

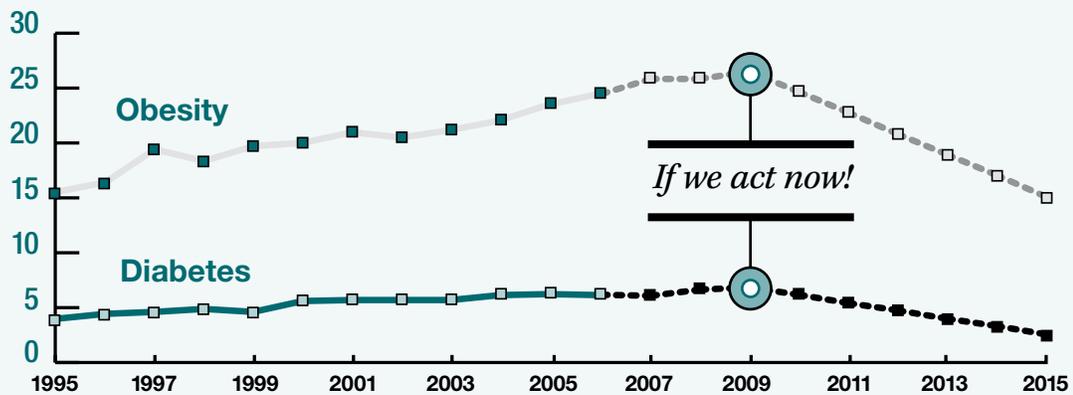
STRATEGIC PLAN

to Slow the Rate of Diabetes in Oregon

“Reversing the trends of obesity and diabetes”

A Report to the 2009 Oregon Legislature from the HB 3486 Advisory Committee

DIABETES AND OBESITY AMONG ADULTS IN OREGON



Source: BRFSS. Age-adjusted to 2000 US Standard Population.



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EXECUTIVE SUMMARY



The 2007 Oregon Legislature approved and Governor Kulongoski signed House Bill 3486, which declared an emergency related to diabetes and obesity. The bill directed the Oregon Department of Human Services (DHS) to develop by 2009 a strategic plan to start to slow the rate of diabetes caused by obesity and other environmental factors by 2010. The plan was to identify actions, including funding and statutory recommendations, that would reduce morbidity and mortality from diabetes by 2015. The plan was developed through a strategic planning process organized and staffed by the Health Promotion and Chronic Disease Prevention Section and Office of Family Health of the Oregon Public Health Division in DHS. The plan will be presented to the 2009 Oregon Legislature.

Oregon is faced with an alarming increase in obesity and Type 2 diabetes. Approximately 262,000 Oregon adults already have diabetes, a condition that currently costs \$1.4 billion annually to treat. An additional 592,000 individuals manifest abnormal metabolism indicative of a prediabetes condition. In addition, 1,710,000 adult Oregonians (60 percent) are obese or overweight, putting them at high risk of developing diabetes or developing severe complications if they already have diabetes. More than 37,000 adult Oregonians become obese each year, and 6,900 Oregonians develop diabetes each year. Tens of thousands of additional Oregonians will develop prediabetes annually unless fundamental changes occur to reverse these trends.

Oregonians with low incomes and those who are African American, American Indian/Alaska Native, and Hispanic/Latino are more

commonly affected by diabetes and obesity and have less access to health care. In addition, many Oregon children already are overweight and some even have Type 2 diabetes, a diagnosis previously very rare in children.

Traditional medical approaches are available, but will not change the rate at which new people develop obesity or diabetes. The costs for treating these current and future cases of diabetes through an increasingly expensive health care system are unaffordable and unsustainable for either the private or public sector. Continuing these approaches would be like using a very expensive “mop” to soak up the water streaming from a wide-open “faucet” of obesity and diabetes, but doing nothing to turn the faucet down or off.

The HB 3486 Advisory Committee developed guiding principles leading to the prioritization of a statewide, population-based, prevention approach as the most likely method for effectively slowing the burden of diabetes and other chronic diseases rapidly emerging in Oregon. The guiding principles highlight the urgency of this public health crisis of diabetes and obesity, and the need to act now to promote and support healthy choices in all the places adults and children in Oregon live, work, play and learn.

The benefits of creating health-promoting community environments go far beyond reducing the prevalence of obesity and diabetes. Such environments also support treatment and management of diabetes, and help reduce the dire complications of diabetes such as heart disease, blindness, amputations and kidney disease. Additionally, related





EXECUTIVE SUMMARY

conditions such as high blood pressure, high cholesterol, heart disease, stroke, cancer and arthritis also will be prevented and/or more effectively managed.

