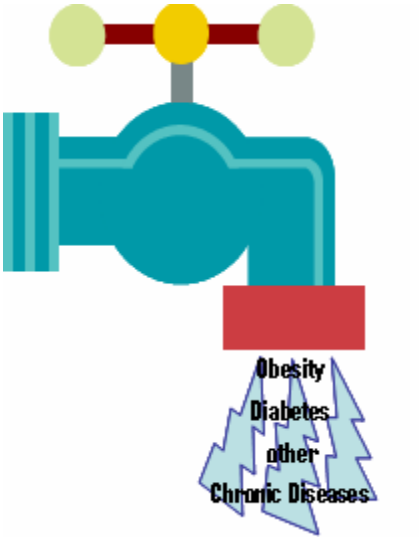
HB 3486 Strategic Plan to Slow the Rate of Diabetes in Oregon



"Turning Off the Faucet of Obesity & Diabetes"

A Report to the 2009 Oregon Legislature

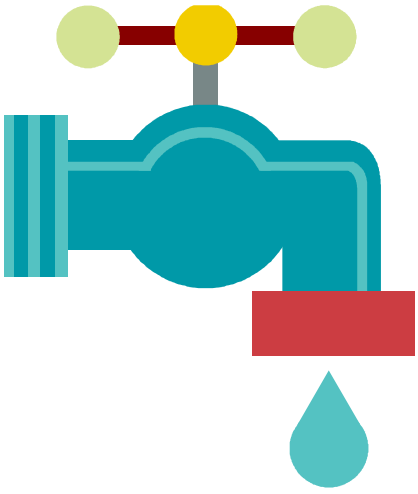


Table of Contents

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HB 3486 Strategic Plan to Slow the Rate of Diabetes in Oregon – "Turning Off the Faucet of Obesity and Diabetes"

Executive Summary

The 2007 Oregon Legislature approved and Governor Kulongoski signed HB3486 which declared an emergency related to diabetes and obesity and directed the Oregon Department of Human Services (DHS) to develop a plan to slow the rate of diabetes caused by obesity and other environmental factors by 2010. The plan is to include funding and statutory recommendations. 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. Over 260,000 Oregonians already have diabetes, a condition that currently costs $1.4 billion annually to treat. Almost 600,000 manifest abnormal metabolism indicative of a prediabetes condition and 60% of adult Oregonians are obese or overweight putting them at high risk of developing diabetes. Over 37,000 adult Oregonians become obese each year, and almost 7,000 Oregonians develop diabetes each year. Tens of thousands of additional Oregonians will develop prediabetes annually unless fundamental changes occur. The "faucet" of diabetes and obesity is wide open in Oregon.

Many Oregon children now have Type 2 diabetes—a diagnosis previously very rare in children. Oregonians with low incomes and Oregon's populations of African Americans, American Indian and Alaska natives, and Hispanic/Latino people are more commonly affected and have less access to the health care system.

Traditional medical approaches are available but will not change the rate at which new people develop either 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. We essentially would be using a very expensive mop to soak up the water streaming from the "faucet" but would do 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 approach to effectively slow the burden of diabetes and other chronic diseases rapidly emerging in Oregon. This includes strategies facilitating healthy choices, changes in built environments, increases in physical activity and comprehensive approaches to increasing the use of healthy foods.

The benefits of creating health-promoting environments go far beyond reducing the prevalence of obesity and diabetes. They also support treatment and management of diabetes and help reduce the dire complications of diabetes like heart disease, blindness, amputations, and kidney disease. Additionally, related conditions like high blood pressure, high cholesterol, heart disease, stroke, cancer and arthritis will be prevented and/or more effectively treated.

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

- Significant funding be dedicated to statewide obesity prevention efforts;
- Serious consideration be given to addressing underlying cause of health inequities;
- Consumers have access to easily available information to make healthy food choices;
- Careful planning be done 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, diabetes, treatment with pharmacologic agents, intensive life style 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 with a chronic care oriented model, and public reporting of clinical outcomes.

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 caused by them. Affected communities need to be part of the discussion and planning.

Introduction

In 2007, the Oregon Legislature passed and Governor Kulongoski signed House Bill 3486, which declared an emergency related to diabetes and obesity and directed the Oregon Department of Human Services (DHS) to develop a strategic plan to start to slow the rate of diabetes caused by obesity and other environmental factors by the year 2010. Chief sponsor of the bill was Representative Scott Bruun.

