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Vermont Psychiatric ASSOCIATION

To: House Health Care Committee
Date: February 24, 2021
From: Vermont Medical Society,
American Academy of Pediatrics Vermont Chapter
Vermont Psychiatric Association
Vermont Academy of Family Physicians
Re: H.210, Health Equity Bill

On behalf of the 2,400 members of the **Vermont Medical Society(VMS), along with the American Academy of Pediatrics Vermont Chapter (AAPVT), the Vermont Academy of Family Physicians (VAFP) and the Vermont Psychiatric Association VPA),** we would like to express our overarching support for H.210, as our organizations have made addressing the impact inherent bias and systemic racism has in driving adverse health outcomes one of our highest priorities. We would also like to provide suggestions on how best to achieve meaningful medical training on this highly complex and evolving issue.

The Vermont Medical Society, like the rest of the world, was gripped last June by the tragic murder of George Floyd at the hands of law enforcement and put out this statement, not only denouncing policy brutality, but also declaring **systemic racism as a public health threat**. Systemic racism destroys the social cohesion of our state and our nation, and has produced devasting health impacts born from trauma, chronic stress and differential access to health care.

Similarly tragic, the COVID-19 global health pandemic has exposed how differential access to care leads to disparities in health outcomes. ,In Vermont and across the nation, incidence of more severe illness is disproportionately impacting certain racial and ethnic populations. Vermont Department of Health data shows BIPOC Vermonters represent 6% of the State's population but 18% of COVID-19 cases. The VMS is committed to addressing bias in health care, as evidenced by our policy from 2018, in which we resolve to support systems designed to combat biases within the health care system and to work to mitigate the unequal treatment of patients and health care professionals. In 2019, we adopted policies to support the humane treatment of migrant families and to protect women's reproductive rights.

Over the past several years, Vermont clinicians have been hungry to learn more and taken an active role to address these structural inequities. VMS, AAPVT, VAFP and VPA have responded by consistently offering and promoting continuing medical education (CME) to broaden our recognition of inherent bias in health care. Here are some of the recent trainings and partnerships our organizations have developed and promoted:

- ***VMS Health Equity website:*** Health Equity a VMS Priority
- ***VMS Resources on limited English proficiency and Interpreter Requirements:*** https://vtmd.org/interpreter-issues-and-resources-2
- ***VPQHC Health Equity Foundational Training Series (Spring 2021):*** Offered at no cost, led by Dr. Maria Mercedes Avilia, VMS currently promoting: https://www.vpqhc.org/new-page-2

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- ***Northern VT AHEC***: 5-part 2020-21 CME "Quality Care is Equitable Care" series, VMS currently promoting
- ***VMS Thursday Webinar:*** February 18, 2021 | "Race & Health Equity" presented by Rebecca Bell, MD. PowerPoint/Handout
- ***VMSERF Physician Executive Leadership Foundational Course:*** September 9, 2020- Health and Health Care Inequities
- ***VMS 2020 Annual Meeting CME:*** Creating an Organizational Culture Through Equity November, 2020
- ***AAP VT Task Force on Racial & Health Equity:*** VCHIP_ At the Intersection of the Pandemic and the Impact of Racism on Child and Adolescent Health, LE Faricy, MD FAAP and Rebecca Bell, MD FAAP
- ***VAHHS 2020 Annual Meeting:*** Achieving Equity in Health Care September, 2020
- ***American Medical Association*** health equity materials/trainings VMS is currently promoting: Prioritizing Equity Video Series, AMA Reshaping Its Path Toward Racial Equity

VMS supports Section 252, which creates an office of health equity within the Department of Health and asks that office to, among other things:

- (K) work collaboratively with the University of Vermont's College of Medicine and other health care professional training programs to develop courses that are designed to address the problem of disparities in health care access, utilization, treatment decisions, quality, and outcomes among BIPOC and LGBTQ patients; and patients with disabilities

- (L) develop curricula and the provision of continuing education courses to teach cultural competency in the practice of medicine.

VMS suggests that, as organizations already working to design and distribute health care professional training programs, the Area Health Education Centers (AHEC) and Vermont Program for Quality in Health Care (VPQHC) be listed as partners in (K) and also that financial resources be provided for the development and provision of these courses.

VMS supports the approach taken to professional education in S. 4248,[1] introduced in Congress, and referenced by Dr. Avila in your Committee on February 24th. That bill directs the Secretary of Health and Human Services to award grants to health care providers, health departments, professional schools and non-profits to support bias and anti-racism training to reduce racial and ethnic disparities. It requires the education to be: (A) evidence-based, community-informed, patient-centered, and ongoing; (B) designed to be culturally competent and accessible and (C) designed to allow applicable State licensing bodies to provide continuing education credit for completion of such training. **We encourage your committee to support the same approach developed by S. 4248 in Vermont: offer funding and support for development of courses, and design them to fulfill existing CME requirements.**

[1] https://www.congress.gov/bill/116th-congress/senate-bill/4248/text?r=74&s=1

However, we do not believe 2 hours of mandatory training is an appropriate way to accomplish the needed behavior and policy change in this extremely important and complex area for the following reasons:

- **A mandatory hour requirement does not mean quality education nor desired behavior change**
    - We have also seen with opiate training that the quality of education can vary from an out of state, for-profit company heavily marketing low-quality "required" courses to meaningful Vermont-developed content.
    - Research shows that the effectiveness of CME can vary widely based on its methods, length and how related it is to outcomes that are considered important by physicians.

- **Required education with listed topics becomes repetitive not meaningful**
    - While a baseline level of education about cultural competence is important, real change needs to go far beyond this – encouraging changes in medical school and residency curricula; changes in organization and practice-level policies, procedures and screening tools; conversations with impacted patients and families; changes in workflow and more. Requiring the same education year after year does not continue to move the needle in terms of behavior and culture change and may instead engender resentment.

- **The list of topics required by Sec 4 (b)(2) could require a "one-sized-fits-all" CME course that is not equally relevant to all specialties**
    - We have seen with the required "prescribing controlled substances" CME credits - which also lists very specific topics that must be covered - that this often leads to a "check the box" mentality that omits the most relevant trainings for a given clinician. For example, trainings on tapering opioids, adapting opiate replacement therapy to the COVID-19 pandemic, research regarding using CBD or cannabinoids to manage pain and pain management in surgery are all topics that our members have asked for and VMS has offered but do NOT meet the very specific list of criteria that are mandated to be covered in Vermont's "controlled substances" training. Flexibility is needed to ensure that education is engaging and relevant to different specialties and practice types.

Nicole LaPointe, Executive Director of the Northern Vermont Area Health Education Center (AHEC) said they do not have a position on this bill or mandated CME training but stated:

"*My colleagues and I are not aware of a strong evidence-base that supports effectiveness of state-mandated, low contact (e.g., 2 hours over 2 years) educational activities to support change, particularly in addressing a highly complex issue, such as this one.*

Delivering equitable healthcare requires multi-level attention to complex issues including structural factors. Workplace culture, work site requirements, organizational policies, resource allocation, and data-driven outcome measures are all important elements to achieving equitable

care. Complex practice improvement and transformation aims are best addressed longitudinally, instead of through periodic, standalone activities.

We have engaged with stakeholders representing Vermont's communities of color and health care practitioners to develop the learning objectives for our Equitable Care series and to ensure that the offering is responsive to health care delivery in VT.

AHEC begins educational awareness about health disparities and culturally and linguistically response care starting in our workforce development initiatives with youth and thread it throughout all our work. Long range work is critical to this discussion and to making systemic changes."

Thank you for your consideration. Please let us know if we can provide further information or answer any questions.