

Community Health Needs Assessment

Arkansas Children's Northwest

2019



Arkansas
Children's
Northwest

Executive Summary

Arkansas Children's Northwest (ACNW) is a private, nonprofit hospital within Arkansas Children's, Inc., the only healthcare system in the state solely dedicated to caring for Arkansas's 710,000 children. This status gives the organization a unique ability to shape the landscape of pediatric care in Arkansas and transform the health of children throughout the region. The private, non-profit organization includes two pediatric hospitals, a pediatric research institute and USDA nutrition center, a philanthropic foundation, a nursery alliance, statewide clinics, and many education and outreach programs. Arkansas Children's Northwest (ACNW), the first and only pediatric hospital in the Northwest Arkansas region, opened in Springdale in early 2018. ACNW operates a 24-bed inpatient unit; a surgical unit with five operating rooms; outpatient clinics offering over 20 subspecialties; diagnostic services; imaging capabilities; occupational therapy services; and Northwest Arkansas' only pediatric emergency department, equipped with 30 exam rooms. Generous philanthropic and volunteer engagement has sustained Arkansas Children's since it began as an orphanage in 1912, and today ensures the system can fundamentally transform the health of children in Arkansas and beyond.

This inaugural 2019 Community Health Needs Assessment (CHNA) provides ACNW its first opportunity to understand and prioritize its community's health needs through input gathered from community members, public health experts, and existing data sets. It also satisfies the requirements of the Internal Revenue Service (IRS) for tri-annual needs assessment for nonprofit hospitals.

For the purposes of the CHNA, ACNW defines its community as all children under age 18 in an eleven-county region in Northwest Arkansas (2017 population 205,767.) The counties include Benton, Carroll, Boone, Washington, Madison, Newton, Crawford, Franklin, Johnson, Sebastian, and Logan. From September 2018 through February 2019, hospital staff gathered data for the CHNA. The following data sources contributed to the wide range of input gathered from community members and organizations who represent children's health interests:

- 6 focus groups targeted to parents and children's service providers across Northwest Arkansas
- 17 key informant interviews targeted to child health thought leaders and subject matter experts
- A telephone survey of 395 Northwest Arkansas parents that was statistically significant at the regional level
- A comprehensive review of child-specific secondary data from local, state, and national sources.

Resulting data were analyzed and prioritized into ten priority themes based on public health and qualitative research methods. Additional perspective is added to each theme through seven cross-cutting factors, including transportation and substance use, which were mentioned frequently as contributing elements to multiple priority themes. The themes, in priority order, are:

1. Equitable Access to Care
2. Mental Health and Substance Use
3. Food Insecurity
4. Parenting Supports
5. Social Issues
6. Child Obesity
7. Reproductive Health
8. Child Injury
9. Oral Health
10. Immunizations

Over the coming months, the CHNA will be used to inform ACNW's strategic initiatives that improve child health, including its first formal Implementation Strategy, population health solutions, and the work of a new local advisory group of key child health stakeholders and community partners.

Table of Contents:

ASSESSMENT	4
A. PURPOSE AND SCOPE	4
B. COMMUNITY DEFINITION	4
C. COMMUNITY HEALTH NEEDS ASSESSMENT PROCESS OVERVIEW	5
METHODS	6
A. SECONDARY QUANTITATIVE DATA COLLECTION	6
B. PRIMARY QUALITATIVE DATA COLLECTION	6
I. PARENT AND CAREGIVER PHONE SURVEY	6
II. KEY INFORMANT INTERVIEWS	8
III. PARENT AND SERVICE PROVIDER FOCUS GROUPS	8
FINDINGS	12
A. PRIORITIZED HEALTH NEEDS	12
B. CROSS CUTTING FACTORS	14
C. PRIORITY HEALTH NEEDS PROFILES	15
EQUITABLE ACCESS TO CARE	17
MENTAL HEALTH AND SUBSTANCE USE	23
SOCIAL ISSUES	29
PARENTING SUPPORTS	35
CHILD OBESITY	41
FOOD INSECURITY	47
ORAL HEALTH	53
IMMUNIZATIONS	59
REPRODUCTIVE HEALTH	65
CHILD INJURY	71
LOOKING FORWARD	76
A. COMMUNITY RESOURCES TO SUPPORT CHILD HEALTH	76
B. CHILD HEALTH ASSETS FROM FOCUS GROUPS AND KEY INFORMANTS	77
C. BIG IDEAS FOR CHILDREN’S HEALTH FROM FOCUS GROUPS	78
D. COMMUNITY LEADER INPUT	79
APPENDICES	80

A. PURPOSE AND SCOPE

This report summarizes the findings of Arkansas Children’s Northwest’s (ACNW) 2019 efforts to engage and understand the health needs of the community served. This inaugural assessment was planned and executed by hospital staff and vetted by a variety of public health and child health stakeholders. In addition to satisfying the federal tax-exemption requirements as laid out in the Affordable Care Act, the purpose of the Community Health Needs Assessment (CHNA) is to:

1. Identify and analyze unmet healthcare needs as well as assets that exist in the community served by ACNW.
2. Inform the hospital’s strategic initiatives that improve child health by using a social determinants of health framework.
3. Guide the collective impact efforts of a number of agencies that serve children statewide.

Authors:

Ellie Wheeler, MA – Public Health Programs Specialist, Arkansas Children’s Hospital
 Mariella Hernandez - Master of Public Service student at the University of Arkansas Clinton School of Public Service

Contributors:

Carla Sparks, MPH- Rural Outreach Coordinator, Arkansas Children’s Hospital
 Bolton Kirchner, MPH, MPS - Program Evaluation Coordinator, Arkansas Children’s Hospital

Comments:

Comments on the 2019 Community Health Needs Assessment can be sent to Ellie Wheeler (wheelerEA@archildrens.org).