The Advisory Committee developed a workplan for the next three legislative biennia based on their findings. Their recommendations include the following key actions during the next three biennia:

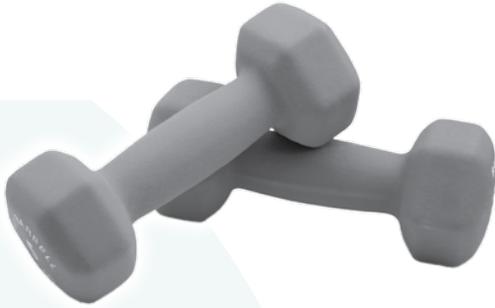
- Dedicate significant funding to obesity prevention and education efforts in communities throughout the state.
- Give serious consideration to addressing underlying causes of health inequities.
- Provide consumers with access to easily available information to make healthy food choices.
- Conduct careful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

Considerable time and analysis was done to determine the feasibility of pursuing a traditional medical approach – mass screening; diagnosis of obesity, prediabetes and diabetes; treatment with pharmacologic agents; intensive lifestyle counseling; and other measures. While evidence supports some effects from such an approach, the current numbers of people with obesity and prediabetes would cause this approach to be enormously expensive with limited effects on reversing either condition or preventing new people from developing them. In contrast, an effective population-based prevention approach would reduce both the development of new cases of obesity and diabetes and help manage and/or reduce the current cases at a much more reasonable cost. However, to improve the health of those who already have diabetes, important clinical tools need to be used more widely – support for self-management and diabetes education, improved primary care and use of the Chronic Care Model, a framework for delivering quality clinical care for people with chronic diseases supported by the Robert Wood Johnson Foundation.

Social factors such as income, education, race and ethnicity play a key role in determining the incidence and severity of obesity, prediabetes and diabetes. Population-based approaches need to recognize these determinants and work to eliminate the disparities they cause. Affected communities need to be part of the discussion and planning.



INTRODUCTION



The 2007 Oregon Legislature passed and Governor Kulongoski signed House Bill 3486, which declared an emergency related to diabetes and obesity. The bill directed the Oregon Department of Human Services (DHS) to develop by 2009 a strategic plan to start to slow the rate of diabetes caused by obesity and other environmental factors by 2010. The plan was to identify actions, including funding and statutory recommendations, that would reduce morbidity and mortality from diabetes by 2015. Chief sponsor of the bill was Representative Scott Bruun.

The bill directed DHS to work in collaboration with key partners to develop the plan. partners included the American Diabetes Association, the Oregon Diabetes Coalition, other professionals, community-based organizations, health educators and researchers specializing in diabetes and obesity prevention, treatment and research. The bill identified the following components to be included in the plan:

- Environmental factors that encourage or support physical activity and healthy eating habits;
- Effective strategies for prevention that are culturally competent and address the populations most at risk for developing diabetes;
- Recommendations for evidence-based screening;
- Recommendations for redesigning and financing primary care practices to facilitate the adoption of the Chronic Care Model

for diabetes screening, support for self-management and regular reporting of preventive clinical screening results;

- Actions and a timeframe to reduce the morbidity and mortality from diabetes by the year 2015; and
- Statutory changes and funding needed to achieve the plan.

The HB 3486 Advisory Committee held its first meeting November 29, 2007. In order to produce a comprehensive strategic plan, representatives from more than 30 organizations and programs were divided into two subcommittees, which met simultaneously over a period of three months with a team from DHS. One subcommittee focused on environmental factors affecting physical activity and healthy eating, as well as prevention and culturally competent strategies. The other addressed evidence-based screening and issues related to primary care and the Chronic Care Model, an approach to improving care of people with chronic illnesses through use of guidelines, information systems, and proven strategies, supported by the Robert Wood Johnson Foundation.

Each subcommittee developed a set of focused recommendations built on those already published in recent reports and plans. These included the Health Policy Commission's report "Promoting Physical Activity and Healthy Eating among Oregon's Children" (2006), the Oregon Action Plan for Diabetes (2005), and the Statewide Physical Activity and Nutrition Plan (2007). The full Advisory Committee reconvened in March, May and June 2008 to review, refine and create the comprehensive strategic plan that follows.



