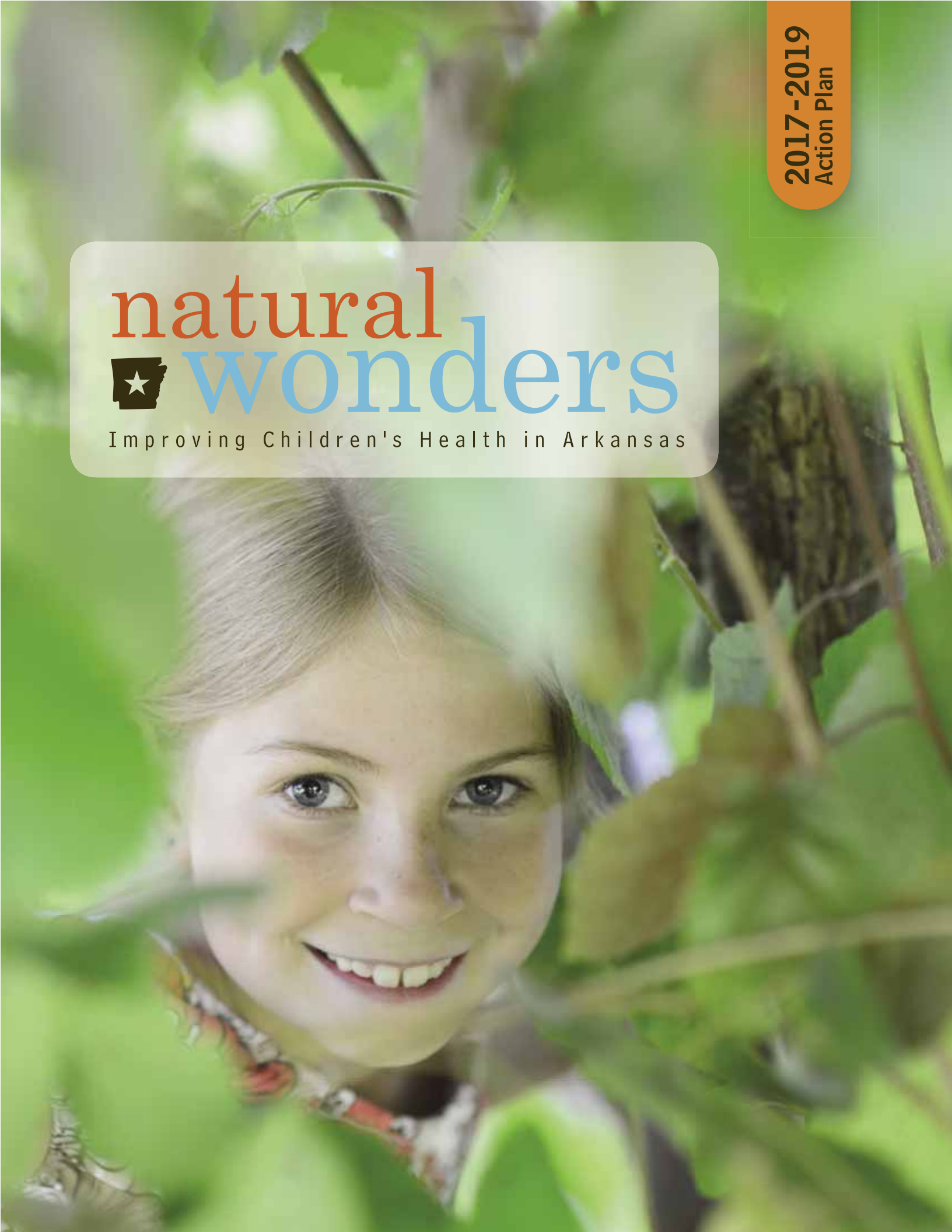


2017-2019
Action Plan

natural wonders

Improving Children's Health in Arkansas

Executive Summary

The Natural Wonders Partnership Council (NWPC) is a coalition of organizations that work together to improve the health of all children in Arkansas. The collaboration among Natural Wonders Partnership Council members has grown and strengthened in the ten years the partners have been working together. With the help of their backbone organization, Arkansas Children's Hospital (ACH), Natural Wonders partners have developed plans to improve child well-being based on public health data and have supported solutions backed by evidence that effectively improve children's health. Historically, the Natural Wonders partners were assessing health needs and identifying solutions to poor child health years before Community Health Needs Assessments became a standard requirement of all nonprofit hospitals. With steadfast support from Arkansas Children's Hospital, the NWPC has published five reports on the status of children's health in Arkansas and the initiatives that Natural Wonders partners champion to address the highest-priority needs.

In its recent planning efforts, the NWPC set the stage for a new era to implement additional strategic programs and track progress of the NWPC's collective work. In 2014, the NWPC decided to utilize the Collective Impact model to shape its first Five-Year Strategic Framework. **The five key elements of Collective Impact initiatives are 1) common agenda, 2) shared measurement system, 3) mutually reinforcing activities, 4) continuous communication, and 5) backbone support.** This framework guides the collaborative activities the NWPC members undertake to improve children's health in Arkansas.

Arkansas Children's Hospital's 2016 community health needs assessment (CHNA) provides a foundation for the work of the NWPC. The CHNA is a periodic, statewide assessment of children's health required by the Internal Revenue Service (IRS) for nonprofit hospitals. It includes both statistical data and feedback from community members and child health experts. United States Department of the Treasury regulations detail CHNA requirements. NWPC used the 2016 CHNA as its **common agenda** for work during FY17 – FY19. The 2016 CHNA process identified twelve-child health priority areas, which the NWPC organized into ten priority areas of work. It identified or created a work group for each priority area. The groups include Access to Quality Care and Prevention, Childhood Obesity, Mental Health & Substance Use, Reproductive Health, Social Issues, Parenting Support, Oral Health, Food Security, Child Injury, and Immunization.

NWPC chose two components for its **shared measurement system** to track progress on the common agenda priority areas. First, the Annie E. Casey Foundation's Kids Count Child Well-Being Ranking provides a broad, national indicator of overall well-being. Secondly, a custom NWPC dashboard of fifty child health indicators showcases progress on Arkansas's strategic initiatives. Each of the ten priority areas developed **mutually reinforcing activities** that will impact chosen measures. Each priority area section includes the group's vision and impact on child health, a data update, and a short excerpt of what parents, caretakers, educators and health providers across Arkansas shared as their concerns for the 2016 CHNA.

As the **backbone** agency, Arkansas Children's Hospital has increasingly committed time and resources to Natural Wonders with the goal of moving the needle on child health and well-being. ACH convenes monthly meetings, part of the **continuous communication** required for Collective Impact. ACH brought community-facing departments together under a single Child Advocacy and Public Health division. This realignment facilitates strategic efforts to measurably improve child health and nurture partnerships across sectors to achieve impact. ACH supports this new division to lead community benefit work and the Natural Wonders Partnership Council, support program evaluation and rural engagement, and oversee community-based clinical services and preventive programs that improve child health.

About the Council

BACKGROUND

The Natural Wonders Partnership Council (NWPC) is a coalition of organizations that serve children statewide. It meets regularly to support collaborations improve the health of all children in Arkansas. It is convened by Arkansas Children's Hospital (ACH), which has provided world-class health care for more than 100 years for Arkansas's most important natural wonders, its children. Since 2006, ACH has served as the backbone agency for the Natural Wonders Partnership Council and has helped coordinate strategic initiatives that make measurable improvements in health and quality of life for Arkansas children and families.

The Affordable Care Act brought a new era of shared planning and engagement on community health needs to hospitals like Arkansas Children's Hospital. However, through Natural Wonders, established years before the new requirements came into effect, Arkansas has been ahead of the curve in addressing identified community needs. The coalition's driving force is the participating organizations' shared vision and commitment to addressing the complex issues affecting all children in the state. The Arkansas Children's Hospital Board of Directors and hospital leaders have increasingly committed time and resources to Natural Wonders, with the goal of moving the needle on child health and wellbeing. As the NWPC nears its 10th anniversary, the partners are pleased to reflect on their decade-long relationship and to continue to build a healthier state for Arkansas's children.

Natural Wonders Partnership Council Member Organizations
American Academy of Pediatrics, Arkansas Chapter
Arkansas Access to Justice Commission
Arkansas Advocates for Children & Families
Arkansas Association of Educational Administrators
Arkansas Blue Cross Blue Shield
Arkansas Campaign for Grade Level Reading
Arkansas Center for Health Improvement
Arkansas Children's Hospital
Arkansas Coalition for Obesity Prevention
Arkansas Department of Education
Arkansas Department of Health
Arkansas Department of Human Services, Division of Behavioral Health Services
Arkansas Department of Human Services, Division of Medical Services
Arkansas Foodbank
Arkansas Foundation of Medical Care
Arkansas Hospital Association
Arkansas Hunger Relief Alliance
Arkansas Minority Health Commission
Arkansas Out of School Network
Arkansas Pharmacist Association
Arkansas State University Childhood Services
Blue & You Foundation
Clinton School of Public Service
Community Health Centers of Arkansas
Delta Dental of Arkansas
First Assembly of God, North Little Rock
Human Rights Campaign - Arkansas
Sixth Judicial District Circuit Court 10th Division
The Clinton Foundation
University of Arkansas for Medical Sciences - College of Public Health
University of Arkansas for Medical Sciences - School of Medicine

Making Meaningful Impact

COLLECTIVE IMPACT MODEL

The NWPC uses the Collective Impact Model to guide the process and work of partners **TO IMPROVE THE HEALTH OF ALL ARKANSAS CHILDREN.** Below are the five key components of the model and a description of how NWPC applies them to its work. [1]

Common Agenda: The statewide Community Health Needs Assessment (CHNA), prepared by Arkansas Children's Hospital every three years, provides the information that helps all members of the NWPC establish a common understanding of child and adolescent health needs. NWPC uses this information to identify priority areas in which to focus efforts to improve child health.

