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**Title:** An Auxiliary Medical Education: Learning Through the Evolution of a Medical Student-Founded Not-for-Profit Organization in Response to the COVID-19 Era Personal Protective Equipment Shortage

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An Auxiliary Medical Education: Learning Through the Evolution of a Medical Student-Founded Not-for-Profit Organization in Response to the COVID-19 Era Personal Protective Equipment Shortage

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Abstract

At the outset of the COVID-19 pandemic, many medical students were removed from clinical duties and had their education put on hold. Some found novel ways to join efforts to respond to the pandemic. Georgetown University School of Medicine medical students created Medical Supply Drive (MSD or MedSupplyDrive), a 501(c)(3), on March 17, 2020, in response to the national shortage of personal protective equipment (PPE). This article reviews the formation of a national response to the pandemic, the methods employed to distribute PPE, and the results of MSD’s work from March 17, 2020, through June 20, 2020. A focus was placed on equitable distribution, both within local regions and on the national scale by distinguishing COVID-19 hotspots, including Native American reservations. As of June 20, over half a million items were donated, with 1,001 deliveries made to 423 hospitals, 182 clinics, 175 long-term care facilities, 25 homeless shelters, 32 public health departments, and 164 other facilities. From 46 states and the District of Columbia, 1,514 individuals volunteered, and 202 signed up as regional coordinators. MSD formed 2 international organizations, MedSupplyDrive UK and MedSupplyDrive Scotland, and established U.S.-based partnerships with 19 different PPE and aid organizations. MSD gained local, national, and international media attention with over 45 interviews conducted about the organization. While the pandemic temporarily disrupted formal medical education, MSD empowered medical students to actively learn about the needs of their communities and organize ways to address them, while incorporating these values into their professional identities. The 3-step framework this organization employed also provides a potential model for future disaster relief efforts in times of crisis. MSD hopes to motivate budding physicians to collaborate and play an active role in tackling public health inequities outside hospitals and within the communities students will one day serve.
In March 2020 in response to the national personal protective equipment (PPE) shortage at the outset of the novel coronavirus disease 2019 (COVID-19) pandemic, 5 Georgetown University School of Medicine medical students created Medical Supply Drive (MSD, or MedSupplyDrive), now a 501(c)(3) not-for-profit organization. Several key events took place leading up to the creation of MSD. On March 11, the World Health Organization declared COVID-19 a pandemic, and on March 13, the president of the United States declared a national emergency.\(^1\) On March 17—the day MedSupplyDrive was established—the United States had 3,503 confirmed cases.\(^2\) By May 30, the United States had 103,605 COVID-19-related deaths and 1,764,671 COVID-19-positive cases.

As case numbers rose nationally, health care facilities activated infection-control protocols to protect their staff and patients. Hospitals around the country were left in dire shortages with the increased demand for PPE. As a result, health care workers were exposed to COVID-19 without appropriate protection and put in compromising situations.

As the virus continued to spread and threaten the lives of health care workers, medical students were abruptly removed from clinical settings. Many students looked for opportunities to help their communities, as they had extra time on their hands and a desire to assist in COVID-19 response efforts. The founders created MSD to mobilize PPE, focusing especially on areas of greatest need. This article describes the rationale, structure, and growth of the organization. It offers a successful framework for organizations looking to address health care inequities and crises on a national scale.

Many factors resulted in the PPE deficit, including uncontrolled case numbers, inconsistent PPE reuse protocols, insufficient funding, and inefficient national distribution.\(^3\) China supplies nearly half of the world’s face masks, but the paucity of international imports made distribution
unreliable, while demand in the United States rose exponentially.\textsuperscript{4} An estimated 33\% of U.S. hospitals regularly operate on a negative profit margin; with the stark decline in elective procedures and patient cancellations, many hospitals were left with inadequate funding.\textsuperscript{5} Smaller hospitals and independent clinics have less funding to make large-scale purchases from suppliers, are frequently outbid by larger hospital systems, and lack experience in the process of vetting suppliers. Early in the pandemic, this often led to spending on faulty PPE, price gouging, or incomplete deliveries. Moreover, states and health care systems competed for what little supply remained. PPE is not always evenly distributed in the U.S, revealing another facet of medical inequity.\textsuperscript{6}

Facing desperate times, health care workers resorted to soliciting donations to meet their needs. In response, MSD sought to fill this deficit. At the time of creation, it was the only organization started by medical students that inspired community PPE donations on a national and international scale.

