



Testimony of
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COVID-19 Part II:
Evaluating the Medical Supply Chain and Pandemic Response
Gaps

United States Senate
Homeland Security &
Governmental Affairs Committee

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Chairman Peters, Ranking Member Portman, Members of the Committee on Homeland Security and Governmental Affairs, my fellow panelists.

My name is Dr. Shereef Elnahal, President and CEO of University Hospital in Newark, New Jersey.

I thank the Committee for the opportunity to offer insights into my institution's experiences during COVID-19, and to offer the institution's support for the Help Onshore Manufacturing Efficiencies for Drugs and Devices Act and the Pharmaceutical Accountability, Responsibility, and Transparency Act.

If they had been enacted prior to the pandemic, the PART and HOME Acts would have helped my hospital better meet the care needs of our community during a difficult time. And I believe they would help the country make great strides in building a more reliable, domestic-based supply chain for future health emergencies.

University Hospital is New Jersey's only state hospital, and one of only 962 state and local government-run community hospitals in the United States. We are the Level 1 Trauma Center for the densely-populated northern New Jersey region. We are an academic medical center, and the principal teaching hospital for all Newark-based medical education, including Rutgers New Jersey Medical School – a robust, preeminent training ground for the next generation of healthcare heroes.

Last year, we had more than 83,000 emergency room visits, admitted some 15,600 patients, and had 200,000 outpatient visits. As one of New Jersey's safety net hospitals, we serve as a critical healthcare provider for a large population of low-income and Black and Brown residents.

Due to our close proximity to Newark Liberty International Airport, we had been closely monitoring the progress of COVID-19 since early January 2020, when the CDC began screening passengers at major U.S. airports, including JFK International, just 31 miles away.

That said, we were completely unprepared to address the surge of patients that followed a few short weeks later.

In April 2020, at the peak of the first surge of COVID-19, we had 300 patients in house being treated for COVID-19.

For decades, our nation has struggled to appropriately focus on the strategic national stockpile of essential supplies and medication. While it is tempting to point fingers,

the fact of the matter is that the failure to maintain the country's strategic national stockpile was a long-term oversight that has spanned many decades.

COVID-19 brought with it things we have never seen before in healthcare – things we hopefully will never see again.

We found ourselves needing to react and pivot every single day to address the surge of patients that followed for weeks and months to come.

As the number of COVID cases in our emergency rooms and intensive care units doubled, tripled and quadrupled, we found ourselves at risk of running out of supplies for which we have never seen shortages before. This includes protective equipment for our staff, and ventilators for the patients with the most severe cases of COVID-19.

Suppliers serviced the highest bidders. Safety net hospitals, like University Hospital, were frequently the last to be called back.

Key medications, especially those which are used to sedate patients on ventilators, were also dangerously low. Failing to sedate someone on a ventilator is agonizing for the patient. As professionals dedicated to healing, this was an outcome that we refused to accept, and we worked around the clock on these issues to help patients survive COVID. No patient went without such medications, but we were days away from this outcome in the most critical times.

In many cases, we needed to find suppliers with whom we had no track record and who had little to no history serving the U.S. medical community. At the same time, we were keenly aware that fraud was happening from many angles across the country. Occasionally, we needed to return or discard deliveries when items purchased were discovered to be ineffective in protecting against infection.

Supply negotiations were a daily occurrence. Our suppliers were taking phone calls from us, along with hundreds of other hospitals and health systems – all of whom had the same urgent need for important medications and essential supplies. In many cases, we needed to find suppliers with whom we had no buying history.

As soon as a new therapy to treat COVID-19 would emerge, the drug would rapidly be ordered from the wholesaler and their existing inventory would disappear.

To manage the situation as best as possible given the supply limitations, we put together a pharmaceutical pandemic plan, as well as a critical list of alternatives to some of the more heavily used pharmaceuticals, in an effort to decrease the burden on our existing stock of critical medications.

Our hospital pharmacy leadership was in near constant contact with colleagues at other New Jersey healthcare institutions in an effort to assist each other. If there were drugs they could spare at a given time, especially when another institution was perilously low on stock, the spirit of cooperation would take over in the name of patient care.

By not making marked changes in the manufacture of medications here in the United States, and by not creating a strategic national stockpile of essential pharmaceuticals for the next public health emergency, the U.S. healthcare system will continue to be reliant on foreign manufacturers where critical medications are made, including China and India.

Domestically, without the ability to bolster domestic production and supply, we are at the mercy of these and other foreign trading partners. With foreign imports come competitive cost pressures on American suppliers. In effect, we have been subsidizing foreign manufacturers of equipment and supplies produced overseas, and during the pandemic, many of these nations stopped or delayed exports to their benefit, but to our detriment.

At University Hospital, we had a particular issue with ventilators. In mid-April we placed an order for 30 German-manufactured Dräger ventilators with an expected lead-time of 12 weeks. One month later, that lead-time had increased to 30 weeks. Although the firm denied it, the rumor in the industry was that the German government prevented their export. Eventually, we cancelled our Dräger order and placed an order for 35 additional Medtronic ventilators, expecting delivery of five units per week beginning the first week of May 2020.

Deliveries were timely early in the pandemic when cases were initially and largely limited to the New York, New Jersey, and only a few other regions nationally. However, supply deliveries slowed and even stopped when COVID-19 cases spiked in the South and Midwest. The last units were not delivered until January 2021 – much later than anticipated and significantly past the time they were needed to make the greatest impact.