Shared Measurement System: The Annie E. Casey Foundation's Kids Count Child Well-Being ranking provides a national data comparison for Arkansas children. Additionally, a custom NWPC Data Dashboard provides data on the priority issues and solutions that the NWPC addresses. Together, these two data sets track progress toward improved children's health.

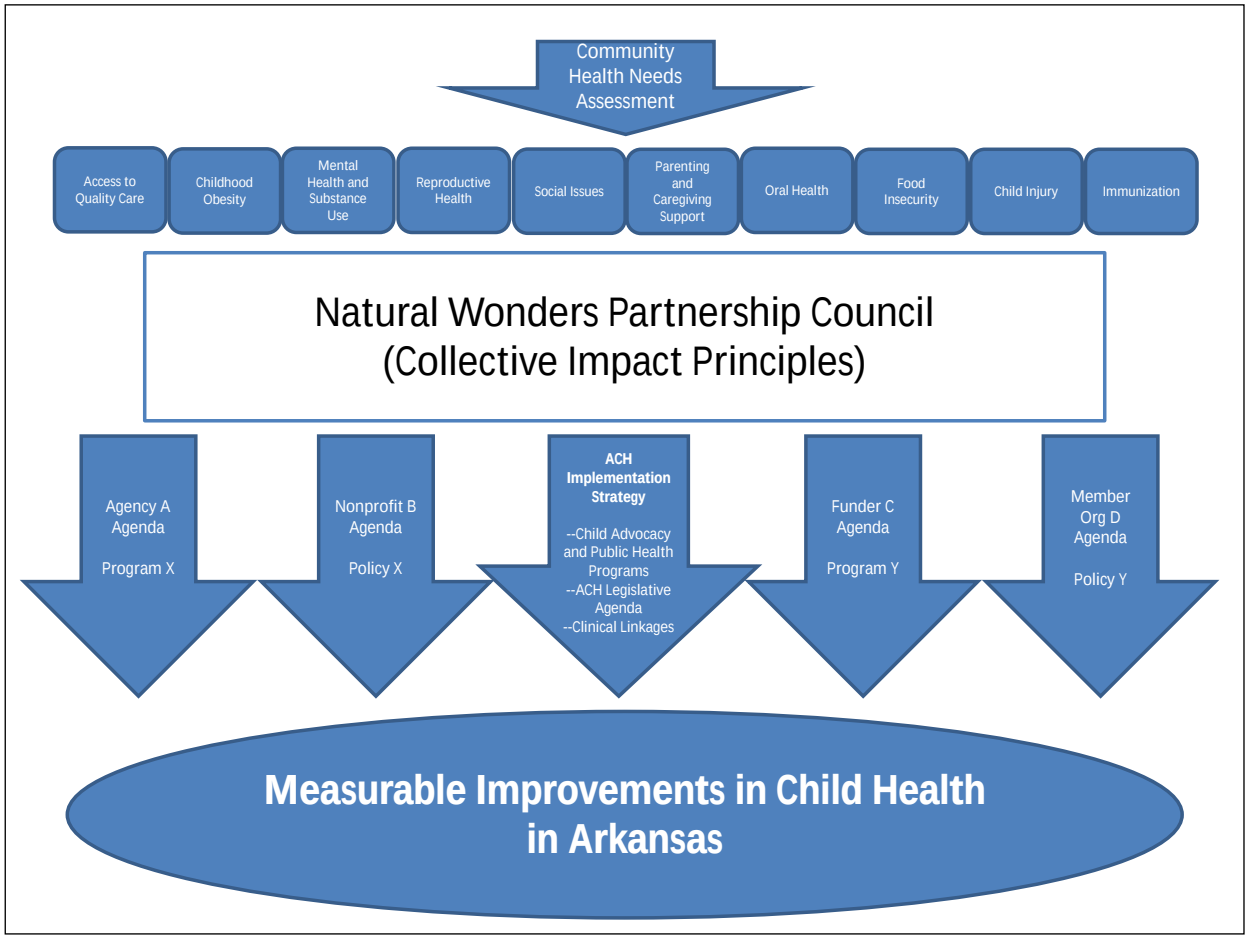
Mutually Reinforcing Activities: Workgroups for each Natural Wonders priority area outline measurable goals owned by specific partners in each group. These goals focus on processes or activities that will improve children's health.

Continuous Communication: Monthly meetings of the primary NWPC group, regular workgroup meetings, email communication, one-on-one meetings, and an independent public presence (website, social media) will help facilitate the conversation needed to improve children's health.

Backbone Support Organization: Arkansas Children's Hospital will continue to serve as the entity that will plan, manage, and support the NWPC's efforts through financial, administrative, logistic, and evaluative support. With the growth of its Child Advocacy and Public Health department, ACH now has more dedicated staff to support the work of the NWPC.

As the NWPC grows, it seeks to tackle cross-sector, multi-organizational solutions to improve child health. The following graphic outlines the integration of the CHNA, NWPC, and member organizations, including Arkansas Children's Hospital.

Figure 1 Natural Wonders Collective Impact Model



Common Agenda

BACKGROUND

From its start in 2007, the NWPC conducted statewide needs assessments focused on children to help guide state leaders' discussions on children's health needs and to assure a child-focused agenda.

NWPC published the results of its first needs assessment in a 2007 report titled "Natural Wonders: The State of Children's Health in Arkansas."[2] The major focus of this first report was to identify child-specific data and report on key child health trends. It also aimed to identify data gaps and needs for planning. In 2008, NWPC engaged the public through focus groups, surveys, and study circles to determine community members' opinions on the most important things to do to improve children's health in the state. This second NWPC report highlighted nine priority areas identified by the NWPC.[3] The third NWPC report, published in 2011, provided an updated data snapshot for child health.[4]

New Internal Revenue Service requirements formalized the NWPC CHNA process as part of Arkansas Children's Hospital's community benefit work. Arkansas Children's Hospital completed and published its first formal Community Health Needs Assessment in 2013. NWPC published its fourth report in 2014, in which it examined potential policy or programmatic solutions to the nine action areas it had previously identified.[5] It also served as a transitional report, setting the stage for a new era of direction and partnership building to implement more strategic programs and evaluation efforts to track the NWPC's collective work.

In 2015, the NWPC developed its first Five-Year Strategic Framework using the Collective Impact Model. It guides the programmatic and educational activities the NWPC members undertake to improve children's health in Arkansas.

2016 COMMUNITY HEALTH NEEDS ASSESSMENT

The 2016 CHNA is the official Arkansas Children's Hospital community health needs assessment, and it is the only periodic, in-depth, statewide assessment of children's health.[6] From September 2015 through March 2016, hospital staff and consultants gathered primary and secondary data for the CHNA. Members of the Natural Wonders Partnership Council provided input to and feedback on the CHNA at all stages of its development, implementation, and reporting. The following data sources contributed to the wide range of input gathered from people and organizations who represent children's health interests:

- Eleven focus groups targeted to a diverse population of parents and children's service providers across Arkansas,
- Thirty-four key informant interviews targeted to Arkansas's child health thought leaders and subject matter experts,
- A telephone survey of 400 Arkansas parents that was statistically significant at the state level,
- A comprehensive review of child-specific secondary data from local, state, and national sources.

Twelve areas of child health needs were identified across the four data sources and then prioritized into two tiers using a criteria-weighting method described in the full community health needs assessment report.[7] The priorities identified were presented to the NWPC to review and consider for adoption in their collective action. The NWPC unanimously agreed to utilize the prioritized areas of focus from the 2016 Arkansas Children's Hospital CHNA to guide their work. All areas identified through the CHNA are important to children's health, but their prioritization allows the NWPC to approach its work in a strategic manner.

After discussing the twelve issue areas identified in the CHNA and exploring existing capacity for addressing them, the NWPC named ten areas of child health to tackle. The "Child Maltreatment and Caregiver Mental Health and Substance Use" topic combined with the Parenting and Caregiving Support workgroup, and "Developmental Screenings and Services" joined the Access to Quality Care workgroup. This ensured that the NWPC did not create new groups unnecessarily. The primary NWPC group will own the category of "social issues." Each child health issue has its own NWPC subgroup – new or existing – to focus on that issue alone. **The ten child health issues below, detailed in ACH's CHNA, are the Common Agenda that guides the NWPC.**

Table 1- Ten NWPC Common Agenda Workgroups

Access to Quality Care (includes Developmental Screenings and Services)	Parenting and Caregiving Support (includes Child Maltreatment and Caregiver Mental Health and Substance Use)
Childhood Obesity	Oral Health
Mental Health and Substance Use	Food Insecurity
Reproductive Health	Child Injury
Social Issues	Immunization

Parents' Vision for Healthy Children in Arkansas, from 2016 CHNA focus groups

Shared Measurement System

BACKGROUND

The second component of the NWPC Strategic Framework is the identification and approval of a "shared measurement system." This list of metrics outlines the data that will inform NWPC members about their progress toward improving children's health in Arkansas. In its 2014-2015 Strategic Framework development process, the NWPC chose two ways of measuring progress on the common agenda focus areas. The Annie E. Casey Foundation's Kids Count Child Well-Being Rankings[8] and a custom NWPC dashboard of indicators for each priority area make up the system.

DEVELOPMENT OF MEASURES

During the summer of 2016, Arkansas Children's Hospital worked with the Natural Wonders Partnership Council workgroups to re-evaluate and update the existing shared measurement system. **The group chose to continue using the Kids Count ranking as a national comparison for child well-being in Arkansas.** Subgroups updated the custom dashboard metrics to reflect changes in the public health landscape in Arkansas. At the August 2016 NWPC retreat, workgroup leads presented each group's updated measures to the entire council. Members asked questions, provided feedback and engaged in lively conversation as they finalized five data indicators for each priority area. **Table 2 presents a complete list and description of the 50 custom dashboard indicators and Annie E. Casey Foundation Kids Count indicators that make up the second component of the shared measurement system.** The 2016 Kids Count rankings were used for baseline data in this report.

