April 29, 2019

Oregon State Legislature
Senate Health Committee
900 Court St NE
Salem, OR 97301

Re: HB 3342 related to plant-based meals

Chair Monnes-Anderson, Vice Chair Linthicum, and Members of the Committee:

Thank you for accepting my comments in opposition to HB 3342.
Based on professional experience and background, I am writing to express concerns and apprise the Senate Health Committee of potential problems should HB 3342 be passed in the Oregon Senate in its present form. While I appreciate the intention to improve the health of Oregonians:

HB3342 is:

- Not necessary because adequate regulations are in place and functioning. Patient choices are not limited now, and physician orders are followed.
- Mis-defined. "Plant-based" diets are not vegan diets.
- Inaccurate and targeting the wrong population to change the health of Oregonians.
- It is very bad policy to legislate human food preferences.
- Has potential to cause expensive equipment, training and supply problems in public and private institutions.
- Does not guarantee consumption of unhealthy highly refined and processed vegan foods will not occur. The term "vegan" has the perception of a "health halo" around it, yet there are many unhealthy high sodium, high sugar vegan foods and snack foods marketed and consumed especially by people who are not interested in home food preparation.

These comments are my own, independent of my employment and professional organization memberships. Please do not interpret these professional concerns below as being opposed to any particular eating pattern. As a Registered Dietitian Nutritionist, I support patients' desires to change to healthier plant-based eating patterns.

My forty years of professional practice includes inpatient acute care hospitals, outpatient nutrition counseling and Long-Term Care (LTC) in several states. Throughout my experience, I have recognized patient health improvements when patients adopt healthier eating patterns described as "plant-based" such as Mediterranean, DASH (dietary approaches to stop hypertension), ChooseMyPlate.gov, and Dietary Guidelines for Americans. The changes patients make have not occurred in the hospital, but after discharge, over time, when

supported and educated to healthier eating patterns and choices by qualified health care professionals.

You may be aware that hospitals are required by Centers for Medicare and Medicaid Services, the State of Oregon hospital guidelines and organizational policy, to plan their inpatient meal offerings according to healthful nutrition principles, and also to accommodate patient food preferences and their physicians' diet orders.

Adding HB3342 as law to specify plant-based, vegan or other eating styles, to existing rules governing hospitals and long-term care dining is not going to change the overall health of Oregonians. Nor will it contribute to hospitalized and long-term care patients' nutrition status since plant-based foods including vegan food choices are already available to patients and residents now when they desire those foods. Patients who are ill or need surgery or other treatments and are hospitalized, stay in hospital about 4 days, and malnourished patients stay 6-12 days or more, and residents of LTC are typically 80+ years old and often frail and challenged by undesired weight loss. It is inappropriate to assume that HB3342 would change anything for these ill patients under these conditions.

Below is more detail on the existing circumstances and management of diets and nutrition in acute and LTC, which describe reasons why HB3342 is not useful and is misplaced in its intention to change the health of Oregonians in these settings.

1. Centers for Medicare and Medicaid Services regulations require hospitals and LTC to assure nutritional adequacy and respect patient choices and preferences in their patient menu offerings. Physician orders must also be followed, including overriding patient preferences when that preference would harm the patient. Physician orders drive the patient meal process, and orders are customized to address patients' particular illnesses and medical and surgical conditions.
    - Hospital physician computerized order entry systems include an array of available therapeutic diet orders and details authorizing many types of diets, religious preferences and additional free text areas to order diets and foods for their patients, including vegan, vegetarian, Kosher, and Halal, and other preferences.
- CMS regulations have a provision to allow registered, licensed dietitians in hospitals, with approval from their medical staff, to order specified diets and adjust the menu to help assure nutritional adequacy of patients' diets, support food intake, and accommodate and incorporate patient preferred eating choices, as long as the preference is not harmful to the patient.
- Hospitals and Long-Term Care are required to maintain a recognized diet manual, that is approved by the medical executives or medical directors. The manual lists orderable therapeutic diets available for the physician or licensed independent practitioners. These diets may be altered in texture, nutrient (energy, protein, etc.) form, and nutrient

distribution at meals. These diets are modified for life-stages (e.g., aging, pregnancy, etc.) and address nutrition therapy and food choices for various diseases.

- Hospitals are audited by CMS and The Joint Commission, for regulatory adherence and oversite, including assurance of nutritional adequacy and that patients have their religious, ethnic and dietary preferences and food allergies addressed, respected and safely managed.
    - Therefore, regulations and methods to accommodate these patient needs exist now, are embedded in hospitals and long-term care protocols. Auditing policies and procedures are in place to assure compliance and support for patients' preferences.
    - These existing activities assure that hospitals and LTC provide foods to patients that they are able to accept, chew, swallow, digest, tolerate and that provide adequate nutrients to sustain themselves and to improve or maintain the best health they can achieve in light of their medical and surgical conditions.
    - HB3342 adds nothing to this existing process and will not alter the health of Oregonians by requiring these changes for patient who are in the hospital or long-term care.

