Oregon Diabetes Report

A report on the burden of diabetes in Oregon and progress on the 2009 Strategic Plan to Slow the Rate of Diabetes.

January 2015

Oregon Health Authority

PUBLIC HEALTH DIVISION
Health Promotion and Chronic Disease Prevention

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I. Executive summary

Oregon is faced with an alarming increase in obesity and diabetes. Approximately 287,000 Oregon adults have diabetes, a condition that costs $2.2 billion annually to treat. About 1.1 million individuals may have prediabetes. An estimated 1,835,000 adult Oregonians are obese or overweight, putting them at high risk of developing diabetes or developing severe complications if they already have diabetes. The burden of obesity and diabetes will continue to increase unless fundamental changes occur to reverse these trends. This report, required by Oregon Senate Bill 169 (2013),* focuses primarily on type 2 diabetes and prediabetes, and how those conditions may be prevented.

Findings of the report include:

- The prevalence of diabetes among adults in Oregon has more than doubled — an increase of 124% — over the past 20 years. There are approximately 287,000 adults with diagnosed diabetes in Oregon and an estimated 110,000 adults with diabetes who do not know it.
- Diabetes is slightly more common among men compared to women (9.2% vs. 7.8%).
- More than 18% of adults aged 65 years and over have been diagnosed with diabetes compared to 2% of adults aged 18 to 34 years.
- African Americans are three times as likely and American Indian and Alaska Natives are twice as likely to have diabetes compared to non-Latino whites.
- An estimated 1.1 million (37%) adults have prediabetes, which puts them at high risk for developing type 2 diabetes.
- In 2013, about 821,000 (27%) adults were considered obese and 1,014,000 (33%) were overweight.
- In 2012, diabetes caused 4,397 hospitalizations in Oregon with a total paid cost of $44 million. Additionally, 7,541 hospitalizations were caused by heart disease among patients with diabetes, with a total paid cost of nearly $112 million. In comparison, hospitalizations due to asthma cost $13 million, chronic lower respiratory disease (CLRD) cost $48 million, stroke cost $128 million, and heart attack cost $129 million in 2012.
- The estimated total cost of diabetes in Oregon is nearly $3 billion per year. Medical expenditures associated with diabetes in Oregon total nearly $2.2 billion each year. Costs associated with reduced productivity from diabetes are estimated at $840 million per year.
- An estimated 38,000 (19%) OHP members have been diagnosed with diabetes. More than $106 million in direct claims cost were paid by OHP in 2012 for diabetes and diabetes-related complications.
- About 5% of Public Employees' Benefit Board (PEBB) and Oregon Educators Benefit Board (OEBB) covered employees have been diagnosed with diabetes. Diabetes and diabetes-related conditions cost PEBB and OEBB more than $46 million in 2012.

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* SB 169 directed OHA to develop this report. OHA's Public Health Division prepared the report.

In 2007, the Oregon Legislature passed House Bill 3486, which required the development of a strategic plan to slow the rate of diabetes caused by obesity and other environmental factors. The highest priority identified in the resulting 2009 Strategic Plan to Slow the Rate of Diabetes continues to be the highest priority today: establish and fund a statewide obesity prevention and education program to support population-wide public health interventions to prevent and reduce obesity and diabetes. The program would include grants to support local public health efforts to increase access to healthy foods and physical activity opportunities, public awareness campaigns to promote healthy choices and educate Oregonians about the risks of obesity and chronic diseases, and community-based chronic disease self-management programs.

The Advisory Committee that drafted the strategic plan developed recommendations for implementation from 2009 through 2015. The plan included recommendations for funding and statutory or nonstatutory actions. As required by SB 169, this report includes the status of strategic plan recommendations, as well as current funding recommendations to complete implementation. Most plan recommendations are in progress, but a comprehensive obesity prevention and education program has not been implemented due to lack of funding. The following table summarizes funding recommendations.

Funding recommendations from the 2009 Strategic Plan to Slow the Rate of Diabetes in Oregon	**Current funding recommendations to complete plan implementation 2015–2021**
Fund obesity prevention and education in communities.	Establish a statewide obesity prevention and education program, with funding starting at a minimum level of $20 million for 2015–2017, and increasing each biennium, as per the strategic plan recommendations.
Continue funding the school physical education grant program.	Establish a sustainable funding mechanism to address school and child care physical education and nutrition standards, through a reliable and dedicated source intended for education, with funding levels to be determined in coordination with ODE.
Provide funds to monitor nutrition standards for foods in schools.	
Provide funds to establish, monitor and enforce minimum standards for physical activity, healthy foods and screen time in all child care settings.	
Increase funding to support the Farm Direct Nutrition Program (FDNP) per eligible participant and provide the benefit for all who are eligible.	Allocate additional FDNP funding to reach all low-income seniors and families enrolled in the WIC (Women Infants & Children) program to purchase locally produced fresh fruit and vegetables. Biennial funding recommendation: WIC FDNP: $3 million Senior FDNP: $1.2 million

The full report is available online at:
http://public.health.oregon.gov/DiseasesConditions/ChronicDisease/Diabetes/Pages/pubs.aspx

Diabetes in Oregon

287,000

The number of adults in Oregon that have diabetes. Over 1 million adults may have prediabetes.

$ 3 billion

The cost of diabetes to Oregonians each year due to health care costs and reduced productivity.

People with diabetes are 2 to 4 times more likely to have heart disease or a stroke.

Certain risk factors can worsen diabetes and diabetes-related complications, and contribute to the development of other chronic diseases like heart disease and stroke.

Among Oregon adults with diabetes, about

- **1 in 2** is obese.
- **1 in 4** smokes cigarettes.
- **2 in 3** have high blood pressure.
- **1 in 2** have high cholesterol.
- **1 in 4** is physically inactive.

Diabetes affects some communities more than others.

Adults with less than a high school education are:

2x

more likely to have diabetes.

African American, American Indian, Alaska Native and Latino people are:

2 to 3x

more likely to have diabetes.

II. Introduction

Senate Bill 169, enacted by the Oregon Legislature in 2013, requires that by February 1, 2015, the Oregon Health Authority (OHA) report on the burden of diabetes in the state, the status of the Strategic Plan to Slow the Rate of Diabetes in Oregon,[1] recommendations to complete implementation of the plan and other strategies to reduce the impact of prediabetes, diabetes and diabetes-related complications.

Diabetes in Oregon

Diabetes is a chronic metabolic disease in which glucose (sugar) levels in the blood are above normal. High blood sugar occurs when the body does not produce enough insulin (type 1), or when the body resists and does not properly respond to insulin (type 2). It is estimated that 90–95% of adults with diagnosed diabetes are classified as having type 2 diabetes, which is largely preventable. Only a small proportion (5%) are classified as type 1.[2]

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[1] The Strategic Plan to Slow the Rate of Diabetes was developed as a result of the 2007 Oregon Legislature's passage of House Bill 3486, which declared an emergency related to diabetes and obesity. The plan, developed by the HB 3486 Advisory Committee, identified actions including funding and statutory recommendations to reduce morbidity and mortality from diabetes by 2015. The HB 3486 Advisory Committee included representatives from more than 30 organizations and programs, and the Oregon Public Health Division. The plan was presented to the 2009 Oregon Legislature and can be viewed on the Public Health Division website at https://public.health.oregon.gov/DiseasesConditions/ChronicDisease/Diabetes/Documents/hb3486/diabstratgicplnsm.pdf.

[2] Centers for Disease Control and Prevention. 2011. *Diabetes successes and opportunities for population-based prevention and control: at a glance, 2011.* Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.

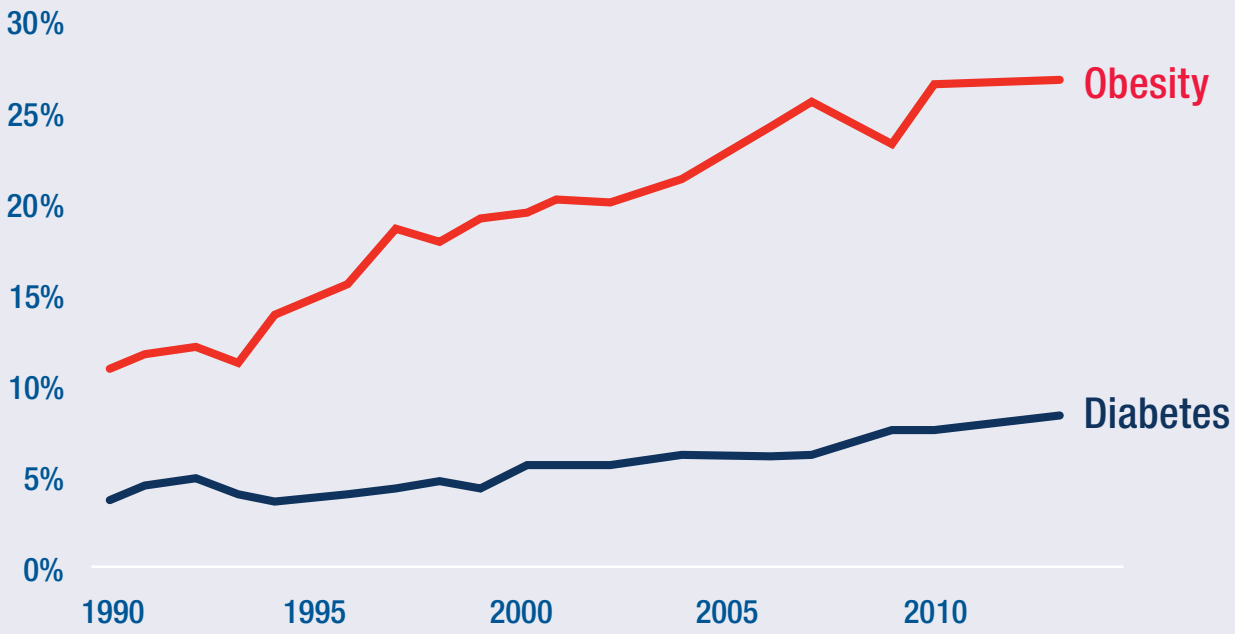
About 287,000 Oregon adults have diabetes, and more than 1 million may have prediabetes.

Approximately 287,000 Oregon adults have been diagnosed with diabetes. Estimates indicate more than 1.1 million Oregon adults have prediabetes, a condition in which blood sugar levels are higher than normal but not high enough to be considered diabetes. Diabetes can cause nerve and kidney damage, skin infections, blindness and can lead to disability and premature death if not carefully managed. Diabetes also adversely affects the cardiovascular system and can contribute to high blood pressure, high cholesterol and heart disease.

The link between obesity and type 2 diabetes is strong and well-documented. Research shows obesity causes 80–90% of type 2 diabetes.[3] The rise of diabetes in Oregon mirrors the rise in obesity. Like diabetes, obesity in Oregon has more than doubled since 1990. Based on current trends, over 350,000 Oregon adults will have diabetes by 2017, an increase of 22% from the 287,000 adults with diagnosed diabetes in 2013.

Today, more than a quarter of adults in Oregon are considered obese.

