

>> Slow the increase of obesity



Obesity is the number two cause of preventable death in Oregon and nationally, second only to tobacco use. Obesity related conditions account for 1,400 deaths in Oregon each year.¹ Preventing obesity among Oregonians lowers the risk of diabetes, heart disease, stroke, cancer, high blood pressure, high cholesterol, arthritis, stress and depression. Children and adolescents who are obese are at increased risk for becoming obese as adults.²

Each year, Oregon spends about \$1.6 billion (\$339 million paid by Medicaid) in medical expenses for obesity-related chronic conditions such as diabetes and heart disease. Annual medical costs of persons who are obese are estimated to be \$1,429 higher than those who are not obese. Nearly 48,000 hospitalizations were due to diabetes, heart disease and stroke in 2011, with a cost of nearly \$1.5 billion.³

Chronic diseases account for approximately 85 cents of every dollar spent on health care costs. For Oregon to successfully transform the health system and achieve the triple aim of better health and better health care at lower costs, Oregon must work to reduce and prevent obesity.

Obesity prevalence among Oregon adults has risen dramatically in the past two decades, from 11.2% in 1990 to 26.8% in 2013. Although the rate of increase has leveled off recently, the obesity rate of 26.8% in 2013 represents 821,400 adults and is the highest rate yet recorded for the adult population in Oregon.⁴

Obesity among adults, Oregon 2010–2013

	Age-adjusted (%)			
	2010	2011	2012	2013
Obese (female)	26.6	27.5	27.2	25.2
Obese (male)	26.8	25.7	26.2	28.4
Obese (total)	26.6	26.6	26.7	26.8

Source: Oregon Behavioral Risk Factors Surveillance System 2010–2013; age-adjusted to the 2000 standard population.

Racial and ethnic disparities exist in obesity rates among Oregon adults. Compared to non-Latino Whites, African Americans, American Indians or Alaska Natives, and Latinos have higher rates of obesity, while Asian or Pacific Islanders have lower rates of obesity. The largest disparity is among American Indian or Alaska Natives, who are affected by obesity at a rate 55% higher than their White counterparts.

Obesity rates do not typically differ by sex within racial and ethnic groups, with the exception of Latinos, among whom females have higher rates of obesity than males.

Obesity among adults by sex, race and ethnicity, Oregon 2010–2011

	White, non-Latino (NL)	African American, NL	Asian or Pacific Islander, NL	American Indian or Alaska Native, NL	Latino
	%	%	%	%	%
Obese (female)	25.4	35.5	10.3[^]	39.8	38.4
Obese (male)	26.0	32.2	16.5	40.1	29.6
Obese (total)	25.7	33.7	13.5	40.0	33.5

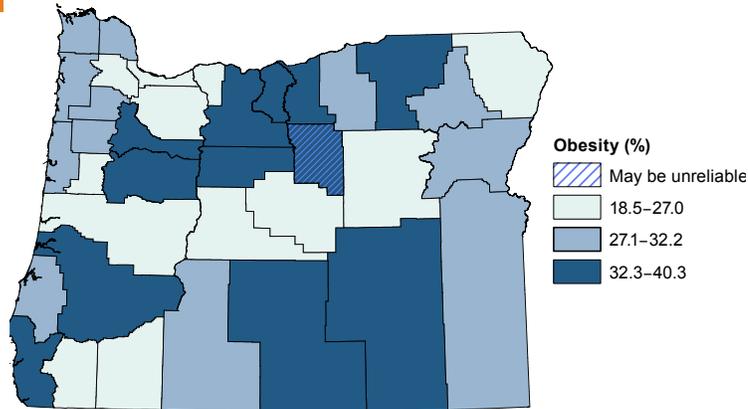
[^] This number may be statistically unreliable and should be interpreted with caution.

Source: Oregon Behavioral Risk Factors Surveillance System Race Oversample Dataset 2010–2011; age-adjusted to the 2000 standard population.

