

2014 EDITION



# natural wonders

The State of Children's Health in Arkansas





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# about the council

The Natural Wonders Partnership Council (NWPC), composed of organizations that serve children, was originally convened by Arkansas Children's Hospital (ACH) to identify the health needs of the state's children and to construct a strategic plan for improving their health and quality of life. For 100 years, ACH has provided world-class health care for Arkansas's children. Long seen as a leader and innovator, it was only natural that ACH would convene a group of partners to address critical children's health issues. The ACH Board of Directors and hospital leaders have committed both time and resources to Natural Wonders and are eager to address the identified needs. Much credit goes to former ACH CEO Dr. Jonathan Bates for his leadership of the Council over seven years. ACH welcomed Marcy Doderer as the new CEO and President. Marcy brings fresh insight and energy, as well as a long track record of involvement and support of community health initiatives. ACH generously funded the production of this report.



Leading the Council's efforts are Marcy Doderer, FACHE, CEO of Arkansas Children's Hospital, Chair, and First Lady of Arkansas, Ginger Beebe, Honorary Chair.

All initiatives outlined in this report reflect the collaborative work of the following members of the Natural Wonders Partnership Council:

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# executive summary

This latest edition of *Natural Wonders: The State of Children's Health in Arkansas* is the fourth comprehensive examination of the needs and possible solutions to child well-being challenges in the state. New Internal Revenue Service requirements formalized and required Arkansas Children's Hospital to conduct needs assessments, such as the past Natural Wonders reports, as part of developing the hospital's community benefit plan. The first Community Health Needs Assessment (CHNA) was published in 2013.

Before delving into the new data, this report examines the most impactful policy or programmatic solutions to the previous set of nine action areas. It also identifies areas where little progress was made to improve outcomes for children, noting those for future work.

This report builds upon the CHNA and establishes a revised set of action areas for the coming years' work to improve the health of children. To gather data and set priorities, the CHNA included the following:

- Secondary data analysis on child health issues
- Eight focus groups with parents, educators, and community leaders
- Twenty-four key informant issues
- Phone survey of 1,000 households (building upon the 2008 format with added questions)

New common themes were identified and prioritized by several factors including the measured needs and the frequency with which issues were mentioned in primary data collection. Subsequently, the author consulted with leaders in the priority areas to determine possible solutions to the top ten identified needs. Eight additional lower-priority items are mentioned at the end of the report.

The new focus areas for Natural Wonders follow.

- Access to Care
- Food Insecurity
- Sexual Health
- Obesity
- Intentional Injury
- Parenting Skills
- Unintentional Injuries
- Oral Health
- Immunizations
- Substance Use

The members of the Natural Wonders Partnership Council will continue to work to improve the health of children from a variety of approaches. This report should guide work of the partners and improve collaboration around existing and emerging issues to improve long-term outcomes for children in Arkansas.



# introduction

Arkansas Children's Hospital has led the Natural Wonders Partnership Council (NWPC) since its inception in 2007. More than two dozen leaders from various fields meet monthly to share information and prioritize action steps that will improve children's health and well-being. Through its comprehensive reports, the NWPC has become Arkansas's central repository for collecting data, measuring progress, and acting upon the identified health needs of children. Members of the NWPC have taken ownership of various areas and share progress with the Council at meetings and in reports.

The Patient Protection and Affordable Care Act formalized the process that the NWPC was already using to examine the health needs of children and to develop a strategic plan for improvement. Every three years, ACH must conduct a community health needs assessment (CHNA) and develop a community benefit plan. The hospital's first CHNA was conducted in 2012, and the hospital developed its community benefit plan for the activities it would conduct to improve the health of the children and families it treats.

This 4th edition of Natural Wonders: The State of Children's Health in Arkansas seeks to use the information gathered to engage partners in addressing the identified health needs of children. The collective expertise and capacity of partners will be used to carry out the new policy and programmatic recommendations outlined in this report.





# making a meaningful impact

The *2008 Natural Wonders* report identified nine areas of emphasis for addressing the health needs of children. These areas were chosen based on the results of primary and secondary data collection that included interviews, focus groups, and dataset analysis. Strong progress on many of the goals has been made, thanks to the collective efforts of the Natural Wonders Partnership Council members as well as foundations and funders who invest in children. Opportunities remain, however, to increase the impact in these and other areas of need.

## Prenatal Care, Infant Mortality, and Teen Pregnancy:

All mothers receive prenatal care as early as the first trimester until birth. All babies are born healthy and survive the first year of life, and they receive well-child visits to monitor developmental benchmarks to address problems before they become life threatening or debilitating. Teens delay bearing children until they are self-sustaining adults.

## Biggest Wins:

- A smaller percentage of births are to teenagers: 15.5% (2002) to 12.6% (2011)
- Final recommendations have been made for regionalization of neonatal intensive care units (NICUs) so premature babies are cared for in the best settings for their special needs.
- The Antenatal Neonatal Guidelines, Education, and Learning System (ANGELS) program at UAMS has expanded access to prenatal care in rural areas of the state.

## Areas of Continued Intervention:

- Although its teen birth rate has fallen, Arkansas remains fourth highest in the nation of babies born to mothers age 15-19.
- Few new programs have been put in place to discourage or prevent teen pregnancy or to support teen parents as they balance parenthood, school, and jobs.
- Not enough young children receive comprehensive well-child screenings (EPSDT). Just 62% of children enrolled in ARKids First A received their screenings in Arkansas in 2011. Though improved from past years, Arkansas ranks behind the national average of 87%.



**In the Fall of 2013,** 60 mothers carrying babies with birth defects or genetic diseases were enrolled in the ANGELS program's Arkansas Fetal Diagnosis and Management program. Through the program, UAMS helped care for families across the state that needed specialized case management to help deliver their babies safely. The program helped ensure that safe deliveries were planned for conjoined twins and babies with various congenital issues requiring surgery right after birth.

## Immunizations:

Infants, children, and adolescents are provided protection from communicable diseases.

### Biggest Wins:

- Arkansas has made progress in vaccinating children, increasing from 57% compliance in 2007 to 72% in 2011.
- Arkansas has a new immunization registry, WebIZ, which launched in June 2013. User-friendly guides are available to help schools, child care centers, and providers use WebIZ.

### Areas of Continued Intervention:

- Vaccination rates for 19- to 35-month-olds lag the national average despite improvement in the state's rates.
- The use of philosophical exemptions from childhood immunizations has skyrocketed since 2003, though the state's overall exemption rate is still relatively low.
- Parents and the public continue to lack accurate information and education about the risks and benefits of immunizations.

## Oral Health:

All children can access dental care no matter where they live or whether they can afford it.

### Biggest Wins:

- Legislation passed in 2011 (and defended in 2013) will help improve fluoridation, expand access to public health dentistry, and fluoride varnish treatments.
- More than 2,000 children receive dental care annually in the three mobile dental vans that are managed and staffed by Arkansas Children's Hospital. Mobile dental clinics have been supported by private donations from Ronald McDonald House Charities, Delta Dental, and Tyson Foods.
- The state's 21 funded school-based health centers must work toward providing oral health services on campus. Currently, three do so.
- The ACH Dental Sealant program has treated over 6,000 children and provided over \$500,000 in services since 2009, helping move the needle from 15% to 27% of children ages 6-9 who have sealants (the Healthy People 2020 Goal is 28.1%). Blue & You Foundation, Walmart Foundation, and private philanthropy have been key to expanding this effort.

