Vermont
Medical
Society

To: **Senate Health and Welfare Committee**
From: **Jessa Barnard, Executive Director**
Date: **February 2, 2022**
RE: **S. 206, Cognitive Impairments**

VMS strongly supports efforts to improve dementia care in Vermont, including efforts to improve and increase clinical education, and to share information regarding medical and nonmedical options for treatment, services, and supports with both providers and patients. **VMS also strongly supports efforts to create a "hub and spoke" model for dementia care in the State and to continue educational programming for primary care providers** such as the Dementia Corner Consults with primary care clinicians, which are currently scheduled to run through June 2022 (see attached handout), and the Vermont Project ECHO Enhanced Diagnosis and Management of Dementia by the Primary Care Team trainings.[1]

However, VMS has concerns with several of the methods proposed in S. 206.

Section 2 calls for a study of continuing education credits related to the diagnosis and treatment of patients with cognitive impairments. VMS does not believe mandatory training for physicians is an appropriate way to accomplish behavior and policy change in this extremely important 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 dementia care is important, clinical change requires steps that 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.

- **Required education can lead to a "one-sized-fits-all" CME course that is not equally relevant to all specialties**

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[1] https://www.med.uvm.edu/ahec/healthprofessionals/continuing-education-and-quality-improvement/project-echo/project_echo_enhanced_diagnosis_and_management_of_dementia_by_the_primary_care_team

- We have seen with the required “prescribing controlled substances” CME credit 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.

Feedback from the Vermont Area Health Education Centers (AHEC) on mandated CME training includes:

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

Further study of education requirements is not needed at this time and instead time and effort should be dedicated to developing and disseminating high-quality, meaningful curriculum, tools and supports to Vermont’s clinicians to assist them in providing care to patients with dementia, such as the Corner Consults and Project ECHO trainings.

VMS also has concerns regarding Section 3 of the bill, mandating that physicians provide family members with a specific list of information including:
- The Alzheimer’s diagnosis
- assistance understanding the diagnosis
- medical and nonmedical options for treatment, services, and supports
- information regarding how to obtain treatment, services, and supports

First, no change is needed in Vermont law to allow relevant clinical information to be shared with family when consistent with the federal HIPAA Privacy Rule.[2] VMS fully supports meaningful efforts to educate providers about what supports and services are available to patients and their families and providers sharing this information with patients. VMS believes that the main barrier to this happening more systematically is both a lack of resources for treatment,

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[2] See the CMS FAQ: Does the HIPAA Privacy Rule permit a doctor to discuss a patient’s health status, treatment, or payment arrangements with the patient’s family and friends?
Answer:
Yes. The HIPAA Privacy Rule at 45 CFR 164.510(b) specifically permits covered entities to share information that is directly relevant to the involvement of a spouse, family members, friends, or other persons identified by a patient, in the patient’s care or payment for health care. If the patient is present, or is otherwise available prior to the disclosure, and has the capacity to make health care decisions, the covered entity may discuss this information with the family and these other persons if the patient agrees or, when given the opportunity, does not object. The covered entity may also share relevant information with the family and these other persons if it can reasonably infer, based on professional judgment, that the patient does not object.

services and supports available consistently throughout the state and uneven knowledge of these services and supports among health care providers. **For these reasons, VMS strongly supports creating a centralized catalog of community resources available to patients and clinicians.** To be most helpful to families and clinicians, these resources should also be broken down by how they may help patients at different points along their disease trajectory as the needs for supports and services vary greatly over time.

However, VMS does not support mandatory disclosure language being placed in state statute for the following reasons:

- **A disclosure requirement will not solve knowledge and availability issues**. As mentioned above, time and resources should be spent to create more available services and support throughout the state, compiling available resources and disseminating this information to providers. Until systematic information is available it is premature to mandate disclosure of this information.

- **VMS does not support legislating clinical practice**. While disclosing the information listed may be entirely appropriate and applicable to certain patients, it may not be appropriate in other circumstance. Perhaps it is unclear if the patient only has early cognitive decline or if it has become a full Alzheimer's diagnosis. Perhaps the patient wants time to consider the diagnosis and would like to discuss treatment and service options at a later time. Is it a violation of the statute to delay providing the information for any reason? Perhaps the physician works with a nurse case manager or social worker to provider options regarding services and supports – is delegating providing information allowed? While not wanting to sound alarmist, VMS would also strongly oppose efforts to legislate that specific information be provided at the time of an ultrasound before an abortion is performed for the same reasons – consent and medical information sharing is tailored to each patient and circumstance and should not be legislated.

- **Further, this language is problematic for additional reasons**: It is unclear how this law intersects with Vermont law on patient consent and surrogate decision-making if the patient lacks capacity to give consent to share diagnosis information with family members. It is also unclear which provider this applies to – the one making an initial diagnosis or any physician who is or becomes aware of the diagnosis? Why does this requirement apply only to physicians and not other providers who may be making a diagnosis or involved in the patient's care? Finally, what is the enforcement mechanism? Does failing to provide the information become unprofessional conduct or the basis of civil malpractice and does this then have the unintended consequence of make physicians less willing to become involved in caring for patients with dementia or providing a timely diagnosis?

In summary, VMS strongly supports efforts to improve dementia care in Vermont, including efforts to improve resources for clinicians, patients and families in the State and looks forward to working with the legislature and other stakeholders to move these efforts forward. However, we believe several of the steps proposed in the bill will distract from the meaningful progress needed.