

2011 3RD 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 almost 100 years, ACH has provided world class health care for Arkansas' 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 developing the plan and are eager to see it implemented. ACH generously funded the information-gathering stage of the Council's work culminating in this recommendations report.

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



Leading the Council's efforts are Dr. Jonathan Bates, CEO of Arkansas Children's Hospital, Chair, and First Lady of Arkansas, Ginger Beebe, Honorary Chair.

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Executive Summary

The 2011 edition of *Natural Wonders: The State of Children's Health in Arkansas*, is the third in a series of publications tackling a range of challenges to improving children's health. Efforts to date include:

- An original compilation of data that set a framework for discussion and action to improve the status of children's health in many areas.
- A set of recommended focus areas that guided work to improve children's health.
- Evaluation of the array of efforts, an ongoing piece of the *Natural Wonders* process.

This third edition revisits data included in the original analysis and provides the latest snapshot of children's health in Arkansas. Additionally, this report updates the numerous projects, programs, and initiatives involving children's health in the past several years. It also demonstrates a concentrated effort toward achieving the goals set out in previous editions. Accomplishments highlighted include:

- Implementation of graduated driver licensing and a new statewide trauma system.
- Investment in education, health, and parent involvement for children ages zero to 5.
- Newborn health screenings that allow for early diagnosis and intervention for complex diseases.
- New initiatives to address oral health needs of Arkansans, including mobile dental clinics, school-based dental sealant program, and passage of statewide water fluoridation during the 2011 legislative session.
- A host of programs to address childhood obesity.
- A system of care to address mental health needs of children.

While the updates are encouraging in many areas, much work remains:

- An increased poverty rate has put more children at risk for poor health.
- Seven percent of Arkansas children (50,000) remain uninsured.
- Immunization exemption rates continue to rise.
- Childhood obesity remains high, raising children's risk for future chronic diseases.
- Persistent dental provider shortage that leaves many children at risk for poor oral health.

The very recent 2011 Legislative session marked important progress in oral health, access to ARKids First, and school expenditures on low-income children. These laws have not yet been implemented, but hold promise for continued progress on goals and recommendations from previous reports.

The recent economic challenges in Arkansas and the nation only increase the acuity of our problems and prompt a renewed commitment to work together to improve children's health. *Natural Wonders* has proven to be an outstanding, nationally recognized forum in which to bring groups and individuals together, working for the common good of our children.



Introduction

Since the 2008 edition of *Natural Wonders* was published, Arkansans have made great strides toward improving children's health. Policy changes, collaborations between public and private organizations, new research, and new programs have created a foundation that will help our state move forward in the nine action areas outlined in the 2008 report.

The 2007 report set baseline data on the state of children's health, and the 2008 report set priorities and recommendations for action. The 2011 report will revisit the statistics and recommendations made in previous years and set the stage for future developments that benefit the health of Arkansas children. Though the data vary by year, each statistic listed is the most current available. This report examines emerging issues, innovations, and trends that affect Arkansas families, such as the new federal Affordable Care Act (ACA) that will be implemented between now and 2014.

During the 2009 Legislative session, child advocates witnessed many victories for Arkansas children, including many called for in earlier *Natural Wonders* reports:

- Substance abuse services and funding for after-school programs, early childhood education, child welfare, and juvenile justice system reforms were approved.
- A health care initiative funded by a 56 cent increase in the tobacco tax supported substance abuse services and ARKids First expansions, a statewide trauma system, school health initiatives, and community health centers.
- A primary seat belt law, graduated driver licensing for teens, and new laws about mobile phone use and texting will improve the safety of everyone on the road.



The very recent 2011 Legislative session marked important progress in oral health, access to ARKids First, and school expenditures on low-income children. These laws have not yet been implemented, but, hold promise for improving children's oral health, as well as more focus on how schools spend dollars dedicated to their lowest income students.

More than ever before, Arkansans are collaborating to address issues that affect child well-being. The Natural Wonders Partnership Council (NWPC) provides a public-private forum for a diverse group of organizations to come together for one purpose: improving the health of Arkansas children. The NWPC works to assure that the state maximizes its resources and employs a comprehensive approach to accomplish goals through partnership and information sharing.

At the state level, these types of partnerships are reflected in innovative efforts. The Antenatal and Neonatal Guidelines, Education and Learning (ANGELS) program at UAMS and PedsPlace, a UAMS Department of Pediatrics partnership, use telemedicine to consult with and train Arkansas physicians. The new statewide trauma system will coordinate the prevention of and responses to traumatic injuries with potentially 73 participating hospitals. The Injury Prevention Center at Arkansas Children's Hospital has partnered with communities across Arkansas to improve the safety of children. Schools, policymakers, and city leaders are engaging families in an active lifestyle to prevent obesity. Meanwhile, the Arkansas Department of Health is addressing infant mortality issues by expanding home visiting for at-risk pregnant mothers. The State Health Alliance for Records Exchange (SHARE), the state's health information exchange, will connect physicians, schools, and parents to appropriate children's health records.

Local communities are mobilizing for their collective health, as well. Several Arkansas towns have begun fluoridating their water supplies, a key to improving dental health. Throughout the state, schools are adding wellness centers and other school-based health programs to address the needs of all students. School teachers and health educators are taking an active role in teaching healthy habits with the use of the HealthTeacher.com website. With support from the Department of Human Services, communities are creating wrap-around services to work with families to address children's mental health challenges.

Arkansas faces many challenges and lags the nation in many areas. However, the leadership of the Natural Wonders Partnership Council focuses organizations and communities on ensuring a bright future for Arkansas children.



Setting the Stage

The Great Recession has taken a big toll on Arkansas families. High unemployment rates have pushed up poverty, especially in states that already felt socioeconomic disparities. The child poverty rate in Arkansas in 2009 was 26.9 percent, or 186,000 children, which is the third highest rate in the nation, while the state's overall poverty rate was 18.8 percent.¹

Several health improvement initiatives that were approved during the 2009 session of the Arkansas General Assembly have been delayed because of tight state revenue. Meanwhile, the number of Arkansans who use state services including Medicaid, supplemental nutrition, and child care increased.

- In 2009, 63 percent of Arkansas children age 19 and under were served by Medicaid.²
- In 2007, 36 percent of children under 19, or 263,908 children, were served by the food stamp program, an increase of 31 percent since 2001.³
- Children receiving comprehensive, preventive health screenings (EPSDT) increased by 60 percent between 2005 and 2009.⁴
- Thanks to the availability of ARKids First, the state's rate of uninsured children has remained low. But Arkansas still had 50,000 Arkansas children under 19 (7 percent) who were uninsured in 2009.⁵
- Premiums for health coverage for families in Arkansas increased by 38 percent between 2003 and 2009 to almost \$11,000 per year.⁶
- Medicaid's Child Health Management Services provide intervention, treatment, and prevention of long-term disability. CHMS spending has increased by 52 percent, to over \$75.5 million, between 2005 and 2009. Now 9,000 children are being served.
- Arkansas has a shortage of about 1,000 primary care providers and could benefit from 400 new Advanced Nurse Practitioners or Physician Assistants.⁷

These challenges have blunted some efforts to improve children's health and welfare in Arkansas. Additionally, many changes take time to produce measurable results, and the NWPC has been working in the state for only four years. Though statistics may not yet show significant improvement, the state has started programs and policies that promise to produce results.

The federal Affordable Care Act (ACA) offers many opportunities to improve the health of Arkansans. It ensures that more Americans have access to affordable coverage and services, regardless of pre-existing conditions, income, job changes, or state of residence. The ACA also reduces the growing cost of health care over time.⁸

While the ACA provides critical coverage for many Arkansans, it does pose challenges for the strained Arkansas health care workforce. An estimated 250,000 more Arkansans will become eligible for state Medicaid services.⁹ This increase will stretch the state budget beginning in 2017, when 5 percent of the federal government's coverage for these new enrollees—an estimated \$100 million—is transferred to the state. The state's portion of Medicaid costs for new enrollees is considerably less than the current rate of 23 percent, but it is still an increased expense. However, the influx of federal Medicaid dollars provides an opportunity to drive economic activity to help generate the revenue needed to cover this expense.¹⁰ A recent report by the Walton College of Business examined the relationship between Medicaid and the state economy. It concluded that for every dollar the state spends on Medicaid, Arkansas can expect to see \$6.31 generated in other economic activity.¹¹





The ACA will:¹²

- Require everyone have health insurance coverage or pay a penalty, with exceptions for low incomes, financial hardships, and others issues.
- Require employers, with exceptions for smaller firms, to offer affordable coverage to employees or pay a fee.
- Significantly increase Medicaid income eligibility levels for low-income individuals under age 65 (children, parents, and childless adults) to 133 percent of the federal poverty level, or \$24,000 for a family of three.
- Create a Health Insurance Exchange, or marketplace, for families to compare and purchase insurance. This would offer a choice of plans to those who cannot otherwise access insurance through employers, or are not eligible for Medicaid or Medicare. Individuals could choose from many plans with minimum benefits and cost-sharing requirements. Subsidies would be available to help pay for coverage through the exchange.

Pieces of the law that directly affect children include money for childhood obesity reduction demonstration projects, an oral health education initiative, home visiting programs for pregnant women or parents of young children, teen pregnancy prevention education, school-based health clinics and health “homes” and community health teams who will improve comprehensive case management. Additionally, the law expands the number of primary care workers, including paraprofessionals, and the public health workforce.¹³

While the full law will not go into effect until 2014, a number of important changes have already started. Young adults are now allowed to stay on their parent’s insurance policies until they are age 26, ensuring that almost 14,000 young Arkansans maintain health coverage immediately.¹⁴ More than 260,000 young adults in the state could benefit in the long term.¹⁵

- Children with insurance will no longer be denied coverage for a pre-existing condition. The same will apply to adults in 2014 once exchanges are operating.
- Insurance companies can’t impose lifetime limits or restrict annual limits, nor can they drop coverage when policy holders become sick.
- New plans must provide free preventive services to enrollees.
- States are required to “hold steady” when it comes to providing Medicaid and CHIP coverage; they must maintain, at minimum, the coverage that they have in place now and cannot add barriers that make it harder for families to sign up for coverage.
- Until the exchanges are operational in 2014, a high-risk pool administered by the Arkansas Insurance Department will cover qualified uninsured adults with pre-existing conditions.

In addition to insurance and Medicaid reforms, the ACA will change the health landscape for Arkansas by providing insurance coverage for hundreds of thousands more Arkansans and forcing the health system to respond to the preventive care needs of a newly insured population.¹⁶

This legislation is the current focus of much debate in Congress and many state legislatures. Legal challenges to defer or delete major components of the ACA are working their way through the federal court system. It is possible that some or all of the ACA could be stricken down by courts.

Investing in Healthy Starts

Arkansas has been praised for investing in the health, education and support services our youngest children need to succeed when they enter school. Though behind the rest of the nation in many areas, Arkansas is ensuring its children have a healthy start in life by improving services such as newborn screenings, frequent doctor's check-ups (EPSDT), early childhood education, and expanded nutrition programs.¹⁷

ENSURING EARLY CHILDHOOD EDUCATION (PRE-K AND CHILD CARE)

The Arkansas Department of Human Services collected data for its 2009 Getting Ready 4 School report on successful programs—and those that need work.¹⁸ It highlighted the importance of the socio-economic status of families and communities in the success of children, as well as role schools can play in assuring children receive a quality education as well as health, nutrition, and social benefits.

- Through the Arkansas Better Chance (ABC) program, the number of at-risk children from birth to age 5 who received quality early childhood education services grew by an impressive 69 percent 2004 to 2008.¹⁹ ABC has been shown to significantly improve skills in language, literacy, and math for children who attend the program at age four.²⁰ Arkansas Better Chance programs and the federally funded Head Start program serve about 65 percent of the nearly 48,000 3- and 4-year-old children below 200 percent of the poverty line, or about 35 percent of the state's 89,000 3- and 4-year-olds.²¹
- Between 2000 and 2007, Arkansas saw a doubling in the use of child care vouchers, which help low-income families afford child care. Also, additional federal funding from the American Recovery and Reinvestment Act of 2009 expanded the program to reach even more Arkansas children. However, in July 2010, the additional money ran out, adding more than 4,500 children to the subsidized child care program waiting list. Fewer than 10,000 children received vouchers in December of 2010,²² but almost 12,000 children were on the waiting list.²³ However, the number of child care licenses has grown, and more programs are meeting state early childhood accreditation and quality approval standards.
- In 2010, DHS launched Better Beginnings, a quality rating and improvement system for all state-licensed child care programs. It gives providers tools to improve their programs and informs parents about certified child care providers in their area. This allows them to compare providers and learn what to look for in a child care facility.

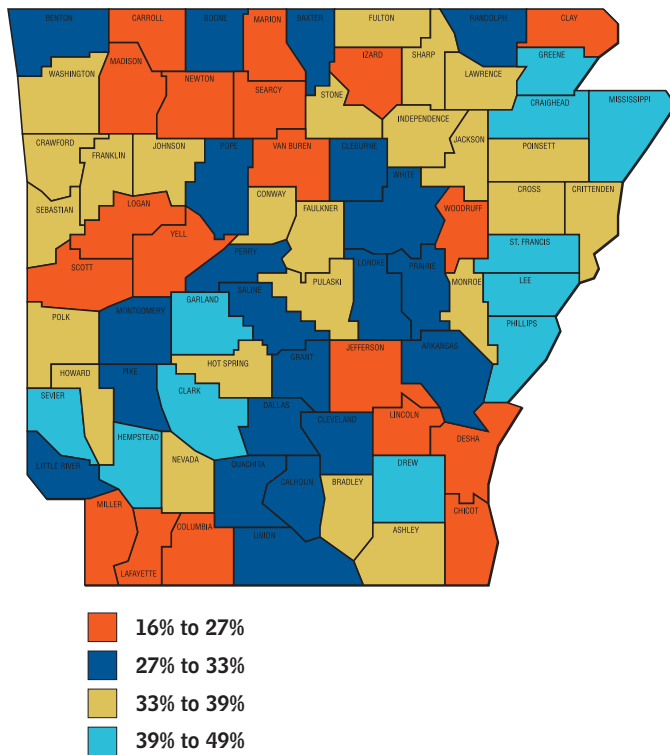
- Arkansas's state-funded pre-K program was named among the ten best in the nation in a recent report, highlighting the investments the state is making in the education of its youngest children.²⁴
- Efforts at the pre-k level are being carried into the school-age years through initiatives such as the Coordinated School Health effort and new Wellness Centers. They provide health care and prevention in schools, where most students have access to services. Food programs at schools and after-school programs have expanded, and obesity screening in schools alerts parents to potential health hazards.²⁵

ENSURING HIGH-QUALITY HEALTH SCREENINGS AND TREATMENT

Arkansas is moving toward ensuring all Arkansas children have a healthy start in life.

- Expanded newborn screening for 28 conditions began in Arkansas in July 2008. In the first two years of expanded screening, the Arkansas Department of Health screened 80,745 newborns, and confirmation testing of initial positive findings was conducted by the ACH laboratory. The screenings made possible the diagnosis of 136 cases of diseases such as cystic fibrosis and congenital hypothyroidism, which would have caused lifelong disability or death as well as high health care costs without an early diagnosis.²⁶
- More Arkansas children are receiving their Early Periodic Screening, Diagnosis, and Treatment (EPSDT) screenings. Arkansas ranked last in national 2008 screening rates, despite improvements in the state. It's important to note that reporting discrepancies make it difficult to compare rates of EPSDT screenings among states.²⁷ However, the number of eligible Arkansas children who received at least one required EPSDT screening increased from 24 percent in 2005 to 38 percent in 2009.²⁸ Overall, eligible Arkansas children received 34 percent of the screenings they should have in 2009, up from 19 percent in 2008.²⁹ In order to improve EPSDT screening rates, Arkansas needs to improve outreach to families, increase the number of providers who take ARKids First and Medicaid, and improve reimbursement rates for EPSDT screenings. Additionally, lack of consistent enrollment in ARKids First or Medicaid is a challenge to children who should receive these screenings. Barriers such as language and transportation are also a problem.