Table 2 – Shared Measurement System

Focus Area	Custom Dashboard	Annie E. Casey	Shared Measurement System	Source
ACCESS TO QUALITY CARE	1	Y - Health	Percent of uninsured kids under age 19	AACF
	2		Percent of Child Core Measures Arkansas is reporting to the Centers for Medicare and Medicaid	AR Medicaid
	3		Percent of children on Medicaid/ARKids First A who should have received at least one screening and who actually received a screening (Participant Ratio)	AR Medicaid/CMS
	4		Total annual Medicaid services billed for Early Intervention Services	AR Medicaid
	5		Number of School-based Health Centers and School-Based Telemedicine sites in high free/reduced price lunch school districts	ACH, ADE
CHILDHOOD OBESITY	6		Percent of public elementary school students actively using GoNoodle	Arkansas Children's
	7		Number of K-8 teachers trained in evidence based physical education	ADE
	8		Percent of birthing hospitals in AR designated as baby friendly	BFH USA
	9		Percent of Arkansas school children who are overweight or obese, by gender and race/ethnicity	ACHI
	10		Percent of adolescents who participated in daily physical activity for at least 60 minutes.	YRBS
MENTAL HEALTH & SUBSTANCE USE	11		Percent of high school students using marijuana and prescription drugs, respectively	YRBS
	12		Percent of high school students who drank alcohol in the last 30 days	YRBS
	13		Percent of youth tobacco use and 12th graders e-cigarette use, respectively	YRBS and APNA
	14		# of children receiving mental health services through Medicaid annually	ADE/AR Medicaid
	15		Percent of pre-k children with significant behavioral concerns	ARECCS-SEW
		Y - Health	Teens who abuse alcohol or drugs	Kids Count
REPRODUCTIVE HEALTH	16		Teen Birth Rate for age groups (15-17 and 18-19) per 1,000 births	ADH
	17		2nd Teen Births for age groups (15-17 and 18-19) per 1000 births	ADH
	18		Percentage of Chlamydia infections in AR that affect 15-24 year olds	ADH
	19		Percent of 12th graders who have had sexual intercourse	YRBS
	20		Percent of adolescents age 10-18 on Medicaid/ARKids First A who should have received at least one screening and who actually received a screening (Participant Ratio)	AR Medicaid/CMS
		Y – Health	Low Birth Weight Babies	Kids Count
		Y - Family	Teen Births per 1,000	Kids Count
		Y - Family	Children in Single-Parent Families	Kids Count

Focus Area	Custom Dashboard	Annie E. Casey	Shared Measurement System	Source
SOCIAL ISSUES	21	Y - Econ	Percent of children living in poverty in Arkansas	Kids Count
	22		Proportion of households living in liquid asset poverty	CFED
	23	Y - Econ	Percent of children living in households with a high housing cost burden	Kids Count
	24	Y - Family	Percent of children living in high poverty areas	Kids Count
	25	Y - Overall	Annie E. Casey overall ranking	Kids Count
PARENTING SUPPORT	26		% of new mothers who report symptoms of maternal depression	ADH - PRAMS
	27		% of parents with 2 or more ACEs	ADH
	28		Total Number of True Assessments of Child Maltreatment	DHS - DCFS
	29		Number of families served concurrently by evidence-based home visiting services	AR-HVN
	30	Y - Econ	Number of children whose parents lack secure employment	Kids Count
ORAL HEALTH	31		Percent of Arkansas third-graders with sealants	ADH/ACH
	32		Percent of Arkansas third-graders with dental caries experience	ADH/ACH
	33		Percent of Arkansas children on Medicaid who received preventive dental services in the past year	AR Medicaid/CMS
	34		Number of pediatric health care providers certified to apply fluoride varnish	ADH
	35		Percent of Arkansas school districts with preventive or restorative dental services delivered at school	ADE/ADH/ ACH
FOOD INSECURITY	36		% of children who are food insecure	Feeding America
	37		# of Arkansas schools participating in the Breakfast After the Bell program	AR Hunger Relief Alliance
	38		# of summer and after-school feeding program meals or snacks distributed when school is not in session for the summer	ADE
	39		# of Cooking Matters participants	AHRA
	40		# of Arkansas school districts that have adopted community eligibility provisions	Share Our Strength

Focus Area	Custom Dashboard	Annie E. Casey	Shared Measurement System	Source
CHILD INJURY	41		Child death rate per 100,000 children ages 0-19 caused by injury	CDC WISQARS
	42		Motor vehicle death rates per 100,000 children ages 0-19	CDC WISQARS
	43		Post-neonatal infant death rate per 1,000 live births	CDC WONDER
	44		Suicide death rate per 100,000 youth ages 10-19	CDC WISQARS
	45		Number of annual All-Terrain Vehicle-related admissions to Arkansas Children's Hospital	ACH
		Y – Health	Child and Teen Deaths per 100,000	Kids Count
IMMUNIZATION	46		Percent of children aged 19-35 months who received the combined vaccination series (4:3:1:3:3:1:4)	ADH
	47		Percent of kindergarteners who received two doses of MMR vaccine	ADH
	48		Percent of females aged 13 – 17 years who received three doses of the HPV vaccine	ADH
	49		Percent of males aged 13 – 17 years who received three doses of the HPV vaccine	ADH
	50		Number of Vaccines For Children sites, by county	ADH
FACTORS NOT ADDRESSED BY NWPC		*Y – Econ*	*Teens not in school and not working*	*Kids Count*
		Y – Ed	*Young children not in school*	*Kids Count*
		Y – Ed	*Fourth graders not proficient in reading*	*Kids Count*
		Y – Ed	*Eighth graders not proficient in math*	*Kids Count*
		Y – Ed	*High school students not graduating on time*	*Kids Count*
		Y – Family	*Children in families where the household head lacks a high school diploma*	*Kids Count*

Mutually Reinforcing Activities

NWPC WORKGROUPS

Natural Wonders identified workgroups to focus on the ten Common Agenda priority areas. Each workgroup has up to three agency leads. Leads are partners who champion statewide efforts in specific areas of child health. To create balance and synergy of ideas, the co-chairs are, whenever possible, representatives from both public and private organizations. Members of each group include representatives from specific programs and organizations or individual citizens interested in the focus area of the group. Committed individuals interested in making Arkansas children healthier tomorrow and who have special interest or expertise in a focus area are welcome and encouraged to join a Natural Wonders working group.

After choosing their shared measurement system metrics, workgroup members developed mutually reinforcing activities, or process-focused goals. These mutually reinforcing activities will guide workgroups' efforts for measurably improving child health over a three-year period.

Each priority area's work is detailed in the following section. Each priority area section includes the group's vision and impact on child health, a data update, and a short excerpt of what parents, caretakers, educators and health providers across Arkansas shared as their concerns for the 2016 CHNA.

Priority Workgroup	Agency lead(s)
1) Access to Quality Care	Arkansas Department of Health, Arkansas Advocates for Families and Children
2) Childhood Obesity	Arkansas Coalition for Obesity Prevention
3) Mental Health and Substance Use	*In Progress*
4) Reproductive Health	Arkansas Department of Health, Arkansas Children's Hospital
5) Social Issues	Natural Wonders Partnership Council
6) Parenting and Caregiving Support	Center for Effective Parenting at Arkansas Children's Hospital, Arkansas Department of Health
7) Oral Health	Arkansas Department of Health, Arkansas Children's Hospital
8) Food Insecurity	Arkansas Hunger Relief Alliance
9) Child Injury	Injury Prevention Center at Arkansas Children's Hospital
10) Immunization	Arkansas Department of Health, Arkansas Pharmacists Association

Access to care focuses on addressing the health care needs of children and adolescents when they are healthy or ill. It includes access to sufficient and consistent health coverage and the ability for children and their families to get care or prevention services when needed. These services include well child visits, vision/hearing screenings, and other developmental screenings and services. The quality of care that children receive should not limited by common barriers like lack of health coverage, parent and caregiver time off, transportation, or the availability of nearby and age-appropriate services.

LEADS - Arkansas Department of Health, Arkansas Advocates for Children & Families

Why access to quality care matters

Timely and appropriate access to quality care and prevention has an important impact on children's quality of life and ability to grow into healthy strong adults. It helps assure their wellbeing and opportunity to realize their full potential physically, academically, mentally and socially.[9]

How is Arkansas doing?

Improving and maintaining the health of children is an important and complex issue. Children in the state have excellent access to health coverage through the ARKids First program, with just 4.9 percent of children under age 19 lacking coverage.[10] However, significant disparities exist for minority and immigrant children especially between the ages of 6 and 11 years of age. Of those children covered, only 48 percent received at least one of their Early Period Screening Diagnosis and Treatment (EPSDT) prevention visits required by Medicaid in 2014. [11] The state's 27 school-based health centers (SBHCs) are bridging barriers to care for more students across Arkansas, but there are geographic and economic disparities regarding the counties where SBHCs are located.[12]

Figure 2 School Based Health Centers

Community Voice

Access to children's care was an important area for rural communities. Gaps in coverage and barriers to access to care and healthcare coverage are still challenges for families. Parents and providers in communities listed poor access to basic and specialty services ranging from primary pediatric care to services that are more specialized. Specialized services noted by parents included behavioral, mental and psychiatric health, as well as vision screening services. Families expressed concern about difficulties maintaining consistent coverage due to the high cost or challenges with paperwork and procedures. Administrative and clerical problems and delays with enrollment can and have interrupted continuity of care or have prevented access to care for children.[13]

#	Shared Measures for Access to Quality Care	Baseline
1 – Annie E. Casey	Percent of uninsured kids under age 19	4.9%
2	Percent of Child Core Measures Arkansas is reporting to the Centers for Medicare and Medicaid	50%
3	Percent of children on Medicaid/ARKids First A who should have received at least one screening and who actually received a screening	48%
4	Total annual Medicaid services billed for Early Intervention Services	TBD
5	Number of School-based Health Centers and School-Based Telemedicine sites in high free/reduced price lunch school districts	27

Mutually Reinforcing Activities for Access to Quality Care:

1. By July 2017, educate partners and advocate to lawmakers to seek a state plan amendment to implement the Immigrant Child Health Improvement Act. (AACF)
2. By December 2017, educate partners and convene two meetings with administrative leaders to reporting about Core measure reporting. (AACF)
3. By June 2019, educate practices serving children on billing appropriately for EPSDTs (AFMC/Arkansas Children's Care Network)
4. By June 2019, research and compile data report on adequate and timely services for Early Intervention and Mental Health services for children with developmental needs. (AACF, AR Campaign for Grade-Level Reading, ACH)
5. Expand school-based telemedicine services to 40 schools in free/reduced price lunch school districts by August 2018 (ACH/ADH/ADE)

Obesity in children occurs when a child or adolescent has excess weight for his or her age and height. Obese children are more likely to become obese adults and can develop health-harming illnesses earlier in their adult life. NWPC is working to decrease the risks of obesity for Arkansas children by addressing quality healthy food and safe opportunities for physical activity in children's homes, schools, and communities. This requires a broad, community-based approach to family health in addition to clinical service offerings.