### Areas of Continued Intervention:

- Though a collaborative practice act passed, the rules and regulations that were established leave barriers to true improvement in access to care.
- Access to dental coverage has improved, but children whose families are purchasing health coverage in the Marketplace under the Affordable Care Act will not be required to purchase dental coverage, even though pediatric dental care is one of the law's 10 "essential health benefits." This issue needs to be remedied at the federal level.
- Parents and the public continue to lack accurate information and education about the risks and benefits of immunizations.

The Future Smiles dental clinic at Wakefield Elementary in Little Rock treats the dental needs of children in several central Arkansas schools. The clinic treats students who have Medicaid, ARKids First, or are uninsured. Mom Lacia Piggee is able to work full time and let her daughter get the dental care she needs while she's at school. "If you could help a kid smile – why not? You build up their self-esteem!" she said.

## Reducing Risky Behavior – Injury Prevention:

Significant injuries to infants, children, and teens are reduced or eliminated due to preventive steps taken by them and their parents.

### Biggest Wins:

- The Graduated Driver License law passed in 2009. A 2010 study estimated that the new restrictions on teen driving saved 32 lives and resulted in a 59% reduction in fatalities from 2008-2010, among other notable improvements.
- The state's Trauma System, formalized by legislation in 2009, routes injured patients to the best facility for their care. It refers about 1,000 patients each year to ACH, the state's only pediatric Level 1 trauma center. Additional capacities include the Trauma Image Repository, the Statewide Injury Prevention Program, and seven Trauma Regional Advisory Councils.
- Multi-disciplinary infant and child death review teams – comprised of medical professionals, coroners, public health officials, and prosecuting attorneys – are in place in certain areas of the state to collect standardized data about child deaths in Arkansas. There are plans to expand this service statewide.

### Areas of Continued Intervention:

- Arkansas's all-terrain vehicle-related death rate is more than double the national rate, and ACH is treating a growing number of patients for these injuries each year. Policy and programmatic interventions are needed to help improve these rates.
- Arkansas's infant mortality rates are high, and death rate due to Sudden Unexplained Infant Death (SUID) and Sudden Infant Death Syndrome (SIDS) are almost double the national rate. Regional, racial, and socioeconomic disparities also exist.
- Arkansas could further improve its child safety seat and seatbelt utilization rates. Arkansas's utilization rates rose to 79% after passage of a primary seatbelt law in 2009, but fell somewhat during recent observational surveys. National rates exceed 85%.

### Spotlight Story:

The 2012 "Your Arkansas Trauma System" report shared the story of a young person who had been struck by a car while on a bicycle and had serious injuries. The Trauma Image Repository pushed her X-ray images from one hospital to another within one minute, and the neurosurgeons were able to be ready to operate immediately when she arrived at the larger hospital. The speedy response allowed the patient to fare very well.



## Tobacco Prevention:

Tobacco use by children and teens is eliminated, as is their exposure to indirect smoke.

### Biggest Wins:

- Smoking rates for youth in Arkansas dropped from 36% to 24% from 2000 to 2010. Arkansas ranks 7th nationally in spending on tobacco prevention.
- Two state laws passed in 2013 will help reduce children's access and exposure to e-cigarettes.
- Arkansas increased the state tax on cigarettes by 56 cents in 2009, which helps reduce minor use of tobacco and raises millions for health-related programs.

### Areas of Continued Intervention:

- Though progress has been made, there is still not a complete ban on indoor cigarette smoking in the state.
- During the 2013 legislative session, cigar taxes were capped at 50 cents per cigar, limiting this proven deterrent to smoking.



During the legislative debate about banning e-cigarettes on public school campuses, high school and college students showed up to the Capitol to support the bill. The students' presence encouraged lawmakers to vote on the issue while they were there. "Teachers and coaches and sometimes even students have been using the products, and we just want to ask the people of Arkansas what kind of example is this setting for students," said Josilyn Mitchell, a freshman at the University of Arkansas.

## Obesity Prevention:

The childhood obesity epidemic is eliminated in Arkansas.

### Biggest Wins:

- ACH supports broad use of HealthTeacher, GoNoodle, and other online classroom-based interventions that help educators introduce health education in their classrooms. Blue & You Foundation has supported a statewide implementation of GoNoodle for 2014.
- In the past few years, Arkansas implemented more than 150 joint use agreements that allow school facilities to be used by the community after regular school hours.
- Growing Healthy Communities is a project developed by the Arkansas Coalition for Obesity Prevention in 2009 to build capacity within local communities to reduce obesity by increasing physical activity, increasing access to healthy foods, and implementing environmental and policy changes that support healthy living. There are now 26 Growing Healthy Communities sites across the state working to make health a local priority.
  - Farmer's markets across the state are accepting food assistance (EBT) cards thanks to a US Department of Agriculture grant. The USDA reports that 18 Arkansas markets accept EBT payment, increasing access to fresh, local foods.

### Areas of Continued Intervention:

- The Child Health Advisory Committee updated its recommendations for nutrition and physical activity to lengthen physical activity requirements, require professional development around lifetime fitness, promote the use of locally grown foods, and allow children sufficient time for eating school meals. However, these recommendations have not yet been adopted by the State Board of Education.
- The state needs stronger regulations for nutrition at concessions and fundraisers at schools.
- Many policies do not reach early childhood settings including pre-K and child care. With one-third of kindergarteners entering school overweight, obesity is an epidemic that needs to be addressed early in life.

With their Growing Healthy Communities grant, New Addition Neighborhood Development Center in Nashville started a Cooking Matters training. The center used a grant of about \$2,300 on food and kitchen materials to offer multiple courses. Twelve participants graduated from the Adults with Diabetes course; 13 families graduated from the Families course; and 33 youth completed the Kids course. Growing Healthy Communities is a collaborative effort funded by the Blue and You Foundation for a Healthier Arkansas, the Arkansas Department of Health's CDC Cooperative Agreement, UAMS Partners for Inclusive Communities, UAMS College of Public Health, and the Winthrop Rockefeller Institute.



## Mental Health Services:

All children, youth, and their families have access to services and supports to treat and maintain health and mental health, which will improve quality of life and promote life-long good health.

## Biggest Wins:

- Youth and parents accessing the state's behavioral health system are completing a standard assessment, the Youth Outcome Questionnaire. More than 76% of patients with claims for Respite Services for Persons with Mental Illness (RSPMI) completed the questionnaire. The purpose of the questionnaire is to assist a clinician and family with creating an individualized, person-centered plan of care.
- Arkansas's System of Care reaches more families than ever. Family Support Partners help families set wraparound goals for at-risk children, local Care Coordinating Councils strengthen community-based services, and local youth- and family-focused activities help support families struggling with behavioral health issues.
- Two behavioral health "episodes of care" have been launched as part of the state's Payment Improvement Initiative, which aims to improve quality of care and reduce costs. Attention Deficit Hyperactivity Disorder (ADHD) and Oppositional Defiant Disorder (ODD) claims are being evaluated for alignment with proper diagnosis and treatment protocols. Health Care providers share risks and savings for these episodes.

## Areas of Continued Intervention:

- Positive Behavior Intervention and Supports (PBIS) is a strong evidence-based program for reducing school discipline needs and improving school safety, but the program has not been as widely adopted as hoped. Only 12 districts in the state are reported to be using it. Act 1329 of 2013 will help curb racial disparities in school discipline procedures and share innovative approaches such as PBIS with schools.
- The Division of Behavioral Health Services is in the process of transforming the state's behavioral health care system under the Payment Improvement Initiative. Features include care management services for clients, an independent assessment to identify appropriate services, and new access to evidence-based home and community-based services through Arkansas Medicaid. Close attention should be paid to the needs of children as the details are developed.