Percent of EPSDT Screenings in 2009



- To improve preventive care for children, the combined efforts of the DHS Division of Child Care and Early Childhood Education, Arkansas Medicaid, and the Arkansas Foundation for Medical Care (AFMC) have improved EPSDT screening rates and other preventive care through better education and outreach to providers. For example, the partners promoted standardized developmental screening tools in physicians' offices through the Assuring Better Child Health and Development project and worked together to provide one-time bonus payments to physicians who improved screening rates in 2007.³⁰
- In Arkansas, children in many Medicaid categories are required to have a regular source of medical care or a primary care physician, but in January 2010 more than 25,000 children enrolled in ARKids First or Medicaid (6 percent of all Arkansas children) did not have a primary care physician on record.³¹ Lack of a primary care physician can be detrimental to establishing quality preventive services for children. Medical homes allow children, especially those with complex health care needs, to receive the best care possible by ensuring that a primary care physician oversees all treatment. Through outreach programs, AFMC and DHS are encouraging families to find a medical home to coordinate services. The Affordable Care Act provides money to test innovative delivery models such as patient-centered medical homes for Medicare, Medicaid, and CHIP programs.³²
- The Centers for Children in Lowell opened in May 2007. In 2010, it expanded to provide primary care services and serve as a medical home for children with Medicaid coverage but no primary care physician. A collaborative effort by Arkansas Children's Hospital and the University of Arkansas for Medical Sciences, the center improves access to primary care and subspecialty care in an underserved part of the state.
- A study conducted at Arkansas Children's Hospital showed that their hospital-based Medical Home, which provides comprehensive and coordinated care for medically complex children, reduced overall cost to Medicaid by \$1,179 per patient *per month*. Multidisciplinary teams ensure that each patient receives necessary medical, nutritional, and developmental care and that there is improved coordination of care with primary care providers, subspecialists, hospitalists, and community-based services.³³
- The new SHARE (State Health Alliance for Records Exchange) health information exchange will help coordinate care between families, school wellness centers, and providers by allowing real-time information to be shared securely and confidentially.³⁴

IMPROVING HOME VISITING AND SERVICES FOR FAMILIES

Arkansas is working to ensure that moms and dads have the tools they need to promote child healthy development and avoid child abuse and neglect.

- Home visiting has been shown to improve infant mortality, child development, and health outcomes. The Arkansas Network for Home Visiting is a coalition of providers and funders of home visiting services that promotes collaboration and communication among stakeholders. The network improves the quality of home visiting programs to address a variety of needs for parents and children across the state. The group hopes to adopt uniform outcome measures, evaluation tools, and data management systems for the state's home visiting programs.³⁵ More than 12,000 adults and 11,000 children were served by the 31 reporting programs, according to a recent survey.³⁶
- The Arkansas Department of Health received a \$1.2 million grant for the Maternal, Infant and Early Childhood Home Visiting Program under the Affordable Care Act and is pursuing further funding for home visiting programs. The state plans to use the evidence-based Nurse Family Partnership model, which matches public health nurses with at-risk first-time mothers from the time they become pregnant until the child is two years old.
- Following Baby Back Home provides home visits to infants who are transitioning from the NICU to home. Home visitors (a social worker and nurse team) provide teaching, support, and case management services for families of high-risk infants in northwest, north central, east, and south Arkansas counties.³⁷

- Home Instruction for Parents of Preschool Youngsters (HIPPY), helps provide a solid educational foundation for more than 5,700 Arkansas children. HIPPY is an in-home program that teaches parents to help their children get ready for school, and Arkansas programs are available in all but six counties. HIPPY was recently named one of seven home visiting models that meets the evidence-based criteria of the federal Maternal, Infant, Early Childhood Home Visiting program. The positive outcomes of their research uniquely position HIPPY to help states and communities meet their goals of increasing school readiness among vulnerable populations.
- The Center for Effective Parenting at Arkansas Children's Hospital offers a variety of free parenting classes to parents in central and northwest Arkansas that help parents learn coping skills and navigate difficult situations. In 2009-2010, more than 241,000 parents—half of them low-income—accessed the Arkansas Parent Information and Resource Center.³⁸
- The Arkansas Children's Trust Fund developed *Core Competencies for Parent Educators* as part of an effort to improve the quality of parent education. It guides specialists working directly with families and could be a step toward certification for parent educators. Additionally, the trust fund is working to build a collaborative training network for providers to strengthen families and prevent child abuse.³⁹ The organization recently received a \$1.1 million grant from the U.S. Department of Health and Human Services to improve home visiting and child abuse prevention.



Addressing the Health of Minority Populations

Minorities in Arkansas generally are in poorer health than the broader population. The Natural Wonders Partnership Council has investigated interventions for the health of minorities and immigrants and developed an action plan. A recent Arkansas Minority Health Commission investigation found billions of dollars in medical expenses that could be eliminated by reducing disparities. A statewide telephone study included the largest sample to date of Hispanics in Arkansas and found that:⁴⁰

- The majority of those surveyed did not realize the magnitude of health disparities and attributed existing disparities to economic and dietary factors.
- Hispanic respondents were the least likely to have health insurance, with half lacking a regular health care provider and half reporting that their health care facility has no one of their ethnicity on staff.
- Nearly 70 percent of Hispanic respondents needed an interpreter to help them speak to a provider, but less than 30 percent had access to one.
- Some minorities felt that people like themselves are treated less fairly in their health care, including 40 percent of urban blacks, 29 percent of rural blacks, and 25 percent of Hispanics.
- Respondents mentioned disrespectful or differential treatment due to ethnicity, such as inferior treatment, negative attitudes of health care providers, or lack of cultural competency.

Though the Affordable Care Act offers promising benefits to vulnerable populations, health insurance alone will not address system-level issues such as discrimination in health care services. AMHC's report suggested four strategies to help reduce disparities in Arkansas:

- Increase awareness about racial and ethnic health disparities. Communities and policy makers are being informed about the issues through publications such as this and the work of other Natural Wonders members. Health disparity researchers must continue to develop innovative solutions to these problems.
- Improve health care access and choice. The Affordable Care Act will improve health insurance coverage for minorities in Arkansas, and unique ways of delivering services are being piloted around the state to reach out to those in rural areas.

- Address disparities as part of quality improvement. Since minorities often receive unequal treatment within the health care system, disparities should be addressed through targeted and general quality improvement efforts.
- Improve cultural competency and diversify the health care workforce with interpreter services, providers from a variety of ethnicities, cultural sensitivity within health services education.

Additionally, a framework was developed by a Clinton School of Public Service student for focus groups aimed at exploring child health attitudes and needs among minority and immigrant populations. Several communities have been selected to participate. The results of the upcoming focus groups will be used to drive patient-centered solutions to health disparities.⁴¹

Other efforts to address the health of minorities in Arkansas include:

- A handbook for the growing Marshallese population in Arkansas helps them access quality health care and live healthier lifestyles.⁴²
- The Arkansas Center for Health Disparities at UAMS partners with several institutions working to address the health of minority populations. For example, it partners with the UAMS Racial and Ethnic Health Disparities Task Force to enhance cultural sensitivity and reduce barriers to health care access in clinical and educational programs.⁴³
- Annual federal grants of \$40 million won by the Community Clinic at St. Francis House in Northwest Arkansas will improve community-based outreach to Hispanic and Marshallese children eligible for ARKids First coverage. These outreach programs also improve access to culturally- and linguistically-appropriate preventive and primary health care.⁴⁴
- Federal support through the Children's Health Insurance Program Reauthorization Act (CHIPRA) extended state children's insurance coverage to legal immigrant children by eliminating a five-year waiting period. States may now choose to cover them during this five-year period with federal support. The law also boosts reimbursement rates for translation services.⁴⁵



Revisiting 2008 Natural Wonders Priorities: Updates and New Statistics

The 2007 Natural Wonders report established a baseline of health statistics and revealed areas needing action. The 2008 report asked for more opinions from parents, medical professionals, and other stakeholders in key health improvement areas. The outcome of the 2008 report was a set of recommendations to improve children's health in eight critical ways. It compared current statistics and health measures to those in the 2007 report to determine progress, while also providing a qualitative update on the 2008 progress areas. Changing children's health is an incremental process, and though statistics may not yet show measurable improvement in the four years since the initial report, it is important to

highlight the wide range of efforts across the state that will ultimately improve the health of Arkansas children.

The table below lists the 2008 recommendations and whether or not they have been addressed according to the following scale:

- ☆☆☆ = Fully addressed
 ☆☆ = Partially addressed
 ☆ = Task force or committee is considering
 No stars = Not addressed

Progress Addressing 2008 Recommendations

SERVICE NEEDS AND EXPANSIONS	ACTION
Provide continuing medical education and/or fellowships for primary care providers to help them stay abreast of medical advances and resources.	☆☆
Promote after-school programs and summer programs to prevent delinquent behavior and provide positive self-esteem building paths toward personal achievement and growth. These programs may also help children with special needs benefit from continuity of education and treatment programs beyond the traditional school year.	☆☆
Expand eligibility requirements for ARKids First to a minimum of 250 percent or a maximum of 300 percent of the federal poverty level.	☆☆
Permit Medicaid coverage for all children residing in Arkansas, regardless of immigration status.	
Expand tuition reimbursement programs to attract more students to medical and allied health profession job paths.	
Secure insurance coverage for preventive health services	☆☆
Add home visiting parenting services for high-risk pregnancies as previously funded by the Department of Health.	☆☆
Improve access to health and preventive health services in rural communities.	☆☆
Expand Coordinated School Health services by: <ul style="list-style-type: none"> • Phase-in state general revenue to support CSH in all schools by 2015. • Ensure schools have sufficient staff to provide CSH services. • Retain school human service workers currently provided by DHS. • Improve the number of qualified social workers in the schools. • Fund nurse to student ratio of 1:750 with goal of funding to a 1:500 ratio. • Fund Parent Resource Coordinators in each school. 	☆☆
PRENATAL CARE, INFANT MORTALITY AND TEEN PREGNANCY	
Improve promotion of prenatal care among minority women and teens by increasing access to Medicaid and assuring access for prenatal health services. Access to obstetrical services in rural areas must be improved with further development of the UAMS ANGELS program and other innovative service delivery strategies by nurse practitioners, telemedicine, and school and community health centers.	☆☆

Increase availability of proven parenting education programs for both teen moms and dads.	☆☆
Use materials and programs affiliated with the AAP's Bright Futures program to build parent knowledge and promote coordination of services that support families raising children.	
Increase programs that discourage and/or prevent teen pregnancy.	☆
Ensure access to education completion for teens who become pregnant while still in school.	
Provide job training and placement services for teen parents.	☆
Provide after-school and summer programs that contain social, emotional and life-skills building, as well as provide drug and violence prevention, youth leadership and character education. The programs should promote physical activity, proper nutrition and healthy lifestyles that include recreational and sport activities.	☆☆
Expand access to substance abuse treatment for pregnant women, mothers with children and children/adolescents by securing at least \$10 million in state funding to allow Arkansas to access federal Medicaid dollars for substance abuse treatment.	☆☆
All children birth to 5 should receive developmental screening as part of comprehensive well-child examinations (otherwise known as EPSDT screenings) in the context of a medical home. This can be accomplished by: (1) Increasing care coordination capacity to support families and providers, (2) Planning for future use of fiscal incentives for EPSDT providers, and (3) Mandating use of a consistent and evidence-driven developmental screening tool.	☆☆
Increase Medicaid EPSDT screening rates to national levels of attainment.	☆
IMMUNIZATIONS	
Reduce the use of immunization exemptions.	
Inform parents and the public about the risks and proven benefits of immunizations.	
Increase rates of childhood immunizations to at least the national average by 2013 and aim to keep the state's performance rate of childhood immunizations consistently in the top tier of performing states.	
Encourage and monitor physician and parental adherence to recommended child and adolescent vaccine schedules.	☆
Increase access to and use of the state's immunization registry.	☆
ORAL HEALTH	
Fluoridate public water systems statewide.	☆☆
Secure policies that enable more children to receive fluoride varnish, sealants and preventive dental services. The NWPC urges consideration of alternative means of delivering some preventive dental services but competent and quality service delivery must be assured. Use of health professionals such as physician assistants, nurse practitioners and dental hygienists may be one option. However, this may require improving and expanding licensure practices and regulations.	☆☆
Increase mobile dental/medical offices to take services to isolated and underserved areas of the state. Ensure that such services are reimbursed by Medicaid and other carriers for sustainability.	☆☆
Expand school-based models of delivering preventive dental services in underserved areas.	☆☆

REDUCING RISKY BEHAVIOR – INJURY PREVENTION	
Secure a graduated driver license (GDL) law to include the following provisions, which reflect the ideal implementation of a GDL policy per the Insurance Institute for Highway Safety: <ul style="list-style-type: none"> • Establish intermediate license stage for beginning drivers. • Set 16 years as the entry age for licensing to drive. • Ensure that learner’s permits are held for a minimum of six months. • Provide criteria for intermediate stage driver’s licenses for those aged 16.5 to 18 years old. • Restrict distracting factors during driving such as cell phones and number of teen passengers per vehicle. • Mandate supervised driving during night hours (with exceptions for school and work). 	☆☆
Mandate primary seatbelt law.	☆☆☆
Fund and secure a statewide trauma system for serious injury.	☆☆☆
Enforce laws that restrict/limit ATV riding on “roads.”	
Re-instate helmet-wearing laws for those riding ATVs and motorcycles.	
Increase the rates of helmet use via educational materials, social messaging campaigns and city ordinances.	
Classify child car seats as durable medical equipment to ensure insurance reimbursement initially for children with special needs and then expand to all children.	
Encourage health insurance discounts for those acting responsibly while riding/driving motor vehicles.	
Provide coordinated injury prevention professional education programs for current and future health care professionals.	☆☆
Enhance statewide child passenger seat program to ensure parent access to equipment and educational resources.	☆☆
Increase partnerships with Coordinated School Health sites to integrate injury prevention curriculum into health and wellness education at school.	☆☆
Support efforts of other coalitions and groups such as the Governor’s Traumatic Brain Injury Task Force in finding solutions to problems faced by families after injury.	☆☆
Re-establish a statewide child fatality review team to monitor and improve interventions.	☆☆
TOBACCO PREVENTION	
Raise the excise tax on cigarettes and other tobacco products, a proven deterrent of teen smoking.	☆☆☆
Encourage media to discontinue portrayal of images of teens and adult actors or characters using tobacco products in films, cartoons, videos, music videos, electronic games and other promotional or entertainment venues.	☆
Maintain and expand the state’s Clean Indoor Air Act of 2006 to all public indoor spaces.	☆
Protect children from exposure to secondhand smoke in public outdoor spaces.	☆☆
OBESITY PREVENTION	
Expand ways to educate parents and children on nutrition, such as with restaurant menu labeling.	☆

Increase the “Safe Routes to School” initiatives that encourage safe routes to walk or ride a bicycle to and from school.	☆☆
Promote school physical activity facilities for community use beyond regular school hours.	☆☆
Increase physical activity requirements during the academic day for all grades and ensure that all students are involved, rather than offering only competitive team sports.	☆☆
Expand safe paths/areas for walking and pedaling and playing in all residential areas. This may include changing city ordinances to require that such areas be built, renovated or maintained.	☆☆
Integrate nutrition education and physical activity options within existing school curricula on a daily basis for all grades.	☆☆
Expand healthy food alternatives in concession stands at public events.	
Investigate and reduce school liability for injuries occurring on school property if a physical activity facility has been opened for community access.	☆☆
Provide incentives to local food stores to increase healthy, affordable food options.	
Increase retail food and farmers markets in lower population areas of rural Arkansas as well as in urban areas.	
MENTAL HEALTH SERVICES	
Adopt a uniform assessment process to increase accountability in the Medicaid program, based on positive child outcomes.	☆☆
Expand the array of community-based services. They should be driven by child needs, family preferences and community priorities. These may include respite care, family preservation, and substance abuse services.	☆☆
Fund schools to implement Positive Behavioral Interventions and Supports (PBIS) to support identification of and response to student behavior challenges in school.	☆☆
Develop Care Coordinating Councils to facilitate cross-system service and resource decisions.	☆☆☆
Develop local care teams for building and maintaining wrap-around planning and services.	☆☆☆
CAPACITY BUILDING	
Ensure that children have a medical home that can guide and coordinate screening, diagnosis, and treatment.	☆☆
Explore ways to deliver routine preventive health services to families in a more expeditious and accessible manner using paraprofessionals or different sites such as mobile health clinics.	☆☆
Create health information systems that can inform the parent, the provider, and the school in coordinating health services including electronic personal health records.	☆
Use technological advances, such as telemedicine, to provide expert diagnosis and treatment.	☆☆
Develop electronic warning systems to ensure follow-up services and medications are provided when screenings demand further attention.	☆
Provide quality markers for providers so that parents are better informed about the care their child should receive and can be assured they are getting it.	☆
Develop school programs that recruit students, especially minorities, into medical careers.	☆

Service Needs or Expansions

Vision of Success: “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.”