**Organizational Structure**

Since its establishment, MSD has strived to meet the specific needs of each area. The initiative began by sharing volunteer opportunities within the medical school at Georgetown University, but it soon became a national and global initiative. Board members created a functional hierarchy of leadership to ensure that tasks within the organization were completed on both local and national scales (Figure 1).

The 5 members of the MSD founding Executive Board ran the organization at the national level. Each member had a designated role; these included but were not limited to:

- National logistics coordinators: Composing legal documents, overseeing and determining partnerships with other organizations, communication with MSD’s
attorney, tracking equitable distribution and donation statistics, monitoring and updating hotspots, onboarding and overseeing regional coordinators (RCs), and hosting weekly video conference meetings for all RCs.

- **Secretary**: Maintenance of email correspondence, transcribing meeting minutes, managing volunteer onboarding and waiver acquisition, updating and managing the MSD website, tracking supply donations, and recording volunteer statistics.

- **Treasurer**: Managing and tracking finances, organizing fundraisers, reimbursing RCs and volunteers, vetting suppliers, and determining purchasing logistics.

- **Communication, outreach, and media relations coordinator**: Monitoring, moderating, and interacting with audiences through MSD social media accounts, creating and curating content to share, determining promotional strategies, managing interviews with news media organizations, and updating MSD press releases.

As the volunteer base grew, the MSD board realized that each region would benefit from a community of volunteers working together, rather than disjointed efforts to achieve the same goal. In order to mobilize communities, MSD created the RC leadership role. RCs led efforts toward mobilization and organization by onboarding of volunteers within their city/region, attending weekly RC video conference calls, updating local and regional donation and outreach (D&O) sheets, and conducting community needs assessments with the help of their volunteers to ensure equitable PPE distribution.

RCs were further organized into 1 of 5 greater regions in the United States based on the state they served: Northeast, Mid-Atlantic, Midwest, South, and West. National statistics were collected from these greater regions.
Each RC oversaw a volunteer base within their city. Volunteers could complete a range of tasks. Those comfortable traveling amidst quarantine restrictions procured donations. Volunteers who preferred working from home were given outreach tasks to solicit donations and organize appropriate drop-offs. To ensure safety, volunteers signed liability waivers committing them to strict safety protocols and guidelines, including social distancing, wearing masks, disinfecting supplies, and prioritizing contactless pick-ups and deliveries. Tasks were recorded on local and regional D&O spreadsheets.

Social media platforms were instrumental to MSD’s evolution and growth. Platforms included Facebook, Instagram, Twitter, and LinkedIn (MedSupplyDrive); each helped engage a unique audience. Weekly social media campaigns helped recruit volunteers and solicit donations for the organization. MSD achieved over 1,000 followers on both Twitter and Instagram by June 2020. Through word of mouth and social media outreach, MSD experienced rapid growth in donations and volunteer sign-ups (Figure 2).

As the organization grew, board members recognized the benefits of becoming a not-for-profit organization: to acquire tax exemption, gain liability protection, and incentivize donations. After acquiring counsel from a pro-bono not-for-profit lawyer for legal advice, MSD filed for 501(c)(3) status as a disaster relief organization in Washington, D.C., 8 days after its establishment. MSD received acceptance on May 8, 2020.

**Donation procurement**

Donations were solicited through direct volunteer outreach, website submissions (MedSupplyDrive.org), and social media advertisements. The process of donation pick-up or drop-off depended upon coordination between the donor, RC, and volunteers. Further, MSD established partnerships with other PPE drive organizations (Chart 1) that could recruit MSD
volunteers to help deliver their supplies, thus maximizing the efficiency of similar regional organizations.

In April, MSD opened a monetary donation option on its website. As in-kind donations stagnated, monetary donations allowed MSD to purchase and ship PPE to areas of greatest need.

In the early stages, distribution depended heavily upon individuals’ contact with facilities and physicians on the ground.

RCs initially delivered statements regarding their region’s PPE needs at weekly national video conference meetings with the executive board. These impromptu statements evolved into standardized needs assessments based upon best practices of volunteers on the ground. A complete example of a needs assessment can be viewed in Supplemental Digital Appendix 1, available at http://links.lww.com/ACADMED/B126. This allowed for a comprehensive process for each region to assess needs and inequities in PPE procurement in their area, providing a foundation upon which PPE could be equitably distributed through MSD.

