2008 2ND EDITION

natural wonders

The State of Children's Health in Arkansas

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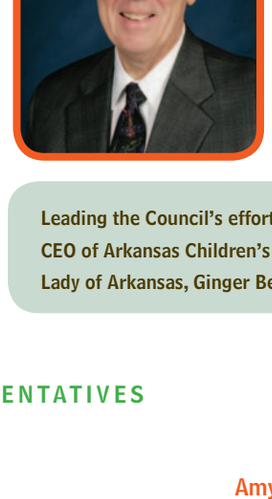
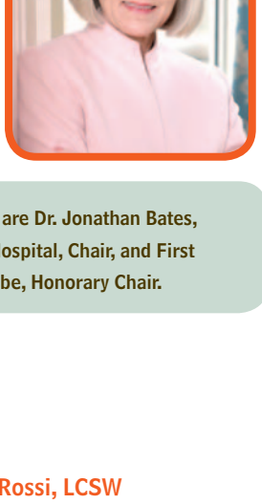
About the Council

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.





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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For further information or to request a copy of this report, contact the Natural Wonders Partnership Council via email at naturalwonders@archildrens.org or via telephone at 501-364-9916.

Introduction

In early 2006, the leadership of Arkansas Children's Hospital (ACH) convened a small group of community partners to discuss the continuing problems of poor socio-economic and health outcomes for children. They asked how they might play a larger role in changing health outcomes for children beyond the clinical intervention usually contained within the walls of their institutions. Partners were delighted to have the hospital leadership express an interest in public policy and finding ways to change the social determinants of health. From that initial discussion, the parties decided that a new exploration and documentation of the best statistical evidence reporting the health and well-being of children should be compiled. In summer 2007, a report titled "Natural Wonders: The State of Children's Health in Arkansas" was distributed widely throughout the state describing the status of child health in Arkansas. The report was saluted by Governor and Mrs. Beebe, and several thousand copies were distributed throughout the state. Upon its release, ACH President and CEO, Dr. Jonathan Bates promised that the hospital and its community partners would not shelve the report but use it as the springboard for a strategic plan to improve child health and well-being. To that end, the original small group of partners expanded their membership and formalized their group to be called the Natural Wonders Partnership Council (NWPC), chaired by Dr. Bates and assisted by Arkansas First Lady Ginger Beebe as honorary co-chair.

The first Natural Wonders report responded to the ACH and American Academy of Pediatrics (AAP) mission statements. It attempted to identify parameters of health as related to social determinants of health. In this second iteration of information to inform and improve conditions of child health in Arkansas, the NWPC is adopting the framework of the AAP's recently revised and improved Bright Futures[1] principles, strategies and tools. Bright Futures employs an ideology that respects both the promotion and the prevention aspects of child health, as well as the clinical practice elements, and utilizes the interface between physician, child (family), community and environment. The development of Bright Futures was facilitated by an interdisciplinary group of experts from the federal and private sectors. It is based on a developmental approach that acknowledges the constant change or interplay in a child's needs, strengths, weaknesses, relationships and experiences as they grow, learn and develop. We believe this framework provides a way to both illustrate and explain our recommendations while also establishing a framework for reporting progress on the health outcomes we are hoping to influence.

Although the first report acknowledged problems facing the state's children and suggested a number of steps to improve that status, the NWPC felt more was needed. We agreed to spend the next year examining the issues identified in the first report. The public was engaged to determine their opinions on the most important things to do to improve child health and well-being in Arkansas, with consideration given to identifying issues that might be more important for one geographic area than another. This exploration was very thorough and was conducted in record time. The NWPC met on a monthly basis to oversee the public engagement process, to share information about efforts underway to improve conditions for children and to engage in new partnerships that could tackle problems immediately. Attendance at these meetings was high, with very few absences at any given meeting. That in itself is testimony of the importance the meetings held for members, all of whom are leaders with little time to spare.

To obtain the detailed results and data associated with the various focus groups, surveys and Study Circle events, please access the Natural Wonders website at www.archildrens.org/NaturalWonders.

Achieving Success Early

Data from the Natural Wonders report[2] acknowledged that the state mortality rates in children 1–14 years of age were 20–30% higher than the national average due largely to increased fatalities in transportation accidents. Other striking deficiencies in health status identified were: in obesity where 40% of fifth graders are overweight or at risk of being overweight; in dental care where only 15% of young children and 17% of teens have had preventive sealant applied to their teeth and just 62% of Arkansans drink fluoridated water. These startling negative standings led some members to move immediately for solutions.

INJURY PREVENTION CENTER

Dr. Mary Aitken, a member of the NWPC, has long been an advocate for improving the state's high rate of childhood injury and death from injuries, particularly motor vehicle crashes. She presented strong evidence to the NWPC that most of the fatalities and serious injuries were preventable if certain safeguards were put in place and policy changes were made. Her discussion and paper spawned keen interest from ACH, and the hospital decided to award Dr. Aitken a start-up grant to launch the Injury Prevention Center (IPC).

The overall goals of the IPC are:

- **Improving the health status of children of the state as injury-related morbidity and mortality rates are reduced;**
- **Fostering collaboration to increase utilization and effectiveness of existing and future prevention strategies;**
- **Evaluating programs and promoting research into new solutions; and**
- **Establishing centralized planning and coordination for emerging injury prevention endeavors.**

Early activities of the IPC include expanding motor vehicle occupant safety to encompass teen drivers, including establishment of a statewide coalition examining potential impacts of laws governing driver's licenses, seatbelts and helmets. Additionally, Dr. Aitken and her team have conducted focus groups regarding these and other injury prevention topics that have helped inform the work of the NWPC and this year's report.