WHAT DO THE DATA TELL US?

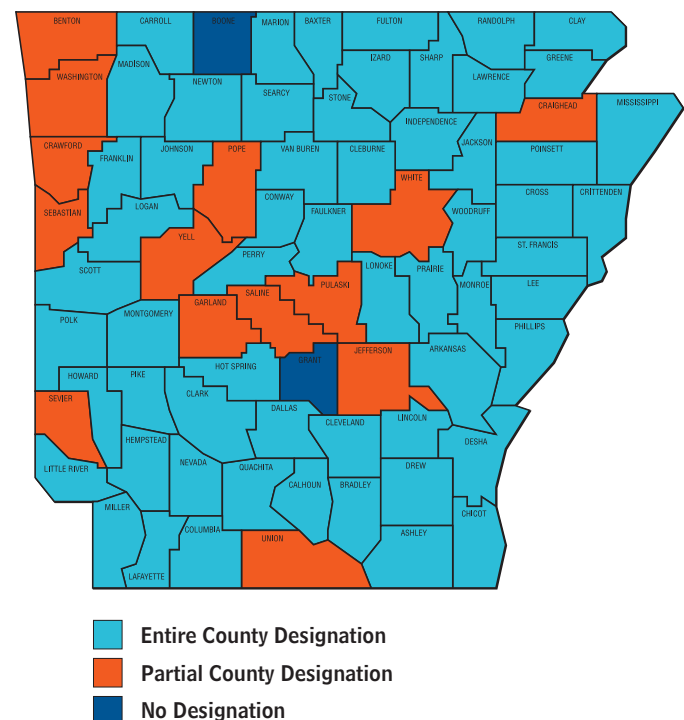
Children in Arkansas still lack access to needed services and are challenged by financial and environmental barriers. With almost 27 percent of children living in poverty, the state has the third highest poverty rate in the United States.⁴⁶ African Americans and Hispanics are more than twice as likely to be poor than their white neighbors, and low educational attainment and single-parenting also increase a family’s odds of being in poverty.⁴⁷ Arkansas’s per-capita income increased from 2001 to 2007 but was still only 78 percent of the U.S. rate in 2007.⁴⁸ The 2010 KIDS COUNT Data Book ranked Arkansas 48th in child well-being, with eight of ten indicators in the bottom ten including “idle” teens, child death rate, and high school dropouts.⁴⁹

Some programs shown to help reduce disparities have not been implemented, further hindering access to services. The promised ARKids First expansion to 250 percent of the poverty level, which has yet to be funded, has left as many as 20,000 eligible Arkansas children without coverage. In 2009, over 50,000 children in Arkansas were uninsured, or about 7 percent of all children.⁵⁰ More than half of these children already qualify for ARKids First, but bureaucratic red tape pushes 20,000 qualified children off ARKids First each year, leaving them without coverage.⁵¹

Additionally, at the end of the 2008-2009 academic year, Arkansas schools were sitting on more than \$25 million of unused National School Lunch Act (NSLA) funds intended to help close the achievement gap by funding quality early childhood education, school-based health, afterschool programs, and other programs that help low-income children succeed.⁵²

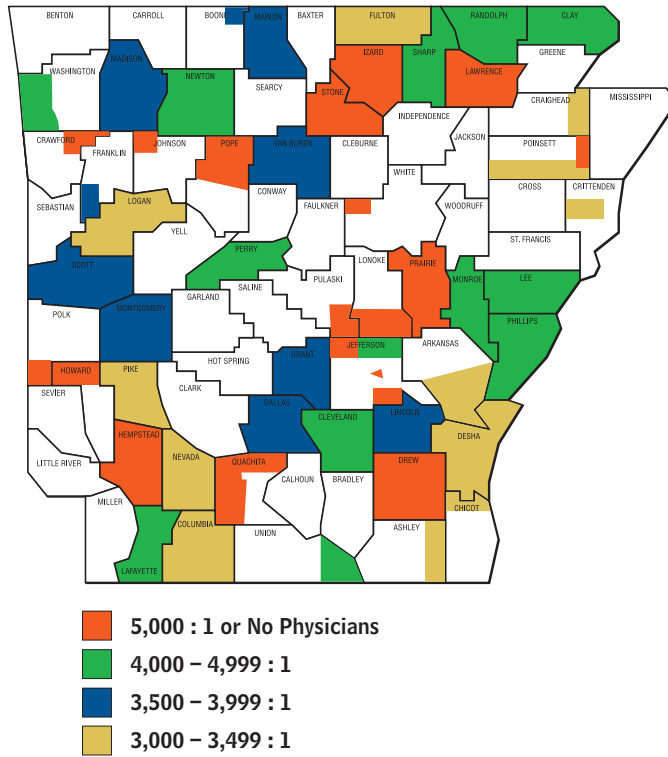
Arkansas ranks 50th in the U.S. in equitable physician distribution with 38 percent of the state’s children living in a region where doctors are scarce, according to a 2010 article in *Pediatrics* journal.⁵³ Between 2001 and 2007, the number of physicians increased by 12.4 percent to 5,684, and nurses increased by 1.6 percent from 2001 to 2007 to 42,063. However, though the number of medical personnel in Arkansas is increasing, there are still underserved areas where children cannot access the care they need.⁵⁴ All but two counties in Arkansas have at least a partial designation as a Medically Underserved Area by the Arkansas Department of Health’s Office of Rural Health and Primary Care, and most counties have a shortage of primary care physicians.⁵⁵ This means most of Arkansas lacks a sufficient supply of health professionals.

Medically Underserved Areas



Source: recreated from Arkansas Department of Health, Office of Rural Health and Primary Care, 3-1-10

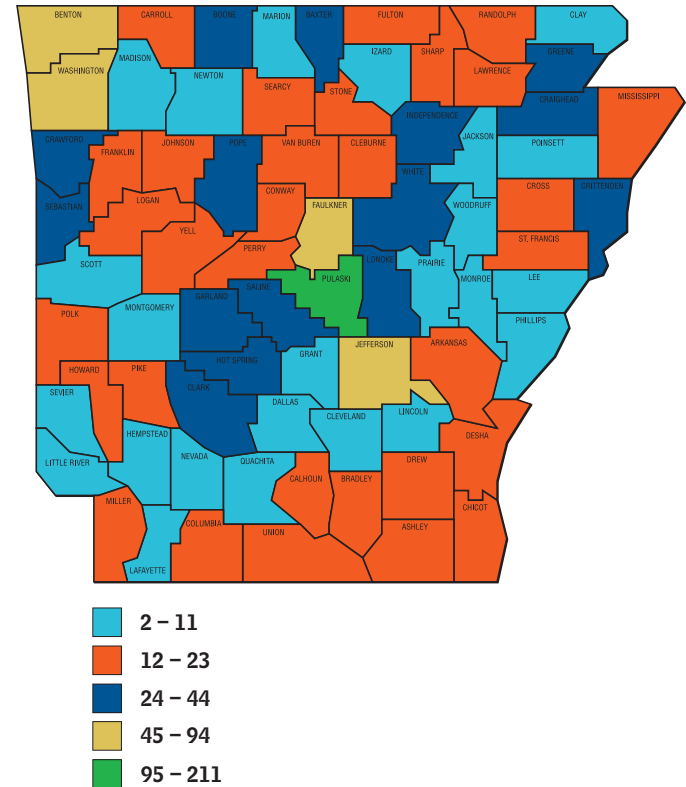
Primary Care Health Professional Shortage Areas



Source: Adapted and recreated from Arkansas Department of Health, Office of Rural Health and Primary Care, 3-1-10

Services that help children are in short supply as well; one third of Arkansas counties have a **low number of after-school programs**. Recent surveys found that only 12 percent of Arkansas children participate in after-school programs. Yet 44 percent of children not enrolled would be likely to participate if a program were available.⁵⁶ These programs are shown to prevent delinquent behavior and provide paths to success, and additional funding would allow more children to receive program benefits.

Number of Out of School Programs per County



Source: Arkansas Advocates for Children and Families, based on numbers provided by Arkansas Department of Education, Arkansas Department of Human Services, Boys and Girls Clubs, and other afterschool and summer program representatives

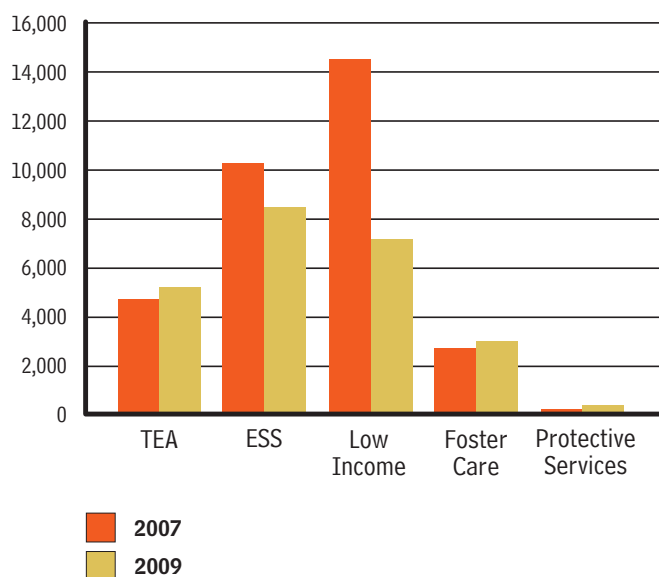
There is a waiting list of almost 12,000 children in Arkansas for child care subsidies. The number of Arkansas children served by all child care assistance programs such as Temporary Employment Assistance (TEA) has decreased by 25 percent in just two years, leaving many families without the help they need.⁵⁷

Children and Families Helped by Child Care Assistance Programs

	CHILDREN		FAMILIES	
	2009	2007	2009	2007
Temporary Employment Assistance (TEA)	5,232	4,718	3,261	2,872
Extended Support Services (ESS)	8,482	10,309	4,394	5,065
Low Income	7,188	14,584	3,995	7,950
Foster Care	3,025	2,697	1,579	1,295
Protective Services	396	206	226	119
Total Served	24,323	32,514	13,455	17,301

Source: DHS 2009 and 2007 Statistical Reports.

Children Served by Child Care Assistance, 2007 and 2009



Source: DHS 2009 and 2007 Statistical Reports.

The combination of poverty and lack of access to care compromises improvement to the health status of Arkansans. Arkansas children remain behind the national average in preventive medical and dental care. Just 16 percent of children age 10 months to 5 years received standard screening for developmental or behavioral problems, behind the national average of 20 percent.⁵⁸ EPSDT screenings required by Medicaid are also underused in Arkansas with 34 percent of eligible children receiving all comprehensive preventive care visits.⁵⁹ Arkansas must continue addressing the recommendations from the 2008 report to ensure that children receive the services they need.

PROGRESS ON 2008 RECOMMENDATIONS

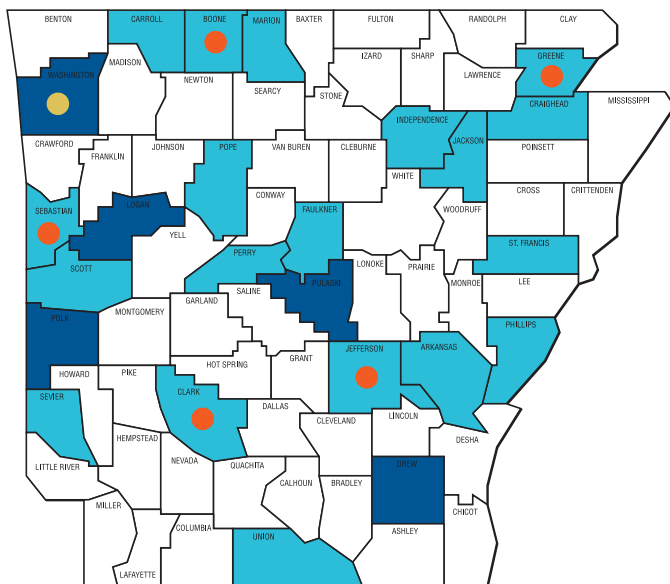
Arkansas is working to provide better access to the services children and families need to be successful. Addressing poverty is vital to the long-term improvement in health outcomes for children and their families.

- Recognizing that the state's high poverty level harms the state, the Arkansas Legislative Task Force on Reducing Poverty and Promoting Economic Opportunity released recommendations in late 2010 that would help cut poverty in Arkansas in half in just 10 years. These recommendations included short- and long-term goals in the areas of community and economic development, education and workforce development, health, individual employment supports, tax relief, and other system-wide needs.⁶⁰
- The Arkansas Finish Line Coalition is making strides in its goal to ensure all children in Arkansas have access to health insurance. The tobacco tax increase supported expanding income eligibility for ARKids First to include children in families up to 250 percent of the poverty level; this would make 9,000 more children eligible upon its implementation and help to enroll an additional 11,000 children who are already eligible.⁶¹ This expansion has not yet occurred due to budget constraints. The coalition is also pursuing new ways to streamline enrollment and retain children so they are not falling off the program because of paperwork.⁶² They were successful in helping pass Act 771 during the 2011 Arkansas General Assembly, which "cut the red tape" in ARKids enrollment. The Act will streamline enrollment and renewal procedures for ARKids First, using existing technology and state databases to assess eligibility, rather than simply mailing a form to families to renew coverage.
- Several initiatives are improving access to care in rural settings, including STAR Health's use of community health workers to address maternal and child health outcomes and Home Visiting for at-risk mothers. The ANGELS and PedsPlace telemedicine programs that connect rural physicians with specialists in academic medical centers for continuing education and consultations.



- Children have better access to health services at school. Thirty-one Arkansas school districts have at least one school that participates in the Coordinated School Health initiative. These schools form partnerships to help communities with pressing student health needs through community-driven solutions. Additionally, eight CSH schools were chosen as Coordinated School Health Wellness Centers during the 2010-2011 academic year. These Wellness Centers receive funds for five years to develop school-based health services for primary and preventive care and mental health counseling, among other services.

Coordinated School Health Districts and School Wellness Center Locations



Coordinated School Health

- 1 Location
- 2 – 3 Locations

Wellness Centers

- 1
- 2 – 3

- During the 2009 Arkansas Legislative session, general improvement funds were provided to after-school and summer programs (also referred to as out-of-school time programs) in low-income and rural school districts. Such programs are designed to help build life skills including youth leadership and character education, which will promote healthy lifestyle choices.⁶³
- Act 166, passed during the 2011 legislative session, directs the Arkansas Department of Education, in partnership with the Department of Human Services, to set up a framework for after-school programs to better coordinate and improve quality of existing programs. This will also create a mechanism for financing quality after-school programs when money becomes available.
- Act 1220 of 2011 was signed by Governor Beebe during the 2011 session. Schools may no longer hold on to large sums of state NSLA dollars intended to close the achievement gap and support low-income children. Act 1220 requires schools to spend 85% percent of their annual NSLA allocation each year. It also allows these funds to be spent on school meals, initiatives to lengthen the school day or school year, and remediation programs, among others.



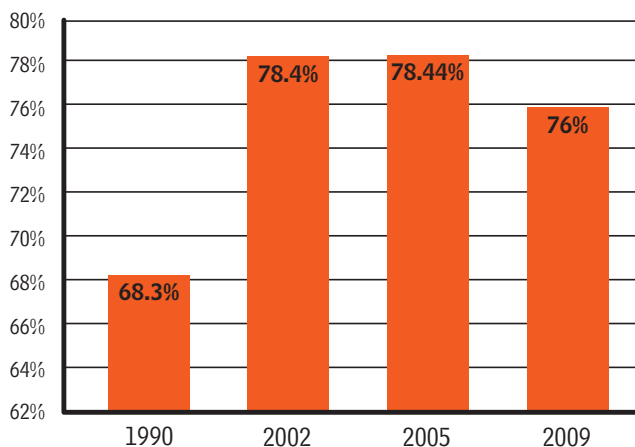
Prenatal Care, Infant Mortality and Teen Pregnancy

Vision of Success: “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 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.”

WHAT DO THE DATA TELL US?