When facilities indicated their ability to purchase PPE from suppliers, MSD paired them with affordable and vetted vendors to advance self-sustainability. MSD selected vendors based upon familiarity with the company or previous sales to other PPE organizations. After communicating with each vendor, MSD requested their Certificate of Compliance or Certificate of Food and Drug Administration (FDA) Registration, then cross-referenced these certificates with the FDA or European Union Safety Federation.\(^7\,\!\!^8\)

**Hotspots and anticipating demand**

Hotspots of COVID-19 cases arose at different times and locations across the country, resulting in differing severities of the PPE shortage. It was imperative that MSD addressed immediate needs while also anticipating new hotspots. The team used case numbers reported by the Johns
Hopkins Coronavirus Resource Center and the Centers for Disease Control and Prevention, as well as volunteer-reported data, as proxies for anticipated PPE needs.\textsuperscript{9,10} In conjunction with the needs assessments, MSD narrowed facilities of greatest need within the hotspot areas. The team dedicated particular attention to underfunded health facilities caring for underrepresented populations to ensure PPE reached areas disconnected from major health care systems. Examples included rural health care facilities, long-term care facilities, incarceration facilities, homeless shelters, and disability programs. Although mainstream hospitals were known to be experiencing a PPE shortage, specific underserved populations were disproportionately affected, both locally and nationally. In particular, the Navajo Nation and other Native American reservations experienced a dramatic escalation of cases while having little access to health care resources.\textsuperscript{11} In response, MSD focused its efforts on shipping donations to contacts made within community hospitals and the Indian Health Service hospitals serving this area.

\textbf{Data collection}

D\&O sheets were implemented as a method of recording daily MSD activities nationwide; MSD used the logged data to track the number and types of PPE procured and donated, types of facilities donated to, and regions receiving donations. Numbers of volunteers and RCs were tracked through spreadsheets linked to the MSD Google Forms used for interested persons to sign up. Monetary donations received and allocated to different states were tracked in separate spreadsheets. Data collected from March 17, 2020, through June 20, 2020, were manually calculated using spreadsheets. One item of PPE was defined as an individual mask, face or body protection, or disinfecting agent.
Each location receiving donations was categorized by facility type. Hospitals were further categorized by size: small (1–124 beds), medium (125–249 beds), or large (250+ beds).¹²

**Data Reporting**

A comprehensive regional breakdown of RCs/volunteers, numbers of donations, and types of facilities donated to can be found in Table 1. As of June 20, 2020, there were 202 active RCs in 45 states and the District of Columbia and 1,514 volunteers in 46 states and the District of Columbia. Of the volunteers, 44.6% were undergraduate students, many indicating premedical interest, 33.8% were MD or DO students, and 21.6% held other jobs, including research assistants, lawyers, and artists. Of note, 39.6% of total donations went to nonmedical facilities, such as long-term care facilities, homeless shelters, public health departments, and others in need of supplies (Table 1). The exponential rise in volunteers working with the organization can be seen in Figure 2. The cumulative PPE collected and donated through MSD volunteers reached 847,448 items by June 20, 2020 (Figure 2). MSD raised a total of $31,272.36 before paying fees to payment platforms. Monetary donations came from various states, with the most individual monetary donations coming from Maryland, New York, California, and Illinois. The largest donation received was $5,192.42, with an average donation of $144.80. MSD used the monetary donations to buy supplies (79.5%), ship supplies nationally (19.5%), reimburse gas mileage and truck rentals to transport supplies (0.8%), and cover administrative costs (0.2%).

MSD gained both local and national media attention, with over 45 interviews conducted (Chart 2). Formats of media interviews included video (14), online articles/features (24), and radio/podcast interviews (7). Media coverage of the organization helped boost MSD’s mission and allowed for increased volunteer recruitment and solicitation of donations.
MSD established 21 partnerships with different organizations and companies (Chart 1). Through these collaborations, MSD performed more strategic needs assessments, gained greater purchasing power, maintained a steady stream of incoming supplies, and better reached areas of need. Four sister organizations began with MSD’s help, but soon thereafter became independent entities, 2 internationally and 2 within the United States. Six PPE donation organizations helped prevent supply from being duplicated in regions. Five affiliate distribution organizations produced or collected PPE that MSD volunteers then distributed on the groups’ behalf.

