



**Statement by the Association of American Medical Colleges on
“The Disproportionate Impact of COVID-19 on Communities of Color”
Submitted for the Record to
The House Committee on Ways and Means
June 10, 2020**

Thank you for holding the May 27 hearing on the “Disproportionate Impact of COVID-19 on Communities of Color,” and for the opportunity to provide written comment for inclusion in the record. Over the past three months, the coronavirus pandemic has laid bare the existing health inequities harming our nation’s racial and ethnic minority communities, exposing the structures, systems, and policies that create social and economic conditions that lead to health disparities, poor health outcomes, and lower life expectancy. This hearing importantly highlights these persistent challenges and the need for academic medicine’s ongoing work with communities to eliminate health disparities, during COVID-19 and beyond.

The Association of American Medical Colleges (AAMC) is a not-for-profit association dedicated to transforming health care through innovative medical education, cutting-edge patient care, groundbreaking medical research, and community collaborations. Its members comprise all 155 accredited U.S. and 17 accredited Canadian 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 173,000 faculty members, 89,000 medical students, 129,000 resident physicians, and more than 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Health equity is paramount to AAMC’s mission of leading and serving academic medicine to improve the health of people everywhere.

Today, the country finds itself shaken to its core as once again we are faced with the increasing tragic demonstrations of the everyday danger of being black in America. Together, and in partnership with the communities we serve, we must work together to heal our nation. We must take the lead in educating ourselves and others to address these issues head-on. We must move from rhetoric to action to eliminate the inequities in our care, research, and education of tomorrow’s doctors.

As healers and educators of the next generation of physicians and scientists, the people of America’s medical schools and teaching hospitals bear the responsibility to ameliorate factors that negatively affect the health of our patients and communities. As leaders of anchor institutions in our communities, academic medicine’s physicians, educators, hospital leaders, faculty, researchers, learners, and staff must lead by example.

Your May 27 hearing highlighted several activities of academic medical centers to work with our communities to address the disproportionate impact of COVID-19 on racial and ethnic minority populations, including a proposed consortium of the nation’s four medical school at Historically Black Colleges and Universities (HBCUs): Meharry Medical College, Howard University

College of Medicine, Morehouse School of Medicine, and Charles R. Drew Medical School. There should also be consideration for partnering with Hispanic Serving Institutions (HSIs), and institutions who have a long-standing history of serving American Indian and Alaska Native communities. Indeed, AAMC-member teaching hospitals, medical schools, students, residents, and physicians have mobilized on all fronts to contain and mitigate COVID-19, and its disproportionate impacts.

Prior to the hearing we shared several ongoing AAMC initiatives with committee staff (see Appendix A). We would like to take this opportunity to highlight the following federal policy recommendations to help the nation's health workforce address health disparities and inequality during COVID-19 and beyond.

Contact Tracing

As the need for increased testing, contact tracing, and quarantine grows, the AAMC encourages the Committee to ensure efforts are grounded in community engagement so they are oriented toward success. Specifically, contact tracers should be hired from the communities in which they will be working to ensure cultural resonance and local knowledge as well as to develop the bidirectional trust necessary for this phase—as well as future phases such as vaccine distribution—of public health effort. Further, the resources needed for tracing and quarantine should be deployed in ways commensurate with current and predicted need. Using measures like the [COVID-19 Community Vulnerability Index](#) or the Centers for Disease Control and Prevention (CDC) [Social Vulnerability Index](#) can help ensure we counter disproportionate disease burden with sufficient resources in a timely way.

Telehealth

To help address the crisis caused by COVID-19, CMS created new coverage and payment policies that have facilitated the widespread use of telehealth and other communication-based technologies and provided other important relief through additional waivers and regulatory changes. By allowing audio-only as well as video telehealth visits, the Agency has leveled the field for many patients who do not have the means to have smart phones or tablets, who don't have home access to high-speed internet, or who are not comfortable with the technology. Hospitals, physicians, and other providers have responded by rapidly implementing telehealth in their practices in order to provide continued access to medical care for their patients. The flexibilities provided by CMS and Congress for telehealth coverage and payment have enabled hospitals, physicians, and other health care providers, and their patients to experience the benefits of telehealth.

