

Memorandum

To: Senator Peter Courtney, Chair, Joint Committee on First Special Session of 2020
Representative Tina Kotek, Co-Chair, Joint Committee on First Special Session of 2020
Senator Fred Girod, Co-Vice Chair, Joint Committee on First Special Session of 2020
Representative Christine Drazan, Co-Vice Chair, Joint Committee on First Special Session of 2020
Members of the Joint Committee on First Special Session of 2020

From: Danielle Sobel, MPH, Policy and Governmental Affairs Senior Director
Carly Hood-Ronick, CCO Strategy and Health Equity Director

Date: June 22, 2020

Re: LC 45

The Oregon Primary Care Association (OPCA) and Oregon's 33 community health centers appreciate the opportunity to provide comments on LC 45.

OPCA is a non-profit organization, with a mission to support Oregon's 33 community health centers, also known as federally qualified health centers, in leading the transformation of primary care to achieve health equity for all. Health centers deliver integrated primary, behavioral and oral health care services to over 433,000 Oregonians, in 232 communities statewide. 41% of health center patients identify as a racial or ethnic minority, 8% are homeless and 2% are veterans. We provide care to some of Oregon's most vulnerable populations, including one in four Medicaid/OHP patients. We don't turn anyone away at our doors and operate on a sliding scale fee for uninsured individuals.

As service-driven organizations whose mission is to care for all in their community, health centers rapidly adapted to virtual care, redeployed staff and opened testing sites. As of June 12, 96% of health centers had testing capacity, with 52% of those offering walk-up or drive up services. Health centers have tested over 7,600 patients; of those, 43% identified as racial or ethnic minorities, and of that demographic, 83% tested positive. We are the safety net for many folks who otherwise wouldn't have access to upstream healthcare interventions and as such are proud of our role in flattening the curve, ensuring our hospitals remain available to those who need them most.

Telehealth

While not in LC 45 or any other legislative concept for this Special Session, OPCA hopes to work with the legislature to extend telehealth parity in any subsequent special session or forthcoming 2021 legislative session. Recent progress around telehealth regulations under the emergency declaration has been a lifeline for community health centers seeking to maintain access for patients in need of routine care or with underlying medical conditions; we must use the success of the emergency need to build a bridge to the next iteration of comprehensive telehealth policy. We are supportive of an extension of telehealth payment parity for all telehealth modalities, including phone calls, through July 2021. The individuals most at risk of adverse health outcomes are often the same individuals who lack access to video-capable technology or the necessary bandwidth to support modalities beyond a telephone call. Telehealth is, and remains, a critical component for improving equity and access in our health care delivery system.

LC 45- Sections 48-51: RACE AND ETHNICITY DATA COLLECTION AND REPORTING DURING COVID-19 PANDEMIC

Since the passage of HB 2134 in 2013, OPCA has been engaged in conversations about race, ethnicity, language and disability (REAL-D) data collection and implications for health care providers in Oregon. We understand the need to identify and address the root causes of inequities in our health care system and beyond,

and, as community health providers, have supported the vision behind REAL-D since inception. Health centers across the country have been required to collect information on patient race/ethnicity for decades as part of Federal funding. It is from this vantage point that we have most recently worked with OHA to inform the drafting of legislative language on how to best implement REAL-D when testing for COVID-19.

As we understand it, there is a potential amendment to Sections 48-51 of LC 45. The amended language does incorporate some of our process recommendations (see below) including a longer implementation deadline, manner and form for reporting, and cost of implementing collection. We appreciate that the amendment encourages consideration of EMR compatibilities and believe this could be strengthened to support provider success by editing (A) to the following: **“Support EMR vendors across the state in developing the requisite reports and technological capabilities to support clinical data collection.”**

Because of our participation on with the HIT Commons and OHA Community Information Exchange Advisory Body we know that there has been ongoing conversation about how to implement the collection of REAL-D data in a culturally appropriate way so as to prevent harm to patients. With that in mind, we recommend an additional clause indicating the importance of clinical staff training to ensure successful roll out and decreased potential for an increased growth in health inequities by race: **“(C) Consider appropriate training and workflow adoption for staff administering questions/surveys in the clinical setting.”**

Process recommendations on REAL-D data collection and COVID-19 testing

Below is a compilation of responses from OPCA health centers and the recommendations we shared with OHA as they were considering language for LC 45, requiring REAL-D data collection for COVID-19 tests.

