Health Promotion and Chronic Disease Prevention: 2017-2025 Strategic Plan

PUBLIC HEALTH DIVISION

Contents

» Contents ii

» Executive Summary iv
- » Addressing health disparities v
- » Reducing risk factors for chronic disease vi
- » How this plan works vii

» Background 1
- » Burden of chronic disease in Oregon 1
- » Risk factors for chronic disease 2
- » Focus on health equity 6
- » Statewide, community-specific approach 7
- » Strategic plan background and development 7

» Goal: Decrease Tobacco Use 10
- » Goal statements and targets for 2025 10
- » Background 11
- » Addressing health equity through tobacco prevention 12
- » Objectives to support tobacco goal statements for 2025 16

» Goal: Increase Physical Activity 19
- » Goal statements and targets for 2025 19
- » Background 20
- » Addressing health equity through more opportunities for physical activity 20
- » Objectives to support physical activity goal statements for 2025 23

» **Goal: Improve Nutrition 26**
  » Goal statements and targets for 2025 26
  » Background 27
  » Addressing health equity through improved nutrition 28
  » Objectives to support nutrition goal statements for 2025 30

» **Goal: Decrease Excessive Alcohol Use 33**
  » Goal statements and targets for 2025 33
  » Background 34
  » Addressing health equity by decreasing excessive alcohol use 37
  » Objectives to support alcohol goal statements for 2025 40

» **Appendix A – Summary of 2017-2025 Goals and Performance Metrics 44**

» **Appendix B – Data Sources 48**

» **Appendix C – Healthy Places, Healthy People Framework 49**

Executive Summary

Every person in Oregon deserves the opportunity to live a healthful life. Yet chronic diseases, including cancer, heart disease, diabetes, addiction and arthritis, are rising here and leaving certain groups of people worse off than others. These diseases affect the lives of our relatives, friends, co-workers and community members. They fall unevenly across Oregon's communities, revealing that good health is not yet accessible to all people in our state.

The Health Promotion and Chronic Disease Prevention section (HPCDP) of the Oregon Health Authority-Public Health Division created this 2017-2025 HPCDP strategic plan to establish clear goals, strategies and objectives to reduce chronic disease and the burden it places on people, communities and the economy.

As a result of previous HPCDP plans, Oregon communities have grown measurably healthier. For example, we have reduced tobacco use* among adults and youth, the leading cause of preventable death in Oregon. We have also increased the percentage of Oregon adults who have been screened for colorectal cancer, the second-deadliest cancer, but one which can be prevented through regular screening.

This 2017-2025 plan demonstrates how we will build upon these achievements over the next eight years. In it we describe how, working with communities and tribes, we will further increase the opportunities for all Oregonians, no matter where they live in the state, to eat better, move more, live tobacco-free, drink less alcohol and take charge of their own health.

* Tobacco in this document always refers to commercial tobacco, unless otherwise noted.

Addressing health disparities

Today in Oregon, fundamental components of health such as nutritious food, space to play and be active, and smoke-free places are out of reach for too many people.

At the same time, Oregonians in too many communities are surrounded by products that are harmful to their health – from tobacco and e-cigarettes to alcohol to sugary drinks – and targeted by excessive advertising and marketing messages that promote unhealthy options. When people don't have access to fundamental components of health and are surrounded by unhealthy products and marketing messages, they are at greater risk for developing a chronic disease.

For example, the tobacco industry has been targeting African Americans since the 1970s with messages that link menthol cigarettes to themes of Black empowerment and identity, in stores, neighborhoods and magazines. Due in part to these targeted industry efforts, African Americans in Oregon smoke at significantly higher rates than Whites, Latinos* or Asian and Pacific Islanders and bear a larger burden of tobacco-related chronic disease.

A chronic disease is a long-term condition that can be managed, but rarely cured, and makes life more difficult, uncomfortable and painful. The leading risk factors that increase a person's chances of developing one or more chronic diseases are tobacco use, physical inactivity, poor nutrition and excessive alcohol use. One in two adults in Oregon live with at least one chronic disease, and chronic diseases account for four of the top five leading causes of death (cancer, heart disease, chronic lower respiratory disease and stroke; the other leading cause is unintentional injuries).

Certain populations in Oregon bear a greater burden of chronic disease than others: Simply put, they live sicker and die younger. These health disparities are fueled by inequities that exist in physical places, such as our homes, schools, neighborhoods and workplaces; and in the social conditions that shape our lives, like different education and income levels, and the discrimination and racism we do or don't encounter. Considered together, these factors form a broad definition of "place" that is useful for understanding how a person's particular place in Oregon affects their health. Your "place" can make it harder or easier to access the nutritious food, safe housing, physical activity and health care that we all need to prevent disease and live a healthful life.

* The conversation about proper terminology for describing the Latino community is a fluid one. For this document, OHA took guidance from Regional Health Equity Coalitions (RHECs) including Oregon Health Equity Alliance (OHEA) and Mid-Columbia Health Equity Advocates (MCHEA). OHA will continue to monitor this conversation as it evolves and adjust our word choices as necessary.

In every facet, this plan seeks to address health disparities in Oregon and the inequities that fuel them. Doing so is crucial to reduce chronic disease for all Oregonians. This work focuses on four risk factors that put people at risk of many chronic conditions, along with strategies for reducing and managing them.

Reducing risk factors for chronic disease

Some risk factors, like age and genes, we can't change. But others we can. By decreasing these risk factors for chronic disease, we can make Oregon a healthier place to live, work, learn, play and age.

For each of the four risk factors below, this plan identifies the disparities that exist among different populations in Oregon; strategies to reduce the inequities that fuel these disparities; and measurable objectives that will support each strategy and reduce chronic disease in Oregon by 2025.

- **Tobacco use:** Decrease cigarette smoking among youth and adults and decrease annual per capita cigarette sales.
- Risk factors related to reducing obesity* among youth and adults:
  - » **Physical inactivity:** Decrease the percentage of youth and adults who engage in little to no physical activity.
  - » **Poor nutrition:** Reduce the percentage of people who consume seven or more sugary drinks each week.
- **Excessive alcohol consumption:** Decrease heavy and binge drinking among youth and adults and decrease total per capita alcohol consumption.

* As used in this document, obesity refers to the medical condition or disease that causes or complicates multiple chronic diseases including diabetes, heart disease and cancer.

Improving communities so individuals can succeed

Oregonians who live with these risk factors are often blamed and stigmatized for them and for the chronic diseases that result. People may assume, for example, that the more than 900,000 Oregonians* who live with obesity are simply making bad choices about the food they eat or are too lazy to improve their health. These assumptions are unfair, uninformed and incomplete. They fail to take into account the powerful ways that place matters to our health; in other words, how the places and circumstances in which we live our lives either expand or limit our opportunities to be healthy.

To reduce the number of people in our state who have risk factors for chronic disease, we must broaden the focus from changing individual behavior to making our communities healthier for everyone. By increasing opportunities for everyone to be healthful in the places where we live, work, learn, play and age, we can reduce the prevalence of risk factors and of chronic diseases; lessen the stigma of living with them; and make a long, healthful life available to every Oregonian.

How this plan works

HPCDP devises strategies that aim to reduce these risk factors in two overarching ways:

- Increasing Oregonians' access to the options they need to live healthful lives
- Decreasing the availability and excessive marketing of harmful products

We work with communities, tribes and other partners to focus resources on pursuing these strategies throughout the state. Our role is to equip tribes, towns and cities with the strategies, data, guidance and support that they need to make the best decisions about sustainable policy solutions for their communities. We create and provide the necessary tools; they prioritize their health challenges and determine when and how to take action.

Additionally, Oregon's ongoing health system transformation has set the stage for new kinds of partnerships between public health, health systems and community partners. With guidance from public health, and aided by the federal Affordable Care Act, health systems are making innovative changes that are preventing chronic disease in communities and statewide – for example, by ensuring that adults receive recommended colorectal cancer screenings, which has reduced the overall burden of this cancer in Oregon.

* See Fig. 5, Selected risk factors among Oregon adults, 2015.

Our approach recognizes how place – both physical environments and social conditions – plays a central role in shaping behaviors and influencing health. Because this approach is grounded in nearly 50 years of chronic disease prevention research and strategies that have increased the number of Oregonians who live tobacco-free, we know that it works.

What success looks like

Oregon's success with reducing tobacco use and increasing cancer screenings is proof that when we define measurable objectives for improving public health and give communities and tribes the tools and support to achieve them, we can create healthier communities and reduce health care costs for everyone.

When Oregonians in every part of the state have more opportunities to choose healthful options and face less exposure to harmful products and excessive marketing, more people will be able to live tobacco-free, eat better, move more, drink less alcohol and better manage their own health.

Everyone – in government, public health, health systems, businesses and local communities – has a role to play in improving health in this state. We call on all Oregonians to seize their roles in this vital endeavor. As a result, Oregon will be a more healthful place to live, work, learn, play and age – for all of us.

Background

Background

Burden of chronic disease in Oregon

A chronic disease is a long-term health condition that can be managed, but rarely cured, and makes life more difficult, uncomfortable and painful. When we help Oregonians eat better, move more, live tobacco-free* and drink less alcohol, we help reduce the burden of chronic disease in Oregon. This means preventing chronic diseases; managing existing chronic conditions; lowering the financial costs of chronic disease to individuals, families and our state; and improving the day-to-day experience of people living with chronic disease.

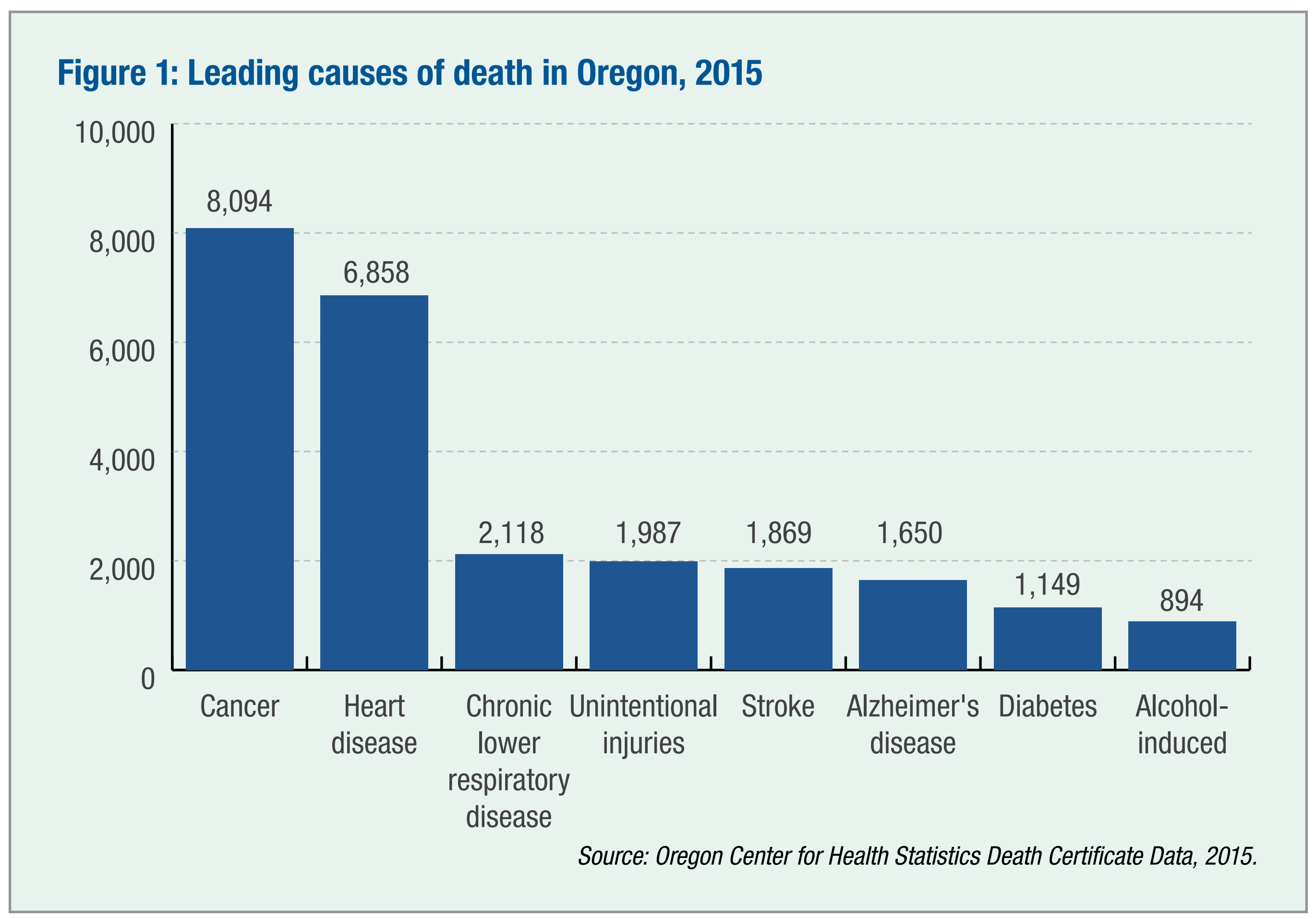
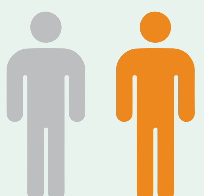


Figure 1: Leading causes of death in Oregon, 2015

Source: Oregon Center for Health Statistics Death Certificate Data, 2015.

