being placed on ventilators in intensive care units (ICUs). Teaching hospitals are treating most of these complex patients and, for many, the cost of care will greatly exceed the reimbursement hospitals receive. And even amid this crisis, teaching hospitals currently battling a surge in infections and managing the needs of their communities are sharing their knowledge with others, including through the [COVID-19 Clinical Guidance Repository](#) curated by the AAMC.

In addition to their role in clinical care, AAMC-member institutions are major centers of cutting-edge medical research, with scientists and clinicians at medical schools and teaching hospitals conducting over 50% of extramural research funded by the National Institutes of Health (NIH). Many of our member institutions have developed much-needed tests for COVID-19, a fluid and rapidly changing area as they bring new equipment online, try to source materials, and stand up reporting procedures in extremely challenging conditions. They are also at the forefront of research efforts to identify and advance clinical care protocols, viable therapeutics, and new vaccines to blunt the pandemic's impact.

Among the earliest challenges identified as our members initiated their emergency response plans related to COVID-19 were difficulties in replenishing their supplies of personal protective equipment and other critical products and in acquiring the necessary reagents and other materials to expand testing capacity. We have not conducted a formal survey, but anecdotal accounts from our members suggest that shortages, varying in nature from institution to institution, persist. Though the urgency in many cases has receded somewhat relative to one or two months ago, new and recurring surges threaten to overwhelm current inventories, and confidence in the nation's supply chain remains low.

Each of these challenges has a different origin; however, we believe that examining such issues together may identify themes that can help guide a more holistic approach to decision-making around limited resources generally, including, but not limited to, PPE. We recognize the hard work and countless hours that dedicated professionals in Congress, across the federal agencies, and throughout state and local jurisdictions have contributed in an effort to mount a vigorous response. We believe that ongoing dialogue with stakeholders on the front lines to identify gaps, systemic shortcomings, and opportunities for continual improvement only will strengthen our national resilience. The following observations compiled by AAMC staff are intended to help inform these analyses as we all strive to contain the current pandemic and better prepare for future threats.

The Honorable James Clyburn  
The Honorable Steve Scalise  
July 1, 2020  
Page Three

### ***Challenges Acquiring PPE, Testing Materials, and Other Needed Supplies***

#### *PPE and Other Needed Supplies*

Personal protective equipment is critical for the safety of health care workers and patients alike. Early in the pandemic, hospitals began feeling additional strain on their existing and stockpiled supplies as visits to the emergency room increased. For example, one hospital used one month's supply of PPE in just four days. While PPE shortages – including N95 and other respirators, gloves, gowns, and other equipment – have been pervasive, our members also have encountered difficulty acquiring a number of critical products, including hand sanitizer, disinfectants, and other supplies. In many cases, turning to their states and the federal Strategic National Stockpile (SNS) offered little relief, as the effects of an under-resourced SNS and a patchy supply chain became apparent. For example, the nation's just-in-time systems of inventory management did not adequately take into account the possibility of international disruptions, leaving the country ill-prepared to backstop suppliers dependent on overseas manufacturing. In addition to hospitals, which regularly use PPE, other entities, such as long-term care facilities, private physician practices, and urgent care settings suddenly needed access to PPE, quickly depleting what little supply existed.

Aside from the SNS, facilities also have faced difficulty in procuring supplies through their usual channels. The distribution methodologies for allocating PPE to both states and individual facilities have been unclear and unreliable. As administrators have scoured potential leads on their own, they have encountered substantially higher prices for routine supplies, often from weak negotiating positions. Institutions have reported delays and uncertainty in whether orders that they place will be fulfilled fully, partially, or at all, and/or have needed to be resourceful in identifying ways to transport purchases successfully to the U.S. Even well-intentioned donations from concerned community members have posed challenges, as facilities must dedicate time and resources to assure quality control and sort such contributions appropriately.

As facilities have waited for the supply chain to stabilize, they have been forced to implement crisis management standards, including disinfecting and reusing N95 masks and other supplies. In addition to limiting the clinical care capacity of health care facilities, particularly around non-emergent care, PPE shortages also have limited a number of other essential functions. Many academic medical centers opted to limit the involvement of medical students in direct patient care activities, in part to help preserve low PPE supplies. Additionally, many labs at medical schools and teaching hospitals have contributed PPE normally used for research activities to their clinical partners. These workarounds provide some temporary relief, but they are not sustainable as attempts to resume normal operations continue. Ongoing efforts to continue ramping up the nation's diagnostic testing capacity also will add to the demand for PPE to protect testing personnel.

