National Coalition of Ethnic Minority Nurse Associations

POSITION PAPER

COVID-19 in Racial and Ethnic Minority Groups

Introduction

Recent studies released by the Centers for Disease Control and Prevention (CDC)[1,2] and the *Morbidity and Mortality Weekly Report (MMWR)* suggests a disproportionate burden of illness and death among racial and ethnic minority groups. About 1 in 3 people who become sick enough to require hospitalization from COVID-19 were ethnic minorities. [3]

"The study of about 1,500 hospitalized patients in 14 states underscores the long-standing racial disparities in health care in the U.S. It also echoes what has been seen in other coronavirus outbreaks around the world — people with chronic health conditions have a higher likelihood of developing a serious illness after being infected with coronavirus. Overall, the report found that about 90% of people in the hospital with COVID-19 had at least one underlying health condition. Half (50%) had high blood pressure, 48% were obese, 35% had chronic lung disease and 28% had diabetes and cardiovascular disease".[4] In 2013, the CDC released the "Health Disparities and Inequalities Report [4] examining some of the key factors that affect health and lead to health disparities in the United States. Significant findings revealed four major concerns on health disparities:

(1) *Cardiovascular disease is the leading cause of death in the United States. Non-Hispanic black adults are at least 50% more likely to die of heart disease or stroke prematurely (i.e., before age 75 years) than their non-Hispanic white counterparts.*
(2) *The prevalence of adult diabetes is higher among Hispanics, non-Hispanic blacks, and those of other or mixed races than among Asians and non-Hispanic whites. Prevalence is also higher among adults without college degrees and those with lower household incomes.*
(3) *The infant mortality rate for non-Hispanic blacks is more than double the rate for non-Hispanic whites. Rates also vary geographically, with higher rates in the South and Midwest than in other parts of the country.*
(4) *Men are far more likely to commit suicide than women, regardless of age or race/ethnicity, with overall rates nearly four times those of women. For both men and women, suicide rates are highest among American Indians/Alaska Natives and non-Hispanic whites.*

These findings illustrate the importance of recognizing the fact that people 65 years and older, and people of all ages with underlying medical conditions are at high risk for severe illness from COVID-19. The high incident rates of underlying medical conditions among racial and ethnic minority groups is particularly alarming. It requires immediate attention by public and private sectors, decision makers, professional organizations and community leaders, amid the COVID - 19 pandemic.

NCEMNA Response to COVID-19

The National Coalition of Ethnic Minority Nurse Associations (NCEMNA) is a coalition of five national nursing organizations that represent diverse communities. It consists of, Asian American Pacific Islander Nurses Association (AAPINA), National Association of Hispanic Nurses (NAHN), National Alaska/Native American Indian Nurses Association (NANAINA), National Black Nurses Association (NBNA), and The Philippine Nurses Association of America (PNAA). The organization has been on the frontline driving healthcare policies to address healthcare disparities and ensure ethnic minority populations have access to culturally appropriate healthcare.

As a concerned nursing voice, our own healthcare professionals and frontline nurses have bravely battled COVID-19. Some have lost their lives and others continue to risk their health due to the inadequate personal protective equipment and/or timely access to COVID testing kits.

Although stay at home policies are in place or have been relaxed, the reality is that many people, especially minority populations, do not have the privilege to stay home as essential workers. Therefore, their risk to exposure is even higher including the risk of infecting their own family.

COVID-19 will co-exist with all of us for a long period until a proven vaccine is available to stop the virus from spreading and prevent resurge in hot spots areas. Our communities have to remain steadfast and reimagine how we work, socially interact, and resume a sense of normalcy in our day-to-day lives.

Meanwhile the immediate, long-term and lasting impacts on the psychological state and mental well-being of our nurses, healthcare workers, and communities disproportionately impacted by COVID-19 is of great concern. Research based on historical events like the 911 attacks and Ebola outbreak tells us that first responders, survivors, and families of victims are highly susceptible to PTSD[5]. The magnitude of the impact of COVID will require swift and long-term interventions.

Nurses are not only directly caring for COVID-19 patients in the hospital setting but are also concerned about their family members, friends, and colleagues who may also be infected with COVID-19. Many of us were not prepared to experience multiple loss of lives in such a short period. This puts them at an additional risk of PTSD. Nurses are sharing stories of stress, exhaustion, fear, and sadness of losing patients, their own colleagues, friends, and family to the virus. These raise concerns about the mental health and well-being for those frontline nurses. The New York Times[6] recently reported the suicide of a New York City ER doctor who worked the frontlines and at one point was, treated for exhaustion. We fear that without taking action to protect the mental health of our frontline healthcare workers, we will continue to hear more unfortunate stories. Hospitalized and dying COVID-19 patients are not allowed to be surrounded by their families and friends. Families are, left to mourn their loved ones who have passed in untraditional ways.