* Tobacco in this document always refers to commercial tobacco, unless otherwise noted.

Figure 2: Oregonians with one or more chronic diseases, 2015



1 in 2

Oregon adults have a chronic disease

(arthritis, asthma, cancer, lung or cardiovascular diseases, depression or diabetes)

Source: Behavioral Risk Factor Surveillance System (BRFSS), 2015.

In Oregon, four of the top five leading causes of death are chronic diseases [Fig. 1]. These and other chronic diseases – including arthritis, depression, and alcohol and drug addiction – are also major causes of disability and diminish the quality of life for many people. Today, more than half of Oregon adults live with one or more chronic diseases [Fig. 2].

Risk factors for chronic disease

Chronic diseases are complex and influenced by multiple risk factors. Some risk factors, like age and genetic makeup, we can't change. But others we can. Increases in these modifiable risk factors are fueling the increases in chronic disease in Oregon.

Risk factors we can change include tobacco use, physical inactivity, poor nutrition and excessive alcohol use. These same four factors put people at risk of many chronic diseases and conditions [Fig. 3].

Exposure to these risk factors is heavily influenced by people's physical and social environments, making it easier or more difficult for them to behave in healthful ways and live healthy lives. These environments, too, can almost always be modified or changed.

Figure 3: Diseases or conditions and risk factors that contribute to them

	Tobacco use	Physical inactivity	Poor nutrition	Excessive alcohol consumption
Cardiovascular disease	✓	✓	✓	✓
Diabetes	✓	✓	✓	✓
Cancer	✓	✓	✓	✓
Obesity		✓	✓	✓
Chronic lung disease	✓			
Depression and anxiety		✓	✓	✓
Drug and alcohol addiction	✓			✓
Injury	✓	✓		✓

Multiple risk factors = more chronic disease

A person with one risk factor – for example, someone who doesn't get enough physical activity – faces a higher risk for developing a long-term, life-shortening chronic disease. As a person's risk factors multiply, their chances of developing one or more chronic diseases also increase. In other words, smoking cigarettes is bad for your health. Smoking cigarettes, drinking too much soda and not moving enough during the day is worse.

Living with one chronic disease can make life difficult, uncomfortable and painful. Living with two or more chronic diseases multiplies the adverse health effects of each disease. The combination also makes it harder for people to manage their diseases and improve their health and quality of life.

In Oregon, four in five adults have a risk factor that can cause or complicate chronic diseases [Fig. 4]. Having obesity is a leading risk factor, affecting more than 900,000 (29%) Oregon adults [Fig. 5].

Figure 4: Oregon adults with one or more risk factors, 2015

4 in 5

Oregon adults have a health risk factor which can cause or complicate chronic diseases

(These risk factors include high blood pressure, high cholesterol, current cigarette smoking or smokeless tobacco use, having obesity, binge drinking or physical inactivity)

Source: BRFSS, 2015.

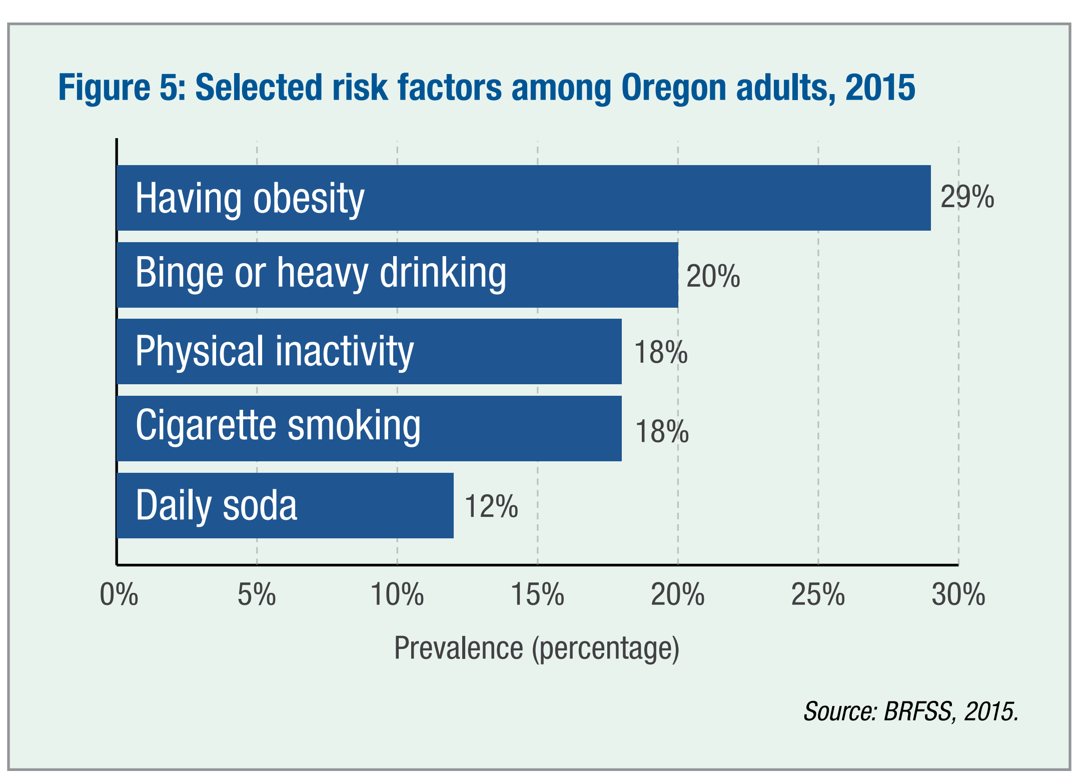


Figure 5: Selected risk factors among Oregon adults, 2015
Having obesity
29%
Binge or heavy drinking
20%
Physical inactivity
18%
Cigarette smoking
18%
Daily soda
12%
0%
5%
10%
15%
20%
25%
30%
Prevalence (percentage)
Source: BRFSS, 2015.

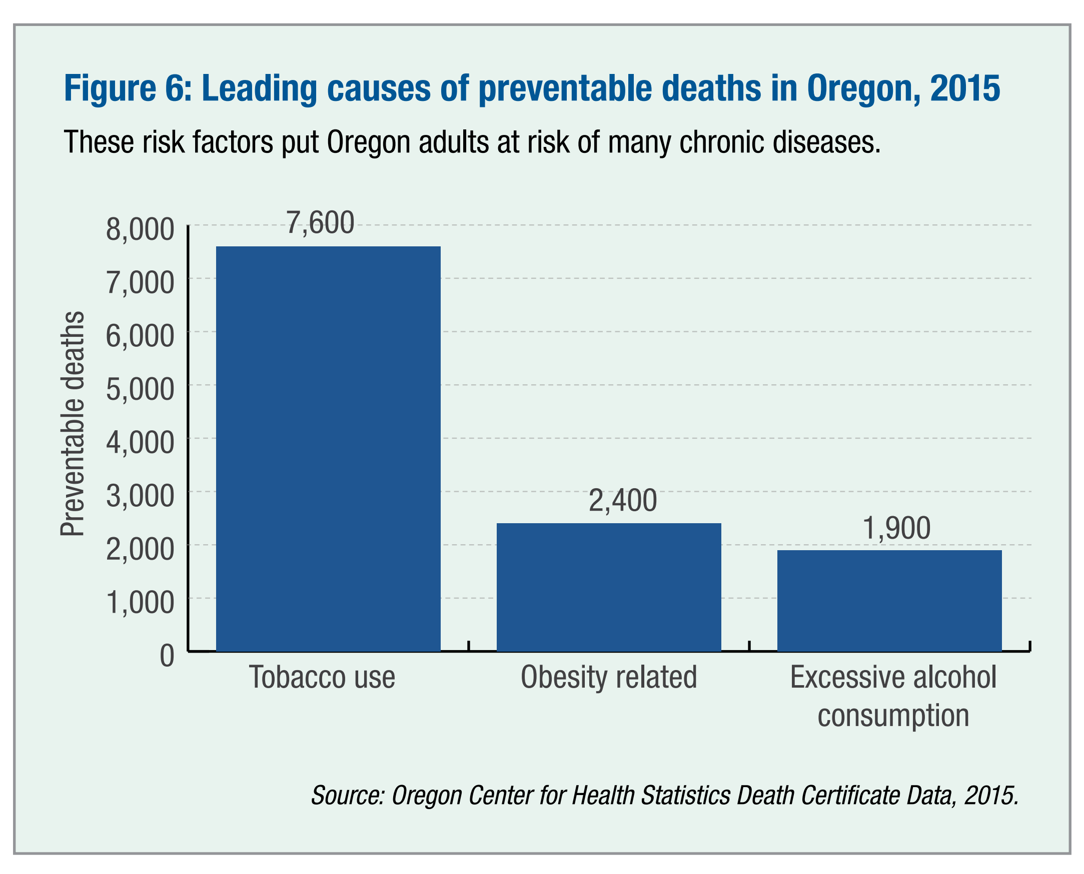


Figure 6: Leading causes of preventable deaths in Oregon, 2015
These risk factors put Oregon adults at risk of many chronic diseases.
Preventable deaths
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
7,600
2,400
1,900
Tobacco use
Obesity related
Excessive alcohol consumption
Source: Oregon Center for Health Statistics Death Certificate Data, 2015.

Focus on health equity

Access to basic opportunities empowers people to live healthful lives. When we enable all people to choose healthy options, all of Oregon benefits.

To achieve our mission of reducing chronic disease in Oregon, we need to identify which communities are worse off in terms of health and put in place strategies that will produce the greatest health benefits for them.

At the foundation of this work is our recognition that not all places in Oregon are created equal. Our places can – whether by design, level of public investment or other factors – make it easier or harder for people who live there to prevent or manage chronic diseases and take charge of their own health. Your "place" in Oregon also extends to social conditions that can make it easier or harder to access the nutritious food, safe housing, physical activity and health care that we all need to prevent disease and live a healthful life. To address these place-based health inequities, we work to change systems and structures throughout our state and society in ways that expand people's access to healthy options and environments.

Resources are limited, so we focus them on the groups who are experiencing the highest rates of disease. Yet, as Oregonians, we share so many places – in our neighborhoods, our communities and across our state. When we make these places healthier for some populations, by providing them with more options and support to live healthful lives, we make Oregon a healthier place for everyone.

Health equity means we all have the basics to be as healthy as possible

Source: Robert Wood Johnson Foundation

Statewide, community-specific approach

A comprehensive, place-based and community-specific approach to chronic disease prevention can create places where people eat better, move more, drink less alcohol, live tobacco-free and better manage their own health.

Fifty years of tobacco prevention research shows that a combination of state interventions, local programs, mass media communications and support for people who want to quit is effective at reducing the burden of tobacco on communities from cigarettes, smokeless tobacco and other tobacco products, as well as from e-cigarettes or vape pens that contain nicotine. This approach leads to better health, better care and lower health care costs for all Oregonians.

This approach is comprehensive because it addresses the components that encourage healthful behaviors, supports clinical and public health-based education, and encourages people to manage their diseases.

This approach is place-based because it acknowledges the central role that physical and social environments play in shaping behaviors and influencing health. By using evidence-based strategies to bring about policy-level, systemic and environmental change, this approach creates more places that provide healthy options and enable people to live healthful lives.

This approach is statewide and community-specific because it ensures that coordinated resources and supports are available for all Oregon communities, particularly those that have been historically underserved or underrepresented.

The Health Promotion and Chronic Disease Prevention section (HPCDP) of the Oregon Health Authority-Public Health Division, together with partners, developed the *Healthy Places, Healthy People Framework* to describe the place-based approach to addressing shared chronic disease risk factors. *The Healthy Places, Healthy People Framework can be found in Appendix C.*

Strategic plan background and development

In 2007, with support from partners and advocates, HPCDP released *Keeping Oregonians Healthy: Preventing Chronic Disease by Reducing Tobacco Use, Improving Diet, and Promoting Physical Activity and Preventive Screenings.* This was Oregon's first integrated chronic disease data report.

It addressed two core risk factors – tobacco use and having obesity – that cause and complicate multiple chronic diseases. The report examined how these diseases affect the lives of Oregonians – the burdens that they impose; how they are distributed across communities; and the ways in which they diminish people's quality of life. The report examined diseases, conditions and risk factors including

asthma, arthritis, heart disease and stroke, obesity, cancer, stress, addiction and depression, among others.

Five years later, in 2012, HPCDP released the *2012-2017 HPCDP Five-Year Strategic Plan.* This report focused on preventing tobacco use and exposure to tobacco, obesity, heart disease and stroke, and colorectal cancer. The plan's strategies and activities continued the work described in the 2007 report to address tobacco use and obesity.

