



**Statement by the Association of American Medical Colleges on
“Road to Recovery: Ramping Up COVID-19 Vaccines, Testing, and Medical Supply Chain”
Submitted for the Record to the
Energy and Commerce Subcommittee on Health
United States House of Representatives
February 2, 2021**

The Association of American Medical Colleges (AAMC) thanks the Subcommittee for convening the February 3 hearing, “Road to Recovery: Ramping Up COVID-19 Vaccines, Testing, and Medical Supply Chain” and for the opportunity to provide written comment for inclusion in the record.

The AAMC 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. 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.

Major teaching hospitals, medical schools, teaching physicians, and scientists at academic medical centers have mobilized on all fronts to contain and mitigate COVID-19. In partnership with their physician faculty from affiliated medical schools, AAMC-member teaching hospitals provide 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 I Trauma Centers. As well-established and respected regional referral centers and centers for tertiary care, they have worked in collaboration with their state and local departments of health, regional emergency management systems, and all other major players in emergency response to develop and activate surge and crisis response plans at their own institutions and throughout their broader communities.

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.

Drawing on the expertise of the AAMC’s staff and the frontline experience of our member institutions, in July, the AAMC released “[The Way Forward on COVID-19: A Road Map to](#)

[Reset the Nation’s Approach to the Pandemic](#),” a blueprint containing 11 evidence-based actions to establish a comprehensive, coordinated plan to respond to the pandemic. The report included a major emphasis on remedying critical supply and drug shortages; increasing availability and accessibility of testing; coordinating distribution of COVID-19 vaccines; and promoting health equity throughout the nation’s response, among other recommendations.

While many of the road map’s recommendations unfortunately still are needed urgently today, we are encouraged that President Biden’s “American Rescue Plan” and “National Strategy for the COVID-19 Response and Pandemic Preparedness” align with many elements of the strategy that the AAMC and other experts have outlined. As the Subcommittee considers opportunities to accelerate and scale up vaccinations and testing, as well as related supply chain issues, the AAMC offers the following observations and recommendations from the experience of academic medical centers across the country:

Ramping Up COVID-19 Vaccines

- There is urgent need to ensure both that vaccine supply continues to increase and that teaching hospitals have direct access to transparent and advance communications about timing and quantity of vaccine allocations to allow for efficient planning.
- There should be appropriate flexibility in applying vaccination prioritization guidance.
- Ongoing and additional support is need for:
 - Community-based partnerships to address hesitancy.
 - Ensuring all individuals receive the vaccine without incurring any cost.
 - Offsetting expenses that teaching hospitals, health departments, and others are incurring in their vaccination efforts.
 - Strengthening and rebuilding core public health infrastructure.
- Policymakers should engage vendors of electronic health records (EHR) systems to ensure that any potential record-keeping solutions are compatible with institutions’ existing EHRs and other existing systems.

Ramping Up COVID-19 Testing

- The national pandemic response should seek sustained and regular testing targets for effective diagnosis and screening and should ensure dedicated funding; continued investment in technology and test development; and more strategic use of resources.
- While commercial labs and an increase in rapid tests for screening play an important role in increasing the nation’s testing capacity, hospitals and health systems also must be able to perform on-site diagnostic testing for patients.
- Maximizing testing capacity requires fully transparent federal coordination of all aspects of the testing supply chain.
- The government should maintain a centralized system to ensure a stockpile of testing supplies and to quickly assess U.S. testing capacity based on all available testing components across sectors and geographic regions.
- We encourage the new federal interagency COVID-19 Pandemic Testing Board to engage the academic medicine community and other stakeholders to inform its efforts.
- The AAMC strongly recommends a robust investment in the nation’s sequencing and surveillance capacity to ensure that our testing, vaccines, therapeutics, and other countermeasures remain reliable tools against the virus as new strains emerge.

The Medical Supply Chain

- In the short term, we strongly support efforts to accelerate domestic production of critical supplies to address all these needs.
- There should be clear guidance from the federal government regarding the quantity and types of supplies states and hospitals should have on hand.
- Federal funding for hospitals to establish and maintain inventories of recommended supplies will be important.
- 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.

The following addresses these observations and recommendations in greater detail.

Ramping Up COVID-19 Vaccines

Even before the Food and Drug Administration (FDA) issued emergency use authorizations (EUA) for the first vaccines, academic medical centers were working with state and local officials to prepare for the large-scale vaccination campaigns. They purchased ultra-cold freezers to store the vaccines, developed agreements to serve as hubs for distribution to other vaccine providers, and worked with community leaders and liaisons to conduct outreach, among other preparations, even as they were forced to respond to surging cases. As vaccine doses have become available, the experience has varied widely as a result of the variation in distribution plans from state to state and even within states.