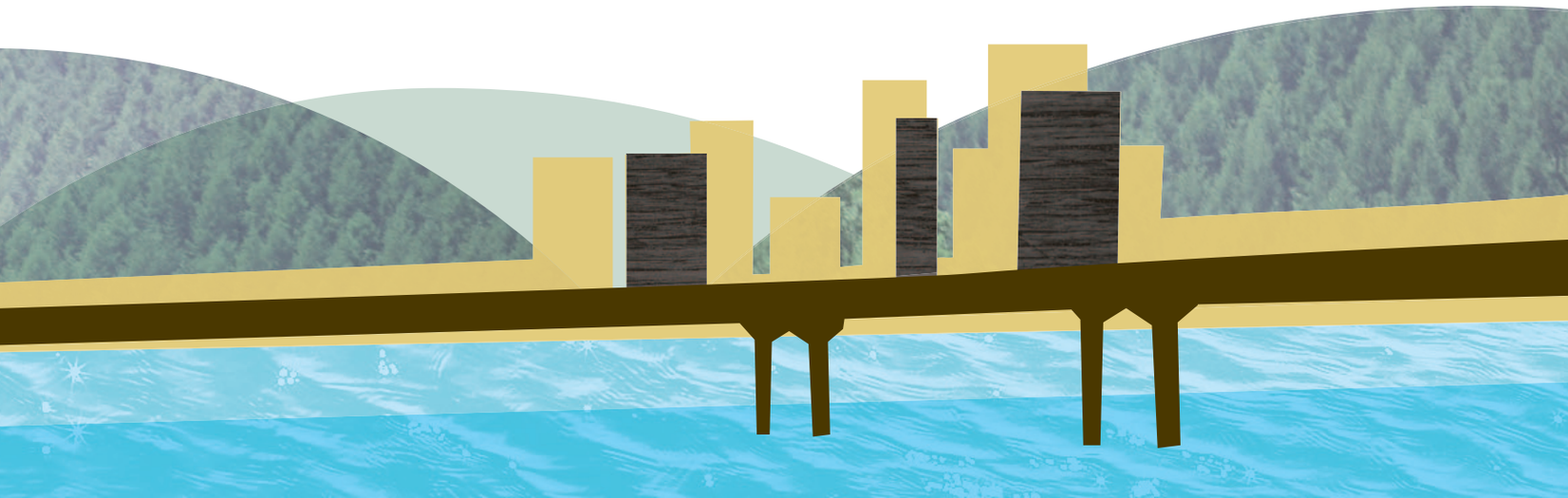
OBESITY PREVENTION

Spurred by membership on the NWPC, the Arkansas Blue & You Foundation and ACH jointly funded a competitive request for proposals that led to two papers and a state summit on obesity. The papers were to inform the people throughout the state. The Arkansas Advocates for Children and Families and the Arkansas Center for Health Improvement compiled the two reports, which were provided to the funders in July. Preliminary findings from the reports were presented to state leaders at an obesity policy summit in May. The obesity policy summit assembled stakeholders in order to develop a new plan for moving the state from halting progression of obesity rates among children to actually reducing the rates. Policy priorities were decided at the summit and workgroups are forming to execute the recommendations. (See summary on the web in Appendix G.)

DENTAL CARE

Several NWPC members formed a small investigatory committee to determine what could be done to increase dental services to children in the state. They initially focused on the low rate of children receiving sealants and found a way to increase access to dental care as well as application of sealants in two underserved areas of the state. Using the strength of the participating NWPC members (Delta Dental, Arkansas Dental Association, the Arkansas Dental Hygienists Association, Arkansas Department of Health and ACH, with financial supporters Tyson Foundation and Ronald McDonald House Charities) the following remedies have been set in motion: increased children's dental services during the Mission of Mercy free dental clinic in May 2008 to serve 1,569 individuals with more than 100 of these being children; and began an application process with local Ronald McDonald House Charities chapters to secure two mobile units from McDonald's Global Charities for delivering restorative and preventive dental services, including sealants. These units are scheduled for use in the central and northwest areas of the state. Additionally, ACH is working with the Arkansas Department of Health to expand a dental sealant program for children across the state. The Wakefield Dental Clinic in Little Rock, at Wakefield Elementary School, continues to see increasing numbers of children, with six schools bussing children into the clinic for care.

Discussions continue for adoption of policies to fluoridate public water supplies in areas not served; to change scope of work policies to allow other health care professionals, using proper guidelines and quality approaches, to administer sealants and to secure reimbursements for such; engagement of a variety of efforts to eliminate the use of smokeless tobacco; and exploration of starting a dental school.



Engaging the Public

ACH generously provided the funds to underwrite four different methods to involve the public in providing information for a strategic plan to improve child health and well-being. Arkansas Advocates for Children and Families, author of the original Natural Wonders statistical report, directed two efforts. One was the phone survey of over 2000 households in Arkansas. The other was to conduct Study Circles with assistance from the Arkansas School Board Association in five communities in Arkansas.

PHONE SURVEY

The phone survey was conducted in the fall of 2007 and findings were reported in January 2008. The public generally concurred with the statistical findings with one exception. Survey respondents were very concerned about uninsured children or those without access to health care due to escalating costs. While Arkansas has greatly reduced the number of children without health insurance (from a high of 24% to currently less than 10%) with the adoption of ARKids First, the national debate about reauthorizing SCHIP (the federal program to help uninsured children) was raging in the media during the time of the survey and may have helped create a more acute public realization about the plight of those without health care. And, as surveys often do, this series of questions invoked lots of comments from respondents regarding the cost of health care and their concern about their own vulnerability for meeting deductibles or retaining coverage. (See summary on the web in Appendix B.)

