PUBLIC HEALTH DIVISION

Kate Brown, Governor

Rosa Klein
Legislative Coordinator
Public Health Division, Oregon Health Authority
971-673-1265, cell:503-803-4274
rosa.klein@state.or.us

Memorandum

To: Co-chair Senator Bates
Co-chair Representative Nancy Nathanson
Joint Committee on Ways and Means, SubCommittee on Human Services

From: Katrina Hedberg, MD, State Health Officer

Date: May 7, 2015

Subject: Follow-up information on programs reducing tobacco use and obesity

---

Members of the Joint Committee on Ways and Means, SubCommittee on Human Services requested the following information during an informational hearing on programs reducing tobacco use and obesity held on April 30, 2015.

Oregon's health rankings

Representative Stark wanted more information on Oregon's health rankings, specifically on physical activity. The rankings are based upon analysis from the United Health Foundation regarding obesity, smoking, diabetes and physical activity for each state, using 2011 Behavioral Risk Factor Surveillance System (BRFSS) data.[1]

The ranking on physical activity is measured by the percent of adults who indicate that they participated in physical activities during the past month.[2] Colorado is the highest ranked state, with 82 percent of adults indicating they participate in physical activity over the last month. Oregon is second, with 81.5 percent of adults.

While Oregonians are relatively physically active compared to other states, only a quarter of adult Oregonians meets the Centers for Disease Control and Prevention (CDC) guidelines for physical activity. The CDC recommends adults get a minimum of 150 minutes of moderate aerobic physical activity per week, along with strengthening activities on two or more days per week.[3]

---

[1] http://www.americashealthrankings.org/ALL/activity
[2] BRFSS question: During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?
[3] 2008 Physical Activity Guideline for Americans
http://www.cdc.gov/physicalactivity/everyone/guidelines/adults.html

Oregon is ranked as the 12th most healthy state. Smoking and obesity are the leading preventable causes of death and disease in Oregon and have a large effect on Oregon's overall health ranking.

Electronic cigarette use among Oregon youth

Senator Bates asked about youth use of electronic cigarettes in Oregon. Current use of e-cigarettes among Oregon 11th grade students increased from two percent to five percent, a 150 percent increase, from 2011 to 2013.

Nationally, current e-cigarette use among middle and high school students tripled from 2013 to 2014. The new data indicate that youth e-cigarette use has surpassed current use of all other tobacco products, including conventional cigarettes.[4]

Youth use of nicotine in any form is unsafe. Nicotine exposure during adolescence, a critical time for brain development, has lasting adverse consequences for brain development, cause addiction, and may lead to sustained use of tobacco products.[5]

The Indoor Clean Air Act (ICAA) and tobacco outcomes

Senator Bates requested information about the effect of the Indoor Clean Air Act (ICAA) on smoking prevalence.

Oregon's comprehensive statewide ICAA law aims to reduce exposure to harmful secondhand smoke and help smokers quit. This law was initially passed in 2001, with exemptions for bars, bar areas of restaurants, bowling centers, and bingo halls. In June 2007, the Oregon Legislature strengthened the ICAA by eliminating almost all exemptions and requiring more indoor workplaces and public places to be smokefree. The new restrictions went into effect on January 1, 2009.

It is difficult to show the full impact of the ICAA on smoking prevalence because of the incremental changes of the law over time. However, the 2009 changes have had a demonstrable health effect for Oregonians.

According to data from the Behavioral Risk Factor Surveillance System (BRFSS), exposure to secondhand smoke among employed Oregon adults has decreased by 13 percent from 2008 (before ICAA implementation) to 2011 (after implementation).

The law has also been associated with significant declines in hospitalizations for acute myocardial infarction (AMI) and stroke. In the two years following implementation of the law, monthly AMI hospitalizations declined by 6.8 percent and monthly stroke hospitalizations declined by 2.8 percent. These results are consistent with findings in other states and

---

[4] Morbidity and Mortality Weekly Report. 2015, April 16. Tobacco Use Among Middle and High School Students-United States, 2011-2014. Accessed April 30, 2015 from http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6414a3.htm?s_cid=mm6414a3_w

[5] US Department of Health and Human Services. Preventing tobacco use among youth and young adults. Atlanta, GA: US Department of Health and Human Services, CDC; 2012. Accessed April 30, 2015 from http://www.cdc.gov/tobacco/data_statistics/sgr/2012/index.htm.

demonstrate the tangible population health benefits of reducing exposure to secondhand smoke.

The Good Behavior Game

Senator Bates asked for additional background and research on the Good Behavior Game (GBG) and associated outcomes. Both the Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Institutes of Health (NIH) describe the GBG as a promising strategy for violence and addiction prevention, when backed up by specific treatment programs:

"The GBG, a universal intervention to manage classroom behavior, reduces schoolchildren's aggressive and disruptive behavior and prevents drug abuse and dependence disorders, violent crime, and other adverse outcomes in young adulthood. Findings from completed and ongoing large-scale GBG trials support the hypothesis that aggressive and disruptive behavior as early as first and second grade plays an etiological role in these adverse outcomes. They also endorse the vision of a national, state, and local human services system, founded in schools, that integrates education and health research and employs a strategy of first-line universal and second-line selective and indicated prevention interventions, backed up by specific treatment programs."[6]

However, the influence of the GBG on tobacco use has had mixed results in research trials with some trials finding decreases in tobacco use in some sub populations and other studies finding no significant differences from control groups.[7] To date, the GBG is not included as an evidence-based tobacco prevention and cessation strategy. The CDC Guide to Community Preventive Services recommends the implementation of universal, school-based programs (GBG is not called out specifically) to prevent violent behavior.

[6] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3188824/.)
The Guide to Community Preventive Services
[7] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3188824/.)
The Guide to Community Preventive Services