The May 2013 CASSP newsletter shared success stories of the System of Care: An 11-year-old client had been referred to the System of Care with several behavioral health diagnoses and a history of defiance, aggression, in-school suspension, and behaviors such as hiding knives and attempting to set fire to his house. After referral to treatment, the student was diagnosed with autism and a chromosome deficiency. The family's wraparound plan included playing cards together after dinner, learning coping skills, and a new school. The student was able to join his church baseball league, take self-time-outs, began making friends, and even started a technology club at his new school. School counselors reported that the wraparound experience meant that the young boy was "now able to be happy."

## Service Needs and Expansions

Needed services will be available and affordable to children requiring treatment or intervention. Professionals will have better access to information so they can be of greater help to their young patients.

### Biggest Wins:

- The Patient Protection and Affordable Care Act (ACA), including Arkansas's "Private Option" expansion of Medicaid, is expected to provide health coverage for approximately 500,000 uninsured Arkansans. As parents secure coverage, up to 40 percent of the state's remaining uninsured children are predicted to be covered as well.
- Act 528 of 2013 ensures that new home visiting programs in Arkansas are evidence-based or "promising" programs, and it establishes an evaluation plan to track and measure outcomes for child and family well-being and school readiness.
- More than 100 Safety Baby Showers were held across the state in 2013, providing new mothers with safety equipment and education on major injury-related causes of infant death and hospitalization. The showers have been shown to increase moms' and other caregivers' knowledge about protecting their young babies. The Injury Prevention Center at Arkansas Children's Hospital (IPC) sponsors a number of showers directly thanks to funding from the Arkansas Children's Hospital Foundation, and many other public health groups now conduct showers after training from the IPC.

### Areas of Continued Intervention:

- The Positive Youth Development Act of 2011 established rules and regulations to govern quality out-of-school-time programs. However, no funding has been allocated for pilot sites.
- Arkansas has yet to take the option to allow lawfully residing immigrant children, including Marshallese children, to enroll in ARKids First under the Immigrant Child Health Improvement Act. This would provide coverage to about 600 children for less than half a million dollars in state funding.
- Coordinated School Health has expanded to 55 of 239 districts (23%), and 20 School-Based Health Centers are funded through the Department of Education to provide medical services to children on campus. An additional five health centers operate without state funding. However, most Arkansas schools lack these additional health care resources.
- The Arkansas Center for Health Improvement examined the health care workforce needs in Arkansas in a recent report funded by the Blue & You Foundation; pediatric needs should be considered as the state moves forward with next steps for workforce development.

## Capacity Building

### Biggest Wins:

- The State Health Alliance for Records Exchange allows health care providers to share electronic health records. As of December 2013, 10 hospitals, 109 medical practices, and almost half a million patients participate in SHARE. Almost 400 clinics are using the secure messaging feature to communicate.
- New Natural Wonders action groups meetings have emerged on current issues. Food Insecurity and Teen Pregnancy Prevention action groups discuss policy and programmatic solutions to timely issues.
- Arkansas Children's Hospital has expanded its remote facilities to include Lowell and Jonesboro. This allows the hospital's specialty clinics to be available locally for more families.

### Areas of Continued Intervention:

- Patient Centered Medical Home eligibility requirements have been set by DHS. Providers who enroll will receive monthly payments for care coordination and will share in savings as they improve quality and reduce costs. The model offers primary care providers improved capacity to meet the needs of their most complex patients; children's needs should be considered during implementation.
- Mobile health and telemedicine use have become more common, but barriers still exist to reimbursement. Broadband availability remains a challenge as well.



# a fresh look at the needs of arkansas's children

New Internal Revenue Service requirements formalize and require periodic community health needs assessments for nonprofit hospitals. This requirement formalizes the “state of child health in Arkansas” reports that the Natural Wonders Partnership Council has produced in past years. Building upon the past work of Natural Wonders, the hospital communicated with public health experts, government agencies, and a wide variety of stakeholders from various communities to determine needs related to children’s health in Arkansas. Special emphasis was placed on reaching out to low-income families and educators in determining issues affecting children.

**DATA WAS COLLECTED IN SEVERAL  
WAYS TO COMPLETE THE PICTURE OF  
DEMONSTRATED AND PERCEIVED NEEDS  
RELATED TO CHILDREN’S HEALTH.**

## Existing data sets:

Data was collected from the U.S. Census Bureau, the Annie E. Casey Foundation Kids Count Data Center, Arkansas state agencies, the Youth Risk Behavior Survey, Arkansas Children’s Hospital, and state-based or neighborhood-focused research by local organizations.

## Eight focus groups:

More than 100 parents, educators, and community members participated in focus groups in Batesville, Forrest City, Gurdon, Lavaca, Little Rock, Jonesboro, and Springdale. Local organizations including school based health centers, health departments, and churches took the lead on recruiting participants to the session.

## Twenty-four key informant interviews:

A set of standard questions was asked of health care providers, community leaders, government employees and educators with specialties ranging from broader statewide policy, to services offered by ACH, UAM and ADH, to smaller, local community service providers.

## Phone survey of 1,000 households:

Conducted in late 2012, the survey examined perceptions about needs, challenges, and assets related to the health of children, with data statistically significant to the congressional district level. Because it expanded upon the 2008 household phone survey for Natural Wonders, many of the survey’s 34 questions gave a second data point to help track progress on previous goals and objectives.

The remainder of this report addresses the common themes that were identified in the data collected through these sources. Topics were prioritized by demonstrated need and the frequency with which they were identified. Data cited in this report are from the community assessment report and its appendices.

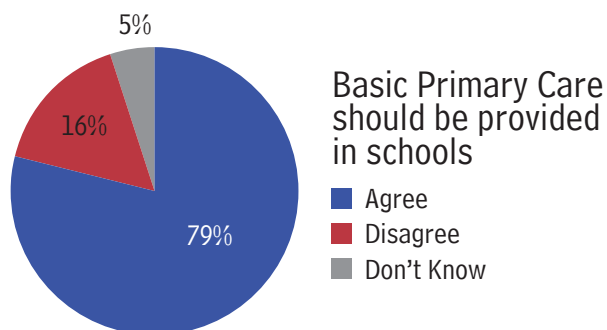


## Access To Care

Topics raised that were related to access to health care services included improving enrollment in health coverage, expanding school-based health centers, requiring time off for parents to care for sick children, expanding clinic hours, increasing providers who accept ARKids First or Medicaid, increasing satellite specialty clinic expansions statewide, and improving the percentage of children who receive well-child exams.

Although just 6 percent of Arkansas children (46,000) lack health coverage, race and household language breakdowns of the data highlight additional disparities. The Affordable Care Act holds much promise for enrolling children as their parents seek new coverage. In fact, Arkansas has already seen success with this close to home. A letter DHS sent to adults whose families were enrolled in food assistance notified them of their eligibility for Arkansas's "Private Option" coverage. This letter, which included eligible children, enrolled more than 3,000 children in ARKids First. However, the state's new law also included plans to move about 40,000 children covered by ARKids First B onto private health insurance plans, a change that must be monitored closely to maintain benefits and access to care for children. Health coverage provides economic security and peace of mind to families, an important step in a state where 27 percent of children live in poverty.

Arkansas children enrolled in Medicaid are behind the national average in receiving the well-child screens they should have. In 2011, 62 percent of the expected check-ups for Arkansas children were given (versus 87 percent nationally.) Improved primary care reimbursement rates under the Affordable Care Act have helped improve the capacity for pediatricians and family doctors to provide care to lower-income children.