The bill directed DHS to work in collaboration with key partners to develop the plan including the American Diabetes Association, the Oregon Diabetes Coalition, other professionals, community-based organizations, health educators and researchers specializing in diabetes and obesity prevention, treatment or 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 preventative clinical screening results.;
- Actions and a time frame to reduce the morbidity and mortality from diabetes by the year 2015;
- Statutory changes and funding needed to achieve the plan.

The HB 3486 Advisory Committee held its first meeting on November 29, 2007. In order to produce a comprehensive strategic plan, representatives from over 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.

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 which follows.

Background/Problem Statement

Diabetes is already 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 that are not receiving appropriate treatment. There are also uninsured Oregonians who are not able to access health care.

Oregon is in the middle of an epidemic of obesity and pre-diabetes and is swiftly heading toward an epidemic of diabetes. While 262,000 Oregon adults already have diabetes, about 6,900 more are diagnosed each year. About 590,000 adults are estimated to have a pre-diabetes condition of abnormal metabolism. Already 1,710,000 Oregon adults overweight/obese and every year 37,000 more become obese placing them at high risk for developing diabetes. The "faucet" of obesity and diabetes is wide open and we need immediate actions to turn this faucet off.

Oregon's children are not immune to this epidemic. Currently about 2,100 Oregon children have diabetes, mostly Type 1. However, some children are now being diagnosed with Type 2 diabetes, a previously unheard of phenomenon. With 165,000 Oregon youth already overweight and 14,000 estimated to have pre-diabetes, the next generation of Oregonians is projected to be in worse health than their parents and grandparents. The 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 like 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% vs 4%) and more than twice as likely to have a stroke (5% vs 2%). Preventing obesity and diabetes would have an enormous impact on reducing the development of many chronic diseases and their complications.

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, 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 following tables.

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
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
Latinos	70%	160,000
Non-Latino whites	60%	1,500,000

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
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
Latinos	19%	28,000
Non-Latino whites	25%	677,000

(Source: 2004-2005 BRFSS Oversample; Presented rates 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. People were included in a particular racial community if they ascribed to themselves that race alone. People were included as "Latino" if they reported they were Latino or Hispanic. These people were not included in the "non-Latino white" category, but were included in other categories if they ascribed to themselves that race alone. The appropriate denominator estimate was then multiplied by the un-adjusted prevalence from the BRFSS oversample to provide the final count estimate.)

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. Turning off the "faucet" of obesity and diabetes is critical to the health and economic wellbeing 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 over $1.3 billion to conduct intensive lifestyle interventions over 3 years for the estimated 590,000 Oregonians who currently have a pre-

diabetes condition. If done to fidelity, this intervention would reduce from 64,900 to 28,320 the number of those Oregonians who would go on to develop diabetes.

3. While keeping 36,580 people with a pre-diabetes 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 pre-diabetes 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. We essentially would be using a very expensive mop to soak up the water streaming from the "faucet" but would do 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 that 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 in our great state.

7. The benefits of creating health-promoting environments will go far beyond reducing the prevalence of obesity and diabetes. They also support treatment and management of diabetes and help reduce the dire complications of diabetes like heart disease, blindness, amputations, and kidney disease. Additionally, related conditions like high blood pressure, high cholesterol, heart disease, stroke, cancer and arthritis will be prevented and/or more effectively treated.

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 evaluating the effects of these programs are critical to success.

9. To meet the needs of a variety of communities, community-specific input and participation needs 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/year. This much funding needs to be invested in an Obesity Prevention and Education Program 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, in order to eliminate health disparities, root causes of health inequities need to be addressed in Oregon. 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 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.

Between 1996, the year before TPEP was established, and 2006, there was a 22% drop in tobacco prevalence among Oregon adults. Over ten years, an Obesity Prevention and Education Program (OPEP) with similar effectiveness in reducing onset of diabetes would save $215 million in medical costs from prevented cases of diabetes.

In fact, an OPEP 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/year) equals a mere 3% of the current cost of treating diabetes.

Detection

HB3486 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 US 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 or occurring medical interactions rather than provided at community screenings or other mass screenings. Screening for obesity should be based on BMI

and also be done opportunistically except in children where more organized screening 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 diagnosis these conditions will also assist in the evaluation of the effectiveness of population-based efforts.

Management

Considerable time and analysis was taken to determine the feasibility of pursuing a traditional medical approach including mass screening, diagnosis of obesity, prediabetes, diabetes, treatment with pharmacologic agents, intensive life style 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% of patients are consistently treated with consensus approaches. Delivery system reform offers the possibility of a more efficient and effective delivery system.

Oregon is currently evaluating reform options as part of SB329. 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 that 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. The HB 3486 Advisory Committee felt the appropriate place for health system reform is at the Health Fund Board rather than as a 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 in order 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 Ezzati, et al, "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]".