The 2017-2025 HPCDP strategic plan builds from more than 10 years of prevention experience with state and local partners and guides coordinated state and community efforts such as:

Alignment with the State Health Improvement Plan (SHIP)

The strategies in the HPCDP strategic plan complement and support the tobacco, obesity and alcohol priorities and strategies contained in the SHIP. Specifically, each HPCDP goal aligns with SHIP's priority areas, including:

- Preventing and reducing the use of all forms of commercial tobacco
- Slowing the increase of obesity
- Reducing harms associated with alcohol and substance abuse

Alignment with public health modernization

This strategic plan also lines up with the Oregon Health Authority-Public Health Division's effort to reorganize the state's public health infrastructure around a new set of foundational capabilities and programs. This process prioritizes prevention and strategies that advance multiple health improvement efforts. In addition to emphasizing prevention, the new foundational capabilities and programs call for a greater focus on working collaboratively and across sectors to implement policy, systems and environmental strategies.

Alignment with health system transformation

This strategic plan supports the triple aim of health system transformation – improved health, better health care and lower costs. These strategies are designed to keep people healthy and reduce their need for costly health care. This plan also calls for collaborating with health system partners to align clinical practices with community prevention efforts.

Goal: Decrease Tobacco Use

Goal: Decrease Tobacco Use

Tobacco is the No. 1 preventable cause of death and disability in Oregon and is responsible for more than 7,000[*] deaths annually. Tobacco-related diseases include asthma, arthritis, cancer, diabetes, heart disease and stroke.

Goal statements and targets for 2025

Decrease the percentage of youth and adults who smoke cigarettes.

- Reduce cigarette smoking prevalence among adults to 13.3 percent or less
  - » Baseline: 17.7 percent (2015 BRFSS)
- Reduce cigarette smoking prevalence among 11th graders to 6.6 percent or less
  - » Baseline: 8.8 percent (2015 Oregon Healthy Teens)
- Reduce cigarette smoking prevalence among 8th graders to 3.7 percent or less
  - » Baseline: 4.3 percent (2015 OHT)

Decrease annual per capita cigarette sales in Oregon.

- Reduce cigarette sales to 34 or fewer packs per person per year
  - » Baseline: 40 packs per person per year (2015)[†]

* 2015 Oregon Vital Statistics Annual Reports, Volume 2: Chapter 6. Mortality. Table 6-19. Available at: http://public.health.oregon.gov/BirthDeathCertificates/VitalStatistics/annualreports/Volume2/Pages/index.aspx

† Orzechowski and Walker, The Tax Burden on Tobacco. Historical compilation Volume 52, 2017. Fairfax and Richmond, Virginia.

Background

Tobacco use remains the No. 1 cause of preventable death in Oregon. It causes more than 7,000 deaths each year and costs the state over $2.5 billion in medical spending, lost productivity and early death.*

The most effective strategies to reduce tobacco use and exposure are to keep youth and young adults from ever starting, to protect people from secondhand smoke and to help people quit.

Combining these efforts can make a significant difference in preventing the use of tobacco and e-cigarettes, which contain nicotine. HPCDP is working with state and local partners including local public health authorities, tribes and health systems to reduce the harms of tobacco and e-cigarettes by:

- Limiting the tobacco industry's influence in stores and other retail settings, which helps prevent youth from becoming addicted to tobacco, helps current users quit and reduces health care costs.
- Increasing the price of tobacco, which reduces tobacco use among youth and lower-income† adults and helps current users quit.
- Conducting hard-hitting counter-advertising campaigns to help people quit tobacco and prevent youth and young adults from starting.
- Implementing tobacco screening, referral and cessation benefits in health systems, which helps adult tobacco users quit and prevents future tobacco-related deaths.

* Centers for Disease Control and Prevention. Smoking-attributable mortality, years of potential life lost, and productivity losses—United States, 2000–2004. Morbidity and Mortality Weekly Report 2008;57(45):1226–8. https://chronicdata.cdc.gov/Health-Consequences-and-Costs/Smoking-Attributable-Mortality-Morbidity-and-Econo/4yyu-3s69

† As used in this document, "low-income" or "lower-income" is synonymous with low socioeconomic status, which includes having less than a high school education or being at 100% or less of the federal poverty level.

Addressing health equity through tobacco prevention

For decades, the tobacco industry has targeted African Americans, American Indian/Alaska Natives, Latinos and the LGBTQ community – as well as people with less education and lower incomes, regardless of race or ethnicity – with excessive advertising and marketing.

Smoking and sexual orientation

Compared to heterosexual women, lesbians are 60 percent more likely to smoke cigarettes, and bisexual women are nearly three times more likely to smoke cigarettes. Compared to heterosexual men, bisexual men are nearly twice as likely to smoke cigarettes.*

* Garland-Forshee RY, Fiala SC, Ngo DL, Moseley K. Sexual Orientation and Sex Differences in Adult Chronic Conditions, Health Risk Factors, and Protective Health Practices, Oregon, 2005–2008. Prev Chronic Dis 2014;11:140126.

For example, starting in the 1970s, the tobacco industry latched onto the African-American community's preference for menthol cigarettes and successfully linked it, most notably with the "Kool" brand, to themes of Black empowerment and identity. The industry amplified the effect by saturating Black magazines and neighborhoods with tailored ads that made smoking menthols seem integral to the Black experience. Today, 85 percent of African Americans who smoke buy menthols, compared to 29 percent of White people who smoke.*

Although the government banned tobacco companies from using TV or billboards to promote their products, tobacco advertising remains a big part of Oregon communities. Each year, the tobacco industry spends more than $100 million to advertise and promote its products at Oregon neighborhood gas stations, convenience stores and grocery stores.† But this massive spending is not distributed evenly across our state.

* Campaign for Tobacco-Free Kids. Tobacco Use Among African Americans. June 2018. https://www.tobaccofreekids.org/assets/factsheets/0006.pdf

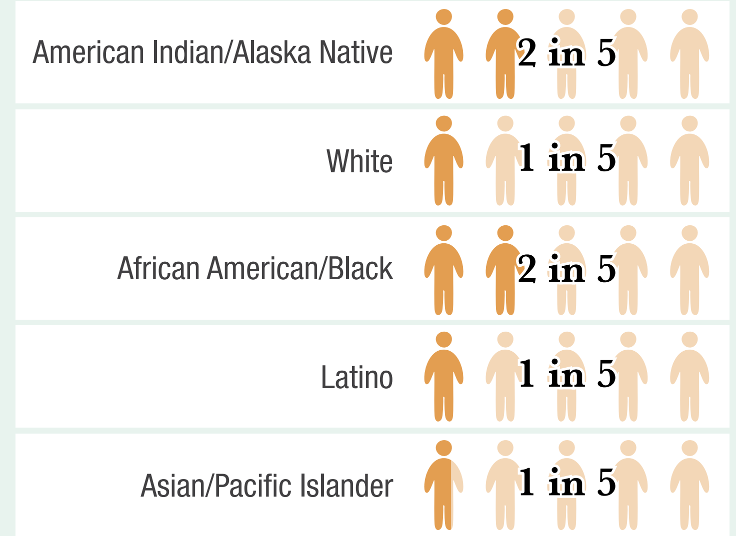
† Oregon Health Authority. 2018 Tobacco Facts. https://www.oregon.gov/oha/ph/PreventionWellness/TobaccoPrevention/Pages/oregon-tobacco-facts.aspx

Tobacco companies sell their products in more stores, at deeper discounts, and place more ads in communities of color and lower-income neighborhoods, compared to wealthier, predominantly White neighborhoods. As a result, children and young people in these communities – and adults who are trying to quit tobacco – are exposed to a greater volume of tobacco marketing and products and encounter them more often than people in wealthier, Whiter areas.

Most Oregon adults who smoke cigarettes say they want to quit, and more than half report trying to quit during the past year.* But it is much harder to quit tobacco or avoid using it when you see it everywhere, in the places you live, work, learn, play and age.

While cigarette use in Oregon continues to decline overall, groups that historically have been targeted by the tobacco industry continue to use it at higher rates, including people with lower incomes, certain racial and ethnic groups, and members of the LGBTQ community. Also, people living with mental illness and addiction to other drugs and alcohol use tobacco at higher rates than the general population. Because these communities use tobacco at higher rates, they experience the harshest health consequences, including higher rates of heart disease and other tobacco-related health problems.

Figure 7: The burden of tobacco is unevenly distributed in Oregon



People with low incomes, certain racial and ethnic groups, members of the LGBTQ community and people with mental illness use tobacco at higher rates and are more likely to suffer from tobacco-related diseases. **Raising the price of tobacco will help these priority populations the most, especially when funds are dedicated to prevention.**

Source: BRFSS Race Oversample, 2015-2017.

* Oregon Health Authority. 2018 Tobacco Facts. https://www.oregon.gov/oha/ph/PreventionWellness/TobaccoPrevention/Pages/oregon-tobacco-facts.aspx

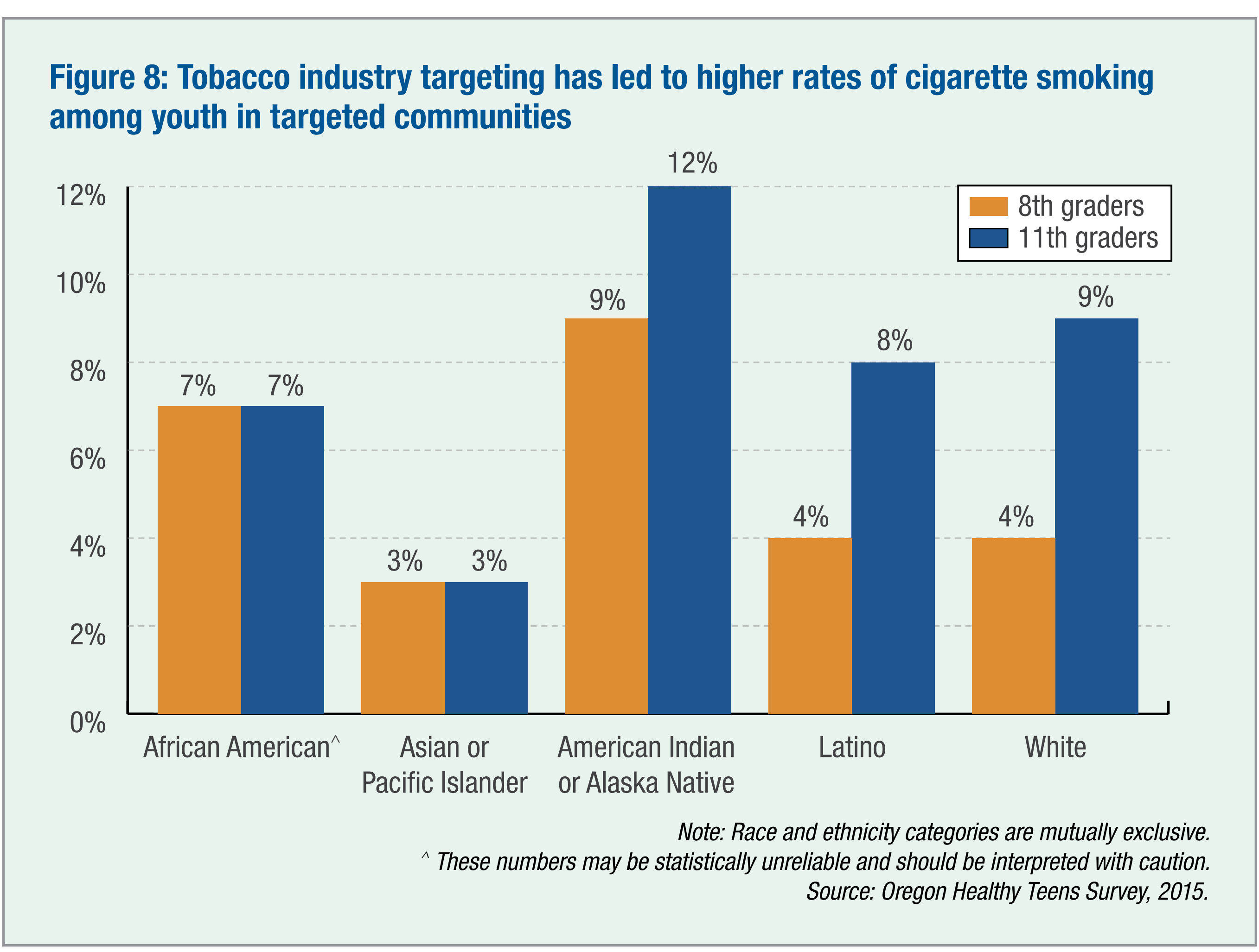
Targeting kids

The tobacco industry also targets young people, of all races and ethnicities, with tobacco products that are marketed to appeal to kids. These products, often with candy-like packaging and sweet flavors, are advertised or placed in areas where children and teens are likely to see them. The industry targets young people in order to survive as a business, by replacing the thousands of tobacco customers who die every year with new tobacco users.

E-cigarettes remain the most commonly used tobacco product among youth. Strong evidence exists that these products increase the possibility that young people will become addicted to nicotine and that they will begin to use conventional tobacco products, particularly cigarettes. Flavors continue to be a key component in making e-cigarettes attractive to youth. E-cigarettes come in more than 15,000 candy and fruit flavors including "Neon Dream," melon and mango.

> "It is important to know as much as possible about teenage smoking patterns and attitudes. Today's teenager is tomorrow's potential regular customer and the overwhelming majority of smokers first begin to smoke while in their teens."
>
> – Phillip Morris researcher*

* Young Smokers Prevalence, Trends, Implications, and Related Demographic Trends, March 31, 1981, a market research report on young smokers written by Philip Morris researcher Myron E. Johnston and approved by Carolyn Levy and Harry Daniel. Bates No. 1000390803.