BACKGROUND/ PROBLEM STATEMENT

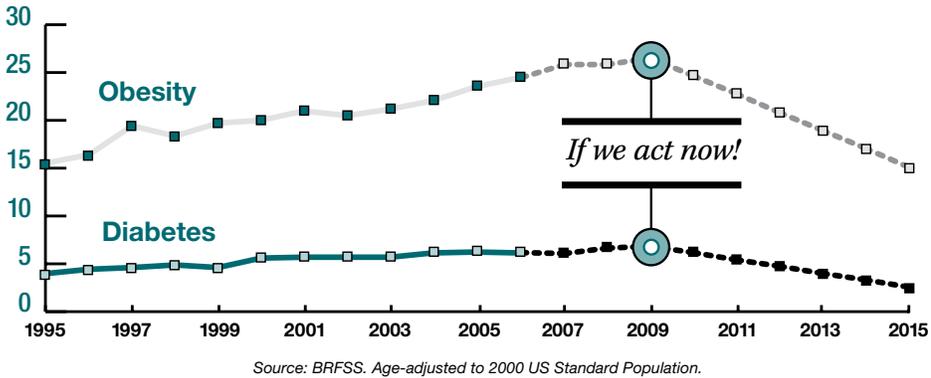


Diabetes already is costly for the health care industry to treat. In Oregon it currently costs the public and private health care system \$1.4 billion each year to treat diabetes. These costs do not reflect the toll in human suffering experienced by those with diabetes and their families.

These costs also do not reflect the provision of health care for all Oregonians with diabetes. Not all of the 262,000 adults in Oregon with diabetes receive health care for their condition. There are an estimated 76,000 adult Oregonians with undiagnosed diabetes who are not receiving appropriate treatment. There also are uninsured Oregonians who are not able to access health care.

Oregon is in the middle of an epidemic of obesity and prediabetes, and is swiftly heading toward an epidemic of diabetes. Since 1995, the rates of obesity and diabetes in Oregon have increased dramatically and in parallel (59% and 62%, respectively, see **Figure 1**). While 262,000 Oregon adults already have diabetes, 6,900 more are diagnosed each year. Approximately 592,000 adults are estimated to have a prediabetes condition of abnormal metabolism. Fully 1,710,000 Oregon adults are overweight/obese and every year 37,000 more become obese, placing them at high risk for developing diabetes. The increase in obesity and diabetes seen in the **Figure 1** requires immediate actions in order to reverse these alarming trends.

Figure 1
DIABETES AND OBESITY AMONG ADULTS IN OREGON



Oregon’s children are not immune to this epidemic. Currently approximately 2,100 Oregon children have diabetes, mostly Type 1 (not related to obesity). However, some children are now being diagnosed with Type 2 diabetes (most commonly related to obesity in adults), a previously unheard of phenomenon. With 165,000 Oregon youth already overweight and 14,000 estimated to have prediabetes, the next generation of Oregonians is projected to be in worse health than their parents and grandparents. The Centers for Disease Control and Prevention (CDC) estimates that 1 in 3 children born in 2000 will develop diabetes if conditions don’t change.

Heart disease, stroke, some cancers and other chronic diseases such as arthritis and asthma are related to obesity. People with diabetes are four times more likely to have heart attacks or angina than people without diabetes (17 percent vs 4 percent) and more than twice as likely to have a stroke (5 percent vs 2 percent). Preventing obesity and diabetes would have an enormous impact on reducing the development of many chronic diseases and their complications.





BACKGROUND/PROBLEM STATEMENT

Certain populations in Oregon are experiencing even more obesity, diabetes and related chronic diseases. People with lower incomes, less education, and those of certain racial/ethnic groups (especially African American,

PREVALENCE OF DIAGNOSED DIABETES BY RACE AND ETHNICITY IN OREGON:

COMMUNITY	PERCENTAGE OF ADULTS WITH DIABETES	NUMBER OF PEOPLE THIS REPRESENTS
African Americans	13%	4,800
American Indians and Alaska Natives	12%	5,300
Asians and Pacific Islanders	7%	6,400
Hispanics/Latinos	10%	14,000
Non-Latino Whites	6%	167,000

PREVALENCE OF OVERWEIGHT OR OBESITY BY RACE AND ETHNICITY IN OREGON:

COMMUNITY	PERCENTAGE REPORTING OVERWEIGHT/OBESITY	NUMBER OF PEOPLE THIS REPRESENTS
African Americans	69%	29,000
American Indians and Alaska Natives	69%	32,000
Asians and Pacific Islanders	43%	46,000
Hispanics/Latinos	70%	160,000
Non-Latino Whites	60%	1,500,000

(Source: 2004-2005 BRFSS Oversample. Presented rates are age-adjusted to the 2000 Standard Population. "Number of people this represents" gives an estimate of how many adults age 18 years or older in Oregon have the specific condition listed. It is based on population estimates from the 2006 American Community Survey.)