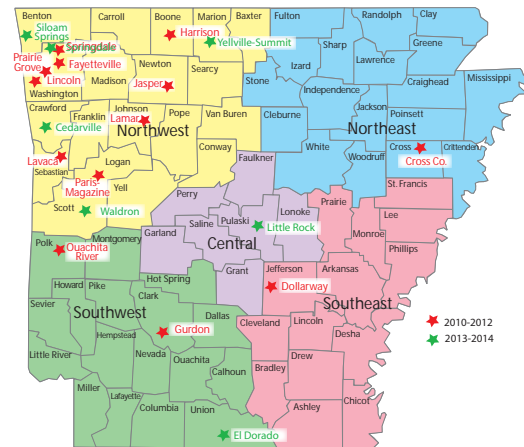


Source: Opinion Research Associates, Inc. A Survey of Arkansas Public Opinion on Children's Health Issues. (2012).

**"Research shows that enrolling parents in health coverage means children are more likely to have coverage and get the care they need. The Affordable Care Act has the potential to lower the rate of uninsured children by 40% as parents and higher-income children gain access to more affordable plans."**

Anna Strong, Director of Health Policy, Arkansas Advocates for Children and Families

School Based Health Centers



Source: Arkansas Department of Health

School-based health centers have emerged as an excellent way to bring the care to the child, and 26 centers now exist in the state. These bring physical, mental, dental, and vision care onto a school campus and accept children without regard to their ability to pay. Lack of paid sick leave for parents, transportation issues, and limited after-hours clinics in many parts of the state also underscore the need for more school-based health centers. However, underperforming schools that struggle to meet the academic needs of students need additional capacity in order to facilitate the development of a well-functioning health center on campus. The great news is that 79 percent of survey respondents felt that basic primary health care services should be provided in schools.

### Possible solutions include:

- Improving use of, and insurance reimbursement for, telemedicine services.
- Increasing capacity for schools to deliver health care services.
- Simplifying enrollment and re-enrollment of children in health care coverage, such as removal of waiting periods and automatic renewals.
- Improving coverage of immigrant and Marshallese children.

**"School-based health care is important for improving access to preventive care for children. Many of the working families we treat do not have sick time at work or cannot afford to lose income by missing hours of work. School-based care brings services to the children so hard-working parents can stay on the job."**

Sip Mouden, CEO, Community Health Centers of Arkansas, Inc.

## Food Insecurity

Data collection showed new concerns in the areas of food insecurity, food deserts, and affordability of quality foods for families. Although Arkansas's network of Feeding America food banks and their agencies provided more than 34 million pounds of emergency food assistance in 2013, Arkansas has the nation's highest rate of food insecurity. One in five households and 28 percent of children are unsure of the source of their next meal. This statistic was revealed as a primary concern from community members during focus groups and interviews as well. Both rural and urban focus group participants felt that they lived in food deserts that lacked grocery stores or had stores with few affordable, fresh foods. Reliable transportation plays a role in access to healthful food as well, especially in rural areas of the state where the nearest grocery store could be in the next county. Many children who receive school meals may be hungry during the summer or on weekends, leaving local food programs to fill the gap.

### FOOD INSECURITY IN ARKANSAS

Food Insecurity, all households, 2011	19.2%
Very low food security, 2011	7.6%
Child food insecurity rate, 2010	27.8%

Source: USDA Household Food Security in the U.S.; Feeding America Map the Meal, 2010

Thankfully, programs exist to help ensure children and families are fed. Women Infants and Children (WIC) helps about 90,000 people access healthy foods, and more than 300,000 households have Supplemental Nutrition Assistance Program (SNAP). Farmer's markets are taking Electronic Benefit Transfer (EBT) cards more regularly thanks to support from the U.S. Department of Agriculture, allowing lower-income families to purchase locally-grown, fresh produce. Thanks to support from Governor Mike Beebe and local partners such as the Arkansas Hunger Relief Alliance, Arkansas has been a strong partner for the national No Kid Hungry campaign. No Kid Hungry works to surround children who struggle with hunger by increasing school breakfast, summer meals programs, and after-school meals programs and by empowering families with the skills, knowledge and confidence to make healthy affordable meals at home. Additionally, Arkansas Children's Hospital has become the first hospital in the nation to help address food insecurity by starting a summer lunch program within the hospital.

### Possible solutions include:

- Expanding nutrition programs around smart food purchase and preparation to reach children and parents "where they are" in creative ways.
- Increasing EBT card acceptance at farmer's markets statewide.
- Developing more summer and after-school food service programs to reach children when they are not in school.

- Monitoring and expanding the "Arkansas Meals for Achievement" program piloted by the Arkansas Hunger Relief Alliance to serve breakfast for all school children in the classroom.
- Protecting SNAP benefits from cuts at the federal level

"During test weeks, schools send a note home with kids encouraging parents to feed their child a good breakfast; if we know how important that is, doesn't it seem like it would be a good idea every day?"

Kathy Webb, Executive Director of the Arkansas Hunger Relief Alliance

## Sexual Health

Data collection identified alarming rates of teen pregnancy, early sexual activity, and high rates of sexually transmitted infections in adolescents. Arkansas has the highest rate in the nation of teen births, with about 51 of every 1,000 babies born to teenagers age 15-19. This is a reduction from the state's rate of 60 per 1,000 in 2007, but the national average is 31 per 1,000. Arkansas's rate is declining more slowly than other states. Focus groups indicated that communities were concerned that teen pregnancy is an acceptable social norm while local role models are hard to find. Instead, children look up to celebrities, and popular television shows glorify young motherhood. In fact, focus group members gave their communities an average grade of "D" for Teen Pregnancy.

In Arkansas, 66 percent of high school students are sexually active by the 12th grade, and the majority of sexually transmitted infections reported in Arkansas affect 15- to 24-year-olds. Under the Centers for Disease Control and Prevention's HIV and sexually transmitted infection grant to the Arkansas Department of Education, 15 pilot schools will receive intense technical assistance over a four-year period as they work toward improving the sexual health of middle and high school students. Plans are underway to conduct a thorough evaluation of the outcomes of this initiative's components of prevention and access to care.

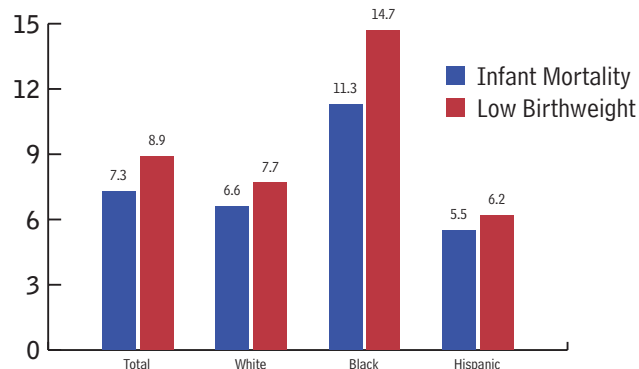
### SEXUALLY TRANSMITTED INFECTIONS BY AGE, 2011

	Chlamydia	Gonorrhea	Syphilis
Total Number of Cases	16,047	4,687	349
Ages 5-14	209 (1%)	48 (1%)	48 (1%)
Ages 15-19	5,976 (37%)	1,444 (31%)	106 (30%)
Ages 20-24	6,051 (37%)	1,692 (36%)	73 (21%)

Source: AR Department of Health, AR STD Annual Report, 2011

These and other risk factors contribute to Arkansas's high infant mortality rate and low birth weight percentage. Only 79 percent of births had first-trimester prenatal care in 2011, and 13 percent of babies were born pre-term.