Some of the additional findings from the survey were:

- **When asked about the biggest problems Arkansas faces with regard to children's health and well-being, an overwhelming majority cited the low quality, cost of and lack of health insurance.**
- **When asked to rate their community on a variety of issues, respondents gave the lowest marks to their community's ability to serve children with learning disabilities and discipline problems. The highest marks were given for education and quality pre-K for 3- and 4-year-olds.**
- **When asked to rank their community on providing a safe environment, respondents in the southeast region of the state gave much lower marks than other areas. For the same question, African Americans more than whites ranked their communities as unsafe.**
- **When asked to rate the seriousness of specific problems in their community, overweight children was cited as a serious to moderate problem by 77% of respondents. Substance abuse in children was also cited as a serious problem by a large number of respondents, as was teen pregnancy.**
- **Respondents were asked to give their opinion on several statements. When asked about Arkansas' child welfare system, respondents showed a serious lack of knowledge. However, when read statements about family access to health care, a large percentage agreed that low-income families have less access to health care. And, while overall, only 37% of respondents agreed that minority children have less access to health care, 72% of African American respondents agreed with that same statement.**
- **Respondents also showed an interest in finding alternatives to the problem of health care access. Ideas such as well-child visits and health screens in schools received high marks, as did stricter laws regarding teenage driving.**

STUDY CIRCLES

The Study Circle process was to facilitate a deliberative discussion to explore the issues and to engage a diverse group of community members to identify problems and seek solutions. The conversations had a structured discussion guide and trained facilitators that managed the process and helped the group arrive at solutions.

The discussion sessions occurred over four or five consecutive weeks and included groups of eight to 10 individuals. A discussion site might have had multiple groups while others may have had only one. Five communities in each respective state health department region participated, and their contributions were recorded in a report delivered to the NWPC. (See summary on the web in Appendix C.)

Some of the Study Circle findings were: When asked to grade a variety of services in their communities, health care routinely received a grade of "D." Participants spoke of lack of access to care, too few providers and little or no dental care for children. They expressed concern about health care costs, especially medicines. Aside from providing financial incentives to get doctors to move to rural areas or building health and wellness facilities, the most popular remedy suggested for improving children's health and increasing access to quality care was to provide school-based health services. Although the topics of family and community were not graded during the third discussion session, the topics were two of the most cited concerns among circle participants. In fact, all five discussion group reports mentioned the breakdown of the family structure as a big problem in their communities, and each expressed concern over the lack of parental responsibility and accountability.* Four of the groups mentioned that parents today lacked parenting skills.

Study Circle participants were asked to discuss their vision with regard to improved health and well-being of children. Most of them expressed visions reflecting the groups' concerns for better health care for all children; equal opportunities for all citizens despite race, ethnicity or social class; more accountability in the social services systems; a fairer distribution of resources; and strengthening families in their communities.

PROVIDER FOCUS GROUPS

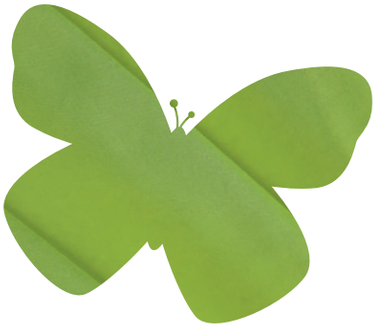
The Arkansas Chapter of the American Academy of Pediatrics conducted focus groups with an array of different child-serving clinical providers in five areas of the state. These focus groups were well attended with no fewer than 10 participants in every discussion. The participants consistently thanked the Academy for soliciting their input and wanted to know when the report would be ready and when would they return to help solve the identified problems. (See summary on the web in Appendix D.)

The overwhelming issue raised by participants was concern about parents, including lack of involvement with their children, limited levels of education and limited financial resources. The participating providers seemed to agree that the parental component was the catalyst for creating "hot-button" issues such as the obesity epidemic, lack of preventive care and dental care, teen pregnancy and rise of sexually transmitted diseases. When asked to consider barriers that prevent providers from effectively treating children, they cited difficulty with navigating the Medicaid system (as well as other payer systems), lack of availability of specialists and an increase in patient loads. Language/communication barriers also were mentioned by each group, with specific reference to the lack of providers from minority communities (both African American and Latino).

INFORMANT INTERVIEWS

The University of Arkansas for Medical Sciences College of Public Health completed the final engagement of stakeholders by conducting small group or individual interviews statewide with academicians who specialized in content areas that had some relation to children's health. Faculty members' comments were mostly similar to those of other participants in public engagement projects. They reported poverty and education levels as a constant deterrent to health improvement. Instead of a lack of dental services rising as a top issue, however, these professionals expressed more concern over the lack of mental health services. They observed that parents often did not link dental services to overall health and that they opted not to take children to a dentist because of cost, a lack of knowledge about its preventive health benefit and its relative lack of urgency among competing priorities. Obesity and substance abuse were two often cited problems suffered by children. Two faculty groups made specific references to the impact on children of parents' manufacture and use of crystal methamphetamine in the home. Faculty members in almost every group expressed frustration at the absence of a central point for the collection and maintenance of data related to children's health, complicating efforts to apply for funding and conduct research leading to health improvement. This is not dissimilar from the information in the Study Circles where community members talked about the difficulty of finding out information about their communities with regard to data and how to find services. (See summary on the web in Appendix E.)