Beyond aiding with the COVID-19 response, telehealth offers the long-term promise of expanding quality healthcare in the future, particularly to individuals with limited access to services due to disparities. Disparities in access to care have been observed due to factors such as distance from medical facilities, lack of reliable transportation, limited access to information, and socioeconomic status. Telehealth shows promise for reducing disparities by overcoming these barriers to health care access.

We recognize that the current flexibilities are limited to the Public Health Emergency (PHE); however, given the massive changes that have occurred as well as the improvements to patient access and patient satisfaction, it is imperative that the progress that has been made since March continue when the PHE ends. Therefore, we urge Congress and CMS to make changes to legislation and regulations that will make permanent the current changes and will ensure that reimbursement remains at a level that will support the infrastructure needed to provide telehealth services.

Data Collection

In an April 10 press statement, the AAMC called for the development of a national, standardized data collection system that accurately captures race and ethnicity data, as well as information on the social and environmental conditions in which people live, work, and play (e.g. crowding, access to food, housing security, etc.) that impact how illness can spread.

The AAMC also recommended capturing community-level data that adequately reflect the neighborhoods to which COVID-19 patients are discharged, noting that county or zip code data are not specific enough for densely populated communities likely to be most impacted by infectious disease. Engaging state and local public health departments, private testing labs, and hospitals – all at the front lines of the pandemic response – in the data collection effort is also essential to avoid undue burden on these systems.

The AAMC also recommends that future data collection efforts and surveillance be patient-centered and developed in collaboration with local community members and community-based organizations who have trusted and established relationships with local residents and leaders. Collecting valid data that both identifies communities disproportionately at-risk and suggests structural interventions is crucial to ensuring just, equitable preparedness and response during a pandemic.

HRSA Diversity Pipeline

A diverse health workforce contributes to culturally responsive care, helps to mitigate bias, and improves access and quality of care to reduce health disparities, such as those seen during COVID-19. The Health Resources and Services Administration (HRSA) Title VII health professions and Title VIII nursing programs play an essential role in improving the diversity of the health workforce and connecting students to health careers by enhancing recruitment, education, training, and mentorship opportunities. Inclusive and diverse education and training experiences expose providers to backgrounds and perspectives other than their own and heighten cultural awareness in health care, resulting in benefits for all patients.

Title VII's health professions diversity programs include:

- Health Career Opportunity Program (HCOP), which invests in K-16 health outreach and education programs through partnerships between health professions schools and local community-based organizations;
- Centers of Excellence (COE), which provides grants for higher education mentorship and training programs;

- Faculty Loan Repayment, which provides loan repayment awards to retain minority health professions faculty in academic settings to serve as mentors to the next generation of providers; and
- Scholarships for Disadvantaged Students (SDS), which grants scholarships for health professions students from minority and/or socioeconomically disadvantaged backgrounds.

Studies have demonstrated the effectiveness of such pipeline programs in strengthening students' academic records, improving test scores, and helping racial and ethnic minority and students who are economically disadvantaged pursue careers in the health professions. Title VII diversity pipeline programs reached over 10,000 students in the 2018-2019 academic year (AY), with SDS graduating nearly 1,400 students and COE reaching more than 5,600 health professionals; 56% of which were located in medically underserved communities.

Title VIII's Nursing Workforce Diversity Program increases nursing education opportunities for individuals from disadvantaged backgrounds, through stipends and scholarships, and a variety of pre-entry and advanced education preparation. In AY 2018-19, the program supported more than 11,000 students, with approximately 46% of the training sites located in underserved communities.

The AAMC appreciates that Congress reauthorized the HRSA Title VII and Title VIII programs in the Coronavirus Aid, Relief, and Economic Security (CARES) Act (P.L. 116-136). However, increased funding is necessary for these programs to reach their full potential. For FY 2021, AAMC joined an alliance of over 80 national organizations, the Health Professions and Nursing Education Coalition (HPNEC), in recommending \$790 million for the Title VII and Title VII programs and an additional \$367 million in emergency supplemental funds for these programs in response to the COVID-19 public health emergency.