In the short term, we strongly support efforts to accelerate domestic production of critical supplies to address all these needs. Additionally, there should be clear guidance from the federal government regarding the quantity and types of supplies states and hospitals should have on hand

The Honorable James Clyburn  
The Honorable Steve Scalise  
July 1, 2020  
Page Four

based on their local population and to be able to respond to different types of public health emergencies. Hospitals and states should have the appropriate level of flexibility on how they meet the recommended federal guidelines, which should also take into account PPE demand from non-hospital facilities, including long-term care facilities, testing personnel, research labs, and other entities. Federal funding for hospitals to establish and maintain inventories of recommended supplies will be important, particularly given that stockpiles would not be used for regular patient care and given space constraints facilities often face.

A real-time dashboard that is kept up-to-date and takes into consideration other state, local, private-sector, and hospital supplies, should be shared with key stakeholders. States and local public health teams must work with hospitals and others to coordinate reserves of supplies. Reliable investment in the SNS to ensure its inventories are current and clear communications about the role of the SNS as a resource of last resort will help clarify confusion about its role. And the federal government should promote and enforce protections against unreasonable product pricing in times of crisis, including prices of existing and new drugs used to treat COVID-19 and other conditions.

#### *Testing Materials*

Laboratories in the United States obtained the genetic sequence for the virus soon after it was identified in China, allowing for the rapid development of the probes and reagents required to develop tests for the virus. However, the infrastructure and coordination to ramp up testing capacity and have a clear picture of where to direct supplies did not exist and has not yet been entirely implemented. In addition to low supply of testing kits, uneven access to reagents, nasopharyngeal swabs, transport media, testing machines, and other equipment has been a major impediment to academic medical centers as they have worked to expand diagnostic testing capacity to fulfill community and national needs and improve testing access for all patients, particularly those from underserved communities. No test can be performed unless a lab simultaneously has adequate numbers of swabs, reagents, testing machines, trained technicians, PPE, and individuals being tested. Each component has a distinct supply chain, and throughout the COVID-19 pandemic, there have been variable shortages in each of these components. With both commercial and academic medical center labs engaged in diagnostic testing, securing ample supplies for both types of entities has been problematic as well. While commercial labs play an important role, hospitals and health systems also must be able to perform on-site testing to assure appropriate turn-around-times to ensure patient and health care worker safety and efficiency of care.

While many institutions have developed workarounds to the extent possible and have sought to diversify their testing capacity to minimize the impact of test-specific shortages, demand is likely to increase as spikes in new cases occur across the country. Additionally, the ability for hospitals, physician practices, and other health care providers to resume delivering non-emergent care and for schools and businesses to reopen safely will depend on a robust, reliable testing capacity.

The Honorable James Clyburn  
The Honorable Steve Scalise  
July 1, 2020  
Page Five

These considerations coupled with the onset of influenza season in the fall underlie concerns that demand for testing supplies may again soon outstrip supply.

To better prepare for diagnostic test development for the next pandemic, we must pre-determine how to secure a reliable, functional supply chain for all testing components. Maximizing testing capacity requires a better and fully transparent federal coordination of all aspects of the testing supply chain, including ensuring that all suppliers do not rely on a single manufacturer. In addition, the government should maintain a centralized system that is ready to be deployed at any time to ensure a stockpile of testing supplies specifically and to quickly assess U.S. testing capacity based on all available testing components across sectors and geographic regions. This will give organizations, academic institutions, and private companies a roadmap of how to pivot quickly to access and/or generate the needed equipment and reagents and implement a plan with specific directions for test development and deployment.

### ***Conclusion***

Applying the lessons we have learned to date in the nation's response to COVID-19 not only is essential in course-correcting any potential ongoing challenges with respect to PPE, testing equipment, and other supplies, but also will be key in avoiding such pitfalls as new therapeutics, vaccines, and other countermeasures become available in limited supplies. An early case-study to apply these lessons to new challenges has been the distribution of the drug remdesivir, which was donated at first in limited quantities to the federal government by the manufacturer and shortens the recovery time for some COVID-19 patients. After initial confusion about the allocation process for the drug, we appreciate the Administration's efforts to find a reasonable and appropriate balance in using hospital-reported data to guide federal distribution to states based on disease burden. We urge a continued commitment in this vein to a transparent and data-informed process to determine the allocation of scarce resources, with clear leadership from the federal government in partnership with states and individual stakeholders as appropriate.

Thank you again for the opportunity to share our perspectives and for your continued efforts toward our mutual goal of improved health for people everywhere. Please do not hesitate to contact AAMC Chief Public Policy Officer Karen Fisher, J.D. ([kfisher@aamc.org](mailto:kfisher@aamc.org)), or me, with any questions.

Sincerely,

A handwritten signature in black ink that reads "David J. Skorton". The signature is fluid and cursive, with the first letters of the first and last names being capitalized and prominent.

David J. Skorton, MD  
President and CEO