THE SPREAD OF COVID-19 AMONG BLACKS: HOW DOES IT IMPACT SPEECH-LANGUAGE PATHOLOGISTS (SLPS)?

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— ABSTRACT —

As the COVID-19 pandemic persists and data becomes available, there is an urgent need to identify and address the reasons Black communities are disproportionately impacted by the virus. While comorbidities among Blacks are part of the problem, we argue that focusing solely on this issue ignores the root causes that lead to the high COVID-19 cases and fatality rates among minorities. Our analysis shows that examining the structural determinants of health, such as income, access to healthcare, built environment, and social exclusion, are crucial to understanding why this specific minority group has been affected so severely by COVID-19. The direct impact of COVID-19 on the role of the speech-language pathologist (SLP) in healthcare settings along with the need to focus on lifelong cultural humility is discussed. Specific suggestions on how to educate SLPs on the structural barriers to care among Blacks are provided.

Keywords: speech-language pathology; health inequities; COVID-19; cultural humility.

Introduction

With the outbreak and spread of COVID-19, many speech-language pathologists (SLPs) are on the frontlines working in healthcare settings where they are expected to provide care for patients with COVID-19. SLPs provide assessments and therapeutic services related to speech, language, swallowing, cognition, and dysphagia for clients diagnosed with COVID-19. SLPs encounter difficult work conditions which include limited personal protection equipment (PPE), supporting overburdened staff members, and being placed at risk with potential contact with high viral concentrations during swallowing evaluations (Law, 2020). In addition, SLPs meet the needs of patients and communities as part of interprofessional teams (American Speech-Language Hearing Association [ASHA], 2020).

As the COVID-19 pandemic persists and data becomes available, there is an urgent need to identify and address the reasons Blacks are disproportionately affected. Recent data shows that 24.3% of COVID-19 fatalities are concentrated among Black patients, despite only representing 12.4% of the population (APM Research Lab, 2020). Blacks are dying at twice the population rate expected. Moreover, although Blacks only represent 18% of the population as a whole, 33% of COVID-19 hospitalized patients are Black, raising significant concerns regarding the over-representation of Blacks among COVID-19 cases (National Center for Immunization and Respiratory Diseases [NCIRD], 2020). Blacks have more co-morbidities than Whites which places them at risk for greater rates of complications and fatalities (Hlavinka, 2020). At the same time, data shows that 40% of Blacks have high blood pressure (Heart.org, 2016). Compared to Whites, Blacks experience higher death rates and higher prevalence rates of chronic conditions in the United States (Cunningham et al., 2017).

While this high rate of associated diseases among Blacks has been known for some time now, health disparities have continued for the last 60 years despite efforts to reduce them (Landrin & Coral, 2009). Although the Affordable Care Act (ACA), enacted in 2010, increased the overall number of insured people, it did not guarantee all Americans had the same access, quality and financial means to pay for health care services. The expansion of Medicaid and other provisions of the ACA lowered the uninsured rate to 6% for Blacks and 4% for Whites (The Henry J. Kaiser Family Foundation, 2020), which is not sufficient for greater access and better health outcomes especially among high risk populations. Focusing predominantly on co-morbidities and insurance among Blacks, ignores contributing factors that have led to high rates of COVID-19 within the Black community. It is crucial to address the underlying structural factors resulting in the high number of cases and fatalities nationally. This paper will examine the impact of COVID-19 by first addressing the social determinants of health to curb its impact on Black communities based on healthcare disparities, income/employment, the built environment, and social exclusion. Second, we will discuss the role of the SLP in healthcare settings, the need to practice cultural awareness/humility, and the importance of awareness regarding the provision of health care services for minority communities. Finally, the social determinants of health will be discussed in order to understand why Black communities are disproportionately impacted by COVID-19.

Addressing the social determinants of health to curb COVID-19

The World Health Organization (WHO) defines the social determinants of health as, *"the daily conditions in which people are born, grow, work and live,"* as the root cause of inequities because they are determined by policy choices (WHO, 2008). Although immediate circumstances such as food choices, biological factors, and behavior are easily understood as related to health outcomes; it is structurally embedded or 'upstream' determinants such as public policies, socio-economic position, ethnicity, occupation and income that set into motion pathways towards subpar or optimal health. Understandably, proximal conditions such as health behaviors and health outcomes are easier to study and operationalize through statistical methods and ascribe blame for the high rate of COVID-19 among Blacks than health inequities. This reasoning is faulty. To overcome health inequities the focus should be on the root causes of unequal distribution of resources and injustice.

Healthcare Disparities

There are countless studies demonstrating the significant health disparities that exist within the USA and these inequities start early in life for minority groups. To understand better why Blacks are vulnerable to COVID-19 several healthcare disparities that already exist in these communities must be examined (for a detailed understanding of racial and ethnic health disparities, see Institutes of Medicine, 2003). According to the Centers for Disease Control and Prevention (CDC, 2020) older adults and people of any age with underlying health conditions are at a higher risk for COVID-19. This includes those who have chronic lung disease or moderate to severe asthma, individuals with heart conditions, immunocompromised individuals (included but not limited

to those receiving cancer treatment, smokers, bone marrow or organ transplantation, immune deficiencies, poorly controlled HIV or AIDS, and prolonged use of corticosteroids and other immune weakening conditions), severe obesity (body mass index [BMI] of 40 or higher), diabetes, chronic kidney disease undergoing dialysis, and liver disease.

