

Invited Testimony- House Bill 2134 declared an emergency (Passed into law on May 2013)

Nguyen-Truong, C. K. Y. (May 7, 2013). Oregon State Legislature - Senate Committee on Health Care and Human Services – HB 2134 (audio starts at 44 minutes and ends at 1 hour and 13 minutes). Dr. Connie Kim Yen Nguyen-Truong's testimony (starts at 48 minutes and 50 seconds and ends at 53 minutes). Retrieved from http://oregon.granicus.com/MediaPlayer.php?clip_id=1458

*House Bill 2134 requires the Oregon Health Authority and Department of Human Services to adopt by rule, using advisory committee, uniform standards for collection of data on race, ethnicity, preferred languages and disability status of public assistance recipients. Provides that standards must be based on local, statewide and national best practices for data collection. Requires report to appropriate committees of Legislative Assembly on implementation of standards. *Dr. Nguyen-Truong's testimony on the study findings from the community-based participatory research work with community members and academic investigators on the Vietnamese Women's Health Project, helped drive health policy change.*

Below is the written version of Dr. Connie Kim Yen Nguyen-Truong's testimony.

Thank you Chair Monnes Anderson, Vice Chair Kruse, and members of the committee, my name is Dr. Connie Kim Yen Nguyen-Truong. I am a Nurse Scientist/researcher at Oregon Health & Science University School of Nursing and Principal Investigator for the Vietnamese Women's Health Project phases II and III.

The Vietnamese Women's Health Project was found due to a grave concern about addressing an unmet community need. At the national level, Vietnamese American women were diagnosed and died from cervical cancer at a much higher rate than White non-Hispanic women. As it is well supported in science, regular cervical cancer screening increases the likelihood of early detection of precancerous and cancerous growths, which could prevent the deaths of many Vietnamese women. In our community, we needed to conduct studies that would provide us with accurate data so that we could appropriately examine how this is impacting health. Based on local non-profit community organizations' study findings of the Tri-County, which included Vietnamese immigrants within the Clackamas, Multnomah, and Washington counties in Oregon, only 74% have ever had a cervical cancer screening within their lifetime. The Vietnamese Women's Health Project also found that only 69% adhered to cervical cancer screening guidelines, which is a poor grade D, much lower compared to the Healthy People objectives. This is a major concern in disparity in health.

Without accurate and current data, we would not be able to generalize our study findings to this at-risk, underserved subgroup within our community. Therefore, the Vietnamese Women's Health Project is able to work on developing a feasible, targeted intervention that is culturally and linguistically appropriate. The consequences of not having accurate data would have led us to develop inappropriate interventions, and as a result would lead us to non-sustaining and poor health outcomes.

One of the most important things I do is to develop the best intervention with primary health care providers and other disciplines for the patients we care for. However, there are many times when I go to review the literature in order to understand the conditions and find little or no information about entire racial and ethnic communities. I often find data that has been aggregated for racial-ethnic groups. For example, heart disease is the #1 killer across racial-ethnic groups. However, cancer is the #1 killer for Asian American Pacific Islander as a group. I know from my own experiences and research with Vietnamese American women, a high risk subgroup, that considering racial and cultural health factors could impact and make a difference in caring for and improving the health outcomes of communities of color.

While we know inconsistencies in data collection affects us, we also know that other communities of color experience similar issues. In order to for us to understand the disparities in health, that is which group or subgroup experiences a heavy/disproportionate burden of a disease and/or life-threatening illness, we need to understand that there may be cultural beliefs particular to each racial ethnic subgroup surrounding the particular disease and treatments. In addition, there could also be multiple factors associated with a particular chronic disease or life-threatening illness.

We must have disaggregated data and there must be a standardized way in which data is collected so that we could begin to improve on how we communicate with each other on these influencing factors about disparities in health. This could help to improve how we examine and address health equity and disparities.

Thank you Chair Monnes Anderson and members of the committee for the opportunity to testify before you today. I would be happy to answer any questions."