American Indian/Alaska Native, and Hispanic/Latino) all experience more obesity and diabetes than other population groups. Data outlining these disparities are included in the tables on pages 10 and 11.

PREVALENCE OF A HISTORY OF HEART ATTACK BY RACE AND ETHNICITY IN OREGON:

COMMUNITY	PERCENTAGE OF ADULTS REPORTING HEART ATTACK	NUMBER OF PEOPLE THIS REPRESENTS
African Americans	8%	2,700
American Indians and Alaska Natives	10%	4,000
Asians and Pacific Islanders	2%	2,000
Hispanics/Latinos	3%	4,300
Non-Latino Whites	4%	100,000

PREVALENCE OF A HISTORY OF HIGH BLOOD PRESSURE BY RACE AND ETHNICITY IN OREGON:

COMMUNITY	PERCENTAGE OF ADULTS REPORTING HIGH BLOOD PRESSURE	NUMBER OF PEOPLE THIS REPRESENTS
African Americans	42%	16,000
American Indians and Alaska Natives	30%	13,000
Asians and Pacific Islanders	19%	18,000
Hispanics/Latinos	19%	28,000
Non-Latino Whites	25%	677,000

Prevalence of overweight or obesity among persons on the Oregon Health Plan: **65%**

Prevalence of diabetes among persons on the Oregon Health Plan: **13%**

Prevalence of high blood pressure among persons on the Oregon Health Plan: **34%**

(Source: 2004 Medicaid Health Risk Health Status Survey. Age-adjusted to the 2000 Standard Population.)



GUIDING PRINCIPLES



The HB 3486 Advisory Committee created a set of overarching principles to guide their work in developing recommendations that would effectively slow the rate of diabetes due to obesity. These principles include:

1. The epidemic of obesity and diabetes is a public health crisis of gigantic proportions that needs immediate attention. Right now 6,900 adult Oregonians are newly diagnosed with diabetes each year. Each year 37,000 additional adult Oregonians become obese. Reversing the trends of obesity and diabetes is critical to the health and economic well-being of Oregon.
2. The costs of effectively reducing the epidemic of obesity and diabetes solely through the health care industry are staggering. Using calculations based on the Diabetes Primary Prevention Trial results, it would cost more than \$1.3 billion to conduct intensive lifestyle interventions over three years for the estimated 592,000 Oregonians who currently have a prediabetes condition. If done to fidelity, this intervention would reduce from 11% to 5% the number of Oregonians who would go on to develop diabetes.
3. While keeping tens of thousands of people with a prediabetes condition from developing diabetes over three years is a great accomplishment, this expensive investment would do nothing to prevent the hundreds of thousands of people who now are overweight or obese from developing prediabetes or diabetes each year in the future. The costs for treating these current and future cases of diabetes through an increasingly expensive

health care system are unaffordable and unsustainable for either the private or public sector. Continuing to use the current approaches essentially would be like using a very expensive “mop” to soak up the water streaming from a wide-open “faucet” of obesity and diabetes, but doing nothing to turn the faucet down or off.

4. The alternative, which is very sustainable and affordable in comparison, is population-wide public health interventions to prevent and reduce obesity and diabetes by addressing calorie-in (healthy eating) and calorie-out (physical activity) strategies.
5. Choices about how active we are and what we eat are affected greatly by our social, cultural and physical environments. These environments are responsible for the current epidemic, and it will take changes in all environments where adults and children work, learn, live and play to turn the epidemic around.
6. We’ve learned from other public health crises that changing health-related behaviors across populations requires a comprehensive approach. A comprehensive approach for obesity and diabetes prevention means the problem needs to be addressed in all environments so that healthy food and physical activity choices are available and reinforced in multiple ways each day for all people in Oregon whether they are in school, at work, or enjoying multiple opportunities to play and recreate.





GUIDING PRINCIPLES

- 7.** The benefits of creating health-promoting environments will go far beyond reducing the prevalence of obesity and diabetes. Such environments also will support treatment and management of diabetes and help reduce the dire complications of diabetes such as heart disease, blindness, amputations and kidney disease. Additionally, other chronic diseases such as high blood pressure, high cholesterol, heart disease, stroke, cancer and arthritis will be prevented and/or more effectively managed.
- 8.** Because population-wide interventions supporting access to healthy food and physical activity opportunities are complex and relatively new, coordination of these multiple interventions and evaluation of the effects of these programs are critical to success.
- 9.** To meet the needs of a variety of communities, community-specific input and participation need to be sought and incorporated in decision-making and planning.
- 10.** An investment of funding for obesity and diabetes prevention needs to at least equal if not exceed that for tobacco prevention. CDC's funding recommendation for an effective tobacco control program in Oregon is \$43 million per year. This much 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.