Prioritizing targeted communities

HPCDP prioritizes resources in Oregon communities that have been targeted by the tobacco industry, where industry practices have resulted in higher tobacco use rates and higher rates of tobacco-related disease and death. We create healthier communities by reducing the exposure of kids, teens and adults to the tobacco industry's harmful, addictive products and excessive advertising and marketing. In doing so, we enable more Oregonians to manage their health and have the opportunity to live a healthful life.

Objectives to support tobacco goal statements for 2025

Objective 1: Increase the price of tobacco products. Dedicate at least 10 percent of this increase to a comprehensive tobacco control program.

- **Rationale:** Raising the price of tobacco is one of the most effective strategies for reducing the number of people who start using tobacco, decreasing tobacco use and increasing quit rates.
- **Connection to equity:** Youth, people living with fewer financial resources and certain communities of color are more price-sensitive than the general population, so price increases will result in greater reductions in consumption and related health burdens. When resources from price increases go first toward supporting these communities in addressing health inequities, the benefits are even greater.

Objective 2: Protect workers and the public from secondhand smoke by strengthening smoke-free workplace laws at state and local levels.

- **Rationale:** Tobacco-free environments protect people from exposure to secondhand smoke, encourage tobacco users to quit and help former smokers remain tobacco-free.
- **Connection to equity:** Exposure to secondhand smoke in workplaces disproportionately affects service and hospitality workers. They experience some of the greatest disparities in protections from secondhand smoke, as well as other social inequities.

Objective 3: Increase the number of jurisdictions that protect youth from exposure to tobacco industry marketing and promotion in stores and other retail settings through strategies such as bans on flavored tobacco products and raising the minimum legal sale age to 21.

- **Rationale:** The National Academies of Sciences, Engineering, and Medicine (formerly the Institute of Medicine) recommends that governments develop and implement ways to restrict the effects of tobacco in the retail environment.*
- **Connection to equity:** The tobacco industry heavily markets its products at point of sale to communities who are already affected by tobacco-related health disparities. Marketing, advertising, and promotional strategies are often directed at communities of color, as well as LGBTQ, lower income, and youth populations.

Objective 4: Reduce access to tobacco products in stores and other retail settings.

- **Rationale:** Limiting the number of places where tobacco is available will reduce the number of Oregon children, teens and young adults who become addicted to tobacco, help current users quit, and reduce health care costs for the State of Oregon.
- **Connection to equity:** The tobacco industry heavily markets its products at point of sale to communities who are already affected by tobacco-related health disparities. Marketing, advertising, and promotional strategies are often directed at communities of color, as well as lower income, LGBTQ, and young adult populations.

Objective 5: By June 30, 2025, decrease the prevalence of smoking among low-income Oregonians.

- **Rationale and connection to equity:** Lower-income Oregonians and certain racial and ethnic communities use tobacco at higher rates and experience the harshest health consequences, including higher rates of heart disease and other tobacco-related health problems.

---

* US Food and Drug Administration. Regulations restricting the sale and distribution of cigarettes and smokeless tobacco. https://www.govinfo.gov/content/pkg/FR-2010-03-19/pdf/2010-6087.pdf. Updated April 2013. Accessed July 18, 2019.

Goal: Increase Physical Activity

Goal: Increase Physical Activity

Obesity[*] is the No. 2 preventable cause of death and disability among Oregonians and is responsible for more than 2,000 deaths annually. Physical inactivity and poor nutrition are the major drivers of obesity.

When a person has obesity, it means that person's body fat and body fat distribution exceed the level considered healthy.[†] This is a harmful and costly medical condition that increases the risk of developing diabetes, heart disease, stroke, arthritis, cancer and other chronic diseases. Physical inactivity and poor nutrition are the major drivers of obesity, and individual choices are important. However, the places we live, work, learn, play and age often determine whether or not safe options to walk and be physically active are even available to us.

Blaming individuals who live with obesity does nothing to improve their health or the health of our communities; in fact, weight bias and stigma can heighten or even create mental health issues. The focus of public health and of this strategic plan is on improving our physical and social environments in ways that help all Oregonians maintain a healthy weight and live healthful lives.

Goal statements and targets for 2025

Develop a comprehensive prevention and education infrastructure – which includes creating and improving places where people can be active – to address the major drivers of obesity: physical inactivity and poor nutrition. These efforts are crucial to expanding state and community capacity for preventing chronic disease.

Decrease the percentage of adults who are physically inactive.

- Reduce prevalence of physical inactivity among adults to 16.4 percent or less
    - » Baseline: 18.2 percent (2015 BRFSS)

Decrease the percentage of youth who do not meet the U.S. Surgeon General's recommended level of physical activity.

---

* As used in this document, obesity refers to the medical condition or disease that causes or complicates multiple chronic diseases including diabetes, heart disease and cancer.

† Trust for America's Health and Robert Wood Johnson Foundation. The State of Obesity: Better Policies for a Healthier America 2018.

- Reduce prevalence of 11th graders who do not meet the recommendation of 60 minutes of daily physical activity to 72.5 percent or less
  - Baseline: 76.3 percent (2015 OHT)
- Reduce prevalence of 8th graders who do not meet the recommendation of 60 minutes of daily physical activity to 65.8 percent or less
  - Baseline: 69.3 percent (2015 OHT)

Background

Physical inactivity – not moving at all or a minimal amount – contributes to obesity and is a strong driver of chronic disease, regardless of how much someone weighs.

People can become more physically active in many ways. Most people are more likely to maintain regular physical activity if they build movement into their everyday lives, for example, by walking to work, school and other places. Walking raises the heart rate, elevates energy levels and improves mood. People with alternative mobility needs can be active by walking with support and rolling in a wheelchair.

Creating and improving places where people can walk, roll and be physically active, combined with encouragement programs and supports, can help more people get moving. Using successful tobacco prevention strategies as our model, HPCDP works with state and local partners – in tribes, transportation, parks, health systems and education – to support people's desire to be healthy by increasing opportunities to move at work and creating more places to be active in their communities.

Addressing health equity through more opportunities for physical activity

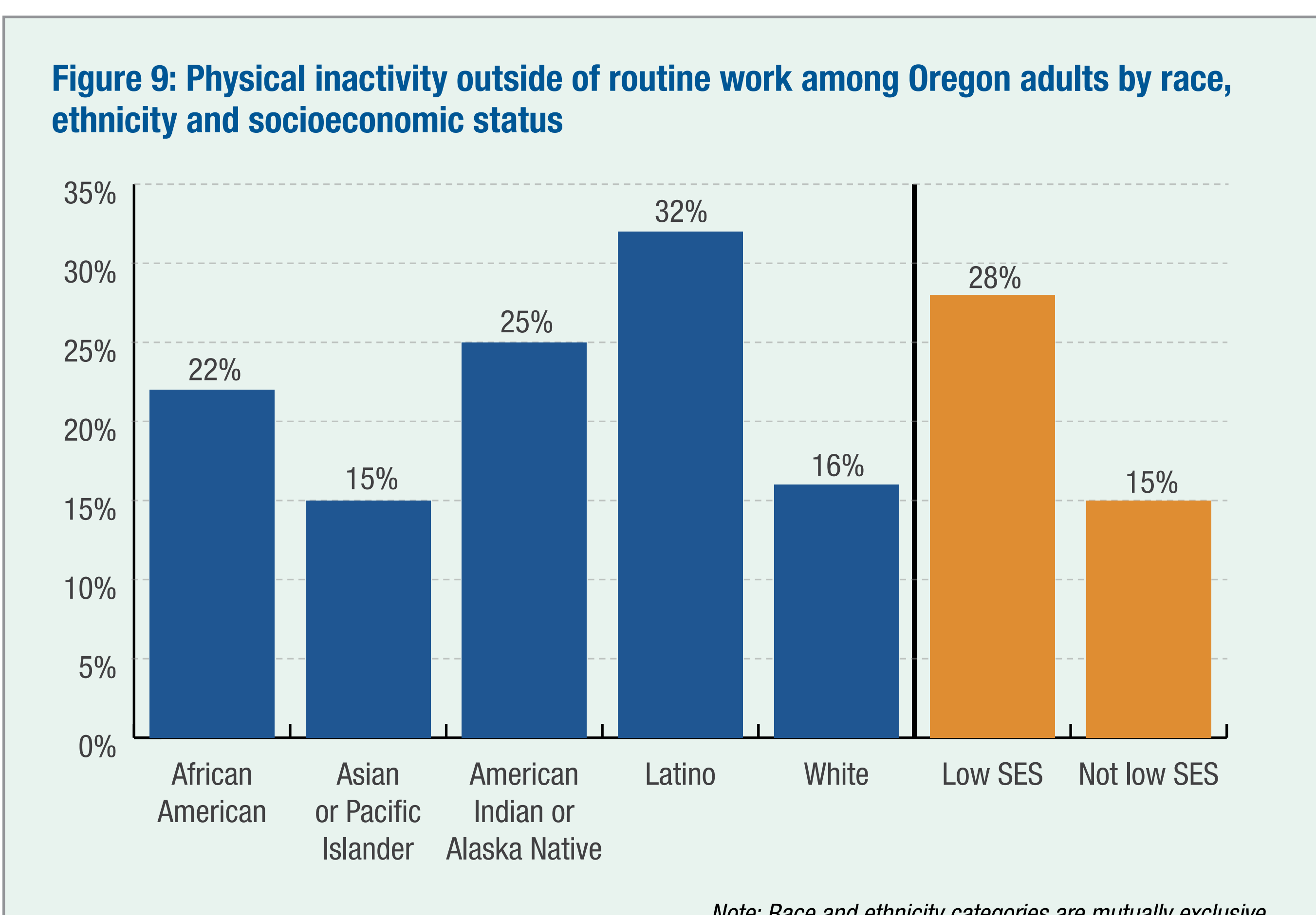
All Oregonians do not have the same access to places to be physically active. People of color and people with lower incomes, in particular, are more likely to live in areas without sidewalks, frequent transit service, parks, active transportation options and other features that support and encourage physical activity and which require investment of public resources.

> **More than 2.5 million Oregon adults (82%) are trying to maintain or lose weight.**
>
> *Source: BRFSS, 2015.*

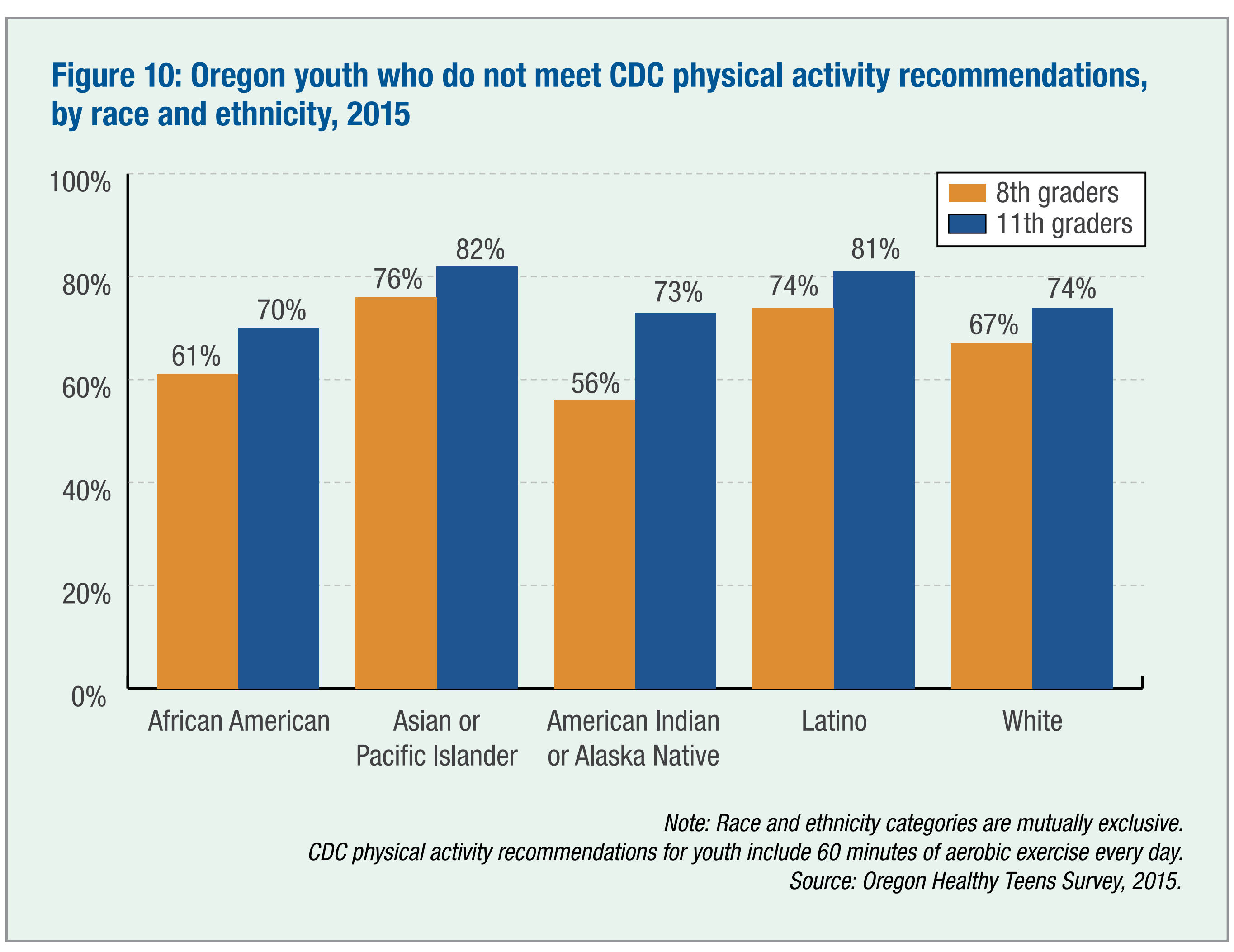
Many factors have contributed to a long-standing lack of public investment in lower-income neighborhoods and communities of color, across Oregon and the nation. These factors have included discriminatory housing policies, disparities in school funding and fewer public dollars spent to maintain streets, streetlights and open spaces like parks. These and other current and past policies and decisions have, intentionally or unintentionally: prevented specific populations, such as African Americans, from living in certain neighborhoods; directed public resources away from lower-income communities and communities of color; and excluded or marginalized people who belong to these communities.