### INFANT MORTALITY (PER 1,000 BIRTHS) AND LOW BIRTH WEIGHT (PERCENT)



Source: Unpublished data from Dr. Nugent of NCHS linked birth/Infant Death files, AR Department of Health, 2009

Arkansas has gaps in its programs and policies to prevent teen pregnancy or provide supports for pregnant and parenting teens. There is an ongoing legislative study on the subject of reducing teenage pregnancy that should lend evidence-based ideas to the policy and programmatic conversation.

Additionally, DHS discontinued the Medicaid women's health waiver, which provided reproductive health care and family planning services to those not eligible for full-coverage Medicaid. However, the Affordable Care Act increases access to affordable health insurance since all plans must cover preventive services, including contraception, and maternity coverage. Arkansas must have a successful outreach and enrollment effort for new plans, and long-term monitoring of young adults' access to reproductive health care needs to be a priority.

### Possible solutions include:

- Improving the capacity of schools and education cooperatives to provide comprehensive health education training and professional development for elementary classroom teachers.
- Providing all secondary health education teachers with targeted, content-specific, health education training that includes prevention of teenage pregnancy and sexually transmitted infections within a comprehensive health education curricula.
- Expanding capacity for home visiting to help pregnant women and new mothers make positive health choices for their families.
- Facilitating a strong enrollment effort in health care coverage under the Affordable Care Act, which includes prevention and reproductive health care.

**"According to the National Campaign to Prevent Teen and Unplanned Pregnancy, Arkansas spent \$143 million in taxpayer funds in 2008 on programs and care related to teen births."**

Counting it Up: The public costs of teen childbearing in Arkansas in 2008.

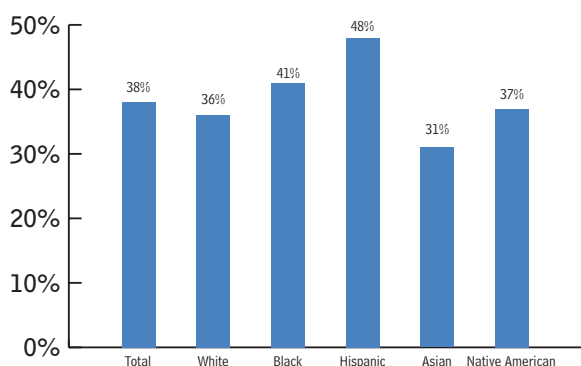


## Childhood Obesity

Poor nutrition and inadequate physical activity are on the minds of Arkansans as they relate to childhood obesity. Of survey respondents, 22 percent were concerned about their child's weight, and respondents chose "overweight children" as the child health issue of most concern to them. Interviews and focus groups also highlighted obesity as the top health issue facing children. Participants cited the lack of availability of healthful food options as contributing to the consumption of high-calorie, high-fat, processed foods.

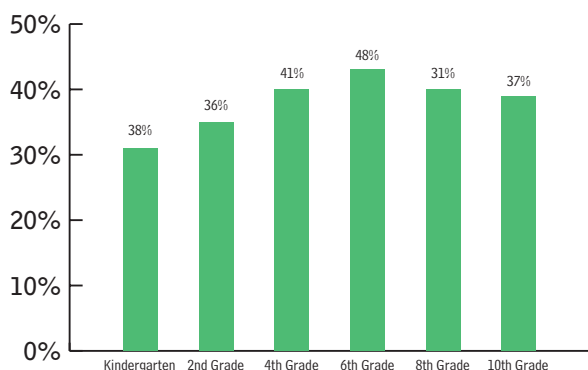
Statistical data backs up these concerns. Nationally, about 32 percent of children are overweight or obese, but 38 percent of Arkansas children are. Arkansas ranks 44th in obese children and 41st in overweight children. Data collected by schools each year most recently aligned with national measurements overall but showed disparities for black, Hispanic, and Native American students. Health behaviors also show a bleak picture. Arkansas children lag the nation in eating fruits and vegetables and being active (particularly females), and they watch television for more hours each day than their peers in other parts of the country.

PERCENT OF STUDENTS OVERWEIGHT  
AND OBESE BY RACE, GRADES K-10



Source: Assessment of childhood and adolescent obesity in Arkansas, year 9 (2011-2012)

PERCENT OF STUDENTS OVERWEIGHT  
AND OBESE BY GRADE



Source: Assessment of childhood and adolescent obesity in Arkansas, year 9 (2011-2012)

How these health risks translate into chronic disease for youth is still relatively unknown because Arkansas does not track Type 2 diabetes, high cholesterol, high blood pressure, or heart disease for children. However, 67 percent of Arkansas adults are overweight or obese, and 39 percent have high cholesterol, indicating that many children may not have strong examples of healthful behaviors in the home. It is time for Arkansas to reinforce its sense of urgency to address the obesity epidemic, and starting with children makes sense.

### Possible solutions include:

- Expanding programs that improve parents' and children's knowledge about healthful food choices, shopping, and food preparation, including through school curriculum (pre-K through college).
- Strengthening policies for physical activity and nutrition in schools.
- Reducing access to sugar-sweetened beverages in public places and educating communities on these beverages' impact on health.
- Investing in safer neighborhoods, sidewalks, city planning, and other factors that encourage active transportation and opportunities for physical activity, such as parks and playgrounds.
- Investing in school gardens and other unique approaches to teaching children about food.
- Encouraging the use of HealthTeacher as a program to assist teachers to develop and deliver quality lessons around good nutrition and other related topics.
- Tracking data related to chronic disease prevalence in Arkansas youth, including Type 2 diabetes, high cholesterol, high blood pressure or heart disease.
- Including obesity prevention, treatment and diagnoses in college curriculum in all health care providers' curriculum.
- Increasing the proportion of infants who are breastfed.
- Expanding physical activity programs, such as GoNoodle, which provides "Brain Breaks" in the classroom to promote in-class physical activity and active and more engaged learning experiences.
- Creating a community culture of fitness and good nutrition through a marketing program that includes strategies to focus on state, county and community level approaches to obesity reduction.

"New studies show the obesity epidemic and its risk for many start even before school. According to a new study in the New England Journal of Medicine, nearly half of children who became obese between the ages of 5 and 14 years had been overweight before kindergarten. We must engage parents and recognize that being overweight as a toddler is a real risk that must be monitored and managed."

Dr. Joe Thompson, Arkansas Surgeon General.

## Intentional Injuries

Suicide, family violence, and bullying were cited as increasingly common issues for children during focus groups and interviews. The phone survey included "Depression, suicide, mental illness" and bullying as top moderate or serious challenges in respondents' communities, and mental health received an average grade of "C-" in the focus group report card. Focus group members mentioned the stigma associated with mental health issues as a barrier to seeking help on violence and suicide. The phone survey identified "physical or sexual abuse" as a top serious or moderate concern around the state.

Twenty-two percent of high school students report being bullied at school in the past year, and 66 percent of teachers surveyed by HealthTeacher identified bullying as the most pressing health issue facing students. High school students in Arkansas mirror national trends for several behavioral risk factors although disparities exist by sex and race/ethnicity. Homicide is the second-leading cause of death for children ages 1-18 in Arkansas, and Arkansas ranks 19th national for females murdered by males in single-victim homicides.

### Possible solutions include:

- Building partnerships with schools, parents, youth, and communities through programs that raise awareness of mental, emotional, or behavioral health issues, encourage early diagnosis and treatment, and prevent suicide, bullying, and youth violence.
- Continuing programs such as HealthTeacher that include anti-bullying training for teachers.
- Improving injury and violence programs through provider education, increased community awareness, and policy improvements.
- Increasing capacity for prevention of abusive head trauma to babies to help families have a plan, including the PURPLE plan to prevent shaken baby syndrome.