11. In the longer term, root causes of health inequities need to be addressed. This requires examination of inequities in education, income, living and working conditions, built environments, and social and economic institutions, taking into consideration culture and history.
12. There is not a moment to lose. Long-term, permanent changes supporting daily physical activity and healthy eating in Oregon need to start now.

PREVENTION

Based on successes achieved by the Oregon Tobacco Prevention and Education Program (TPEP) in decreasing smoking prevalence, it is probable that a similar comprehensive effort designed to promote physical activity, healthy eating and weight management through policies and environmental support could achieve important reductions in obesity and, as a consequence, diabetes prevalence. The fact that health care costs are rising faster than the general rate of inflation makes this disease prevention strategy very cost-effective.

Evidence that this prevention approach works is being demonstrated in rural areas in seven states, 12 urban areas and three tribal areas. CDC-funded projects in these rural, urban and tribal areas are demonstrating increases in physical activity, fruit and vegetable consumption, weight loss, decreased tobacco use, control of high blood pressure, and improved management of diabetes and asthma. These grants provide resources for public health staff to work in partnership with schools,



PREVENTION

businesses, local transportation and land use planners, parks and recreation districts, health care settings, and many other community organizations. Together they are increasing 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.

Between 1996, the year before TPEP was established, and 2006 there was a 22 percent drop in the prevalence of tobacco use among Oregon adults. If similar effectiveness is achieved in reducing the onset of diabetes over 10 years, an investment in obesity prevention and education would save \$215 million in medical costs from prevented cases of diabetes.

In fact, such an investment in obesity prevention and education would need to prevent only one in every six expected new cases of diabetes in Oregon to pay for itself within 10 years, based on savings in the cost of diabetes care alone. Additional savings in health care costs would result from decreases in high blood pressure, high cholesterol, heart disease and stroke, among other conditions, as well as clinical improvement in people who already have these diseases.

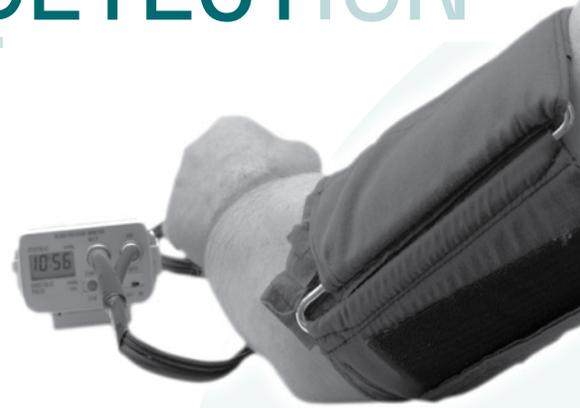
A public health obesity and diabetes prevention effort funded at the same level as is recommended by CDC for tobacco prevention in Oregon (\$43 million per year) equals a mere 3 percent of the current cost of treating diabetes.



DETECTION

HB 3486 calls for increased emphasis on screening and detection of obesity, prediabetes and diabetes. The planning committee reviewed the evidence related to screening from multiple sources including the U.S. Preventive Services Task Force and the American Diabetes Association. Evidence is available to support screening for diabetes and prediabetes in patients with any of several different risk factors. This screening, however, should be opportunistic – occurring at already – scheduled medical interactions rather than at community screenings or other mass screenings. Screening for obesity should be based on Body Mass Index (BMI) and should be done opportunistically except in children, where more organized screenings should be considered.

While medical management (see below) is not the most effective overall approach to slowing the rate of diabetes, opportunistic screening and diagnosis was thought to be worth pursuing in primary care practices in order to increase awareness of the epidemic and increase referral of affected patients to community resources organized as part of the proposed population approach. Increased efforts to diagnose these conditions also will assist in the evaluation of the effectiveness of population-based efforts.



MANAGEMENT

Considerable time and analysis was spent by the HB 3486 Advisory Committee to determine the feasibility of pursuing a traditional medical



MANAGEMENT

approach including mass screenings; diagnosis of obesity, prediabetes and diabetes; treatment with pharmacologic agents; intensive lifestyle counseling; and other measures. The present health care delivery system is struggling to perform. Implementation of universally agreed upon measures takes many years to accomplish and only 55-60 percent of patients are consistently treated with consensus approaches. Health care system reform offers the possibility of a more efficient and effective delivery system.