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 US. 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 were 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 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 HB3486 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, the 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 like diabetes. However, the language of HB3486 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, it is recommended that 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.

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.

Workplan for HB 3486

Outlined on the next pages is a workplan 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".

In the workplan for each biennium recommendations are included for legislative activity including funding and statutory changes. Additional activities are also included that do not require statutory change.

2009-2011 Biennium

Legislative Action

Funding:

$ 20 million	Fund Obesity Prevention & Education in Communities
$ 1.72 million	Continue funding to ODE for grant programs for school PE
$ 0.70 million	Fund ODE to monitor minimum 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, 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 preempt local jurisdictions' ability to require calorie or other nutrition information on menus in restaurants.
- Support SB 329 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 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 for:

- a "Healthy Schools Act" to be introduced 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 PE, and conducting health screenings;
- 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;
- developing and establishing minimum standards for physical activity, healthy foods, and screen time in all childcare settings .

2011-2013 Biennium

Legislative Action

Funding:

$ 43 million	Continue funding for Obesity Prevention & Education in Communities
$ 1.72+ million	Continue funding to ODE for grant programs for school PE
$ 0.70+ million	Continue funding ODE to monitor minimum nutrition standards for foods in schools
$ TBD	Increase funding for Farm Direct Nutrition Program per eligible participant and provide the benefit for all who are eligible
$ TBD	Fund Dept. of Employment to work collaborately with ODE and DHS to establish, monitor, and enforce minimum standards for physical activity, healthy foods, screen time in all childcare 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 on-going 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 prior biennium, these activities would be determined by current gaps and priorities.

2013-2015 Biennium

Legislative Action

Funding:

$ 86 million	Continue Funding for Obesity Prevention & Education in Communities
$ 1.72+ million	Continue funding to ODE for grant programs for school PE
$ 0.70+ million in schools	Continue funding ODE to monitor minimum nutrition standards for foods
$ TBD	Increase funding for Farm Direct Nutrition Program per eligible participant and provide the benefit for all who are eligible
$ TBD	Fund Dept. of Employment to work collaboratively with ODE and DHS to establish, monitor, and enforce minimum standards for physical activity, healthy foods, screen time in all childcare settings

Statutory Change:

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

Partnership Activities

Based on progress made in prior biennium, 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 agreed that the current medical care system has plenty of money, they are just not using it effectively. Further, current resources in Oregon dedicated to prevention are woefully inadequate to "turn off the faucet" of obesity and diabetes which are growing at an alarming rate in Oregon's population of adults and children.

The highest priority funding recommendation from the advisory committee echoes the 2006 Oregon Health Policy Commission report on Childhood Obesity. That is to establish and fund an Obesity Prevention and Education Program. The $20 million, $43 million, $86 million recommended funding level over three biennia is 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/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/biennium, tobacco use rates leveled off and after a few years started to rise again. While $5 - $6 million can begin to establish an infrastructure in communities for addressing obesity and diabetes, 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/biennium is needed to achieve the outcome of beginning to reduce obesity and diabetes incidence. The CDC recommendation of $43 million/year would assure reaching all Oregon populations including those with disparities in all areas of the state.

The funding recommendations to continue the grants to schools for Physical Education and to monitor implementation of nutrition standards in schools build on the work of the 2007 Legislature. This funding assures 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 childcare settings

Summary of Statutory Recommendations

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

Specific recommendations include:

- Creating an Interagency Coordinating Council to develop a strategic plan to eliminate underlying causes of health disparities;
- Requiring restaurants to post calorie and other nutrition information at the point of decision;

- Supporting SB 329 Oregon Health Fund Board recommendations for health care reform;
- Establishing a "Healthy Schools Act";
- Establishing Health as a consideration in land use and transportation policies and funding priorities; and
- Increasing 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 PEBB and the Oregon 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:

- Healthy Schools, to include a wide range of issues from school siting decisions and use of Systems Development Charges to allow locating schools where safe biking and walking are possible, to banning advertising, offering Physical Education, and conducting health screenings;
- Consideration of Health in land-use planning and transportation funding and decisions to support safe and convenient biking and walking facilities and to allow easy access to healthy, affordable foods in for all communities;
- Developing and establishing minimum standards for physical activity, healthy foods, and screen time in all childcare settings to assure that all young children spend their time in health-promoting environments.

Appendix

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.

Advisory Committee Members

Keith Bachman, MD	Kaiser Permanente East Interstate Internal Medicine
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Nancy Becker	Community Health Partnership / OR Nutrition Policy Alliance
Bev Bromfield	ADA
Scott Bruun	House of Representatives
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