B. COMMUNITY DEFINITION

The ACNW community (2017 Pop. 205,767)¹ is defined for the purposes of this needs assessment as all children under age 18 living in the ACNW service region. This region is defined by 11 counties in the northwestern part of the state: (Benton, Carrol, Boone, Washington, Madison, Newton, Crawford, Franklin, Johnson, Sebastian and Logan).

ACNW is a private, nonprofit institution working to champion children by making them better today and healthier tomorrow. As a pediatric medical center that treats children from every county in Northwest Arkansas and some from neighboring areas, ACNW defines the community it serves as all children from birth to age 18 in the 11-county Northwest region of Arkansas. According to the U.S. Census Bureau, there are about 206,000 children under age 18 in this region. Arkansas Children’s Northwest (ACNW) hospital is Northwest Arkansas’s first and only children’s hospital. The newly opened hospital is a 24 bed, 233,613-foot facility with access to pediatric emergency services, primary and specialty care services, a full range of ancillary and diagnostic services and a pediatric surgery unit with 5 operating rooms.

The overall Arkansas child population is increasingly diverse. Twelve percent of Arkansas kids live in immigrant families, up from 10 percent in 2010.² Similarly, Hispanic or Latino children make up 12 percent of kids in Arkansas, up from 11 percent in 2010. The percentage of the population made up of white children has decreased over that time, from 65 percent to 63 percent. African American children also make up a slightly smaller share of the child population in Arkansas now, at 18 percent (compared to 19 percent in 2010).

C. COMMUNITY HEALTH NEEDS ASSESSMENT PROCESS OVERVIEW

From September 2018 through February 2019, hospital staff gathered primary and secondary data for the CHNA. The following data sources contributed to the wide range of input gathered from community members and organizations who represent children’s health interests:

- 6 focus groups targeted to a diverse population of parents and children’s service providers across Arkansas,
- 17 key informant interviews targeted to Arkansas’s child health thought leaders and subject matter experts,
- A telephone survey of 395 Arkansas parents that was statistically significant at the regional level,
- A comprehensive review of child-specific secondary data from local, state, and national sources.

Resulting data were sorted into 10 priority themes, coded, and ranked (below). The ranked categories are intended to be broad while allowing for detailed analysis of current trends and issues within each theme. The Priority Health Needs Profile section provides a description and analysis of each ranked theme.

1. EQUITABLE ACCESS TO CARE
2. MENTAL HEALTH AND SUBSTANCE USE
3. FOOD INSECURITY
4. PARENTING SUPPORTS
5. SOCIAL ISSUES
6. CHILD OBESITY
7. REPRODUCTIVE HEALTH
8. CHILD INJURY
9. ORAL HEALTH
10. IMMUNIZATIONS

	Child Population by age		Child Population by race			Child Population change 2010-2016 by race			Language spoken at home		
Source	ACS 5-Year Table B09001: 2013-2017		ACS Survey 5-year, Tables B17001B, I, A: 2012-2016			ACS 5-year, Tables B17001B, I, A: 2006-2010, 2012-2016			Census 2012-2016 ACS table S1601, S1602, S1603, S1604		
Location	Total under 18	Total under 3	African American	Hispanic	White	African-American	Hispanic	White	Spanish	Other Indo-European	Asian/Pacific Islander
Arkansas (State)	705,718	112,504	126,755	80,547.00	495,489	-5.1%	20.7%	-.12%	1.4%	0.1%	0.2%
Northwest Arkansas	205,767	32,747	5,927	42,079	160,903	17.6%	19.9%	5.83%			
Benton	67,957	10,495	883	15,118.00	56,487	30%	18%	24%	2.7%	0.1%	0.4%
Boone	8,475	1,454	3	279.00	7,791	-25%	6%	-1%	0.0%	0.0%	0.0%
Carroll	6,195	907	103	1,584.00	5,627	194%	19%	12%	3.1%	0.4%	0.3%
Crawford	15,515	2,355	226	1,644.00	13,385	-25%	12%	-5%	1.9%	0.0%	0.2%
Franklin	4,152	655	9	198.00	3,774	29%	41%	-10%	0.1%	0.0%	0.1%
Johnson	6,407	1,051	60	1,355.00	5,839	173%	25%	1%	2.8%	0.1%	0.1%
Logan	4,894	777	85	215.00	4,277	70%	-2%	-15%	0.0%	0.0%	0.7%
Madison	3,747	597	36	308.00	3,351	260%	20%	-4%	1.2%	0.0%	0.0%
Newton	1,574	161	-	38.00	1,520	-100%	81%	-7%	0.0%	0.0%	0.0%
Sebastian	31,052	4,997	2,177	6,831.00	22,236	10%	17%	-6%	3.0%	0.1%	0.6%
Washington	55,799	9,298	2,345	14,509.00	36,616	21%	25%	3%	4.1%	0.1%	0.9%

A. SECONDARY QUANTITATIVE DATA COLLECTION

Hospital staff collected a range of child-specific secondary data from local, state, and national sources. Local data includes sources such as Arkansas Children's Northwest and research studies that focus on specific diseases or groups. The Arkansas Health Department, other state agencies, and statewide nonprofit organizations provided state-level data and analysis, some of which can be viewed at the county level. Nationally, sources included the Annie E. Casey Foundation's Kids Count Data Center, the Centers for Disease Control and Prevention, the Youth Risk Behavior Survey, and the U.S. Census Bureau. When possible, year-over-year trends and comparisons to state and national data are noted. This comprehensive review of child health data informed the prioritization of health needs and complemented the perspectives gathered from community members which are fully explained in the Priority Health Needs Profile Section. A full collection of data tables and sources can be found in the appendix.