Seeing MSD’s work in the United States, a group of medical students and clinicians from the United Kingdom (UK) and Scotland reached out to the executive board for assistance in establishing MSD branches of their own. The UK branch has since recruited 228 volunteers and donated 237,000 items of PPE.

Concluding Observations

MSD’s mission is to collect and donate PPE to those in need, whether on the front lines or in underserved facilities and communities. Within 3 months, MSD achieved these goals through its ability to procure PPE to donate to such populations. In reflecting on the creation of MSD and the scope to which this organization has grown, there are 3 key factors that enhanced its success: adaptability, teamwork, and the compassion of students and community members to help in a time of need.

The landscape of COVID-19 changed daily and MSD exponentially grew in a short timeframe, requiring a continually evolving system. Leading an organization founded by medical students, the executive board was in the unique position of understanding the basics of the health care system while having the flexibility to meet regularly and change protocols as needed. MSD gained momentum by responding to and leading the social media discussions surrounding PPE.
and the importance of controlling the spread of COVID-19.

It was integral to MSD’s structure to acquire and maintain a network of individuals who could help navigate this novel terrain. On an internal scale, the team did its best to maintain open communication and encourage frequent updates from volunteers. By bringing these individuals together for national meetings each Sunday, individuals shared innovative ideas lending to an overall collaborative discussion of the work. Externally, MSD sought out legal counsel, media partnerships, physician advisors, and business contacts. It built relationships with health care and medical supply chain entities in order to accomplish its work. The partnerships formed and the open communication established with similar organizations seeking to acquire and help distribute PPE was an important aspect contributing to MSD’s success.

Finally, the united compassion of generous individuals enabled MSD to achieve its mission. These individuals were moved by the needs of a nation and graciously donated their time and resources. Volunteers quickly expanded from the direct community of friends, family members, and colleagues to a diverse range of individuals across the nation who sought a common purpose. Donors ranged from university research laboratories to private physician practices, art galleries, dental offices, construction facilities, and law offices.

**Challenges**

Throughout the evolution of MSD, there were several challenges pushing it to restrategize its model to meet the needs of its mission. First, there was an increasing trend of health systems enforcing gag orders on frontline workers, which prevented them from speaking out regarding lack of PPE and COVID-19 caseloads. To navigate around this challenge, MSD ensured that all supply requests submitted through the website were anonymized and confidential, to protect health care workers’ identities. This established a relationship of trust between MSD and
frontline workers, allowing them to request supplies in a safe environment.

Another challenge was the changing face of the pandemic with regard to number of cases, number of requests, phased re-openings, and reaching marginalized communities and areas beyond MSD’s social media outreach. To meet these needs, MSD frequently performed needs assessments on the local and national level to understand and respond to the PPE climate. The changing conversation surrounding PPE and a decline in volunteers due to students returning to classes posed another challenge. As months pass during this pandemic, the nation experiences “COVID fatigue,” resulting in a less robust call to action in terms of donations and volunteer sign-ups. Further, many facilities have increased purchases and replenished their supply of PPE.

In order to return to clinical rotations and classes in a predominantly student-run organization, an election process was set up to allow for leadership turnover. To address the decline in donations, MSD increased fundraising strategies and formed longer-lasting partnerships with large companies. This allowed for greater purchasing power to supplement PPE donations to MSD.

Due to fewer active volunteers and donations over time, MSD has decreased outreach and refocused on fundraising for the populations still requesting supplies.

**Medical education**

The pandemic has affected the medical education status quo, challenging medical students to learn new skills to help their communities. MSD took this opportunity to devise strategies to address health disparities by gaining an understanding of the logistics associated with supply chains and health care administration through its grassroots efforts. This is not the didactic learning that traditionally schooled students would have been taught, but it was a true case of experiential learning borne out of necessity and a desire to contribute during an unprecedented time. The lessons learned are invaluable. As future physicians, medical students have the
responsibility to advocate for those with fewer resources. The MSD team has learned to speak up and act when people are in need, and will continue doing so for its future patients.