Note: For an explanation of using unadjusted versus age-adjusted estimates, please see http://public.health.oregon.gov/DiseasesConditions/ChronicDisease/DataReports/Documents/datatables/ORRaceEthnicity_riskfactors.pdf

Obesity rates among Oregon counties vary, ranging from a low of 18.5% of adults in Hood River County, to a high of 40.3% in Curry County.

Obesity rates among Oregon adults, by county, 2010–2013



County	Obese (%)
State	25.9
Baker	29.0
Benton	21.2
Clackamas	25.2
Clatsop	29.1
Columbia	31.9
Coos	28.6
Crook	25.1
Curry	40.3
Deschutes	21.8
Douglas	34.4
Grant	23.8
Harney	38.7
Hood River	18.5
Jackson	22.3
Jefferson	40.1
Josephine	22.7
Klamath	28.1

County	Obese (%)
Lake	34.1
Lane	27.0
Lincoln	30.3
Linn	33.2
Malheur	31.0
Marion	32.7
Morrow	29.5
Multnomah	21.4
North Central*	33.6
Polk	31.4
Tillamook	31.8
Umatilla	33.2
Union	27.7
Wallowa	22.2
Washington	22.9
Wheeler	37.7^
Yamhill	32.2

^ This number may be statistically unreliable and should be interpreted with caution.

* North Central Public Health District includes Gilliam, Sherman and Wasco counties.

Source: Oregon Behavioral Risk Factors Surveillance System 2010–2013 county combined; age-adjusted to the 2000 standard population.

Obesity is less prevalent among younger (18–24) and older (75+) age groups. Obesity is most prevalent between the ages of 35 to 74.

As with tobacco use, obesity rates in Oregon vary by education and income level. The prevalence of obesity among adults with less than a high school education is nearly double that of adults with a college degree. Among Oregon adults enrolled in Medicaid, 36.2% are currently obese.⁵

Strategies to slow the increase of obesity in Oregon

To reduce obesity, Oregon must take a comprehensive approach. Key strategies include:

- Monitor obesity and obesity-related conditions;
- Raise the price of unhealthful foods;
- Lower the price of healthful foods;
- Enforce laws that enable healthy eating and active living;
- Create safe places for physical activity;
- Offer support for people to manage their weight.

These strategies to prevent and reduce obesity are modeled after Best Practices for Comprehensive Tobacco Control Programs.⁶

Obesity rates by age among Oregon adults, 2013

Age	Obese (%)
18–24	9.6
25–34	25.9
35–44	30.0
45–54	32.1
55–64	32.3
65–74	30.9
75+	19.9

Source: 2013 Oregon Behavioral Risk Factors Surveillance System

Priorities, strategies and measures

Priority targets

Obesity prevalence among 2- to 5-year-olds

Target: 14.5%

Baseline: 15.5% (2013)

Data source: WIC administrative data

Obesity prevalence among youth

Target: 11th grade 10%, eighth grade 9%

Baseline: 11th grade 11%, eighth grade 10% (2013)

Data source: Oregon Healthy Teens Survey

Obesity prevalence among adults

Target: 25%

Baseline: 27% (2013)

Data source: Behavioral Risk Factor Surveillance System (BRFSS)

Diabetes prevalence among adults

Target: 8%

Baseline: 9% (2013)

Data source: BRFSS

Population interventions

Strategy 1: Increase the price of sugary drinks

Justification: Sugary drinks are the number one source of empty calories in the American diet. Studies suggest raising the price of sugary drinks would decrease calorie consumption and improve population-wide weight status.

Measure 1.1: Amount of state tax on sugary drinks

Target: \$0.01/oz

Baseline: \$0.00/oz (2015)

Data source: Budget information

Measure 1.2: Percentage of adults who consume seven or more sodas per week

Target: 9%

Baseline: 11% (2013)

Data source: BRFSS

Measure 1.3: Percentage of youth who consume seven or more sodas per week

Target: 11th grade: 9%, eighth grade: 10%

Baseline: 11th grade: 11%, eighth grade: 12% (2013)

Data source: Oregon Healthy Teens Survey

Strategy 2: Increase the number of private and public businesses and other places that adopt standards for healthy food and beverages, physical activity and breastfeeding.