Graduate Medical Education

Growing physician workforce shortages exacerbate health inequities in the United States. While U.S. medical schools have increased enrollment by over 30% since 2002, a commensurate increase in Graduate Medical Education (GME) is necessary to meet growing patient demand. According to HRSA, over 117 million Americans live in federally designated Health Professional Shortage Areas. The impact of these shortages is often worse for patients in rural areas or with low socioeconomic status, who are more likely to lack access to quality care.

In 1997, Congress effectively froze Medicare GME funding until physician needs in the U.S. could be re-evaluated. The U.S. is expected to experience a shortage of between 46,900 and 121,900 physicians by 2032 in both primary and specialty care. Furthermore, the U.S. would need an additional 95,900 doctors immediately if health care use patterns were equalized across race, insurance coverage, and geographic location. This shortage would be in addition to the number of providers necessary to meet demand in federally designated HPSAs.

We believe that the increasing physician shortage over the last two decades has demonstrated that we need to increase the number of physicians for the future. This shortage is being felt

acutely as we mobilize on the front lines to combat COVID-19. In fact, data have shown that the U.S. has fewer practicing physicians per 1,000 people than nearly all comparable countries. It is clear that an investment is needed now to ensure an appropriate physician workforce that is able to serve a growing and more diverse population, as well as mitigate future crises.

The Resident Physician Shortage Reduction Act (H.R. 1763/S. 348) would take a step toward addressing the physician shortage by gradually and responsibly increasing Medicare's cap on GME by 15,000 slots over five years. We estimate that this will produce an estimated 3,750 new physicians annually when fully implemented. The additional primary care and specialist physicians trained by lifting the cap on Medicare-supported GME will allow the U.S. to more robustly respond to the needs of patients across the country both in the near term and into the future.

Physician Immigration and Citizenship

The U.S. health workforce and the patients it serves rely on physicians from other countries, particularly in rural and other underserved communities. These providers help ameliorate the growing workforce shortage and add diversity of culture and experience to our nation's workforce. Their role is amplified each year as the nation faces growing physician workforce shortages and acutely during the COVID-19 national emergency. This year, thousands of physicians from other countries already in the U.S., and more than 4,200 who just matched to medical residency programs at U.S. teaching hospitals, will encounter significant barriers to enter or remain in the country (typically on H-1B and J-1 visas).

As most medical residency programs start around July 1, a predictable and timely visa application process is paramount. These physicians frequently use the State Conrad 30 J-1 Visa Waiver program to practice in rural and underserved areas. Furthermore, more than 27,000 medical professionals are at risk of losing their work authorization under the (DACA) program at the peak of the COVID-19 pandemic pending the U.S. Supreme Court decision.

In addition, a significant proportion of the U.S. research workforce, including the majority of biomedical postdoctoral researchers, is composed of international scholars, but the ability to obtain visas and travel is severely restricted during the pandemic. Many postdoctoral scholars who had secured positions in the U.S. are delayed in entering the country. This restriction of the scientific workforce will cause both short- and long-term stress on the U.S. research workforce pipeline and could stifle innovation and significantly impact our country's ability to attract the best and brightest scholars.

In light of the country's significant reliance on these providers and researchers, AAMC urges Congress to pass the:

- The Conrad State 30 and Physician Access Act (H.R. 2895/S. 948), which would reauthorize and expand the State Conrad 30 J-1 visa waiver program to help underserved communities; and
- The American Dream and Promise Act of 2019 (H.R. 6) or the Dream Act of 2019 (S.874), which would provide a pathway to citizenship for certain undocumented

individuals, including many health professionals with DACA status who are currently treating COVID-19 patients.

Additionally, the AAMC has urged the Administration to:

- Temporarily extend nonimmigrant status for physicians and medical residents through the COVID-19 national emergency to allow them to continue to treat patients in the U.S.;
- Expedite approvals of extensions and changes of status for physicians and medical residents practicing or otherwise lawfully present in the U.S.; and
- Resume H-1B premium processing for physicians and medical residents to facilitate expedited processing.

