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**Written Testimony of the
American Psychological Association
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**Submitted to the
Subcommittee on Health of the
Committee on Energy and Commerce
HEARING: ON ROAD TO RECOVERY: RAMPING UP COVID-19 VACCINES,
TESTING, AND MEDICAL SUPPLY CHAIN
Wednesday, February 3, 2021 - 11:00am**

The American Psychological Association (APA) is the leading scientific and professional organization representing psychology in the United States, with over 121,000 researchers, educators, clinicians, consultants, and students. APA's mission is to make a positive impact on critical societal issues through the application of psychological science and practice. APA applauds the Sub-committee for examining the nation's evolving response to COVID-19. As of February 2nd, there are over 26 million COVID-19 cases and over 440,000 deaths attributable to COVID-19.

LEGISLATIVE PRIORITIES IN THE 117TH CONGRESS

APA recommends that the Subcommittee do all that is within its jurisdiction to support the following congressional actions:

- Enact the \$1.9 trillion COVID Relief Plan proposed by the Biden administration, which includes \$4.5 billion for mental and behavioral health care.
- Support robust investments in national recovery efforts and sound public health measures through FY 2022 appropriations.
- Enact legislation to address the racial and ethnic disparities in access to mental health care exacerbated by the COVID-19 public health emergency.
- Enact legislation allowing Medicare to continue to pay for a broad range of mental and behavioral health services furnished through audio-only telephone after the public health emergency ends.
- Enact legislation requiring Employee Retirement Income Security Act (ERISA) health plans to cover tele-mental health, at parity, and through multiple access modalities to ensure equitable access to essential mental and behavioral health care.
- Ensure that the functions of the [National Vaccine Program Office](#) at the Centers for Disease Control and Prevention (CDC) are restored and elevated to include acceleration

and coordination of [genetic sequencing](#) of SARS-CoV-2 variants across the United States.

- Promote wide availability, usability, and use of [FDA approved at-home SARS-CoV-2 test kits](#) to ensure that those without access to technology are not disenfranchised from participation in data-reporting systems.
- Ensure that [FDA device approval](#) requires inclusion of representative Black, Indigenous, and People of Color (BIPOC) populations and eliminates bias in device evaluation so that potentially life-saving devices, such as [pulse oximeters](#), can accurately detect oxygen saturation levels through skin at all levels of pigmentation.
- Enact legislation protecting pregnant women, especially Black women and other women of color, during the pandemic by promoting vaccinations in a culturally competent way and providing funding to support maternal health.
- Consider federal programs to incentivize vaccination following the leadership of [programs initiated by private industry](#).
- Call for the inclusion of behavioral scientists, including those with knowledge and expertise in psychological science, on federal agency panels and task forces advising on COVID-19 response.
- Incentivize robust investment in rapid research examining disparities among BIPOC populations, including disparities in infections and deaths, adoption of attitudes regarding safety precautions, vaccine acceptance, and clinical trials participation.

THE PATHWAY TO RECOVERY

We ask the Subcommittee to consider the following key points in fulfilling its oversight role, and to direct the Department of Health and Human Services (HHS) and its counterparts among the states to implement policies accordingly.

Equity

Data show diverse racial and ethnic groups are being disproportionately affected by COVID-19. Inequities in the social determinants of health affecting these groups are interrelated and influence a wide range of health and quality-of-life outcomes and risks. The pandemic highlighted long-standing systemic health and social inequities that put many racial and ethnic minorities at increased risk of contracting the coronavirus and of becoming ill and dying from COVID-19.ⁱ While it is true that underlying comorbidities contribute to disparities in COVID-19 diagnoses and worse outcomes among racial and ethnic minorities, this analysis overlooks the root causes of the health gap: historic and contemporary racism and discrimination.ⁱⁱ¹ Social and economic inequality, discrimination, stigma, and marginalization are at the root of the differences we see among racial and ethnic minorities. Research documents that even when these groups can access care, a variety of factors – including providers’ implicit biases and the inequitable distribution of health care resources – contribute to a lower overall quality of care and worse outcomes for these groups relative to white patients.^{iii,iv} These factors, combined with

higher risks for chronic health conditions, put racial and ethnic minorities at greater risk. The Subcommittee and HHS should work together to mitigate these observed inequities, engaging hard-hit groups while doing so. Psychological research demonstrates that communities that work together to address the needs of all members can flatten the curve faster than those fraught with division and distrust.^v

Vaccines

APA believes that building a community of trust is necessary for successful vaccine engagement. The COVID-19 pandemic has magnified long embedded racial, ethnic, and socioeconomic inequities across the public health sector. Community leaders, grassroots activists, and health care providers need to be able to recognize barriers to vaccination acceptance, while at the same time maintaining respect for the factors underlying these barriers. Out of such understanding, it is hoped that culturally competent interventions and deployment strategies will promote positive individual health choices and civic responsibility.