B. PRIMARY QUALITATIVE DATA COLLECTION

i. PARENT AND CAREGIVER PHONE SURVEY

Arkansas Children's contracted with the University of Arkansas at Little Rock (UALR) Survey Research Center (SRC) to design and carry out a telephone survey of parents and guardians living in Northwest Arkansas who had children currently living in their home. The goal of the survey was to assess Arkansas caregivers' views and attitudes toward their children's health and community health needs.

Methodology: Hospital and UALR staff worked together to develop a questionnaire that would highlight parents' perspectives on needs regarding existing and emerging child health issues and access to health care. When possible, previously-tested questions from other prominent public health surveys were used to guide phrasing. A total of 395 completed interviews were conducted with Northwest Arkansas adult residents who are a parent, stepparent, or guardian of a child under the age of 18 who lives in the household, either full or part-time. With the number of completed interviews, one can say with 95 percent confidence that the margin of sampling error is ± 5 percentage points.

Data collection was conducted between November 29, 2018, and February 11, 2019. The survey was conducted in English and Spanish. The study used a wireless-frame sample of phone numbers drawn from both random digit dialing and list-assisted cell phone banks generated by Scientific Telephone Samples. This research was conducted in accordance with protocols and procedures approved by the UALR Institutional Review Board for Human Subjects Research.

The telephone survey asked parents open-ended and multiple-choice questions about their opinions on community problems, access to health care services, social determinants of health, and top public health issues. Additionally, demographic data was collected from each participant. The complete questionnaire used in this survey as well as demographic data summaries and question outcomes is available in the appendix.

Key Takeaways: Parents were asked “When it comes to your child’s health and well-being, what do you consider to be the number one problem being faced by your community today?” The affordability of health insurance topped the list, followed by lack of health care services, obesity or lack of exercise and poor nutrition (see list below for all rankings and percentages). When asked specifically about a range of child health issues, child obesity was ranked as the most severe child health need, followed by poverty and mental health issues.

Topics parents reported as the “number one community problem”:

- 1. Affordable health insurance (10%)**
- 2. Lack of healthcare services (9%)**
- 3. Obesity/Lack of exercise (8%)**
- 4. Poor Nutrition (7%)**
- 5. Access to quality healthcare (7%)**
- 6. Mental health issues (incl. bullying) (6%)**
- 7. Vaccination issues (6%)**
- 8. Contagions/Cold/Flu (5%)**
- 9. Drugs (5%)**
- 10. More focus on specific health issue (5%)**
- 11. Better schools/school programs (3%)**
- 12. Social Media/Internet/Pop culture (3%)**
- 13. Poor parenting (3%)**
- 14. Food insecurity (2%)**
- 15. Poverty/Finances (2%)**
- 16. Violence/Guns (1%)**
- 17. Irregular health visits (1%)**

ii. KEY INFORMANT INTERVIEWS

Community members representing Northwest Arkansas were asked to participate in interviews that were conducted in person or via telephone by hospital staff. Interviews were conducted with 17 providers, business and industry leaders, faith leaders, and key decision makers who work in or oversee child health priorities in Northwest Arkansas. Questions for key informant interviews were structured with broad topic domains based on the Social Determinants of Health as well as open-ended questions designed to obtain seminal information. The full guide is included in the appendix.

Methodology: Hospital staff identified the primary themes and cross cutting factors that emerged during each interview. Up to three primary themes were identified for each interview session, and up to three cross cutting factors were matched to each of those primary themes. These results were then coded and tabulated to determine which primary themes were most important to interviewees, and to understand which cross cutting factors were most commonly cited as driving those themes.

Key Takeaways: The top three child health related needs brought up by key informants concerned access to care, social issues, and parent supports. When asked about the root causes of these areas of need, key informants were most likely to discuss problems associated with transportation barriers. They also very frequently mentioned a need for increased quality affordable housing, health education, and linguistic or cultural awareness.

iii. PARENT AND SERVICE PROVIDER FOCUS GROUPS

Community members from across Northwest Arkansas were invited to share their experience as parents, guardians, educators, service providers for children in Arkansas, or stakeholders with knowledge of child health through community discussions. Each focus group involved recorded conversations in groups of 5-15 people for about 90 minutes. Hospital staff conducted 6 total focus groups, with 76 total participants, in three languages (English, Spanish, and Marshallese). Focus groups were split among consumers (the lay community of legal parents or guardians of children under 18 years of age) and providers (healthcare providers or educators who serve children and their families such as school nurses and teachers, social service agency employees, and health educators).

To ensure inclusion of under-served, low-income and minority populations, staff reached out to diverse areas of the state, both rural and urban, seeking feedback from providers and guardians in culturally and linguistically underrepresented groups. Staff led three focus groups in Spanish throughout the state and one in Marshallese in the northwest, conducting participant outreach through community representatives and advocates, non-profit community-based services, religious and secular organizations, and health and educational organizations. See the appendix for more details on focus group locations and participant counts.

Participant Information: Study facilitators used a 15-item Participant Information Questionnaire to obtain basic information about focus group participants, their children, and their families. The questionnaire asked about demographic information, number of children, family insurance coverage, and availability of resources. Focus group demographic information can be found in the appendix.