"...I work in a low-income area, and our students need all the support and information they can get regarding health subjects, and bullying."

Little Rock School District teacher using HealthTeacher

BEHAVIORAL HEALTH RISK FACTORS FOR ARKANSAS HIGH SCHOOL STUDENTS	ARKANSAS	UNITED STATES
% feel sad, hopeless	28%	29%
% seriously considered suicide	14%	16%
• Females	18%	19%
• Hispanic	18%	17%
% kids made plan for suicide	13%	13%
• Hispanic	22%	14%
% attempted suicide	10%	8%
Students bullied at school in last 12 months	22%	20%
Students who considered suicide in the past 12 months	14%	16%

## Parenting Skills

"Being a good parent is perhaps the most challenging task of our adult life – but, unfortunately, one for which we typically have little preparation or training. Helping parents make good parenting decisions is the foundation of parenting education. For many Arkansans, being an effective parent can be especially difficult because our state is above the national average on many indicators of family stress such as teen parenthood, divorce rate, children living in single-parent households, and financial hardship. Parenting education services, especially those for parents of young children, have been found to prevent the escalation of problems to the point where they become more costly to society."

Nicholas Long, Ph.D., Director, Center for Effective Parenting and the Arkansas Home Visiting Network Training Institute, UAMS Department of Pediatrics & Arkansas Children's Hospital

Parents want and need education about many subjects related to raising their children. Focus group and interview participants indicated a need for help dealing with children's discipline problems, behavioral health diagnoses, nutrition, balancing work and family, and general child health issues. Data show that many Arkansas adults do not exhibit healthy behaviors or that they have poor health status, and home visiting and other parenting interventions could help change health outcomes for the next generation.

Many adults lack formal education, with less than 20 percent of adults holding a four-year college degree or advanced degree. Parents can have a difficult time navigating "the system" as they try to provide for their children in the best way they know how. Infant mental health is a growing concern that could be addressed through parenting skills. Early brain connections are developed with the help of healthy caregiver attachments, and avoiding trauma and abuse is shown to have long-term effects on child development.

More than half of survey respondents were unaware of the availability of home visiting programs that work to give parents the skills they need to be effective, engaged parents. Many cited "irresponsible parenting" as a major child health concern.

### Possible solutions include:

- Implementing the monitoring and evaluation component of Act 528 of 2013 to evaluate best practices for working with parents for optimal child outcomes through home visiting.
- Funding additional home visiting programs and scaling up outreach efforts by statewide and local home visiting resources.
- Training mental health providers throughout the state in evidence-based treatment programs that involve teaching parents strategies to address young children's oppositional/disruptive behaviors.
- Disseminate a continuum of evidenced-based parenting education programs statewide.
- Engaging health care providers in parent education opportunities and reimbursing time spent on health education and care coordination.
- Including care coordination and parent education as reimbursable services as health coverage reforms are implemented.

**"Arkansas has a long history of using evidence-based home visiting to strengthen families. With new funding, we are able to reach even more families with these programs and help them achieve brighter futures."**

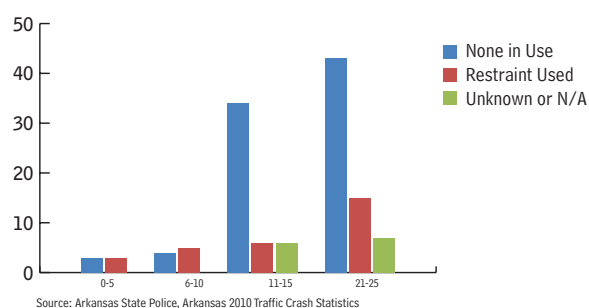
Kathy Pillow Price, Director, Arkansas Home Visiting Network.

## Unintentional Injury

Unintentional injury is the leading cause of death for Arkansans ages 1 to 44. For children ages 1 to 14, the death rate is 26 per 100,000 children. This is significantly higher than the national average of 18 deaths per 100,000 children. Arkansas infants die at almost double the national rate from Sudden Infant Death Syndrome. Despite these alarming statistics, progress has been made. Arkansas's rate of unintentional child deaths has dropped by 40 percent in the last decade.

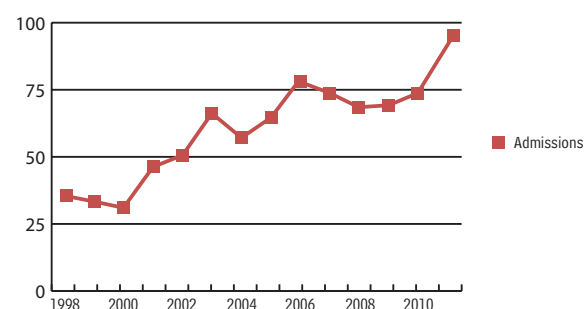
Motor vehicle fatalities are a leading cause of unintentional injury deaths in Arkansas, and alcohol and drugs played a role in 46 percent of fatal vehicle injuries in 2010. In 69 percent of fatalities, for ages 0-25, no restraint (seat belt or car seat) was used.

MOTOR VEHICLE FATALITIES BY RESTRAINT USE



All-terrain vehicles (ATVs) are another major health risk for children. ATV admissions to Arkansas Children's Hospital have increased quickly to 95 in 2011, with children ages 10 to 14 being admitted most often. Arkansas's ATV-related death rate for children ages 0-18 is more than double the national rate.

ATV-RELATED ADMISSIONS TO ACH, 1998-2011



Focus group participants also found injuries to be a challenge, giving it a grade of "C" on the community report cards. However, the phone survey showed that they were very supportive of new teen driving laws, with 97 percent supporting regulation of cell phone use while driving and 88 percent supporting graduated driver licenses. Promising outcomes have been reported following legislation that strengthened teen driving laws, but areas of improvement such as restraint use policies, car seat installation and use, and restricted use of ATVs by children.

Other risky behaviors for children including riding with someone who was drinking, carrying weapons, or driving while drinking are reported by Arkansas youth to be about equal to national rates.

### Possible solutions include:

- Restricting use of ATVs on public roads and by children.
- Continuing advocacy to improve restraint use policies and their enforcement.
- Reinstating a helmet law for motorcycles and extending the law to include ATV riders.
- Expanding coordinated resources for disseminating evidence-based interventions statewide through the Statewide Injury Prevention Program to include local partners not associated with trauma-related providers.
- Utilizing schools to further injury prevention initiatives, including use of mobile phones while driving, ATV safety, bicycle safety, or seat belt use.
- Classifying child car seats as durable medical equipment to ensure insurance reimbursement.
- Improving the state's public health response to injury prevention needs by implementing recommendations from the CDC-affiliated Safe States organization.

Arkansas resident Ashley Mays of New Hope learned first-hand the tragedy associated with improper ATV use when her son was injured on an ATV when he was only 3 years old. Now, at age 5, her son is still dealing with injuries from the accident. "I am willing to tell my story for so many different reasons, but the main reason is to save another family from going through what we went through and are continuing to go through," Mays said.

<http://www.aetn.org/programs/atvsafety>

## Oral Health

Parents and other focus group participants recognize that oral health is important to overall health for children, and expert interviews noted that not having oral health providers who take ARKids First can mean that children do not have access to a dentist. The survey indicated that 59 percent of respondents reported excellent or good availability of dental care for children in their communities.