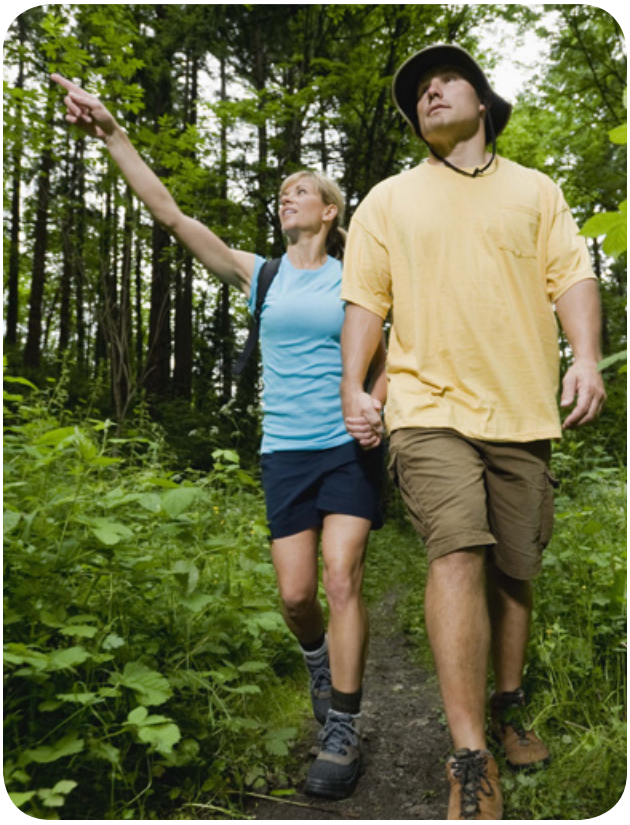
Diabetes and obesity have more than doubled among Oregon adults since 1990



Estimates are age-adjusted. Source: Oregon Behavioral Risk Factor Surveillance System

[3] Astrup, A., Finer, N. 2000. *Redefining type 2 diabetes:'diabesity' or 'obesity dependent diabetes mellitus'?* Obesity Reviews. 1:57-59.

How can diabetes be prevented or controlled?



Maintaining a healthy diet and getting regular physical activity is effective in preventing or delaying the onset of type 2 diabetes and reducing the risk of complications for people with diabetes. Some behavioral and environmental factors associated with diabetes include cigarette smoking and exposure to secondhand smoke, obesity, high blood pressure, high cholesterol, inadequate consumption of fruits and vegetables, and lack of physical activity. These risk factors can be addressed through lifestyle changes and environments that support Oregonians in eating better, moving more and living tobacco-free. Effectively reducing these risk factors will help decrease the prevalence of diabetes in the future.

Reducing the burden of diabetes in Oregon

The HB 3486 Advisory Committee's Strategic Plan to Slow the Rate of Diabetes in Oregon (2009) recommended actions by the legislature and state agencies to reverse the trend of increased obesity and diabetes. The committee's highest priority recommendation was to establish and fund a statewide obesity prevention and education program using a coordinated, multi-sector approach to interventions for health improvement. This model is based on Oregon's success with tobacco control, which reduced cigarette smoking between 1996 and 2013 by 25% among adults, 64% among 11th graders and 80% among 8th graders.

A comprehensive statewide obesity prevention and education program would establish social norms and policies that promote daily physical activity, healthful eating, and living tobacco-free. The program could help Oregonians make healthy lifestyle changes, prevent serious chronic diseases caused by obesity, including diabetes, heart disease and stroke and support statewide access to evidence-based resources for healthy weight management and educational programs warning of the dangers of obesity.

While no state funding has been allocated to date for a statewide obesity prevention and education program, OHA has leveraged limited federal funds to address the recommendations in the strategic plan. A summary of progress and next steps are presented in this report.

OHA is committed to preventing diabetes and reducing the risk of diabetes complications through evidence-based practices such as those recommended in the HB 3486 strategic plan. OHA is working with local and state partners, including local public health authorities and coordinated care organizations (CCOs) to:

- Increase availability of healthy foods and beverages in child care facilities, schools, worksites and neighborhoods;
- Increase places where people can move more safely;
- Increase the number of tobacco-free environments;
- Increase referrals to self-management and prevention programs such as the National Diabetes Prevention Program so people with diabetes or prediabetes can live well and take care of themselves;
- Improve delivery and use of quality health care services including promotion of the ABCS — **A**1C checks, **B**lood **P**ressure control, **C**holesterol control and **S**moking cessation.

OHA and local public health authorities are partnering with CCOs to support health system transformation and advance the triple aim of bringing better health, better care and lower costs to all Oregonians. OHA promotes and supports strategies to improve the delivery and use of quality clinical services to prevent diabetes and diabetes-related complications. These strategies include conducting recommended screenings for blood pressure, cholesterol and blood sugar; increasing clinical referrals to self-management education programs; and following sound clinical practice guidelines when delivering health care.

Many resources are available in Oregon to help individuals, families and employers prevent and control diabetes.[4] However, the current capacity of these programs is not sufficient to reach all those in need. To reduce diabetes at a population level, we recommend a coordinated, systems approach at the state level. This will use existing resources and identify local innovations that can be scaled and coordinated. Existing resources include:

- The National Diabetes Prevention Program, a community-based lifestyle change program for people with prediabetes that helps prevent the onset of type 2 diabetes;
- Oregon's chronic disease self-management programs, which provide tools for living a healthy life with chronic health conditions such as diabetes and obesity (Living Well with Chronic Conditions, Tomando Control de su Salud, Diabetes Self-Management Program);
- Diabetes self-management education programs that help people gain the knowledge and skills needed to modify their behavior and successfully self-manage diabetes and related conditions; and
- The Oregon Tobacco Quit Line, which provides free tobacco cessation coaching to help people live tobacco-free.

[4] More information on programs to help people manage diabetes and other conditions and live healthier lives can be found at www.healthoregon.org/takecontrol.

III. The burden of diabetes in Oregon

Diabetes affects approximately 287,000 adults in Oregon. Nearly 1 in 10 Oregon adults (9.4%) has been diagnosed with diabetes. An additional 110,000 Oregon adults are estimated to have diabetes and do not know it. Together, diagnosed and undiagnosed diabetes affects up to 12% of the adult population, or approximately 1 in 8 Oregon adults. Diabetes in Oregon has risen steadily over the past 20 years. Diagnosed diabetes among Oregon adults has more than doubled since 1990. Diabetes was the seventh leading cause of death in Oregon in 2012, accounting for 3.5% of all deaths.

Risk factors for diabetes

Many factors can increase one's risk of developing diabetes. Age, family history, race and ethnicity are risk factors that cannot be modified or controlled. However, many other risk factors can be controlled, including obesity, high blood pressure, abnormal cholesterol, low fruit and vegetable consumption, lack of physical activity and cigarette smoking.[2,5]

In Oregon, diabetes is slightly more common among men compared to women (9.2% vs. 7.8%). Older adults are more affected by diabetes. Over 18% of adults aged 65 years

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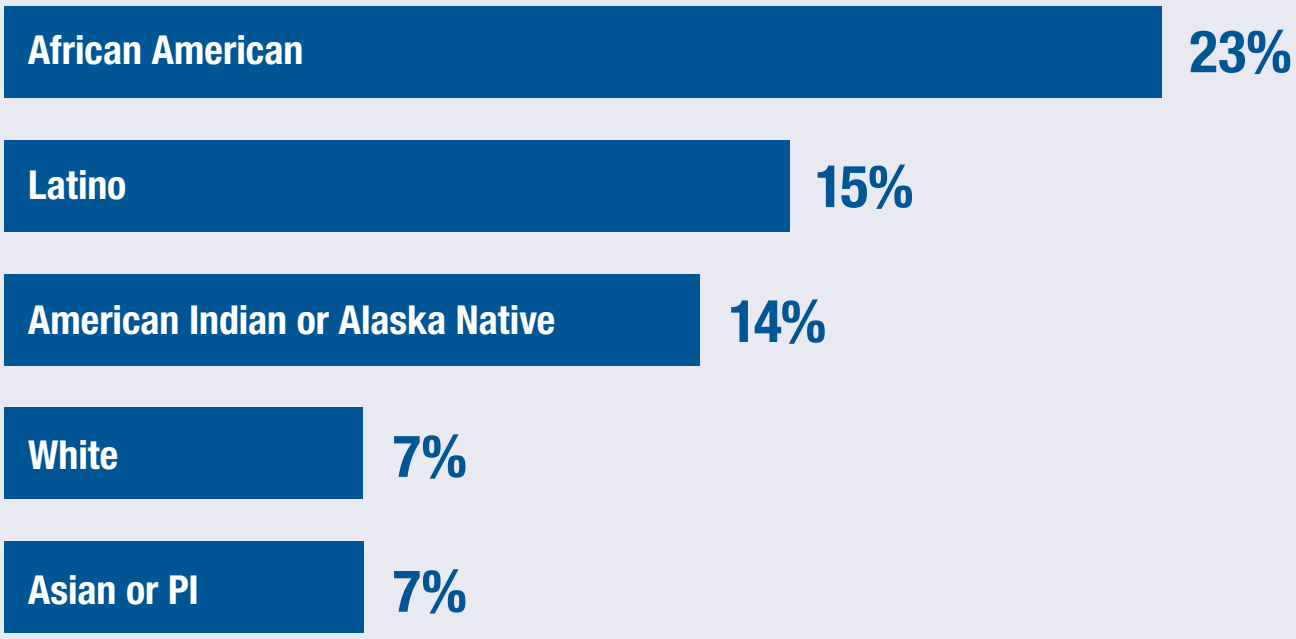
[5] Centers for Disease Control and Prevention. 2014. *National diabetes fact sheet: national estimates and general information on diabetes and prediabetes in the United States, 2014.* Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.

and over have been diagnosed with diabetes compared to 2% of adults aged 18 to 34 years.

Diabetes disproportionately affects some racial and ethnic communities more than others. Compared to non-Latino whites, African Americans are three times as likely to have diabetes, and American Indian and Alaska Natives are twice as likely to have diabetes. These communities are also more likely to experience risk factors that can lead to diabetes such as obesity, high blood pressure, high cholesterol and cigarette smoking.

Diabetes among African Americans is three times that of non-Latino whites in Oregon



Estimates are age-adjusted. Source: 2010–2011 Oregon Behavioral Risk Factor Surveillance System Race Oversample

Note: Race categories refer to non-Latino; PI=Pacific Islander

Diabetes and obesity

More than a quarter of adults in Oregon are considered obese (defined as having a Body Mass Index [BMI] of 30.0 or greater). Sixteen percent of obese adults have been diagnosed with diabetes, compared to 3% of adults who are at a healthy weight. Among adults who are obese, nearly one in five is considered morbidly obese, which is defined as having a BMI of 40.0 or greater. Nearly one-quarter of morbidly obese adults in Oregon have been diagnosed with diabetes. People who are obese are more likely to have high blood pressure and high cholesterol, which can lead to cardiovascular disease and cause severe complications with diabetes. Obesity also increases the risk of developing prediabetes and gestational diabetes, both of which can lead to type 2 diabetes later on.