Focus Group Guide: Hospital staff created and implemented a Focus Group Interview guide. This guide was structured to solicit input on community health assets and gaps by allowing for open-ended response before probing for details on specific topics and reactions to data points tailored to each community. The focus group guide included 8 questions, which can be found in the appendix.

To ensure a holistic look at the state of children's health, staff asked focus group and interview participants about social determinants of health in addition to child health themes. Social determinant of health topics included education, socio-economic status, physical environment, employment, social support networks, and access to health care.

Methodology: To analyze the focus group data, staff utilized the Constant Comparative Method from the Grounded Theory Approach developed by Glaser and Strauss.³ This method was used because it provides a structured inductive methodology to gather, summarize, and analyze qualitative data, allowing the participants' answers to inform results instead of trying to match the participants' responses to an already existing framework.

To conduct the research, staff collected responses from the focus groups via typed notes backed up by audio recordings. The audio recordings for the Spanish focus groups were transcribed and translated, and the Marshallese group was conducted via an interpreter, so the notes were collected in the same manner as the English-speaking groups. Responses for all focus groups were then compiled in a document and sorted using typological coding, with a classification system based on themes. For the themes, staff utilized pre-identified codes in key child health issues and codes that emerged from the data. Staff then analyzed each theme to understand which aspects were most frequently mentioned and their significance to participants, utilizing this information to prioritize health needs. In addition, staff identified aspects that intersected among themes, and these informed the cross-cutting factors.

Focus Group Locations and Types

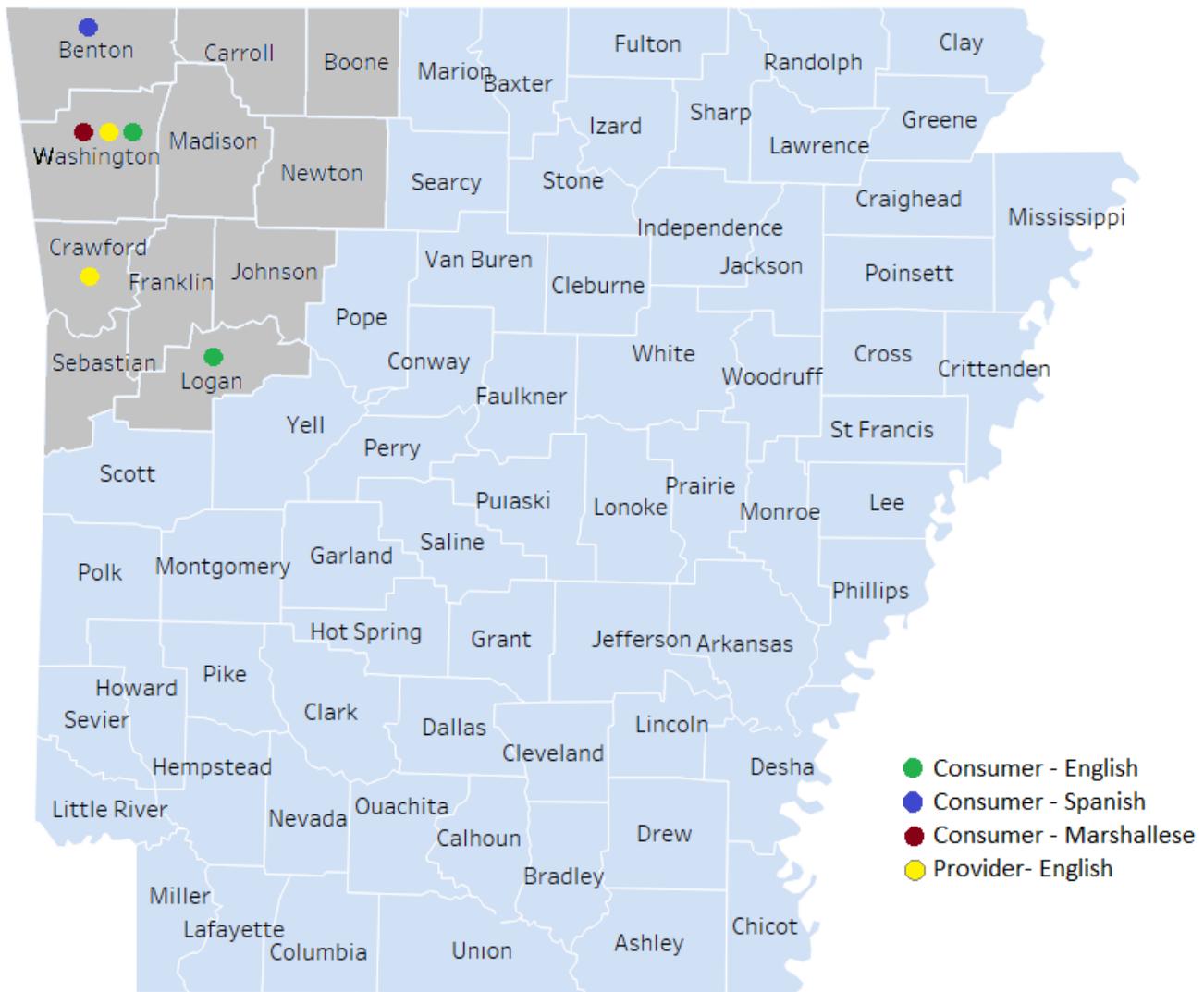


Figure 1



Key Takeaways: The leading topics of interest for focus group participants were Access to Care, Social Issues, and Parenting Supports. Participants reported the new hospital as a major asset, but still described difficulties with access to care that are complicated by issues like transportation, urban isolation, and parents' work schedules. A lack of providers, especially specialty care, was another frequently mentioned problem for many participants. Other social issues like language barriers and cultural or racial discrimination were reported to impede access to health care and other services for many families and their children, especially for the Marshallese population. Parenting Supports needs focused primarily on parent education, access to safe, affordable child care centers, and availability of safe and affordable housing options.