* Problems mentioned included the lack of family "together time," both parents working, single parent households and grandparents raising grandchildren.



Setting the Stage

The NWPC adopted both a definition of health and a conceptual framework with which to guide the development of a strategic plan for improving child health. The diversity of NWPC membership, and the need to involve multiple sectors to tackle the problems, motivated members to develop language that everyone would understand and embrace. The Council understood that its work was not exclusive and that there were other stakeholders who were undertaking separate efforts on health issues of concern to children. Thus, members also reviewed and incorporated work by other panels undertaking similar tasks. They did not find a need to create new tools if others were available and met the needs. The NWPC adopted the definition for child health recommended in 2004 by the Committee on Evaluation of Children's Health, National Research Council of the Institute of Medicine (IOM).[3]

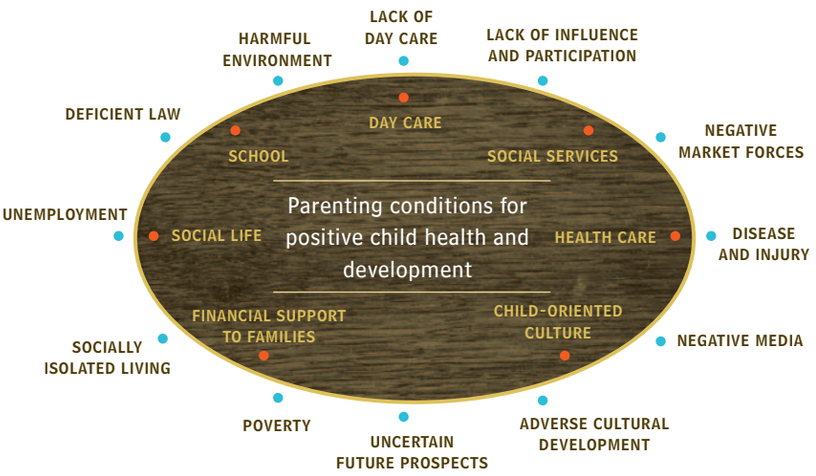
The definition of child health adopted by the NWPC is identical to the IOM definition with one addition noted within: "Children's health is the extent to which individual children or groups of children are able or enabled to (a) develop and realize their potential, (b) satisfy their needs, and (c) develop the capacities that allow them to interact successfully [and responsibly] with their biological, physical, and social environments."

Additionally, the NWPC endorsed the revised update of the American Academy of Pediatrics' "Bright Futures"[5] approach to health service delivery.

The AAP explanation of Bright Futures is: "Bright Futures is a set of principles, strategies, and tools that are theory based, evidence driven, and systems oriented that can be used to improve the health and well-being of all children through culturally appropriate interventions that address their current and emerging health promotion needs at the family, clinical practice, community, health system, and policy levels." AAP 2007.

Finally, the NWPC determined that an illustration provided by a collaborative effort of the 15 member states of the European Union Health Monitoring Programme—CHILD: Child Health Indicators of Life and Development—is a good model to explain the context for reviewing, refining and reporting progress in improving and sustaining a quality of life that gives a child optimal advantages.[4]

Detriments of the Child Health and Development Context



The overall determinants of the child health and development context can be illustrated as shown in the figure above.[5] This is the domain which the CHILD Project sought to address, with a particular focus on responsibilities within the health sector, but with a strong inter-sectoral viewpoint as to other policy and service responsibilities, too.

The NWPC organized its activities in three strategic phases: 1) data gathering to build evidence of the problems; 2)public engagement to determine public interest and seek recognition of issues; 3) recommendation setting and implementation. This report represents the third and final phase. The NWPC deliberately determined that the information-gathering and priority-setting phases would be time-limited. Its overall goal was to set a strategic vision for the state and to lay a foundation from which to build an action agenda that would emphasize improvement and involve multiple stakeholders including parents, children, private and public sectors, faith communities, civic organizations and decision leaders.

It is important to provide these points of reference as the context used by NWPC to guide the implementation period for its recommendations. The terms provide essential starting points from which a variety of individual, community, and governmental stakeholders can find a way to engage in the big job ahead.

Recommendations to Improve Arkansas' Children's Quality of Life and Health

In late May 2008, the majority of NWPC members attended a day-long retreat to:

- **Discuss findings from the various public engagement processes conducted over the year;**
- **Review publications that ranked Arkansas on various health indicators;**
- **Refresh their memories about last year's statistical evidence-based report; and**
- **Use their collective expertise to build a series of recommendations to address child health.**

The recommendations are captured under specific topic areas that require policy and/or practice improvements. Within the framework, there are recommendations that are likely to produce improvements for all age groups but may have specificity by age, i.e. "improve immunization rates," which would include specific reference to age protocols for administering vaccines.

It is not the Council's intent to override or diminish the significance of the efforts of other groups studying specific areas of interest regarding health and quality of life for children. Instead, our work embraces that of our colleagues and incorporates some of their recommendations within this report to be inclusive and supportive of their work. And, we offer their additional recommendations to complement ours and to assure that our examination of critical issues for children include things that may not have arisen in our deliberations but are of paramount interest to other stakeholders concerned about children.