Arkansas has made progress in the areas of healthy pregnancies and births during the past two decades, yet the state lags behind the rest of the nation in many areas. As of 2007, the state’s birth rate remained at 14.6 births per 1000 people, slightly above the national average of 14.3.⁶⁴ From 2002 to 2009, the percentage of Arkansas women who sought prenatal care has *declined* by 3 percentage points to 76 percent. The national rate is 83.9 percent. The percent of low-birth weight babies in Arkansas grew from 8.6 percent to 8.9 percent.^{66 67} These statistics show that Arkansas hasn’t improved in ensuring women receive prenatal care to help reduce infant mortality.

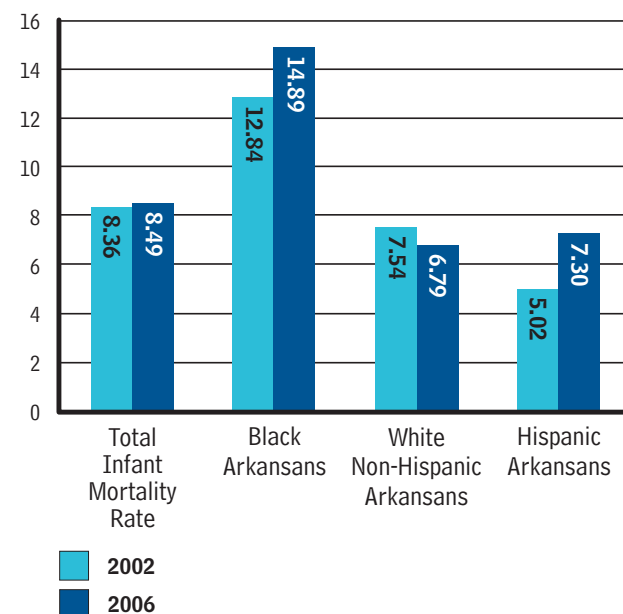
Percent of Pregnant Women Who Sought Prenatal Care, Arkansas



Source: *The Current Birth Data by State, Region and County: A Monthly Profile of Selected Public Health Indicators for Arkansas Counties, May 2010*

More alarming is the growth in infant mortality, one of the most important indicators of a community’s overall health. Studies showed an overall increase to 8.5 infant deaths per 1000 births in 2006, leaving the state far behind the 2007 national rate of 6.75.^{68 69} Infant mortality highlights high racial disparities as well; in 2006, 14.9 of every 1000 African American infants in Arkansas died; this rate is 12.5 percent higher than the national average of 13.2 for African Americans.^{70 71} In 2006, the top causes of neonatal death were birth defects and low birth weight, while the leading causes of infant deaths were Sudden Infant Death Syndrome (SIDS) and birth defects.⁷² Many of these deaths could be prevented with proper prenatal care and patient education on safe sleep practices. Low birth weight deaths are going up and are thus being thoroughly examined.⁷³

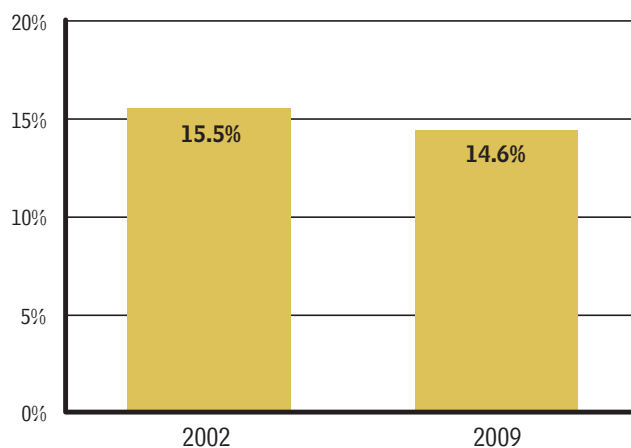
Infant Mortality Rate per 1,000 Births, Arkansas



Source: Arkansas Center for Health Statistics Query System

The teen birth rate in Arkansas remains 45 percent higher than the national average, despite improvements since the 1990s. In 2009, 14 percent—or one of every seven—births in Arkansas was to a teenager between the ages of 15 and 19.^{74 75} This parallels the fact that 39 percent of Arkansas teens are sexually active, an increase of almost 10 percent since 2005.⁷⁶ Twice as many Arkansas adolescents—one in ten—have sexual intercourse before age 13 compared to the national rate. One in five teenagers has had four or more sexual partners.⁷⁷ These risky sexual behaviors contribute to generational cycles of early childbearing and poverty but could be allayed with comprehensive sexual health education.

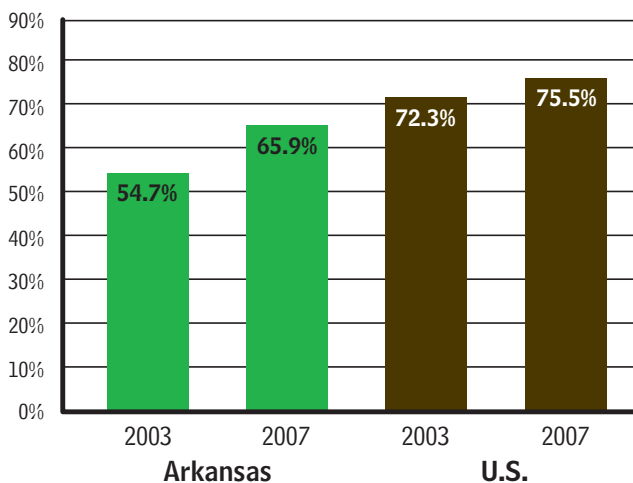
Percent of Arkansas Births to Teenagers



Source: *The Current Birth Data by State, Region and County: A Monthly Profile of Selected Public Health Indicators for Arkansas Counties, May 2010*

Other factors affect the health of infants from the start. In 2009, 15 percent of Arkansas babies were born to smoking mothers, down from 18 percent in 1990.⁷⁸ The national average is 13.8 percent.⁷⁹ Smoking during pregnancy can cause birth defects, low birth weight, and other lifelong health problems for the child. Breastfeeding has been shown to help babies avoid infections and establish a bond between the mother and child, among other benefits.⁸⁰ Nationally, women initiated breastfeeding for about 75 percent of babies in 2007; in Arkansas the rate was 66 percent—up from 55 percent in 2003.⁸¹ The number of children exclusively breastfed at 6 months in Arkansas was just 11.8% in 2010, leaving room for improvement.⁸² The Affordable Care Act requires employers to provide reasonable break time and facilities that allow nursing mothers to continue to feed children breast milk after returning to work.⁸³

Percent of Children 0-5 Who Were Ever Breastfed



Source: National Survey of Children's Health

PROGRESS ON 2008 RECOMMENDATIONS

Many programs are working together across systems to remove institutional barriers and improve outcomes for mothers and children as recommended by the 2008 Natural Wonders report, despite a lack of significant improvement in some statistics.

- The Antenatal and Neonatal Guidelines, Education and Learning System (ANGELS) program at the University of Arkansas for Medical Sciences (UAMS) is helping women with high-risk pregnancies access critical prenatal care by using real-time video conferencing (telemedicine) to diagnose and treat patients around the state. In 2009, ANGELS answered more than 118,000 calls, provided more than 2,000 video consultations, and provided teleconferenced medical education to 45 states and rural Arkansas.⁸⁴
- Another telemedicine endeavor under the umbrella of ANGELS is the TOUCH program (Telemedicine Outreach Utilizing Collaborative Healthcare), which partners UAMS with Arkansas Children's Hospital and nine outlying hospitals in an effort to reduce neonatal and infant mortality. To achieve this goal, TOUCH ensures that the tiniest Arkansas babies have access to the care they need and testing for heart defects.⁸⁵
- STAR-Health, a grant-funded program sponsored by the Arkansas Minority Health Commission, began work in 2009 in Chicot, Desha, and Lincoln counties. It addresses maternal and child health outcomes and other initiatives through the use of community health workers in some of the counties most challenged by high infant mortality and lack of prenatal care. Community health workers are community members who are trained to help educate local families about prenatal care, parenting skills, and other health needs.
- Several initiatives are improving teen pregnancy outcomes. Eight new Coordinated School Health Wellness Centers help lower teen pregnancy rates in their school districts with preventive services. Some schools employing the Coordinated School Health model include reproductive health education as a component of their efforts. The Affordable Care Act provides money for "Personal Responsibility Education," which includes abstinence, sexual health, and pregnancy prevention. It also supports a Pregnancy Assistance Fund to educate parents on becoming positive role models.⁸⁶
- The Arkansas Infant Mortality Action Group (IMAG) works through the Natural Wonders Partnership to support infant death investigation, apply for grant funding, and bring stakeholders together to address high infant mortality, child abuse, and unintended pregnancies in Arkansas. The IMAG's Infant Death Review subgroup is exploring ways to investigate and categorize infant deaths and to educate the public and professionals about infant death.
- Substance abuse treatment for pregnant women and adolescents will be available under Medicaid in Arkansas beginning in July 2011, improving access to needed treatments and improved outcomes for these groups.⁸⁷ Treatment providers began enrolling and receiving certification to provide these services in March 2011.

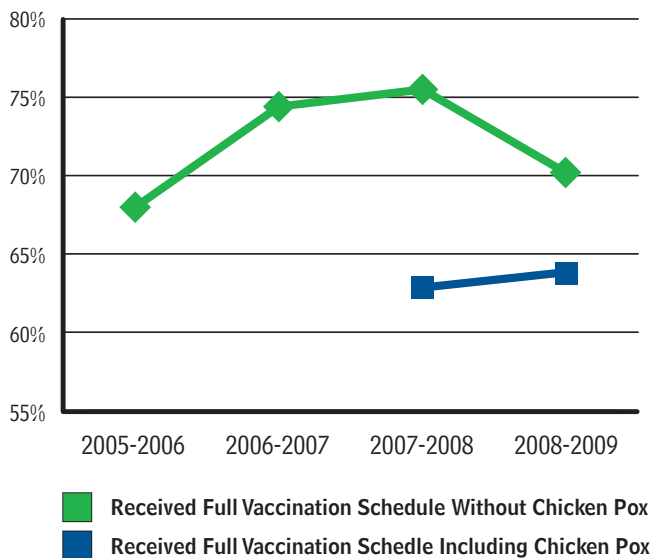
Immunizations

Vision of Success: “Infants, children, and adolescents are provided protection from communicable disease i.e. measles, chicken pox, etc.”

WHAT DO THE DATA TELL US?

Immunizations and the “herd immunity” created by them protect the population from a variety of contagious diseases. They also maintain very low prevalence of many historically deadly childhood diseases. Arkansas remains slightly behind the national average of 65.7 percent in vaccination coverage with 63.9 percent of Arkansas children between the ages of 19 and 35 months on target with the vaccination schedule recommended by the Centers for Disease Control and Prevention.⁸⁸

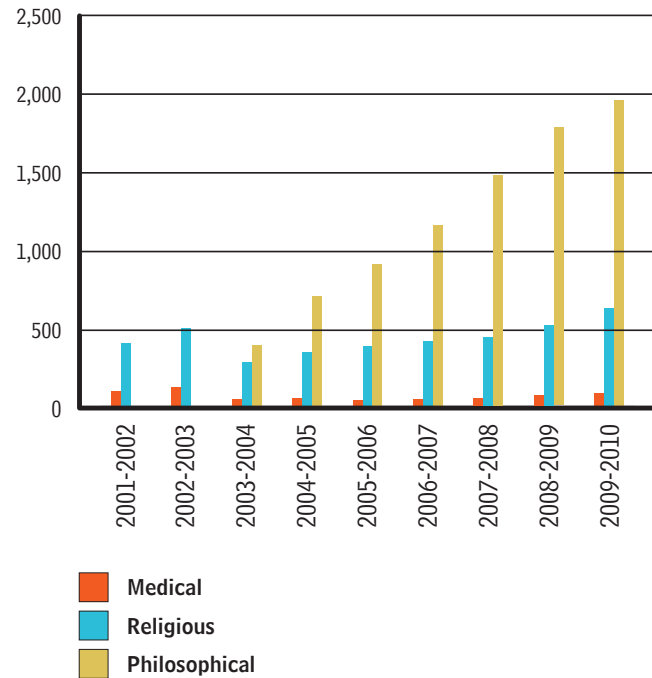
Vaccination Coverage for Children Age 19-35 Months, Arkansas



Source: Centers for Disease Control and Prevention, <http://www.cdc.gov/vaccines/stats-surv/imz-coverage.htm>.

However, the use of immunization exemptions has been steadily increasing over the past several years, especially since the addition of a new “philosophical” exemption option in 2003 and perpetuation of the medically unfounded link between autism and vaccinations.⁸⁹ The philosophical exemptions accounted for 73 percent of all exemption requests in 2009-2010. In the same school year, 2,714 Arkansas children remained unvaccinated, concerning public health officials about outbreaks of childhood diseases that have not been prevalent in decades.⁹⁰

Arkansas Vaccination Exemptions by Type



Source: Arkansas Department of Health, Dr. Haytham Safi

Concern is growing in the health care community about several Arkansas counties that have growing numbers of exemption requests. Studies show that exempt children are 35 times more likely to contract measles and nearly six times more likely to contract pertussis, also known as whooping cough, than vaccinated youth. Increases in the number of exempt children could put vaccinated populations at risk for an outbreak. Doubling the number of exempt children could increase infection in the vaccinated population by more than 30 percent.^{91 92} Needless to say, rising exemption rates could have enormous public health consequences for Arkansas children.



Counties with Highest Number Exemption Requests, 2009-2010 School Year

County	Total Exemption Requests
Benton	213
Washington	172
Pulaski	116
Sebastian	66
Faulkner	46
Garland	40
White	34
Carroll	33
Baxter	32
Arkansas	31

Source: Arkansas Department of Health, Dr. Haytham Safi



PROGRESS ON 2008 RECOMMENDATIONS

Arkansas has simplified the process of delivering and receiving childhood immunizations in order to improve immunization rates in Arkansas.

Counties with Highest Exemption Rates, 2009-2010 School Year

County	Exemption Rate per 1000 students
Carroll	13.57
Baxter	12.19
Stone	10.07
Arkansas	9.51
Benton	8.56
Searcy	8.06
Boone	7.90
Newton	7.89
Washington	7.26
Pike	6.51

Source: Arkansas Department of Health, Dr. Haytham Safi

- In 2009, the Arkansas departments of health and education and partners received national recognition for the fifth highest percentage of children immunized against H1N1 in the country through their school influenza campaign. ADH held 1,098 school events and gave more than 345,000 doses (H1N1 and seasonal) of vaccine in the school clinics. This success was due to collaboration among state agencies and community-based collaboration between school districts, local health units and community volunteers.⁹³
- The Immunization Network for Children, Arkansas's statewide immunization registry, is being used in all known immunization providers. Approximately 2,400 facilities including health care providers, schools, and daycares have access to the registry. It features round-the-clock provider access, immunization recommendations, and storage of immunization records.⁹⁴ This helps providers track vaccinations for their patients.
- The Arkansas Foundation for Medical Care has received a nearly \$300,000 U.S. Department of Health and Human Services grant to improve immunization reminder and recall systems to ensure that more children receive vaccinations. The study results will help health care providers in Arkansas implement immunization reminder and recall procedures.⁹⁵
- Coordinated School Health Wellness Centers will help to provide immunization services to their students. Eight Arkansas schools are currently in the first year of the program and will be providing these services to their students.

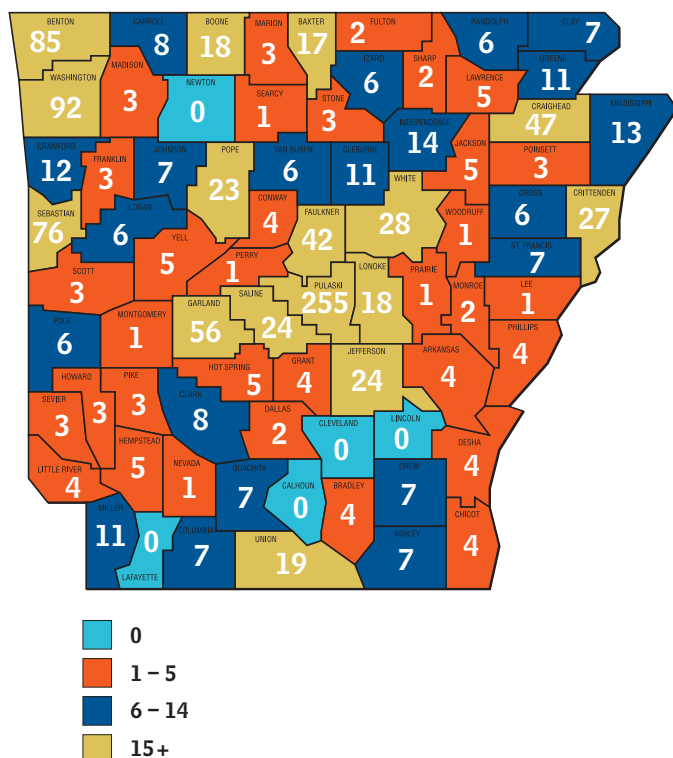
Oral Health

Vision of Success: “All children can access dental care no matter where they live or whether they can afford it.”