Justification: Local policies and the physical environment influence daily choices that affect health and weight status. The Centers for Disease Control and Prevention's recommended Strategies for Obesity Prevention include increasing the availability of healthier food and beverage choices, increasing opportunities for physical activity and increasing support for breastfeeding.⁷

Measure 2.1: Number of state agencies with comprehensive nutrition, physical activity and breastfeeding standards policies

Target: 25

Baseline: 0 (2015)

Data source: Policy database

Measure 2.2: Number of local government settings with comprehensive nutrition, physical activity and breastfeeding standards policies

Target: 10

Baseline: Unknown, developmental measure (2015)

Data source: Policy database

Strategy 3: Increase opportunities for physical activity for adults and youth

Justification: Local policies and the physical environment influence daily choices that affect health and weight status. The Centers for Disease Control and Prevention's recommended Strategies for Obesity Prevention include increasing opportunities for physical activity.

Measure 3.1: Number of community design plans that include physical activity as a consideration for land use and transportation

Target: Pending

Baseline: Unknown, developmental measure (2015)

Data source: Policy database

Measure 3.2: Number of formal agreements between two or more government entities that set terms and conditions for shared use of public properties or facilities (e.g., joint-use agreements) that promote physical activity

Target: Pending

Baseline: Unknown, developmental measure (2015)

Data source: Policy database

Measure 3.3: Percentage of adults that get at least 150 minutes of physical activity per week

Target: 66%

Baseline: 64% (2013)

Data source: BRFSS

Measure 3.4: Percentage of youth that participated in 60 or more minutes of physical activity, five or more days a week

Target: 62%

Baseline: 59.5% (2013)

Data source: Oregon Healthy Teens Survey

Strategy 4: Improve availability of affordable, healthy food and beverage choices

Justification: Local policies and the physical environment influence daily choices that affect health and weight status. The Centers for Disease Control and Prevention's recommended Strategies for Obesity Prevention include increasing the availability of affordable healthier food and beverage choices.

Measure 4.1: Percentage of adults who consume five or more servings of fruits and vegetables a day

Target: 25%

Baseline: 22% (2013)

Data source: BRFSS

Measure 4.2: Percentage of eighth graders who consume five or more servings of fruits and vegetables a day

Target: 27%

Baseline: 25% (2013)

Data source: Oregon Healthy Teens Survey

Measure 4.3: Percentage of issued cash value vouchers used by WIC participants to purchase fresh and frozen fruits and vegetables

Target: 85%

Baseline: 83% (2014)

Data source: WIC administrative data

Measure 4.4: Percentage of issued WIC Farmer Direct Nutrition Program (FDNP) checks used to purchase fresh fruits and vegetables at farmers markets and farm stands

Target: 75%

Baseline: 72% (2014)

Data source: WIC administrative data

Measure 4.5: Percentage of issued Senior FDNP checks used to purchase fresh fruits and vegetables at farmers markets and farm stands

Target: 80%

Baseline: 78% (2014)

Data source: WIC administrative data

Health equity interventions

Strategy 1: Increase the number of Department of Human Services (DHS) and Oregon Health Authority (OHA) mental and behavioral health service providers that adopt standards for healthy food and beverages, physical activity and breast-feeding for clients and employees

Justification: DHS and OHA provide essential social and health services to clients and consumers. In 2014, DHS and OHA served over 1.4 million Oregonians. DHS and OHA are two of the largest state agencies that jointly employ over 11,000 people.