LEADS - Arkansas Coalition for Obesity Prevention

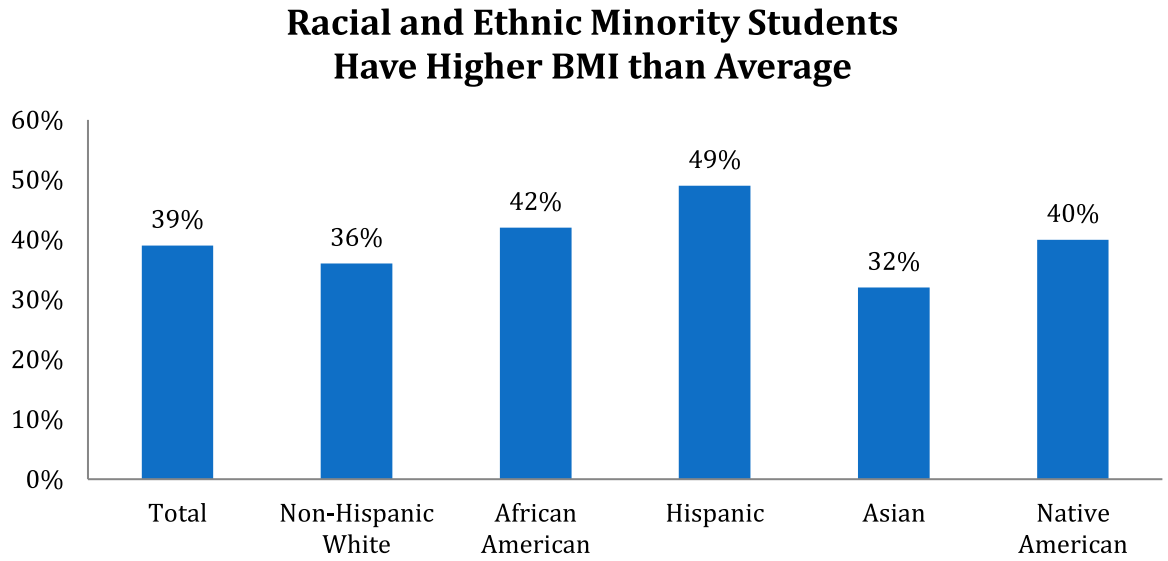
Why childhood obesity matters

Children or adolescents who are obese have more problems with serious illnesses such as diabetes and cardiovascular diseases at a younger age, and their lifespan may be shorter. [14]

> *"Children will not change their own diets. Parents need to be able to get healthy nutritious food on children's plates. If they can't then obesity rates will not change."*
>
> ***CHNA 2016 Participant***

How is Arkansas doing?

Arkansas's obesity rate does not seem to be increasing over time, but it is not going down either. During the 2013-2014 school year, **39 percent of Arkansas students had a BMI in the overweight or obese category.**[15] Children who entered kindergarten overweight or obese were likely to continue to be overweight throughout their youth – **most kids do not "grow out of it."**[16] Minority children are at higher risk.



Source: Arkansas Center for Health Improvement. Assessment of Childhood and Adolescent Obesity in Arkansas: Year Eleven (Fall 2013 – Spring 2014). Little Rock, AR: ACHI; October 2014.

Figure 3 Body Mass Index by Race

A national report showed that 34 percent of Arkansas children across the age spectrum are overweight or obese.[17] State BMI data shows that middle school students have higher BMIs than younger students. However, only 32 percent of Arkansas high school students described themselves as slightly or very overweight.[18]

Community Voice

Parents, especially among Spanish speaking parents and rural communities, expressed concern about obesity with their own children and in others in the community. Top concerns for parents included food served to children at school, lack of access to healthy and affordable food, and limited physical activity opportunities for children especially for those who are not in sports.

In the CHNA telephone survey, 37 percent of parents considered obesity a "serious problem," and 75 percent saw this as a serious or moderate problem, making it one of top issues identified as affecting the health and wellbeing of children. Parents cited lack of access to healthy food and exercise as main reasons.

#	Shared Measures for Childhood Obesity	Baseline
6	Percent of public elementary school students actively using GoNoodle	66%
7	Number of K-8 teachers trained in evidence based physical education	0
8	Percent of birthing hospitals in AR designated as baby friendly	5%
9	Percent of Arkansas school children who are overweight or obese, by gender and race/ethnicity	39%
10	Percent of adolescents who participated in daily physical activity for at least 60 minutes.	23%

Mutually Reinforcing Activities for Childhood Obesity:

1. By June 2019, 65% of elementary classrooms active with GoNoodle. (ACH)
2. By June 2019, 25% of birthing hospitals will designated baby friendly. (ArCOP)
3. By Dec 2017, train 300 K-8 teachers in evidence based physical education. (ADE/ACH/Blue & You Foundation)
4. By June 2019, 60% of school districts will have a joint use agreement in place that increases opportunities for physical activity. (ADE)
5. By June 2019, expand the # of days per week that Arkansas Children's Hospital patients can enroll in WIC while attending healthcare appointments. (ACH/ADH)

Untreated mental health problems and use of illicit and prescription drugs, alcohol, and tobacco by children or their caregivers affect their physical and mental health. Children of parents or caregivers who are using these substances are at risk of experiencing higher rates of adverse childhood experiences, which can have profound lifelong health effects. While the state's school-based mental health program provides access to behavioral health care for many children, preventive services and treatment for substance use are limited through public and private health coverage.

LEADS: Group Formation In Progress

Why mental health and substance use matters

Social emotional development is important to a child's overall health. Poor mental health can lead to dire outcomes including suicide, and lack of access to treatment for substance use disorders can result in a lifetime of addiction. Tobacco use has a host of negative health impacts. Children of parents or caregivers who are using these substances are at risk of experiencing higher rates of adverse childhood experiences (ACEs) which can have profound lifelong health effects for future generations.

How is Arkansas doing?

One in five Arkansas children under age 5 has at least one emotional or behavioral difficulty, and 16 percent of children screened in pre-k programs have significant behavioral concerns. [19] These concerns continue to develop in adolescence and often occur along with other risky behaviors. Only 32 percent of youth age 12-17 received treatment for their major depressive episode.[20] Suicide is the second leading cause of death for children ages 1-18, and Arkansas's suicide rate for all ages is 48 percent higher than the U.S. rate.[21] Additionally, preventive services and care coordination for a broad range of family support and recovery-oriented services are currently limited through public and private health coverage.

National substance use surveys found about 5.4 percent of Arkansans age 12 and older (128,000 people) to be dependent on alcohol, and 3 percent (72,000) were dependent on or abused illicit drugs between 2008 and 2012. Only 11.8 percent of those using alcohol received treatment, but 21 percent of those using illicit drugs received treatment.[22]

One in five Arkansas youth report current cigarette use, and thirty-seven percent of high school seniors have used e-cigarettes. Though the overall smoking rate for teens has gone down, 19 percent of high school students in Arkansas report smoking at least one cigarette in the past 30 days.[23] Additionally, 37 percent of high school seniors have used e-cigarettes.[24]

Community Voice

Both urban and rural communities noted and prioritized behavioral and mental health problems as top areas of concern. Use of illicit and prescription drugs was identified as a main concern. Participants also emphasized that, in their opinion, problems with behavioral and mental health affect too many children, increasing the need for more specialized care for these problems. Their concerns for these challenges were not limited to older kids but extend to younger children who are exhibiting behavioral problems earlier in their development.[25]

#	Shared Measures for Mental Health and Substance Use	Baseline
11	Percent of high school students using marijuana and prescription drugs, respectively	37% /22%
12	Percent of high school students who drank alcohol in the last 30 days	36%
13	Percent of youth tobacco use and 12th graders e-cigarette use, respectively	19% /37%
14	# of children receiving mental health services through Medicaid annually	TBD
15	Percent of pre-k children with significant behavioral concerns	16%
Annie E. Casey	Teens who abuse alcohol or drugs	6%

Mutually Reinforcing Activities for Mental Health and Substance Use:

1. By February 2017, establish a new behavioral health workgroup.(TBD)
2. By June 2017, determine membership and leadership of new behavioral health workgroup. (TBD)
3. By June 2017, purpose mission and scope. (TBD)
4. By Dec 2017, conduct a needs assessment regarding behavioral health workgroup. (TBD)
5. By June 2019, develop messaging for behavioral health needs in Arkansas. (ACH)

Adolescent reproductive health includes an opportunity for male and female youth to achieve overall wellbeing in matters relating to their reproductive system and their roles and actions relating to their human sexual development. Arkansas has the highest teen birth rate in the nation, and youth in the state experience other reproductive health risk factors that could be mitigated through education and improved access to comprehensive health care services for adolescents.