A heart wrenching article by the Los Angeles Times[7] exposed the ethical dilemmas that critical care doctors, nurses and first responders across the United States are faced with as cases of COVID-19 surge: "Whose lives should we save? Three patients struggling to breath, crammed in a hospital triage tent, and only one ventilator left, who gets it first? Do we allocate ICU beds on a first come first served basis? Should age play a role? A 75-year old who has lived a good life, or a young mother with three children with nobody to take care of the kids if she's gone?" Although the CDC outlines general principles, it is down to individual hospitals and health systems to decide the policy. Some States have drawn up detailed guidelines of allocating resources. Others have not talked about it much at all.

Recommendations:
NCEMNA supports CDC's preventive measures of social distancing, hand hygiene, and wearing face coverings in public and hospital settings where social distancing measures are difficult to maintain to protect older adults and persons with underlying medical conditions, as well as protecting health care workers and the general public.

In addition, NCEMNA recommends the following:

1. Employers should provide employee resources and counseling programs for their frontline workers and suicide prevention lines should be widely advertised for anyone in crisis.

2. Healthcare organizations need to have an open dialogue and streamline policies that address the underlying structural issues of protective equipment, access to test and evidence-based treatments to mitigate the risks and alleviate the fears and concerns of our frontline nurses.

3. Collaborate with other professional organizations and healthcare leaders in representing diverse communities towards culturally congruent interventions and relevant policies that will reduce the disparities highlighted by the COVID-19 pandemic.

4. The Federal government must monitor and track disparities among racial and ethnic groups in the number of COVID-19 cases and deaths. Data should be translated into usable information to improve management of patients, allocation of resources and targeted public health education.

5. Hospitals and healthcare systems must establish ethical guidelines to assist frontline workers to make decisions during emergency crisis such as COVID-19. The Hastings Center[8] offers an ethically sound framework for health care during public health emergencies that balances the patient-centered duty of care with public focused duties to promote equality of persons and equity in distribution of risks and benefits in society.

[1] Retrieved 5/5/2020. NPR. (April 8, 2020) "CDC Hospital Data Point to Racial Disparity in COVID-19 Cases." https://www.npr.org/sections/coronavirus-live-updates/2020/04/08/830030932/cdc-hospital- data-point-to-racial-disparity-in-covid-19-cases.

[2] Retrieved 5/5/2020. Center for Disease Control. (n.d.) "Coronavirus Disease 2019 (COVID-19): Racial & Ethnic Minority Groups." https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/racial-ethnic-minorities.html?mod=article_inline.

[3] Retrieved 5/5/2020. Shikha et.al. (April 17, 2020) "Hospitalization Rates and Characteristics of Patients Hospitalized with Laboratory-Confirmed Coronavirus Disease 2019 — COVID-NET, 14 States, March 1–30, 2020" MMWR *Weekly*, *69*(15), 458–464. https://www.cdc.gov/mmwr/volumes/69/wr/mm6915e3.htm?s_cid=mm6915e3_w

[4] Retrieved 5/5/2020. Center for Disease Control. (November 22, 2013). "CDC Health Disparity and Inequalities Report". MMWR, *62*(3), 1-187. https://www.cdc.gov/mmwr/preview/ind2013_su.html#HealthDisparities2013

[5] Retrieved 5/5/2020. Paladino, L., Sharpe, R. P., Galwankar, S. C., Sholevar, F., Marchionni, C., Papadimos, T. J., Paul, E., Hansoti, B., Firstenberg, M., Garg, M., Watson, M., Baxter, R. A., Stawicki, S. P., & American College of Academic International Medicine (ACAIM) (2017). Reflections on the Ebola Public Health Emergency of International Concern, Part 2: The Unseen Epidemic of Posttraumatic Stress among Health-care Personnel and Survivors of the 2014-2016 Ebola Outbreak. *Journal of global infectious diseases*, *9*(2), 45–50. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5452550/#ref16

[6] Retrieved 5/5/2020. Watkins, A., Rothfield, M., Rashbaum, W.K., & Rosenthal, B.M. (April 27, 2020). "Top E.R. Doctor Who Treated Virus Patients Dies by Suicide". The New York Times. https://www.nytimes.com/2020/04/27/nyregion/new-york-city-doctor-suicide-coronavirus.html

[7] Retrieved 5/5/2020. Jarvie, J. (March 19, 2020). "Ethical Dilemmas in the Age of Coronavirus – Whose Lives Should We Save". The Los Angeles Times. https://www.latimes.com/world-nation/story/2020-03-19/ethical-dilemmas-in-the-age-of-coronavirus-whose-lives-should-we-save

[8] Retrieved 5/5/2020. Berlinger, Nancy, et. al. (March 16, 2020) "Ethical Framework for Healthcare Institutions Responding to COVID-19. Guidelines for Institutional Ethics Services Responding to COVID-19. The Hastings Center. March 16, 2020 https://www.thehastingscenter.org/ethicalframeworkcovid19/