Comments from focus group participants also varied based on income, socioeconomic status, and primary language. Providers and parents also disagreed on some areas of child health. These distinctions are summarized below.

Input from medically underserved, low-income, and minority populations: Rural or isolated areas of the state desired better access to medical services. They suggested more pediatricians and specialist care, mobile health units, and telemedicine. Travel to Little Rock or other larger cities to obtain medical services is often made difficult by the lack of transportation or funds for the travel and lodging. Parents had difficulty taking time off from work for the trips as well.

Low-income populations are also reported to live in unhealthy housing, due in part to the high rents and a lack of housing safety regulations. Substandard housing was seen as unsafe for children because of mold, crime, and lack of safe places to play. This was said to cause physical ailments, such as asthma as well as mental health issues, such as anxiety and stress. Minority populations also expressed a desire to improve relations with law enforcement agencies.

Provider versus parent perceptions: Providers and parents would like to see an increase in access to healthcare services and insurance coverage. Both groups also see the benefit of school-based health centers. Some providers believe that parents are not using available resources for their child's well-being and fear that too many parental responsibilities are being shifted onto schools. Parents however, see barriers to access services related to work schedules and transportation. Parents say this is often compounded by a lack of awareness of the services available.

Language considerations (Marshallese and Spanish populations): Linguistic and cultural barriers persist for Marshallese and Spanish speaking families in the state. Both groups report difficulty in finding bilingual health providers or qualified interpreters. Language challenges are especially difficult for the provision of mental health care. This also makes it difficult for parents to schedule preventive or follow-up care appointments and for providers to educate parents on health issues.

The Marshallese population said that medical information is frequently available in Spanish, but rarely in Marshallese. Both groups have problems accessing care due to difficulty securing insurance. Many families live in fear of deportation and therefore do not seek preventive care for their children and abstain from programs like WIC and SNAP. Benefits are generally seen as having the potential to disqualify families from gaining US citizenship. This fear of deportation also places a mental strain on children.

Provider versus parent perceptions: Providers and parents would like to see an increase in access to healthcare services and insurance coverage. Both groups also see the benefit of school-based health centers. Some providers believe that parents are not using available resources for their child’s well-being and fear that too many parental responsibilities are shifting onto schools. Parents however, see barriers to access services related to work schedules and transportation. Parents say this is often compounded by a lack of awareness of the services available.

¡Le invitamos a...

Hablar

Escuchar

Compartir





sobre la salud infantil en su comunidad!

Qué: El hospital de niños de Arkansas está llevando a cabo discusiones sobre la salud infantil en comunidades alrededor del estado para una evaluación comunitaria sobre necesidades de la salud

Cuándo: El 8 de noviembre del 2018 a las 5:30 – 7:30 pm

Dónde: Centro de Actividad de Rogers (Rogers Activity Center)
315 W. Olive St
Rogers, AR 72756

Detalles: Proveremos bebidas y refrigerios. Los participantes recibirán una tarjeta de obsequio por su tiempo

Registración: Carla Sparks o Mariella Hernandez
(501) 364-4453
mxhernandez@clintonschool.uasys.edu
sparkscc@archildrens.org



Figure 2: Recruitment flyer for Spanish Focus Groups

A. PRIORITIZED HEALTH NEEDS

After all four data sources (focus groups, interviews, telephone survey, and secondary data) were analyzed and prioritized individually, the results of all data collection were combined into a single overall ranking. Data was grouped around top issues facing Arkansas children. Ten issues were prioritized.

The CHNA team prioritized this list of child health issues using a criteria weighted ranking method. The ranking consisted of identifying severe, major, and moderate need issues in each data source and assigning a point based value. The scores were 2 points for a severe need, 1 point for a major need, and 0 points for a moderate need. The values were summed to a total score for each issue across all 4 data sources. Based on the total score for each issue area, issues were defined as:

- Severe (total score of more than 5 points): These needs were Parenting Supports, Social Issues, and Mental Health.
- Major (total score of 3 to 5 points.): These needs were Access to Care, Food Insecurity, Obesity, and Reproductive Health.
- Moderate (0 to 3 points points): These needs were Oral Health, Child Injury, and Immunization.

For the secondary data section, a primary indicator was selected for each of the ten themes. Indicators were selected based on their ability to represent progress in their associated theme area, as well as the availability of recent state and county-level data. A population weighted average was created for Northwest Arkansas based on the 11 subject counties and Census Bureau population counts. This average was then compared to the state using the number of standard deviations from the Arkansas average. Secondary data themes were then ranked according to how many standard deviations they each were from their respective state average (see chart). Profiles for each of the issue areas, along with details on focus group, key informant, phone survey, and secondary data results can be found in the Priority Health Needs Profiles section.