**Future recommendations**

The MSD team saw how the lack of an adequate national response, organization, and coordination surrounding PPE played out in real time. MSD responded rapidly to the unexpected national shortage of PPE; other groups can use a similar response model in cases of future crises. A framework to follow includes the vested interest of the population resulting in rapid gathering of a large volunteer base; tiered leadership to manage large regions; and daily and weekly communications on a national scale to allow collective work to meet the goals of the organization. Organizations such as MSD should be established when the status quo is disrupted. Normally, facilities know their supply needs. When crises arise that were not proactively planned for, groups such as MSD can help supplement these deficits.

The Strategic National Stockpile of medical equipment has helped the United States recover from pandemics and natural disasters, but it was severely taxed and never fully replenished after the 2009 H1N1 influenza pandemic.\(^{17}\) As America recovers from the COVID-19 pandemic, the medical community should push for legislation to allocate funding to replenish the stockpile and assure public health readiness for the next pandemic.

When COVID-19 cases decrease and the medical supply chain slowly catches up, it is anticipated that MSD will continue to function and serve those in need of supplies. The team looks ahead to its future and its unique network of medical students and volunteers who are connected nationwide in an effort to address public health needs.
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Figure Legends

Figure 1
Leadership organization and hierarchy of MSD and the subsequent workflow of PPE donation, collection, and distribution that was in place from March 17, 2020, to June 20, 2020. Leadership starts with the National Executive Board, directed by the 5 founding student members divided into 5 roles: 2 national logistic coordinators, a secretary, a treasurer, and a communication, outreach, and media relations coordinator. This board jointly directed the initiatives in different regions of the country through the direction of RCs positions.

Abbreviations: MSD, Medical Supply Drive; PPE, personal protective equipment; RC, regional coordinator; D&O, donation and outreach.

Figure 2
Timeline and growth of MSD in numbers of volunteers and items of PPE donated from March 17, 2020, through June 20, 2020. The solid line and right axis represent the number of volunteers based on sign-up information. The dotted line and left axis represent the total number of items of PPE donated by MSD nationally based on data collected nationally by RCs and the Executive Board.

Abbreviations: MSD, Medical Supply Drive; PPE, personal protective equipment; RC, regional coordinator; D&O, donation and outreach.
Table 1

Breakdown of Regional Data\(^a\) Regarding PPE Donations, Monetary Donations, Numbers of Volunteers and RCs, and Types of Facilities Donated to, From March 2020 Through June 2020, Using Nationally Collected Data by Medical Supply Drive

<table>
<thead>
<tr>
<th>Donation parameter</th>
<th>Mid-Atlantic</th>
<th>Midwest</th>
<th>Northeast</th>
<th>South</th>
<th>West</th>
<th>Native American Reservation Land</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of PPE items donated</td>
<td>200,761</td>
<td>82,799</td>
<td>276,841</td>
<td>121,337</td>
<td>151,271</td>
<td>14,439</td>
<td>847,448</td>
</tr>
<tr>
<td>Total monetary donations(^b)</td>
<td>$14,907.07</td>
<td>$3,810.36</td>
<td>$7,304.68</td>
<td>$2,149.79</td>
<td>$2,285.46</td>
<td>n/a</td>
<td>$31,272.36(^c)</td>
</tr>
<tr>
<td>Total volunteers</td>
<td>274</td>
<td>406</td>
<td>237</td>
<td>309</td>
<td>288</td>
<td>n/a</td>
<td>1514</td>
</tr>
<tr>
<td>Total RCs</td>
<td>23</td>
<td>54</td>
<td>29</td>
<td>52</td>
<td>44</td>
<td>n/a</td>
<td>202</td>
</tr>
<tr>
<td>Total number of deliveries</td>
<td>227</td>
<td>172</td>
<td>347</td>
<td>133</td>
<td>110</td>
<td>12</td>
<td>1,001</td>
</tr>
<tr>
<td>Total hospital deliveries</td>
<td>82</td>
<td>47</td>
<td>137</td>
<td>62</td>
<td>90</td>
<td>5</td>
<td>423</td>
</tr>
<tr>
<td>Small</td>
<td>1</td>
<td>5</td>
<td>7</td>
<td>14</td>
<td>4</td>
<td>5</td>
<td>36</td>
</tr>
<tr>
<td>Medium</td>
<td>22</td>
<td>8</td>
<td>15</td>
<td>6</td>
<td>17</td>
<td>0</td>
<td>68</td>
</tr>
<tr>
<td>Large</td>
<td>57</td>
<td>34</td>
<td>115</td>
<td>42</td>
<td>69</td>
<td>0</td>
<td>317</td>
</tr>
<tr>
<td>Total clinic deliveries</td>
<td>52</td>
<td>54</td>
<td>48</td>
<td>17</td>
<td>10</td>
<td>1</td>
<td>182</td>
</tr>
<tr>
<td>Total long-term facility deliveries(^d)</td>
<td>37</td>
<td>41</td>
<td>70</td>
<td>17</td>
<td>8</td>
<td>2</td>
<td>175</td>
</tr>
<tr>
<td>Total homeless shelter deliveries</td>
<td>0</td>
<td>4</td>
<td>19</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>25</td>
</tr>
<tr>
<td>Total Public Health Department deliveries</td>
<td>0</td>
<td>5</td>
<td>0</td>
<td>27</td>
<td>0</td>
<td>0</td>
<td>32</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>----</td>
<td>---</td>
<td>---</td>
<td>----</td>
</tr>
<tr>
<td>Total other deliveries^a</td>
<td>56</td>
<td>21</td>
<td>73</td>
<td>10</td>
<td>0</td>
<td>4</td>
<td>164</td>
</tr>
</tbody>
</table>

