OREGON MEDICAL ASSOCIATION

OREGON ACADEMY OF FAMILY PHYSICIANS

MEMORANDUM

To: Co-Chair Peter Courtney, Senate President
Co-Chair Tina Kotek, Speaker of the House
Members of the Joint Interim Committiee of the First Special Session of 2020

From: Betsy Boyd-Flynn, Oregon Academy of Family Physicians
Courtni Dresser, Oregon Medical Assocaition

Date: June 22, 2020

Re: Race and Ethnicity Data Collection for COVID-19 Testing: LC 45, Sec. 48-50 and LC 84, Sec 37-40

The Oregon Medical Assocaition and the Oregon Academy of Family Physicians are in complete agreement that data on race, ethnicity, language and disability is critical to understand and correct health care disparities. It is concerning that REALD passed in 2014 and there is currently not a program that is equitable across the state and across provider types in collecting this important information. Collection of REALD data will allow researchers, clinicians, policymakers, and community-based organizations to identify areas of inequity across the healthcare system, and target interventions to address them.

Currently health care systems are being challenged in ways that we have not seen before. Workforce safety, lack of workforce due to lower patient volume, high use of telemedicine, PPE resource constraints, new and changing guidelines, and numerous other issues have made providing and delivering health care challenging during the pandemic.

Data like this is most useful when it is collected consistently, and validated. We are concerned that Sections 48-51 of LC 45 and Section 37-40 of LC 84 will not achieve their important intended goals, but rather will push an unfunded mandate on providers that is unlikely to be implemented usefully, straining a workforce already under immense stress, with minimal benefit to patients.

As one of our physicians told us, "If this is something wanted immediately I think it would totally break our front office staff that are already overwhelmed with COVID-19 protocols, rescheduling

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canceled appointments, and directing patients on how to use our telemedicine platform. There has been a lot of tension in staff lately as they are dealing with very frustrated patients all day long."

Training for staff is necessary so that collection of REALD data is trauma-informed and patient-centered. Even with training, clinics that rely on fee-for-service reimbursement will struggle without funding to support the time required for accurate and thoughtful data collection, and will likely have no resources to act on the data once collected. Some clinics will fare better. Clinics like the Richmond Clinic receive mostly capitated payments that are flexible and support care for the whole person; it and clinics with payment arrangements like it will be more readily able to adapt to these new requirements and use the process to inform rapid and meaningful changes.

As you consider legislation that mandates collection of REALD data, OAFP and OMA strongly urge you to consider how to move commercial carriers and OEBB/PEBB to capitated reimbursement models that support this kind of work. Upwards of 40% of CCO reimbursement is non-FFS, compared to less than 15% of commercial and OEBB/PEBB reimbursement. Expanding the use of capitated payment across payer types supports initiatives like this which rely on non-reimbursable activity.

While we recognize and applaud the long-term health equity goal of this concept and of the REALD program, we believe there are more urgent legislative opportunities to pursue, which can then enable legislation like this to move Oregon closer to that goal. Physicians and data scientists would tell you that what is needed is a database similar to the PDMP that could collect and store REALD data, COVID-19 status, as well as a patient's social needs. Such a system could be used by community based organizations, public health agencies, providers and payers to help coordinate real time solutions during this crisis *and beyond* that address social determinants of health. Additionally, it would provide a *single* entry point for all such information, negating the need for redundant surveys and retrofitted EHRs or paper reporting.

That said, we recognize the urgency in collecting REALD data, and we thank you for your continued work on this legislative concept and we are glad to make ourselves available for further discussion and input. We have submitted suggested changes to the concept to Speaker Tina Kotek, Rep. Andrea Salinas and the OHA, which I attached to the testimony.

We will be pleased to work with stakeholders to implement REALD in a manner that ensures high-quality data to support understanding and correcting health care disparities.

Thank you.

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OMA Requested Changes to LC 45 6/19/20 Sections 48-51

Section 48, paragraph (1)(b) defining "Encounter"

- **Our concern:** The term encounter should be clear and exact about the timing of when a form is provided to a patient and it should be limited to only an encounter where there is the provision of a COVID-19 viral test. Any other type of COVID-19 related service is going to cause confusion about when a form should be provided and how many times will the same patient receive the form. Also, antibody testing is different from viral testing and we believe the clearest timing about when a form should be provided is when viral testing is ordered.
- **Our request:** Strike the phrase "the provision of health care services related to COVID-19, including but not limited to ordering a COVID-19 test" and replace that with the phrase "ordering a COVID-19 viral test"

Section 48, paragraph (1)(c) defining "Health care provider"

- **Our concern:** If the term encounter is amended to limit it to the ordering of a test, not all of the providers listed are authorized to order COVID-19 viral testing.
- **Our request:** This paragraph should be limited to only those providers that are authorized to order COVID-19 viral testing.

Section 48, paragraph (2)(a) regarding data collection

- **Our concern:** Providers should not be put in a position of making patients feel like if they do not provide data to the provider, they cannot get a test. We also are concerned about requiring providers to collect data and possibly have to enter it into an electronic health record raises concerns about privacy of the data for both patients and the provider.
- **Our request:** Amend paragraph (2)(a) to clarify that a provider only is providing an OHA form to a patient or their representative for the patient's voluntary completion and that the form is not required to receive a test.

Section 48, paragraph (2)(b) regarding reporting data

- **Our concern:** While we still feel that having the patient voluntarily submit an OHA form to OHA is the best option for the provider and the patient to ensure patient comfort with completing a form, if a provider must submit a collected form, the form only should be submitted once to OHA and through a secure and easy to use OHA electronic portal. We are unclear about why a form would have to be submitted to three separate locations which greatly increases administrative burdens on providers. Further, if a provider is only collecting and submitting an OHA form, the only notation that might be needed in a patient's health record is that a form was provided which would ensure the administrative and cost burden on providers is limited.
- **Our request:** Clarify paragraph (2)(b) to state that only the OHA form is reported to OHA (not to a lab or DHS) and that the form may be submitted through a simple to use secure OHA electronic portal.

Section 48, paragraph (3) regarding rulemaking

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- **Our concern:** Providers should not have to worry that a simple data collection statute creates a larger administrative burden through detailed rulemaking. If the data collection statute is clear and limited to a form, the rulemaking should be limited only to creating a starting point for collection of forms, the timing of submitting forms, the creation of the form itself which we believe should not collect any individual identifiable information about a patient such as name or address, and the manner of submitting a form which should be a secure and easy to use electronic process for providers.
- **Our request:** Amend paragraph (3) to limit rulemaking to: (a) a starting point which should be at a later and more realistic time than August 1, 2020; (b) timing of form submission should be as soon as practicable for a provider not necessarily at the time of the encounter; (c) form creation which should be a standard easy to complete form that does not identify a patient by name; and (d) the process for submitting a form which should be through an easily accessible secure electronic OHA portal.

Section 48, paragraph (5) regarding incentives

- **Our concern:** The language about incentives is unclear and needs further understanding about the cost to providers about implementation of this concept.
- **Our request:** The legislative concept should be limited to the provision of a form to a patient and possible collection and submission of that form to OHA. Any broader concept such as requiring electronic health records to be changed to build out forms would be extremely costly. Imposing significant costs onto providers that are struggling financially during this COVID-19 pandemic would further burden those providers.

Section 48, paragraph (6) regarding enforcement

- **Our concern:** The bill language about enforcing the concept through any means permitted under the law is ominous and not helpful to the discussion.
- **Our request:** Strike all of paragraph (6) and (6)(a), (b), and (c).

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