Prediabetes

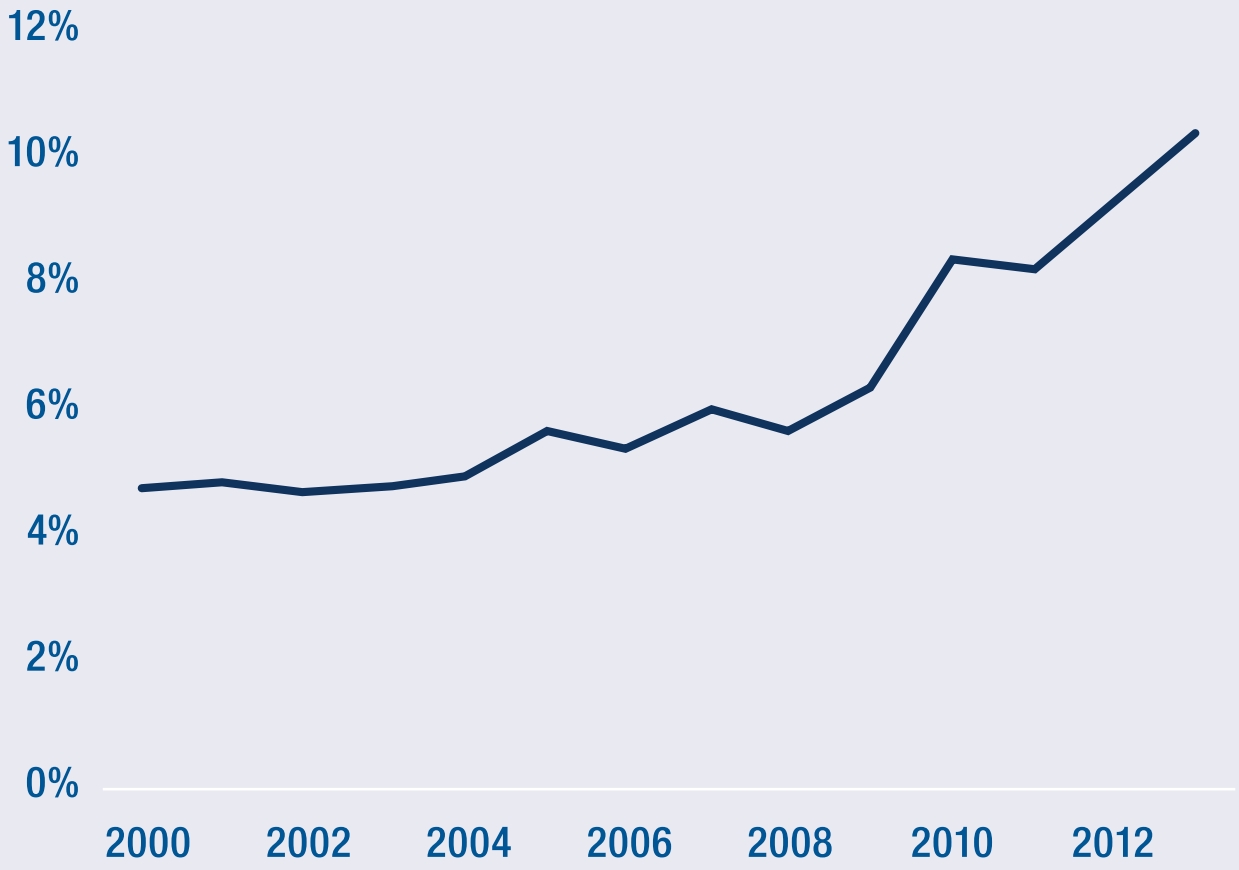
Prediabetes occurs when blood glucose levels are higher than normal but not yet in the range of diabetes. Nearly 266,000 Oregon adults have been diagnosed with prediabetes (8.7%). However, the Centers for Disease Control and Prevention (CDC) estimates that 37% of adults have prediabetes,[6] meaning that over 1.1 million Oregonians could have prediabetes,[6] and most do not know it. The American Diabetes Association (ADA) recommends that all adults aged 45 and over be tested for diabetes and prediabetes once every three years, regardless of whether risk factors for diabetes or prediabetes are present. However, only about 60% of adults aged 45 and older who do not already have diabetes have had a blood sugar test within the past three years.

Gestational diabetes

Gestational diabetes is a type of diabetes that occurs during pregnancy. Similar to the rise in diabetes, gestational diabetes among Oregon mothers has also been steadily increasing. The percentage of births to Oregon mothers diagnosed with gestational diabetes during pregnancy has more than doubled over the last 15 years. In 2013, 10% of all births in Oregon (3,424) were born to mothers with gestational diabetes.

In most cases, gestational diabetes goes away after pregnancy. However, 5–10% of women with gestational diabetes are found to have diabetes immediately after pregnancy, and women who have had gestational diabetes have a 35–60% chance of developing diabetes within 20 years after their pregnancy.[2] Gestational diabetes can

The percent of births to Oregon mothers with gestational diabetes has more than doubled since 2000



Estimates are age-adjusted. Source: Oregon Birth Certificate Statistical Files

result in increased health risks for pregnant women and their babies, including preeclampsia, preterm birth and C-section.[6] It can also cause the baby to grow very large (nine pounds or more) before birth, which increases the risk of complications during birth and the risk of the baby being overweight or developing diabetes later in life.[6]

Gestational diabetes disproportionately affects women in racial and ethnic minority groups.

In 2013, 17% of Latina mothers, 16% of Asian mothers, and 12% of American Indian or Alaska Native mothers were diagnosed with gestational diabetes during their pregnancies, compared to 8% of non-Latino white mothers.

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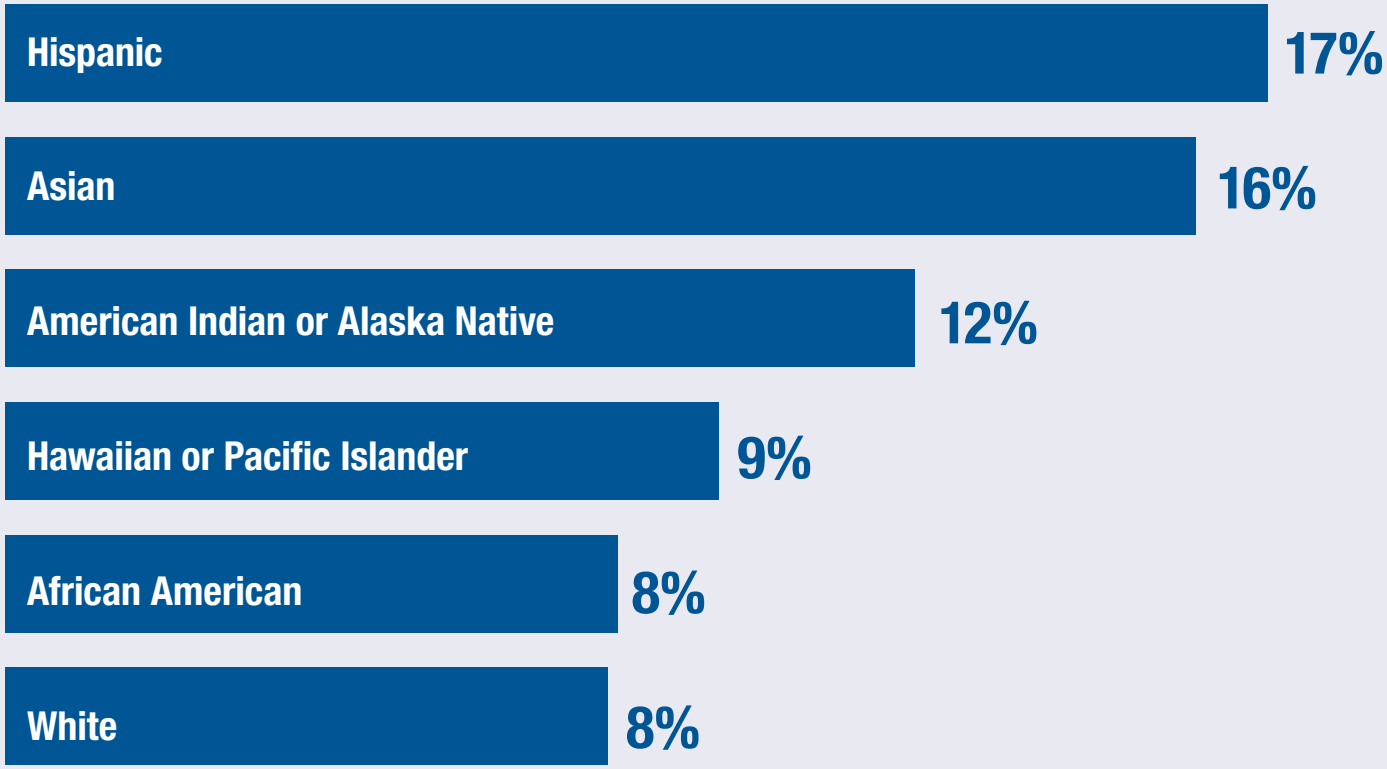
[6] Centers for Disease Control and Prevention. Diabetes and pregnancy – gestational diabetes. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. Available at www.cdc.gov/pregnancy/documents/Diabetes_and_Pregnancy508.pdf. Accessed September 16, 2014

Gestational diabetes disproportionately affects women in racial and ethnic minority groups



Estimates are age-adjusted. Source: Oregon Birth Certificate Statistical File, 2013

The cost of diabetes in Oregon

Diabetes has serious complications, can be difficult to treat and be expensive to manage if not properly controlled.[3] Diabetes creates a significant economic burden at the state and community level. The American Diabetes Association (ADA) estimates 23% of total health care costs in the United States can be attributed to diabetes. According to the ADA, nearly $2.2 billion in excess medical expenditures are associated with diabetes each year in Oregon, averaging $7,800 per person with diabetes. Additional costs associated with reduced productivity from diabetes are estimated at $840 million. The ADA estimates the total cost of diabetes in Oregon is nearly $3 billion per year.[7] These costs can be reduced through early diagnosis of diabetes and strategies to prevent and manage the disease to avoid costly complications.

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[7] American Diabetes Association. 2013. *Economic costs of diabetes in the U.S. in 2012.* Diabetes Care. 36(4): 1033–1046.

Hospitalization costs

If diabetes is not properly managed or controlled, severe complications such as infections, nerve damage and kidney damage can develop and lead to hospitalization. Many of the medical expenditures related to diabetes are from hospitalizations due to complications of diabetes, including heart disease. Heart disease and stroke are major complications of diabetes. Adults with diabetes are two to four times more likely to have heart disease or suffer a stroke than people without diabetes.[8]

There were 4,397 hospitalizations in Oregon primarily caused by diabetes in 2012, with an average cost of nearly $10,000. The total cost of all hospitalizations primarily caused by diabetes was nearly $44 million. In addition, there were 7,541 hospitalizations caused by heart disease in patients with diabetes. The average cost of these heart disease hospitalizations was nearly $15,000, with the total cost of all hospitalizations reaching nearly $112 million. In total, the cost of hospitalizations primarily caused by diabetes, heart disease and stroke was about $680 million in 2012.

Primary cause of hospitalization	Total paid cost
Asthma	$13 million
Diabetes	**$44 million**
Chronic lower respiratory disease (CLRD)	$48 million
Heart attack	$129 million
Stroke	$128 million
Heart disease and stroke	$636 million

Nearly 19% of adult Oregon Health Plan members have been diagnosed with diabetes, compared to 7% of adults with employer-provided health insurance.

Medicaid (Oregon Health Plan) costs

Adults who are members of the Oregon Health Plan (OHP) are disproportionately affected by diabetes. Nearly 19% of OHP members have been diagnosed with diabetes, compared to 7% of adults with employer-provided health insurance. It is estimated that 38,000 OHP members have diagnosed diabetes, accounting for about 13% of all people with diagnosed diabetes in the state of Oregon. Risk factors such as obesity, high blood pressure, high cholesterol and cigarette smoking are more common among OHP members, which can lead to the development of diabetes or contribute to complications of the disease.

[8] National Diabetes Information Clearinghouse, National Institute of Diabetes and Digestive and Kidney Diseases. 2012. *Diabetes, Heart Disease, and Stroke.* Bethesda, MD: U.S. Department of Health and Human Services, National Institutes of Health. Available at http://diabetes.niddk.nih.gov/dm/pubs/stroke/.

Oregon Medicaid-funded programs paid more than $50 million in direct claims costs due to diabetes in 2012. This included diabetic supplies, diagnostic tests and prescription medications. An additional $56 million was paid due to complications of diabetes, including cardiovascular, neurological, peripheral vascular, renal, ophthalmic and other complications. In total, more than $106 million was paid by the OHP in direct claims costs due to diabetes and diabetes-related complications. This may be an underestimate of the true cost as it does not include prescription costs for complications, out-of-pocket costs to the patient or indirect costs such as reduced productivity. These estimates do not include people who are now covered under the Affordable Care Act (ACA).

State and school employee costs

About 5% of employees enrolled with the Public Employees' Benefit Board (PEBB) and Oregon Educators Benefit Board (OEBB) have been diagnosed with diabetes. The prevalence of diabetes among PEBB and OEBB enrolled employees is about 28% lower compared to the general insured population in Oregon.

Direct claims costs due to diabetes were nearly $12 million in 2012 for PEBB, and more than $10 million for OEBB during the same period. Diabetes-related complications cost an additional $11 million for PEBB and more than $13 million for OEBB. In total, diabetes and diabetes-related complications cost PEBB and OEBB nearly $23 million each. These estimates reflect the costs of diabetes among enrolled employees and their dependents.