One other point needs to be mentioned. This list is not presented in a prioritized fashion with one preceding the other in importance. Instead, this list is a compilation of tasks that need to be done to improve the health of our children. Some individuals and groups will be more interested in some recommendations than others. We give these in the spirit that there is something for everyone to embrace as their own so that we may make a significant change in the quality of life afforded all of our children. We sincerely hope there will be multiple efforts occurring simultaneously so that many hands, hearts and minds are united to make this list dynamic and ever-improving, with the common goal of making Arkansas the best place to raise a healthy, productive child.

The current state task forces, coalitions or interest groups considered during our deliberations are the following:

- **"Closing the Addiction Treatment Gap" staffed by Partners for Inclusive Communities in partnership with Arkansas Advocates for Children and Families and DHS-DBHS.**
- **Finish Line Coalition staffed by Arkansas Advocates for Children and Families.**
- **The Arkansas Children's Behavioral Health Care Commission, chaired by Judge Joyce Warren, convened by law that will provide advice and guidance to the Department of Human Services and other state agencies providing behavioral health care services to children, youth and their families.**
- **Arkansas State Leadership Workshop on EPSDT: Advancing a Collaborative Action Agenda to Improve Child Health.**
- **Assuring Better Child Health Development Stakeholders' Committee. Staffed by DHS-DCCECE.**
- **The Governor's Task Force on Best Practices for After-School and Summer programs.**

The Council's vision of success in each topic area is represented by a gold star. Each gold star achieved will mean optimum improvement in the quality of life and health of Arkansas' children.

PRENATAL CARE, INFANT MORTALITY AND TEEN PREGNANCY

Although prenatal care has been improving significantly over the last decade, the news about birthweight and infant mortality is not good. Rates for both low birthweight and infant mortality exceed national averages at 8.6% of all births and 8.3 per 1,000 births respectively. Particularly disturbing is the higher rate of infant mortality for African American babies compared to white babies. In 2002, there were 13.8 deaths per 1,000 live births for African American babies compared to 7.2 deaths per 1,000 live births for white babies. Too many teens are still having babies in Arkansas at a rate of 15.5% of all births in 2002 compared to the national rate of 10.8%.

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.

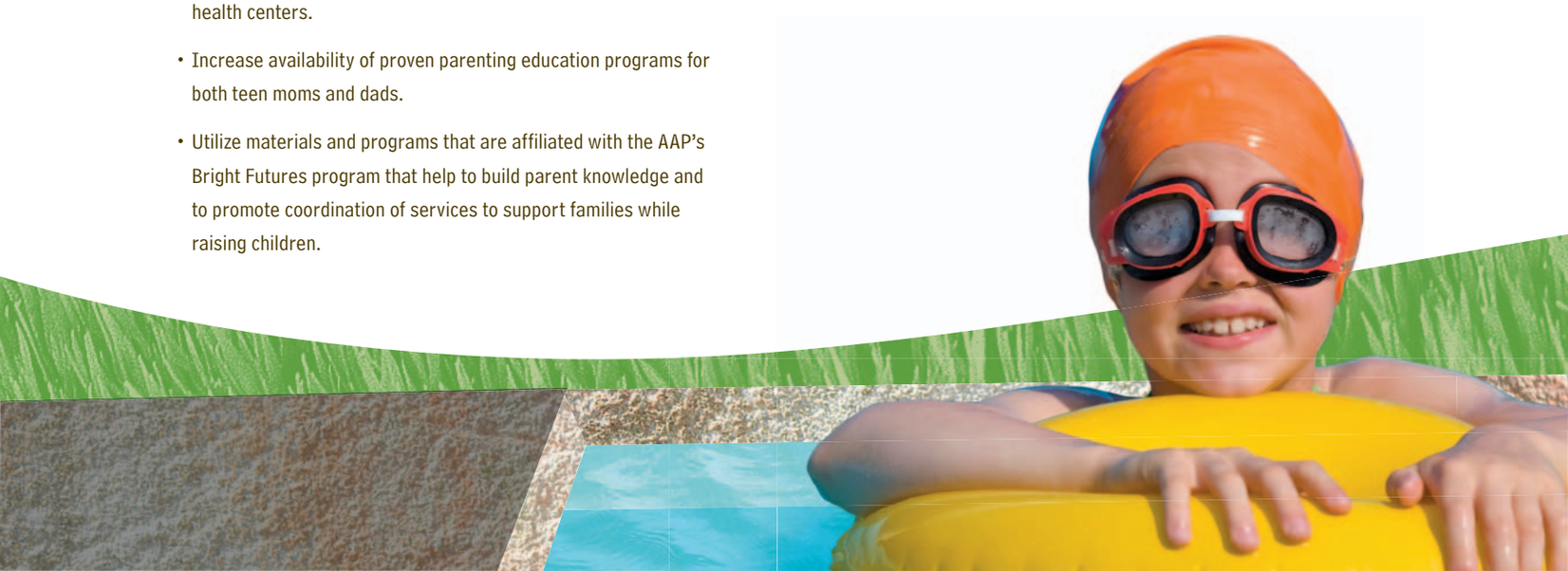
Recommendations

- 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 solved 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.
- Utilize materials and programs that are affiliated with the AAP's Bright Futures program that help to build parent knowledge and to promote coordination of services to support families while 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 school-linked after-school and summer programs that contain social, emotional and life-skills-building to include 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 screens) 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.

*Governor's Task Force on Best Practices for After-School and Summer Programs 8/08.