Oregon currently is evaluating health care reform options as part of SB 329 (2007), which established the Oregon Health Fund Board. The Board is developing a comprehensive plan to ensure affordable quality health care for every Oregonian. The Board's plan addresses four fundamental issues: contain rising costs, improve access to and equity of care, gain better quality and value from the delivery system, and improve public health and healthy behaviors.

Universal coverage with safeguards prohibiting deselection of people with obesity and diabetes would result in substantial improvement in the health of people with diabetes and prediabetes. The HB 3486 Advisory Committee believes a health care delivery system that practices evidence-based primary care, supports and promotes self-management, tracks and reports health outcomes of patient populations, and links patients with community-based health promotion resources will go a long way toward improving the actual health of Oregonians. Such a health care system would be an effective partner with public health approaches to preventing and managing obesity, diabetes and other associated chronic diseases. However, the HB 3486 Advisory Committee

felt the appropriate place for recommending health system reform measures is at the Health Fund Board rather than as part of the HB 3486 strategic plan. Though a positive direction, such reform is unlikely to be implemented and result in clinical improvements for 8-10 years.

In the meantime, important medical tools need to be used more widely – support for self-management and diabetes education, improved primary care with a chronic care oriented model to improve family and community knowledge of diabetes and its treatment, and public reporting of clinical outcomes. Of most importance will be coordination with and support of the population-based prevention approach by the traditional medical system. Patients and families with obesity, diabetes and other chronic diseases will need to be referred to community-based resources that support self-management.

SOCIAL DETERMINANTS OF HEALTH

According to a study conducted by Ezzati, et alia, (from Harvard, University of California, University of Washington), “The average life expectancy in the United States has increased steadily in the past few decades, rising by more than 7 years for men and more than 6 years for women. Parallel to this aggregate improvement, there are large disparities in health and mortality across population subgroups defined by race, income, geography, social class, education and community deprivation.”¹

¹“The Reversal of Fortunes: Trends in County Mortality and Cross-County Mortality Disparities in the United States” Majid Ezzati, Ari B. Friedman, Sandeep C. Kulkarni, Christopher J.L. Murry; PLoS Medicine / www.plosmedicine.org, April 2008, Vol. 5, Issue 4, e66.



SOCIAL DETERMINANTS OF HEALTH

When Ezzati and his team examined the life expectancy in individual counties over four decades they found a worsening of life expectancy, particularly for women of color, in a large number of counties in the United States. The rise in mortality was caused by an increase in cancers, diabetes, chronic obstructive pulmonary disease, and a reduction in the rate of decline of cardiovascular diseases due primarily to tobacco use and obesity. While none of the counties identified with rising mortality was in Oregon, we can be certain that this trend will reach our state soon if we don't act now.

There is a strong association between disease and socioeconomic status. We will not eliminate disparities in the prevalence of obesity, diabetes and other chronic diseases without addressing the fundamental social determinants of health. These underlying societal conditions include affordable housing, quality education, employment, safe neighborhoods and access to resources such as health care. Greater emphasis needs to be placed on inequities in education, income, living and working conditions, built environment, and social and economic institutions, taking into consideration culture and history. Some social conditions may be the fundamental causes of disease, and can even defy efforts to resolve them.

During the creation of the HB 3486 strategic plan, representatives from affected communities participated in robust discussions regarding health disparities. The African American Health Coalition, Asian Health and Service Center, Oregon Latino Health Coalition, Northwest Portland Area Indian Health Board, and experts from Portland State University School of Community Health led multiple intense discussions regarding these critical issues. It was agreed that, to have the greatest impact,



efforts must be made to examine the underlying factors that put people at risk for chronic diseases such as diabetes. However, the language of HB 3486 did not focus specifically on these broader solutions.

After discussion and review of the literature by committee members, it was decided to underscore the critical importance and overall complexity of this issue by addressing it in the strategic plan. The committee is recommending the creation of a task force to focus on social determinants of health. In doing so, the committee recommends the Legislature take a more global approach, not focusing on just one disease, but rather addressing the fundamental causes affecting multiple diseases and health issues.

WORKPLAN FOR HB 3486

Outlined on the next pages is a work plan for each of the next three biennia in response to the direction in HB 3486 to “identify actions to be taken to reduce the morbidity and mortality from diabetes by the year 2015 and a time frame for taking those actions.”