Coordinated care organizations and quality of diabetes care data

Coordinated care organizations (CCOs) work on a local level to transform the health care delivery system to bring better health, better care and lower costs to Oregonians. The Oregon Health Authority (OHA) tracks several quality measures among CCOs to gauge progress towards improving care, making quality care accessible, eliminating health disparities and controlling costs for the populations they serve.

One of the quality measures OHA tracks, Hemoglobin A1C Poor Control (National Quality Forum [NQF] Measure 59), will help assess the effectiveness of diabetes care in Oregon. Controlling blood sugar levels is key to manage the disease. High blood sugar levels can lead to serious complications and hospitalizations. A1C tests provide an overview of average blood sugar control for the past 2 or 3 months. The results indicate how well a patient's diabetes treatment plan is working. An A1C value greater than or equal to 9% is considered poor control. The American Diabetes Association recommends people with diabetes have an A1C test at least twice a year.

The reporting data for NQF Measure 59 must come from electronic health records (EHRs). Based on extensive discussions and feedback from CCOs on collecting clinical data from EHRs, OHA proposed a multi-pronged, incremental approach to ensure a successful and sustainable reporting process. Beginning with the 2013 measurement year ("year one"), CCOs were to submit data for a subset of measures, including NQF Measure 59.

OHA received year one data for NQF Measure 59 from all 16 CCOs in May 2014. The receipt and analysis of these data supports Oregon's efforts towards health system transformation and represents a crucial step in the incremental approach to build capacity for reporting clinical data. However, at this time, it should not be considered a representative baseline for the following reasons:

- **Self-selection:** The CCOs selected practices to include in their data submission, based on whether or not the practices were considered 'key' (e.g., serving a large portion of Medicaid beneficiaries) and whether or not they had the technological capability to submit the data as requested.
- **Unequal representation:** The CCOs were required to submit a minimum of 10% of the population for the diabetes measure. However, the percentage of the CCO population submitted ranged from 10–87%.
- **Variation:** While the CCOs adhered to a set of parameters for reporting, these parameters were somewhat flexible and allowed for variation among reporting periods, which payers were included, etc.
- **Validity:** The data in year one was considered proof-of-concept and therefore acceptance criteria did not include validation of the measure data. Post-submission, a validity check on all proof-of-concept data was conducted by an external consultant in order to inform future requirements.

These caveats for the proof-of-concept data submissions were designed into the incremental approach to allow capacity building among CCOs. However, to obtain true baseline data, OHA contracted with Acumentra Health to perform a statewide medical record review to calculate statewide performance.

Based on the statewide medical record review, 28% of Medicaid patients with diabetes were in poor control in 2013. This estimate included cases where A1C was greater than or equal to 9%, and cases where A1C was not measured at all.

OHA will continue to build capacity for reporting NQF Measure 59. In measurement year two (calendar year 2014), CCOs are required to submit data for at least 50% of the CCO population, and future years will require quarterly submissions. Regular quarterly submissions are not currently a requirement due to the administrative burden that would be placed on CCOs and providers to submit the data. OHA plans to have a reporting platform in operation by Quarter 1 of 2016 to reduce the administrative burden and facilitate regular data reporting.

IV. Progress on the strategic plan to slow the rate of diabetes caused by obesity and other environmental factors

The HB 3486 Advisory Committee recommended a statewide, population-based approach as the most effective method for reducing the burden of diabetes and other chronic diseases in Oregon. The committee highlighted the public health crisis of diabetes and obesity, and the need for urgent action to promote and support healthy choices in places adults and children in Oregon live, work, play and learn.

The HB 3486 Advisory Committee work plan recommended funding, statutory changes and additional activities that do not require statutory change. Their recommendations highlighted six key actions for the three biennia from 2009–2015:

1. Dedicate significant funding to obesity prevention and education efforts in communities throughout the state.
2. Give serious consideration to addressing underlying causes of health inequities.
3. Provide consumers with access to easily available information to make healthy food choices.
4. Conduct careful planning to enact a “healthy schools act”.
5. Make health a priority consideration in land use and transportation policy and funding.
6. Improve quality of medical care through effective health care reform measures.

The following is a summary of progress on the committee's recommendations, and plans for next steps to move these actions forward, where applicable.

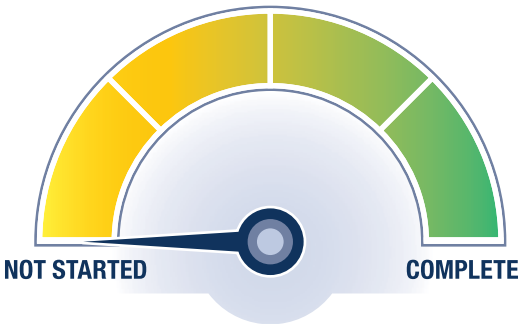
1 Dedicate significant funding to obesity prevention and education efforts in communities throughout the state.

Recommendation from the 2009 strategic plan: Establish and fund an obesity prevention and education program.

Status: Not met; no funding received

Lead agency/division: OHA/PHD

Partners: Coalition of Local Health Officials, local public health authorities, federally-recognized tribes



Background:

The HB 3486 Advisory Committee's highest priority funding recommendation was to establish and fund an obesity prevention and education program to support population-wide public health interventions to prevent and reduce obesity and diabetes. The recommended components included grants to support local public health efforts to increase access to healthy foods and physical activity opportunities, public awareness campaigns to promote healthy choices and educate Oregonians about the risks of obesity and chronic diseases, and community-based chronic disease self-management programs. The report recommended the program include data collection, analysis and publication to evaluate the effectiveness of interventions, and leadership, coordination, training and contract management to ensure effectiveness, efficiency and accountability.

The recommended funding levels for an obesity prevention and education program over three biennia were based on estimates of effectiveness from similar population-based public health programs and CDC recommendations. The committee recommended looking to the Oregon Tobacco Prevention and Education Program and its successes in reducing tobacco use[9] as a model for this approach. Given the magnitude of the problem and because it continues to increase, the committee suggested that an investment of funding for obesity and diabetes prevention needs to at least equal, if not exceed, that for tobacco prevention.

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[9] From 1996 (when the Oregon Tobacco Prevention and Education Program was established) through 2013, cigarette smoking decreased 25% among adults, 64% among 11th graders, and 80% among 8th graders.

CDC's funding recommendation for an effective tobacco control program in Oregon is $39.3 million per year. That level of funding needs to be invested in obesity prevention and education to effectively prevent, detect and manage obesity and diabetes for all Oregon populations in all geographic regions of the state.

Progress summary:

The HB 3486 Advisory Committee recommended an initial funding level for a comprehensive obesity prevention program of $20 million for 2009–2011, $43 million for 2011–2013 and $86 million for 2013–2015. State funding has not been provided. However, the Oregon Health Authority has leveraged funds from a variety of CDC grants to start some of the work recommended in the strategic plan.

The following describes progress related to the specific components of an obesity prevention and education program.

a) Provide grants to local public health agencies, tribes and community-based organizations to work in partnership with schools, businesses, transportation and land use planners, parks and recreation districts, health care settings, and other community organizations to increase access to healthy foods and physical activity opportunities for children in schools, for employees in private and public workplaces, and for all community members through community gardens, farmers markets, recreational facilities, and walking and biking lanes and trails.

The HB 3486 Advisory Committee recommended a comprehensive, statewide approach to address obesity prevention and education as a primary strategy for diabetes prevention and control. At the time that HB 3486 was enacted in 2007, the Oregon Public Health Division (PHD) had a history of providing small grants to a few counties for special projects such as disease-specific coalition meetings, conferences and trainings. Only the state Tobacco Prevention and Education Program had sufficient funds to provide grants to all county health departments and federally recognized tribes in Oregon.

To begin to build statewide infrastructure for obesity prevention, PHD combined its chronic disease categorical program funds from the CDC to support prevention, early detection and self-management of chronic diseases, including diabetes. This approach formed the basis for the Healthy Communities: Building Capacity Training Institute, an initiative to plan local, population-based approaches to reduce the burden of chronic diseases most closely linked to physical inactivity, poor nutrition and tobacco use. This work fostered new partnerships between public health and community partners, and focused broadly on policy, environmental and system changes that influence the prevention and management of chronic diseases, rather than on individual services or health education.

From 2008–2011, Healthy Communities Building Capacity provided funding to 32 local public health authorities (representing 34 counties) and seven tribal grantees. Participating county and tribal public health authorities each received a one-time annual grant of $32,500 to be primarily used for program staffing and coordination. Grantees were required to participate in a chronic disease training institute; collaborate with community partners; gather local data and complete a community needs assessment; develop an implementation plan to reduce the burden of chronic diseases in the community; and promote the Oregon Tobacco Quit Line and other evidence-based chronic disease self-management programs.[10]

PHD awarded competitive three-year grants to fund 12 counties from 2009–2012 to support implementation of local action plans. Three-year Healthy Communities implementation grants were awarded to nine counties and one tribe for 2012–2015. Another round of competitive Healthy Communities grant funding for counties and tribes will be awarded for 2015-2018. In addition, a new competitive grant opportunity will be available in 2015 to cohorts of local public health authorities, CCOs, and community-based organizations to develop innovative models of care for heart disease, stroke and diabetes that align with health system transformation.

PHD pools funds from CDC grants for the Healthy Communities work. With the limited funds available, PHD has not been able to support all local actions to address obesity and diabetes. Additional funding is needed to establish programs in other counties. Counties and tribes have been encouraged to seek out other sources of funding, and some have had success in obtaining funds through federal grant awards, county general funds, or private foundation grants.

Strategic priorities for county and tribal Healthy Communities programs are based on the CDC's Best Practices for Tobacco Control, the Guide to Community Preventive Services, and direction from CDC categorical chronic disease programs. Strategies focus on increasing access to healthy options that help people in Oregon eat better, move more and live tobacco-free. Healthy Communities programs collaborate with a wide range of local stakeholders to raise the priority of obesity and diabetes and implement effective strategies. Local health departments have partnered with CCOs to identify needs and plan evidence-based strategies as part of Community Health Improvement Plans to address obesity and diabetes in their communities.

PHD partners with OHA's Office of Equity and Inclusion to fund six regional health equity coalitions that are implementing community-driven environmental change strategies to address disparities among vulnerable populations.

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[10] For more information, see the Healthy Communities: Building Capacity Based on Local Tobacco Control Efforts 2011 Report at https://public.health.oregon.gov/diseasesconditions/chronicdisease/documents/healthy_communities_building_capacity_2011_report.pdf

b) Conduct public awareness campaigns to promote healthy choices and educate Oregonians about the risks of obesity and chronic diseases.

An important component of this work is to conduct public awareness campaigns to promote healthy choices and educate Oregonians about the risks of obesity and chronic diseases. OHA is developing a campaign, Place Matters Oregon, to show how healthy options where Oregonians live, work, play and learn, influence chronic disease outcomes.

This campaign will explain how social factors (income, education, race or ethnicity), risk factors (tobacco use, lack of physical activity and poor nutrition) and environmental settings impact the health of Oregonians. Federal and state funding for a comprehensive statewide obesity prevention and education campaign would support the development of this critical public awareness campaign to reduce the risk of obesity and diabetes among Oregonians.

c) Provide weight and chronic disease self-management resources and support through community-based programs, and phone and Internet-based services.

Limited state funding has been provided for weight and chronic disease self-management resources, primarily for Weight Watchers benefits for PEBB and OEBB members. Federal grants have supported OHA and Department of Human Services (DHS) in developing statewide infrastructure to provide community-based weight and chronic disease self-management programs. Current programs include the Arthritis Foundation's Walk With Ease six-week walking program, the Stanford Chronic Disease Self-Management Program (known in Oregon as Living Well) and the National Diabetes Prevention Program (DPP).