When neighborhoods lack features that support and encourage physical activity, people who live there are less likely to be physically active, regardless of race, income or other demographic characteristics. These inequities are reflected in rates of physical inactivity among different populations [Fig. 9] and of chronic diseases related to physical inactivity.

Figure 9: Physical inactivity outside of routine work among Oregon adults by race, ethnicity and socioeconomic status



Note: Race and ethnicity categories are mutually exclusive.
Low socioeconomic status includes having less than a high school education or being at 100% or less of the federal poverty level.
Sources: BRFSS Race Oversample (race and ethnicity estimates), 2015-2017; BRFSS, 2015 (SES estimates).
Estimates are age-adjusted.



To help counteract the negative health effects of the factors discussed on the previous page, HPCDP supports policies and plans that prioritize public investments in bike, pedestrian and transit infrastructure, and options in underserved communities.

Objectives to support physical activity goal statements for 2025

Objective 1: Expand the availability, safety, convenience and appeal of places for people to be physically active, with priority on helping people who are physically inactive become more active by walking or rolling.

- **Rationale:** The Community Guide and the Centers for Disease Control and Prevention cite strong evidence for the effectiveness of creating or improving places that help people move more. Examples include exercise facilities, trails and the physical design features and infrastructure of a community, such as sidewalks. A combination of high-level land use and transportation policy, financial investment and street-level design changes can make communities more walkable and make physical activity more accessible to people of all ages and abilities.
- **Connection to equity:** Some lower-income communities and communities of color can be less physically active than the general population. Safe streets and sidewalks, and access to parks and recreation areas, are integral to providing fair opportunities to be physically active for all communities.

Objective 2: Increase the number of worksites in state and local agencies, hospitals, Coordinated Care Organizations (CCOs) and schools that adopt strategies for changing policy, systems and environments in ways that will increase physical activity, especially among people who are physically inactive.

- **Rationale:** The Community Guide and the Centers for Disease Control and Prevention cite strong evidence that workplace initiatives can measurably increase physical activity through a combination of physical infrastructure, employee benefits and health promotion programs. These include promotional activities such as stairwell campaigns; individually-adapted behavior change programs paired with social support interventions that integrate physical activity; and access to places to be physically active.
- **Connection to equity:** A core function of local and state health departments is to address the institutional and structural barriers that lead to poor health. Rates of physical inactivity and sedentary lifestyles are not evenly distributed across the population. Worksite policies and practices to increase physical activity could address inequities through incentives that

encourage walking, rolling, or cycling, or public transport options tailored for groups that experience health disparities. Governments can model best practices at their locations, benefiting employees as well as clients who visit or access services there.

Objective 3: Ensure that comprehensive chronic disease screening, referral and disease self-management benefits are available through public health plans.

- **Rationale:** Disease self-management programs can empower and encourage people to adopt healthful behaviors, such as eating better and moving more. Developing a sustainable delivery system for disease self-management programs will increase access and referrals to evidence-based programs that can address risk factors for obesity.
- **Connection to equity:** People of color and people with lower incomes make up a relatively high proportion of people on the Oregon Health Plan (OHP). Programs that serve OHP members serve a relatively high number of people from these communities. It is essential to health equity that we make sure that people experiencing health disparities have access to screening and referral to resources at the right time, in a culturally appropriate manner and in ways that best reach the communities who are experiencing the greatest burden of disease.

Goal:
Improve Nutrition

Goal: Improve Nutrition

Obesity* is the No. 2 preventable cause of death and disability among Oregonians and is responsible for more than 2,000 deaths annually. Poor nutrition and physical inactivity are the major drivers of obesity.

When a person has obesity, it means that person's body fat and body fat distribution exceed the level considered healthy.† This is a harmful and costly medical condition that increases the risk of developing diabetes, heart disease, stroke, arthritis, cancer and other chronic diseases. Poor nutrition and physical inactivity are the major drivers of obesity, and individual choices are important. However, the places we live, work, learn, play and age have significant effects. They can determine if nutritious options are available to us, how often we are exposed to harmful products including sugary drinks, and whether or not we will be targeted by excessive advertising and marketing messages that promote unhealthy options.

Blaming individuals who live with obesity does nothing to improve their health or the health of our communities; in fact, weight bias and stigma can heighten or even create mental health issues. The focus of public health and of this strategic plan is on improving our physical and social environments in ways that help all Oregonians maintain a healthy weight and live healthful lives.

Goal statements and targets for 2025

- Reduce obesity prevalence among adults to 28.3 percent or less
  - » Baseline: 29.2 percent (2015 BRFSS)
- Reduce obesity prevalence among 11th graders to 12.8 percent or less
  - » Baseline: 13.2 percent (2015 OHT)
- Reduce obesity prevalence among 8th graders to 11.1 percent or less
  - » Baseline: 11.4 percent (2015 OHT)

---

* As used in this document, obesity refers to the medical condition or disease that causes or complicates multiple chronic diseases including diabetes, heart disease and cancer.

† Trust for America's Health and Robert Wood Johnson Foundation. The State of Obesity: Better Policies for a Healthier America 2018.

Decrease the percentage of youth and adults who consume seven or more sugary drinks per week.

- Reduce prevalence of daily soda consumption among adults to 10.9 percent or less
  - » Baseline: 12.2 percent (2015 BRFSS)
- Reduce prevalence of daily soda consumption among 11th graders to 10.2 percent or less
  - » Baseline: 11.3 percent (2015 OHT)
- Reduce prevalence of daily soda consumption among 8th graders to 9.4 percent or less
  - » Baseline: 10.4 percent (2015 OHT)

Background

What we drink and eat are linked in many ways to chronic diseases.

Increases in the amount of sugar that people drink and eat are driving the rise in chronic diseases, particularly diabetes, obesity, some cancers and heart disease. Sodas and other sugary drinks are the primary source of added sugars in most people's diets. In Oregon, more than one in 10 people report drinking soda every day.* Accordingly, the nutrition component of this plan prioritizes strategies for reducing the amount of sugary drinks that Oregonians consume.

As with other components of this plan, HPCDP's approach is modeled after our successful efforts to reduce tobacco use in Oregon. We work with state and local partners to support people's desire to be healthy by providing healthful drink options, reducing access to sugary drinks and warning people of the dangers of sugary drinks.

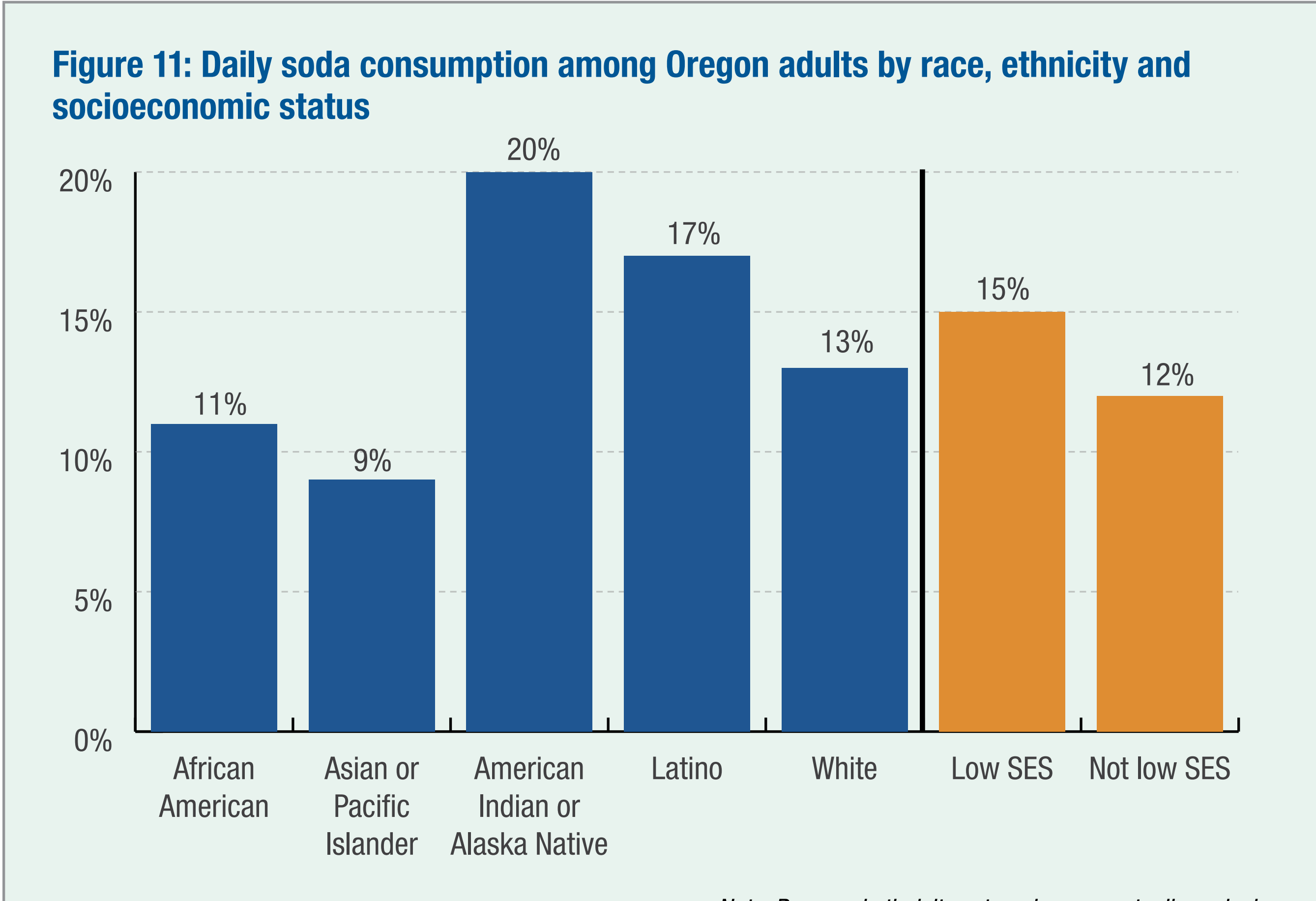
Over the next eight years, HPCDP will focus on increasing awareness of the health effects of sugary drinks. We will also build support for evidence-based strategies that can improve nutrition through changes in policy, systems and environments. In addition, HPCDP will address sugary drinks and other nutrition objectives through existing worksite wellness and disease self-management programs.

* BRFSS, 2015.