2. The definition of "plant-based meals" as "vegan" in HB 3342 misrepresents and undervalues the variety of healthful, plant-based eating patterns that are currently practiced and described in existing national recommendations for healthful eating patterns for the public, as mentioned above. There is no clear definition of the term "plant-based", however this term implies a diet that includes an emphasis on plant foods (such as whole grains, fruits, vegetables, oils, nuts, legumes, seeds, food products originating with these ingredients), yet not to the exclusion of modest amounts of animal foods. Yet there is a wide variation in interpretation of the term 'plant-based', lending evidence to a confusion of terminology and confusion for the public interpretation, perception and for application in regulations should HB 3342 become law.

    - Defining "plant-based meals" as "vegan" in law limits the variety of choices that plant-based eating plans offer. "Plant-based" and "vegan" are not identical in definition. A healthful plant-based meal can be vegan or vegetarian, or it could be primarily plant-based incorporating modest amounts of meat, poultry, fish, dairy and eggs. An unhealthful vegan diet is able to be consumed just as any other unhealthful diet. And may be more dangerous due to nutrient concerns inherent with a strict vegan diet.
    - There are very many vegan foods and snack foods that are high in sodium, sugar and saturated fats. The "health halo" perception from use of the term "vegan" does not mean that all vegan foods are healthful. Oregonians may not

understand that it takes planning and work to prepare healthful meals, including vegan meals.

3. Hospitals and LTC nursing homes admit highly vulnerable patients. Nationally it is reported 30-50% of acute care admissions have or are at risk of protein-energy malnutrition, or other forms of malnutrition (1).

- In the hospital and LTC, the ill and infirm, aged, clinically vulnerable, those undergoing major surgery, radiation therapy, rehabilitation and intense medication therapy are very challenged to consume adequate food volumes and types to sustain themselves during these treatments and their recovery. Creating a law emphasizing one healthy eating pattern over another is not going to change these real challenges.
- Rather, for effective lifestyle change, and a better setting than hospitals and LTC are community health education settings, public health programs, and ambulatory care settings for medical nutrition therapy, teaching kitchens and educational programs where patients may engage with the appropriate professionals to learn how to improve the quality of their diet with an emphasis on plant foods.
    - This approach offers an ideal mechanism using qualified educators and counselors who over time, can support their clients' behavior changes and the necessary skills needed to support individual and family efforts towards healthier diets and lifestyles.
    - Education and counseling of all healthy dining patterns in ambulatory and community settings will be more effective than applying HB3342 during short hospital stays or during LTC stays. Challenges among long term care and hospitalized patients include difficulty eating… period. Ill patients also have difficulty learning and remembering such things as how to take their medications, stop smoking, dress their wounds, walk and get back to daily activities. Therefore, programs such as outpatient cardiac rehabilitation, drug and alcohol treatment, occupational and physical therapy and outpatient nutrition therapy, diabetes treatment programs and stop smoking programs exist to support patient progress back to healthier lifestyles after hospital discharge.
    - Acute care physicians, dietitians and other therapies may advise the patient to a lifestyle change and communicate the recommendations in patients' discharge materials to the patients' primary care physicians. Primary care physicians are already aware of their patients' nutrition and may use the opportunity after discharge to engage in discussion and prioritize acceptable lifestyle changes with the patient and refer them to services for their most critical problems for care, education and therapy. This action will do more than HB3342 to impact the health of Oregonians.

4. Appropriately planned and consumed vegetarian, including vegan, diets are healthful, nutritionally adequate, and may provide health benefits for the prevention and treatment of certain diseases. And other healthful food choices and eating patterns do the same.
    - Education is critical for a healthy diet. Any poorly planned and imbalanced diet causes health problems. However, in a poorly planned or consumed vegan diet there is a smaller margin of nutritional error and the risk of nutritional deficit and negative health consequences is higher if that diet excludes the variety and balance of vegan foods; Or includes excessive amounts of highly refined, high sodium, sugar and unhealthy vegan fats.
        i. This nutrient risk is because of either missing, difficult to obtain or absorb nutrients in vegan foods. This becomes of increased concern at high nutrient demand times such as when a person is ill, growth for infants, children, adolescents, pregnant and nursing mothers, the elderly, those having surgery, and those who are immune suppressed. If the patient is not educated to- or does not apply that knowledge of the need for a variety of vegan foods and supplements, is physically unable to consume the needed food volume, or does not know to balance the foods for adequate protein, vitamin and mineral intake for their vegan diet and their stage of life. They become at risk for malnutrition at a critical time of their health.
    - Nutrients at risk in poorly planned or inadequate consumption of the variety and amount of needed nutrients in a vegan diet, with short and long term associated health problems across the lifespan include protein, vitamin B - 12, Iron, calcium, zinc and others. The related conditions include:
        i. Protein – protein-calorie malnutrition, failure to heal wounds, growth failure
        ii. Vitamin B -12 - pernicious anemia
        iii. Iron - iron deficiency anemia
        iv. Calcium – poor bone development, osteopenia and osteoporosis
        v. Zinc – zinc deficiency impacting immunity, growth and development