Children in Arkansas still struggle to access the preventive and restorative oral health care they need. Several counties lack a dentist,

and only about a third of Arkansas dentists accept Medicaid or ARKids First. Arkansas has not yet reached its fluoridation goals, though 65 percent of water systems are fluoridated.

New legislation passed in 2011 should help improve access to "public health dentistry" including sealant placement at schools, but the rules and regulations that have been promulgated leave challenges to successful implementation. Arkansas should see more schools with on-site dental clinics as more school-based health centers implement the dental care component.

The Affordable Care Act helps improve access to relatively affordable stand-alone dental plans in its Marketplace. However, pediatric dental coverage is the only "essential health benefit" that is optional, which means lower-income families may choose not to pay extra for this important piece of coverage.

### Possible solutions include:

- Improving parent education about the impact of poor dental hygiene and proper care of children's teeth.
- Increasing capacity of mobile dental vans to reach more children.
- Monitoring implementation of public health dentistry law and revising the rules and regulations if needed to improve access to care.
- Tracking use of physician and nurse application of fluoride varnishes.
- Developing a solution to the Affordable Care Act's pediatric dental coverage "glitch" to ensure children receive oral health coverage with Marketplace plans.

"We will make sure children have access to care they need, through the dental clinic at the hospital, through school-based dental clinics, through the ACH Dental Sealant program, and through the mobile dental programs across the state."

Dr. James Koonce, ACH Dental Services Medical Director

## Substance Use

Children's use of tobacco, illegal drugs, and alcohol remain of concern in Arkansas. Although survey respondents did not see cigarettes or drug and alcohol abuse as worrisome as they did during the 2007 survey, these issues still rank among top health concerns. Studies from Arkansas Children's Hospital have shown smoking to be correlated with higher rates of childhood asthma in addition to causing other direct health concerns.

In 2011, more than one-third of youth had drunk alcohol in the past month, and more than half had attempted smoking. One-third had tried marijuana, and 26 percent were offered, sold, or given drugs on school property. Thirty percent of HealthTeacher survey respondents identified drugs and alcohol as a pressing health issue for their students. Focus group participants identified parental use of drugs as an issue for children as well. The state ranks 42nd in adult alcohol consumption, and its rate of methamphetamine use is higher than the national average.

CIGARETTE USE, HIGH SCHOOL STUDENTS	2010	2000
Current cigarette use	23.5%	35.8%
• Males	27.8%	37.8%
• Females	18.7%	33.7%

Source: Arkansas Department of Health; AR Youth tobacco Survey, 2010

In 2011, 16 percent of youth in Arkansas had taken prescription drugs that were not prescribed to them. Arkansas ranks third in the United States for nonmedical use of prescription pain relievers in adolescents. Most people who abuse prescription painkillers receive them from a friend or relative, many from primary care and dental provider prescriptions. Nationally, deaths from poisoning, including drug overdoses, have surpassed deaths from motor vehicles for all ages. E-cigarettes are another emerging issue for children, and Arkansas passed legislation in 2013 to restrict e-cigarette sales to children and to ban their use on school campuses.

### Possible solutions include:

- Finalizing a complete ban on indoor cigarette smoking in Arkansas by removing remaining exceptions.
- Continuing to fund tobacco prevention activities with additional emphasis on smokeless tobacco, e-cigarettes, and harder-to-reach populations.
- Expanding the capacity of the prescription drug monitoring program and educational programs about prescription drug abuse.
- Improving access to substance use disorder treatment for children and families through the state's behavioral health transformation and the Affordable Care Act, including recovery/transition and care coordination services.

"Over-the counter and prescription drug use is increasing faster for middle school children than alcohol or tobacco use. Arkansas's death rate due to overdoses is above the national average, and the state has seen a 520 percent increase in admissions for treatment for substance use disorders from 1998 – 2008. In a recent

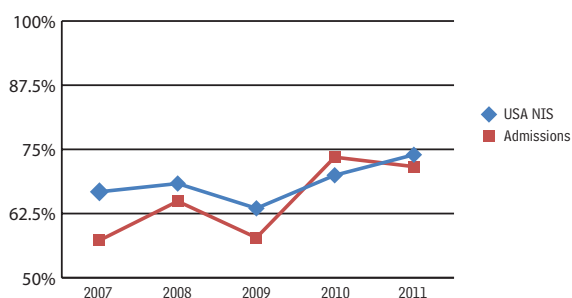
report, Arkansas had in place six of 10 "promising practices" for addressing substance use. A multi-pronged approach is needed to curb these results, including monitoring and prevention, education for the public and for health care providers, and improved access to mental health and substance use disorder treatment."

Dr. Mary Aitken, Department of Pediatrics, UAMS, Injury Prevention Center, Arkansas Children's Hospital

## Immunization

Arkansas children mirror the nation in vaccination rates for young children, with just over 71 percent of 19- to 35-month-olds being fully vaccinated. Philosophical exemptions from required vaccinations continue to add to the overall number of unvaccinated children, with more than 4,300 Arkansas children remaining unvaccinated in 2012-2013. Less than 1 percent of Arkansas children are unvaccinated, but approximately 30 percent of children are not fully immunized.

### VACCINATION RATES (INCLUDING CHICKEN POX), 19-35 MONTHS OLD



Source: Arkansas Children's Hospital Injury Prevention Center

Communities participating in the focus groups gave a "C+" to immunizations, the highest grade any health issue received on the report card. However, interviews with public health experts revealed a more substantial concern for this issue. In 2012, Arkansas ranked 49th in the country for adolescents receiving the Tdap vaccination for tetanus, diphtheria, and pertussis and in administering the full HPV vaccination for human papillomavirus to adolescent girls with only 18 percent of girls receiving the immunization that protects them from cervical cancer. Arkansas ranked last in vaccinating youth for meningococcal meningitis.

The Arkansas Department of Health local health units are beginning to bill health insurance for vaccinations, a new challenge brought on by the Affordable Care Act and a potential loss of federal funding for vaccinating those without health insurance. A new immunization registry, WebIZ, launched in 2013. Despite some challenges with the roll-out, the new registry is designed to improve access to immunization data by multiple sites, including primary care providers and schools.

In 2012, more than four dozen people in Clinton, Arkansas contracted whooping cough (pertussis). Thankfully, the 29 Clinton Public School students who contracted the disease were treated successfully. An outbreak such as this can spread more quickly to other students and their family members when children are not fully vaccinated. **“We know pertussis immunizations are effective, but it is important that children and adults receive the recommended vaccinations and boosters that maximize their efficacy so they help keep all students safe,”** said Dr. Gary Wheeler with the Arkansas Department of Health.

### Possible solutions include:

- Improving families' health literacy regarding vaccinations from childhood through adolescence and adulthood via public education and the health care provider community.
- Engaging schools in efforts to vaccinate adolescents.

