

Health Department

Date April 8, 2021

TO: The Honorable Rachel Prusak, Chair
House Committee on Health Care

SUBJECT: HB 3159, Relating to data collection

Chair Prusak and members of the committee,

I am Dr. Aileen Duldulao, Research Scientist and Senior Epidemiologist with the Epidemiology, Analytics, and Evaluation Division of Multnomah County Health Department. I am also a member of the Oregon Health Authority's Race, Ethnicity, Language and Disability (REALD) Data and Governance Committee and have been involved with REALD implementation since 2016. I am testifying on behalf of Multnomah County to support House Bill 3159 and to bring clarity and information regarding implementation challenges that have been raised.

REALD and SOGI are proxies for structural racism and structural oppression and are essential to measuring and addressing health inequities: The REALD and Sexual Orientation and Gender Identity (SOGI) are proxy measures for structural racism, oppression, and implicit bias related to race, ethnicity, language, disability, sexual orientation, and gender identity in all aspects of health care.¹ Peter Drucker states that "What gets measured, gets managed" and in my early training as an epidemiologist, I was taught "If it isn't measured, it doesn't exist." Before REALD, many Black, Indigenous, and People of Color (BIPOC) communities were not measured at the granular level in OHA datasets. This was tantamount to saying that the structural racism, structural oppression, and implicit bias deeply embedded in our health care systems did not exist. We know this is false. We need REALD and SOGI data to begin to make inroads to battling structural racism and oppression in our communities, health care systems, and all systems where implicit bias is deeply embedded.

We must use measures that reflect local, specific populations: The race and ethnicity categories developed by the Federal Government are minimum standards and are not meant to be static categories.² The OMB clearly states that consideration needs

¹ Camara Phyllis Jones, Invited Commentary: "Race," Racism, and the Practice of Epidemiology, *American Journal of Epidemiology*, Volume 154, Issue 4, 15 August 2001, Pages 299–304, <https://doi.org/10.1093/aje/154.4.299>

² Federal Register, Vol. 62, No. 131, 1997, p. 36881, "6. The standards should be developed to meet, at a minimum, Federal legislative and programmatic requirements. Consideration should also be given to needs at the State and local government levels, including American Indian tribal and Alaska Native village governments, as well as to general societal needs for these data. 7. The categories should set forth a minimum standard; additional categories should be permitted provided they can be aggregated to the

to be given to local jurisdictions to ensure that these categories are applicable and have continuous utility. The current REALD and SOGI measures do align with Federal minimum standards but also align with the experiences of communities most impacted by health inequities. The REALD and SOGI measures have been through and continue to go through a very thorough vetting process with researchers and members of the communities most impacted by health inequities.

Health equity work is hard, and difficulties should not be viewed as impossibilities - this work requires long timelines and adequate resources:

Anyone who has worked to combat health inequities knows this is a deeply embedded and entrenched issue that impacts multiple systems and processes. But difficulties in implementation should not be construed as impossibilities. I have heard many complaints that implementation of REALD is a burden, too difficult, costs too much, or is too complicated. Yet structural racism, oppression, and implicit bias, and the suffering of our friends and family members, are larger and more harmful burdens on the health of our communities, and cost society billions of dollars.³ Harmonizing data sets is intrinsically difficult, regardless if you are working with REALD, SOGI, or other health measures. Doing the right thing can be done, if we want it done, and we need the time and resources to do it well. We know this at Multnomah County, when our communicable disease epidemiologists started collecting REALD data as part of their COVID-19 investigations even before OHA did, where they set up their own ad hoc collection system using Qualtrics. If there is a willingness to do the hard work of health equity, there is always a way to do it.

Thank you for the opportunity to express support for HB 3159.

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standard categories. The number of standard categories should be kept to a manageable size, determined by statistical concerns and data needs.”

<https://www.govinfo.gov/content/pkg/FR-1997-07-09/pdf/97-17664.pdf>

³LaVeist TA, Gaskin D, Richard P. Estimating the economic burden of racial health inequalities in the United States. *Int J Health Serv.* 2011;41(2):231-8. doi: 10.2190/HS.41.2.c. PMID: 21563622.

Testimony: HB 3159, Dr. Aileen Duldulao, Multnomah County