**Adopted from the "Closing the Addiction Treatment Gap" Partnership.

***Adopted from the Assuring Better Child Health Development (ABCD) Initiative Final Report from Arkansas.



IMMUNIZATIONS

Rates of childhood immunizations, particularly those occurring after infancy, have not been keeping pace with the rest of the country. In fact, laws passed in 2003 allowing parents to opt out of immunizing their children for philosophical reasons have contributed to a reduced emphasis on keeping children up-to-date on their immunizations. Those securing permission to not have their children immunized have increased annually since passage of the legislation, causing officials to be concerned about potential outbreaks of communicable disease. Additionally, the modern myth linking immunizations to increased rates of childhood autism is unfounded but has been perpetuated in popular media.

Infants, children, and adolescents are provided protection from communicable disease i.e., measles, chicken pox, etc.

Recommendations

- Reduce immunization exemption usage.
- Inform parents and the public about the risks and proven effects 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 utilization of the state's immunization registry.

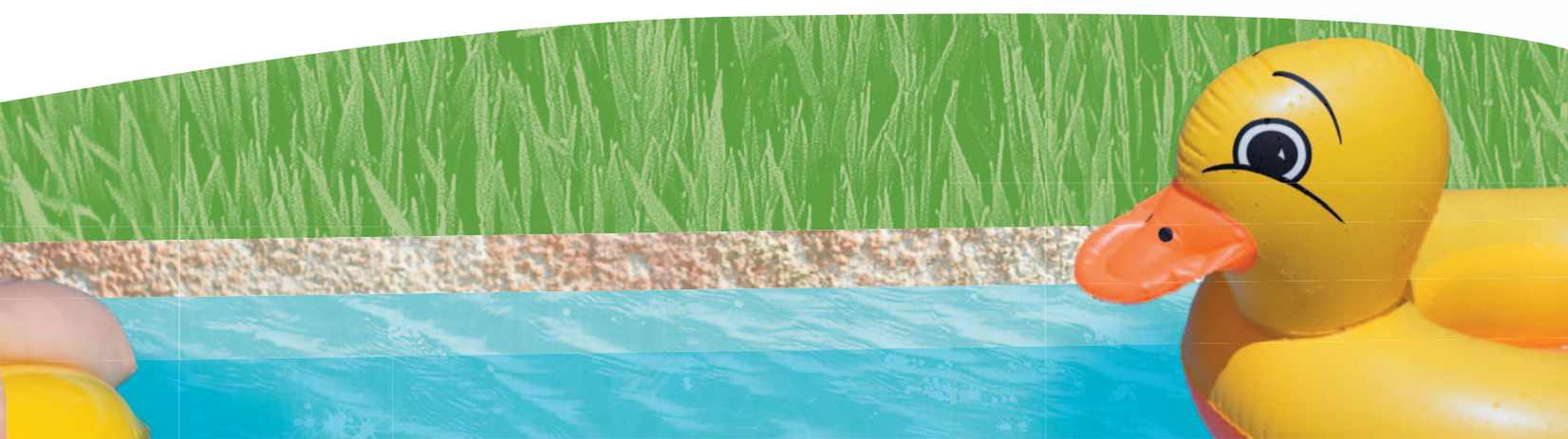
ORAL HEALTH

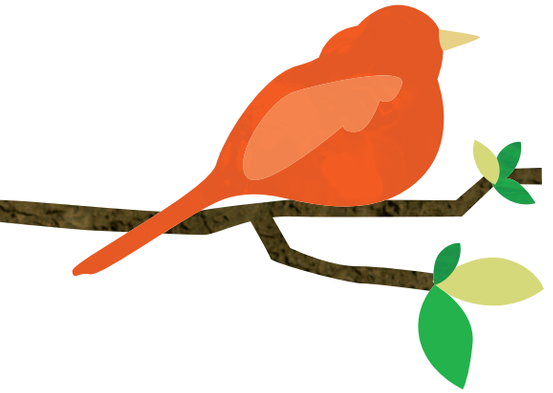
Too few children have access to dental services. A 2003 survey of 7100 third graders found that 61% had evidence of current or past cavities, 31% had untreated cavities, 21% needed routine dental care and 6% had urgent dental needs.[2] Preventable solutions to common dental problems in children could be achieved if more children had applications of dental sealants and fluoride varnish and lived in communities with fluoridated water systems. Only 62% of Arkansas counties fluoridate the water systems.

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

Recommendations

- 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. Utilization 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 of the state.





REDUCING RISKY BEHAVIOR—INJURY PREVENTION

The number of Arkansas children dying from preventable injuries exceeds the national average by up to 40%. In 2005, 63% of deaths for children age 1–4 and 60% of deaths for those ages 5–18 were due to unintentional injury. Transportation-related causes made up the majority of all injury-related deaths.

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

Recommendations

- Secure a graduated driver's license (GDL) to include the following provisions, which reflect the ideal implementation of a GDL policy per the Insurance Institute for Highway Safety:
  - Establish intermediate license stage for beginning drivers.
  - Set 16 years of age 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 16½ 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 (provide exceptions for school and work).
- Mandate primary seat belt 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.
- Incentivize with things such as 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 to implement into practice.
- Enhance statewide child passenger seat program to ensure parental access to equipment and educational resources.
- Increase partnerships with Coordinated School Health (a collaboration effort among ADH, DOE and local school districts) 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

Teenage smoking habits, as well as exposure to secondhand smoke, in Arkansas top the national average. Additionally, a growing number of teens report the use of chewing tobacco and other forms of tobacco. Evidence supports the use of different policies that relate to teen marketing, which can delay or prevent initial use of tobacco products

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

Recommendations

- 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

Almost 40% of Arkansas children are overweight or at risk for becoming overweight. Overweight conditions emerging and continuing throughout childhood often result in lifelong health risks that can lead to early death. Electronic entertainment and the lack of safe accessible areas to play are causing more children to limit or abstain from physical activity. Over-reliance on high-calorie fast food combined with lessened physical activity is provoking an increasing weight gain for children and their parents. These rates of obesity are significantly higher for Hispanic/Latino and African American children.