WHAT DO THE DATA TELL US?

Access to oral health care remains a challenge for underserved Arkansans. The number of dentists practicing in the state of Arkansas remains low but increased from 1,158 in 2005 to 1,178 in 2009. However, the number of dentists per capita remained relatively static at around 1 per 2,400 residents. The state gained six pediatric dentists during the past two years, for a total of 46.⁹⁶ There are just 53 low-income, community-based dental clinics around the state and only one school-based dental clinic, which is based in Little Rock.⁹⁷ Distribution of dental practitioners remains a challenge; **five Arkansas counties do not have a dentist at all**, and more than 60 percent of dentists practice in eight counties. The state's 1,194 practicing dental hygienists are similarly concentrated.⁹⁸ In 2009, 58.2 percent of dentists were enrolled in Medicaid, a drastic increase from 2005 when only 39.6 percent were enrolled.⁹⁹

Number of Dentists by County, 2008



Source: Adapted from “Oral Health in Arkansas, 2009” Arkansas Department of Health, Office of Oral Health

Children who are on ARKids First have better access to dentists who will treat them; in fact, 54 percent of Medicaid-enrolled children received some form of dental services in 2009, which is better than the national average.¹⁰⁰ However, all do not receive the care they need. A recent survey of several thousand third graders indicated an increase in kids who need routine dental care, from 21 percent in 2003 to 27 percent in 2010. Of these third graders, 64 percent had current or past dental cavities, 29% had untreated cavities, and 4 percent needed urgent dental care.¹⁰¹ Sealants, which have been shown to reduce cavities incidence and long-term restorative care in children, have been applied to the molars of less than a third of Arkansas children. Racial disparities are high for dental care, indicating that more effort should be made to improve access to care for minority children.

Oral Health Indicators of Arkansas 3rd Graders by Race

	White	Black	Hispanic
Untreated Cavities	26%	34%	31%
Cavities Experience	61%	69%	69%
Needs Routine Care	26%	28%	27%
Needs Urgent Care	3%	5%	3%
Sealants Applied	31%	17%	28%

Source: Arkansas Department of Health, Office of Oral Health, AR Smiles 2010. Arkansas Oral Health Screening 2010

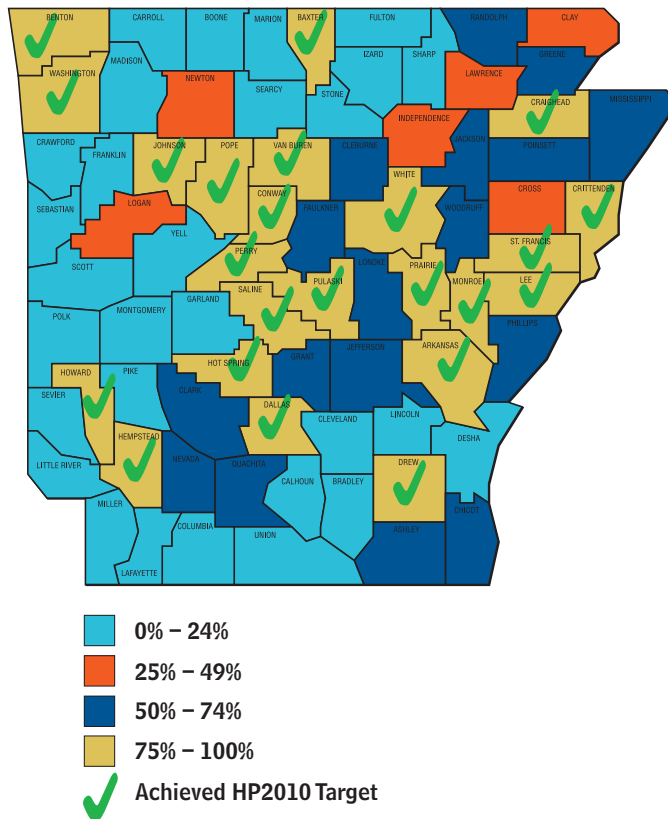
Community water fluoridation is a safe, effective, and economical way to prevent tooth decay, and increasing access to fluoridated water supplies is one of the *Healthy People 2010* objective set at 75 percent.¹⁰² Arkansas is making headway in fluoridating more of the state's water supplies. As of 2008, 65 percent of Arkansans using public water systems had access to fluoridated water, with another 1 percent to be added when El Dorado's fluoridation begins in March 2011. Several other cities have passed ordinances and are waiting for a fluoridation license. However, 23 counties do not have a fluoridated water system, and 12 percent of Arkansas's population receives water from springs or wells.¹⁰⁴

PROGRESS ON 2008 RECOMMENDATIONS

Several recent initiatives and funding opportunities have improved access to preventive and restorative oral health treatments for children in Arkansas.

- The Delta Dental of Arkansas Foundation has provided \$500,000 in grants to pay for fluoridation equipment for communities adding it to their water systems, and Arkansas is moving toward its goal of 75 percent fluoridation. At 65 percent fluoridation in public water systems, Arkansas is not far behind the national average of 72 percent.¹⁰⁵

Water Fluoridation



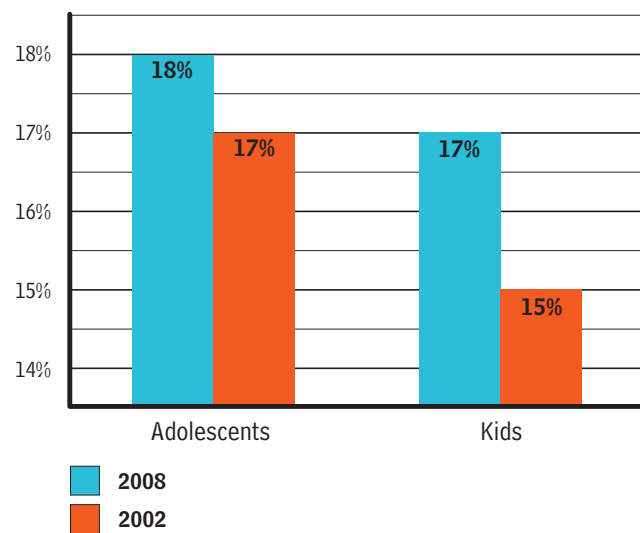
Source: Centers for Disease Control and Prevention. Water Fluoridation.
<http://apps.nccd.cdc.gov/gisdo/waterfluor.aspx>

- During the 2011 Arkansas General Assembly, Act 197 was signed into law, requiring water systems that serve more than 5,000 people to fluoridate their water. Additionally, Act 89 permitted dental hygienists to perform dental hygiene procedures in a public setting without the supervision of a dentist, greatly expanding capacity for public health dentistry. Act 90 authorized physicians and nurses to apply fluoride varnish to children's teeth, increasing the chance that they will receive this preventive service. Once implemented, these three acts will have a tremendous impact on the oral health of children. When all required water systems fluoridate, estimates suggest the percentage of Arkansans with access to fluoridated water will increase to 81%, exceeding the Healthy People 2010 75% target.
- Through a partnership with local Ronald McDonald House Charities, Inc.[®] chapters and corporate sponsorships from Delta Dental and Tyson Foods, Inc., Arkansas has two mobile Ronald McDonald Care Mobile[®] dental clinics managed and staffed by Arkansas Children's Hospital. A team of five dental professionals travel to elementary schools in Central, Northwest, and Southeast Arkansas as part of this program.

Each state-of-the-art mobile dental clinic provides full-service dental services to underserved children who do not have a dental home or regular source of dental care. Each clinic is estimated to see 1,000 children per year and to provide comprehensive dental care to the children it treats.

- Through Arkansas's Seal-the-State initiative, a partnership between Arkansas Children's Hospital, the Office of Oral Health at the Arkansas Department of Health, and local school districts, more than 2,400 children have received dental sealants, free of charge, since 2007. A complete set of portable dental equipment allows the program to operate around the state. Additionally, Seal-the-State promotes dental sealants to encourage more families to take advantage of this preventive measure.

Percent of Adolescents and Children with Applied Sealants, Arkansas



Source: "Oral Health in Arkansas" – ACH Office of Oral Health

- Legislation passed in 2009 regulates mobile dental clinics to ensure services are high quality and connected to community providers. Arkansas established regulations for the operation of these mobile dental clinics, and dental services provided in a mobile setting became a reimbursable service as of January 1, 2011.
- Coordinated School Health Wellness Centers will help to provide dental exams and access to a dentist. These centers will enable more children to receive school-based dental services.

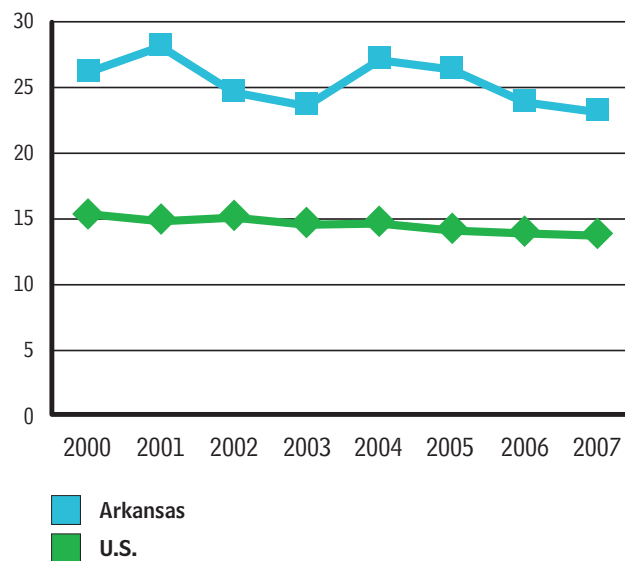
Reducing Risky Behavior – Injury Prevention

Vision of Success: “Significant injuries to infants, children, and teens are reduced or eliminated due to preventive steps taken by them and their parents.”

WHAT DO THE DATA TELL US?

Unintentional injuries remain the leading cause of death in Arkansas for children under age 24.¹⁰⁶ In 2007, Arkansas ranked 46th in the nation in child death rates, with almost half of the deaths due to unintentional injury.^{107 108} Total deaths and deaths due to unintentional injuries from 2000 to 2007 for various age groups remain much higher than national averages and are not improving much compared to national rates, although a few show improvement.

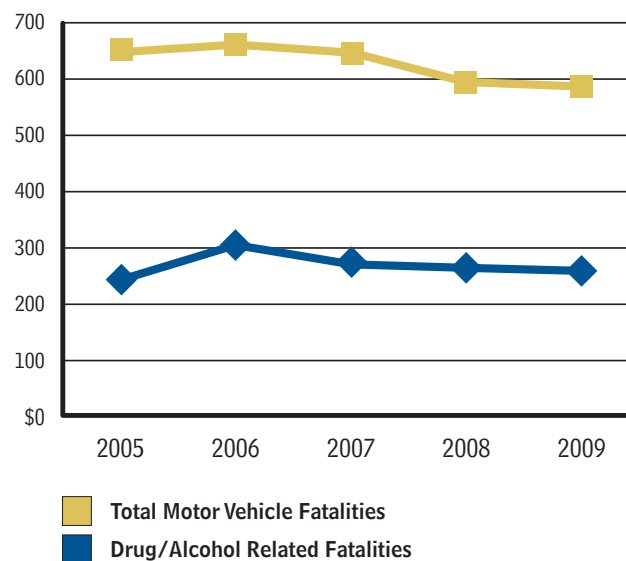
Unintentional Injury Mortality, Ages 0-19



Source: Centers for Disease Control and Prevention, WISQARS database

Unintentional **motor vehicle injuries** remain a large proportion of unintentional injury deaths. In 2007, almost 70 percent of unintentional injury deaths in children ages 5 to 14 involved a motor vehicle.¹⁰⁹ Additionally, drug and alcohol remain a factor in almost half of all motor vehicle fatalities for all age groups.¹¹⁰

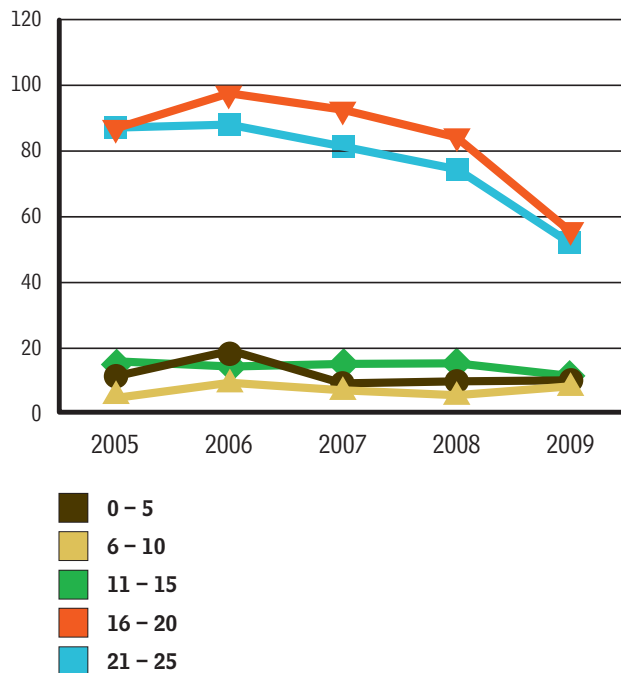
Drug/Alcohol-Related Motor Vehicle Fatalities in Arkansas, All Ages



Source: Arkansas State Police Crash Data and Arkansas Center for Health Improvement

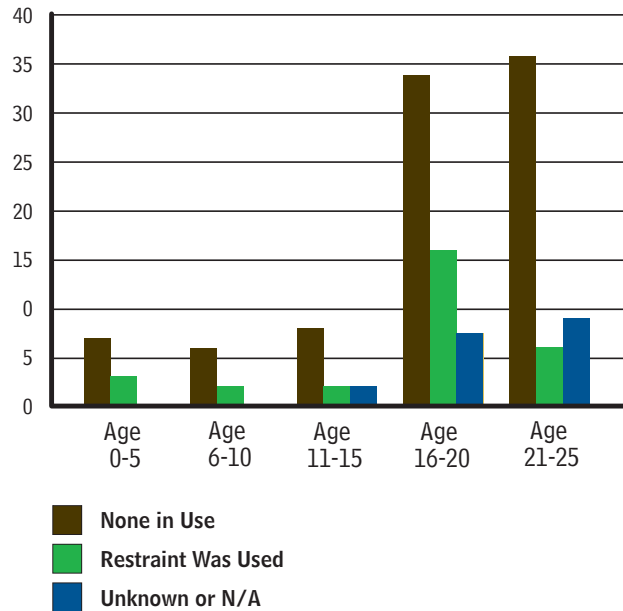
Motor vehicle fatalities are declining in adolescents. Between 2006 and 2009, motor vehicle fatalities declined by 43 percent. The primary seat belt law passed in early 2009 allows law enforcement officials to pull over drivers for not wearing a seatbelt without a corresponding offense could be one factor in this improvement. The majority of fatalities occurred when restraints were not in use.

Motor Vehicle Fatalities by Age Group, Arkansas



Source: Arkansas State Police Crash Data and ACHI

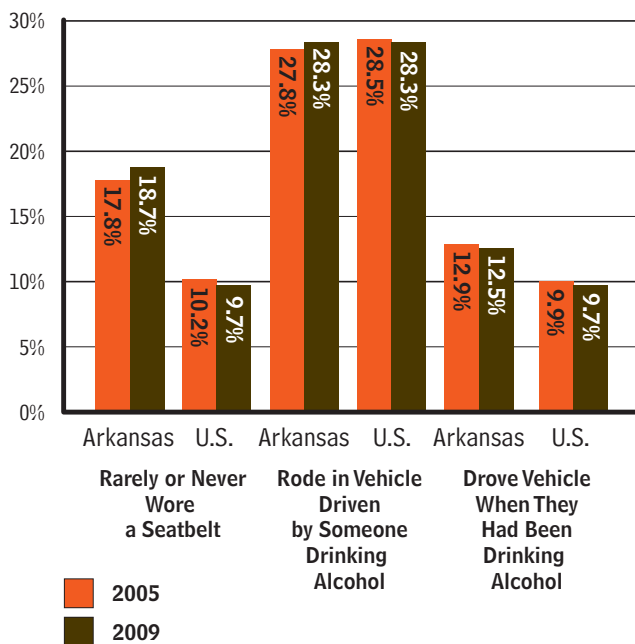
Motor Vehicle Fatalities by Restraint Use and Age in Arkansas, 2009



Source: Arkansas State Police Crash Data and ACHI

Teens continue to engage in risky behavior while driving. Seat belt use and drinking and driving put young adults at risk for severe injury and death.

