Senate Health and Human Services Committee
SB-287 Testimony
Ohio Commission on Minority Health
May 4, 2016

Good afternoon Chairman Jones, Ranking Minority Member Tavares and esteemed members of the Senate Health and Human Services Committee. My name is Angela Dawson; I am the Executive Director of the Ohio Commission on Minority Health where I am honored to serve. I appreciate the opportunity to provide proponent testimony for Senate Bill 287.

The Ohio Commission on Minority Health is dedicated to eliminating disparities in minority health through innovative strategies and financial opportunities, public health promotion, legislative action, public policy and systems change.

SB 287 proposes that the Office of Health Transformation convene meetings with staff of certain state agencies, including the Commission on Minority Health, to share and analyze existing diabetes prevalence data, highlight the benefits of existing programs, and make evidence-based recommendations for legislative action to reduce the impact of pre diabetes, diabetes and diabetes-related complications, make recommendations to the legislature for reducing the prevalence of diabetes in the state along with a budget for each recommendation, and produce a report every two years to re-assess, measure progress, and make additional recommendations.

The Commission commends Senator Hite and his co-sponsors for their support of this important bill which can lay the groundwork for the implementation of recommendations to reduce disparities in diabetes, improve health outcomes, and reduce Ohio's costs related to diabetes and the Commission appreciates being included in this initiative.

According to the National Healthcare Disparities Report for 2008, Americans are living longer, healthier lives than ever before because of social, public health and medical technology advances. However, not every community benefits equally from these improvement. Good health is elusive for far too many racial and ethnic minorities in the United States, since appropriate care is often associated with an individual's economic status, race and gender.

Persistent and well-documented health disparities exist between various racial and ethnic populations, even when accounting for economic status and access to health care according to the National Research Council. Health disparities are defined as significant differences in the overall rate of disease incidence, prevalence, morbidity, and mortality rates between one population and another. These disparities or differences in health outcomes among racial and ethnic populations often are driven by the social conditions in which people live, learn, work and play.

According to the Center from Disease Control and Prevention, many factors contribute to disparities including inadequate access to care, quality of care and personal behaviors.

However, there are other factors that can harm one's health as well. Examples include living in an area that has poor environmental conditions such as poverty, inadequate access to healthy foods, inadequate personal support systems, limited access to preventative services, as well as illiteracy or limited English proficiency. In the United States, these differences are caused by a complex array of factors, which makes it necessary for states to devise actions plans that have cross cutting policy solutions.

According to the 2011 United States of Diabetes Report, more than 50% of Americans could have diabetes or pre-diabetes by 2020. This will result in a cost of $3.3 trillion for the federal government in Medicaid, Medicare and other public programs. The U.S. government's National Diabetes Education Program reports that 25.8 million Americans have diabetes which constitutes 8.3 percent of the U.S. population. Of these, 7 million do not know they have the disease. It is estimated that another 79 million adults aged 20 and older have the prediabetes. The financial impact of diabetes on American rose to $45 billion in 2012 of which $176 billion is attributed to direct costs associated with diabetes. Direct costs include the medical costs involved with treating diabetes.

According to the 2014 Center for Disease Control Diabetes Report card, Type 2 diabetes is also associated with a host of health problems such as obesity, hypertension, stroke, blindness, kidney disorders, end-stage renal disease, amputations and other problems. Indirect costs associated with diabetes include, but are not limited to, lost productivity and missed days at work, physical disability and premature death.

The American Diabetes Association reports that in Ohio, more than 1.3 million people have diabetes and an additional 3 million have pre diabetes that, if not addressed, could lead to type 2 diabetes. Since people with diabetes tend to have medical expenses more than double that of people without diabetes, the direct medical expenses for diagnosed and undiagnosed diabetes, prediabetes, and gestational diabetes has been estimated at $9.1 billion.

While the cost is significant, the disparities in the personal and social impact within racial and ethnic populations is troubling. Families USA reports that nationally:

- African Americans are 60% more likely to be diabetic and 2 times as likely to undergo leg, foot or toe amputations;
- Asian American and Pacific Islanders are 60% more likely to have end-stage renal disease;
- Latinos are 55% more likely to have end-stage renal disease; and
- American Indians are 45% more likely to be obese.

The Ohio Department of Health 2015 Report on Impact of Chronic Disease in Ohio reflects that:

- In 2012, Ohio had the 6th highest age-adjusted death rate nationally.
- Black Ohioan's were more likely to die of diabetes in 2012 than their white peers;
- Black Ohioans experience a 79% higher age adjusted death rate than whites.

This legislation provides the opportunity to address this unacceptable rate of death that is preventable.

The Agency for Healthcare Research and Quality creates state level dashboards. In the 2012 report Ohio was ranked as “very weak” in the disease and condition area of diabetes and “weak” regarding preventative programs as well as access to these program for racial and ethnic minorities.

According to the 2010 National Healthcare Disparities Report, there is a need to improve access to preventative care, specifically chronic disease self-management programs. To that end, the Commission pursued and was awarded a federal grant. This grant effort was a partnership with the Department of Aging and the Department of Health which concluded in 2014. This initiative expanded the implementation of the adopted evidenced based model of the Department of Aging. This workforce diversity grant increased the numbers of individuals (12 Master Trainers and 99 Healthy U leaders) trained from racial and ethnic communities while ensuring the capacity to penetrate communities with the provision of chronic disease self-management services to over 500 participants from the targeted populations. The Ohio Department of Aging is responsible for providing access to the free “Healthy U” program which is an evidenced based model of both chronic disease and diabetes self-management programs through their twelve Area Agencies on Aging throughout the state and would serve as a key state agency partner at the table in this effort.

It is important to note that health disparities are also the result of social, economic and environmental differences, and clinical care accounts for the health outcome of only about 20 percent of the population. According the Health Policy Institute of Ohio’s 2014 Health Value Dashboard, ranked Ohio 47th in nation for health value and noted that Ohio struggles when it comes to addressing the physical, social and economic environments that impact health. To improve health value Ohio must address the many factors that impact population health outcomes and healthcare costs.

The Commission on Minority Health has recently initiated a statewide Medical Expert Panel on Obesity and Diabetes to further examine the impact of diabetes and to develop upstream, midstream and downstream policy recommendations.

Effective state action plans are ones that are comprehensive with a holistic approach that identifies health disparities within population groups, shifts healthcare and preventative strategies to populations most in need, requires disaggregated data by racial and ethnic populations and targets multiple social determinants of health.
Such an approach can narrow the gap by reallocating needed services to at-risk patients, educating providers, tailoring prevention messages, increasing access to health care and preventative care where it is most needed, and implementing culturally competent and cost effective care.