	Overall Points	Focus Group Rank (# mentions)	Focus Group Score 0=(0-20) 1=(20-80) 2=(80+)	Key Informant Interview Rank (# mentions)	Key Informant Score 0=(0-5) 1=(5-10) 2=(10+)	Phone Survey (% Ranked as "Serious Problem")	Phone Survey Score 0=(1-20) 1=(20-30) 2=(30+)	Secondary Data Score 0=STDV (-1 to -.5) 1=STDV between (-.5 to 0) 2=STDV more than 0
Equitable Access to Care	7	1(167)	2	1(12)	2	30%	1	2
Mental Health and Substance Use	6	4(38)	1	5(5)	1	37%	2	2
Social Issues	6	2(91)	2	2(8)	1	38%	2	1
Parenting Supports	5	3(78)	1	3(7)	1	37%	2	1
Child Obesity	4	7(23)	1	6(4)	0	35%	2	1
Food Insecurity	4	6(24)	1	4(6)	1	34%	2	0
Oral Health	3	10(4)	0	8(2)	0	24%	1	2
Immunization	2	8(16)	0	7(3)	0	18%	0	2
Reproductive Health	2	5(27)	1	10(0)	0	19%	0	1
Child Injury	0	10(4)	0	9(1)	0	14%	0	0

B. CROSS CUTTING FACTORS

Each of the ten prioritized health themes has a complex array of subtopics and emerging issues. To shine light on the root causes behind these dynamic health needs, hospital staff also identified 7 cross cutting factors (below). Each cross cutting factor was mentioned as a contributing element for multiple priority themes during key informant interviews and focus group discussions, but was not prominent enough to be its own health need category. These cross cutting factors help describe how the ten themes are interrelated. For instance, “Transportation and Rural Isolation” is a cross cutting theme that drives outcomes in virtually every category of health need. Lack of transportation makes specialty care more difficult (Access to Care), but it also creates a barrier for everything from buying fresh produce (Food Insecurity) to attending parenting classes (Parenting Supports). The Priority Health Needs Profiles section includes descriptions of the top cross cutting themes for each health need.

Health Education: Focus group participants in Northwest Arkansas repeatedly discussed the need for education on healthy behaviors as a way to improve community wellbeing. Participants would like to see policy changes to reinstate physical education and health courses to the curriculum. They suggested the health courses should cover nutritional, oral, and reproductive health among other subjects.

A two generation approach to health education was also discussed in focus groups, with participants reporting a need for education to be extended to the parents on topics like parenting skills and healthy habits for their children. Focus group parents and providers also saw a direct link between academic education and health. Participants reported desiring an increased emphasis on life and job skills for school children and discussed literacy and education as being key to a healthier population.

Early childhood education was also recommended by focus group participants and key informants. One Washington County provider asked “wouldn’t it be great if public education started at [age] 0?”. Focus group participants identified early childhood education as a way to extend preventive health services and identify instances of abuse, neglect, and behavioral health needs before children start public school.

Adverse Childhood Experiences (ACEs): Adverse Childhood Experiences, or ACEs, are events that occur in childhood but can have long-lasting influences on mental and physical health. These traumas include having a parent incarcerated, extreme economic hardship, neighborhood violence, domestic violence, mental illness or drug abuse in the family, divorce or parental separation, and death of a parent. Focus group participants reported a need for more education on recognizing trauma and how to deal with it, both for adults and children. Groups reported that there are a few resources at the schools but teachers and counselors need more training. Participants reported that some parents are hesitant to reach out for help because they are afraid their children will be taken away or they simply distrust the available resources. Focus group participants link ACEs to untreated trauma and mental health issues, which they describe as often leading to drugs or alcohol and creating other problems.

Substance Abuse and Tobacco Usage: Focus group participants discussed a perceived drug crisis stemming from kids having easy access to drugs as well as from doctors over-prescribing to adults. Focus group participants linked adult substance use to child health by noting that for some children, substance abuse starts at home with adults using or providing drugs and alcohol. Participants also reported little to no education for kids or their parents on substance abuse and a lessening of the perceived seriousness of drugs like marijuana and prescription drugs, which have reportedly become widespread.

Many focus group and key informant interview participants also described a connection between mental health and substance use. One Northwest Arkansas focus group parent commented “It is easier to get drugs than mental health”. Parents, Providers and Key Informants noted that access to mental health and substance use treatment is limited or cost prohibitive. Focus group parents reported that the legal system can send families on a downward spiral of abuse for minor offenses.

Housing and Environmental Quality: During focus group discussions, participants described how unsafe neighborhoods and high crime prevents children from participating in outdoor activities and creates stress for children. Parents and providers cited a need for more outdoor and indoor recreational safe spaces, sidewalks, or afterschool activities for kids.

Unsafe housing was also a major concern. These concerns included dangerous, unhealthy or poor housing conditions, lack of water or electricity, lack of landlord maintenance or accountability, overcrowded conditions, and transient housing. At the root of the problem, participants identified unaffordable housing options and lack of legislative oversight on housing conditions. Participants mentioned a need for increased police presence while also improving the community relationship with police. Several focus group parents report living in a culture of fear, and this was particularly true for minorities.

Discrimination based on Language, Culture, or Race: The lack of access to healthcare was a primary concern for focus group parents who were undocumented. The fear of deportation was described as making these parents hesitant to take their children to the doctor. Language barriers were also brought up as a major issue in the healthcare system, and families report a need for more access to care that is culturally and linguistically appropriate.

Focus group parents from mixed immigration status homes reported avoiding or discontinuing their social benefits (even if their child is an American citizen) for fear that using those benefits would impede their progress toward naturalization. Legal worries and fear of deportation places a mental strain on undocumented families and they described an intrinsic fear of the authorities, with some participants reporting police racial profiling.