Addressing health equity through improved nutrition

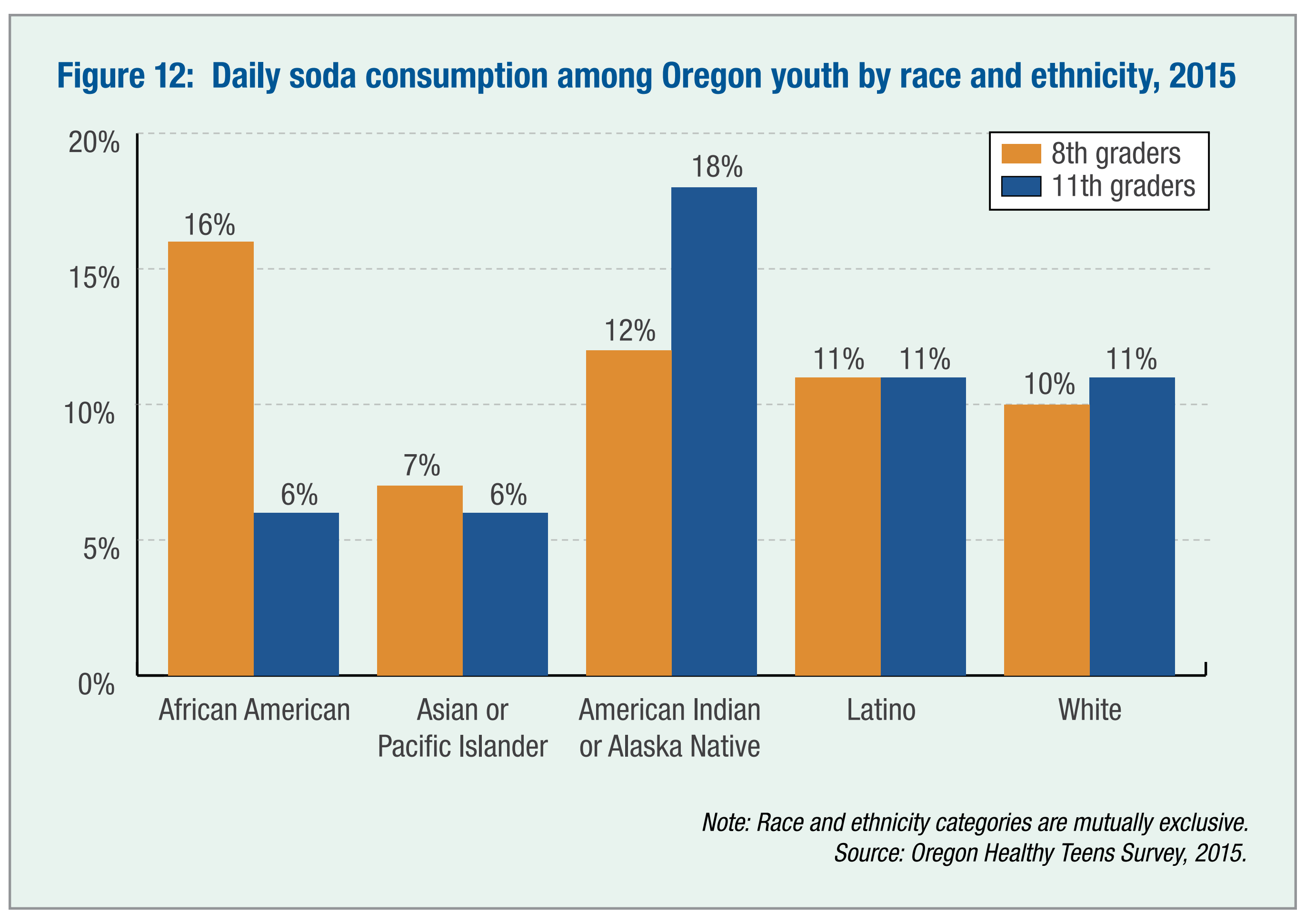
For years, the sugary drink industry has targeted people of color and people with lower incomes, regardless of their race or ethnicity. As a result, sugary drink consumption is more prevalent among communities of color and people who have lower incomes or less education [Fig. 11], and among rural populations. These disparities in sugary drink consumption are generally reflected in rates of chronic diseases related to excessive consumption of added sugars, including heart disease, diabetes and obesity.*

Figure 11: Daily soda consumption among Oregon adults by race, ethnicity and socioeconomic status



Note: Race and ethnicity categories are mutually exclusive.
Low socioeconomic status includes having less than a high school education or being at 100% or less of the federal poverty level.
Sources: BRFSS Race Oversample (race and ethnicity estimates), 2015-2017; BRFSS, 2015 (SES estimates).
Estimates are age-adjusted.

* VS Malik, BM Popkin, GA Bray, JP Després, FB Hu. 2010. Sugar-sweetened beverages, obesity, type 2 diabetes mellitus, and cardiovascular disease risk. Circulation. 121:1356-1364. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2862465/



To increase health equity and help address disparities in sugary drink consumption and related chronic diseases, this plan focuses on increasing the price of sugary drinks. Evidence shows that price increases on sugary drinks are more likely to improve health when the funds collected contribute to programs that reduce consumption – such as efforts to decrease or eliminate soda industry marketing and advertising that target certain communities.

Objectives to support nutrition goal statements for 2025

Objective 1: Work toward raising the price of sugary drinks to address the major drivers of obesity, which are physical inactivity and poor nutrition. Dedicate at least 10 percent of the increase to a comprehensive obesity prevention program.

- **Rationale:** Rising consumption of sugary drinks has been a major contributor to the obesity epidemic. Raising the price of sugary drinks reduces consumption and makes obesity prevention more successful.
- **Connection to equity:** The sugary drink industry has targeted disadvantaged communities for years. As a result, sugary drink consumption is more prevalent among communities of color, those who have lower incomes or less education, and rural populations. The disparities in sugary drink consumption are generally reflected in the disparities in rates of chronic diseases related to excessive consumption of added sugars, including heart disease, diabetes and obesity. Raising the price of sugary drinks has the potential to reduce health disparities in communities with higher sugary-drink consumption rates. When resources from price increases go first toward supporting these communities in addressing health inequities, the benefits are even greater.

Objective 2: Educate the public, policy makers and partners about the dangers of sugary drinks and the role of place in healthful eating and physical activity.

- **Rationale:** Education and awareness messages, when combined with other obesity interventions, are an effective strategy to increase healthful eating and reduce the consumption of sugary drinks.
- **Connection to equity:** Communities experiencing health disparities are the same communities that are disproportionally targeted by sugary-drink industry marketing and advertising. Education and awareness messages, led by and representing these communities, can ensure that policies address these and other equity considerations.

Objective 3: Increase the number of worksites in state and local agencies, hospitals, CCOs and schools that adopt policy, system and environmental changes that support access to nutritious foods and beverages.

- **Rationale:** The Community Guide and the Centers for Disease Control and Prevention cite strong evidence that workplace initiatives can measurably increase healthful eating. Workplaces and other environments that promote and provide safe and sustainable options to eat better and move more, and that discourage or prohibit the consumption of sugary drinks, support healthful eating and active living. This support can occur through complementary and appropriate physical infrastructure, employee benefits and health promotion programs.
- **Connection to equity:** A core function of local and state health departments is to address the institutional and structural barriers that lead to poor health. Making healthier foods and beverages available can also help make the food environment more equitable, by making such items more accessible and affordable to consumers who may otherwise lack access to them. Additionally, the practice of improving food service policies and contracts can promote fair labor practices, environmental sustainability and partnerships with businesses owned by women and people of color.

Objective 4: Ensure that comprehensive chronic disease screening, referral and disease self-management benefits are available through public health plans.

- **Rationale:** Disease self-management programs can empower and encourage people to adopt healthful behaviors, such as eating better and moving more. Developing a sustainable delivery system for self-management programs will increase access and referrals to evidence-based programs that can address risk factors for obesity.
- **Connection to equity:** People of color and people with lower incomes make up a relatively high proportion of people on the Oregon Health Plan (OHP). Programs that serve OHP members serve a relatively high number of people from these communities. It is essential to health equity that we make sure that people experiencing health disparities have access to screening and referral to resources at the right time, in a culturally appropriate manner and in ways that best reach the communities who are experiencing the greatest burden of disease.

Goal: Decrease Excessive Alcohol Use

Goal: Decrease Excessive Alcohol Use

Excessive alcohol use remains the No. 3 preventable cause of death among Oregonians and is responsible for nearly 2,000 deaths annually.* Diseases related to excessive alcohol use and misuse include cancer, liver disease, diabetes and alcohol dependence. Related injuries include those from motor vehicle crashes and violence.

Goal statements and targets for 2025

Decrease heavy drinking among Oregon adults.

- Reduce heavy drinking prevalence among adults to 6.9 percent or less
  - Baseline: 7.3 percent (2015 BRFSS)

Decrease binge drinking among Oregon adults and youth.

- Reduce binge drinking prevalence among adults to 16.1 percent or less
  - Baseline: 17.9 percent (2015 BRFSS)
- Reduce binge drinking prevalence among 11th graders to 13.2 percent or less
  - Baseline: 16.5 percent (2015 OHT)
- Reduce binge drinking prevalence among 8th graders to 4.2 percent
  - Baseline: 5.3 percent (2015 OHT)

Decrease total per capita alcohol consumption in Oregon.

- Reduce gallons of pure alcohol consumed per person per year by those age 14 and older to 2.6 gallons or less
  - Baseline: 2.7 gallons†

---

* Oregon Center for Health Statistics Death Certificate Data (2015).

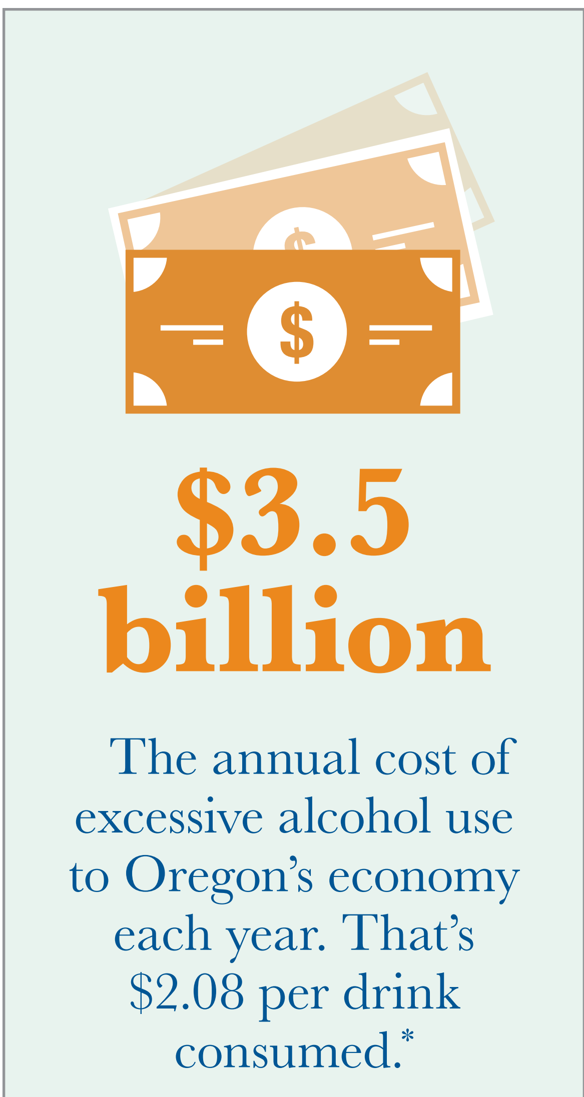
† Haughwout, BS and Slater ME. Apparent per capita alcohol consumption: National, state, and regional trends, 1977-2015. NIAAA Surveillance Report #108. https://pubs.niaaa.nih.gov/publications/surveillance108/CONS15.pdf

Background

Excessive alcohol use has serious consequences for public health. It can lead to significant problems including liver disease, diabetes, cancer, alcohol dependence and injuries from motor vehicle crashes and violence.

Conversely, consuming less alcohol lowers a person's risk for injuries and for developing a chronic disease. Drinking less alcohol also helps people manage existing chronic diseases, including liver disease, cancers and alcohol dependence.

In 2010, the economic costs of excessive alcohol consumption in the United States were estimated at $249 billion. In Oregon, excessive alcohol use costs the state economy over $3.5 billion per year, or roughly $2.08 per drink. This includes the cost of lost workplace productivity, health care expenses, criminal justice costs and motor vehicle crashes related to excessive alcohol use.*



Excessive alcohol use is not limited to people who are addicted to or dependent on alcohol. This category also includes binge drinking, heavy drinking, underage drinking and drinking by pregnant women. In fact, most people who drink excessively (90 percent) are not alcohol dependent, addicted or "alcoholic."†

* Sacks, J, Gonzalez K, Bouchery E,Tomedi L, Brewer, R. 2010 National and State Costs of Excessive Alcohol Consumption. Am J of Prev Med 2015; 49; Issue 5; 73-79.

† Esser MB, Hedden SL, Kanny D, Brewer RD, Gfroerer JC, Naimi TS. Prevalence of Alcohol Dependence Among US Adult Drinkers, 2009–2011. Prev Chronic Dis 2014;11:140329.