Each biennium’s work plan includes recommendations for funding and statutory changes. Additional activities also are included that do not require statutory change.





2009-2011 BIENNIUM

LEGISLATIVE ACTION

FUNDING:

- \$ 20 MILLION** Fund obesity prevention and education in communities.
- \$ 1.72 MILLION** Continue funding the school Physical Education grant program.
- \$ 0.70 MILLION** Provide funds to monitor nutrition standards for foods in schools.

STATUTORY CHANGE:

- Create an Oregon 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.
- Require restaurants (with 15 or more outlets) to list calories on menu boards and other nutrition information on menus.
- Block any legislation that would pre-empt local jurisdictions' ability to require calorie or other nutrition information on menus in restaurants.
- Support Health Fund Board recommendations for health care reform including improving quality of medical care, establishing medical homes, and promoting prevention and self-management of chronic diseases.
- Participate in legislative discussions regarding transportation priorities and funding, and advocate that health issues including bike and pedestrian facilities be considered.

GOVERNOR'S EXECUTIVE ORDER

- Establish a Governor's Executive Order requiring state agencies to establish wellness programs and policies including promotion of fruits and vegetables, physical activity, and chronic disease self-management. Monitor implementation and recognize exemplary agencies.

PARTNERSHIP ACTIVITIES

DHS will convene key stakeholders to build partnerships to:

- Introduce a "Healthy Schools Act" in 2011, including but not limited to, requiring that school siting decisions facilitate biking and walking, allowing inclusion of school costs in system development charges paid by developers, banning advertising, offering physical education, and conducting health screenings;
- Establish health as a priority in land-use planning and transportation decisions and possible legislation in 2011, including but not limited to, policies and funding for bike/pedestrian facilities on all appropriate streets statewide, adding health as a consideration in land-use planning policies and decisions; and
- Develop and establish minimum standards for physical activity, healthy foods and screen time in all child care settings.





2011-2013 BIENNIUM

LEGISLATIVE ACTION

FUNDING:

- \$ 43 MILLION** Continue funding for obesity prevention and education in communities.
- \$ 1.72+ MILLION** Continue funding the school Physical Education grant program.
- \$ 0.70+ MILLION** Continue funding to monitor nutrition standards for foods in schools.
- \$ TBD** Increase funding for the Farm Direct Nutrition Program per eligible participant and provide the benefit for all who are eligible.
- \$ TBD** Fund the Oregon Employment Department to work collaborately with the Oregon Department of Education and DHS to establish, monitor and enforce minimum standards for physical activity, healthy foods and screen time in all child care settings.

STATUTORY CHANGE:

- Establish the “Healthy Schools Act.”
- Establish health as a consideration in land-use and transportation policies and funding priorities.
- Increase insurance reimbursement for diabetes education and supplies.
- Support ongoing health care reform efforts including improving quality of medical care, establishing medical homes, and promoting wellness and prevention of chronic diseases.

PARTNERSHIP ACTIVITIES

Based on progress made in the 2009-2011 biennium, these activities would be determined by current gaps and priorities.

2013-2015 BIENNIUM

LEGISLATIVE ACTION

FUNDING:

- \$ 86 MILLION Continue funding for obesity prevention and education in communities.
- \$ 1.72+ MILLION Continue funding the school Physical Education grant program.
- \$ 0.70+ MILLION Continue funding to monitor nutrition standards for foods in schools.
- \$ TBD Increase funding for the Farm Direct Nutrition Program per eligible participant and provide the benefit for all who are eligible.
- \$ TBD Fund the Oregon Employment Department to work collaborately with the Oregon Department of Education and DHS to establish, monitor and enforce minimum standards for physical activity, healthy foods and screen time in all child care settings.

STATUTORY CHANGE:

- Based on progress made in the prior biennia, recommendations for statutory change would be determined by current gaps and priorities.

PARTNERSHIP ACTIVITIES

Based on progress made in the prior biennia, these activities would be determined by current gaps and priorities.



SUMMARY OF FUNDING RECOMMENDATIONS



The HB 3486 Advisory Committee is recommending a substantial investment in the prevention of obesity and diabetes. Members agree the current medical care system has sufficient money, but is not using it effectively. Further, current resources in Oregon dedicated to prevention are woefully inadequate to reverse the trends of obesity and diabetes both of which are growing at an alarming rate in Oregon's adults and children.

