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CD Summary

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CENTER FOR DISEASE PREVENTION & EPIDEMIOLOGY • OREGON HEALTH DIVISION

DIABETES GUIDELINES DISTRIBUTED

RECENTLY the Oregon Health Division sent *Measuring Quality of Care in Health Systems: Population-Based Guidelines for Diabetes Mellitus* to over 4,000 Oregon physicians.* These diabetes guidelines are population-based and include measurable outcomes that health systems can use to assess quality of care on a system-wide basis. A summary of the recommended procedures from the guidelines is included in the table (*infra*).

The guidelines are relevant to physicians because they include a short list of clinical procedures which are increasingly being monitored by health care plans, purchasers and oversight agencies. The guidelines are compatible with clinical practice guidelines such as the ADA guidelines, though they are not designed to prescribe detailed care for individual patients with diabetes.

These guidelines are being used to monitor and improve the quality of care given to patients with diabetes. Managed care plans and auditing agencies are making a deliberate effort to base their reviews on these guidelines—an advantage to the provider participating in more than one plan. Included in the mailing to physicians were the results of a quality of care study done by the Oregon Medical Peer Review Organization (OMPRO). Also included were descriptions of quality improvement projects by Oregon's Medicaid program and the Providence Good Health Plan. Other health systems will be doing quality improvement programs this year as well.

The OHD has also recently released *Diabetes in Oregon: An Assessment Report.* Section I of the report, "The Burden of Diabetes in Oregon," focuses on diabetes health outcomes in the state. This section contains an analysis of currently available data from such sources as public surveys, hospitalization data, and birth and death certificates. Section II, "Diabetes Care and Self-Management in Oregon: Influences from the Personal to the Political," describes the processes that influence diabetes outcomes including self-care, families, providers and the health care system, community, and public policy.

Physicians on the selected mailing list should receive a copy of the diabetes guidelines by the first week in June. To receive free copies of the guidelines or the assessment report, call the Health Promotion and Chronic Disease Prevention Section at 503/731-4273.

*The mailing was sent to physicians whose specialty indicated a likely role in diabetes care.

The Spending Smokescreen

OVER 6,000 Oregonians die each year from tobacco-related causes. The annual costs in Oregon for the direct and indirect consequences of tobacco use are approximately $1 billion.[1] In response to this considerable health burden, a statewide coalition of health-care and tobacco-use prevention interests supported a citizen initiative known as Ballot Measure 44. The measure increased the tax on a pack of cigarettes from 38¢ to 68¢ and the tax on non-cigarette tobacco products from 35% to 65% of wholesale price beginning February 1, 1997. It authorized 10% of the new revenue for a statewide tobacco prevention and education program managed by the Health Division, and 90% for expansion of the Oregon Health Plan (OHP). The initiative was approved by 56% to 44%.[2]

It is clear from both pre- and post-election surveys that the voters understood the meaning of Measure 44 and intended that money be spent, on the OHP and a statewide tobacco prevention and education program. In both surveys, respondents indicated that support for the measure increased by dedicating a portion of the new revenue to tobacco prevention and education and to expanded coverage for low-income citizens under the OHP.

Recommended Procedures

Initial visit & when indicated	Patient education Preconception counseling Pneumonia vaccination
Each routine visit	Visual foot inspection Tobacco counseling and referral for users
Semiannually	HbA1c measurement and risk assessment (Type I) Blood pressure measurement
Annually	HbA1c measurement and risk assessment (Type II) Dilated eye exam Microalbuminuria/proteinuria screening Tobacco use assessment if under 25 or past user Oral screening Influenza vaccination Preconception counseling assessment Self-management goal development Fasting lipid profile and LDL risk categorization (unless low risk)
Annually & when indicated	Complete foot exam with risk categorization, education, and metabolic assessment
When HbA1c > 8	Behavioral/physiological assessment and glucose management plan review
When indicated by positive findings	Ophthalmologist exam Dental referral
Age 40 with vascular risk factors OR at onset of vascular disease	Aspirin prophylaxis
At onset of microalbuminuria or onset of hypertension	ACE inhibitor therapy
Per NCEP guidelines	Lipid treatment

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In the 1994 pre-election survey of Oregon adults,[3] 68% of those surveyed favored an increase in tobacco taxes, including 76% of those who reported no current tobacco use and 44% of current smokers. However, 89% of those surveyed favored an increase if the funds were used for the Oregon Health Plan; 67% if the funds were used for tobacco-use prevention; 67%, if the funds were used for other health programs; and 20%, if the funds were added to state general funds.

In a survey of voters held after the 1996 election,[4] 61% of those surveyed reported voting for the measure and 38% reported voting against it. Of those who supported the initiative, 66% said the primary reason for their support was "to discourage tobacco consumption," while 27% supported the initiative "to expand the health plan."

It is clear from these surveys that support for the new tobacco taxes was increased by dedication of new revenue from the tax for both a statewide tobacco prevention and education program and expandion of insurance coverage under the OHP.

Although increasing excise taxes on cigarettes has been suggested as one of the most cost-effective short-term strategies to reduce tobacco consumption among adults and prevent youth initiation of tobacco use,[5] a tax increase combined with an antismoking campaign can be more effective in sustaining the reduction in per capita consumption than a tax increase alone.[6] With the implementation of a statewide program, both California and Massachusetts have sustained greater declines in per capita tobacco use than the rest of the nation. From 1992 through 1996, per capita consumption declined 19.7% in Massachusetts and 15.8% in California but only 6.1% in the remaining 48 states and the District of Columbia combined.[6] Although youth smoking rates have grown in both states, recent analyses suggest that the rates would have increased more rapidly in the absence of new excise taxes and tobacco-control programs.[7]

The Health Division is developing a comprehensive tobacco prevention and education program incorporating components that have been effective in other statewide efforts. Based on projections for 1997-1998, the program will receive approximately $17 million per biennium. The funds raised through this tax initiative will be used for 1) active community coalitions coordinated through local health departments; 2) prevention programs targeted toward youths that incorporate comprehensive school-based programs linked to community efforts; 3) public education through paid advertising and promotional activities; 4) cessation services for adults and youths that are integrated into the existing health-care delivery systems; 5) grants for special populations, a quitter's hotline, and innovative programs and training; and 6) an evaluation system to measure program effectiveness.

In order to achieve the goals of the initiative and to support the will of the voters, it is important that the money be spent on effective programs. Although an important element of the prevention efforts will be to reach young Oregonians with the message that tobacco is harmful, it is important that this be done effectively. According to the Surgeon General's report: *Preventing Tobacco Use Among Young People*, smoking-cessation programs tend to have low success rates, and recruiting and retaining adolescents in formal cessation programs are difficult. And while school-based smoking prevention programs are important, their effectiveness is enhanced and sustained when included as part of comprehensive school health education, with community-wide programs that involve parents, media, community organizations, and other elements of an adolescent's social environment.[8] Given this opportunity to have a significant impact on tobacco use among Oregonians, it will be important to spend the money wisely, on effective programs, rather than on programs which may sound good, but which are likely to have no lasting effect.

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