



## Perspectives

# When Disparities and Disabilities Collide: Inequities during the COVID-19 Pandemic

Monica Verduzco-Gutierrez, MD , Allan M. Lara, MD, Thiru M. Annaswamy, MD, MA 

Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) and the resultant coronavirus disease 2019 (COVID-19) is currently a global pandemic that is causing morbidity and mortality around the world. When initial reports emerged in early 2020 that people in the United States were testing positive for the virus, physiatrists began to worry about the effects it could have on persons with disabilities, a vulnerable patient population. According to the Centers for Disease Control and Prevention (CDC), 61 million adults in the United States live with a disability.<sup>1</sup> Efforts have been made domestically and globally to highlight the need for a disability inclusive response to the COVID-19 pandemic.<sup>2,3</sup>

## Accentuated Health Disparities during COVID-19

The National Institutes of Health (NIH) defines health disparities as: “Differences in the incidence, prevalence, mortality and burden of disease and other adverse health conditions that exist among specific population groups in the United States.” According to the U.S. Department of Health and Human Services’ Office of Minority Health, Hispanics are uninsured at the highest rate of any racial or ethnic group within the United States.<sup>4</sup> Lack of or loss of health insurance can keep this population from receiving necessary care. And although disparities have been documented for Hispanic patients seeking rehabilitative care, including in a recent narrative review published by Flores et al,<sup>5</sup> little is known about the intersectionality between disability, race, and ethnicity and its effect on the health and health care of affected people.<sup>6</sup> Troubling trends from across the country reveal that minority populations are at higher risk for COVID-19 infections and death, especially in the Native American and African American populations.<sup>7</sup> However, we do not have published data on how COVID-19 is affecting persons with disabilities *who also* belong to

racial and ethnic minority groups. Steere and colleagues recently described the development of a telehealth post-COVID-19 rehabilitation program in New York City and Boston.<sup>8</sup> In their described experience, early in the pandemic, they cared for a high percentage of persons from racial and ethnic minority groups including a 35% Hispanic, 15% Black, and 33% White patient population via telehealth. With the troubling trend of increased risk of infection and mortality in people belonging to minority groups, there is reason to suspect that long-term health and functional outcomes are even more devastating for those with disabilities who come from communities of color.

## Higher Risk of Vulnerable Populations Due to Resource Challenges

In the current resource-challenged climate of COVID-19, which is adversely affecting the ability of health care systems to serve underserved populations, decisions are being made that may not fulfill our goal of health equity. Since the inception of the pandemic surge, critical care crisis triage protocols have worried the disability community. Earlier this year, disability rights advocates urged congress to ensure that there is no “resource allocation discrimination when needs exceed supply.”<sup>9</sup> Another article by Odonkor and colleagues urged physiatrists to provide rehabilitation care to Black survivors of COVID-19 given the disproportionate impact and morbidity in the Black community.<sup>10</sup> It is especially important to protect individuals with disabilities from discrimination at all levels.

## Additional Risks of Care via Telemedicine

Due to social-distancing guidelines to shield our patients from COVID-19, many clinicians transitioned from in-person to telemedicine visits.<sup>11,12</sup> Although

telemedicine is being implemented widely and has provided virtual access to health care for a wide swath of the U.S. population, persons with disabilities and especially those from minority groups may face insurmountable barriers limiting their access to health care. A Pew Research Center survey from the fall of 2016 reported that 23% of disabled Americans did not go online compared with 8% who did not have a disability. It also showed that disabled Americans were less likely to have broadband or tech devices such as computer or smartphone.<sup>13</sup> Even for phone visits, many people of color use prepaid phones that afford limited minutes. In our experience, several of our Hispanic patients have not had access to a secure patient online portal such as MyChart. This is often due to sign-up instructions being in English only and support staff speaking only English. Similarly, there are a growing variety of platforms currently in use for telemedicine including an expansion to familiar apps such as FaceTime, Doximity, or Skype due to a pandemic-related waiver. Despite these familiar applications being used with the hope a patient has telecommunication capability, none of them allow for the easy use of translators. If the clinician does not speak Spanish, then a synchronous telemedicine visit cannot be done.

In addition, there may be physical or cognitive limitations that prevent persons with disabilities from successfully using technological platforms for health visits. Our patients who live in long-term care facilities may not have access to the appropriate equipment for telemedicine visits. For individuals with physical impairments that restrict mobility, physical examination performed via telemedicine is limited without the presence of a caregiver or the use of special equipment or assistive devices to facilitate such assessments that may routinely be available in a clinic or hospital.

The right to receive care in our health care system is a fundamental right that should not be denied due to disability or the color of a person's skin. The limitations of telemedicine platforms to accommodate for persons with disabilities are not entirely new. The Americans with Disabilities Act (ADA)—passed before the Internet—was initially designed to address physical spaces, not virtual.<sup>14</sup> There was one piece of the ADA—Title IV—that required telecommunication companies to ensure functionally equivalent services for those with disabilities. This title focused on those who were deaf, hard of hearing, or had a speech impairment and required the use of a non-voice device or a teletype writer. For the small group of patients with chronic disabilities who previously used telemedicine, accommodations such as a trained caregiver providing manual assistance, individualized assistive technology that provided accessible interface, or special equipment installed in their homes were necessary means by which they could access health care providers. However, during the time of COVID-19, the sudden and immediate emergence of widespread telemedicine use has not accounted for the lack of such accommodations. Although

telemedicine has allowed continued access to health care with few additional costs to most people, while minimizing infection exposure, it has left the population with disabilities without reasonable accommodations or access to health care.

