Executive Directive 2020 - 07

Executive Directive

No. 2020-7

To: State Department Directors and Autonomous Agency Heads

From: Governor Gretchen Whitmer

Date: July 9, 2020

Re: Improving equity in the delivery of health care

The COVID-19 pandemic has illustrated, with brutal proof, the persistence of racial disparities in our society. As of July 5, 2020, Black Michiganders represented 14% of the state population, but over 35% of confirmed COVID-19 cases where the race of the patient was known. COVID-19 is over four times more prevalent among Black Michiganders than among white Michiganders. And Michigan is no outlier. According to the Centers for Disease Control and Prevention (CDC), “non-Hispanic Black persons have a [COVID-19 associated hospitalization] rate approximately 4.7 times that of non-Hispanic White persons.” Moreover, Black and Latino people have been nearly twice as likely to die from the virus as white people, according to CDC data. Indigenous populations have experienced a hospitalization rate even higher than that of Black Americans.

This disparity is not limited to COVID-19. People of color face disparities in terms of morbidity, mortality, and health status. Black, Hispanic, and Indigenous Americans have higher infant mortality rates than white and Asian Americans. The premature death rate from heart disease and stroke is highest among Black Americans.

Race and ethnicity are not the only demographic factors associated with disparity in health outcomes. For example, women are more likely to experience delayed diagnosis of heart disease compared to men, as well as inferior heart attack treatment. Sometimes, these disparities intersect, as in the case of childbirth, where the United States is one of the few countries experiencing a rise in the maternal mortality rate, and Black women are nearly four times as likely to die during childbirth as are white women.

Faced with these disparities during the COVID-19 pandemic, Michigan has led the way in identifying and addressing the problem. Michigan was one of the first states to report COVID-19 data by race and ethnicity. When it became clear the virus had devastated communities of color with particular force, I issued Executive Order 2020-55, creating the Michigan Coronavirus Task Force on Racial Disparities—a group dedicated to studying, reporting on, and finding solutions to the disparate effects of COVID-19 on people of color.

But much work remains. To be sure, the causes of these disparities are multiple and complex. Social determinants of health such as education, employment, and environmental factors—all of which correlate with race and ethnicity—are part of the explanation. Research also shows that disparities result in part because of differences in the delivery of medical services to people of different races. The National Healthcare Disparities Report concluded that white patients received care of a higher quality than did Black, Hispanic, Indigenous, and Asian Americans. People of color face more barriers to accessing health care than do white people, and are generally less satisfied with their interactions with health care providers.

These disparities can arise even when not intended because of the prevalence of what is sometimes called *implicit bias*: thoughts and feelings that, by definition, often exist outside of conscious awareness, and therefore are difficult to control.**[12]** But they can shape behavior, including the behavior of health care professionals. One way to reduce disparities in health outcomes, therefore, is to seek to eliminate the unconscious biases, misconceptions, and stereotypes that can lead to disparities in how health care is provided.

Michigan's front-line health-care workers have been its greatest heroes in the fight against COVID-19. Without their selfless and courageous service, many more lives would be lost and disrupted due to this pandemic. Nevertheless, we—all of us—need to do better, and training health-care workers how to recognize and mitigate implicit bias will only help these workers carry out their mission of providing the best health care to all they serve. For this reason, and on the recommendation of the Michigan Coronavirus Task Force on Racial Disparities, I am calling on the Department of Licensing and Regulatory Affairs to establish new rules requiring all health care professionals to receive training on implicit bias and the way it affects delivery of

health care services. This type of training has value for all Michiganders in all professions and walks of life, which is why my staff has begun this kind of training and every member of my team, including me, will complete this type of training on an annual basis. We all have room to grow.

Acting under sections 1 and 8 of article 5 of the Michigan Constitution of 1963, I direct the following:

1. The Department of Licensing and Regulatory Affairs (LARA), acting under the authority granted in MCL 333.16148(1) and MCL 333.17060(b), and in consultation with the relevant boards and task forces, must begin the process of promulgating rules to establish implicit bias training standards as part of the knowledge and skills necessary for licensure, registration, and renewal of licenses and registrations of health professionals in Michigan.

2. Not later than November 1, 2020, LARA must consult with relevant stakeholders in the licensed health professions, in state government, and elsewhere in the community, to receive input regarding proposed training standards.

3. This executive directive applies to the occupations under Article 15 of the Public Health Code, except for persons practicing under Part 188 (veterinary medicine).

This directive is effective immediately.

Thank you for your cooperation in implementing this directive.

[1] *Michigan Data, Cases by Demographic Characteristics*, Mich. Coronavirus, **https://www.michigan.gov/coronavirus/0,9753,7-406-98163_98173---,00.html**, (last visited July 5, 2020).

[2] *Id.*

[3] *COVIDView, A Weekly Surveillance Summary of U.S. COVID-19 Activity*, Ctr. Disease Control & Prevention, **https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covidview/index.html**, (last visited July 5, 2020).

[4] Richard A. Oppel Jr., et al., *The Fullest Look Yet at the Racial Inequity of the Coronavirus*, N.Y. Times (Jul. 5, 2020), **https://www.nytimes.com/interactive/2020/07/05/us/coronavirus-latinos-african-americans-cdc-data.html**..

[5] *Id.* (observing that "Non-Hispanic American Indian or Alaska Native persons have an age-adjusted hospitalization rate approximately 5.7 times that of non-Hispanic White persons.")

[6] *CDC Health Disparities and Inequalities Report – United States*, *2013*, 62 MNWR (Supp. 3) 1, 1-187 (2013), **https://www.cdc.gov/mmwr/pdf/other/su6203.pdf**.

[7] *Id.* at 157-160.

[8] *The Heart Attack Gender Gap*, U. Edinburgh: Edinburgh Friends (Oct. 29, 2019), **https://www.ed.ac.uk/edinburgh-friends/supplements/the-heart-attack-gender-gap**.

[9] *Deadly Delivery: The Maternal Health Crisis in the USA,* Amnesty Int'l. (May 7, 2011),**https://www.amnestyusa.org/reports/deadly-delivery-the-maternal-health-care-crisis-in-the-usa/**.

[10] Agency for Healthcare Res. and Quality, U.S. Dep't of Health and Human Serv., Pub No. 14-0006, National Healthcare Disparities Rep. (2013).

[11] *Id.*

[12] William J. Hall , et al., *Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systematic Review*, 105 Am. J. Public Health 2588 (Dec. 2015), **https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4638275/#bib1**.

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