These vital supply shortages illustrate a systemic, industry-wide issue. The things we needed the most were the exact same resources that all hospitals needed. So, every hospital was working their contacts across the global supply chain at the same time. This was compounded by businesses and individuals, outside the healthcare setting, taxing the supply chain even further as they attempted to purchase hospital-grade materials for their employees and families.

Our situation was dire – both within our hospital’s walls and on our financial balance sheets. Things were so grave that we briefly ran out of space in our hospital morgue, resorting to freezer trucks in a parking lot adjacent to the hospital. Regardless, each deceased patient was treated with the same dignity, care and respect as they received prior to their passing.

The CARES Act saved our hospital. Without funds that kept our hospital afloat during the worst of this, we projected that we would have found ourselves unable to make payroll by August of 2020. Hospitals simply cannot fail during a pandemic. If we had to close, it would have been a catastrophe in our community, on top of a pandemic.

Aside from the federal assistance, New Jersey’s state government – including Governor Phil Murphy – helped University Hospital receive a share of the national stockpile, including N-95 masks, gowns, ventilators and more. Without the CARES Act, University Hospital would have struggled in ways that some other hospitals had to just across the Hudson River, when some staff found themselves using trash bags as isolation gowns to provide patient care.

As a Level 1 trauma center, we were also the regional coordinator for hospital beds across New Jersey’s densely populated northern region during the acute surges. CARES Act funding was particularly helpful for this arduous task, which would not have been possible without federal government support.

Timing also played a key factor. We received federal and state aid at exactly the time we needed it the most. We ultimately used \$25 million in federal funds for PPE and other COVID-related purchases. These vital supplies were purchased for our own hospital, as well as the New Jersey emergency field hospitals that we coordinated and outfitted for the State of New Jersey.

We also received vital staffing support when we needed it most. The Department of Defense assigned 85 military healthcare providers to our hospital in April and May of 2020. These providers, part of the United States Army’s Urban Augmentation Medical Task Forces, embedded with our staff and helped us provide necessary relief to our overworked team members and those in our hospital family who turned into COVID-19 patients themselves.

And our important work did not stop with patient care. We were one of a few sites nationwide that conducted the Moderna vaccine trial in a majority-minority community. We were also the first hospital to administer a vaccine in New Jersey

outside of a clinical trial last December, and we continue to provide all three approved vaccines to our community.

We did many virtual town halls to reassure our community that they can trust the vaccine, helping to quell the justified mistrust in the healthcare establishment dating back to slavery and the horrors of the Tuskegee experiment, and acknowledging the implicit bias that people of color continue to face in health care settings. More and more people in the community we serve accepted the vaccine over time. Now, the challenge is access. We have re-routed our vaccination strategy in recent days to be where people are with mobile vaccination efforts in collaboration with our city, county, and state governments, and hope that more organizations will join us in this effort in the coming months.

Vaccine hesitancy persists, and we continue to work with our neighbors and community leaders to offer many virtual community forums, in-person health fairs, and community direct outreach to address the safety and efficacy of the vaccines.

Finally, our hospital continues to work diligently and intently to vaccinate the community. On a recent Saturday, for example, we vaccinated 338 people at a health and wellness festival. By the end of the week, we will have provided 39,000 vaccine injections and fully vaccinated 20,000 members of our community. A number of people were able to receive vaccines with no appointment needed.

Today, nearly 33 million Americans have been diagnosed with COVID-19. Nearly 600,000 have passed away. 35% of the entire population has been fully vaccinated.

Today, we are in the final miles of the pandemic, but our public health crisis isn't completely over. We need to repair the cracks in our national healthcare foundation, including the medical supply chain, while there is time.

The reality is that I am still not convinced that we are prepared for the next pandemic – whether from a vaccine-resistant variant of COVID-19 or a different pathogen altogether. While we are better off now as a result of many initiatives from the Biden administration on supply chain resiliency, there is still much work to do.

Maximizing the use of the authorities under the Defense Production Act has had a beneficial impact and has led to real changes for vaccine accessibility. One of the first Executive Orders President Biden signed after taking office dealt directly with the nation's supply chain, calling for a public health supply chain resilience plan among other, thoughtful efforts.

Still, there remains the matter of financial solvency for institutions like University Hospital during times of crisis like this. To continue depending on herculean, federal rescue efforts during these crises would indicate a failure to prepare. We need meaningful, value-based payment reform to this effect, sooner rather than later.

When the pandemic struck, there was never a higher demand for health care in American hospitals, and yet, the financial risk for hospitals and health systems was never higher. This fundamental disconnect between payment and value has existed for decades, and has forced hospitals with thin margins to use just-in-time inventory practices for these critical items. There was little incentive or capability to build stockpiles at the facility level, and we found that state and national stockpiles were also depleted.

We ultimately need a system of payment for care that does not rely on advanced medical procedures or elective surgeries for hospitals to remain afloat, but rather, allows the health care safety net to thrive by paying institutions for services that keep people healthy.

University Hospital has always been there for each and every person that seeks our care. We are honored and humbled to do so, and will always be there for our patients and the community.

In the meantime, we need to act now to ensure we are prepared for the next pandemic with the supplies, medication, and equipment we need to care for anyone who walks through our doors.

Thank you for the opportunity to provide our perspective, and I look forward to your questions.