The childhood obesity epidemic is eliminated in Arkansas.

Recommendations

- Expand the methods for transferring nutrition education/ information to parents and children to include such things as restaurant menu labeling.
- Increase the "Safe Routes to School" initiatives that encourage safe routes to walk or ride a bicycle from home to school and back for children.
- Promote the use of school physical activity facilities for community use beyond regular school hours.
- Increase PE and 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

The NWPC and the public are aware that too few behavioral health services are available for all the children who need them and that there is poor coordination among different services. While some communities can offer an array of services, often the lengthy waiting list for appointments makes the service unavailable.

At the same time, other communities have so few resources that parents give up before they even start. Couple the lack of service availability with requirements that limit participation or make participation difficult and you have families unable to navigate the very systems that are supposed to help them. The NWPC identified a series of services that need special attention as well as areas that need strengthening or revitalizing. We are particularly supportive of the Arkansas Children's Behavioral Health Care Commission's intent for development of a coordinated system of care for children and youth with mental health and developmental needs.

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.

Recommendations

Reform the children's behavioral health system by:*

- Adopt a uniform assessment process to increase accountability in the Medicaid program, based on positive child outcomes;
- Support communities, possibly through pilot programs, to expand an array of community-based services, driven by child needs, family preferences and community priorities. These include, for example, respite care, family preservation, and substance abuse services;
- Fund schools to implement Positive Behavioral Interventions and Supports (PBIS), an evidence-based approach, to support identification of and response to student behavior challenges in school;
- Develop Care Coordinating Councils to facilitate cross-system service and resource decisions; and
- Develop local care teams for building and maintaining wrap-around planning and services.

*Per the recommendations of Arkansas Children's Behavioral Health Care Commission. A full list of the recommendations is available in the appendix on the web.

SERVICE NEEDS OR EXPANSIONS

Families throughout the state face hurdles when trying to navigate the variety of health systems when they need routine care. For those families whose children have conditions that require specialized treatment, however, the task of securing help is often more than they can handle. The frustration in finding the right care, the right agency and the right way to pay for it confounds both the parent, as well as their physician or referral source. NWPC offers these recommendations to improve the quality of services delivered, increase service options in all regions and improve access.

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.

Recommendations

- 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% or a maximum of 300% of poverty.
- 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 the access to an array of health and preventive health services in rural communities.
- Expand Coordinated School Health Services by:
  - Committing state general revenue to support CSH in schools in a phased-in process so that all schools have this service by 2015.
  - Ensuring schools have sufficient staff to provide the CSH.
  - 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.

CAPACITY BUILDING

Throughout these recommendations, the Council has suggested adding, creating or improving services. During deliberations, the Council also paid close attention to those areas where improvements were needed to build a cohesive, coordinated and practical array of interventions that would serve even the most isolated community in our state. To do that, some of the following recommendations address the need for different methods or timing of innovations that would jumpstart or increase productivity and quality in the delivery of services to children and their families. At least three of the other groups searching for solutions to issues influencing children have recommended a position that serves as an information guide to help parents and providers find appropriate help when a child has a particular need. These health navigator positions were recommended not only for information and referral but also to assist parents in following up on making applications and getting in for appointments. Complex service systems and funding sources have created a maze of requirements and instructions that make even the most educated and tenacious parent fail to secure a needed resource for their child. Too many parents are diverted and give up the pursuit before they secure the necessary assistance.

Recommendations

- Ensure that children have a medical home that can guide and coordinate screening diagnosis and treatment. (See appendix G on the web for definition of medical home.)
- Explore novel methods for delivering routine preventive health services to families in a more expeditious and accessible manner such as 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, web-based personal health records.
- Use technological advances, such as telemedicine, to provide expert diagnosis and treatment.
- Develop electronic warning systems to ensure follow-up services, medications, etc. are provided when screens come back with results that 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 programs that recruit students, especially minority students, in middle and high school into health career paths.

A Distinct Priority

Through its year of work, and reflected in some of these recommendations, the Council recognized that minority children often bear a disproportionately negative impact in health outcomes, risk factors and service delivery. The Council is particularly concerned about children in immigrant families. Whether these children are immigrants themselves or are citizens of the United States with immigrant parents, they face dual obstacles: a higher likelihood of living in poverty and a lower likelihood that they may qualify for government supports like Medicaid and Food Stamps. This may be due to their immigrant status or programs that poorly penetrate immigrant families with unique language and cultural backgrounds. Many groups acknowledge the higher death, disease and poverty rates for minority children, but few have established specific action plans to reduce, mitigate or eliminate the disparities. We have made some specific recommendations to improve access to services for minority children, and particularly children in immigrant families, but we realize that this population deserves focused attention. In the next year, we intend to engage minority youth, parents and communities to hear their concerns and learn from their experiences to root further recommendations on these issues. In addition, a separate committee of our members will investigate interventions that have been successful in achieving health equity for minority children. This group will then turn to a search for resources to adapt these successes in Arkansas communities. The next report of the Council will contain a synthesis of this information and identify specific action steps that the state and other stakeholders should take to improve health outcomes for minority children. We recognize this is a critical step to improve the health of all children in Arkansas.

