



AMERICAN
PSYCHOLOGICAL
ASSOCIATION

SERVICES, INC.

December 18, 2020

The Honorable Rosa DeLauro
Chair
House Appropriations Committee
Washington, DC 20515

The Honorable Kay Granger
Ranking Member
House Appropriations Committee
Washington, DC 20515

The Honorable Carolyn B. Maloney
Chair
House Oversight and Reform Committee
Washington, DC 20515

The Honorable James Comer
Ranking Member
House Oversight & Reform Committee
Washington, DC 20515

Dear Chair DeLauro, Ranking Member Granger, Chair Maloney and Ranking Member Comer:

On behalf of the American Psychological Association (APA)—the leading organization in psychological science, representing more than 121,000 researchers, educators, clinicians, consultants, and students—I would like to express our appreciation for Congressional efforts to address the mental health and socioeconomic impact of the COVID-19 pandemic. In April, we [called](#) on the Trump administration to establish “a public-private partnership to coordinate with state and local public health authorities to collect, disaggregate, and report on data related to COVID-19 to more effectively address this current pandemic and any future outbreaks.” APA recognizes that the ongoing COVID-19 pandemic is a high priority for the 117th Congress and the new administration, and I would like to share some issues that we have uncovered concerning the need to address health disparities in the detection of COVID-19. We ask that the Committee consider holding oversight hearings on state efforts to achieve health equity during the COVID-19 pandemic early in the 117th Congress.

Ambiguities in State Plans to Address COVID-19 Disparities

Federal Requirements for COVID-19 Testing Plans

On April 24, 2020, President Trump signed Congress’ fourth COVID-19 bill, the Paycheck Protection Program and Health Care Enhancement Act ([Pub. L. 116-139](#)). Among other provisions, the law required each state or local government receiving funds from the law to submit a plan that would, among other measures, describe “how the State, locality, territory, tribe, or tribal organization will use its resources for testing, including as it relates to easing any COVID-19 community mitigation policies.” Shortly thereafter, HHS released [guidance and instructions](#), as well as a template reporting form, to assist states and localities with completing their respective testing plans. However, the guidance did not specify a definition for “vulnerable and at-risk

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populations,” instead referring to a broad, non-exclusive list of descriptors such as “racial and ethnic minorities.”

Testing Plan Review and Assessment

APA reviewed each state and local plan to assess the extent to which the plans adequately address vulnerable populations. These plans take a wide array of approaches to interpreting HHS’ guidance, leaving it unclear whether states have a clear strategy for ensuring testing availability in congregate settings and for underserved groups that exist in all states. While plans often referenced a general need to test “vulnerable or at-risk populations,” many plans lacked specific strategies on how they are reaching those groups.

Many of these plans also fail to specify an outreach strategy that considers the unique characteristics of the state’s Black, Hispanic, or other underrepresented communities. For example, the greatest segment of these plans uses broad terms such as “racial,” “ethnic,” and/or “minority” to describe the state’s panoply of underrepresented communities as a single monolithic group. However, less than 27% of these plans describe specific strategies for Black or African-American communities, only 14% for Latino/Latina/Hispanic communities, and less than 4% for Asian-Americans. Approximately 35% of these plans reference “Indian,” “Native,” or “Tribe/Tribal” populations, most frequently in reference to enrolled members of a sovereign tribal nation that exists within the state. Certain minority groups, such as people with disabilities or the LGBTQ community, are all but absent from these plans altogether.

Additionally, to the extent that data is available on minority subgroups, we also recommend that state plans capture the needs of these subgroups, which may pose unique challenges or whose members may reside in different geographic areas. For example, although Asian-Americans may refer to one of 26 different communities in California, there is currently no disaggregation of information on those communities in the state’s plan. A similar issue exists regarding tribal populations, as the California state plan only references a “tribal populations” identifier, although the state’s numerous tribal communities tend to be concentrated in specific geographic regions that are scattered across the state.