Binge drinking

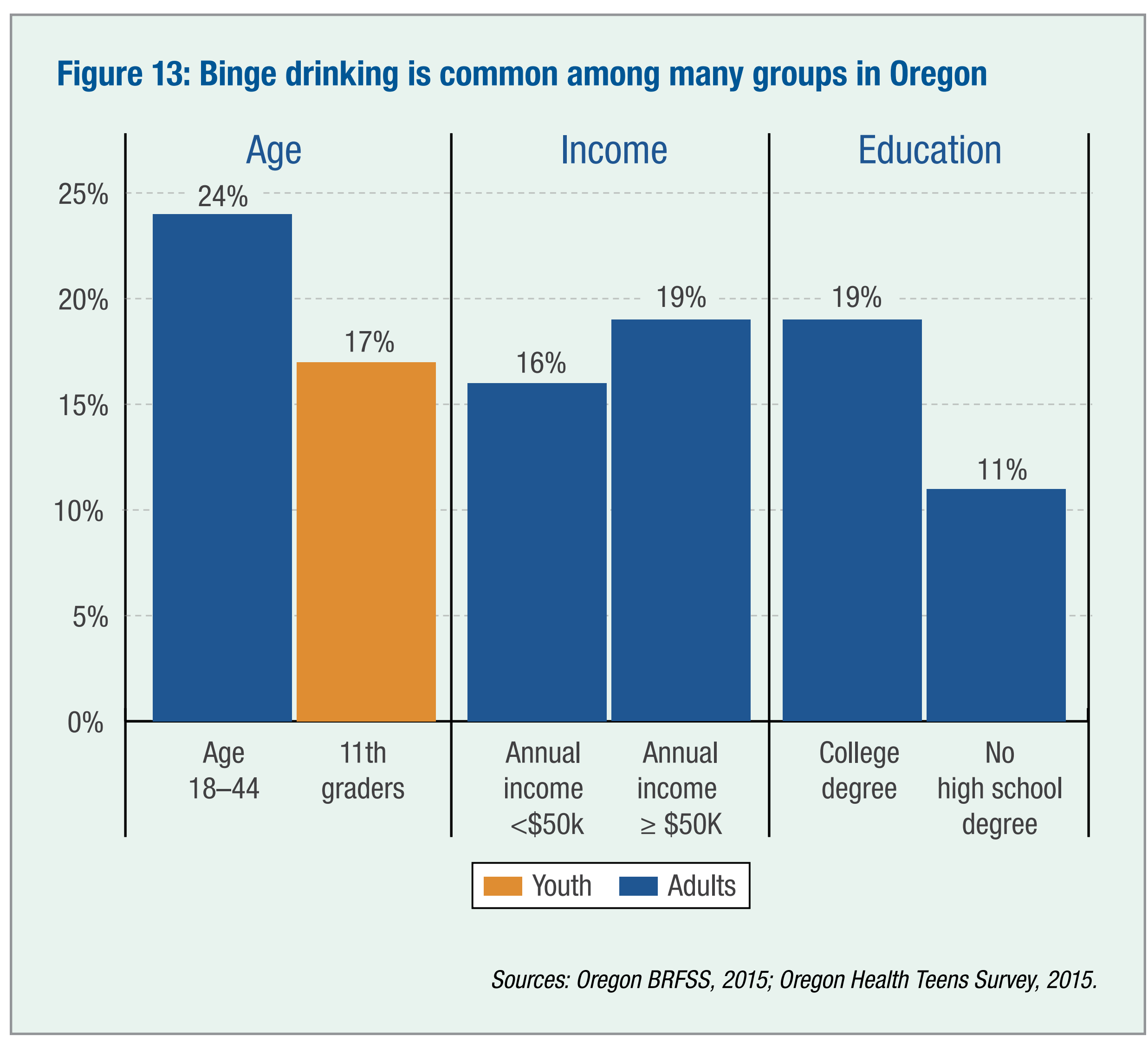
Binge drinking is the most common and most dangerous pattern of excessive alcohol use. It is responsible for more than half of the deaths and three-quarters of the economic costs associated with excessive alcohol use in the nation.

In Oregon, binge drinking among youth has decreased by one-third since 2001. In 2015, 17 percent of Oregon 11th graders reported binge drinking in the last 30 days, compared to 25 percent in 2001.

However, binge drinking among young adults in Oregon remains high: 29 percent of adults age 18 to 24 reported binge drinking in 2015, the highest rate among all age groups.

Among all Oregon adults, binge drinking has trended upwards over the past 15 years, from 15% in 2001 to 18% in 2016.

Figure 13: Binge drinking is common among many groups in Oregon



Sources: Oregon BRFSS, 2015; Oregon Health Teens Survey, 2015.

Preventing excessive alcohol use

A combination of efforts can make a significant difference in preventing excessive alcohol use:

- Increasing the price of alcohol reduces use among youth. It can also reduce excessive drinking and alcohol-related problems, including alcohol-impaired driving, among adults.
- Certain retail restrictions can reduce alcohol-related problems such as violence, crime and injuries from motor vehicle crashes. These restrictions include limiting the density of stores that sell alcohol and the hours when alcohol can be purchased.

Reducing the burden of binge drinking and heavy drinking through multiple evidence-based strategies will improve health in Oregon communities and lower health care costs. HPCDP works with state and local partners such as local mental health and public health authorities, health systems, tribes, education partners and the Oregon Liquor Control Commission (OLCC) to support people's desire to be healthy by creating polices and environments that discourage excessive alcohol use and prevent related harms in Oregon communities.

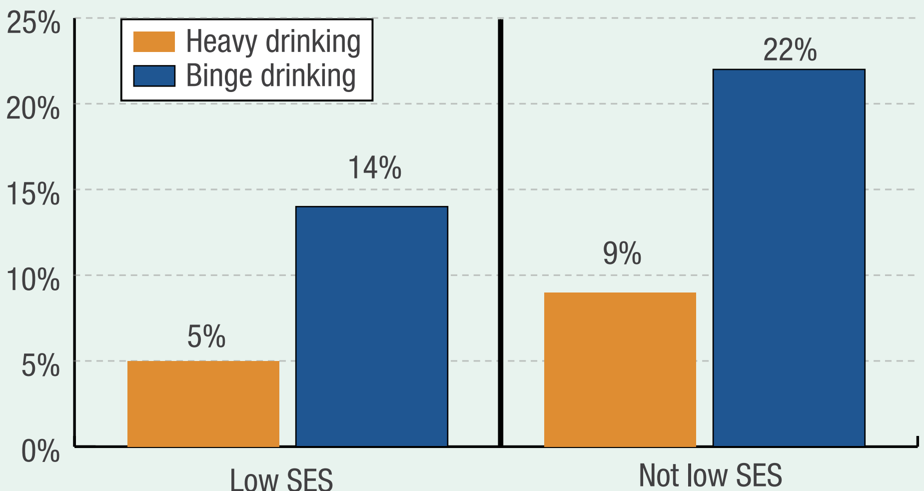
Addressing health equity by decreasing excessive alcohol use

Excessive alcohol use, including binge drinking, affects a wide range of Oregonians at all income and education levels. But it plays out in communities in different ways.

For example, while tobacco use, physical inactivity and poor nutrition are more common among people with lower incomes and less education, binge drinking is more prevalent among people with more education and higher incomes. Yet studies show that people with lower incomes and less education drink more often and consume more alcohol per episode of binge drinking.*

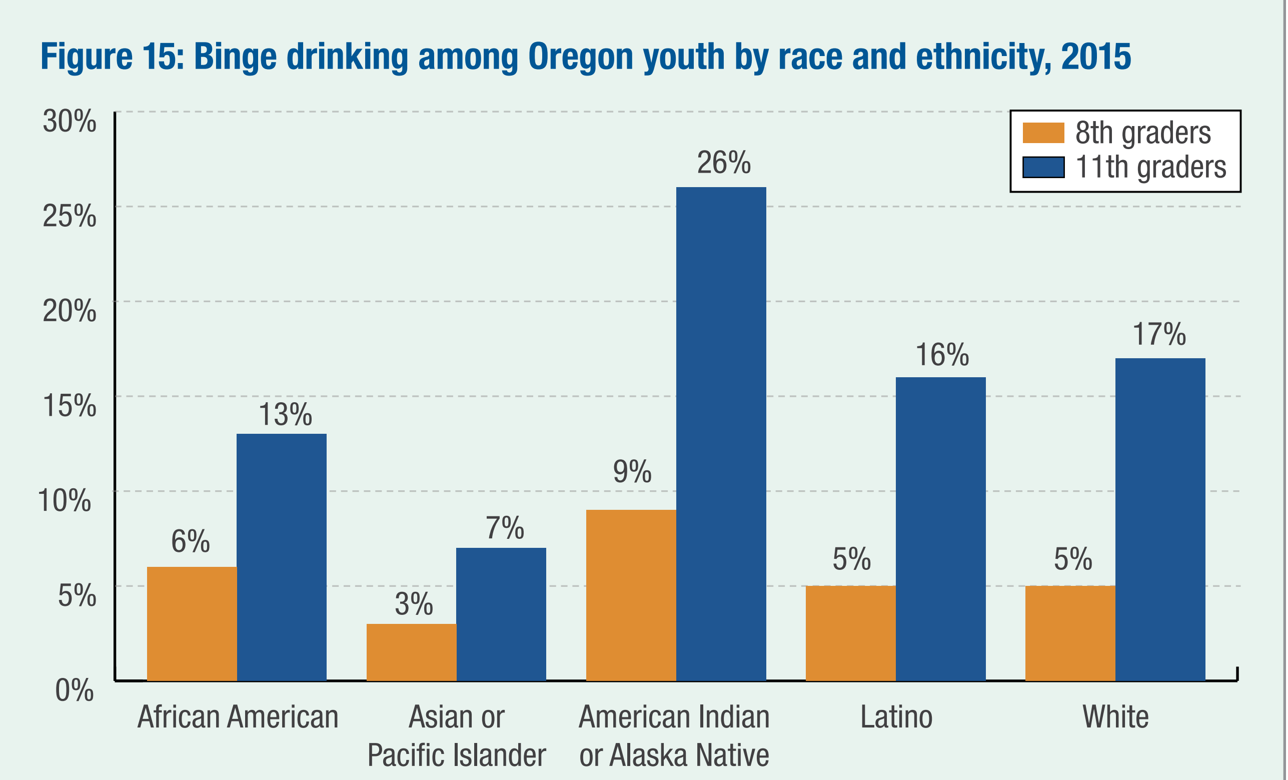
* Kanny D, Naimi TS, Liu Y, Lu H, Brewer RD. Annual Total Binge Drinks Consumed by U.S. Adults, 2015. Am J Prev Med 2018;54:486–496.

Figure 14: Binge and heavy drinking among Oregon adults by socioeconomic status, 2015



Heavy drinking is consuming an average of more than two drinks a day for men or more than one drink a day for women.
Binge drinking is consuming five or more drinks for men, or four or more drinks for women, on one occasion.
Low socioeconomic status includes having less than a high school education or being at 100% or less of the federal poverty level.
Source: BRFSS, 2015. Estimates are age-adjusted.

Figure 15: Binge drinking among Oregon youth by race and ethnicity, 2015

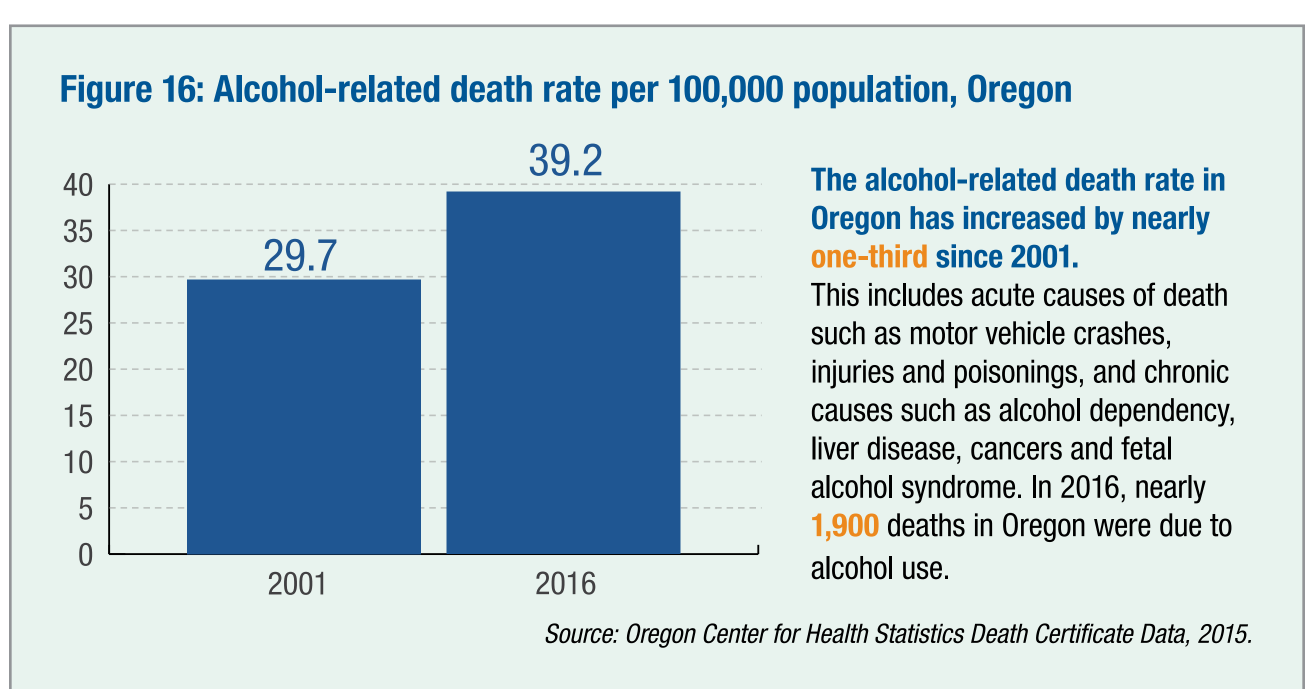


Note: Race and ethnicity categories are mutually exclusive.
In this chart, binge drinking includes having 5 or more drinks of alcohol in a row during the past month.
Source: Oregon Healthy Teens Survey, 2015.

Data about excessive alcohol use among adults of different racial and ethnic backgrounds is more limited. Generally, we know that excessive drinking is linked to chronic diseases that affect some communities of color, as well as people with lower incomes and less education, at significantly higher rates.