LIST OF ABBREVIATIONS

AAP	American Academy of Pediatrics
ABCD	Assuring Better Child Health Development
ACH	Arkansas Children's Hospital
ADH	Arkansas Department of Health
ATV	All Terrain Vehicle
CHILD	Child Heath Indicators of Life and Development
CSH	Coordinated School Health
DBHS	Division of Behavioral Health Services
DHS	Department of Human Services
DCCECE	Division of Child Care and Early Childhood Education
DOE	Department of Education
EPSDT	Early Periodic Screening Diagnosis and Treatment
GDL	Graduated Driver's License
IOM	Institute of Medicine
IPC	Injury Prevention Center
NWPC	Natural Wonders Partnership Council
PBIS	Positive Behavioral Interventions and Supports
PE	Physical Education
SCHIP	State Children's Health Insurance Program
TBI	Traumatic Brain Injury

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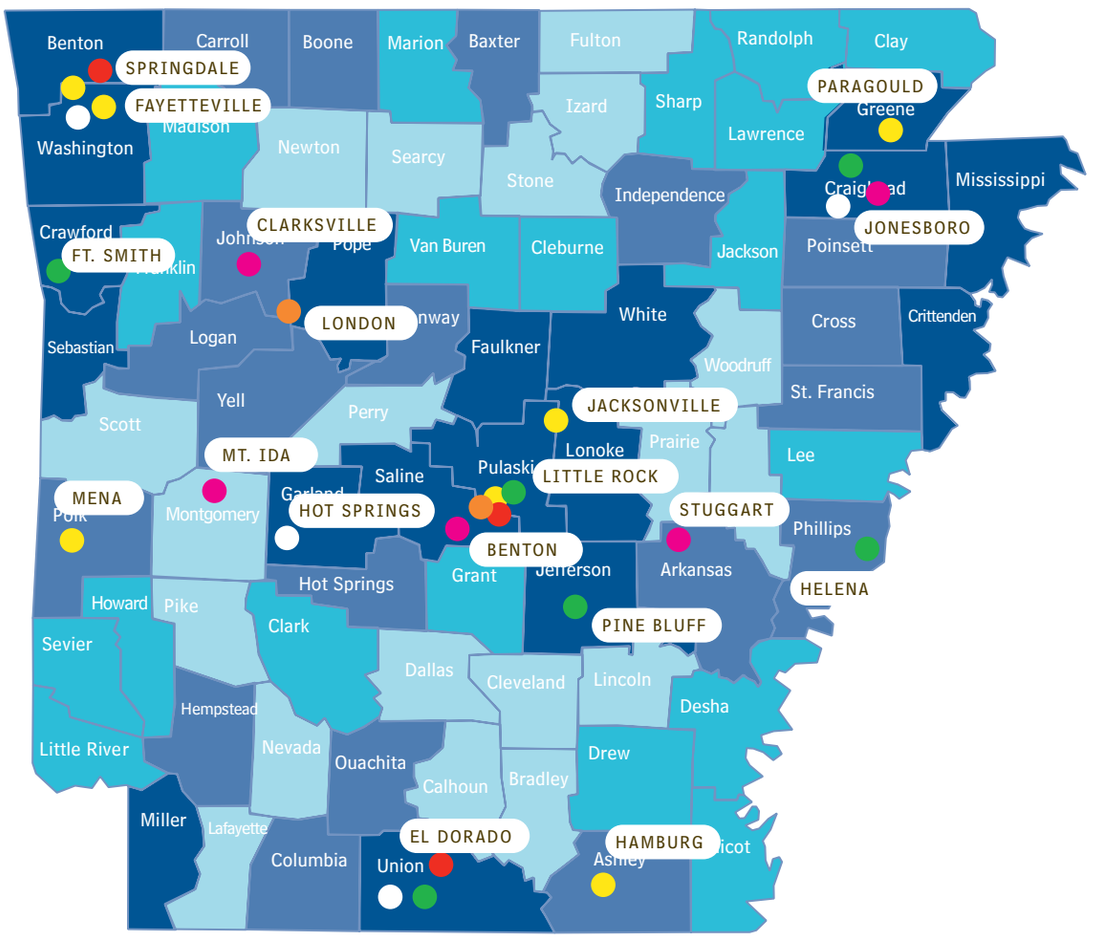
Public Engagement Map



TYPE OF GROUP

- Study Circle
- AAP Focus Groups
- ATV
- TBI
- Teen Driving
- Safe Routes to School

POPULATION

- 1–3,215
- 3,216–5,122
- 5,123–8,513
- 8,514–100,000

Source: Center for Applied Research & Evaluation (CARE)
Questions: Contact Hope Mullins 501-364-4932

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aaea

ASDA Arkansas State Dental Association

Arkansas Advocates for Children & Families

Arkansas Kids Count

American Academy of Pediatrics
Dedicated to the health of all children™
Arkansas Chapter

Delta Dental

Arkansas BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

IEA Institute for Economic Advancement
UALR College of Business

ACHI
Arkansas Center for Health Improvement

Injury Prevention Center
archildrens.org

Arkansas Department of Education

University of Arkansas Clinton School of Public Service

Arkansas Department of Human Services

UALR University of Arkansas at Little Rock

ADH

UAMS Fay W. Boozman College of Public Health
University of Arkansas for Medical Sciences

Arkansas Hunger Relief Alliance

UAMS College of Medicine Department of Pediatrics
University of Arkansas for Medical Sciences

For further information or to request a copy of this report, contact the Natural Wonders Partnership Council via email at naturalwonders@archildrens.org or via telephone at 501-364-9916.