Universally, however, the limited supply of vaccines has posed major challenges for facilities. Because of the low supply, reliable and early communication about the timing and volume of vaccines to be delivered to facilities is essential but has been elusive. Abrupt cancellations and reductions of shipments have been extraordinarily disruptive both to the individuals who had been scheduled to be vaccinated and to the clinicians, staff, volunteers, and administrators coordinating the large-scale vaccination clinics. In addition to inconvenience, when planned vaccination clinics need to be cancelled or rescheduled, the resulting confusion may lead the public to cast doubt on the vaccination program – and even the vaccine itself – if they perceive this critical undertaking is not well organized.

The AAMC welcomes the recent White House announcement that jurisdictions will be receiving an increase in their weekly supply of vaccines and that the Department of Health and Human Services (HHS) will be providing a three-week look ahead of supply allocation estimates for states, Tribes, and territories. **We encourage Congress and the Administration to act with urgency to ensure both that supply continues to increase and that teaching hospitals and others coordinating vaccination clinics have direct access to transparent and advance communications about timing and quantity of vaccine allocations to allow for efficient planning.** Without access to accurate information about expected supply, logistical planning is substantially more difficult, a challenge that only will increase as additional vaccine candidates – including one whose dosage and storage requirements differ from the two current products – become available.

Changing, inconsistent, and unclear guidance at the federal, state, and local levels also affects planning and leads to gaps in vaccination strategies. At the same time, overly rigid prioritization directives in some states could force facilities to discard doses unnecessarily and may also inadvertently be exacerbating inequities. For example, in many parts of the country, life expectancy for some populations is well below 75 years, so strict adherence to age-based priority eligibility for individuals 75 years and older likely excludes high-risk individuals from initial vaccination rounds. In other cases, states have adopted a model that progresses through prioritization categories by closing eligibility for earlier categories – for example, prohibiting health care workers who delayed seeking vaccination in phase 1a from receiving the vaccine once the jurisdiction has advanced to phase 1b. As another example, hospitals in some states are not able to include cancer patients in the early priority groups, despite their susceptibility.

To ensure efficient distribution of the vaccine, it is important to allow teaching hospitals to apply the issued prioritization guidance in a manner that allows them the appropriate flexibility to vaccinate high-risk patients and preserves their ability to continue providing care to their greater communities – including priority eligibility for physicians and other clinicians but also non-clinical staff. Food service staff, registration staff, environmental services staff, IT staff, and others at academic medical centers are essential to supporting continuity of clinical operations at teaching hospitals. Additionally, because medical students interact with patients and may be involved in clinical care, the AAMC supports vaccinating medical students with other frontline workers; however, not all states allow facilities to include students in their initial eligibility categories.

While uptake among faculty and staff at academic medical centers is generally high, some – including non-clinical staff – have delayed vaccination. Some of this hesitancy is rooted in historic mistrust as a result of racial bias in health care and unethical research practices in the past. In other cases, women of childbearing age have expressed concerns. Frequent and extensive outreach and education efforts are underway at medical schools and teaching hospitals nationwide and in partnership with community leaders. The Centers for Disease Control and Prevention (CDC) recently awarded the AAMC the Building Confidence in COVID-19 Vaccines Cooperative Agreement. We will be working with the CDC to build trust and confidence in the COVID-19 vaccine among health care personnel and individuals from communities disproportionately impacted by COVID-19 around the country. **The AAMC strongly supports ongoing and additional efforts to support community-based partnerships to address hesitancy and promote vaccinations among those populations disproportionately impacted by the pandemic.** In addition to the immediate benefit of encouraging higher vaccination rates among these populations, such efforts may also lay the groundwork for connecting individuals who have not previously sought preventive care to a medical home over the long term.

As AAMC-member institutions extend vaccination efforts beyond their campuses to the general population, additional challenges are emerging and are expected to increase. For example, vaccination clinics are pulling the health care workforce away from other clinical duties, which is especially challenging during the current COVID-19 surge in many regions. Many institutions are training and leveraging medical students, other health professions students, and other health professionals to assist with administering vaccines. Because individuals must be monitored for 15 minutes after vaccination, in addition to having a sufficient number of clinicians to administer

the vaccine, facilities must ensure that attending physicians and/or other qualified staff are on site to monitor and respond to any potential adverse events, rare as they may be. Additional personnel are needed for other responsibilities such as scheduling, collecting needed consents, taking medical histories, and providing other logistical support. As the scale of the vaccination clinics increases, the workforce needs will expand as well.

Securing a space that can accommodate such a massive operation while allowing for the necessary social distancing is also a challenge. Existing venues on teaching hospital campuses are unlikely to meet the need. Ensuring accessibility and geographic proximity will be another key consideration to make the vaccine available to the general population, and in some cases mobile units may be necessary.