LEADS - Arkansas Department of Health, Arkansas Children's Hospital

Why reproductive health matters

Youth who delay initiation of sexual activity experience lower risk for emotional and physical health problems. Delaying sexual activity can decrease adolescents' risks for sexually transmitted diseases and or unplanned pregnancy. Adolescent mothers and fathers often lack knowledge, education, experience, income necessary to care for their child.

How is Arkansas doing?

Though Arkansas's teen birth rate has fallen by half from 1991 to 2014, it has not been falling as quickly as other states'. Unfortunately, Arkansas's teen birth rate ranks 50th in the nation at 39.5 births to teens age 15-19 per 1,000 girls.[26] Pregnancy rates are much higher among 18- to 19-year-olds than younger teens in Arkansas.[27]

Arkansas teenagers also contract sexually transmitted infections (STIs). Arkansas students are engaging in risky sexual behaviors that contribute to these statistics. By 12th grade, 65 percent of students have engaged in sexual activity, and half are currently sexually active.[28] Due to a lack of requirements in Arkansas for reproductive health education in a school setting, many students may receive no evidence-based education about the dangers of risky behaviors that could lead to pregnancy or sexually transmitted infections.

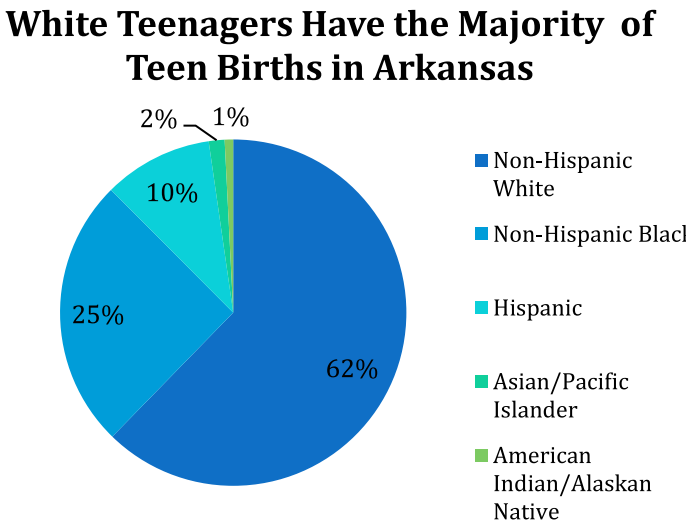


Figure 4 Teen Births by Race, 2014

Source: National Campaign to Prevent Teen and Unplanned Pregnancy, Arkansas Data 2014

Community Voice

> *"I know some are not educated, I was one. You are not aware of certain things, and when you find out it is too late."*
>
> **Teen Parent 2016 CHNA Participant**

Focus group participants graded reproductive health poorly, citing that too many teens get pregnant and that there was poor or lack of reproductive health education in their community. One teen parent participant made clear that her friends needed education on sexually transmitted infections. Some parents were surprised that sexual and reproductive health are not discussed or explained more completely to adolescents in school. Problems identified as related to teen pregnancy included a chronic cycle of poverty, lower educational attainment, a higher social cost to the community, and a lack of parenting skills. Hygiene was another concern participants often cited as an issue among adolescents and that health education classes could address.

#	Shared Measures for Reproductive Health	Baseline
16	Teen Birth Rate for age groups (15-17 and 18-19) per 1,000 births	16.1/75.3
17	2nd Teen Births for age groups (15-17 and 18-19) per 1000 births	TBD
18	Percentage of Chlamydia infections in AR that affect 15-24 year olds	72 %
19	Percent of 12th graders who have had sexual intercourse	65 %
20	Percent of adolescents age 10-18 on Medicaid/ARKids First A who should have received at least one screening and who actually received a screening (Participant Ratio)	32%
Annie E. Casey	Low Birth Weight Babies	8.9%
Annie E. Casey	Teen Birth Rate for ages 15-19 per 1,000 births	40%
Annie E. Casey	Children in Single-Parent Families	39%

Mutually Reinforcing Activities for Reproductive Health:

1. By June 2019, the Changing the Story workgroup will have worked with 15 communities to utilize the "Preventing Teen Pregnancy in Arkansas" toolkit to pilot evidence-based health education programs. (Changing the Story/Women's Foundation)
2. By June 2018, revise the AR Department of Education Frameworks with evidence-based content and skills for reproductive health, improving teacher preparedness. (ADE)
3. By August 2017, develop process and outcome metrics to evaluate Act 943 implementation of college and university action plans to reduce unplanned pregnancies for 18- and 19-year-olds. (AR Campaign to Reduce Unplanned Pregnancy)
4. By June 2019, ensure that health care providers across Arkansas have been trained and educated about prescribing a range of birth control options, including long-acting reversible contraceptives, and billing for these options appropriately. (AFMC, ADH, Merck)
5. By June 2017, determine the feasibility of a mobile health van that provides comprehensive adolescent well care to teens in underserved areas of Arkansas, including red counties. (ACH)

Poverty, unemployment and underemployment, lack of transportation, homelessness, poor home environment, and low educational attainment are all important determinants that are interrelated and affect health outcomes for children and adolescents.

LEADS - Natural Wonders Partnership Council

Why social issues matter

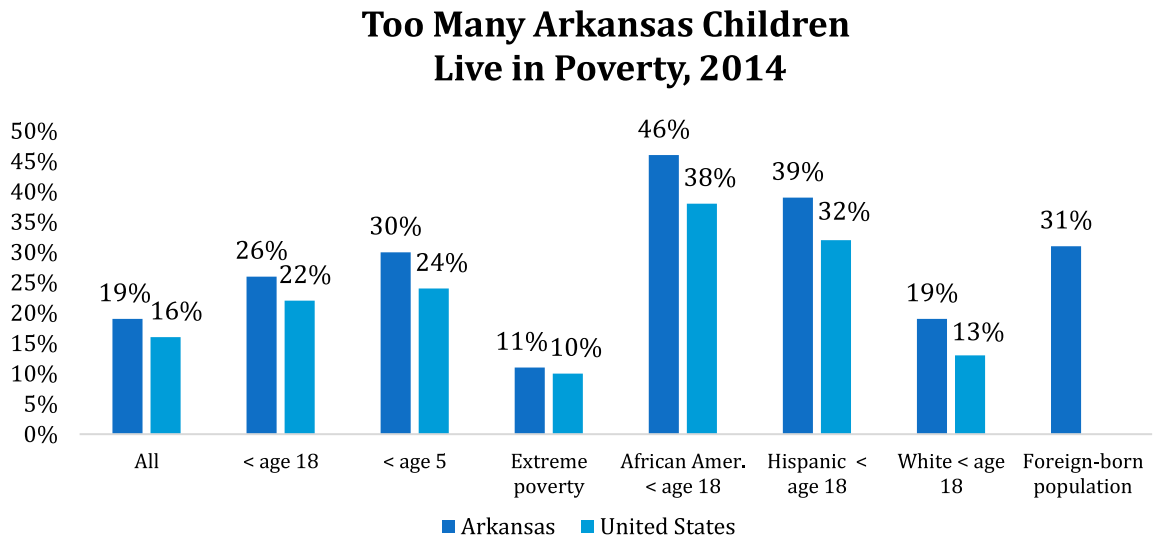
> *"You have really poor people, middle of the road people, and the rich people who can get whatever, a doctor anytime because he may be a friend or have …, but on the other end you have people who are going all around town and don't even know exactly where to go or how to get care for their children."*
>
> **2016 CHNA Parent Participant**

Children living in poverty are vulnerable to environmental, educational, health, and safety risks. Compared with their peers, children living in poverty - especially young children - are more likely to have problems learning and relating to others. These problems can continue for the rest of a child's life. Poor children complete fewer years of school and experience more years of unemployment than their wealthier peers.[29] Child poverty rates in the United States vary considerably by race and Hispanic origin, a pattern that is important given the links between poverty and other economic and social outcomes.

How is Arkansas doing?

Arkansas's population of almost 3 million residents includes 710,236 children who make up almost a quarter (23.8 percent) of the population.[30] Younger segments of the population in Arkansas are significantly more racially and ethnically diverse than older segments of the population, signifying a national trend toward majority-minority communities. Arkansas children face significant challenges to optimal well-being due to many basic demographic factors. The Annie E. Casey Foundation 2015 Kids Count Data Book ranks Arkansas 44th in the nation in overall child well-being, a move down from 2014 when the state was 41st and 2013 when the state was 40th. This trend is moving in the wrong direction for Arkansas children.

Figure 5 Percent of Child Population Living Below Poverty, 2014



Source: Population Reference Bureau, analysis of data from the U.S. Census

Community Voice

The child health disparity most identified by parents and providers in Arkansas communities was "poverty." Participants' conversations included issues of "living wages" and adequate "job opportunities" as well as limited prospect for financial support of young parents to take care of their children. Their discussions were often on the relationship of poverty to other social and behavioral aspects that influence children's health. The disparity identified by both parents and providers that most strongly affects Arkansas children's health is having young, poor, uneducated parents, which in communities' opinion affects their ability to parent well.

#	Shared Measures for Social Issues	Baseline
21 – Annie E. Casey	Percent of children living in poverty in Arkansas	26%
22	Proportion of households living in liquid asset poverty	52%
23 – Annie E. Casey	Percent of children living in households with a high housing cost burden	28%
24 – Annie E. Casey	Percent of children living in high poverty areas	17%
25 – Annie E. Casey	Annie E. Casey overall ranking	44th

Mutually Reinforcing Activities for Social Issues:

1. By June 2019, educate partners and advocate to lawmakers to implement a state Earned Income Tax Credit. (AACF)
2. By December 2017, host three continuing education events and one statewide Medical Legal Partnership summit to increase the number of children served by a Medical Legal Partnership statewide. (ACH and Legal Aid of Arkansas)
3. By June 2017, educate partners and advocate to lawmakers to establish paid leave in Arkansas. (AACF, Women's Foundation)
4. By June 2018, explore the health needs of children in rural Arkansas by conducting community conversations and interviews and compiling a report with recommendations for addressing community concerns. (ACH)
5. By June 2017, pilot a social needs screener and referral to associated services in four community primary care sites in Arkansas. (ACH/AFMC)

, "…there are some kids that experience more problems than others. For a lot of reasons, social economic, cultural, education level, especially of the parents, and even their nationality."