The critical need to urgently and systematically address the infrastructure and access barriers; operational and systems-level challenges; and regulatory, communication, and legislative barriers of persons with disabilities to access health care via telemedicine was outlined in a recent publication.<sup>3</sup> The authors emphasized the importance of addressing these issues not only during the ongoing pandemic, but also emphasized the likelihood that this higher use of telemedicine is sustained post-COVID-19 even as in-person health care visits resume with easing of social restrictions.

To address these disparities for disabled people who have other intersecting identities such as belonging to a historically underrepresented racial or ethnic group, we need significant, long-term changes in technological, regulatory, and legislative infrastructure. More practical, short-term recommendations include providing instructions about telemedicine—both written and verbal—in languages other than English. Another solution is to use translators that may be embedded in certain telemedicine applications. Synchronous visits via telephone may be used as an initial screening tool, and depending on the severity of the health concerns, an in-person visit may be scheduled.

## Conclusions

Even beyond the devastating novel coronavirus pandemic, we need to collect data to better understand the intersection of race and disability. We need to prioritize health equity initiatives that would systematically assess barriers to health care delivered via telemedicine for people belonging to minority groups and those with disabilities. These studies should evaluate infrastructure, regulatory, communication, and legal barriers. With the forced adoption of universal telemedicine during the coronavirus pandemic, this inquiry must happen immediately, to allow timely and appropriate remedial actions to ensure health care access to these disadvantaged populations.

## Acknowledgments

The authors would like to thank Lex Frieden, MA, LL.D. for his contributions to this report.

## References

- Centers for Disease Control and Prevention (CDC). Disability Impacts All of Us; September 9, 2019. <https://www.cdc.gov/ncbddd/disabilityandhealth/infographic-disability-impacts-all.html>. Accessed April 26, 2020.

2. Armitage R, Nellums LB. The COVID-19 response must be disability inclusive. *Lancet Public Health*. 2020;5:e257. [https://doi.org/10.1016/S2468-2667\(20\)30076-1](https://doi.org/10.1016/S2468-2667(20)30076-1).
3. Annaswamy TM, Verduzco-Gutierrez M, Frieden L. Telemedicine barriers and challenges for persons with disabilities: COVID-19 and beyond. *Disabil Health J*. 2020;13(4):100973. <https://doi.org/10.1016/j.dhjo.2020.100973>.
4. US Department of Health and Human Services. Profile: Hispanic/Latino Americans. Office of Minority Health website; August 22, 2019. <https://www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=64>. Accessed April 26, 2020.
5. Flores LE, Verduzco-Gutierrez M, Molinares D, Silver JK. Disparities in health care for Hispanic patients in physical medicine and rehabilitation in the United States: a narrative review. *Am J Phys Med Rehabil*. 2020;99(4):338-347. <https://doi.org/10.1097/PHM.0000000000001342>.
6. Mahmoudi E, Meade MA. Disparities in access to health care among adults with physical disabilities: analysis of a representative national sample for a ten-year period. *Disabil Health J*. 2015;8(2):182-190. <https://doi.org/10.1016/j.dhjo.2014.08.007>.
7. Centers for Disease Control and Prevention. COVID-19 Hospitalization and Death by Race/Ethnicity. <https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html>. Accessed November 16, 2020.
8. Steere HK, Polich G, Silver JK, et al. Ambulatory rehabilitation of patients hospitalized with SARS CoV-2 infections: early pandemic experience in new York City and Boston. *PM R*. 2020. <https://doi.org/10.1002/pmrj.12506>.
9. American Association of People with Disabilities. AAPD letter to Senate majority and minority leaders: COVID-19 response package; March 18, 2020 (<https://www.aapd.com/covid-19-response-package/>).
10. Odonkor CA, Sholas MG, Verduzco-Gutierrez M, Zafonte RD, Silver JK. African American patient disparities in COVID-19 outcomes: a call to action for physiatrists to provide rehabilitation care to black survivors. *Am J Phys Med Rehabil*. 2020;99(11):986-987. <https://doi.org/10.1097/PHM.0000000000001568>.
11. Verduzco-Gutierrez M, Bean AC, Tenforde AS, Tapia RN, Silver JK. How to conduct an outpatient telemedicine rehabilitation or Prehabilitation visit. *PM R*. 2020;12:714-720. <https://doi.org/10.1002/pmrj.12380>.
12. Office of Public and Intergovernmental Affairs. US Department of Veteran Affairs. VA Video Connect visits increase 1000% during COVID-19 Pandemic; June 12, 2020. <https://www.va.gov/opa/pressrel/pressrelease.cfm?id=5467#:~:text=Video%20appointments%20provide%20Veterans%20safe,February%20and%20May%20of%202020>. Accessed November 21, 2020.
13. Anderson M, Perrin A. Disabled Americans are less likely to use technology. *Pew Research Center*; April 7, 2017. <https://www.pewresearch.org/fact-tank/2017/04/07/disabled-americans-are-less-likely-to-use-technology/>. Accessed November 21, 2020.
14. Powers GM, Frieden L, Nguyen V. Telemedicine: access to health care for people with disabilities. *Houston J Health Law Policy*. 2017;17:7-20.

---

## Disclosure

M.V.-G. and A.M.L. Department of Rehabilitation Medicine, UT Health San Antonio, San Antonio, TX. Address correspondence to: M.V.-G.; e-mail: [gutierrezm19@uthscsa.edu](mailto:gutierrezm19@uthscsa.edu)

T.M.A. VA North Texas Health Care System, UT Southwestern Medical Center, Dallas, TX

Disclosure: We report that none of the authors have any relevant disclosures related to the funding of the project or any financial benefits received in relation to this report. Unrelated to this work, Dr. Verduzco-Gutierrez has been a consultant with Allergan, Merz, Ipsen, and Medtronic in the last 12 months.

Submitted for publication December 2, 2020; accepted December 24, 2020.

---