Well known disparities exist among Blacks in comparison to Whites in terms of health. These health disparities include health behaviors and chronic diseases such as asthma, diabetes, and hypertension. Unfortunately, disease and death are not randomly distributed among the United States population; instead it varies by race and socioeconomic status (SES).

Differences in health care risk behaviors also exist, such as diet and physical activity. It is also recognized that although diet and physical activity vary among races, these disparities in health-risk behaviors contribute to disproportionate rates of obesity. Obesity often leads to further health complications such as diabetes, hypertension, and other diseases. These conditions place Blacks at a higher risk of being susceptible to COVID-19 complicated deaths than other groups.

Income and employment

Income is a key indicator of health disparities. Disease and death are not randomly distributed among the US population. Instead they vary with race and socioeconomic status. Income is also associated with employment. The pandemic is a reminder that minority populations comprise a large part of the essential workers. Risk of infection is usually greater for workers in this industry due to the nature of their work. These workers are required to be at their place of employment despite outbreaks in their communities, and some workers may need to continue working because of their economic circumstances (Center for Disease Control and Prevention, 2020). Recent data shows that minorities provide or represent 57% of cleaning services, 45% of public transit workers, and 40% of healthcare workers (Rho, Braum, & Fremstad, 2020). These jobs entail greater risk for transmission due to the number of people workers must interact with on a daily basis. Further, most of these positions are insecure, without full benefits. Additionally, 44% of Black American adults have reported a pay cut or job loss due to the pandemic, compared to 38% of White Americans (Lopez, Rainie, & Budiman, 2020). Moreover, the generation of wealth and social mobility for Blacks has been encumbered by a long history of discrimination and segregation involving employment, housing, and education (Brown, 2020).

The built environment

Access to housing and quality of living conditions also has a significant impact on health. When affordable housing is available, it is often substandard with poor ventilation and/or other factors that facilitate transmission of illnesses. Even before the COVID-19 crisis, there were multiple reports of severe maintenance issues in subsidized housing with little done to resolve this issue based on reports (Goodman, Baker, & Glanz, 2018). Unsurprisingly, substandard living conditions exacerbate clinical factors. Conditions within households increase the severity of diseases such as asthma (e.g. through allergens in the air), as well as those found in the general environment (e.g. through proximity to factories and highways).

Even more concerning, asthma is frequently associated with the built environment and Blacks have the highest asthma rates in the USA (Asthma & Allergy Foundation of America and the National Pharmaceutical Council, 2005), while also being three times more likely to die from asthma than Whites (Asthma & Americans, n.d). This finding is supported by increasing evidence-linking susceptibility to COVID-19 to exposure to air pollution. For example, according to the Asthma and Allergy Foundation of America and the National Pharmaceutical Council (2005), the highest number of emergency room visits and hospital stays due to asthma are experienced by Blacks both with genetics and the environment increasing asthma risk. In addition, a family history of asthma, increases an individual's risk for developing it. Other environmental pollutants attributed to increased risk for asthma due to allergens in the air, includes but is not limited to, dust mites, pets, tobacco smoke, cockroaches, and mold which is linked to increased susceptibility to COVID-19 following exposure to air pollution (Wu, Sabath, Braun, & Dominici, 2020).

Social exclusion

Marginalization is another factor that has direct effects on health by depriving individuals from critical resources. Other areas of deprivation include labor market discrimination and housing segregation, among other issues. Racism is also associated with poor health outcomes. The added stress of racism discrimination and perceptions of inequality, have psychological effects reducing access to health services (Brown, Yamey, & Wamala, 2014). Lack of access to care only partially explains the disparity in care. Many Blacks avoid accessing health services due to distrust of the health system. This distrust has extensive historical roots (Corbie-Smith, Thomas, & St. George, 2002) and is worsened by lack of representation among health providers. In New York State, the representation of minorities in the health field is dire. A 2008 report analyzed underrepresented minority physicians found that only 8% of physicians were from these groups (Armstrong, Martiano, &

Moore, 2006). Similarly, 11.8% of registered nurses were Black (CHWS.org, 2012).

Systemic discrimination in healthcare is another key contributor to poor health resulting from institutional practices and unconscious bias (Williams & Rucker, 2000). Blair and colleagues (2013) demonstrated that clinicians' implicit bias negatively affects perceptions of care among minority patients, especially Blacks. The same bias is worsened in emergency situations such as COVID-19, when health workers make quick decisions yet have little time to reflect and correct their unconscious biases.