5. Practical Concerns including staff training costs in institutional settings if HB3342 passes. Assuming HB3342 requires an increase in menu planning, management, reporting and auditing, vegan menu planning and meal service will require additional knowledge and skills for food preparation staff in private and public institutions. This may impact labor costs to train depending on the existing skills of the food preparation and service staff.
    - Those planning menus and preparing food may or may not have the knowledge to plan a healthful vegan menu or may not have access to a dietitian on a regular basis to support the planning of these menus or assure the nutritional content.

- Purchasing, storage, preparation, taste, and presentation are important for all foods and there are unique challenges to food preparation and service of vegan foods including baked products, and food presentation that may be unfamiliar to existing food management, preparation and service staff.
    i. These preparation topics may require training and education to chefs, cooks and serving staff. Depending on the facility, the staff skill and their capacity to prepare, there may become a need to purchase additional premade foods or additional ingredients that replace traditional ingredients and impact the quality of the food and snack products. This may cause financial, equipment and labor challenges, depending on the circumstances of the public or private facility.
- Should HB3342 pass the Senate in its present form, there is no financial or educational funding to support this change and provide skill training, or education to manage new ingredients and new quantity recipes as would be required in institutional settings.
- There are excellent ingredients available to support vegan food choices however, they may not be in quantity food packaging or available from local or contracted vendors. This will also increase the storage and rotation capacity needs in facility structures and add to cost depending on the scope and level of compliance required by a law and circumstances of the institutions.
- There is no need for state resources to regulate by bills such as HB3342 this type of consumer preference change in food taste. Institutional menus respond to the food preferences of their patients and residents over time. As public dining and taste trends change, so too do institutional menus and the infrastructure to support those menus. For example, 10 years ago there was no hummus or smoothies on patient menus, now there is. As consumers prefer new foods, the industry manufacturers and institutional kitchens respond.

<u>In summary</u>:

HB3342 will not accomplish its intended purpose to improve the health of Oregonians by targeting the acute care and LTC audience. The bill targets the wrong audience-- of sick people in the hospital or very aged and or in rehabilitation in LTC.

If the Bill passes, there is potential an unnecessary burden to already financially strapped hospitals and other public and private institutions where regulations already exist, are applied and audited to support patient preferences to their diet, be it vegan, vegetarian or other eating style or dining preference.

Acute care hospitalized inpatients and long-term care residents are the wrong location to target for impactful public health behavior change. Education can and does start there, however patients are better directed to the primary care physicians after discharge, for their ongoing support and direction for the complexity involved in lifestyle and dietary changes.

Many health care systems already conduct community outreach activities to educate about healthy lifestyle including stop smoking, drug and alcohol addictions, exercise, better food choices, eating patterns, support for food insecurity, and diet and disease management, however that activity is a completely different audience than in acute care or the elderly in LTC, and is for people choosing to improve their health who are ready for the discussion. State programs in the public health arena, community centers and some religious communities have excellent training programs and social support systems to assist Oregonians in lifestyle changes and are therefore already better positioned to effect lifestyle changes needed to improve the health of Oregonians, rather than focusing on a single type of plant-based eating pattern during the overwhelming and challenging time of hospitalization.

With the variety of diets, eating patterns, and food preferences Oregonians have, there is no value in ensconcing this rule into law that hospitals and LTC would be required to comply. Therefore, while the intentions of HB3342 are to promote healthier Oregonians, the intention is misplaced with unintended problems that will not alter the health of Oregonians.

I urge the Health Care Committee to be thoughtful as to the consequences, and potential for misinterpretation and misapplication of HB3342, as it could truly harm the most vulnerable in our communities, increase expenses for public and private institutions, and completely miss its intended targets of improving the health of Oregonians.

Thank you for allowing submission of this rather long list of concerns as I am unable to attend the May 1 discussion in person due to previous commitments.

Respectfully,

Terese Scollard, MBA RDN LD FAND

Beaverton, Oregon

Reference 1:
https://www.nutritioncare.org/Press_Room/2013/New_Research_Finds_U_S__Hospitals_Markedly_Underreporting_Patient_Malnutrition/