PEBB included a Weight Watchers benefit in 2009 to help support members' weight management efforts. In the first year, more than 5,500 PEBB members used the Weight Watchers program to lose more than 67,000 pounds. More than 5,000 PEBB members lost in excess of 44,000 pounds in 2010. OEBB added a Weight Watchers benefit for their members in 2010. That year, nearly 12,000 OEBB members lost more than 127,000 pounds using the program. More than 10,000 OEBB members participated in Weight Watchers the following year and shed more than 80,000 pounds.

Walk With Ease and DPP, which are less well established in Oregon, are rapidly growing as a result of federally-funded efforts. A grant through OEBB and Moda Health supports Living Well and DPP expansion in the 12-county Eastern Oregon CCO coverage region. The Oregon Tobacco Quit Line, which provides free phone and internet-based tobacco cessation counseling, also refers callers with chronic conditions (including diabetes and obesity) to community-based self-management programs.

With limited direct funding for self-management resources, stakeholders have managed significant progress establishing and ensuring the sustainability of these resources in Oregon. The Oregon Self-Management Network of health systems, community-based organizations, aging and disability services agencies and local public health has created statewide program marketing resources, identified per-participant costs, and developed quality assurance and fidelity monitoring tools.

Medicaid fee-for-service care coordination refers appropriate clients to local self-management resources and the Quit Line. The OHA Division of Medical Assistance Programs attempted to add self-management programs to the Prioritized List of Health Services in 2011, which would have dramatically increased access for the Medicaid population. However, financial analysis indicated that mandated billing rates for the Federally Qualified Health Centers that provide primary care for many Medicaid beneficiaries would make implementation unsustainable.

Two large statewide insurers, PEBB and OEBB, have approved Living Well and the DPP as covered benefits. OEBB offered the online version of Living Well to enrollees in August 2014 and piloted the DPP in 14 counties in December. Implementation of the community-based program benefit has been delayed by lack of a billing infrastructure. However, with federal grant support and the Oregon Tobacco Quit Line as a model, OHA is establishing a centralized process to allow self-management provider organizations to bill health care purchasers.

d) Conduct data collection, analysis and publication to evaluate the effectiveness of interventions.

Data collection, analysis and publication of data pertaining to diabetes and associated risk and protective factors are necessary for Oregon to effectively address the diabetes epidemic. These foundational activities enable Oregon to have accurate information on the burden of disease and evaluate the effectiveness of interventions.

To date, no state funds support the collection of data, analysis and reporting to evaluate the effectiveness of interventions. By leveraging limited federal dollars, OHA has developed and maintained a sufficient data collection and analysis system to assess diabetes and the factors that put Oregonians at higher or lower risk of developing the disease. Data are collected from birth certificates, death certificates and hospital discharge records. OHA also conducts a statewide survey of Oregon adults (the Behavioral Risk Factor Surveillance System), and surveys among other subpopulations such as racial and ethnic minorities, Medicaid recipients, and state and school employees. A report published in April 2014, Diabetes, Heart Disease and Stroke in Oregon 2013, contains comprehensive analyses of data from several of these sources. (https://public.health.oregon.gov/DiseasesConditions/ChronicDisease/Documents/OHA8582_AllVolumes.pdf)

There is an ongoing need to collect, analyze and publish data to make sure that we are focusing on the right intervention at the right time.to get the improved health outcomes we want. Dedicated funding to support these activities would ensure that the system currently in place can continue to meet the needs of decision-makers interested in combating the diabetes epidemic.

e) Provide leadership, coordination, training and contract management to ensure effectiveness, efficiency and accountability.

PHD coordinates all health promotion and chronic disease prevention efforts across state and federally-funded programs to minimize duplication, leverage resources, address health equity and maximize reach and impact. In 2006, PHD aligned all chronic disease and risk factor-specific categorical programs into a coordinated and integrated section. The new streamlined structure leverages existing staff and resources to ensure no duplication of effort while increasing reach and impact.

In July 2012, PHD placed Oregon's Title V Maternal and Child Health Programs, WIC, Adolescent and Reproductive Health, and Injury Prevention programs under the same center as Oregon's chronic disease and risk factor programs (Center for Prevention and Health Promotion). These organizational changes have led to greater collaboration across programs and more efficient use of staff and financial resources. For example, PHD sections collaborate to implement strategies funded by a CDC grant to prevent and control diabetes, heart disease, obesity and associated risk factors, and promote school health.

PHD has established partnerships with a wide variety of organizations and agencies to enhance health promotion and chronic disease prevention in Oregon. Within OHA, PHD collaborates with other programs including Medical Assistance Programs, Office of Health Policy and Research, Office of Equity and Inclusion and the Transformation Center to consolidate Medicaid managed care plans into CCOs. CCO's provide unprecedented leverage to improve population health by building on the state's requirement that CCO's must focus on prevention and health improvement, not solely health care.

With minimal resources available, PHD has made modest strides towards reducing obesity through high-level policy and systems change focusing on priority populations at greater risk for developing diabetes. For example, PHD convenes OHA and DHS agency leadership in the Cross Agency Health Improvement Project (CAHIP). CAHIP builds on Oregon's successes in supporting tobacco-free living, healthy eating, active living, early disease detection and chronic disease self-management for the more than 1.4 million Oregon clients and consumers of OHA and DHS services. Results from this high-level collaboration include Oregon's Tobacco Freedom Policy that requires all addiction and mental health residential properties be tobacco-free, the addition of the National Diabetes Prevention Program as a covered benefit for all state and public

school employees, and the development of state nutrition guidelines exceeding the federal standards for congregate and home-delivered meals.

PHD has developed a strong local public health infrastructure through Healthy Communities and Tobacco Prevention and Education Program grants. Oregon's highly-skilled local public health workforce in counties and tribes is prepared to respond to any future funding opportunities for expansion of chronic disease prevention efforts. PHD has extensive experience providing robust technical assistance for local health departments, tribes, regional health equity coalitions and local State Innovation Model grantees. PHD has also demonstrated the ability to conduct program evaluation and monitor performance, including the ability to collect and use population-level data to demonstrate progress towards achieving health improvement outcomes for general and priority populations.

Action needed:

Establishment of a statewide comprehensive obesity prevention and education program as recommended by the HB 3486 Advisory Committee continues to be a high priority need. Specific next steps and actions include:

1) Establish a sustainable source of state funding for an obesity prevention and education program, at the funding levels recommended in the 2009 strategic plan, while continuing to leverage federal funding for grants to local public health agencies, tribes and community-based organizations.

2) Build a sustained conversation with Oregonians about the social determinants and risk factors that lead to obesity and diabetes. Funding for a comprehensive statewide obesity prevention and education campaign would support the development of these critical public awareness campaigns to reduce the risk of obesity and diabetes.

3) Continue efforts to make self-management resources available to people with diabetes and prediabetes, and those at risk. Self-management resources supported by public funds must be evidence-based, with demonstrated outcomes such as weight loss, increased physical activity, improved quality of life, decreased hospitalizations, decreased emergency room visits and/or increased self-efficacy for healthy lifestyle choices. To fully implement the HB 3486 Committee recommendation and make these resources accessible to all Oregonians, they would be fully covered by public and private insurers and reimbursements for program participation would flow back to community-based program provider organizations to promote statewide access.

4) Continue conducting data collection, analysis and publication to evaluate the effectiveness of interventions. Dedicated funding to support these activities would ensure that the system currently in place will continue to meet the needs of decision-makers interested in combating the diabetes epidemic.

2 Address underlying causes of health inequities.

Recommendation from the 2009 strategic plan: Create an Interagency Coordinating Council on Health Disparities to include appropriate state agencies, tribes, and community and advocacy organizations to develop a strategic plan to eliminate underlying causes of health disparities including, but not limited to, education, living wage jobs, access to health insurance and health care, racism, and safe and healthy neighborhoods.

Status: In progress (25% complete).

Lead agency/divisions: OHA/PHD, Office of Equity and Inclusion

Partners: Regional health equity coalitions, early learning hubs

Background:

Diabetes affects some communities more than others. Compared to adults with a college degree, adults with less than a high school education are twice as likely to have diabetes. Compared to non-Latino whites, African American, American Indian, Alaska Native and Latino people are two to three times more likely to have diabetes.

Progress summary:

The HB 3486 Advisory Committee's recommendation for the legislature to create an Interagency Coordinating Council on Health Disparities is in progress. Numerous community-based, regional and state level efforts have taken place, laying the groundwork to help inform the development of such a council:

- As part of its mission to engage and align diverse community voices to eliminate avoidable health gaps and promote optimal health in Oregon, the OHA Office of Equity and Inclusion (OEI) conducted a multi-phase, strength-based community engagement process. Representatives of communities experiencing health disparities were first surveyed to seek ideas around advancing health equity. Then interdisciplinary stakeholders gave feedback on policy priorities that address the underlying causes of health disparities. The top ranked general policy areas were: affordable and safe housing and neighborhoods, employment opportunities and education.

- Oregon's Early Learning Council is establishing early learning hubs in multiple counties across Oregon. These hubs bring together a community's child care, health and education efforts to support children and their families to prepare Oregon children, particularly the most vulnerable, to be successful in kindergarten and beyond. The concept of early learning hubs was established by the Oregon Legislature in July 2013 to achieve the Governor's goal to build a seamless system of education from birth to college and career.

- Regional health equity coalitions: OEI and PHD have partnered to fund six regional health equity coalitions to implement community-driven policy, systems and environmental changes to address disparities among vulnerable populations. In specific cases, these changes could indirectly result in reduction of diabetes (e.g. local school district policy to eliminate chocolate milk from school menus).
- The SB 770 Committee engages state agencies in developing and implementing policies on tribal relations to effectively resolve potential conflicts, maximize key intergovernmental relations, and enhance an exchange of ideas and resources for the greater good of all people living in Oregon.
- The Cross Agency Health Improvement Project (CAHIP) aims to improve the health of OHA and DHS consumers, clients and employees by implementing culturally and linguistically appropriate policies to encourage worksite wellness, tobacco-free living, and increase nutrition and physical activity.
- The feedback from OEI's community engagement process, the growth of the regional health equity coalitions and early learning hubs, and the success of the SB 770 Committee and CAHIP combine to contribute valuable baseline information and identify key stakeholders that could inform the development of an Interagency Coordinating Council on Health Disparities.

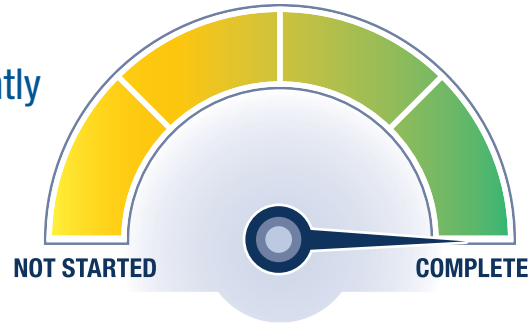
Action needed:

The current context still supports this recommendation. All of these efforts work on various levels to lay the groundwork to help inform the initial development of an Interagency Coordinating Council on Health Disparities.

3 Provide consumers with access to easily available information to make healthy food choices.

Recommendation from the 2009 strategic plan: Require restaurants (with 15 or more outlets) to list calories on menu boards and other nutrition information on menus. Block any legislation that would preempt local jurisdictions' ability to require calorie or other nutrition information on menus in restaurants.

Status: Recommendation to require restaurant menu labeling – met (State law was subsequently preempted by federal law)



Lead: The 75th Oregon Legislative Assembly

Background:

Access to nutritional information about menu items at the point of purchase provides consumers with the information they need to choose menu items with a lower number of calories. Evaluation on the effectiveness of menu labeling policies is mixed.

Progress summary:

The recommendation to pass a menu labeling law was met in 2009 when the Oregon State Legislature passed a law that applies to all Oregon restaurants that are part of a chain of 15 or more restaurants within the United States. The following year, menu labeling requirements were included in the Patient Protection and Affordable Care Act of 2010. Section 4205 requires restaurants and similar retail food establishments with 20 or more locations to list calorie content information for standard menu items on menus and menu boards and to provide other nutritional information, such as sodium and fat content, to consumers in writing.

