Senate

Education Committee

 Ohio Commission on Minority Health

October 1, 2019

Good morning Chairwoman Lehner, Vice Chair Terhar, Ranking Member Fedor and members of the Senate Education Committee. My name is Angela Dawson; I am the Executive Director of the Ohio Commission on Minority Health. Thank you for the opportunity to give proponent testimony on Senate Bill 121, which required the State Board of Education to create health education standards for K-12 school.

The Ohio Commission on Minority Health is dedicated to eliminating disparities in minority health through the prevention of chronic diseases and conditions. In 2016, the Commission released a Medical Expert Panel White Paper on Obesity and Diabetes that highlighted prevention education as a policy recommendation to eliminate health disparities

Diabetes is one of the most prevalent and serious chronic diseases in the United States. According to the Robert Wood Johnson Foundation report “State of Obesity – Making policies for a healthier America”, Ohio has the 17th highest adult obesity rate in the nation, and the sixth highest obesity rate for youth ages 10 to 17. Ohio's adult obesity rate is currently 34.0%, up from 20.6% in 2000 and from 11.3% in 1990.

In 2016, nearly 1 million or 11 percent of Ohio adults were diagnosed with diabetes (Source: 2018 Ohio Chronic Disease Burden Report). In addition, nearly 800,000 adults in Ohio had been diagnosed with prediabetes, and it is estimated that more than 1 million Ohio adults have prediabetes but have not been diagnosed, increasing their risk of progressing to type 2 diabetes later in life (Source: 2018 Ohio Chronic Disease Burden Report). Diabetes is the seventh leading cause of death in Ohio and the United States (Source: 2018 Ohio Chronic Disease Burden Report).

The Ohio Department of Health’s recent reports indicate that obesity has reached epidemic levels in Ohio, like much of the nation. Children who are obese are at an increased risk for health problems, including those that were once primarily seen in adults: such as high blood pressure, high cholesterol, Type 2 diabetes and other conditions. Children who have obesity are more likely to become adults with obesity.

Most children spend time in care outside of their home, making Early Care and Education (ECE) settings and schools some of the best places to reach children with obesity prevention efforts.
Annually, an additional $2.9 billion is spent on health care to treat the preventable diseases associated with childhood obesity.

Without significant policy, systems, and environmental changes, those costs are expected to double by 2030.

Unfortunately, Ohio is the only state in the nation without health education standards, in addition, health education is the only subject area without standards. Health risks such as poor dietary choices, inadequate physical activity, physical and emotional abuse, substance abuse, and gang involvement have a significant impact on how well students perform in school.

Educational standards are the learning goals for what students should know and be able to do at each grade level. Each state sets its own standards—or “benchmarks”—for core curriculum areas such as language arts, mathematics, physical education, science, social studies, technology and health. Education standards ensure better accountability and the practice of aligning learning to standards also helps ensure that a higher level of learning and skill is attained. Education standards are not a curriculum. Local communities choose their own curriculum, which is a detailed plan for day-to-day teaching.

It is often stated that, an ounce of prevention is worth pound of cure, this is clearly seen in the case of childhood obesity, which is one of the biggest threats to our state’s health and economy.

The Centers for Disease Control and Prevention estimates that diabetes costs $15.8 billion in Ohio each year, and these costs are projected to increase. According to the 2018 Ohio Diabetes Action Plan, diabetes represents a significant burden in the state of Ohio. In 1996, 1 in 20 Ohio adults had diabetes; today 1 in 9 do. There are significant racial, ethnic and socioeconomic disparities in the prevalence of diabetes in Ohio, and the financial burden is costly. Further, diabetes disproportionately impacts the adult Medicaid population, among which 16.0 percent (333,000 beneficiaries) have diabetes. Nearly $76 million was spent on diabetes-related hospital admissions and emergency department visits for Medicaid beneficiaries in 2015.

The Ohio Department of Health, [2016 Early Childhood Data Brief](https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/early-childhood-health-program/childhood-obesity-data/childhood-obesity-data/%21ut/p/z1/jZFbc4IwEIV_DY-QpVWqfWPo1CtaRxhoXjqhRJIZZJkk2suvb9SX2lFL3vbknHzZXUJJTmjD9rJiRmLDalu_0uBtMRyFvj-DBTyte7BaJg_-YryMklWPZOeGQdIPrSFIR7Pn9STp9QntkocrJ4Ru-RsGevv56X8AO4E7FUdxRWjLjHBls0GSvwtZlwKxdLHgWpovt2SGXdUzQs85o2A-tJw4mfoQTyAK_houDLJDK1WNxWlrYVPcD-yfFd9wxZW3U1YWxrT60QEHsBQeColehXsHPlrtQIvKsNqBo2LvHeCfbY2KH1twWVO62jBzcO6KWmrBS1fxQ0pfAgrUhuS_OaTdpmn-PR-DfNlmAx3-AIayAIw%21/?1dmy&urile=wcm%3apath%3a%2Fohio%2Bcontent%2Benglish%2Fodh%2Fknow-our-programs%2Fearly-childhood-health-program%2Fchildhood-obesity-data%2F2016-early-childhood-data-brief) shows the health and economic impact of childhood overweight and obesity in Ohio. Childhood obesity can also lead to continued complications later in life. In Ohio in 2014, more than a third (35.7 percent) of Head Start students were classified as overweight or obese. As previously stated, overweight children are more likely to become overweight or obese as adults, with the same disease risks. In addition, childhood obesity remains a source of significant, persistent disparities, especially among African Americans, Native Americans and Latinos.

