

**TO: Oregon House Health Care Committee**  
**FR: Kalpana Krishnamurthy**  
**DA: February 15, 2013**  
**RE: Testimony in support of HB 2134 and -1 amendments**

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Chair Greenlick and Members of the Committee:

Thank you Chair and Members of the Committee. My name is Kalpana Krishnamurthy, and for the past eight years I've been the RACE Program Director at the Western States Center. Western States Center recently spearheaded the 2011 Oregon Legislative Report Card on Racial Equity and I served as the primary author and researcher. HB 2134 was a top recommendation in our 2011 Report Card and is one of the bills being considered for the 2013 Racial Equity Report Card.

### **Health Disparities in Oregon**

As you all know, health disparities are defined as population-specific differences in the presence of disease, health outcomes, or access to health care. In Oregon, health disparities mean that communities of color are sicker and dying earlier than White Oregonians. Some recent statistics include:

- Black Oregonians are three times more likely to die from diabetes than White Oregonians.
- Black babies are 50% more likely to be born with low birth weight than White babies
- Asian/Pacific Islanders have higher cancer mortality rates than other racial and ethnic groups due to lack of access to appropriate screening.
- Breast cancer – one of the most curable forms of cancer - is the leading cause of cancer deaths amongst both Latinas and API women in Oregon.
- American Indians/Alaska Natives have the highest rates of death due to chronic lower respiratory disease and unintentional injuries in Oregon.

### **Why Data Collection is Critical**

Uniform data collection is critically important in the effort to understand and eliminate racial and ethnic disparities in health care. Having data on patient race, ethnicity, and language would allow researchers to better analyze factors that are associated with healthcare disparities. This can help health care systems monitor performance, ensure accountability to enrolled members, improve patient choice, and allow for evaluation of intervention programs.

Uniform data on racial, ethnic, and language differences in health care are generally unavailable. Federal, private, and state supported data collection efforts are scattered and inconsistent and many health plans, with a few notable exceptions don't even collect data on enrollees' race, ethnicity, or primary language.

Uniform data collection in health care is also recognized by the medical community as an important way to assess both quality of care and health outcomes. Nationally, the Institute of Medicine (IOM) and the American Medical Association (AMA) recommend the collection and reporting of health care access and utilization data by patients' race, ethnicity, socioeconomic status, and where possible, primary language. Furthermore, this has been a recommendation made by the Governor's 2000 Racial and Ethnic Health Task Force and by subsequent health equity reports over the last 13 years.

**HB 2134 brings OR into alignment with other data efforts**

HB 2134 brings OHA and DHS into alignment with emerging best practices for addressing health disparities. For example, Multnomah County Health Department's Health Equity Initiative is pursuing a policy to require all County Departments that provide direct services to collect race and ethnicity data in a format that will allow disaggregating by ethnicity of each client. This will increase the accuracy of needs assessments, increase the efficiency and effectiveness of program development, and ultimately drive equitable outcomes.

Clearly, when and how data is collected will have broad cost implications. Given the Affordable Care Act, our state's health transformation and new data systems, HB 2134 gives our state the opportunity to put the systems in place that will make the gathering of this data efficient and economical.

Please support HB 2134 with the -1 amendments.

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