The expenses associated with these efforts far exceeds the reimbursement providers may receive for administering the vaccine, and the reimbursement process only adds to the administrative burden providers are facing. **The AAMC strongly supports ensuring all individuals receive the vaccine without incurring any cost. Additionally, we encourage development of a mechanism to offset the expenses that teaching hospitals are incurring in administering large-scale vaccination clinics and/or in storing vaccine supplies for their communities.** Such support should, to the extent possible, minimize administrative burdens to the providers, and should supplement, not replace, aid to state and local health departments for their vaccine distribution expenses. Ensuring ongoing support for health departments is also key.

Developing an easy, efficient process for supporting these clinics is especially critical as teaching hospitals begin vaccinating individuals beyond their own patients. Establishing accessible and efficient scheduling and tracking systems to accommodate appointments for large-scale vaccination clinics has been challenging even within the institution's own patient population. Extending these efforts to individuals who are not affiliated with their health systems will pose extensive logistical and administrative challenges, including corresponding paperwork, data entry, and tracking challenges. **As policymakers consider potential federal strategies to support such work, the AAMC encourages engaging vendors of electronic health records (EHR) systems to identify solutions that are compatible with institutions' existing EHRs.**

Additionally, we support additional investment in and attention to existing public health data systems and other core public health infrastructure, which has languished after years of underinvestment. Understaffed and under-resourced public health functions at all levels of government and nationwide have complicated the already complex response to the novel coronavirus and vaccination efforts specifically. Robust, sustained support for foundational capabilities at health departments will be necessary to rebuild this critical infrastructure and help stabilize the nation's response.

Ramping Up COVID-19 Testing

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 highly sensitive diagnostic 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 conducting polymerase chain reaction (PCR) tests to diagnose COVID-19 in all stages of infection, hospitals and academic labs continue to be hampered by inconsistent and sporadic changes in access to reagents, nasopharyngeal swabs, transport media, testing machines, and other equipment. These shortfalls have impeded the ability to expand diagnostic testing capacity to fulfill community and national needs and improve testing access for all individuals, particularly those from underserved communities. **While commercial labs and an increase in rapid tests for screening play an important role in greatly increasing the nation's testing capacity, hospitals and health systems also must be able to perform on-site diagnostic testing for patients 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 continue to 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.

To help meet this goal, the AAMC recommends that the national pandemic response should seek sustained and regular testing targets for effective diagnosis and screening. Improvements in testing technology and availability have increased daily test rates to nearly 1 million per day, but we are far short of the number of tests that should be administered daily under current conditions. **A commitment to increasing the number of tests and suppressing the virus requires dedicated funding; continued investment in technology and test development; and smarter, more strategic use of our resources.**

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.

We welcome the establishment of the federal interagency COVID-19 Pandemic Testing Board via the president's recent Executive Order, and we applaud its commitment to harmonizing the nation's approach to testing. **As the group begins its work, we encourage the Board to engage the academic medicine community,** who can help inform the Administration's efforts to reverse testing supply shortfalls and to expand short- and long-term lab capacity, as described in the president's National Strategy.

In addition to addressing specific testing and supply chain issues, to contain the pandemic, we must be more agile in responding to the virus as it changes. Paramount in this effort is the need

to better understand which existing or emerging variants of the virus are infecting people in the U.S. Currently, we are sequencing only a small fragment of the nation’s confirmed cases, leaving us vulnerable to wide infection by undetected variants. We cannot know if tests are detecting new variants or if vaccines are protective against those variants without greatly increased sequencing. **The AAMC strongly recommends a robust investment in the nation’s sequencing and surveillance capacity to ensure that our testing, vaccines, therapeutics, and other countermeasures remain reliable tools against the virus as new strains emerge.** We are pleased that the president’s Rescue Plan proposes “to dramatically increase” funding for these efforts, and we encourage Congress to provide the necessary resources without delay.

The Medical Supply Chain

Early in the pandemic, hospitals began feeling additional strain on their existing and stockpiled supplies as visits to the emergency room increased. While shortages of personal protective equipment (PPE) – including N95 and other respirators, gloves, gowns, and other equipment – have been pervasive, our members also 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 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.

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 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.

Conclusion

The physicians, other health professionals, and scientists at the nation's medical schools and teaching hospitals are committed to defeating this virus. We are grateful for the steps Congress has taken to date to support their work, and we look forward to continuing to work with both Congress and the Administration to end this public health crisis. Thank you again for examining these issues in the Subcommittee's hearing, and please consider the AAMC a resource if additional information about vaccines, testing, medical supply chain issues, or other aspects of academic medicine's pandemic response and preparedness would be helpful. Please do not hesitate to contact AAMC Chief Public Policy Officer Karen Fisher, J.D. (kfisher@aamc.org) or AAMC Senior Director Tannaz Rasouli (trasouli@aamc.org) with any questions.