Measure 1.1: Number of DHS and OHA policies that support health for clients and employees

Target: 5

Baseline: 2 (2015)

Data source: OHA administrative data

Strategy 2: Increase the number of people at high risk of type 2 diabetes who participate in the National Diabetes Prevention Program

Justification: The National Diabetes Prevention Program (National DPP) is an evidence-based lifestyle change program for preventing type 2 diabetes. Nearly 90 percent of adults who have prediabetes are unaware they have it. Private and public health plans play a critical role in identifying those at high risk for type 2 diabetes, promoting awareness of prediabetes, and referring to CDC-recognized lifestyle change programs. Oregonians of low socioeconomic status, African Americans and Native Americans are disproportionately affected by diabetes.

Measure 2.1: Number of public health plans with policies or practices to refer persons with prediabetes to a CDC-recognized lifestyle change program.

Target: 16 CCOs, PEBB and OEBC carriers

Baseline: Unknown, developmental measure (2015)

Data source: OHA administrative data

Measure 2.2: Number of participants in CDC-recognized lifestyle change programs

Target: Pending

Baseline: Unknown, developmental measure (2015)

Data source: CDC aggregate data. If possible, the target, baseline and data source will be updated to collect and report race/ethnicity data during the state health improvement plan implementation period.

Strategy 3: Increase access to parks and recreational facilities for people in Oregon experiencing socioeconomic or racial/ethnic disparities

Justification: Local policies and the physical environment influence daily choices that affect health and weight status. The Centers for Disease Control and Prevention's recommended Strategies for Obesity Prevention include increasing opportunities for physical activity.

Measure 3.1: Number of communities with significant low socioeconomic status (SES) or racial/ethnic populations with access to locations for physical activity, including parks or recreational facilities.

Target: Pending

Baseline: Unknown, developmental measure (2015)

Data source: Environmental Public Health Tracking GIS data

Measure 3.2: Number of counties with significant low SES or racial/ethnic populations with access to locations for physical activity, including parks or recreational facilities.

Target: Pending

Baseline: Unknown, developmental measure (2015)

Data source: Robert Wood Johnson Foundation County Health Rankings data

Strategy 4: Increase access to healthy foods in low income communities and with poor access to healthy foods

Justification: Areas with poor access to healthy and affordable food, also known as “food deserts,” can contribute to disparities in diet and diet-related health outcomes.

Measure 4.1: Number of low income communities with access to healthy foods

Target: 740 out of 830 census tracts

Baseline: 738 out of 830 census (2010)

Data source: USDA Food Atlas

Health system interventions

Strategy 1: Create incentives for private and public health plans and health care providers to decrease the prevalence of obesity

Justification: Incentive measures and alternative payment methodologies ensure health plans and health care providers are working on a common set of priority areas designed to improve care and access, eliminate disparities and contain health care costs. The measures currently focus on public health plans, but measures will be expanded to include private insurers as data become available.

Measure 1.1: Number of public health plans that receive an incentive or shared savings payment for obesity prevention

Target: 16 CCOs, PEBB and OEBC carriers

Baseline: 0 CCOs, PEBB and OEBC unknown (2015)

Data source: OHA Metrics and Scoring, PEBB and OEBC contracts

Measure 1.2: Number of public health plans that incorporate obesity prevention in alternative payment methodologies for contracted providers

Target: 16 CCOs, PEBB and OEBC carriers

Baseline: Unknown, developmental measure (2015)

Data source: CCO Transformation Plans, PEBB and OEBC contracts

Strategy 2: Increase the number of hospitals that meet baby-friendly standards

Justification: Evidence-based hospital practices play a critical role in assisting mothers to initiate and establish breastfeeding. Studies have demonstrated a strong association between hospital staff training and increased breastfeeding initiation as well as significant increases when hospitals adopt the 10 standards specified by Baby Friendly USA.⁸ Implementation of these steps does not significantly increase hospitals' labor and delivery costs.