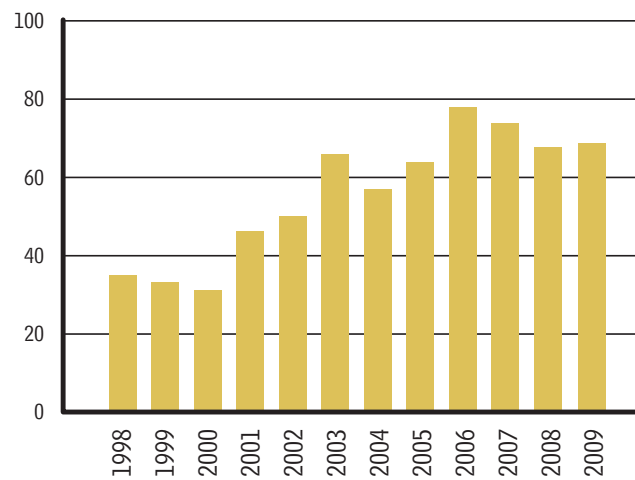
Risky Driving Behavior for Teens, Arkansas



Source: Youth Risk Behavior Surveillance Survey

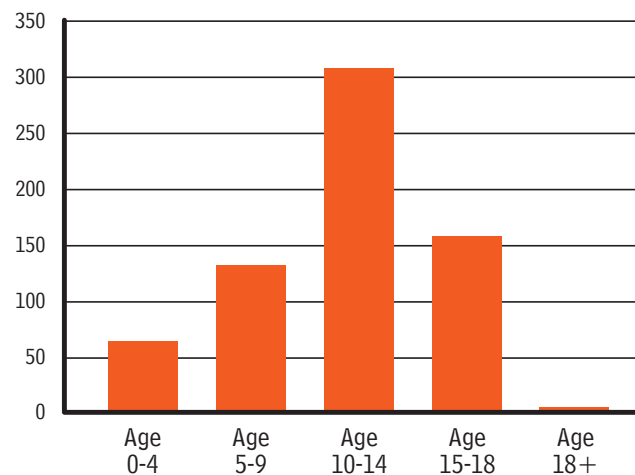
All-terrain Vehicles (ATVs) are a significant health challenge in the state, and their use is largely unregulated and does not require licensing or training. Arkansas Children's Hospital admits an average of one child per week with ATV-related injuries, and approximately 10 children die each year in ATV-related crashes.¹¹¹ Even more troubling is the increasing number of ATV-related crashes over the past 10 years—the majority of which occur when the child is driving the vehicle.¹¹²

ATV-Related Admissions to Arkansas Children's Hospital, 1998-2009



Source: Arkansas Children's Hospital Trauma Registry Data

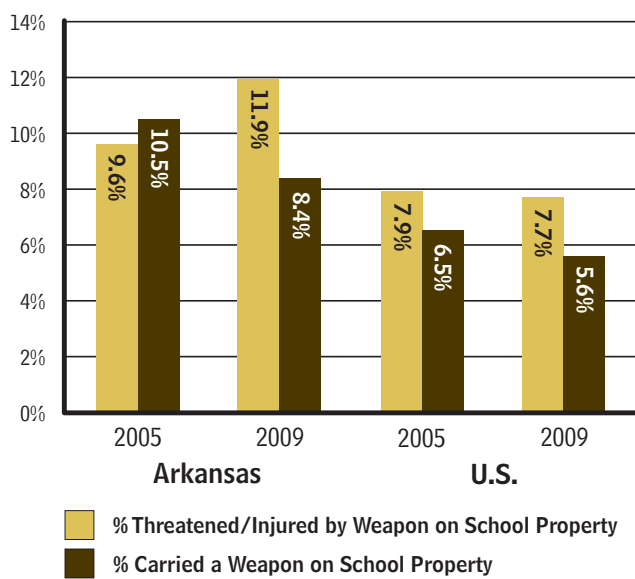
ATV-Related Admissions to Arkansas Children's Hospital by Age, 1998-2009



Source: Arkansas Children's Hospital Trauma Registry Data

Other risky behaviors continue to put kids at risk. The number of Arkansas teens who currently use alcohol has decreased from 43 percent in 2005 to 40 percent in 2009, compared to a 2009 national average of 42 percent. Schools remain an unsafe place for many Arkansas students: 12 percent of students have been threatened or injured with a weapon on school property, and more than 8 percent have carried a weapon to school.¹¹³

Trends in School Safety



Source: 2009 Youth Risk Behavior Surveillance Survey



PROGRESS ON 2008 RECOMMENDATIONS

Progress has been made in efforts to prevent unintentional injuries in children and adolescents in Arkansas since the 2008 report.

- Graduated Driver Licensing was implemented, restricting non-related passengers and late-night driving for teens. Teenagers under age 18 cannot use wireless phones while driving, and young adults age 18 to 21 must use hands-free devices. Texting while driving was banned for everyone. In 2009, Arkansas saw fewer deadly crashes that it has in past years, potentially in response to new restrictions.¹¹⁴
- A primary seat belt law was established, allowing officers to pull over and cite drivers for not wearing a seatbelt. A racial profiling task force was also established to address concerns that the seatbelt law could lead to increased racial profiling.¹¹⁵
- The tobacco tax increase funded a statewide trauma system to streamline medical care for traumatic injury. Seventy-three hospitals indicate that they will be a part of the system, which will be partially operational by January 2011.¹¹⁶ The leading cause of death for Arkansans between the first year of life and age 44 is unintentional injury,¹¹⁷ and research has shown that states with a comprehensive trauma system reduce fatalities and long-term disability caused by traumatic injuries.
- HealthTeacher.com, an online health curriculum for K-12 teachers that addresses the top six health risk behaviors identified by the CDC, is being used in more than 300 schools in Arkansas. Additionally, Coordinated School Health and the Injury Prevention Center at ACH work together on school-based efforts to reduce injury incidence.¹¹⁸
- Per the “Antony Hobbs III Act,” every school campus in Arkansas is now required to have an Automated External Defibrillator (AED) and personnel trained to use it. The Arkansas Department of Health distributed AEDs worth \$325,000 to every school in the state that needed one.¹¹⁹ The AEDs will allow schools to respond more quickly in emergency situations where students encounter unexpected heart problems.¹²⁰
- The Injury Prevention Center (IPC) at Arkansas Children’s Hospital provides services to reduce injuries of children. Efforts include the following:
 - o A partnership with the Arkansas Foundation for Medical Care and DHS provides injury prevention materials in physician offices throughout the state.
 - o Pedestrian and bicycle safety are promoted through Safe Routes to School (SRTS), a program funded by the Arkansas Highway Transportation Department. The Injury Prevention Center has an education grant from the department to promote Safe Routes and provide technical assistance to schools.¹²¹
 - o Injury Prevention Center programs encourage safe driving in teens and promote ATV safety and include the distribution of ATV Safety “toolkits.”
 - o Drive Smart Challenge, a youth-led, school-based program to increase safer teen driving behaviors has demonstrated increased seat belt use and decreased cell phone use in participating schools. .
 - o An evaluation of a parent-teen driving contract to encourage in-house rules enforcing strategies of graduated driver licensing. Funding for the evaluation is through an Arkansas Children’s Hospital Research Institute Intramural grant and the National Highway Traffic Safety Administration.
 - o Child Passenger Safety Technicians are trained throughout the state via a grant from the Arkansas State Police Highway Safety Office. An Arkansas-specific website gives caregivers and professionals local child passenger safety resources.
 - o Safety Baby Showers in Phillips and Clark County give mothers newborn safety education, a home safety kit, and car seats for their children. These showers should reach up to 600 mothers and also provide education about shaken baby syndrome and other coping strategies for new mothers. The program will expand to Ouachita and Union counties in summer 2010. In addition, a “train the trainer” model encourages community partners throughout Arkansas to implement their own Safety Baby Showers.¹²²
 - o A Statewide Injury Prevention Program works through the state’s new trauma centers and Emergency Medical Service providers provide better primary prevention services in communities. It is supported by the Arkansas Department of Health.¹²³
 - o Education programs are provided for nurse practitioners, medical students, nurses, and residents.
 - o Traumatic Brain Injury (TBI) is more prevalent in Arkansas than the U.S., yet Arkansas is one of only three states that does not have a state-funded TBI agency. The state’s TBI Task Force recommended the development of a TBI commission to establish a centralized TBI registry, link families to services, and advocate for TBI survivors.¹²⁴ The Injury Prevention Center at Arkansas Children’s Hospital was designated as the state leader on prevention of pediatric TBI for the south-central region as part of the National Pediatric Acquired Brain Injury (PABI) Plan.

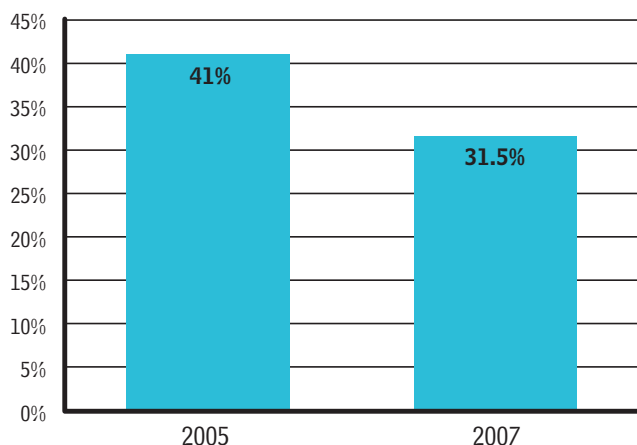
Tobacco Prevention

Vision of Success: "Tobacco use by children and teens is eliminated as is their exposure to indirect smoke."

WHAT DO THE DATA TELL US?

Arkansas children and adolescents are using fewer tobacco products than in years past, although the state still has room for improvement compared to the nation as a whole. The number of Arkansas children who live in houses with tobacco smoke has decreased from 41 percent to 31.5 percent in 2007, yet the state falls far behind the national average of 26.2 percent.¹²⁵

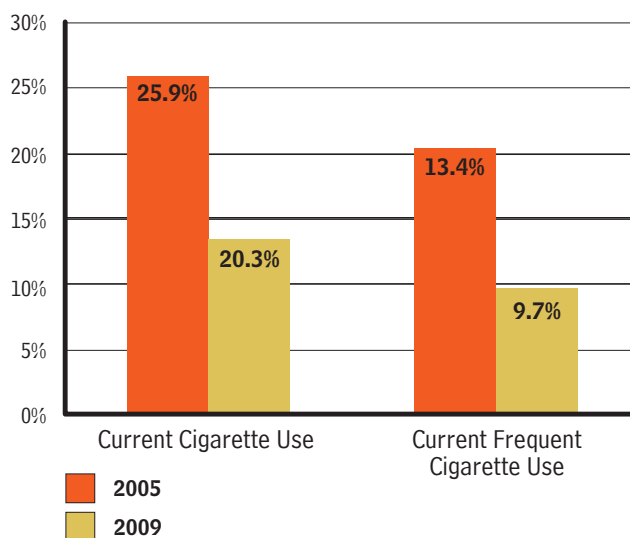
Percent of Arkansas Kids Who Live in Houses with Tobacco Smoke



Source: National Survey of Children's Health

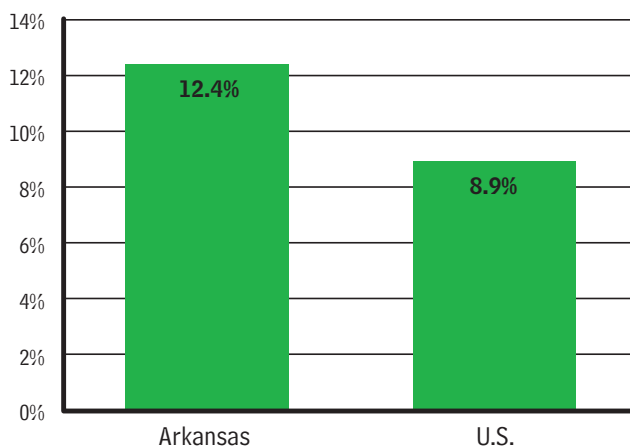
Tobacco use by teenagers is also decreasing. In 2009, 20.3 percent of teenagers reported that they currently smoke cigarettes, down from 25.9 percent in 2005. In 2009, 9.7 percent of teens reported frequent cigarette use—a 28 percent decrease from 2005. Nationally, 19.5 percent of teens smoke; Arkansas ranked 49th in teen smoking rates in 2010. Smokeless tobacco use is 40 percent higher than the national average at 12.4 percent of Arkansas teens.^{126 127}

Teenage Smoking Habits, Arkansas



Source: 2009 Youth Risk Behavior Surveillance Survey

Percent of Teenagers Using Smokeless Tobacco, 2009



Source: 2009 Youth Risk Behavior Surveillance Survey

PROGRESS ON 2008 RECOMMENDATIONS

- Arkansas passed Act 180 during the 2009 legislative session, raising the state tax on cigarettes by 56 cents and also taxes other tobacco products. This discourages young people from starting to smoke and curbs overall tobacco use rates. Additionally, the tax was estimated to raise \$71 million annually to support health-related initiatives.¹²⁸
- Coordinated School Health Wellness Centers were funded by the state cigarette tax increase and the Department of Health Tobacco Prevention and Cessation program and include tobacco prevention activities in their initiatives.
- Arkansas passed Act 13, The Arkansas Protection from Secondhand Smoke for Children Act, in 2006. The act protects children who are restrained in a child safety seat from the dangers of secondhand smoke. Arkansas was the first state in the nation to enact a law that made it a primary offense for someone to smoke in a car with a child; quickly, other states have followed suit with efforts to enact even stronger protective measures. Efforts continue in Arkansas to educate the public about this important law and the impact that secondhand smoke has on non-smokers.
- Thirteen Coordinated School Health School Districts have adopted Comprehensive Tobacco Policies that include all of the Centers for Disease Control and Prevention's recommended eight fundamental elements for including instruction on avoiding tobacco use, prohibition against tobacco marketing, and other prevention components that are stronger than the state requirement.
- The Youth Extinguishing Tobacco, or Y.E.S. Team, is a statewide, youth-led anti-tobacco movement working through schools, community groups and anti-tobacco coalitions to eliminate tobacco use. Y.E.S., which is organized by the Tobacco Control Youth Board into statewide teams, grew to more than 2,500 youth members in 2010. They have been instrumental in successful initiatives such as a smoke-free zoo in Little Rock, tobacco-free parks in Little Rock, North Little Rock and across the state, and many other efforts to encourage their peers and adult mentors to live, work and play tobacco-free.



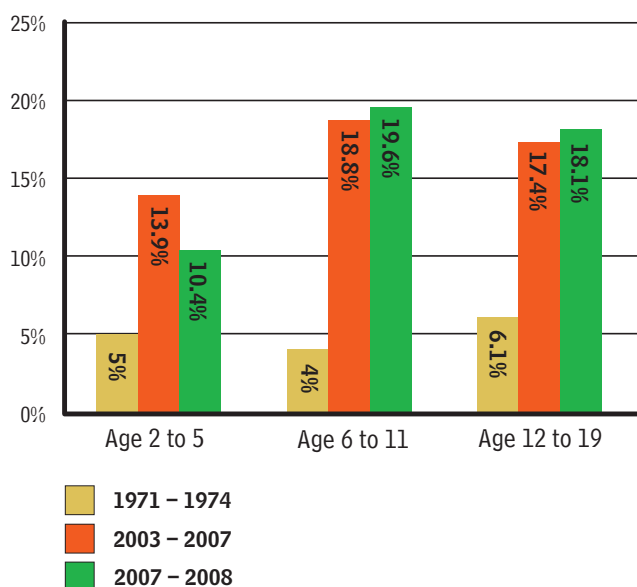
Obesity Prevention

Vision of Success: “The childhood obesity epidemic is eliminated in Arkansas.”

WHAT DO THE DATA TELL US?