2016 CHNA Parent Participant

Parents and caregivers are very important in the wellbeing and development of children. Parenting skills, home visiting programs, and teen parenting support are important support services that can help all families to succeed in their parenting role and improve child health and education outcomes.

LEADS – Center for Effective Parenting at Arkansas Children's Hospital, Arkansas Department of Health

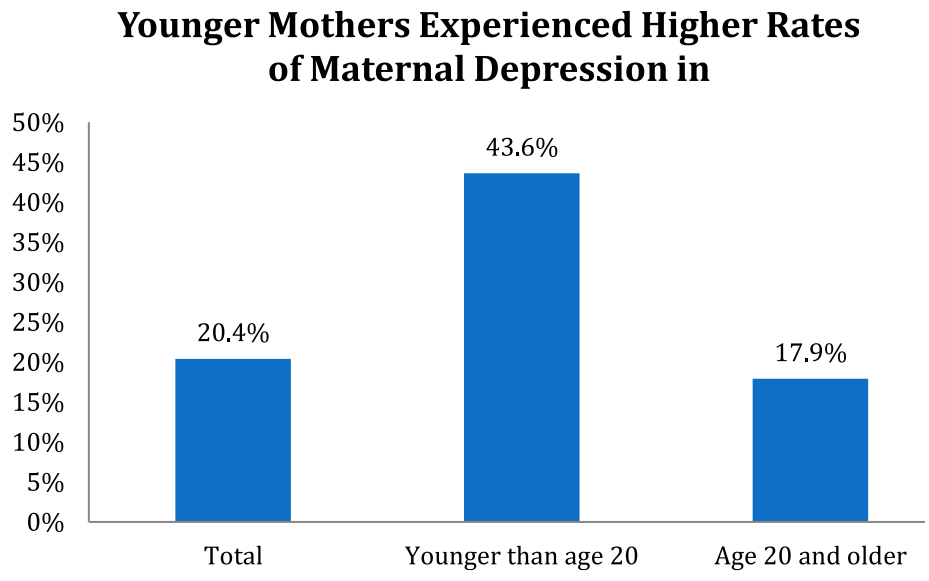
Why parenting and caregiving support matters

Children depend on parents and caregivers for the most important things in life; shelter, food, clothing, health care, nurture and love. Parents have the most important role in shaping a child's attitude, confidence and skills to participate in the world. The pressures of parenting, poverty, adverse childhood experiences (ACES) and other issues can take a toll on parents. Parent education and support from various social and community networks are important to assure they are able to raise happy, healthy children capable for life-long learning.

How is Arkansas doing?

Twenty-seven percent of mothers participating in home visiting programs screened positive for depressive symptoms. [31] In 2015, Arkansas's Division of Child and Family Services at the Department of Human Services responded to 33,683 reports of child maltreatment and found 9,543 children to be victims of substantiated maltreatment.[32] In the same year, 4,418 children were in the foster care system, and 40 children died due to a maltreatment incidence.[33]

Figure 6 Maternal Depression Rates in Arkansas by Age, 2012-2013



Source: Pregnancy Risk Assessment Monitoring System (PRAMS), Arkansas Department of Health

Community Voice

In the 2016 CHNA focus groups, parents and providers brought up a consistent theme across almost every child health issue discussed: The need for improving parenting skills and other concrete parental supports. All groups identified "parenting" as an important factor for children to be healthy. Explanations offered by parents for the contrast between the ideal healthy child and the actual health of children in Arkansas focused in on parenting. Participants explained that healthy children have parents who care about their health and wellbeing, and have sufficient resources both financial and personal to care for their children. Community focus groups related strongly unhealthy children as children who had parents who do not have one or more of these resources.

#	Shared Measures for Parenting and Caregiving Support	Baseline
26	Percent of new mothers who report symptoms of maternal depression	20.4%
27	Percent of parents with 2 or more Adverse Childhood Experiences	TBD
28	Total Number of True Assessments of Child Maltreatment	9,543
29	Number of families served concurrently by evidence-based home visiting services	6,900
30 – Annie E. Casey	Number of children whose parents lack secure employment	33%

Mutually Reinforcing Activities for Parenting and Caregiving Support:

1. By June 2017, conduct a needs assessment, gap analysis, and messaging tests for parenting supports in Arkansas. (Consultant)
2. By June 2018, develop a Parenting Risk Index for Arkansas that combines measures related to strong parenting. (Consultant)
3. By June 2018, identify evidence-based parenting interventions, make policy recommendations, and identify messaging for low-, intermediate-, and high-need families to improve utilization of evidence-based parenting services. (ADH)
4. By June 2019, expand the availability of evidence-based parenting services (including home visiting services to all counties in Arkansas). (AHVN)
5. By June 2019, implement standard screening in Arkansas Children's Epic Electronic Medical Record to assess maternal depression. (Arkansas Children's)

With appropriate prevention services and treatment, children and adolescents can be free from chronic mouth and facial pain and experience less tooth decay, tooth loss and other diseases of the mouth and gums. Children and adolescents with good oral health should have a dental home where they are able to get consistent, age-appropriate dental check-ups.

LEADS - Arkansas Department of Health, Arkansas Children's Hospital

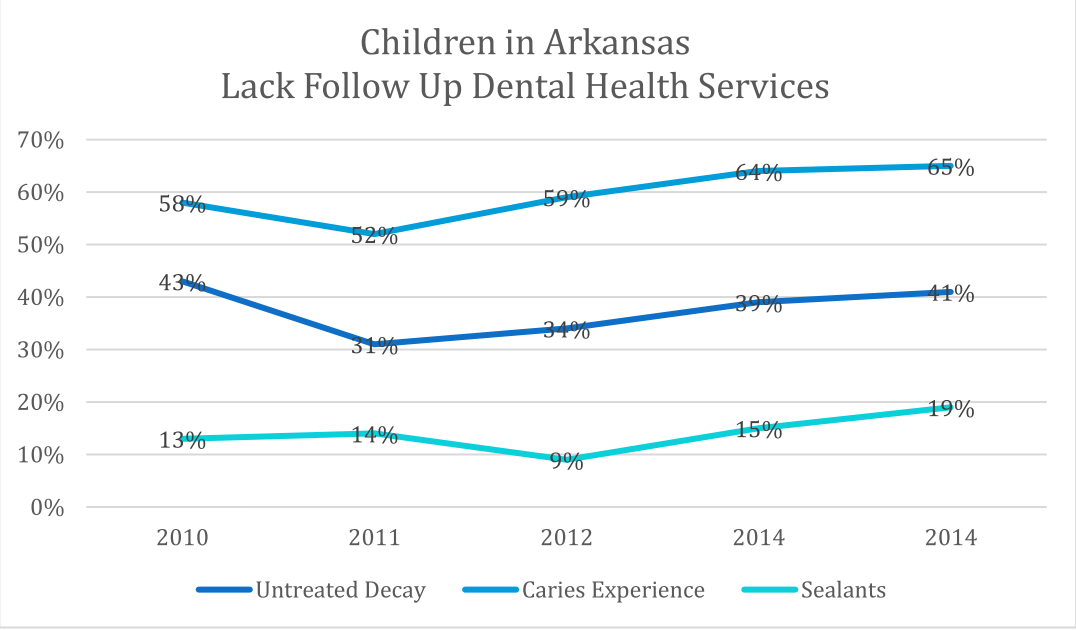
Why oral health matters

Strong, healthy teeth are important to a child's overall health and self-esteem. Cavities are one of the most common chronic conditions of children in the U.S. Poor oral health can cause pain and infections that may lead to problems with eating, speaking, playing and learning.[34]

How is Arkansas doing?

In 2010, only 27 percent of children had sealants, with significant disparities by race. More than a quarter of children were in need of routine dental care. Approximately, two-thirds of children (64 percent) had past dental caries experience and one-third (29 percent) had untreated caries.[35] The Arkansas Children's Hospital Dental Sealant Program initiative tracked data for second and third grade children it served across the state five years in the past five years. This program data is useful as a snapshot of children's dental health status. In its first year in 2010, the program screened 454 children. Screening doubled in 2014, with over 1,000 screenings completed that year. Figure 7 illustrates the trends for results from the screenings completed by the program in five years.

Figure 7 Arkansas Children's Dental Sealant Program - Screening Results, 2010-2014



Source: Arkansas Children's Dental Sealant Program Data

Community Voice

> *"…there are a lot of kids with bad teeth here."*
>
> **2016 CHNA Parent Participant**

Parents and providers agreed that ARKids First expanded dental care access to children. However, lack of knowledge about coverage and the services available mean parents may not access adequate levels of oral care for their children. Marginalized populations, particularly children not born in the U.S., often cannot access oral care services dues to parents' ability to pay. Parents, especially in Spanish-speaking groups, cited poor oral health and a high number of cavities in children. Access to oral care for children, especially in rural communities, at times that are convenient for parents was another barrier identified by the community. As a participant said, *"… no after-hours care, hard to get in to see the dentist."*

#	Shared Measures for Oral Health	Baseline
31	% of Arkansas third-graders with sealants	27%
32	% of Arkansas third-graders with dental caries experience	64%
33	% of Arkansas children on Medicaid who received preventive dental services in the past year	45%
34	# of pediatric health care providers certified to apply fluoride varnish	TBD
35	% of Arkansas school districts with preventive or restorative dental services delivered at school	TBD

Mutually Reinforcing Activities for Oral Health:

1. By June 2017, conduct statewide surveillance on children's oral health status and needs to identify baseline data. (ACH)
2. By June 2019, secure sufficient resources so ADH sealant partners can increase the annual number of children receiving sealants by 10% (ADH/funder partners)
3. By June 2018, provide education and distribute supplies to primary care providers to integrate oral health care into primary care (ADH/funder partners)
4. By June 2019, secure funding to study the economic impact to schools and to dental practices of investing in innovative solutions such as portable dentistry, collaborative care, or school based clinics (ADH)
5. By June 2019, provide annual oral health education to 30,000 children in Arkansas (America's Tooth Fairy)

Food Insecurity affects children when they live in a home where a parent or caregiver is unable to provide enough affordable, nutritious food throughout the year for everyone in the home. Food insecurity can mean that families make health trade-offs in order to feed their families.

