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Inequitable Care Delivery Toward COVID-19 Positive People of Color and People with Disabilities

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BACKGROUND

It is well-documented that Black, Indigenous, and People of Color (BIPOC) as well as people with disabilities experience discrimination and bias in the health care they receive that contribute to inequities in health outcomes in these populations.[1,2] The COVID-19 pandemic further exposed these inequities. Few studies have examined how bias among providers may be negatively affecting treatment decisions or quality of care related to COVID-19. This study examined frontline providers' observations of inequitable care delivery towards COVID-19 positive patients who are BIPOC and/or have disabilities and health workforce related drivers and facilitators contributing to and compounding inequitable care.

METHODS

We conducted semi-structured interviews between April and November 2021 with 19 frontline healthcare providers (physicians, nurses, nurse practitioners, and rehabilitation professionals) from Washington, Florida, Illinois, and New York. These four states were selected to represent regional diversity as well as varying state COVID-19 management and policies. Interviews included questions regarding equity in applying crisis standards of care protocols towards COVID-19 patients who are BIPOC and/or have disabilities, equity in treatments among those patients, and perceptions around stigma related to COVID-19. Major themes were developed using thematic analysis.

KEY FINDINGS

The key findings of this study are:

- Most participants reported observations of inequitable care in the form of *decreased care, delayed care, and different options for care*.
  - o *Decreased care* manifested in:
    - *Less explanation of care* related to lack of communication accommodations for patients with limited English proficiency (LEP), deaf patients, and patients with cognitive impairments.
    - *Less interaction* evident by a provider phoning into the room or avoiding the patient all together due to fear of contracting COVID.
    - *Limitations accessing telehealth services* for follow-up care among those with LEP and disabilities.
  - o *Delayed care*, particularly when additional services were needed. Participants reported delays entering the room if interpretation was required or delays in ancillary services for patients who require more time (such as physical or occupational therapy). Participants shared how such delays in care contributed to patients feeling like "*there's*

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CONCLUSIONS AND POLICY IMPLICATIONS

Findings suggest that BIPOC patients and patients with disabilities may be experiencing lower quality of healthcare related to COVID-19 in forms of decreased care, delayed care, and fewer options of care. This inequitable treatment was often driven by factors unique to and/or exacerbated by the pandemic, including providers' bias such as ableism, ageism, and racism, organizational policies (e.g., visitor restrictions), lack of work setting resources, an overwhelmed medical environment and provider burnout. The provider perspective provides further insight regarding the nature of side-conversations, inadequate care, and fewer care options.

Preventive multi-level interventions in crisis planning and care are needed and may include integrating enhanced provider training and policies around bias and discrimination as well as supportive services and systems. Changes at the organizational level could include using resource allocation protocols that are equitably designed (e.g., remove age as a consideration, avoid assigning value based on a patient's functional level) and provide less opportunity for bias and subjective judgement (e.g., have treatment protocols in place). Hospitals need to re-examine their current services and resources for providing accommodations and establish a system that is sustainable even when the healthcare system and staff are overwhelmed. Voices of multiple and diverse stakeholders, especially patient advocates representing diverse identities, are critical in the process of developing these trainings and policies. All efforts should be institutionalized so that during crisis situations like the COVID-19 pandemic, inequities are monitored and resolved in real time.

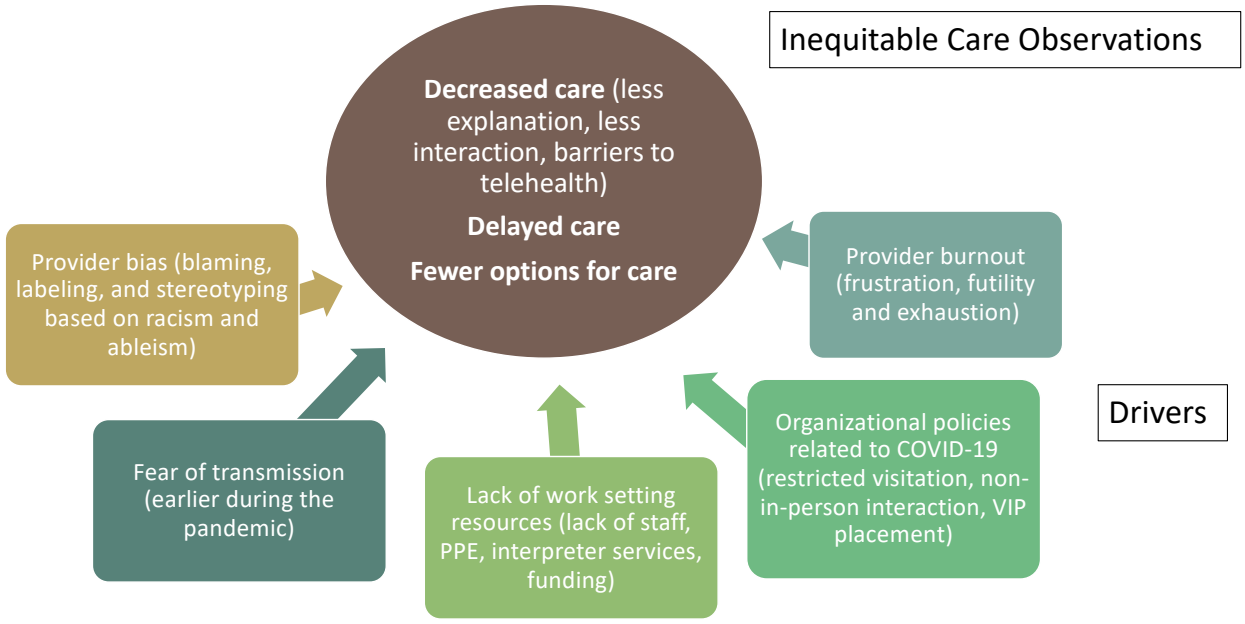
KEY FINDINGS *continued*

nobody taking care of them" and an overall experience with care that was "*less than optimal.*"

o *Different options for care* were observed with "*instances where options were not being presented to people of color.*"

- Within these observations, participants described a number of drivers underlying inequitable care, including *bias connected to racism and ableism, patient mistrust, provider-patient disconnect, organizational policies, lack of work setting resources, and provider burnout* (Fig 1).
- Two participants reported they did not observe inequitable care in their setting.

FIGURE 1 Major themes of the study



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FULL REPORT

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