1) How feasible the request is in taking into account the need to acquire or upgrade technology, train staff, build into practice workflows?

Clinic 1 - “Options for us:

1) Try to get [our EMR] to rush this through but likelihood of that happening by August 1 is minimal. Individual FQHCs don’t have ability to ‘add’ this questionnaire into the EMR in a reportable way – it would have to go through the EMR platform. And it might require some customization to limit to just Oregon organizations.

2) Collect on paper and then just scan into EMR and/or manually tally responses outside of our EMR. I believe that our OHP Enrollment team is already doing this – and we end up with lots of skipped questions due to its length.”

Clinic 2 – “I believe we would be able to collect data on everything listed except disability status. This would take an additional process for non-established patients being tested.”

Clinic 3 – “We ask our medical assistants to collect a TON of data. We’ve already started asking patients to come early because it can take 10 minutes to do all of the pre-visit work. This will add time and effort and, I’m guessing, will not come with any additional funds. This can’t be something that is just forced on the OHA without careful consideration of how it’s done. Past research has shown that, when done without that care, often times staff end up just putting down what they think the patient “is” based on their appearance. It’s not due to malice, just a lack of time and training. Any mandate to collect these data MUST be accompanied by a clear plan for how they will be used. Who will have access to these data? What decisions will they be used to influence? How will disparities in care be addressed? If there aren’t answers to these questions, there is no reason to collect the data.”

OPCA process recommendation: Consider how to build a process measurement that would first support EMR development and staff training to ensure accuracy of data collected and efficiency in roll out. Might delay the actual data collection a bit, but this legislation has been in place for 7 years without active collection; let’s collectively work as a state to address the reasons it’s not being collected.

2) **What would ease the process of both collecting the data (and inputting it into an EHR/EMR) as well as reporting it?**

Clinic 1 - "If [our EMR] implemented it quickly (using 'Flowsheets') the reporting would be easy. Reporting outside of the EMR would require Excel manual tallying. Collecting the data for us would mean adding a new questionnaire for all COVID tests. We are only doing a handful of COVID tests weekly but even for us, getting 7 clinics on board would be a burden and likely met with frustration. We, of course, already collect Race/Ethnicity/Language for all patients as part of HRSA UDS reporting however the options list is much shorter. Patients (and especially staff) will be annoyed at duplicative work if doing a separate questionnaire. Organizations doing more COVID tests would have proportionally more impact obviously. Long term solution is likely to come up with a REAL+D to UDS demographic crosswalk that would allow for patients to only have to fill out one race/ethnicity questionnaire."

OPCA process recommendation: Consider talking with EMR vendors soon to have reporting tools developed that will ease burden on clinic staff and increase uptake. Additionally, could consider a "best practices" peer learning opportunity for later in the year/next year whereby clinics (and OHA) could hear from one another about what is working and what's not in this space. Some of those quick adopters could be harnessed to catalyze further roll out.

3) **Any potential costs associated with this?**

OPCA process recommendation: The more this is aligned with HRSA reporting requirements, including categories, cadence for reporting, and templates, the easier this will be for FQHCs in particular who are serving very diverse patient populations. We suggest looking at a clinic's existing reporting (process and data) for HRSA and seeing if that would suffice for State level needs.

Thank you for the opportunity to submit testimony on LC 45. We look forward to the dialogue and commitment of the legislature to address the inequities in care, whether through the collection of data or comprehensive policy supports to care for patients across modalities.