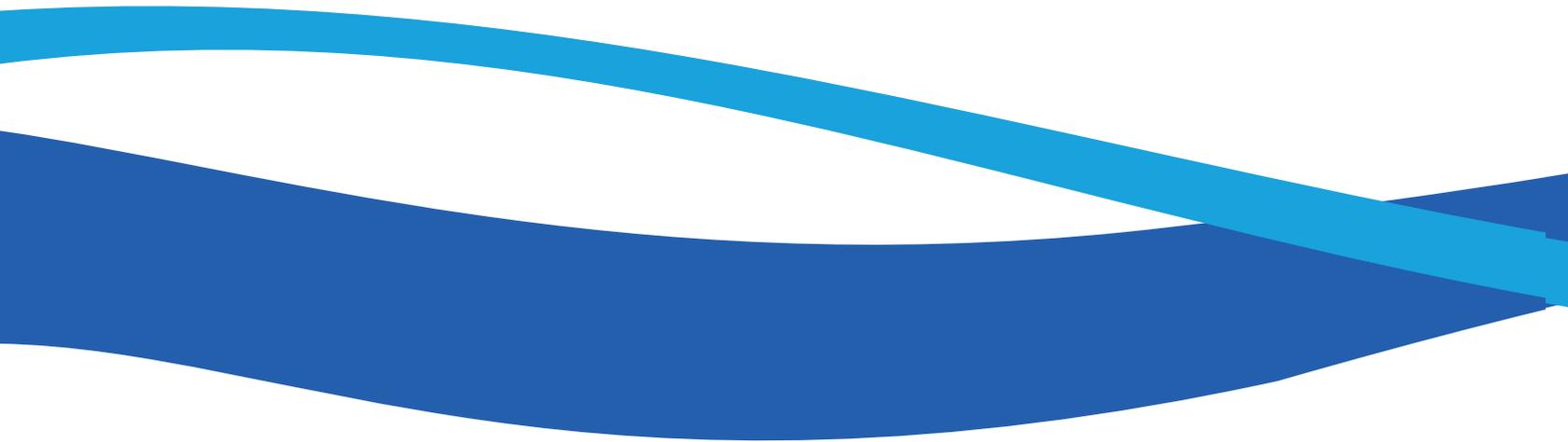
Focus group participants report that low-income and immigrant families have fewer opportunities and they therefore work long hours. Participants report that these families often have no option but to leave children unattended or under the care of siblings or friends. These parents report a need for cultural awareness training for the community as a whole in order to break down barriers.

Transportation, transit, and rural isolation: Focus group participants and Key Informants repeatedly reported problems with transportation, with rural areas having a more pronounced need. Lack of transportation was identified as creating barriers for parents seeking healthcare for their children, attending school meetings, and obtaining quality work or education. The distance in travel to healthcare centers and specialists was cited as an issue especially for people in rural areas of the state. Several participants mentioned that telemedicine could be a way to increase healthcare access to underserved areas. Participants also expressed strong support for mobile healthcare services (like dental vans) and would like to see those expanded.

Technology: Participants reported that children and adults have too much screen time. They report that this affects ability to communicate and interact in person, and shortens children's attention span. Focus group discussions frequently circled back to social media, which was seen as impacting people's perceptions of themselves and general healthcare knowledge. The reported impacts of this were broad, from people opting not to immunize their children to increasing feelings of inadequacy and isolation in children, which can manifest in depression and even suicide.

C. PRIORITY HEALTH NEEDS PROFILES

The following section provides profiles of all ten of the prioritized child health needs. Each profile contains the major cross cutting factors associated with that issue, and feedback from focus groups, key informant interviews and the phone survey. Profiles also contain major secondary data indicators and analysis. There is a leading metric for each health care need that has an ACNW regional data point and an Arkansas State data point for context and comparison.



Equitable Access to Care

Equitable access to care allows all families to receive appropriate, convenient, affordable, and consistent health services, including preventive care and specialty care, vision and hearing screenings, and other developmental screenings and services. This also includes removing barriers like transportation as well as language and cultural barriers.

Leading metric: Well-Child Visits (3-6 years)

Northwest Arkansas: 54.88%

Arkansas: 56.79%

Equitable Access to Care

KEY INFORMANT FEEDBACK

“[Parents] often have to make a decision about how someone has to stop working so that they can access this level of Medicaid [for their child]. The economic stipulation that ‘I need to be impoverished to access disability services’, is pretty problematic.”

“For so many families, they aren’t interacting with that formal system until their kids start school. Pre-k then becomes so important, it’s not just about starting the academic journey off on the right foot, it’s about exposing families to the resource systems and social support.”

“One of the things we find when providing health services is a trust issue. Does that community trust you to provide services to them and their families? We have a challenge in dispensing services... dispensing them and being sensitive to a particular culture or situation.”

Transportation was that number one barrier to families accessing medical care according to key informants. Some parts of Arkansas are more isolated and have fewer providers and very minimal public transportation options. Low-income residents were reported to have less access to transportation and are particularly vulnerable to this type of barrier. Telemedicine was frequently mentioned as a solution to this.

Confidence in the healthcare system was another barrier to care that came up in discussions. A lack of trust between parents and health systems was reported, especially among marginalized groups. A lack of cultural awareness was mentioned as driving this mistrust.

FOCUS GROUP FEEDBACK

“If there were more clinics with more services to serve low income families, without us having to resort to the emergency room, I think that would be more convenient.”-Benton County Parent

“I think that when Children’s moved to Northwest Arkansas, people thought they would have all the specialty care available, but we are still sending kids to Little Rock.”-Washington County Provider

“The third time I took my son to the hospital, the case worker told me ‘we are taking him and there’s nothing you can do’, and I had no way of pleading my case, they said I was starving him... I had to show my feeding log and get a genetic test done and he has a rare disease.”-Washington County Parent

Participants are very enthusiastic about school-based health centers as a way to provide care for children while avoiding transportation issues and work obligations. Telemedicine and mobile vans were also suggested as options to increase access to care. Participants are glad to see the expansion of health services with ACNW but say that limited numbers of providers and specialists still pose a problem, and families sometimes still have to travel to Little Rock for services.