The federal law preempts Oregon law for establishments with 20 or more locations. It specifies that state or local governments cannot have nutrition labeling requirements for foods sold in establishments covered by the final rule, unless the requirements are identical to the federal requirements. The federal law does not apply to establishments with 15 to 19 locations, as the Oregon law does.

The Food and Drug Administration issued final rules, 21 CFR 101, in November 2014. Implementation of these rules went into effect December 1, 2015.

No federal or state funding has been appropriated for implementation of this law.

Action needed:

OHA will determine next steps for possible implementation of the state law for the restaurants that fall within the Oregon menu labeling law and outside the federal menu labeling law.

4 Conduct careful planning to enact a healthy schools act.

Recommendation from the 2009 strategic plan: Establish a healthy schools act including but not limited to requiring that school siting decisions facilitate biking and walking, allow inclusion of school costs in system development charges paid by developers, ban advertising, offer physical education and conduct health screenings.

Status: The direction has evolved from the initial recommendation.

Lead agency/Division: OHA/PHD

Partners: ODE, Oregon School Boards Association, Healthy Kids Learn Better Coalition

Background:

Students and school employees spend a significant amount of time in schools and schools are often hubs for community engagement. Ensuring these places are located in safe areas and provide increased access to healthy options can lead to better health outcomes that prevent obesity and diabetes.

Progress summary:

A significant subset of policy strategies designed to improve nutrition and physical activity for school-aged youth focus on the school-community environment. PHD and community partners convened to explore this concept in 2010. The group identified that a multi-component, coordinated approach is most effective at improving the health and academic success of students. This comprehensive approach is broader than the HB 3486 Advisory recommendations and includes family and community involvement; comprehensive school health education, physical education and physical activity; school health services; school nutrition services; mental health and social services; school policy and the environment; and school employee wellness. PHD and ODE have been working to advance effective agency level collaboration and planning to support health and educational achievement. Key steps in the PHD and ODE collaboration include meeting quarterly since January 2014 and development of a memorandum of understanding to formalize the partnership.

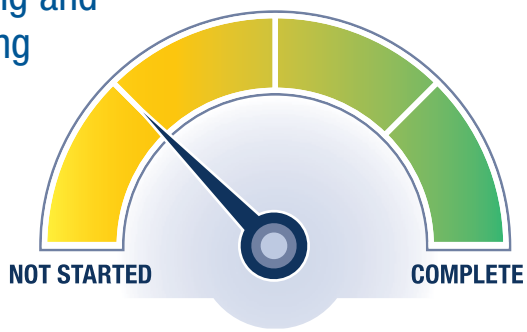
Action needed:

Legislatively establishing a healthy schools act is no longer recommended. The scope and nature of stakeholder recommendations are a better fit for high-level administrative action. It is recommended that the Department of Education and OHA convene to identify

alternative strategies to inform and participate in education system transformation efforts, promote evidence-based tools, support key data collection activities and establish school and/or district advisory councils to support local wellness policy implementation.

5 Make health a priority consideration in land use and transportation policy and funding.

Recommendation from the 2009 strategic plan:
Establish health as a priority in land use planning and transportation decisions and legislation, including but not limited to, policies and funding for bike/pedestrian facilities on all appropriate streets statewide and adding health as a consideration in land use planning and policies.



Status: In progress (25%)

Lead agency/Division: OHA/PHD, Oregon Department of Transportation

Partners: The Oregon Transportation Commission and the 11 regional Area Commissions on Transportation, which approve transportation plans and prioritize projects in their regions; tribal and county health departments publicly funded under the Healthy Communities grant through OHA/PHD; cities (Eugene and Lincoln City) that received OHA/PHD grant funding for pedestrian safety efforts; Safe Routes to Schools (SRTS) National Partnership – Pacific NW Region and SRTS coordinators around the state; American Association of Retired Persons – Oregon; Kaiser Permanente; the Bicycle Transportation Alliance; Asian Pacific American Network Organization; and Oregon Walks, which also received pedestrian safety grant funding.

Background:

The HB 3486 Advisory Committee recommended changing statute and convening key stakeholders to establish health as a priority in land use and transportation policies, funding to support safe and convenient biking and walking facilities, and allow easy access to healthy, affordable food for all communities. Increasing physical activity reduces the risk of developing obesity and diabetes. To address low rates of physical inactivity, the CDC recommends:

1. Creating or enhancing access to places for physical activity, combined with informational outreach;
2. Adopting street-scale urban design and land use policies;

3. Adopting community-scale urban design and land use policies;
4. Promoting active transport to school; and
5. Adopting transportation travel policies.[11]

Progress summary:

Legislative actions since 2009 support greater resources toward biking and walking infrastructure in Oregon. In 2013, SB 260 added nonroadway bicycle and pedestrian projects to those eligible to apply to the *Connect*Oregon V grant program, funded by lottery proceeds designated to the Multimodal Transportation Fund. Also in 2013, HB 5533 authorized $42 million in lottery net proceeds to the *Connect*Oregon V program. Of the $42 million available, approximately 17% of funds were awarded to bicycle and pedestrian projects. Other bills to increase funds toward active transportation have been introduced but not passed. SB 247 (2013) proposed that 9% of lottery proceeds go toward active transportation, but the bill did not move beyond a public hearing. House Joint Resolution 9 (2013) would have broadened the Highway Trust Fund (a major source of revenue for ODOT funded by the gas tax and other vehicle fees) to include greater eligibility for active transportation projects. It was referred to the Transportation and Economic Development Committee for a public hearing, but did not receive a vote.

The Oregon Legislature has passed legislation that makes biking and walking easier for Oregonians. SB 345 (2013) lets cities determine which roadways (often narrow side streets) to designate as shared roadways, gives pedestrians greater legal standing in roadways where there is no sidewalk, and requires cars to yield the right of way. This was the first bill of its kind in the nation.

There has been success within state agencies to bring health concerns to land use and transportation sector work. In 2011, Governor Kitzhaber called upon the Oregon Transportation Commission (OTC) to move Oregon closer to a multi-modal system. As a result, the OTC first adopted health as one of its six priorities in its 2012–2013 work plan.

An ongoing partnership exists between the Oregon Health Authority, Public Health Division (OHA-PHD) and the Oregon Department of Transportation (ODOT). The OTC and the Public Health Advisory Board signed a Memorandum of Understanding (MOU) formalizing the partnership in December 2013. The MOU creates mutual understanding, builds a framework to establish the connection between health and transportation, and identifies joint policy objectives.

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[11] Centers for Disease Control and Prevention. 2011. *Strategies to Prevent Obesity and Other Chronic Diseases: The CDC Guide to Increase Physical Activity in the Community.* Atlanta: U.S. Dept. of Health and Human Services.

The OHA-PHD partnership with ODOT aligns with CDC-recommended practices to increase physical activity through design, policy and funding decisions that prioritize active modes of transportation. OHA-PHD/ODOT projects include:

- A white paper for congressional representatives on the intersection of health and transportation;
- Outreach to inform Area Commissions on Transportation about the partnership;
- A GIS-based EMS crash reporting system;
- Training and mini-grants for local actions to support pedestrian safety;
- Planning safe routes to schools programs with local representatives; and
- Appointing health representatives to ODOT committees:
    - Transportation and Growth Management Advisory Committee;
    - Statewide Transportation Improvement Program;
    - Oregon Bicycle/Pedestrian Plan Update Technical Advisory Committee;
    - Transportation Options Plan Advisory Committee; and
    - Oregon Modeling Steering Committee (survey design, data sharing, modeling).

Action needed:

OHA-PHD and ODOT will continue partnership efforts to help move Oregon's transportation system to more explicitly consider health outcomes in decision-making.

6 Improve quality of medical care through effective health care reform measures.

Recommendations from the 2009 strategic plan:

- Support Oregon Health Fund Board recommendations for health care reform to improve quality of medical care, establish medical homes, and promote prevention and self-management of chronic diseases.
- Increase insurance reimbursement for diabetes education and supplies.

Status: In progress (50%)

Lead agency/division: OHA/Office for Oregon Health Policy and Research, Division of Medical Assistance Programs, PHD

Partners: Coordinated care organizations (CCOs), CCO community advisory councils, regional health equity coalitions

Background:

The HB 3486 Advisory Committee noted the importance of quality medical care and chronic disease self-management programs.

While the HB 3486 Advisory Committee was preparing its report, Oregon was evaluating health care reform options as part of SB 329 (2007), which established the Oregon Health Fund Board. The Advisory Committee determined the Health Fund Board was the appropriate place for recommending health system reform measures, rather than as part of the HB 3486 strategic plan. The Advisory Committee noted the importance of a health care delivery system that practices evidence-based primary care, supports and promotes diabetes self-management and education, and tracks and reports health outcomes of patient populations.

Diabetes self-management education (DSME) programs help people with diabetes gain the knowledge and skills to modify their behaviors and successfully manage the disease and related conditions. DSME may be offered in clinical settings or through community-based organizations, and is covered under the Oregon Health Plan.

PHD completed a survey of the state's accredited and certified DSME programs in 2013. Many reported reimbursement rates for diabetes education frequently did not cover delivery costs. Diabetes education programs noted restrictions on the type and frequency of services covered (including lack of coverage for prediabetes education), cost-related access barriers for patients and quality issues due to restrictions on the amount of education time covered.

Progress summary:

HB 2009 concluded the work of the Oregon Health Fund Board and established the Oregon Health Policy Board (OHPB) in 2009. OHPB serves as the policy-making and oversight body for OHA and is committed to providing access to quality, affordable health care for all Oregonians and to improving population health. In 2011, the Oregon legislature passed HB 3650 to transform the way services are delivered to Oregon Health Plan (OHP) clients through local CCOs. OHA supports CCOs in providing services with the goal of meeting the triple aim of better health, better care and lower costs.

Diabetes control tracking through CCOs: In 2012, Senate Bill 1580 created the Oregon Metrics and Scoring Committee, which identified 17 initial measures to be used in an incentive program (quality pool) and fulfill federal requirements. One CCO metric, NQF Measure 59, reports on the percentage of adults with diabetes whose overall blood glucose level is poorly controlled (HbA1c > 9.0%). Because this reporting relies upon medical record data, each CCO has submitted a plan to outline how they will build the capacity to collect it. CCOs submitted sample data in 2014.

Patient-Centered Primary Care Homes: Patient-Centered Primary Care Homes (PCPCHs) are health care clinics recognized for their commitment to providing high-quality care. This comprehensive, continuous, accessible, accountable, coordinated and patient-centered care is especially supportive for patients with chronic conditions such as diabetes and obesity. OHA's PCPCH Program developed standards for recognition and promotes PCPCH establishment and utilization. As of October 2014, more than 500 clinics across Oregon had been recognized as PCPCHs.

Evidence-based OHP diabetes supplies coverage rules: In January 2015, OHA revised its administrative rules on provision of diabetes supplies and allowed quantities. The revised rule aligns more closely with changes the Health Evidence Review Commission (HERC) made to the Prioritized List of Health Services in 2013, limiting use of blood glucose test strips for patients for whom evidence shows a lack of benefit. Persons with Type 1 diabetes and persons with type 2 diabetes requiring multiple daily insulin injections can receive supplies for 100 home tests per month. The HERC guideline changes limits on testing supplies for type 2 diabetics not requiring insulin injections. These limits result from the HERC's review of medical research showing additional blood glucose test strips do not result in better outcomes for these patients. The HERC also found evidence supporting continued coverage of structured education and feedback programs for all patients using test strips. Rules continue to allow individual medical review of requests for quantities that exceed current limits.

Retrospective continuous glucose monitoring (CGM) is covered under the OHP, and there are no proposed changes to this coverage. Aligning with changes the HERC made in 2014 to the Prioritized List of Health Services, criteria that specify when real-time CGM equipment and supplies may be covered by OHA will be implemented pending further fiscal analysis in autumn 2014. Requests are reviewed on a case-by-case basis using the HERC coverage guideline.