Psychological science indicates that vaccine acceptance is an outcome behavior that can be influenced by a wide array of factors.^{vi} Mistrust concerning vaccines has become directed at public health systems, the media, and pharmaceutical companies. This mistrust derives in large part from prior histories of unethical practices by public health systems directed at BIPOC; religious traditions that prohibit routine vaccinations across the life cycle, vocal interest groups and movements known as anti-vaxxers, and the politicization of vaccine development in the past election cycle by both parties. These barriers contribute to vaccination hesitancy characterized by a delay in acceptance or refusal of vaccines despite availability.

Yet, we are guided by previous research on vaccine acceptance in society. The CDC concluded that only 47% of adults in the U.S. between July 2018 and May 2019 participated in flu immunization^{vii}. Social norms can also influence vaccine acceptance behaviors. In a study focused on flu vaccination among adults, decisions to vaccinate were influenced by their social circles' actions and the consequences of the flu without immunization.^{viii} Unfortunately, persistent gaps and racial disparities still exist in vaccine uptake. Preliminary CDC data shows Black and Latinx people are getting vaccinated at much lower rates than white people, despite being disproportionately impacted.^{ix} Research has demonstrated that trust building borne of effective and respectful communication can influence communities and individuals to participate in immunization. APA, through the attached "Building Vaccine Confidence Through Community Engagement" document, has developed information that can be used to facilitate transparent and thoughtful conversations between community leaders and individuals to foster informed decisions about vaccine behaviors.

APA would also like to highlight the recently released report by the National Institutes of Health (NIH) [Behavioral and Social Sciences Research Coordinating Committee](#). The [report](#) "COVID-19 Vaccination Communication: Applying Behavioral and Social Science to Address Vaccine Hesitancy and Foster Vaccine Confidence," was developed in consultation with leading experts in social and behavioral sciences and public health. This important contribution to the discussion outlines evidence-informed communication strategies designed to support COVID-19 distribution. The report's recommendations provide useful information to public health officials,

policymakers, and the public in responding to the unique challenges the U.S. currently faces in responding to the COVID-19 pandemic. We are including it as an attachment to this testimony [along with APA’s Council of Representatives’ statement on [*Psychology’s Understanding of the Challenges Related to the COVID-19 Global Pandemic in the United States*](#)]. Further, novel collaborations between science agencies and the National Academies of Science, Engineering, and Medicine should be encouraged and expanded. The [*Societal Experts Action Network*](#) (SEAN) has provided essential rapid consultation to provide real-time advice on pandemic-related issues informed by the social, behavioral, and economic sciences. A permanent program like SEAN could have broad impact beyond this pandemic by applying behavioral and social science to a wide range of societal problems as did the [*Social and Behavioral Science Team*](#) in the Obama administration.

Ultimately, there remain several obstacles to an effective and equitable vaccine engagement and deployment apparatus in the U.S. The authoritative national vaccine distribution platform is underperforming. The Vaccine Administration Management System (VAMS) is supported by the CDC but has been plagued by a multitude of problems and abandoned for alternatives by most states.^x An effective national distribution dashboard should contain up-to-date evidence on vaccine distribution, efficacy, and safety in addition to issues involving racial, ethnic, and socioeconomic status. Psychological science can be useful in the design of a vaccine distribution platform, helping to ensure usability and characterizing performance in decision-related terms. The vaccine distribution system is also severely flawed. Greater resources were needed at the outset of this effort, and insufficient federal funding has led to an outsourcing of distribution. Unfortunately, this may contribute to access issues with communities most in need unable to receive the vaccines meant for them. Vaccine hesitancy further compounds information deficits, vaccine scheduling issues, and transportation barriers that shrink the number of available individuals. Comprehensive reviews of the psychological literature reveal that successful vaccination campaigns involve understanding how people think and feel about vaccination, the multitude of social processes leading to vaccination, and optimizing approaches to changing vaccination behavior directly.^{xi} Promotional materials, informed by psychological science and empirical evidence, can mitigate these obstacles and increase vaccine uptake during this crucial period. There is limited data about the extent of viral shedding following vaccination, so science-based health promotion programs should be instituted to [*guide post-vaccination behavior*](#) to mitigate community spread of SARS-CoV-2, and research programs should be instituted to better understand it.