Measure 2.1: Maternity Practices in Infant Nutrition and Care (mPINC) survey composite score

Target: 90

Baseline: 85 (2013)

Data source: mPINC

Measure 2.2: Maternity Practices in Infant Nutrition and Care survey support after discharge score

Target: 41

Baseline: 31 (2013)

Data source: mPINC

Strategy 3: Ensure coverage for weight management and chronic disease self-management programs by private and public health plans

Justification: Evidence-based weight management and chronic disease self-management programs help people learn appropriate use of the health care system, how to communicate with providers, adhere to medication, and set goals and action plans. Private and public health plans can support members in losing or maintaining weight, or managing a chronic condition by providing these programs as a covered benefit.

Measure 3.1: Number of public health plans that provide coverage for weight management programs

Target: 16 CCOs, PEBB and OEBC carriers

Baseline: 100% of PEBB and OEBC carriers; CCOs unknown (2015)

Data source: OHA administrative data

Measure 3.2: Number of public health plans that cover chronic disease self-management programs

Target: 16 CCOs, PEBB and OEBC carriers

Baseline: Unknown, developmental measure (2015)

Data source: OHA administrative data

Strategy 4: Adopt and implement standards for food and beverages sold or available at private and public health plans, clinics and hospitals

Justification: Local policies and the physical environment influence daily choices that affect health and weight status. The Centers for Disease Control and Prevention's recommended Strategies for Obesity Prevention include increasing the availability of healthier food and beverage choices.

Measure 4.1: Number of public health plans, clinics and hospitals that apply nutrition standards to foods and beverages sold or available to employees, clients, patients and visitors

Target: 16 CCOs

Baseline: 0 CCOs (2015)

Data source: Policy database

¹ Oregon Health Authority, Public Health Division, Health Promotion & Chronic Disease Prevention Program. Oregon Overweight, Obesity, Physical Activity and Nutrition Facts. 2012. Retrieved from: https://public.health.oregon.gov/PreventionWellness/PhysicalActivity/Documents/Oregon_PANfactst_2012.pdf.

² US Burden of Disease Collaborators. The State of US Health, 1990–2010: Burden of Disease, Injuries, and Risk Factors. Journal of the American Medical Association. 2013;310:6. Retrieved from: <http://jama.jamanetwork.com/article.aspx?articleid=1710486>.

³ Oregon Health Authority, Public Health Division, Health Promotion & Chronic Disease Prevention section. Diabetes, Heart Disease and Stroke in Oregon. 2014. Retrieved from: <http://public.health.oregon.gov/DiseasesConditions/ChronicDisease/Diabetes/Documents/volume1.pdf>.

⁴ Oregon Health Authority, Public Health Authority, Health Promotion & Chronic Disease Prevention section. Health Risk and Protective Factors Among Adults, Oregon 2013. 2014. Retrieved from: http://public.health.oregon.gov/DiseasesConditions/ChronicDisease/DataReports/Documents/datatables/ORAnnual-BRFSS_riskfactors.pdf.

⁵ Oregon Health Authority, Office of Health Analytics. 2014 Medicaid Behavioral Risk Factor Surveillance Survey. 2015. Retrieved from: www.oregon.gov/oha/analytics/MBRFSS%20Docs/2014%20MBRFSS%20State%20Total%20Data%20Tables.pdf.

⁶ Centers for Disease Control and Prevention. Best Practices for Comprehensive Tobacco Control Programs-2014. 2014. Retrieved from: www.cdc.gov/tobacco/stateandcommunity/best_practices/.

⁷ Centers for Disease Control and Prevention (CDC). (2009). Recommended Community Strategies and Measurements to Prevent Obesity in the United States: Implementation and Measurement Guide. Available at: http://www.cdc.gov/obesity/downloads/community_strategies_guide.pdf.

⁸ Baby Friendly USA. The Ten Steps to Successful Breastfeeding. Available at: <https://www.babyfriendlyusa.org/about-us/baby-friendly-hospital-initiative/the-ten-steps>.