Childhood obesity in the U.S. leads to unnecessary medical costs associated with preventable diseases in both obese children and those that remain obese into adulthood. More than $2.9 billion are spent in additional health costs for overweight and obese children in the U.S., compared with children who maintain a healthy weight. Without significant change, these costs are projected to increase by nearly $100 billion by 2023.

Given that more than 54 million U.S. children attend schools, their attendance presents the opportunity to ensure the achievement of their knowledge and skills through the establishment of health education standards. Across America, communities are helping to reverse the trend of childhood obesity through changes in public policy, community environments and industry practices that support healthy eating, physical activity, and healthier choices for kids and families. The establishment of health education standards can help to advance these types of changes, so we can ensure all children are able to grow up at a healthy weight, and have a healthy start in life.

According to the CDC, if Ohio achieves a reduction in obesity of 2.5 percent among our youngest children, the State of Ohio could realize a net return of $42 million in economic benefits, not even accounting for the reduced indirect costs and burdens of obesity over a lifetime.

In summary, national and state data both indicate that obese and overweight youth experience multiple health risks and those health risks can contribute to poor health outcomes in adulthood. Therefore, it is important that we promote health education standards that can ensure consistency in learning information about health. Delayed action regarding obesity prevention can lead to steeply rising costs and morbidity, while early intervention can lead to decreased health risks later.

I would like to inform you that I have profound bilateral hearing loss, which will likely require me to ask you to repeat your questions. Thank you in advance for your accommodation. I will be happy to answer any questions you may have at this time.

References and Resources

1. CDC. Community Health and Program Services (CHAPS): Health Disparities Among Racial/Ethnic Populations. Atlanta: U.S. Department of Health and Human Services; 2008
2. [Minority Health and Health Disparities Research and Education Act](http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=106_cong_public_laws&docid=f:publ525.106.pdf) United States Public Law 106-525 (2000)
3. United Health Center for Health Reform and Modernization. (2010) *United States of Diabetes Report: Challenges and Opportunities in the Decade Ahead.* (Working paper 5). Minnetonka: United Health Group.

Retrieved from: <http://www.unitedhealthgroup.com/~/media/uhg/pdf/2010/unh-working-paper-5.ashx>

1. Ohio Department of Health, 2015. The Impact of Chronic Disease in Ohio: 2015. Chronic Disease Epidemiology and Evaluation Section, Bureau of Health Promotion, Ohio Department of Health, 2015 Retrieved from:

<http://www.healthy.ohio.gov/-/media/ODH/ASSETS/Files/health/Chronic-Disease-Plan/CD-Burden-Final_Webv2.pdf?la=en>

1. Ohio Commission on Minority, 2016. Achieving Equity and Eliminating Obesity and Diabetes within Racial and Ethnic Populations, Medical Expert Panel – Volume 2, Ohio Commission on Minority Health, September 2016. Retrieved from:

<http://mih.ohio.gov/Portals/0/Medical%20Expert%20Panel/White%20Paper%20Version%202.2%209.20.pdf>

1. Centers for Disease Control and Prevention (US), Office of Minority Health and Health Equity. OMHHE's guiding principle. Retrieved from: URL:<http://www.cdc.gov/minorityhealth/about/OMHHE.pdf>
2. Steiner RJ, Sheremenko G, Lesesne C, et al. [Adolescent Connectedness and Adult Health Outcomesexternal icon](https://pediatrics.aappublications.org/content/early/2019/06/20/peds.2018-3766). Pediatrics. 2019;144(1):e20183766
3. Kann, L., McManus, T., Harris, W. A., et al. (2018). [Youth Risk Behavior Surveillance—United States, 2017](https://www.cdc.gov/mmwr/volumes/67/ss/ss6708a1.htm?s_cid=ss6708a1_w). MMWR Surveillance Summary, 67(8), 1-479.
4. Choi Y. Academic achievement and problem behaviors among Asian Pacific Islander American adolescents. Journal of Youth Adolescence 2007;(36)4:403–415.
5. Stuart S, Sachs M, Lidicker J, Brett S, Wright A, Libonati J. Decreased scholastic achievement in overweight middle school students. Obesity 2008;16(7):1535–1538.
6. Valois RF, MacDonald JM, Bretous L, Fischer MA, Drane JW. Risk factors and behaviors associated with adolescent violence and aggression. American Journal of Health Behavior 2002;26(6):454–464.
7. Chomitz V, Slining M, McGowan R, Mitchell S, Dawson G, Hacker K. Is there a relationship between physical fitness and academic achievement? Positive results from public school children in the Northeastern United States. Journal of School Health 2009;79(1):30-37.
8. Field T, Diego M, Sanders CE. Exercise is positively related to adolescents’ relationships and academics. Adolescence 2001;36(141):105-110.
9. . Centers for Disease Control and Prevention. National Diabetes Statistics Report, 2017. Atlanta, GA: Centers for Disease Control and Prevention, US Dept of Health and Human Services; 2017.
10. Saydah S, Imperatore G, Cheng Y, Geiss LS, Albright A. Disparities in diabetes deaths among children and adolescents — United States, 2000–2014. MMWR Morb Mortal Wkly Rep. 2017;66(19):502–505.
11. Ohio Department of Health (2014). “Early Childhood Overweight and Obesity.” http://www.odh.ohio.gov/~/media/ODH/ASSETS/Files/data%20statistics/maternal%20and%20child%20health/ec\_overweightobesity.ashx