LEADS - Arkansas Hunger Relief Alliance

Why food insecurity matters

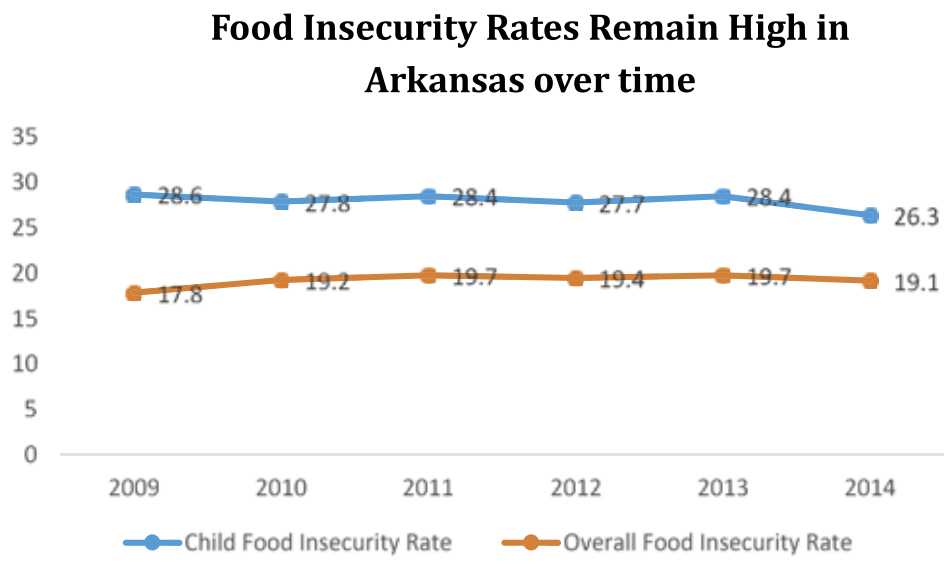
Children living in food insecure households often do not have their nutritional needs met. Hungry children have difficulty learning, and when school is out, children are especially vulnerable to food insecurity. Although families may prefer cooking healthy, nutritious meals at home, they don't always know what to buy or how to prepare it. Food insecurity can mean that families make health trade-offs in order to feed their families.

How is Arkansas doing?

Many Arkansans live in food deserts and have limited access to healthy and affordable food. For the past three years, Arkansas has had the second-highest food insecurity rate in the United States. In 2014, the overall food insecurity rate was 19.1 percent, and more than 26 percent of households with children identify as food insecure.[36] Surveys in the emergency department at Arkansas Children's Hospital found that 23 percent of families with children under age four were food insecure.[37]

Arkansas's SNAP program serves a higher percentage of families with children (72 percent) than the national average (69 percent).[38] Children's programs such as school breakfast and summer and after-school meals help ensure that children receive two to three healthy meals each day, but the number of sites participating in these programs needs to grow to reach all children.[39]

Figure 8 Child and Overall Food Insecurity Rates in Arkansas, 2009-2014



Source: Feeding America Map the Meal Gap, 2016

Community Voice

> [Food insecurity] is "*something we experience way too much in Arkansas.*"
>
> ***2014 CHNA Participant***

Parents from rural areas more often identified and wanted to discuss the issues of food insecurity than in urban areas. Stakeholders discussed food insecurity in relation to poverty and obesity. They expressed concern for the ability to support and promote programs that address food insecurity with more innovation and collaboration. In the statewide parent child health phone survey, although just 13 percent of respondents had been personally concerned about having enough food for themselves or their family in the past year, lack of access to healthy food was one component of the second-most-frequently-mentioned top child health problem.

#	Shared Measures for Food Insecurity	Baseline
36	% of children who are food insecure	26.3
37	# of Arkansas schools participating in the Breakfast After the Bell program	370
38	# of summer and after-school feeding program meals or snacks distributed when school is not in session for the summer	2.5 million
39	# of Cooking Matters participants	9,000
40	# of Arkansas school districts that have adopted community eligibility provisions	45

Mutually Reinforcing Activities for Food Insecurity:

1. By June 2019, increase the number of schools offering Breakfast After the Bell by 20 percent. (AHRA)
2. By June 2019, support food banks in increasing the number of school-pantry partnerships. (AHRA)
3. By June 2019, establish summer meal sites in all 75 counties. (AHRA)
4. By June 2019, increase by 10% the number of youth or families with children who participate in Cooking Matters or Cooking Matters at the Store programs. (ACH)
5. By June 2019, support eligible school districts in the process of adopting the community eligibility provision that allows schools to provide subsidized meals to all students, ensuring that 60% have adopted it. (AHRA)

Child injuries can be intentional or unintentional and may be inflicted by the child herself or others. Injuries include burns, falls, drowning, motor or recreation vehicle crashes, suffocation, poisoning, suicide and homicide. Unintentional injuries remain the leading cause of death for Arkansans children. NWPC is working to address the top child injury concerns in Arkansas through evidence-based prevention, education, targeted advocacy and by building capacity of parents and providers.

LEADS - Injury Prevention Center at Arkansas Children's Hospital

Why it matters?

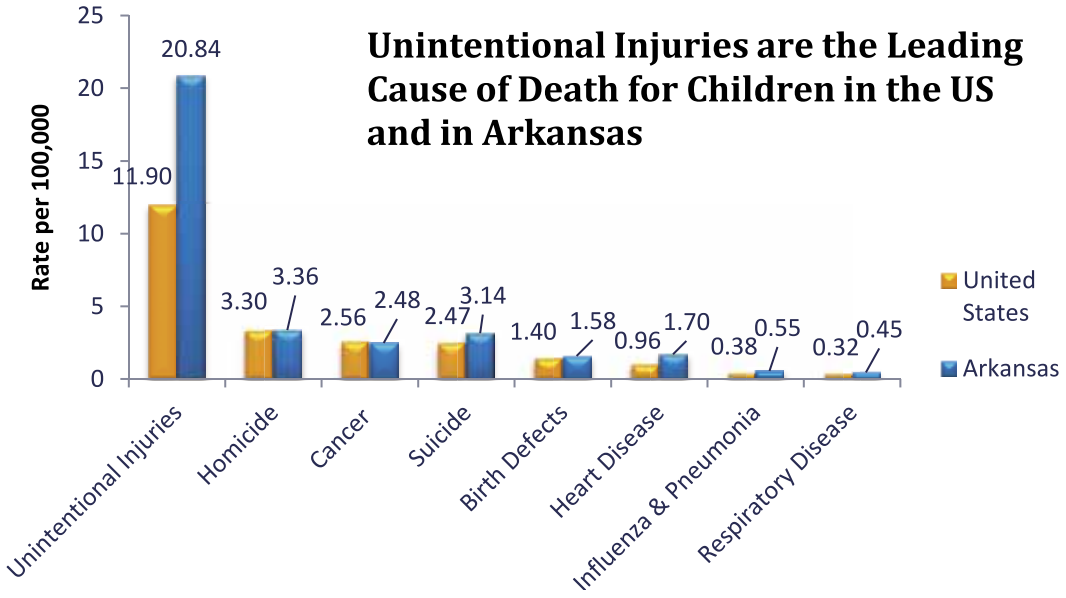
Unintentional injuries are the leading cause of death for Arkansas children. Child injuries are predictable and preventable, and without using data to develop and target evidence-based preventive efforts to protect children, they can have a significant impact on the health and life of children and adolescents.[40]

How is Arkansas doing?

From 2006 – 2014, Arkansas had a 37 percent decrease in its injury-related child death rate, but the state rate (21.2 per 100,000) is still 39 percent higher than the national rate.[41] For unintentional injury-related child deaths, Arkansas's rate (13.2 per 100,000) is still 46 percent higher than the United States rate. [42]

Sudden Infant Death Syndrome (SIDS) and suffocation account for more than half of all Sudden Unexpected Infant Deaths, and in Arkansas, the SIDS rate is 133% higher than the national rate. Universal adoption of risk reduction strategies, including "back to sleep" positioning and a safe sleep environment, is critical for prevention, but community-based education strategies are needed to help families adopt these practices.[43]

Figure 9 Leading Causes of Deaths, Children 1-19 Years of Age, 2000-2014



Motor vehicle crashes remain a prominent cause of injury-related death for children and youth in Arkansas. Despite progress, Arkansas still lags the nation on reducing motor vehicle-related deaths. All-Terrain Vehicles (ATVs) and firearm-related injuries are also of concern as they are often severe and frequently result in life-long medical needs and disabilities or death.

Community Voice

Parents who participated in the child health focus groups did not often mention child injuries happening to their own or other children in their communities. Surprisingly, in a focus group conducted in a community that had just experienced a deadly crash involving teenagers, none of the focus group members brought up the incident or identified motor vehicle injuries as a significant child health problem in their community. Of parent respondents in the CHNA telephone survey who reported having firearms kept in or around their home, 41 percent said that the firearms were "unlocked." This represents 18 percent of all parents surveyed who stored unlocked firearms in their home. Although communities did not voice concerns about injury frequently, data shows that this is an incredibly important area to address to keep children safe and alive.