Testing and Contact Tracing

While APA applauds the efforts among states to distribute vaccines in a prompt and reasoned manner, at the same time we hope that this Subcommittee will seek transparency from states on their plans to distribute vaccines in an equitable manner. With the assistance of APA’s “Equity Flattens the Curve” network, APA staff analyzed the state COVID-19 testing plans required under the Paycheck Protection Program and Health Care Enhancement Act. Overall, APA’s analysis found that many of these plans rely on overly broad categories of these communities, such as “racial,” “ethnic,” and/or “minority” rather than specifying an outreach strategy that

considers the unique characteristics of the state’s Black, Latino/a/x, or other underrepresented communities. Additionally, although a significant portion of the deaths attributable to COVID-19 derive from congregate settings, many of these plans failed to identify a testing strategy for them. For example, while prison populations—including individuals who have been convicted of a crime, defendants awaiting trial, and prison staff—are infected at a five times higher rate and die at a significantly higher rate than the overall national rate, a plan for testing in “jails,” “prisons,” or “correctional” facilities only appears in 14% of state plans. These deficiencies call into serious question whether states have a strategy to address the vaccination needs of these communities and calls into question the role of Congress to ensure state plans uniformly address these inequities.

APA’s findings, summarized in the [letter](#) circulated to the bipartisan leadership of the House Oversight and Appropriations Committees, also found certain inconsistencies in the systematic collection and reporting of data concerning the spread of COVID-19. Further, the CDC reports that only 20 states include race and ethnicity data on their vaccine dashboards, even though people of color make up a large segment of the health care workforce and the long-term care workforce whom many states identify as priority populations for vaccination.^{xii} We also understand 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 in South Dakota as an example, as of October 17th, 2020, 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.

APA thanks the Subcommittee for taking its recommendations into consideration. For more information, please contact Katherine B. McGuire, Chief Advocacy Officer at (kmcguire@apa.org).

ⁱCenters for Disease Control and Prevention. (04, July 2020). Health Equity Considerations and Racial and Ethnic Minority Groups. <https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/race-ethnicity.html#fn1>

ⁱⁱ Smedley BD. (2019). Multilevel interventions to undo the health consequences of racism: The need for comprehensive approaches. *Cultural Diversity and Ethnic Minority Psychology*, 25(1), 123-125.

ⁱⁱⁱ Williams, D. R., & Mohammed, S. A. (2013). Racism and health I: Pathways and scientific evidence. *American Behavioral Scientist*, 57, 1152-1173.

^{iv} Institute of Medicine. (2003). *Unequal Treatment: Confronting Racial and Ethnic Healthcare Disparities*. Smedley B.D., Stith, A.S., & Nelson, A.R. (Eds.). Washington, DC: National Academies Press.

^v Miller PK, and Weller BE. (2019). Uncovering profiles of economic, social, and cultural capital to explore depression across racial groups. *Journal of Racial and Ethnic Health Disparities*, 6(6), 1167–1181. <https://doi.org/10.1007/s40615-019-00618-4>

^{vi} Hornsey, M. J., & Fielding, K. S. (2017). Attitude roots and Jiu Jitsu persuasion: Understanding and overcoming the motivated rejection of science. *American Psychologist*, 72(5), 459–473. <https://doi-org.libdata.lib.ua.edu/10.1037/a0040437>

^{vii} cdc.gov/flu/fluview/coverage-1819estimates.htm

^{viii} *Ibid.*

^{ix} <https://khn.org/news/article/black-americans-are-getting-vaccinated-at-lower-rates-than-white-americans/>

^x <https://www.technologyreview.com/2021/01/30/1017086/cdc-44-million-vaccine-data-vams-problems/>

^{xi} Brewer, N. T., Chapman, G. B., Rothman, A. J., Leask, J., & Kempe, A. (2017). Increasing vaccination: putting psychological science into action. *Psychological Science in the Public Interest*, 18(3), 149-207

^{xii} Painter EM, Ussery EN, Patel A, et al. Demographic Characteristics of Persons Vaccinated During the First Month of the COVID-19 Vaccination Program — United States, December 14, 2020–January 14, 2021. *MMWR Morb Mortal Wkly Rep*. ePub: 1 February 2021. DOI: <http://dx.doi.org/10.15585/mmwr.mm7005e1external icon>