Health Department

February 3, 2021

Senate Committee on Health Care
900 Court St. NE - Remote B
Salem, Oregon 97301

Re: SB 70 - Relating to disparities in health outcomes for communities impacted by discrimination; declaring an emergency

Chair Patterson, Vice-Chairs Knopp, and members of the Committee, my name is Jessica Guernsey and I am the Public Health Director and Local Public Health Administrator for Multnomah County Health Department. Thank you for the opportunity to provide testimony in support of SB 70 and offer a few suggestions for strengthening the bill.

This bill supports Regional Health Equity Coalitions (RHEC's) to expand statewide and develop their capacity to support health equity efforts across Oregon. Ultimately, this will standardize the Regional Health Equity Coalition model; expand this program to fully fund the existing RHECs; adds four new coalitions; and increase staffing to sufficiently support this important program.

RHECs are local community-driven, cross-sector groups that use their strength and resilience to advocate for solutions to increase health equity for communities of color that share intersectional identities of specific race/ethnicities and other targeted identities. We support RHECs model that creates a space for meaningful collaboration, sharing community wisdom and lived experiences, and shifts power to non-governmental organizations and community members.

During this pandemic, we have been reminded of the importance of listening to and trusting leaders that propose solutions that support their communities. Community leaders provided data, shared stories, and culturally specific knowledge. Their knowledge was used to understand community strengths and disparities, make decisions about allocating resources, funding, and inform programs and policies such as community testing and resource events, culturally specific food drives, and COVID-19 resources in multiple languages. In order to dismantle institutionalized and interpersonal racism, white supremacy, and other systems of oppression, we must be led by the people who are most impacted. As Rep. Ayanna Pressley, "people closest to the pain should be closest to the power." Liberation and healing starts with transferring power to the communities of color and targeted populations.

There are two pieces of this legislation that could be adjusted for a stronger bill that supports this vital work for our communities including how we define certain identities and who is included in priority populations.

We encourage the committee to look at page one, lines 12 that outlines the “communities of color” “Native Hawaiians or Pacific Islander” and instead separate out those two communities; *Native Hawaiians* and *Pacific Islanders* have distinct cultures and needs that should be addressed independently of each other.

Many communities are not included in the *priority populations* list on page two, lines 25-33, which would benefit greatly from access to and participation in RHECs. We recommend the addition of four community groups:

(1) *Compact of Free Association (COFA) community members from the Republic of Palau, Republic of the Marshall Islands, and the Federated States of Micronesia*. This community is typically left out of programs and policies due to the complexities of contracted agreements between the United States and each Free Associated state. COFA members have the right to travel to the United States without a visa to live and work. As residents, they pay local and federal taxes, but since the Welfare Reform Act of 1995, they have not been able to benefit from most federal programs. They have unique lived experience compared to Native Hawaiians and other Pacific Islanders that need to be shared and addressed.

(2) *Undocumented community members*. This community can face complex stress and disproportionate health outcomes with limited incomes, less access to health insurance, and multiple life stressors. Our undocumented community members experience higher acuity in health crisis, morbidity rates that exceed other priority groups, and in general longer hospital stays and poorer outcomes when they do seek care[1]. They are often left out of decision making spaces and face inaccessible healthcare, high healthcare expenses when seeking care, and lack advocacy spaces to work toward equitable public health because of their documentation status and risk for deportation.

(3) *Urban Native American/Alaskan Native community members*. Whereas the nine tribes of Oregon have treaty rights with government to government relations that must be upheld, Portland is also the ninth largest urban Native American/Alaska

[1] Ruiz-Casares, M., Rousseau, C., Derluyn, I., Watters, C., & Crepeau, F. (2009). Right and access to healthcare for undocumented children: Addressing the gap between international conventions and disparate implementations in North America and Europe. *Social Science & Medicine,* 1-8. doi:10.1016/j.socscimed.2009.10.013

Native community with residents from all over the country who may be descendants of tribal members from outside of Oregon[2]. These are two distinct groups with two distinct protocols for engagement and policy decisions, and healthcare access and needs. Identifying them as such provides us the opportunity to meet their needs individually.

And (4) *Unhoused community members*. Homelessness is a public health issue that impacts and furthers racial disparities in health outcomes. Consistent exposure to the elements, inconsistent access to preventative care, and unstable incomes can create a health crisis. Access to decision making bodies over healthcare is often out of reach for community members who live outside or in shelters, who then do not have the access needed to advocate on their own behalf[3].

We also encourage the specification of page 2, line 33-34. Adjusting this language is arguably a more clear and nuanced description of a robust community of identities that includes people who hold gender identities, sexual orientations, and gender expressions that continue to experience disproportionate health outcomes and would benefit greatly from the self-determination of priority communities under this legislation.

A suggestion for more inclusive legislation might be: *Individuals with sexual orientations and/or gender identities and expressions including: lesbian, gay, bisexual, queer, questioning, asexual, pansexual, Two-Spirit, intersex, transgender, gender non-conforming, gender queer, agender, and other forms of non-binary gender identity or expression.*

Thank you for your time and I am happy to answer any questions you may have.

Thank you,

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[2] Osife, M., & Croover-Payette, A. (2017, July 10). The roots of Portland's Native American community. Retrieved from https://www.oregonmetro.gov/news/roots-portlands-native-american-community
[3] Health in Housing: Exploring the intersection between housing and health care. Providence Health Services, The Center for Outcomes Research and Education. Accessed on 2/2/21
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