Additional Health Equity Legislation

To help communities across the nation—and the medical schools and teaching hospitals that serve them—address the nonmedical factors that affect health and result in unfair and avoidable inequities, the AAMC has endorsed the Social Determinants Accelerator Act of 2019 (H.R. 4004/S. 2986). This bill would establish an inter-agency technical advisory panel on social determinants of health and to authorize planning grants for state, local and Tribal governments for accelerator programs.

H.R. 4004 is also part of the Health Equity and Accountability Act of 2020 (HEAA, H.R. 6637), a measure introduced by the Congressional Tri-Caucus for the past several Congresses that broadly addresses health care disparities affecting communities of color, rural communities, and other underserved populations. The HEAA seeks to address disparities by promoting culturally appropriate care, data collection, and reporting. Among numerous other provisions, it would:

- expand financial support for the HRSA Title VII health professions and Title VIII nursing workforce development programs;
- reinforce that hospitals can count the time a resident spends in cultural and linguistic competency education training as part of the hospital's GME full-time equivalency (FTE) calculation as proposed under the Medical Education for a Diverse America Act (H.R. 5432);
- reauthorize and expand the Conrad-30 J-1 visa program; and
- recognize via a "Sense of the Congress" that the physician shortage in the United States can be mitigated by eliminating the cap on Medicare support for GME as discussed above.

In closing, health and health care inequities are deeply rooted in the conditions in which people are born, grow, live, work and age. Medical schools and teaching hospitals are committed to ensuring all people have the same opportunity to reach their full health potential—a state of health equity. We look forward to working with you to ensure legislation passes to help improve the health of everyone during COVID-19 and beyond. Please do not hesitate to reach out to Matthew Shick, Sr. Director, Government Relations, <mshick@aamc.org>.

Thank you again for your leadership on this important issue.

APPENDIX A

Equity, Diversity, and Inclusion (EDI) Competencies

The EDI Competencies project is part of AAMC's Medical Education's Cross-Continuum Targeted Competencies Initiative. It's designed to reach consensus within the medical education community on competencies in current and evolving targeted areas that graduating medical students, graduating residents, and experienced faculty should demonstrate. The goals of this work are to enhance the competencies of physicians through competency-based educational efforts, create a more seamless continuum of medical education, and ultimately, enhance the care of patients and populations. The AAMC is following a similar process to develop physician competencies in the areas of Telehealth and in Equity, Diversity, & Inclusion (EDI), and other topics based on new, emerging, and evolving demands in health care.

AAMC-CDC Cooperative Agreement

The AAMC entered into its first Cooperative Agreement with the CDC in 2000 to enhance collaborations between the academic medical and public health practice communities. In August 2017, the CDC awarded the AAMC and three other national academic associations funds to support public health workforce activities to enhance population health education for medical, nursing, and public health students. This funding supports several initiatives including:

[AAMC Nurturing Experiences for Tomorrow's Community Leaders \(NEXT\)](#)

- The AAMC NEXT Award provides funding to AAMC-member institutions to develop or enhance a learning opportunity that seeks to improve community health and eliminate health disparities while applying population health leadership principles and promoting collaboration among diverse stakeholders. Projects must target medical students or residents, or both. We also encourage the inclusion of interprofessional learners.

AAMC-CDC Webinar Series

- We produce webinars featuring AAMC-member institutions to promote increased public health awareness and encourage inclusion of public health perspectives. Experts in the field speak about their personal experiences practicing and teaching medicine from a public health vantage point.

Curricular Resources & Publications

We develop and disseminate curricular resources and content to assist our members with enhancing population health education in the health professions. Recent examples include:

[Teaching Residents Population Health Management Report](#)

- It presents profiles of successful practices at primary care residency programs to help residency program directors incorporate Population Health Management principles into education programs. There is specific mention of principles of community

engagement, addressing social determinants of health and applying a healthy equity lens to clinical care.

3000 X 2000 Initiative and Increasing Diversity

Reflections on Diversity and Inclusion in Academic Medicine: Commemorating Dr. Herbert W. Nickens' Legacy, 15th Anniversary (available from AAMC as a pdf upon request)

[Reshaping the Journey](#)

[An Updated Look at the Economic Diversity of the U.S. Medical Students](#)

[Trends in Ethnic and Minority Applicants and Matriculants to U.S. Medical Schools 1980 - 2016](#)