The highest priority funding recommendation from the advisory committee echoes the 2006 Oregon Health Policy Commission report on Childhood Obesity. To establish and fund an Obesity Prevention and Education Program. The \$20 million, \$43 million and \$86 million recommended funding levels over three biennia are based on best estimates of effectiveness from other similar population-based public health programs and CDC recommendations.

When Oregon's TPEP was funded at \$18 - \$20 million per biennium, rates of tobacco use were declining twice as quickly as that of the nation as a whole. When TPEP was closed down and then refunded at only \$5 - \$6 million per biennium, tobacco use rates leveled off and after a few years started to rise again.

Applying the results of TPEP's funding history to obesity prevention, \$5 - \$6 million can begin to establish an infrastructure in communities for addressing obesity and diabetes. However, that level of funding over the long term will not achieve the slowing of the rate of diabetes called for in HB 3486. It is estimated that at least \$20 million per biennium is needed to achieve the outcome of beginning to reduce the incidence of obesity and diabetes. The CDC recommendation of \$43 million per year

would ensure reaching all Oregon populations in all areas of the state including those with disparities.

Funding for an Obesity Prevention and Education Program would be used for the following activities:

- Provide grants to local public health agencies, tribes and community-based organizations to work in partnership with schools, businesses, local transportation and land-use planners, parks and recreation districts, health care settings, and many 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.
- Conduct public awareness campaigns to promote healthy choices and educate Oregonians about the risks of obesity and chronic diseases.
- Provide weight and chronic disease self-management resources and support through community-based programs, and phone and Internet-based services.
- Conduct data collection, analysis and publication to evaluate the effectiveness of interventions.
- Provide leadership, coordination, training and contract management to ensure effectiveness, efficiency and accountability.

The funding recommendations to continue the grants to schools for physical education and to monitor implementation of nutrition standards





SUMMARY OF FUNDING RECOMMENDATIONS

in schools build on the work of the 2007 Legislature. This funding ensures the continuation of efforts to create supportive environments in schools for healthy eating and physical activity opportunities for students.

Additional funding is recommended beginning in 2011 to support the Farm Direct Nutrition Program and to develop and establish minimum standards for physical activity, healthy foods and screen time in all child care settings.

SUMMARY OF STATUTORY RECOMMENDATIONS

Recommendations for statutory changes fall into five general areas. These include 1) addressing underlying causes of health disparities, 2) providing nutrition information for consumers, 3) ensuring that land-use and transportation policies and funding support health, 4) creating healthy environments in schools and child care settings, and 5) supporting health care reform efforts that provide quality and effective care for people with diabetes.

SPECIFIC RECOMMENDATIONS INCLUDE:

- Create an Interagency Coordinating Council to develop a strategic plan to eliminate underlying causes of health disparities.
- Require restaurants to post calorie and other nutrition information at the point of decision.
- Support Oregon Health Fund Board recommendations for health care reform.

- Establish a “Healthy Schools Act.”
- Establish health as a consideration in land-use and transportation policies and funding priorities.
- Increase insurance reimbursement for diabetes education and supplies.

SUMMARY OF NON-STATUTORY RECOMMENDATIONS

The non-statutory recommendations from the HB 3486 Advisory Committee include one Governor’s Executive Order and several partnership activities for 2009-2011.

The Governor’s Executive Order would require state agencies to establish wellness programs and policies including promotion of fruits and vegetables, physical activity, and chronic disease self-management. This Executive Order would expand to all state agencies the Healthy Worksite Initiative pilot project conducted by the Public Employees Benefits Board (PEBB) and the DHS Public Health Division. State agencies can and should establish workplace norms and environments supportive of employee health and well-being.

DHS WILL CONVENE KEY STAKEHOLDERS AND BUILD PARTNERSHIPS IN THREE AREAS:

- The Healthy Schools Act, would include a range of issues such as school siting decisions and use of systems development charges to



SUMMARY OF FUNDING RECOMMENDATIONS

allow locating schools where safe biking and walking are possible, banning advertising, offering physical education, and conducting health screenings.

- Consideration of health in land-use planning and transportation funding and decisions would support safe and convenient biking and walking facilities and allow easy access to healthy, affordable foods for all communities.
- Developing and establishing minimum standards for physical activity, healthy foods and screen time in all child care settings would ensure that all young children spend their time in health-promoting environments.

ADVISORY COMMITTEE

HB 3486 Advisory Committee members and DHS staff are listed below. All graciously gave of their time and expertise to develop this strategic plan in response to the 2007 Legislature's declaration of an emergency related to diabetes and obesity in Oregon.

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