Obesity in Arkansas and the nation is high. The prevalence of obesity continues to be an issue for children across the United States. The disease is a risk factor for a host of chronic diseases including heart disease and type II diabetes. Nationally, almost one of every 5 children is considered obese, and 38 percent of Arkansas children are overweight or obese, a fairly static rate over the past 6 years.¹²⁹ The good news is that obesity does not appear to be growing significantly, but a reduction in obesity rates would be beneficial to children’s health. Obesity is defined as having a Body Mass Index (BMI) at or above the 95th percentile for children of the same sex and age, and children are considered overweight when their BMI is between the 85th and 95th percentile.¹³⁰

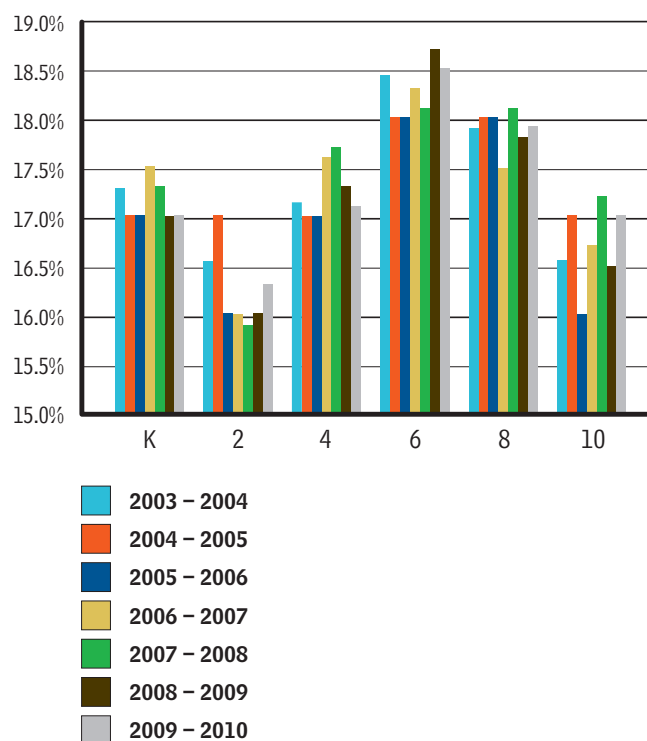
Prevalence of Obesity, U.S.



Source: Centers for Disease Control and Prevention, Overweight and Obesity

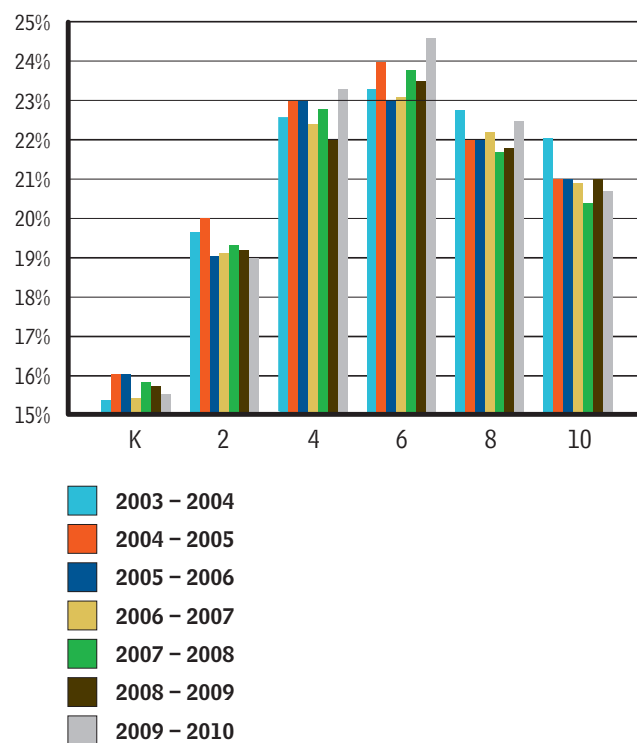
Since 80 percent of overweight children remain overweight as adults, there is much work to be done.¹³¹ Some studies show improvement in the way students view their weight. Of Arkansas students in grades 9 through 12 surveyed in the 2009 Youth Risk Behavior Surveillance, 27.3 percent of students identified themselves as overweight compared to 33 percent in 2005. The number of students trying to lose weight decreased from 50 percent in 2005 to 45.8 percent, compared to 44.4 percent nationally.¹³² Through a partnership between the Department of Health, the Department of Education, and the Arkansas Center for Health Improvement, the state has been tracking BMI rates in school children since 2003. Schools notify parents if a child’s BMI is of concern. These numbers are also useful for tracking obesity rates from year to year.

Overweight Children by Grade, Arkansas



Source: Arkansas Center for Health Improvement

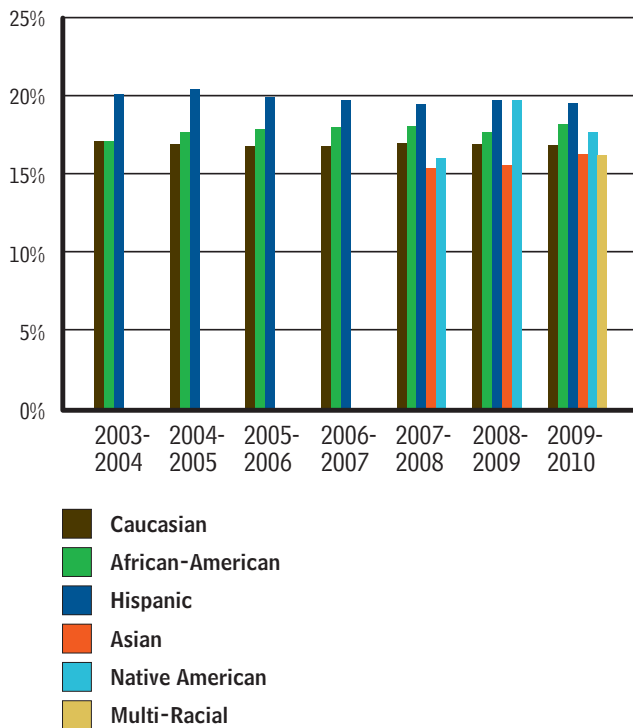
Obese Children by Grade, Arkansas



Source: Arkansas Center for Health Improvement

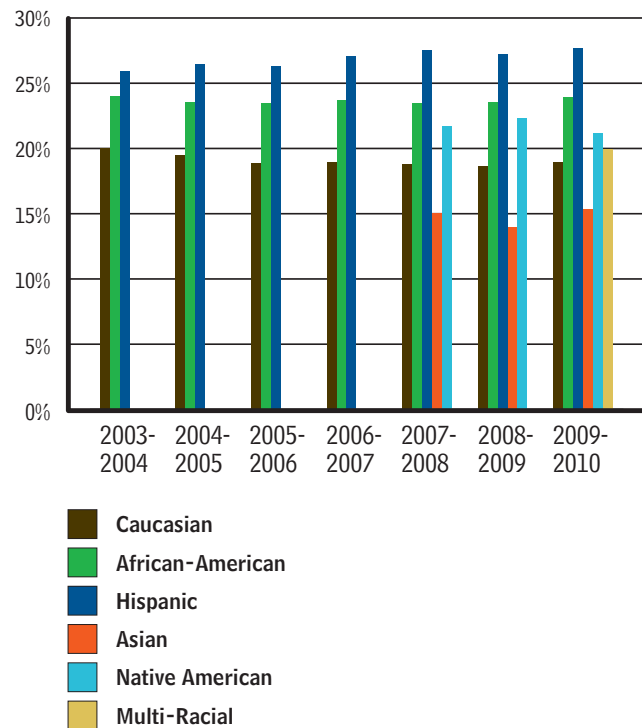
Racial disparities continue to exist within the prevalence of overweight and obesity. African Americans, Hispanics, and Native Americans tend to have higher BMI measurements than do Caucasian or Asian Americans. Hispanics continually appear to have the highest percentage of obesity. Poverty and other factors that also affect minorities disproportionately contribute to the prevalence of obesity.

Overweight School Children by Race, Arkansas



Nutrition and physical activity need improvement. Nutrition and physical activity are growing concerns, and Arkansas trails the nation in most areas including fruits and vegetables consumed, sodas consumed, and hours of physical activity.¹³³ These statistics all point to the reality that Arkansas children are not receiving proper nutrition or physical activity, both risk factors for obesity.

Obese School Children by Race, Arkansas



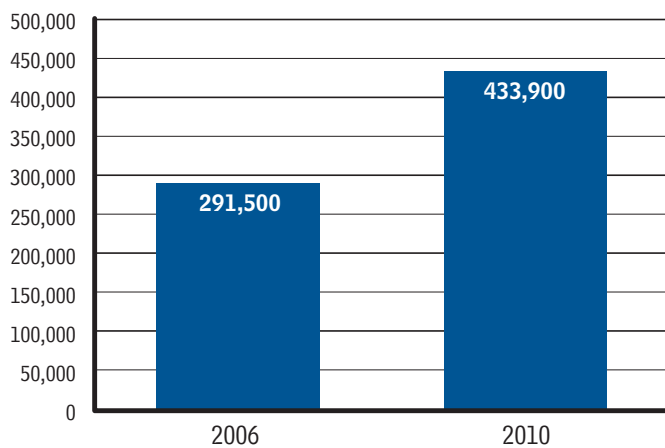
Nutrition and Physical Activity Trends in High School Students

	Arkansas	U.S.
Ate fruits or vegetables 5+ times a day	14.9%	22.3%
Drank 3+ glasses of milk a day	8.5%	14.5%
Drank at least one soda per day	33.5%	29.2%
Attended physical education classes daily	22.7%	33.3%
Reported 5 days per week of physical activity	42.0%	37.0%
Did not participate in any physical activity	19.5%	23.1%
Watched 3+ hours of television daily	36.4%	32.8%

Source: 2009 Youth Risk Behavior Surveillance Survey

Food insecurity and hunger are challenges for many Arkansas families. Food insecurity means that at some point, a family lacks access to enough food for an active, healthy life. Arkansas is ranked first in child food insecurity, with almost one-fourth of all Arkansas children (166,371 children) experiencing food insecurity in 2006-2008. This is a drastic increase from 2005-2007, when only 18.3 percent were in this category.^{134 135} Many Arkansans struggle to consume food that meets their dietary needs. Low-income families often lack access to nutritious foods as well as knowledge, skills and tools to prepare foods that are available to them. Researchers and clinicians are realizing that individuals can be both obese and hungry. Rates of food assistance are increasing, likely due to effects from the national recession, and the number of people receiving assistance from food banks in Arkansas increased by almost 50 percent from 2006 to 2010.¹³⁶

Individuals Receiving Aid from Feeding American Food Banks, Arkansas



Source: Arkansas Hunger Relief Alliance – “2010 Hunger Study”

Hunger and food security are directly linked to poverty and lack of access to resources. Improving the economic security of families will ultimately lead to self-sufficiency. In 2009, 163,571 Arkansans were served by the Women, Infants, and Children program (WIC), which provides supplemental nutrition to pregnant or breastfeeding women and children under age 5, and 573,299 received aid from the Supplemental Nutrition Assistance Program (SNAP).

School breakfasts, lunches and summer-time feeding programs have helped Arkansas improve food security for many children. Since 2006, the number of Arkansas students receiving free or reduced-price meals has increased by 11 percent to 286,652 children during the 2009-2010 school year. The number of children participating in the summer feeding program has grown by almost 40 percent since 2006, with 1.1 million children receiving assistance in 2009.¹³⁷



PROGRESS ON 2008 RECOMMENDATIONS

Arkansas has become a national leader in obesity prevention through policy, infrastructure development, and community-level awareness and intervention work. The Arkansas Coalition for Obesity Prevention, a network of dozens of partners working to address the obesity epidemic, encourages healthy eating and physical activity by engaging stakeholders from community centers, faith-based organizations, work places, schools, and other facilities in its mission.¹³⁸ The Child Health Advisory Committee was created as a part of Arkansas Act 1220, which combats childhood obesity through a variety of initiatives, to address childhood obesity and develop statewide nutrition and physical activity standards. The sixth-year evaluation of Act 1220 found that school environments continue to get healthier for students due to policy changes, availability of healthy food, and assessment of students' Body Mass Index.¹³⁹ Community Health Nurse Specialists and Community Health Promotion Specialists work through Coordinated School health initiatives to oversee efforts within schools.

- The Joint Use Agreement Grant is a new grant available through the Department of Education funded by the tobacco tax increase. It promotes healthy lifestyles through community partnerships by encouraging schools and other community organizations to share indoor and outdoor spaces such as gymnasiums, athletic fields, playgrounds and walking tracks. These facilities help children and adults be more physically active and lead healthier lifestyles. Twenty-five schools around the state have been awarded JUA funds.¹⁴⁰
- The Safe Routes to School initiative, now in its third year, educates children about safety when walking or biking to school. The program also helps develop the infrastructure to ensure the safety of children who do walk or bike to class.¹⁴¹
- HealthTeacher.com's curriculum, funded by Arkansas Children's Hospital, is being used in more than 300 Arkansas schools to integrate health-related education into classrooms daily. Teachers agree that HealthTeacher.com has enhanced students' health advocacy, enhanced teachers' connections with students, and improved classroom culture.¹⁴²
- The Child Wellness Intervention Project (CWIP) promotes quality physical education in schools to reduce chronic disease in children. The state's 50-plus CWIP grantees receive curriculum, training, and resources; HealthTeacher.com and SPARK physical education will serve as primary resources for the schools.¹⁴³
- Growing Healthy Communities is an initiative driven by the Arkansas Coalition for Obesity Prevention to improve access to physical activity and healthy, affordable foods, as well as drive policy changes. Ten funded and eight unfunded communities around the state have been selected to receive training, materials, and technical assistance.¹⁴⁴
- The Affordable Care Act (ACA) includes several provisions aimed at reducing obesity. Federal dollars will support a Prevention and Public Health fund to reduce obesity as well as Childhood Obesity Demonstration Projects. New health plans will be required to cover obesity screening and counseling for children and adults with no fees. The act also requires a menu labeling provision for restaurants with more than 20 locations starting in 2011. Nutritional information will be displayed prominently on menus and menu boards to inform eaters.¹⁴⁵
- The Delta Garden Study is a \$2 million research study on integrating school gardens into core class curricula to prevent childhood obesity, reduce risky behaviors, and improve academic achievement in middle school children in the Delta and Central regions of Arkansas. The study supports the Farm-to-School effort by providing fresh, locally grown produce to schools. It is the largest and most scientifically rigorous school garden research study in the nation. The Delta Garden Study is funded through a cooperative agreement between Arkansas Children's Hospital Research Institute and the USDA Agricultural Research Service's Delta Obesity Prevention Research Unit. In addition, they have received funding from the Arkansas Community Foundation to purchase cooking supplies for use in recipes and taste-tests.¹⁴⁶
- The Nutrition and Physical Activity Self Assessment for Child Care (NAP SACC) program encourages nutritious food, physical activity, staff-child interactions, and improved nutrition and activity policies in child care settings. In 2009-2010, 60 programs participated in the project.¹⁴⁷
- The Arkansas No Kid Hungry Campaign is a partnership between the Arkansas Governor's Office, Share Our Strength and the Arkansas Hunger Relief Alliance. The campaign includes multiple stakeholders and seeks to increase availability of nutritious foods to low income families and children in the state. The targeted areas include: ensuring families eligible for SNAP benefits access the program, increase the number of USDA summer feeding sites available and the children participating in the program, and to increase school breakfast participation rates in Arkansas schools. The program began in the fall of 2010 and has already seen improvements in all targeted areas.

Mental Health Services

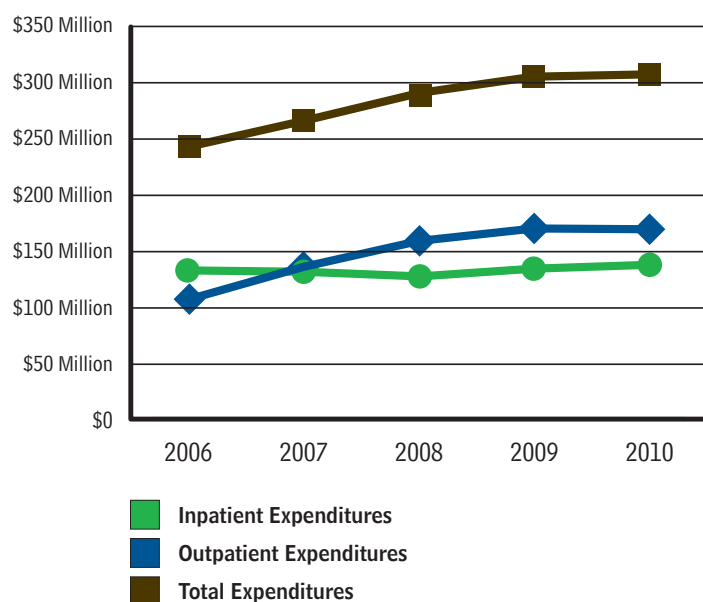
Vision of Success: “All children, youth, and their families have access to services and supports to treat and maintain health and mental health, which will improve quality of life and promote life-long good health.”

