April 14, 2020

The Honorable Donald J. Trump, President
The White House
1600 Pennsylvania Avenue, NW
Washington, DC 20500

Dear Mr. President:

On behalf of the 121,000 members and affiliates of the American Psychological Association (APA), I write to urgently request that you direct the Department of Health and Human Services (HHS) to immediately establish within the Centers for Disease Control and Prevention (CDC) 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.

Psychology has contributed much to our understanding of public health interventions necessary during pandemics. Behavioral science offers key insights into means of viral transmission, strategies to keep individuals and communities safe, and understanding the needs of populations that are at higher risk for exposure, given their specific needs and circumstances. Psychology also helps shed light on the role of bias, stigma, and discrimination as factors that may exacerbate viral spread. None of these insights, however, would be possible without comprehensive surveillance and reporting of public health data.[1]

Consequently, establishing the public-private partnership is a critical public health priority. Specifically, the partnership would provide urgent information on the impact of COVID-19 on key populations and their characteristics, including socioeconomic status, race, ethnicity, gender, sexual orientation, gender identity, ability status, English language proficiency, nativity, and religious beliefs. Importantly, this data would be integrated and cross-tabulated with existing federally-required data sets.

You have demonstrated leadership in launching the COVID-19 Open Research Dataset, known as CORD-19, to engage scientists around the world to apply artificial intelligence to quickly explore prevention and treatment for the virus. This proposed public-private partnership would also employ machine learning techniques to this government-wide collection of data sets to provide insights to inform the numerous challenging decisions facing our country. This partnership would contribute to reducing the spread of COVID-19 and the underlying causes for negative health outcomes. Special attention should, of course, be paid to protecting privacy, including health records and other personally identifiable information, security breaches, and creating robust protocols for the sharing of information across federal agencies.

States and local jurisdictions have reported higher rates and infections among certain groups, such as racial and ethnic minorities. For example, according to the Louisiana Department of Health, African

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Americans make up 32 percent of the population, but 70 percent of its COVID-19 related deaths.[4] And in Chicago, the Department of Public Health has reported that black Americans account for 68 percent of the city's 118 deaths and 52 percent of the roughly 5,000 confirmed coronavirus cases, despite making up just 30 percent of the city's population.[5] Finally, even CDC's own Morbidity and Mortality Weekly Report for March 1-30, 2020, has found disparities and recognizes the need for additional data by stating that:

> *…in the COVID-NET catchment population, approximately 59% of residents are white, 18% are black, and 14% are Hispanic; however, among 580 hospitalized COVID-19 patients with race/ethnicity data, approximately 45% were white, 33% were black, and 8% were Hispanic, suggesting that black populations might be disproportionately affected by COVID-19. These findings, including the potential impact of both sex and race on COVID-19-associated hospitalization rates, need to be confirmed with additional data.*[6]

Given these stark disparities, health equity (i.e., ensuring that everyone has a fair and just opportunity to be as healthy as possible) should be a high priority in our efforts to address the current pandemic. Research has documented that even when stigmatized 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 poorer outcomes for these groups relative to white patients.[2,3] These health care disparities, combined with higher risks for chronic health conditions, tend to make African Americans and other groups that experience health disparities more vulnerable to COVID-19 and other diseases. Furthermore, Anthony S. Fauci, M.D., Director of the National Institute of Allergy and Infectious Diseases at the National Institutes of Health, recently stated that the coronavirus outbreak's disproportionate death toll among black Americans is reminiscent of the outsized impact of HIV/AIDS on the LGBTQ community. And fortunately, federal investments in CDC's HIV/AIDS surveillance program provided the data scientists and policy makers urgently needed data to first observe and then respond to serious racial and ethnic disparities that have characterized the U.S. HIV epidemic. Using surveillance data to target resources to the hardest hit counties is the cornerstone of your Ending the HIV Epidemic Initiative and the same theory applies to COVID-19. The creation of the partnership would bring together all the socio-economic data collected across government and make it available for analysis in combination with the data collected through the COVID-19 national surveillance program.

Just as our government invests in real-time, continuous monitoring systems to combat cyberterrorism, so should it invest in real-time, continuous monitoring to bolster and protect Americans against health disparities that overtly expose them to public health crises, such as the COVID-19 pandemic. Consistent data collection, including cross-agency data-sharing, analysis, and reporting are an essential public health function that is currently falling short. APA strongly supports robust data collection efforts[7] as they provide researchers and policymakers with rich information that can help us better understand and address the causes of the disproportionate impact of diseases, such as COVID-19, on African Americans and other populations. Therefore, we recommend that CDC provide states and local jurisdictions with supplemental funding to build capacity and improve compliance with CDC principles for data collection in their public health surveillance systems to collect and report COVID-19 specifically as it relates to testing, positive tests, hospitalizations, treatments, morbidity, and mortality by factors such as socioeconomic status, race, ethnicity, gender, sexual orientation, gender identity, ability status, English language proficiency, nativity, and religious beliefs. Components of this effort should also incorporate specific recommendations from the recently published *COVID-19 SURVEILLANCE SYSTEM: ACHIEVING CONTAINMENT* by Duke University's Center for Health Policy.[8]

Collecting this information, in a standard format, will allow for identifying and gaining a clearer understanding of the unique circumstances resulting in why certain populations are affected by COVID-19 more than others, and ultimately facilitate the prevention of the disease and resultant deaths. We are confident that CDC has the capacity to collect this crucial data with the assistance of other HHS agencies, such as the Office of the Assistant Secretary for Preparedness and Response, Centers for Medicare and Medicaid Services, and the Agency for Healthcare Research and Quality, to name a few.

We look forward to working with you to pull together a community of interested stakeholders to establish this new public-private partnership. Putting this crucial data in the hands of scientists and researchers will create an information-rich environment that could result in more accurate ability to predict and identify at-risk communities and populations and provide targeted support before they become COVID-19 hotspots. If APA can be of any further assistance, please contact me at aevans@apa.org or 202-336-6080.

Sincerely,

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

CC: Michael Pence, Vice President
    Alex Azar II, Secretary, U.S. Department of Health and Human Services

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