- For example, African Americans in Oregon experience higher rates of stroke and heart attack compared to other groups; both diseases are linked to excessive alcohol use, among other factors.
- Among youth, American Indians and Alaska Natives are more likely to drink alcohol and binge drink compared to other groups [Fig. 15].
- And the rate of alcohol-related deaths is more than double among American Indian and Alaska Native adults (84 per 100,000) compared to other groups (e.g., 41 per 100,000 among non-Hispanic Whites).

Excessive drinking can directly cause disease and death, as in the case of liver cancer, or motor vehicle crashes caused by alcohol-impaired driving. Excessive drinking also can increase a person's risk for developing chronic diseases such as liver disease, obesity and diabetes; make these diseases worse; and make it harder for people to manage them. For example, because alcohol is high in sugar, people with diabetes who drink excessively may struggle to manage their disease, which affects the body's ability to regulate its blood sugar levels.



HPCDP prioritizes resources in communities with lower incomes and less education, as well as certain ethnic and racial communities, where people experience higher rates of alcohol-related diseases. To expand these resources, this plan focuses on increasing the price of alcohol where at least 10 percent of the money raised would provide communities and families with tools and support to make their neighborhoods healthier. One strategy, among others, is to reduce the prevalence of stores that sell alcohol in the places where Oregonians live, work, learn, play and age.

Objectives to support alcohol goal statements for 2025

Objective 1: Increase the price of alcohol. Dedicate at least 10 percent of this increase to a comprehensive program to prevent excessive alcohol use.

Proposed for tribal programs: Support tribes to explore options to dedicate a portion of alcohol tax revenue to tribal substance use prevention.

- **Rationale:** Raising the price of alcohol can reduce excessive alcohol use and alcohol-related problems, including alcohol-impaired driving. A 10 percent increase in the price of alcohol would reduce overall alcohol consumption by about 7 percent.* A comprehensive program, funded by a significant portion of alcohol tax revenue, could educate and raise awareness about excessive alcohol use in Oregon and promote systemic and environmental changes that reduce excessive alcohol use in the state.
- **Connection to equity:** Alcohol pricing strategies have been shown to reduce alcohol consumption rates among people with lower incomes. Lowering alcohol consumption has been shown to have a greater positive effect on the health of lower income people, compared to reducing consumption among more affluent drinkers. Youth, people living with fewer financial resources and certain communities of color are more price-sensitive than the general population, so price increases will result in greater reductions in consumption and related health burdens. When resources from price increases go first toward supporting these communities in addressing health inequities, the benefits are even greater.

* Elder RW, et al. Am J Prev Med 2010 38(2) 217-229.

Objective 2: Increase the number of jurisdictions covered by restrictions on alcohol marketing, promotion and stores that sell alcohol. These may include limits on outlet density, price promotions and days or hours of sale, as well as point of purchase interventions.

- **Rationale:** According to the U.S. Surgeon General, higher density of places that sell alcohol is associated with an increase in alcohol-related problems such as violence, crime and injuries. Environments that reduce alcohol availability and exposure to alcohol marketing and promotion discourage excessive alcohol use.

- **Connection to equity:** Studies have shown that greater density of places that sell alcohol is associated with higher levels of poverty and with higher proportions of people of color in urban census tracts.

Objective 3: Increase the number of colleges and universities with restrictions on alcohol promotion, sale or sponsorship at college or university events.

- **Rationale:** According to the U.S. Surgeon General, a higher density of places that sell alcohol is associated with an increase in alcohol-related problems such as violence, crime and injuries. Environments that reduce alcohol availability and exposure to alcohol marketing and promotion discourage excessive alcohol use.

- **Connection to equity:** Risk factors such as socioeconomic status, race and ethnicity, stress, social networks, exposure to media messages about substance use, and pre-college drinking have been found to influence high school completion rates and students' substance use during their transition to college. Enacting environmental strategies such as prohibiting the use or sale of alcohol at campus events reduces alcohol consumption rates among students.

Objective 4: Ensure that comprehensive alcohol screening, referral and treatment benefits are available through public and private health plans.

- **Rationale:** Coordinated Care Organizations (CCOs) play an important role in helping reduce excessive alcohol use, through accurate assessment of members' excessive drinking status; benefit design (expanding coverage and reducing barriers to service); benefit promotion; alcohol-free campus policies; and partnerships with local public health authorities and other concerned groups to create community spaces that don't promote excessive alcohol use.
- **Connection to equity:** People of color and people with lower incomes make up a relatively high proportion of people on the Oregon Health Plan (OHP). CCOs and programs that serve OHP members serve a relatively high number of people from these communities. It is essential to health equity that we make sure that people experiencing health disparities have access to screening and referral to resources at the right time, in a culturally appropriate manner, and in ways that best reach the communities who are experiencing the greatest burden of disease.

Objective 5: Maintain Oregon's state alcohol beverage control to prevent and reduce excessive alcohol use.

- **Rationale:** The Community Preventive Services Task Force recommends against the further privatization of alcohol sales in settings with current government control of retail sales. This recommendation is based on the task force's charge to identify effective disease and injury prevention measures as well as strong evidence that privatization results in increased per capita alcohol consumption, a well-established proxy for excessive consumption and related harms.
- **Connection to equity:** Lower-income groups and communities of color are disproportionately affected by the negative social and health consequences of alcohol. Alcohol is disproportionately available for sale in lower-income neighborhoods. Further privatization of alcohol sales could lead to greater alcohol consumption, further increasing the negative consequences of alcohol in these communities.

Appendices

Appendix A – Summary of 2017-2025 Goals and Performance Metrics

Tobacco Goals for 2025

Decrease the percentage of youth and adults who smoke cigarettes.

- Reduce cigarette smoking prevalence among adults to 13.3 percent or less
  - » Baseline: 17.7 percent (2015 BRFSS)
- Reduce cigarette smoking prevalence among 11th graders to 6.6 percent or less
  - » Baseline: 8.8 percent (2015 Oregon Healthy Teens)
- Reduce cigarette smoking prevalence among 8th graders to 3.7 percent or less
  - » Baseline: 4.3 percent (2015 OHT)

Decrease annual per capita cigarette sales in Oregon.

- Reduce cigarette sales to 34 or fewer packs per person per year
  - » Baseline: 40 packs per person per year (2015)*

* Orzechowski and Walker, The Tax Burden on Tobacco. Historical compilation Volume 52, 2017. Fairfax and Richmond, Virginia.

Physical Activity Goals for 2025

Develop a comprehensive prevention and education infrastructure – which includes creating and improving places where people can be active – to address the major drivers of obesity: physical inactivity and poor nutrition. These efforts are crucial to expanding state and community capacity for preventing chronic disease.

Decrease the percentage of adults who are physically inactive.

- Reduce prevalence of physical inactivity among adults to 16.4 percent or less
  - » Baseline: 18.2 percent (2015 BRFSS)

Decrease the percentage of youth who do not meet the U.S. Surgeon General's recommended level of physical activity.

- Reduce prevalence of 11th graders who do not meet the recommendation of 60 minutes of daily physical activity to 72.5 percent or less
  - » Baseline: 76.3 percent (2015 OHT)
- Reduce prevalence of 8th graders who do not meet the recommendation of 60 minutes of daily physical activity to 65.8 percent or less
  - » Baseline: 69.3 percent (2015 OHT)

Nutrition Goals for 2025

- Reduce obesity prevalence among adults to 28.3 percent or less
  - Baseline: 29.2 percent (2015 BRFSS)
- Reduce obesity prevalence among 11th graders to 12.8 percent or less
  - Baseline: 13.2 percent (2015 OHT)
- Reduce obesity prevalence among 8th graders to 11.1 percent or less
  - Baseline: 11.4 percent (2015 OHT)

Decrease the percentage of youth and adults who consume seven or more sugary drinks per week.

- Reduce prevalence of daily soda consumption among adults to 10.9 percent or less
  - Baseline: 12.2 percent (2015 BRFSS)
- Reduce prevalence of daily soda consumption among 11th graders to 10.2 percent or less
  - Baseline: 11.3 percent (2015 OHT)
- Reduce prevalence of daily soda consumption among 8th graders to 9.4 percent or less
  - Baseline: 10.4 percent (2015 OHT)

Alcohol Goals for 2025

Decrease heavy drinking among Oregon adults.

- Reduce heavy drinking prevalence among adults to 6.9 percent or less
  - » Baseline: 7.3 percent (2015 BRFSS)

Decrease binge drinking among Oregon adults and youth.

- Reduce binge drinking prevalence among adults to 16.1 percent or less
  - » Baseline: 17.9 percent (2015 BRFSS)
- Reduce binge drinking prevalence among 11th graders to 13.2 percent or less
  - » Baseline: 16.5 percent (2015 OHT)
- Reduce binge drinking prevalence among 8th graders to 4.2 percent
  - » Baseline: 5.3 percent (2015 OHT)

Decrease total per capita alcohol consumption in Oregon.

- Reduce gallons of pure alcohol consumed per person per year by those age 14 and older to 2.6 gallons or less
  - » Baseline: 2.7 gallons (2015)*

* Haughwout, BS and Slater ME. Apparent per capita alcohol consumption: National, state, and regional trends, 1977-2015. NIAAA Surveillance Report #108. https://pubs.niaaa.nih.gov/publications/surveillance108/CONS15.pdf

Appendix B – Data Sources

Behavioral Risk Factor Surveillance System Survey (BRFSS)

- **Description:** The BRFSS is an annual random-digit dialed telephone survey that is conducted year-round among Oregon adults aged 18 years or older. The BRFSS includes questions on diagnosis of chronic diseases and health behavior risk factors such as diet, weight control, tobacco and alcohol use, physical activity, preventive health screenings and use of health care services. The data are weighted to represent all adults age 18 and older. A core set of questions is asked annually, and other topics are surveyed on a rotating basis. Starting in 2010, Oregonians who use cell phones were added to the survey, which changed the method for adjusting (weighting) the data to the demographics of the state. This new method is called "raking." Because of these changes, data prior to 2010 are not directly comparable to data from 2010 forward. The national BRFSS implemented these changes in 2011.
- **Limitations:** BRFSS estimates are only for the adult population aged 18 years or older who live in households. Respondents are identified through telephone-based methods. Results obtained through BRFSS surveys are limited in that they represent self-reported responses. Not all questions on the BRFSS have been validated.

Oregon Healthy Teens Survey (OHT)

- **Description:** The OHT survey has been conducted since 2000. The sample size varies from 1,600 to 32,000 per year, and the final data are weighted to more accurately represent Oregon 8th and 11th graders. The survey assesses health topics such as tobacco and alcohol use, HIV knowledge and attitudes, eating behaviors, nutrition and exercise. From 2000 to 2008 the survey was done annually. Since 2009 the survey has been administered every other year. Learn more about OHT.
- **Limitations:** Participation by school systems in the OHT is voluntary. However, participation rates are high. Another limitation is that 3 percent of surveys were eliminated due to combinations of "dubious" answers and another 5 percent were eliminated because students did not fill out grade or gender information.

Appendix C – Healthy Places, Healthy People Framework

Download "Healthy places, healthy people: a framework for Oregon" (.PDF)
https://tinyurl.com/y3ot758d

Healthy places, healthy people: a framework for Oregon

Healthy Oregon

Statewide policies put healthy options within reach of all people, and protect people from unhealthy options and influences.

- Public places are tobacco-free and smoke-free and follow standards for nutrition and physical activity.
- Transportation and land use planning initiatives prioritize health.
- Tobacco, alcohol and sugary beverages are priced higher to discourage use.
- Health effects of policy decisions are considered across agencies, organizations and populations.

Public health efforts help people eat better, move more, live tobacco-free and take care of themselves so they can live healthier lives and do the things they enjoy.

- Tobacco, obesity, alcohol and drug prevention and education programs are adequately funded and build state and community capacity for chronic disease prevention and health promotion.
- Oregon and its many diverse communities collect, analyze and report information about health and the economic cost of chronic diseases and use it to improve everyone's health.
- Awareness and education messages promote healthy options and warn of the dangers of tobacco, alcohol and sugary beverages in ways that are meaningful to all people in Oregon.
    - Everyone in Oregon has access to a coordinated and patient-centered health system that supports effective chronic disease prevention, early detection and self-management.

State, local and tribal governments collaborate with community partners to put health within reach of all people in Oregon.

Healthy Communities

In every Oregon community, all people have access to healthy options where they live, work, play and learn.

Local policies, systems and environments put health within reach today and for future generations.

All people have convenient access to:

- Healthful foods and drinking water.
- Safe biking, walking and rolling routes.
- Active transportation and recreation options.
- Resources to help people take care of themselves, to stay healthy and live better with diseases they already have.

There is minimal exposure or access to:

- Secondhand smoke.
- Tobacco products.
- Unhealthful foods and beverages.
- Advertising and promotion of tobacco, alcohol, marijuana and sugary beverages.

PUBLIC HEALTH DIVISION
Health Promotion and
Chronic Disease Prevention

September 2017

PUBLIC HEALTH DIVISION
Health Promotion and
Chronic Disease Prevention
800 N.E. Oregon St., Suite 730
Portland, OR 97232
Telephone: 971-673-0984
Website: public.health.oregon.gov

You can get this document in other languages, large print, braille or a format you prefer. Contact the Public Health Division at 971-673-0984. We accept all relay calls or you can dial 711.

Rev 07/19