WHAT DO THE DATA TELL US?

Mental health services in Arkansas have been changing rapidly in recent years. The Arkansas Department of Human Services has been building the capacity of communities to offer wraparound services to youth in need of mental health services since the Children’s Behavioral Health Care Commission was created in 2007 to establish a System of Care. Fourteen demonstration sites around the state established local care teams, wraparound care coordination, and respite and intensive family services. Each community also hired a community care director and a wraparound specialist to oversee the coordination of care. DHS supports the System of Care with training and technical assistance, developing standards, and exploring additional services.¹⁴⁸

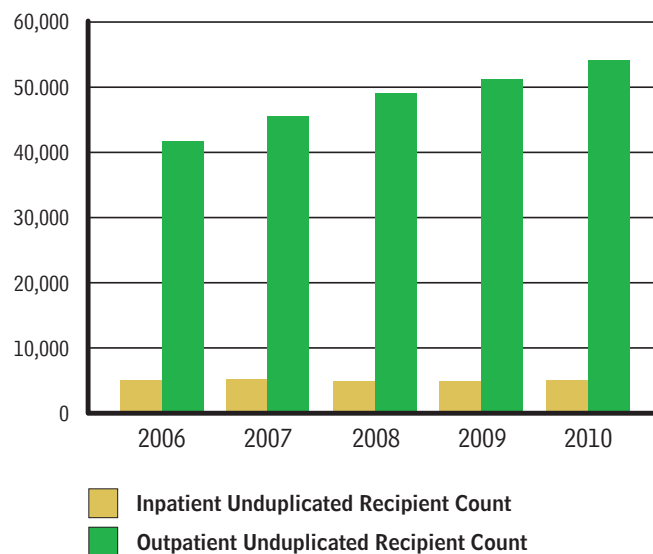
Arkansas has seen rapid growth in children’s Medicaid expenditures for mental health. Between 2006 and 2010, total spending on mental health for children under 21 grew by 27 percent, while the total number of patients seen grew by 29 percent.

Medicaid Expenditures, Children’s Mental Health Services



Source: Arkansas Department of Human Services

Arkansas Medicaid Recipients, Children’s Mental Health Services



Source: Arkansas Department of Human Services

Community-based clinical and rehabilitative mental health treatment that allows patients to remain in their homes is a priority across the state. More than 55,500 patients under age 21 received outpatient mental health services in State Fiscal Year (SFY) 2010, according to the Arkansas Department of Human Services Division of Medical Services RSPMI SFY2010 Program Analysis.¹⁴⁹ When necessary, referrals to the Arkansas State Hospital were made; 116 youth under age 18 were treated there in 2009, an increase from 2005.¹⁵⁰

The 2009 Youth Risk Behavior Surveillance survey showed that Arkansas teens exhibit higher mental health symptoms than the teens nationally. Arkansas’s System of Care and other initiatives are making mental health services available to more children and address their needs.¹⁵¹

Mental Health Indicators, 2009

	Arkansas	U.S.
% youth feel sad/ hopeless	28.1%	26.1%
% youth seriously considered suicide	18.0%	13.8%
% kids made plan for suicide	14.1%	11.0%
% youth attempted suicide	12.0%	6.3%

Source: 2009 Youth Risk Behavior Surveillance Survey

PROGRESS ON 2008 RECOMMENDATIONS

- Progress on the Arkansas System of Care (SOC) meant more children were helped through a community-based, team approach that involves children, youth, and their families as full partners with providers and schools.¹⁵² The System of Care facilitated 506 multi-agency action plans and wraparounds as of July 2010. Core elements at the community level include development of Care Coordinating Councils headed by a Community Care Director, funding and training for wraparound care coordination, local care teams, and flexible funds for nontraditional services and supports.
- Each county now has designated providers of Intensive Family Services (IFS), which are time-limited intensive counseling and skill building support services that help families learn how to stay together. The service is for families whose children are at imminent risk being removed. IFS adopted the North Carolina Family Assessment Scale to measure mental health outcomes and assure quality service.¹⁵³
- The Family Youth Assistance Network (FYAN) provides leadership and direction to key SOC projects and works with families, youth, and family organizations to ensure the SOC is family driven, youth-guided, and child-centered. FYAN is working with DHS to implement Arkansas Wraparound Training Academies and online resource directories.¹⁵⁴
- Action for Kids, a federally funded¹⁵⁵ pilot in northeast Arkansas, provides comprehensive mental health services for children, youth, and families in Craighead, Lee, Mississippi, and Philips counties. Action for Kids was recognized by federal project officers as a national leader in the development of a model program for wraparound services and for the success it is showing in youth and family ownership and their treatment.¹⁵⁶
- In the Action for Kids counties, 37 schools participate in Positive Behavior Interventions and Support (PBIS), which helps schools to be effective learning environments for all students.¹⁵⁷ Schools that have participated in PBIS for four years have had a 45 percent average decrease in office discipline referrals. During three years, the 16 four-year schools saved almost \$34,000 from the decreased time students, teachers, and administrators spent on discipline.¹⁵⁸
- In 2010, the Youth Outcome Questionnaire was rolled out in Arkansas to ensure every child entering the behavioral health system receives the same standardized assessment. The regular use of the questionnaire will help clinicians and families make more informed and collaborative decisions about the progress and status of youth receiving therapeutic services.¹⁵⁹
- The Early Childhood Mental Health Consultation Project places mental health professionals in early education classrooms to train teachers and work with students. The program will develop an early childhood mental health model that is tailored to the needs of Arkansas. The program's social-emotional and mental health interventions have improved the classroom environment for students and teachers and reduced physical aggression.¹⁶⁰



- Arkansas community-based services have been expanded to reach youth in need.
 - o In 2009, the legislature dedicated general improvement funds to substance abuse, rehabilitation centers, and substance abuse prevention. DHS is planning to implement the first phase of substance abuse treatment in spring of 2011.¹⁶¹
 - o Revisions were made to the Rehabilitative Services for Persons with Mental Illnesses program (outpatient treatment) to improve access to medically necessary services and promote individualized treatment plans. The revisions also call for increased role for caregivers during treatment, which helps ensure long-term success.¹⁶²
 - o The Division of Youth Services partnered with Youth Bridge to address serious antisocial behavior in juvenile offenders through Multi-Systemic Therapy and with United Family Services and Community Services to provide a community-based Youth Advocate Program to address youth violence.

Capacity Building

PROGRESS ON 2008 RECOMMENDATIONS

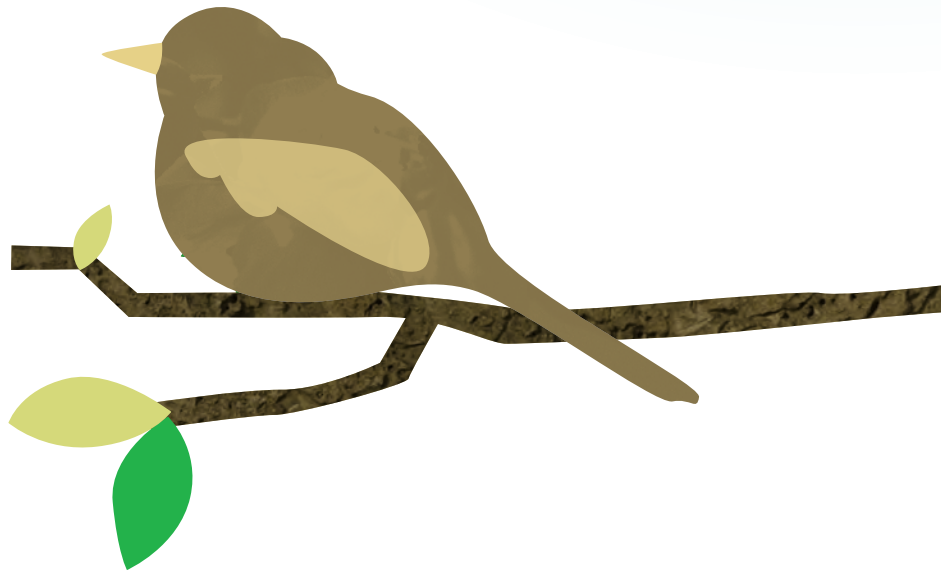
In the 2008 Natural Wonders report, suggestions were made for new or improved services that would benefit Arkansas children by establishing a coordinated set of interventions to improve their health and welfare. In addition to other successes mentioned earlier in the report, efforts highlighted below contributed to improving the capacity of institutions and organizations to improve the health of children.

- Children have increased access to care. Preventive services and medical care are being offered in unique settings across the state to improve access to care, including school health efforts, mobile dental clinics, and telemedicine consultations, and they are offered by a variety of providers from community health workers to home visiting professionals.
- SHARE, the State Health Alliance for Records Exchange, will be Arkansas's system of electronic health records exchange. When fully operational, SHARE will provide access to appropriate personal health information, allowing parents, providers, and schools to coordinate health services and access electronic health records in a secure and timely manner. Additionally, SHARE will be able to monitor and notify physicians about prescription information, immunizations, follow-up care, and chronic diseases.¹⁶³



- The Arkansas Foundation for Medical Care and DHS are collaborating on an initiative to ensure families establish a medical home. The Patient-Centered Medical Home is an approach to assuring comprehensive primary care for children, youth, and adults by facilitating partnerships between individual patients and their personal physicians.¹⁶⁴
- Families have better access to information about their children's care. HIPPIY, Better Beginnings, and other early childhood education efforts are ensuring that parents are better informed about the quality of services their children receive by publishing standards and establishing quality ratings. Arkansas Early Childhood Comprehensive Systems (ECCS) has collaborated with other early childhood stakeholders to address other early childhood system efforts such as standardized developmental screening tools and sharing resources.¹⁶⁵

- State-level collaborations impact specific issues. Through Natural Wonders, Arkansas Children's Hospital has opened communication among those interested in children's health issues and encouraged local agencies to take the lead on certain issues. In addition to the Natural Wonders Partnership Council, these include the School Health Action Group, the Infant Mortality Action Group, and several other health literacy initiatives.
- Arkansas is planning for an increased demand for health professionals. Efforts include a fast-track nursing program at UAMS that grants a Bachelor's of Science in Nursing to college-degree holders in one calendar year and the addition of 30 new family practice residency positions in Area Health Education Centers around the state.¹⁶⁶ A 2008 study outlined the need for dental professional education in Arkansas and led to the creation of Arkansas Center for Dental Studies at UAMS, which recently received a \$1 million grant for construction and operation.^{167 168}
- The new Centers for Children in Lowell, Arkansas opened in May 2007 as part of a collaborative effort by Arkansas Children's Hospital and UAMS. The center is designed to improve access to pediatric developmental and subspecialty care in the northwest part of the state. In late 2010, a Primary Care Clinic was opened to serve as a medical home for children with Medicaid coverage but no primary care provider. This will help address the needs of more than 7,000 Northwest Arkansas children who do not have access to a primary care provider.¹⁶⁹
¹⁷⁰ Statewide, about 6 percent of kids—25,000 children—enrolled in ARKids First did not have a primary care physician assigned to them, highlighting the struggle to find regular, consistent access to medical care.¹⁷¹



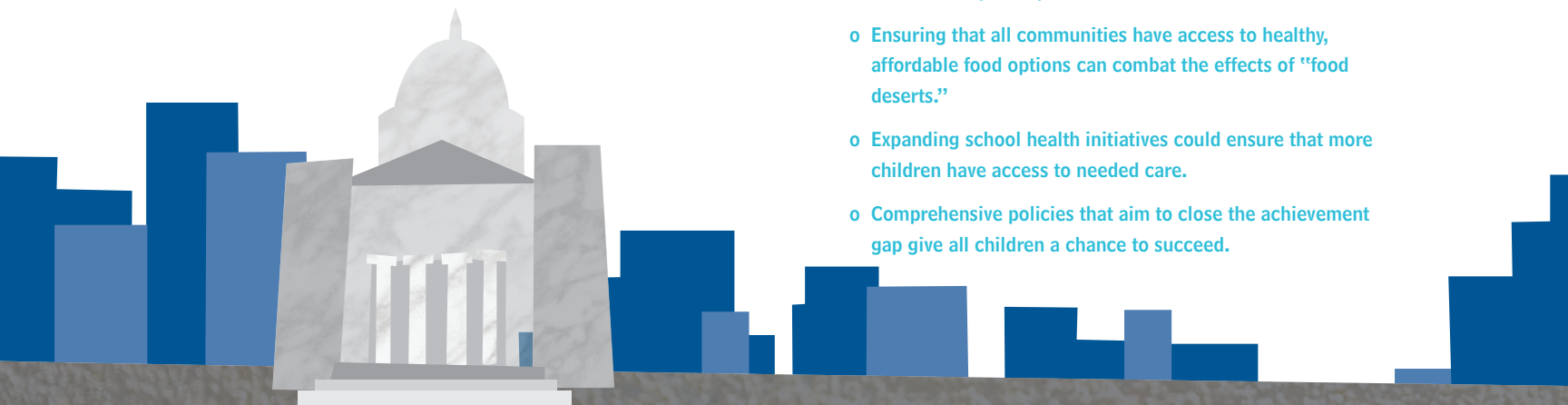
Future Focus Areas

Several issues from the 2008 Natural Wonders report were not fully addressed, and new focus areas have been brought to light as important to the health and welfare of Arkansas children. The state must take advantage of opportunities to address these issues proactively.

- Health reform will introduce a host of new policies, procedures, regulations, and funding opportunities for the state. The specific impact on children's health programs and policies should be addressed to ensure that children receive maximum benefits from the new laws and regulations.
- In a survey by HealthTeacher.com, bullying was identified as the second-highest concern for teachers in the area of health issues and behavior.¹⁷² With the recent national attention on bullying due to the suicides of several teens taunted by peers, Arkansas could place new focus on addressing the issue.
- Texting while driving is a distraction from the road. Nearly 80 percent of crashes and 65 percent of near-crashes involved some form of driver inattention within three seconds before the event. Through the *Texting While Driving: I Will Wait* campaign, spearheaded by the Arkansas Coalition Against Texting while Driving, teenagers in schools around the state are pledging to make their school a distracted driving-free school and to raise the awareness of the dangers of texting and driving.¹⁷³



- Several agenda items from the past report remain on the agenda of child health advocates. Breaking these down into smaller, more easily achievable objectives for each of these areas could pave the path to change and measure incremental progress toward achieving policy change.
 - o Support for pregnant and parenting teens needs to be expanded, including access to education completion and job training and placement.
 - o Medical and dental professional workforce expansion will need to be addressed soon to accommodate growth of the eligible population and meet the needs of the underserved around the state. Both professional education efforts and scope of practice adjustments will need to be included in these discussions.
 - o The state needs to reduce the rapidly expanding use of immunization exemptions.
 - o Laws that ensure the safety of children could save the lives of countless children each year. These include ATV regulations or classifying car seats and cribs as durable medical equipment to ensure insurance reimbursement.
 - o Laws could protect children from the perils of tobacco smoke in all public places.
 - o Ensuring that all communities have access to healthy, affordable food options can combat the effects of "food deserts."
 - o Expanding school health initiatives could ensure that more children have access to needed care.
 - o Comprehensive policies that aim to close the achievement gap give all children a chance to succeed.



Conclusion

Arkansas has made great strides in improving the health of children and building the infrastructure necessary to continue those initiatives. However, we cannot lose focus—there is still much work to be done. Prenatal care and infant mortality, immunizations, oral health, injury prevention, tobacco prevention, obesity prevention, mental health, service needs or expansions, and capacity building remain focus areas for the state along with several new focus areas. Though the specific objectives in these areas may be adjusted, maintaining a level of service and focusing on improving access to care will guide decision-making. The Natural Wonders Partnership Council serves as the catalyst for mobilizing resources and communities to make all Arkansas children healthy.

Acknowledgments

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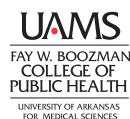


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