

May 8, 2019
The Honorable
Ohio Senate
77 S. High St., 12th Floor
Columbus, OH 43215

RE: S.B. 121- Adopt health education standards/GA need only approve VD ed

Good afternoon Chairwoman Lehner, Vice Chair Terhar, Ranking Member Fedor, and Members of the Senate Education Committee. My name is Kelly Trautner. I currently serve as interim Chief Executive Officer of the Ohio Nurses Association and my background also includes work as an attorney and extensive policy and advocacy work here in Ohio and in our nation's capital involving health issues, our healthcare system and workforce issues. Prior to my current role, I served as President and CEO of The Center for Balanced Living, a facility devoted to the treatment of eating disorders and Director for the Healthcare Division of the American Federation of Teachers. I also worked as a guest teacher for Plain City and Worthington City School Districts prior to becoming a lawyer.

I am testifying today to speak in favor of S.B. 121 as an important step toward not only generally addressing Ohio's poorly ranked health outcomes, but also as a fundamental stride toward addressing health disparities among Ohioans in vulnerable and underserved communities. I hope to illustrate more specifically the potential impact of health education standards as an important role in prevention and outcome efforts by using an example of a mental health condition that often results in debilitating physical health morbidity and even mortality- eating disorders.

Alarming, Ohio ranks 43rd in population health and 46th in health value as compared to all other states, according to the Health Policy Institute of Ohio's Health Value Dashboard report. A state's health outcomes are heavily influenced by non-clinical factors (or "determinants") of health that include public policy, access to clinical care, public health infrastructure, behaviors, social and economic factors, environmental factors, and the disparate distribution of resources and opportunities across a population. Compared to other states, the Health Value Dashboard report demonstrates that our health outcomes are abysmal and we pay too much for our care. With Ohio being the only state lacking health education standards (and with health as Ohio's only academic subject area without standards), S.B. 121 seems to be a fundamental component for a comprehensive effort to improve the health of Ohioans, starting with our kids.

Too many children face barriers to quality healthcare care in our state and the current system does not have the capacity to meet all their needs. Youth in underserved areas (including rural and impoverished areas, as well as areas with high minority populations) and in vulnerable populations (like LGBTQIA) can face many barriers to accessing healthcare services; like proximity to providers, lack of health insurance, lack of reliable transportation, parental work demands, lack of social and/or familial support, and poverty. While S.B. 121 is not an intervention that would remove these barriers to health equity in our state, the development of health education standards can provide Ohio's children with a baseline of health literacy that will increase the likelihood of their growth into healthy, productive adults.

It is well-settled that education is also a social determinant of health; that is, more educated people experience better health outcomes than those with less education. (Ross, Wu, 1995). Where education

about health occurs within schools, health education becomes an important public health tool. (Peters, Kok, Ten, Buijs, Paulussen, 1995). Health education standards will ensure that we capitalize on the critical role schools serve in the health of kids and of the broader community. Health education, therefore, has an important role to play in Ohio's overall efforts to address our state's poor health outcomes, particularly where inequities and barriers exist.

To illustrate these points, I offer a perspective on how S.B. 121 might help improve health outcomes related to eating disorders, one of the most common chronic illnesses among adolescent girls and also among a significant number of adolescent males; and a condition that affects approximately 10% of the population at some point during their life. (Hudson, Hiripi, Pope, Kessler, 2007). This means that more than 1 million residents of the State of Ohio will experience an eating disorder firsthand. With eating disorders, we see among the highest mortality rates of all psychiatric conditions, according to recent mortality statistics. And the physical health problems associated with eating disorders certainly contributes to our overall health outcomes in the youth population.

Barriers to eating disorder treatment, as well as other mental health services, heighten the risk of eating disorders in Ohio's youth. An April 2016 Kaiser Family Foundation Tracking Poll found that one-fourth of Americans report that they or someone in their household has been diagnosed with serious mental illness; and one in five reported that there was a time when they or their family member thought they needed mental health care, but did not receive it. (Firth, Kirzinger, Brodie, 2016). With only three specialized treatment facilities in the state, Ohio lacks capacity to meet the need of the population, making education and other prevention efforts critically important.

As is the case with substance abuse, chronic diseases and other conditions; education and other prevention efforts are more crucial in communities with disparate access to healthcare services. For example, African American teenagers are 50% more likely to exhibit bulimic behavior than white teenagers, yet people of color are less likely to have been asked by a healthcare provider about eating disorder symptoms despite similar rates of eating disorders across ethnic groups. (Goeree, Sovinsky, & Iorio, 2011; Becker, 2003). Additionally, a survey by the Trevor project found that over 50% of LGBTQ youth struggle with eating disorders.

In the first study to assess eating disorder pathology in a low-income marginalized population with food insecurity, researchers also have discovered a correlation between food insecurity and increased risk for eating disorders. At the same time national eating disorder advocacy groups claim upwards of 80% of 10 year olds fear being "fat". Researchers are also beginning to explore connections between body image, eating attitudes, BMI and physical activity in urban versus rural settings. Research among different populations and geographic areas underscores the need to incorporate different types of education about eating disorders and related behaviors in health education by community needs, supporting the importance of the local control aspects of S.B. 121.

Eating disorders is only one example that could be replaced with other health conditions and other factors affecting the health and well-being of Ohioans. Inclusion of health curriculum about health, healthy living, and other conditions that affect well-being represents a low-cost, and potentially high-impact component of prevention and early intervention in our state and communities- thus potentially improving health outcomes and undoubtedly saving the lives of Ohioans. Certainly, comprehensive strategies must be at play to truly move the needle on Ohio's sub-standard population health and health value ratings, and interagency collaboration will bolster the efforts of state and local planners to target

efforts to improve the health, education and well-being of Ohio's children. Our schools cannot and should not singularly bear the burden of fixing these problems. Yet the undeniable link of education as a social determinant of health is one we cannot ignore. Passage of health education standards is an important step in the right direction for our state.

I want to thank you for the critically important work that you do. I am eager to provide additional information and would be happy to answer any questions you might have on this issue.

Sincerely,

Kelly D. Trautner