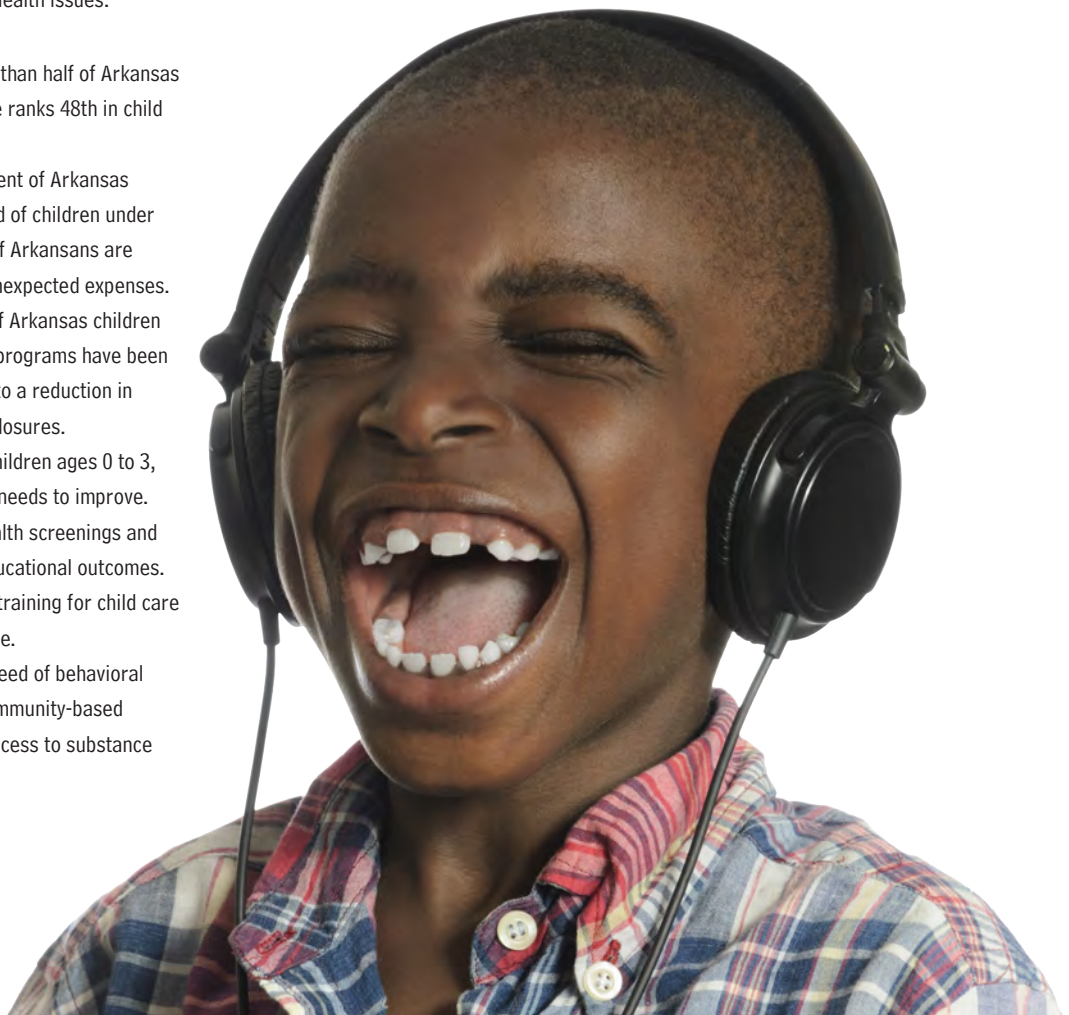
## Other Priority Issues

The following issues were deemed lower-priority based on the frequency with which they were mentioned by communities or noted in the data. Some require additional research to determine the best course of action, and some touch on a variety of health issues.

- Homelessness or Housing Insecurity: More than half of Arkansas children are housing-insecure, and the state ranks 48th in child homelessness.
- Poverty and Child Poverty: In 2011, 28 percent of Arkansas children were living in poverty, and one-third of children under age 5 live in poverty. More than a quarter of Arkansans are “asset poor” and do not have savings for unexpected expenses.
- Early Childhood Education: More than half of Arkansas children do not attend preschool. Arkansas's pre-K programs have been flat-funded for five years, which could lead to a reduction in students who can attend or even program closures.
- Quality Child Care: Especially for younger children ages 0 to 3, access to quality early childhood education needs to improve. Quality child care programs incorporate health screenings and improve school readiness and long-term educational outcomes. Improving health and safety education and training for child care providers can help promote quality child care.
- Mental Health: Many Arkansas children in need of behavioral health care services still lack home- and community-based services. Improving infant mental health, access to substance

use disorder services, and access to school-based services is an important factor in supporting children with behavioral health care needs.

- Health Literacy: Improving Arkansans' understanding of health concepts, public health, and child well-being is a cross-cutting issue. Provider education, public information campaigns, and simplified forms and documents are just a few steps that could be taken to improve the health literacy of Arkansas families.
- Meeting the Needs of the State's Growing Hispanic Population: With the percent of Hispanic children under age five doubling in the past decade, Arkansas needs to improve its capacity to provide appropriate services to a diverse population. Though access to care for Hispanic children has improved due to investments by Arkansas Children's Hospital and others, statewide access to bilingual physicians or translators is still limited. More broadly, the state can improve access to social services for the Hispanic community.
- High School Graduation Rate: This issue points broadly to the tie between education and health. Arkansas's high school graduation rate is just 81%, and stark racial disparities exist as well. Long before graduation, educational performance suffers with just 30 of fourth-graders proficient in reading and 29% of eighth-graders proficient in math. Formal educational achievement ties to long-term earnings as well as health literacy.
- Asthma: Local studies by researchers at Arkansas Children's Hospital show that fifteen percent of Arkansas children have had asthma, with racial disparities and increased prevalence for families where someone smokes inside the home. Rural children had more asthma complications than urban children.





## conclusion

This report provides a comprehensive overview of the current health needs of children and pathways to improve children's well-being in Arkansas. While the Natural Wonders Partnership Council's past successes are undeniable, much work remains to ensure every child has a chance for long-term health and success here in Arkansas.

Going forward, collaboration to achieve the needed policy and programmatic goals may indicate the need for additional workgroups or convening around specific issues under the Natural Wonders umbrella. Additionally, public-private partnerships and philanthropic investments in building the state's capacity for meeting children's needs will continue to be important, especially as state and federal spending is tightened. Thankfully, the strength of the Natural Wonders Partnership Council and the individual efforts of its partners provide a strong foundation for continued progress on the ever-important task of creating a healthier, successful generation of future leaders.

## acknowledgments

Special thanks go out to the members of the Natural Wonders Partnership Council who lent their time and expertise to ensure that this fourth edition of the Natural Wonders report was accurate and included all relevant developments in the health of children in Arkansas. Anna Strong, MPS, MPH, with Arkansas Advocates for Children and Families compiled this report.

## endnotes

- 1 National Campaign to Prevent Teen and Unwanted Pregnancy. <http://www.thenationalcampaign.org>
- 2 Campaign for Tobacco-Free Kids. [http://www.tobaccofreekids.org/what\\_we\\_do/state\\_local/tobacco\\_settlement/arkansas](http://www.tobaccofreekids.org/what_we_do/state_local/tobacco_settlement/arkansas)
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- 5 Martin, J.A., Hamilton, B.E., Ventura, S.J., Osterman, M.J.K., & Matthews, T.J.(2013). Births: Final Data for 2011. National Vital Statistics Reports,62 (1). Retrieved from [http://http://www.cdc.gov/nchs/data/nvsr/nvsr62/nvsr62\\_01.pdf](http://http://www.cdc.gov/nchs/data/nvsr/nvsr62/nvsr62_01.pdf) [July 2013]
- 6 Arkansas Department of Health. "An Assessment of the ADH Injury Prevention Section." (2011). <http://www.healthy.arkansas.gov/programsServices/injuryPreventionControl/TraumaticSystems/Documents/trauma/Reports/STATARFinalReport.pdf>
- 7 Dr. Mary Aitken, presentation. "Overview of Prescription Drug Abuse and Overdose."
- 8 Arkansas Department of Health immunization data from Dr. Haytham Safi
- 9 Centers for Disease Control and Prevention. <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6234a1.htm>



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