#	Shared Measures for Child Injury	Baseline
41	Child death rate per 100,000 children ages 0-19 caused by injury	21.2
42	Motor vehicle death rates per 100,000 children ages 0-19	7.8
43	Post-neonatal infant death rate per 1,000 live births	7.8
44	Suicide death rate per 100,000 youth ages 10-19	5.6
45	Number of annual All-Terrain Vehicle-related admissions to Arkansas Children's Hospital	85
Annie E. Casey	Child and Teen Deaths per 100,000	34

Mutually Reinforcing Activities for Child Injury:

1. By June 2017, Arkansas Children's will refine its process and structure for providing child passenger safety seats and car seat checks to patients, including patients with special medical needs. (ACH)
2. By June 2019, Arkansas Children's will increase to 20 the number of counties with an annual car seat fitting station event. (ACH, UAMS, ASP HSO)
3. By June 2019, 50% of Arkansas birthing hospitals will be safe-sleep certified by Cribs for Kids (ACH/ADH)
4. By December 2017, design and conduct focus groups and complete data analysis that will inform messaging recommendations for safe firearm storage (ACH, funder partners)
5. By June 2019, secure sufficient resources and begin a study to increase parents' understanding of the risk of ATV use by children (ACH with National Institute of Health grant submitted via ACRI)

Immunizations protect children from dangerous childhood diseases that can cause costly complications or premature death. Children in Arkansas should receive key child and adolescents vaccinations, and parents should be able to access educational resources and needed vaccinations.

LEAD - Arkansas Department of Health, Arkansas Pharmacists Association

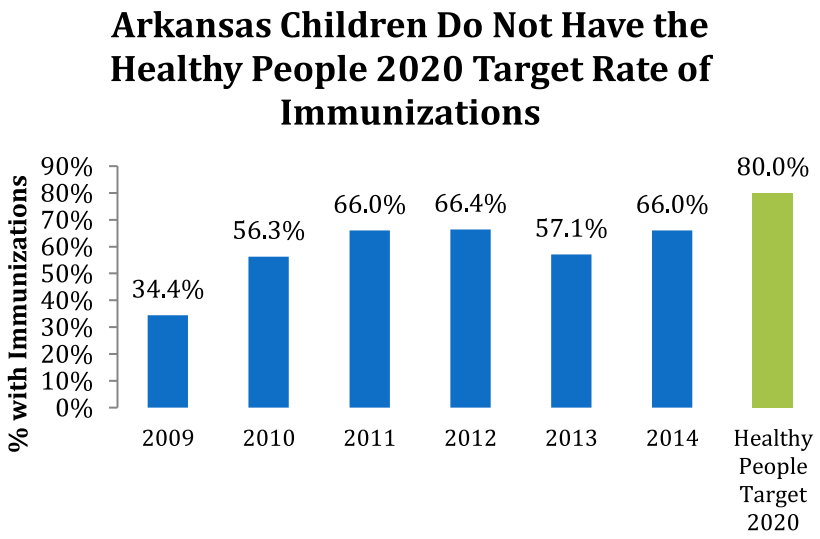
Why it matters?

Immunizations save children's lives and protect them from infectious diseases that young children's bodies are not able to fight on their own. They are safe and effective and protect the lives and health of other family and community members who may have weak defenses due to other illnesses.[44]

How is Arkansas doing?

Arkansas's children continue to be vaccinated at lower rates than the rest of the nation. In 2014, only 66 percent of children aged 19-35 months completed their full series of vaccinations as recommended by the Advisory Committee for Immunization Practices and the American Academy of Pediatrics.[45] Happily, vaccination rates in Arkansas are rising, and the state recently received a "biggest improvement" award for adolescent vaccination rates. However, teenagers continue to have low vaccination rates for the HPV vaccine that protects against Human Papillomavirus, which causes cancer. Only 23 percent of female and 11 percent of male teenagers have received all three of the vaccines in the HPV series.[46] Barriers to children receiving recommended vaccinations on time include problems with the state immunization registry, low reimbursement rates for providing vaccines, parent education, and compliance by schools and childcare providers with immunization requirements for attendance.

Figure 10 Vaccination Coverage among Arkansas Children 19-35 months, 2009-2014



Source: National Immunization Survey 4:3:1:3:3:1:4 Series.

Community Voice

Parents interviewed in community groups often identified immunizations as an important characteristic of a healthy child. However, they did not prioritize immunizations as one of their top health concerns. One out of ten parents (10 percent) who participated in the statewide telephone survey said they had elected not to get their child a vaccine shot for reasons other than illness or allergy.

#	Shared Measures for Immunizations	Baseline
46	Percent of children aged 19-35 months who received the combined vaccination series (4:3:1:3:3:1:4).	66.0 %
47	Percent of kindergarteners who received two doses of MMR vaccine.	88.4 %
48	Percent of females aged 13 – 17 years who received three doses of the HPV vaccine.	23.4 %
49	Percent of males aged 13 – 17 years who received three doses of the HPV vaccine.	11.4%
50	Number of Vaccines For Children sites, by county	340

Mutually Reinforcing Activities for Immunizations

1. By June 2018, collect and compile information to understand better immunization hesitancy in Arkansas. (ADH/ ACH)
2. By June 2017, collect and compile information to better understand immunization registry reporting (ADH)
3. By Jan 2017, hold regular monthly workgroup meetings with Childhood Immunization Task Force (CITF) workgroup. (ACH/ADH/Arkansas Pharmacist Association/AR Immunization Action Coalition Child Immunization Task Force)
4. By June 2018, add a pediatric immunization quality measure to the Patient Centered Medical Home model. (AR Immunization Action Coalition Child Immunization Task Force)
5. By June 2018, increase compliance for required school immunizations by identifying and addressing barriers to HIPPA and FERPA in regards to immunization reporting. (Consultant)

Looking Ahead for the NWPC

In 2017, the Natural Wonders Partnership Council will celebrate 10 years of collaboration to improve child health. The coalition members have worked together to address some of the highest priorities for child health. As the **backbone agency**, Arkansas Children's Hospital continues to invest staff time, financial support, and overall program management and leadership for the NWPC. **Continuous Communication** is supported through regular meetings of the NWPC and its 9 workgroups, as well as public events such as the 2017 Healthy Child Summit and retreats to address specific child health issues.

Some of the most important "wins" for the NWPC over the past decade include, but are not limited to, the following:

- **Increased access to oral health care for children**. Public policy changes, mobile and portable dental solutions that partner with schools, and public-private partnerships that help support children's access to oral health care have made a measurable, positive impact on children's dental health.
- **Reduced rates of child injuries and deaths.** Advocacy, research, and targeted programming have helped mitigate some of the leading causes of death for children in Arkansas. In particular, the 2009 law that implemented graduated driver licenses for teenagers helped reduce teen driving deaths by 59 percent from 2008 – 2010, and a host of safe-sleep-related programs have helped reduce infant mortality in Arkansas.
- **Increased access to school-based health care**. In the past decade, nearly three dozen tobacco-tax-funded school-based health centers have opened to bring full-service primary care to children on their school campuses. This model allows parents to remain at work and children to minimize time out of the classroom, supporting both health and learning.
- **Increased levels of children's activity at school.** GoNoodle has provided an easy way for teachers to incorporate movement into children's school days. In the past few years, Arkansas has remained at the top of the GoNoodle Movement Index for minutes of movement per elementary school child. GoNoodle reaches children in every public elementary school in Arkansas, and it provided more than 74 million minutes of activity to Arkansas students during the 2016-2017 school year.
- **Statewide parent support through home visiting.** State and federal funding have supported public-private partnerships to provide home visiting to families in almost every county in Arkansas. Evidence-based home visiting programs positively impact children and their parents, building stronger families and brighter futures for Arkansas children. The Arkansas Home Visiting Network is nationally recognized for its work to deliver evidence-based programs, provide training and professional development to home visitors, and evaluate the impact of home visiting on health, developmental, and educational outcomes.

The **Natural Wonders Innovation Fund**, debuted in fiscal year 2017, supported eight projects in its first year that will help "move the needle" on the child health issues outlined in this report. Evidence-based or evidence-informed projects were chosen by the NWPC and carried out by NWPC partners, with generous funding from ACH. An impact brief will be released in coming months to capture the process and outcome measures for the first year's projects as second-year projects are chosen in the summer of 2017.

A bright future is ahead for the children of Arkansas thanks to the collaborative efforts of the Natural Wonders Partnership Council!

Alphabet Soup

ACRONYM	NAME
AACF	- Arkansas Advocates For Children And Families
AC	- Arkansas Children's
ACH	- Arkansas Children's Hospital
ACHI	- Arkansas Center for Health Improvement
ACRI	- Arkansas Children's Research Institute
ADE	- Arkansas Department of Education
ADH	- Arkansas Department of Health
AHRA	- Arkansas Hunger Relief Alliance
APNA	- Arkansas Prevention Needs Assessment
ARECS-SEW	- Arkansas Early Childhood Comprehensive Systems: Social-Emotional Workgroup
AR-HVN	- Arkansas Home Visiting Network
BFH	- Baby Friendly Hospital
CDC	- Centers for Disease Control and Prevention
CFED	- Corporation for Enterprise Development
CSH	- Coordinated School Health
DCFS	- Division of Child and Family Services
DHS	- Department of Human Services
EC	- Early Childhood
Kids Count	- Annie E. Casey: Kids Count Data
SBH	- School Based Health
SBMH	- School Based Mental Health
USDA	- US Department of Agriculture
YRBS	- Youth Risk Behavior Survey

Acknowledgements

Thank you to all the Natural Wonders partners and loyal supporters who have been generous with their time and knowledge. These partners, with their commitment and work, keep alive the hope that a committed group of organizations can change the future for Arkansas's children.

Thank you also to the families, educators, health providers and child health experts who participated in the 2016 Community Health Needs Assessment sharing their stories, experiences and opinions to better understand the pertinent child health needs of children in Arkansas.

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