Abbreviations: PPE, personal protective equipment; n/a, not applicable; RCs, regional coordinators.

^aStates were categorized into the following regions: Mid-Atlantic: District of Columbia, Maryland, Virginia, West Virginia; Midwest: Colorado, Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, Oklahoma, South Dakota, Wisconsin; Northeast: Connecticut, Delaware, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont; South: Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee and Texas; West: Alaska, Arizona, California, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, Wyoming; Native American Reservation Land: Navajo Nation, Northern Cheyenne, and St. Regis Mohawk.

^bBefore fees.

^cThis total number also includes donations made by individuals who did not list a state.

^dLong-term care facilities included nursing homes, skilled nursing facilities, rehabilitation facilities, and home care facilities.

^eOther deliveries included those facilities not otherwise classified, such as disability programs, social justice groups, children’s homes, animal rescue, post offices, health promotion groups, and more.
Figure 1
Figure 2
# Chart 1

National and International Partnering Organizations of Medical Supply Drive, March 2020 through June 2020

<table>
<thead>
<tr>
<th>Sister organizations</th>
<th>PPE drive organizations</th>
<th>Affiliate distribution organizations</th>
<th>Fundraising organizations</th>
<th>Other organizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama PPE Drive</td>
<td>DonateDE</td>
<td>DonatePPE</td>
<td>AUC Covid Volunteers</td>
<td>Covid Relief Foundation</td>
</tr>
<tr>
<td>UAMS Northwest Affiliates</td>
<td>GetMePPE Chicago</td>
<td>Framebridge</td>
<td>Merch.House</td>
<td>Future MDs vs Covid</td>
</tr>
<tr>
<td>MedSupplyDrive UK</td>
<td>GetUsPPE</td>
<td>MakeMasks2020</td>
<td></td>
<td>National Student Response Network</td>
</tr>
<tr>
<td>MedSupplyDrive Scotland</td>
<td>MasksforDocs</td>
<td>ProjectPPE</td>
<td></td>
<td>Seeding Sovereignty</td>
</tr>
<tr>
<td></td>
<td>Project NM</td>
<td>Until We Do It</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Students4Covid</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Abbreviations: PPE, personal protective equipment; UAMS, University of Arkansas for Medical Sciences; UK, United Kingdom; DE, Delaware; NM, New Mexico; AUC, American University of the Caribbean School of Medicine.
## Chart 2

### National Media Coverage of Medical Supply Drive, March 2020 Through June 2020

<table>
<thead>
<tr>
<th>Video</th>
<th>Online article/features</th>
<th>Podcast/radio</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABC7 WJLA News (D.C.)</td>
<td>The Cabin (Arkansas)</td>
<td>106.9 The Fox (Virginia)</td>
</tr>
<tr>
<td>Broadway World TV (New York)</td>
<td>The California Aggie (California)</td>
<td>iHeartRadio (Delaware)</td>
</tr>
<tr>
<td>CTV News (Toronto, Canada)</td>
<td>The Clinton Foundation (National)</td>
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