Nursing facilities remain a major hotspot for COVID-19 infections and especially for COVID-related deaths. According to data collected before the recent surge in COVID-19 cases, nursing home residents and staff represent only 8% of COVID-19 cases but account for 41% of deaths attributable to COVID-19, a trend that is only exacerbated by persistent delays in patients receiving test results.¹ However, according to our review of these plans, only 7% of states describe a plan to test for COVID-19 among “older” or “elderly” populations, while 9% describe a plan specific to “nursing homes.” Other congregate care settings are also underrepresented in these state plans, as only 32% of these state plans describe strategies for testing residents in “mental,” “behavioral,” or “psychiatric” facilities; even fewer plans describe a strategy for individuals in “opioid” or

¹ Coronavirus Commission for Safety and Quality in Nursing Homes, “Commission Final Report” (September 2020).

“substance use” disorder treatment facilities. Plans in three states (Massachusetts, West Virginia, and Wisconsin) used the term “congregate” as a type of umbrella term to describe a broad array of settings where multiple people live together.

There is no clear strategy to address the needs of additional populations. The absence of a plan to address the needs of incarcerated individuals and staff in jails and prisons is also a notable omission from many state plans. Prison populations—including individuals who have been convicted of a crime, defendants awaiting trial, and prison staff—are infected at a rate five times higher and die at significantly higher rates than the overall national rate.² However, a plan for testing in “jails,” “prisons,” or “correctional” facilities only appears in 14% of state plans.

To the extent that the 117th Congress will rely on state officials to describe their plans for COVID-19 testing or vaccine distribution, we ask that any future guidance released by the administration define a clearer standard for these plans that takes into account the above considerations. We would welcome an opportunity to work with the new Congress on its COVID-19 response to ensure that all states are held accountable for identifying and meeting the testing and treatment needs of all their citizens.

Inconsistencies in Testing and Contact Tracing Data

We believe states should be encouraged to monitor and address difficulties in testing availability, accessibility, and affordability for underrepresented and high-risk populations. The success or failure of any public health efforts to combat COVID-19 in an equitable manner depends on the availability of reliable and consistent data concerning the testing and spread of COVID-19. This pandemic continues to exacerbate inequities in American society by widening economic gaps and health disparities amongst racial and ethnic groups. Even with the limited data available, we know that the pandemic has so far disproportionately infected and killed Black, Hispanic, and Native Americans. We urge Congress to encourage states to systemically collect, to the maximum extent practicable, data on race and ethnicity as part of routine COVID-19 testing. We also believe that states should be encouraged to develop clear procedures to routinely report COVID testing rates for statistically significant racial and ethnic minority populations within each state. Without a clear understanding of the ratio of positive tests to total tests administered within these populations, we fear the data may be subject to misinterpretation.

We are also aware that contact tracing data is not systematically collected or reported publicly, which misses an opportunity to obtain and disseminate data identifying the sources of infections. Using last summer’s Sturgis motorcycle rally as an example, as of October 17, 330 cases were linked to the rally. However, many experts believe this drastically understates the actual number of infections, which they estimate to be in the tens of thousands, and that the lack of interstate cooperation on contact tracing undermined any individual state’s efforts to collect this information. Accurate and trustworthy data on infection sources is vital for accurate policymaking and for

² Equal Justice Initiative, “COVID-19’s Impact on People in Prison” (Aug. 21, 2020), available at: <https://eji.org/news/covid-19s-impact-on-people-in-prison/>.

campaigns to change the public's behaviors. We encourage the incentivization of interstate cooperation on data sharing and it should be included in future state plan guidance and revisions.

We look forward to joining you in the Committee's COVID-19 oversight efforts. For additional information about APA's ongoing work on health equity and the mental health impact of COVID-19, please feel free to reach out to Leo Rennie, Senior Director of Congressional and Federal Relations, at lrennie@apa.org or Andrew Strickland, Legislative and Regulatory Officer, at astrickland@apa.org.

Sincerely,

A handwritten signature in black ink, appearing to read 'Arthur C. Evans, Jr.', with a long horizontal flourish extending to the right.

Arthur C. Evans, Jr., PhD
Chief Executive Officer