Reduced out-of-pocket costs for diabetes in pregnancy: Recognizing specific concerns related to diabetes during pregnancy, the Oregon Legislature enacted HB 2432 in 2013, which eliminates cost-sharing for covered medically necessary health services, medications or supplies to manage diabetes during pregnancy through six weeks postpartum. While this is a step in the right direction, broader coverage requirements for evidence-based services such as diabetes self-management education and lifestyle change programs for type 2 diabetes prevention would increase use and compliance with diabetes management protocols, and improve health outcomes.

Increased state employee diabetes prevention benefits: As described above, PEBB and OEBB approved the National Diabetes Prevention Program as a covered benefit in 2013. This year-long lifestyle change program helps participants with high risk of developing diabetes to lose weight, move more and establish healthy habits that last for a lifetime. Implementation of this benefit is in process as details related to payment processes and program reach are assessed and planned. In October 2014, OEBB began a DPP coverage pilot; providing organizations in Marion and Polk counties and in a 12-county region of eastern Oregon may be reimbursed.

Action needed:

OHA will continue to support health system transformation through partnerships with CCOs and local public health to improve quality of medical care, establish medical homes, and promote chronic disease prevention and self-management, using the following strategies:

- Conduct screenings according to recommended guidelines for blood pressure, cholesterol and hemoglobin A1C.
- Increase clinical referrals to sustainable, evidence-based prevention and self-management education and support services for people with or at risk for diabetes, heart disease and stroke.
- Assess patients for tobacco use, provide advice to quit and refer tobacco users to the Oregon Tobacco Quit Line, 1-800-QUIT-NOW (1-800-784-8669), and other evidence-based cessation programs.
- Deliver health care for people with and at risk for diabetes, heart disease and stroke using clinical practice guidelines to improve control of shared risk factors for the diseases and their complications.
- Measure performance using standardized metrics to identify practice changes and improve quality.

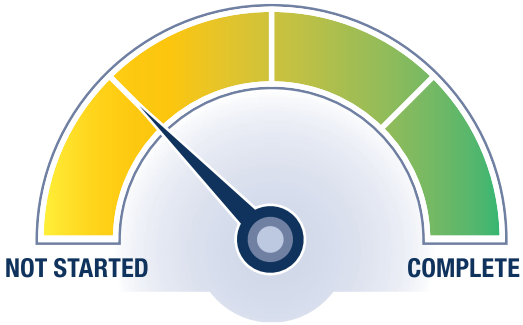
The current context continues to support the HB 3486 Strategic Plan recommendation to promote insurance reimbursement for diabetes education and supplies based on effectiveness. Evidence-based diabetes education resources should be accessible to those at risk for the disease. Additionally, a centralized process to streamline payment processes between health care purchasers and community-based DPP provider organizations would make coverage of education resources more administratively feasible.

Other strategic plan recommendations

The 2009 Strategic Plan to Slow the Rate of Diabetes included the following additional recommendations that did not fall specifically within the plan's six "key actions" described above.

State Agency Worksite Wellness Policy

Recommendation from 2009 strategic plan: Establish a Governor's Executive Order requiring state agencies to create wellness programs and policies to promote nutrition, physical activity and chronic disease self-management.



Status: In progress (25%)

Lead Agency: OHA/PHD

Partners: CAHIP Steering Committee (with representatives from OHA and DHS), Department of Administrative Services, PEBB and OEBB.

Background:

Effective worksite wellness programs improve the health of the workforce and support the prevention and self-management of obesity and diabetes. State agency policies address worksite wellness for state employees through leadership and technical support for agencies to implement evidence-based worksite wellness strategies.

Progress summary:

PHD has a long history of collaboration with PEBB and state agencies to support employee wellness, including providing trainings and information to agency wellness coordinators on worksite wellness strategies. PEBB wellness coordinators currently have varying levels of support, time and knowledge to fully plan and implement activities that lead to better health outcomes. Worksite wellness efforts as recommended by the HB 3846 Advisory Committee would expand a Healthy Worksite Initiative pilot project conducted by PEBB and PHD to all state agencies and would create a more systemic, robust infrastructure for achieving health outcomes.

The tobacco-free state properties policy provides a successful example of a statewide policy supporting employee health. Governor Kitzhaber signed an Executive Order in 2012 requiring state agencies to implement a tobacco-free campus policy. Oregon is one of only two states to pass a tobacco-free state properties policy.

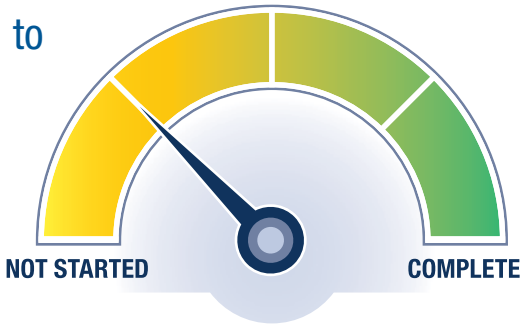
Action needed:

State agency worksite wellness efforts could be required by executive order or agency policy. The Public Health Division will continue to convene the CAHIP Steering Committee, collaborate with PEBB and other state agencies on worksite wellness and identify opportunities to build support for comprehensive worksite wellness.

School physical education standards

Recommendation from 2009 strategic plan: Continue funding the school physical education grant program.

Status: Partially met; additional funding needed to meet the 2017 physical education mandate



Lead Agency/Division: Oregon Department of Education (ODE)

Partners: OHA/PHD

Background:

Resource and time constraints in schools have curtailed physical education in many schools. Opportunity for physical activity throughout the day is important for preventing obesity and diabetes. The HB 3486 Advisory Committee recommended funding to build on the work of the 2007 legislature related to school physical education programs and school nutrition standards.

Progress summary:

The recommendation has been partially funded.

The 2007 Oregon Legislature passed HB 3141, which set standards for minimum number of minutes of physical education to be achieved by 2017. HB 3141 established Physical Education Expansion K-8 (PEEK-8) grants called Teacher Hire and Professional Development grants designed to meet the physical education instructional requirements for students in kindergarten through grade 8 as described in OAR 581-020-0250.

Grants have been periodically administered since 2007:

Grant year	Funding	Number of grants to school districts
2007–09	$860,000 General Fund	3 Professional Development grants, 10 Teacher Hire grants
2009–10	$476,855 General Fund	Continuation of 8 Teacher Hire grants
2010–11	No funding allocated	
2011–12	$370,000 General Fund	2 Professional Development grants, 7 Teacher Hire grants
2013–15	$4 TMSA	5 Professional Development grants 19 Teacher Hire grants.

The school physical education grants program is administered by ODE. Since 2007, 99 schools in 33 unique school districts have been funded for professional development and teacher hires through PEEK-8 grants.

No sustainable funding source or consistent infrastructure for administration and grant monitoring has been established.

Action needed:

School districts still need support to achieve the required number of minutes for physical education by 2017 (2007 House Bill 3141). In order for this to be successful, funding mechanisms have to be sustainable and demonstrate outcomes for achieving the required number of minutes. Funding needs to come from a reliable and dedicated source and be included in the education budget, reinforcing the connection between health and academic outcomes.

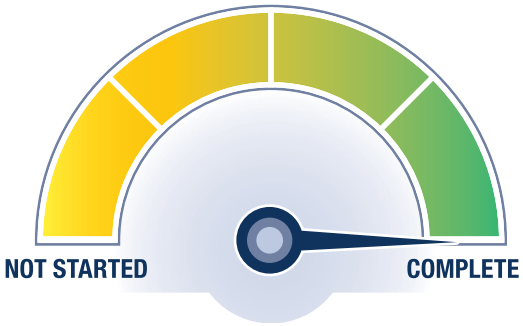
School nutrition standards

Recommendation from 2009 strategic plan: Provide funds to monitor nutrition standards for foods in schools.

Status: Met; additional action recommended

Lead Agency/Division: ODE/Child Nutrition Programs

Partners: OHA/Public Health



Background:

To prevent obesity and diabetes it is important to maintain and monitor nutritional standards for foods served to children in schools.

Progress summary:

Beginning July 1, 2014, the Healthy Hunger-Free Kids Act (HHFKA) 2010 set nutrition standards for competitive foods and beverages sold outside of the federal reimbursable school meals program during the school day. Compliance with nutrition standards is tied to federal USDA school district meal reimbursement. Therefore, funding is not needed at this time to cover enforcement.

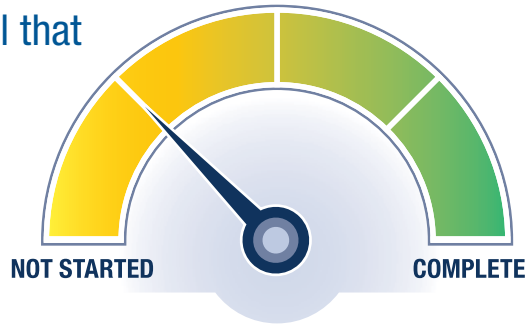
Action needed:

Technical assistance and training is needed at the local level to support implementation of local school wellness policies. As part of the 2010 HHFKA, each district that participates in the National School Lunch Program or other federal Child Nutrition programs must establish a local school wellness policy for all schools under its jurisdiction. At a minimum, school districts must include goals for nutrition education and physical activity, set nutrition guidelines for all foods available and ensure guidelines meet federal requirements. USDA released proposed rules in 2014 to strengthen the implementation, assessment and public engagement requirements, and limit advertising of foods that don't meet HHFKA nutrition standards. Currently school districts do not receive funding to implement model school wellness policies. Collaboration and integration between local public health and education is needed to support school health advisory councils and wellness coordinators, healthy fundraising, classroom rewards and employee wellness.

Farm Direct Nutrition Program

Recommendation from 2009 strategic plan: Increase funding to support the Farm Direct Nutrition Program (FDNP) per eligible participant and provide the benefit for all who are eligible.

Status: Funding has increased but not to a level that serves all eligible participants. (25% complete, based on the 2013–2015 funding level)



Lead agency/Division: OHA/PHD

Partners: Oregon Department of Agriculture, Oregon DHS/Aging and People with Disabilities

Background:

An evidence-based strategy to prevent and manage diabetes is increasing access to fresh fruits and vegetables.

Progress summary:

State-administered federal nutrition programs currently provide opportunities for farmers to sell directly to consumers in Oregon. The Farm Direct Nutrition Program (FDNP) distributes approximately $1 million of federal and state funds annually to families enrolled in the Women Infants & Children (WIC) program and to eligible seniors. Participants receive these funds specifically to purchase locally produced, unprocessed fresh fruit and vegetables directly from authorized farmers at farm stands and farmers markets from June 1 to October 31. In the 2013–2015 biennium, $0.56 million of state funds will be used to support FDNP, including the state's matching requirement for the federal funds.

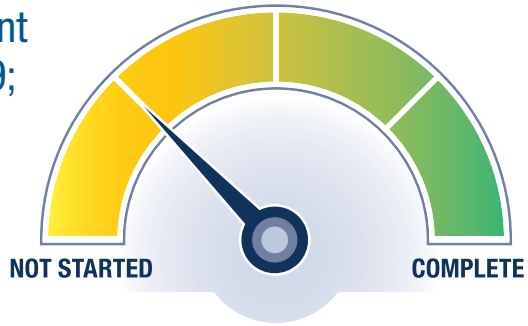
WIC FDNP planned to serve about 23% of eligible participants in the 2013–2015 biennium. Senior FDNP planned to serve 100% of those who are eligible and interested. This is higher than in the past because the benefit amount was lowered in order to serve all eligible seniors.

Action needed:

The current context still supports this recommendation as written. Additional funding is needed to reach all low-income seniors and families enrolled in the WIC program. The funding amount to provide this benefit for all eligible participants is $3 million for WIC FDNP and $1.2 million for Senior FDNP per biennium.