The field of speech-language pathology is an example of a healthcare discipline that lacks diverse representation within the profession. White professionals make up the majority of SLPs in the United States (Ebert, 2013). Only 7.5% of the American Speech-Language-Hearing Association (ASHA) members belong to a racial minority group. As of 2018, the demographic profile of ASHA member and nonmember certificate-holders in speech-language pathology indicates that 92% identify as White. Approximately 8% of ASHA's certificate-holders belong to a racial minority group, which is important to note when thinking about our role within health care settings and impact on care of Blacks.

Role of the SLP in Health Care Settings

SLPs play a direct and critical role within the health care system. In fact, during the pandemic SLPs were considered frontline workers according to Governor Andrew Cuomo of the State of New York. He made the determination that essential workers were those employees whose jobs were involved in the COVID-19 response (Cuomo, 2020). This included patients with swallowing disorders and the scope of practice of SLPs. SLPs within the healthcare systems focus on the diagnosis and treatment of clients that have speech, language, cognitive, and swallowing difficulties. Yet, their roles are poorly understood, particularly in marginalized and minority communities.

COVID-19 has had an unprecedented impact on how SLPs provide service delivery as well as the patients served. As healthcare providers it must be noted that each patient has unique characteristics and medical challenges. Part of the role of SLPs in healthcare is recognizing the communities served and the impact of social determinants on patient health and care. SLPs must be aware of the health disparities that currently exist as well as the impact of income/employment, the built environment, and social exclusion for specific individuals. It is important for SLPs to be aware of these social determinants of health to provide effective care to clients during assessment and treatment. Chung et al. (2016) presents guidelines for clinicians to address social determinants of health through screening and surveillance. The process of screening and surveillance includes asking about the concerns of patients, identifying risk factors and social issues, and referring patients to appropriate organizations and agencies. Schickedanz et al. (2019) conducted a study analyzing clinician attitudes towards screening for social determinants. Although many clinicians recognized the benefits of screening and addressing social determinants, major barriers were time constraints, training, and knowledge of resources. SLPs are equipped with training to integrate the client expertise as part of their decision making process in utilizing evidence-based practice. Knowledge of patient resources will require a SLPs to rely on the expertise of other health professionals on the interprofessional team. Their decisions during patient care requires a clear understanding of patient-centered care and interprofessional practice approaches. Patient-centered care and interprofessional practice approaches should include effective communication with patients and families, understanding individual needs, and goals of care (Centers for Medicaid and Medicare Services [CMS], 2020).

The Importance of Being Aware of Specific Groups

Gaining an understanding of the specific needs and challenges different clients face must be rooted in the cultural awareness and humility of SLPs. Cultural awareness and humility is critically important when working with communities of color and more specifically Blacks. The field of SLP must move away from the commonly used concept of *cultural competence to cultural humility*. The word "competency" implies a training model that results in mastery of a certain topic or skill (Trevalon & Murray-Garcia, 1998). Cultural competency should never be represented as a mastered skill. A shift to cultural humility as a lifelong dedication to the evaluation and critique of self is a more appropriate and accurate term (Tervalon & Murray-Garcia, 1998), and should be the gold standard for working interprofessionally. In this way, cultural humility should be thought of and taught as a transformational skill, as opposed to focused information about various cultures (Foronda, Baptiste, Reinholdt, & Ousman, 2015). Cultural humility skills and characteristics include openness, self-awareness, egoless, supportive interactions, and self-reflection and critique (Foronda, Baptiste, Reinholdt, & Ousman, 2015; Tervalon & Murray-Garcia, 1998).

Offering clinicians a transferable skill with the opportunity to engage with other disciplines will challenge SLPs and other health care providers to find commonality and increase understanding between personal and professional beliefs (Ortega & Coulborn

2011). A solution to finding commonalities may be in exposing SLPs to working with individuals in public health, social sciences, nursing, occupational therapy, and physical therapy to gain a better understanding of various roles on the patient care team

To truly address the needs of Blacks, SLPs may need to confront their own lack of understanding Black culture. Knowing the history and systems that lead to health disparities can provide the correct perspective when providing client care to those on the negative end of the disparity gap. Such a change will necessitate addressing one's own cultural humility and the need to learn more about communities and individuals based on their lived and learned experiences. Increasing individual cultural humility can lead to improved care for our all clients and improve systemic issues within the healthcare system. COVID-19 served as a catalyst to unveil some of the social determinants of health that made Blacks vulnerable to being disproportionately impacted by COVID-19.

Conclusion

The high rate of COVID-19 among Blacks, is unfortunately not surprising and further illustrates the existing inequities in the United States. It is critical that all levels of society address this issue. Within the field of speech-language pathology, cultural awareness and humility as an ongoing part of our training and clinical care is warranted. Providing culturally-sensitive care must occur at the undergraduate level and continue at the graduate level as a part of continuing education throughout a clinician's career. SLPs must become active participants and advocates on interprofessional teams that demand and provide better access to health services by and for Blacks. To advocate, promote, and provide better access to health care, knowledge of issues that put Blacks at high-risk for COVID-19 is requisite. Further, reflecting on and addressing their own cultural awareness and humility on an ongoing basis will reduce unconscious bias and promote excellence in care.

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