Standards for child care settings

Recommendation from 2009 strategic plan: Fund the Oregon Employment Department to work collaboratively with the ODE and DHS to establish, monitor and enforce minimum standards for physical activity, healthy foods and screen time in all child care settings. (Note: The Office of Child Care was in the Employment Department when this recommendation was written in 2009; it is now within ODE.)



Status: In progress (25%)

Lead agency/division: OHA/PHD

Partners: ODE/Office of Child Care; DHS/Employment Related Day Care Program; Oregon Center for Career Development; Oregon Central Coordination for Child Care Resource and Referral

Background:

Centers and Family Child Care Homes provide spaces for 104,977 children under age 13.[12] Child care settings create environments that promote healthy eating and physical activity to prevent childhood obesity, support children's health and development, and prevent the occurrence of later chronic disease. National health and child care organizations, including the Institute of Medicine, have recommended specific state-level standards for child care providers to prevent obesity among young children.

There are three categories of regulated child care facilities in Oregon: certified child care centers, certified family child care homes and registered family child care homes. Administrative rules vary across child care types. Food, beverages, infant feeding, physical activity and screen time vary by license type and do not currently require all licensed facilities to meet best practices.

Progress summary:

The HB 3486 Advisory Committee's report recommended that state agencies collaborate to set nutrition and physical activity standards in child care settings across Oregon.

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[12] Weber, B. (2013). *Child Care and Education in Oregon and its Counties: 2012.* Oregon Child Care Research Partnership. Available at: http://health.oregonstate.edu/sbhs/family-policy-program/occrp/childcare-dynamics-publications/child-care-and-education-in-oregon-and-its-counties-2012

The first step was to create and codify minimum standards for physical activity, healthy foods, and screen time in child care settings through existing licensing systems and the Quality Rating and Improvement System (QRIS).

QRIS assesses, improves and communicates the level of quality in early care and education programs. Similar to rating systems for restaurants and hotels, QRIS awards quality ratings to early care and education programs that meet a set of defined program standards, including food.

Groundwork has been started to provide education and build awareness of using the child care environment to influence health. This groundwork is critical to the next step of improving and aligning rules, policies and definitions to bring child care health and safety practices closer to best practices.

PHD has used CDC grant funding for the "I Am Moving I Am Learning (IMIL) Train the Trainer" workshop to build training capacity in nutrition and physical activity. The first workshop was held July 23–24, 2014 for 38 new IMIL trainers from all regions in the state. When completed, 48 IMIL trainers, including the 10 current trainers, will have the capacity to present IMIL training in English, Spanish, Russian, Vietnamese and Cantonese.

No federal or state funding has been appropriated to assist with developing and establishing minimum standards for physical activity, healthy foods, and screen time in all child care settings.

PHD continues to work on policy in these areas with Early Care and Education partners. The state education and health transformation efforts have changed the policy-making bodies and disrupted some of ways that PHD has collaborated on policy. However, efforts continue to influence state Early Care and Education licensing and QRIS standards.

Action needed:

The recommendation is still current. Continued collaboration between PHD and ODE is needed. PHD has reduced its full time child care health and safety lead position to less than 0.25 FTE due to budgetary limitations. This greatly reduces the capacity of PHD to participate in policy development activities and to provide health and safety technical assistance to partners. Funding is needed to expand work across state agencies and build capacity in child care settings to eventually establish, monitor and enforce minimum standards for physical activity, healthy foods and screen time in all child care settings. Funding to train child care providers is needed to operationalize the standards for physical activity, healthy foods and screen time in all child care settings.

V. Funding recommendations to complete implementation of the plan

The HB 3486 Advisory Committee developed funding recommendations to implement the strategic plan from 2009 through 2015. No state funds have been allocated for the committee's priority recommendation to establish a comprehensive statewide obesity prevention and education program.

This report provides current funding recommendations to complete implementation of the Strategic Plan to Slow the Rate of Diabetes in Oregon. The following table summarizes funding amounts recommended in 2009, funding received to date and current funding recommendations, which have not changed from the original recommendations.

	HB 3486 Advisory Committee's 2009 state funding recommendations and amounts funded			Current OHA recommendations to complete plan implementation
Funding recommendations from the 2009 Strategic Plan to Slow the Rate of Diabetes in Oregon	**2009–2011**	**2011–2013**	**2013–2015**	**2015–2021** **State funding recommended**
Fund obesity prevention and education in communities	**Recommended:** $20 million **Received:** $0	**Recommended:** $43 million **Received:** $0	**Recommended:** $86 million **Received:** $0	Establish a statewide obesity prevention and education program, with funding starting at a minimum level of $20 million for 2015–2017, and increasing each biennium, as per the strategic plan recommendations.
Continue funding the school physical education grant program	**Recommended:** $1.72 million **Received:** $0.48 million	**Recommended:** $1.72+ million **Received:** $0.37 million	**Recommended:** $1.72+ million **Received:** $4 million	Establish a sustainable funding mechanism to address school and child care physical education and nutrition standards, through a reliable and dedicated source intended for education, with funding levels to be determined in coordination with ODE.
Provide funds to monitor nutrition standards for foods in schools	**Recommended:** $0.70 million **Received:** $0	**Recommended:** $0.70+ million **Received:** $0	**Recommended:** $0.70+ million **Received:** $0	
Provide funds to establish, monitor and enforce minimum standards for physical activity, healthy foods and screen time in all child care settings.		**Recommended:** $ TBD*	**Recommended:** $ TBD*	
Increase funding to support the Farm Direct Nutrition Program (FDNP) per eligible participant and provide the benefit for all who are eligible		**Recommended:** $ TBD*	**Recommended:** $ TBD*	Allocate additional FDNP funding to reach all low-income seniors and families enrolled in the WIC (Women Infants & Children) program to purchase locally produced fresh fruit and vegetables. Biennial funding recommendation (based on projected needs for 2015–2017): WIC FDNP: $3 million Senior FDNP: $1.2 million
WIC FDNP (funding received):	$0.22 million	$0.22 million	$0.32 million	
Senior FDNP (funding received):	$0.044 million	$0.044 million	$0.24 million	

* The strategic plan did not set a specific funding recommendation.

VI. Conclusion

Better health, better care and lower costs are achievable aims in Oregon if we prevent and reduce the burden of diabetes. However, diabetes in Oregon continues to be on the rise. During the past 20 years, the prevalence of diabetes among adults in Oregon has more than doubled. Based on current trends, over 350,000 Oregon adults will have diabetes by 2017, an increase of 22% from the 287,000 adults with diagnosed diabetes in 2013.

The estimated cost of diabetes in Oregon, due to excess medical expenditures and reduced productivity, is nearly $3 billion per year. While the burden of diabetes is significant, in many cases diabetes can be prevented or controlled to avoid costly complications.

A healthy diet, regular physical activity, and living tobacco-free may prevent or delay the onset of type 2 diabetes and reduce the risk of complications for people with diabetes. Some of the behavioral and environmental factors associated with diabetes include cigarette smoking and exposure to secondhand smoke, obesity, high blood pressure, high cholesterol, inadequate consumption of fruits and vegetables, and lack of physical activity. Many of these factors can be addressed through lifestyle changes and environments that support Oregonians in eating better, moving more and living tobacco-free. Effectively reducing these risk factors will help reduce the prevalence of diabetes in the future.

This report has provided an update on the status of the recommendations in the 2009 Strategic Plan to Slow the Rate of Diabetes in Oregon, with changes to systems, policies and environments needed to continue to reduce the impact of prediabetes, diabetes and diabetes-related complications at a population level. The highest priority recommendation identified in the 2009 strategic plan continues to be the highest priority

today: to establish and fund a statewide obesity prevention and education program to support population-wide public health interventions, modeled after the successful Oregon Tobacco Prevention and Education Program.

While no state funding has been allocated to date for a comprehensive statewide obesity prevention and education program, OHA has leveraged limited federal funds to address the recommendations in the strategic plan. OHA is working with local and state partners, including local public health authorities and coordinated care organizations (CCOs) to:

- Increase availability of healthy foods and beverages in child care facilities, schools, worksites and neighborhoods;
- Increase places where people can move more safely;
- Increase the number of tobacco-free environments;
- Increase referrals to self-management and prevention programs such as the National Diabetes Prevention Program so people with diabetes or prediabetes can live well and take care of themselves;
- Improve delivery and use of quality health care services including promotion of the ABCS — **A**1C checks, **B**lood pressure control, **C**holesterol control, and **S**moking cessation.

This comprehensive, community-wide approach makes eating better, moving more and living tobacco-free easier for all Oregonians wherever they live, work, play and learn.

Enrolled
Senate Bill 169

Printed pursuant to Senate Interim Rule 213.28 by order of the President of the Senate in conformance with presession filing rules, indicating neither advocacy nor opposition on the part of the President (at the request of Senate Interim Committee on Health Care, Human Services and Rural Health Policy for Oregon Diabetes Coalition)

CHAPTER .....

AN ACT

Relating to diabetes; and declaring an emergency.

Be It Enacted by the People of the State of Oregon:

SECTION 1. The Oregon Health Authority shall report in the manner described in ORS 192.245 to the regular session of the Legislative Assembly not later than February 1, 2015, the following:

(1) The burden of diabetes in this state as measured by:

(a) The estimated prevalence of diagnosed and undiagnosed adult diabetes and, for diagnosed diabetes, the estimated prevalence by age, race and sex;

(b) The estimated prevalence of prediabetes and of diagnosed Type I diabetes, Type II diabetes and gestational diabetes;

(c) The number of hospitalizations and the estimated cost of hospitalizations due to diabetes and due to heart disease in patients diagnosed with diabetes;

(d) The estimated costs of hospitalizations for diabetes compared to hospitalizations for other common chronic diseases;

(e) The National Quality Forum Measure 59, HbA1c Poor Control, publicly reported for coordinated care organizations, including the baseline measurements and all available quarterly data;

(f) The estimated prevalence of obesity and overweight in the most recent year for which data are readily available;

(g) The estimated direct and indirect costs of diabetes in the most recent year for which data are readily available;

(h) The estimated prevalence of diabetes among participants in Medicaid-funded state programs;

(i) The direct claims costs of diabetes to Medicaid-funded state programs;

(j) The estimated prevalence of diabetes among enrollees in health benefit plans offered by the Public Employees' Benefit Board;

(k) The direct claims costs to the Public Employees' Benefit Board for treating diabetes and diabetes-related complications;

(L) The estimated prevalence of diabetes among enrollees in health benefit plans offered by the Oregon Educators Benefit Board; and

(m) The direct claims costs to the Oregon Educators Benefit Board for treating diabetes and diabetes-related complications.

(2) The status of:

(a) The strategic plan to start to slow the rate of diabetes caused by obesity and other environmental factors by the year 2010 that was developed in accordance with section 2, chapter 460, Oregon Laws 2007 (Enrolled House Bill 3486), including the authority's current funding recommendations to complete the implementation of the plan; and

(b) Other strategies developed by the authority to reduce the impact of prediabetes, diabetes and diabetes-related complications including strategies to reduce hospitalizations and improve diabetes care for participants in state-funded health programs.

SECTION 2. Section 1 of this 2013 Act is repealed on the date of the convening of the 2016 regular session of the Legislative Assembly.

SECTION 3. This 2013 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2013 Act takes effect on its passage.

Passed by Senate April 23, 2013

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Robert Taylor, Secretary of Senate

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Peter Courtney, President of Senate

Passed by House May 30, 2013

.....
Tina Kotek, Speaker of House

Received by Governor:

.....M.,....., 2013

Approved:

.....M.,....., 2013

.....
John Kitzhaber, Governor

Filed in Office of Secretary of State:

.....M.,....., 2013

.....
Kate Brown, Secretary of State

Oregon Health Authority

PUBLIC HEALTH DIVISION
Health Promotion and Chronic Disease Prevention
Phone: 971-673-0984

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OHA 8681 (11/14)