Many participants identified a need for free or more discounted healthcare. They also described Medicaid and DHS services as inefficient and said many families are losing services due to departmental red tape. Undocumented families or families with language barriers were described as having an especially hard time navigating the system.

FOCUS GROUP FEEDBACK CONTINUED

Immigrant populations report difficulty in accessing healthcare due to language and cultural barriers. Some mixed status families fear authorities and have stopped receiving social benefits for the whole family in case they harm the parents' path to naturalization. They also reported that the bureaucracy involved in Medicaid and DHS many times results in loss of coverage and leaves children unable to access care. For the undocumented community, obtaining medical insurance is almost impossible. The high costs for those who have insurance also limit provision of care.

PHONE SURVEY RESULTS

Parents reported "affordability of healthcare" as the number one community problem. The second most commonly cited problem was lack of healthcare services. Most parents (71 percent) said kids not receiving regular health checkups is either a serious or moderate problem. 5 percent said that it was not at all a problem. When asked about the health care provider that serves their own children, most parents (93 percent) rated them as excellent or good. 1 percent rated them as poor.

Parents were also in favor of school-based health services for their kids. Most (83 percent) said that it was either very important or moderately important for schools to offer basic health care services. Parents were more divided on a preference for telemedicine services. More than half (62 percent) reported being very or somewhat interested in having their child receive an online doctor's visit. Thirty six percent were either only a little interested or not at all interested.

CROSS CUTTING FACTORS:

(Themes identified by parents, providers, and key informants as root causes of issues with Access to Care)

- **Technology:** School Based Health Centers (SBHCs) were identified as a way that technology can help provide access to preventive medicine and help parents not to miss work or incur extra costs.
- **Health Education:** There is a desire for education on how to navigate the medical system, including which providers to visit as well as information on healthy habits and preventive care.
- **Discrimination based on Language, Culture, or Race:** Language barriers and lack of trust with systems make accessing care more difficult for some families in Arkansas.
- **Transportation and Rural Isolation:** Respondents frequently cited transportation, especially among low-income families with restrictive work schedules, as a barrier to getting kids to the doctor when needed.

Screening ratio:

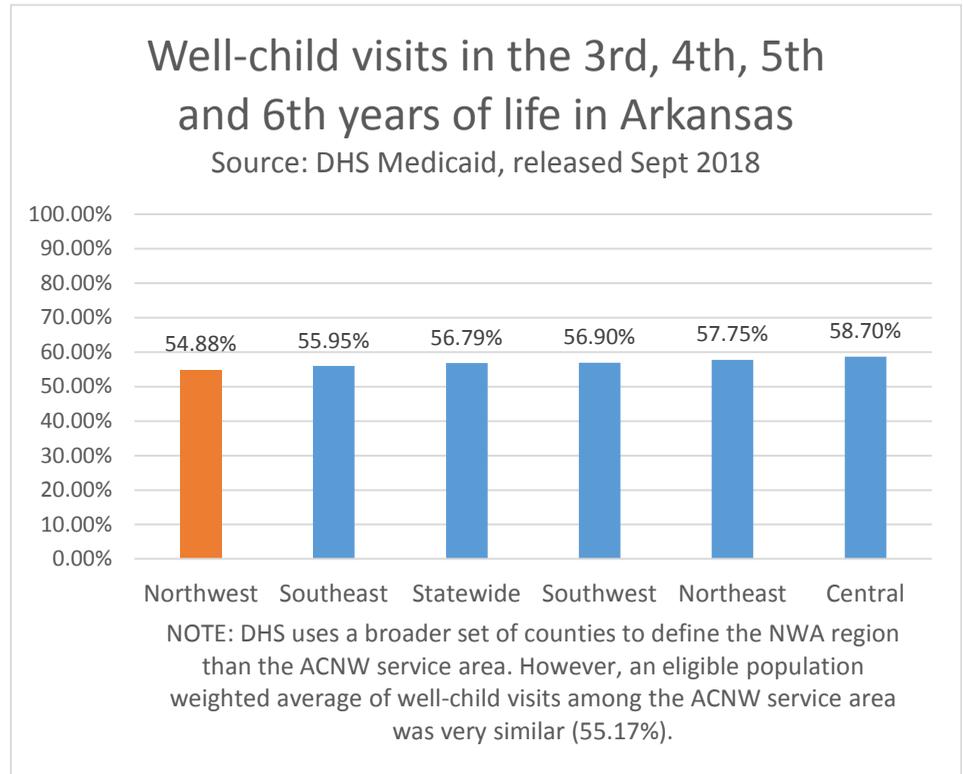
Of children enrolled in traditional Medicaid or ARKids First A, 50 percent received at least one Early Period Screening Diagnosis and Treatment (EPSDT) preventive visit required by Medicaid in 2017 compared to 58 percent nationwide.⁴ Despite being behind national average, Arkansas has improved its screening ratios over the past several years. However, children in Northwest Arkansas are less likely than kids in the state overall to have their well-child visits in the 3rd, 4th, 5th, and 6th years of life.

A July 2016 convening of child health and education stakeholders in Arkansas identified Arkansas specific barriers to developmental and social-emotional screenings. These barriers included family transportation issues, family lack of understanding about the importance of screenings, lack of pediatrician access, and billing complications.⁵

Child health insurance coverage:

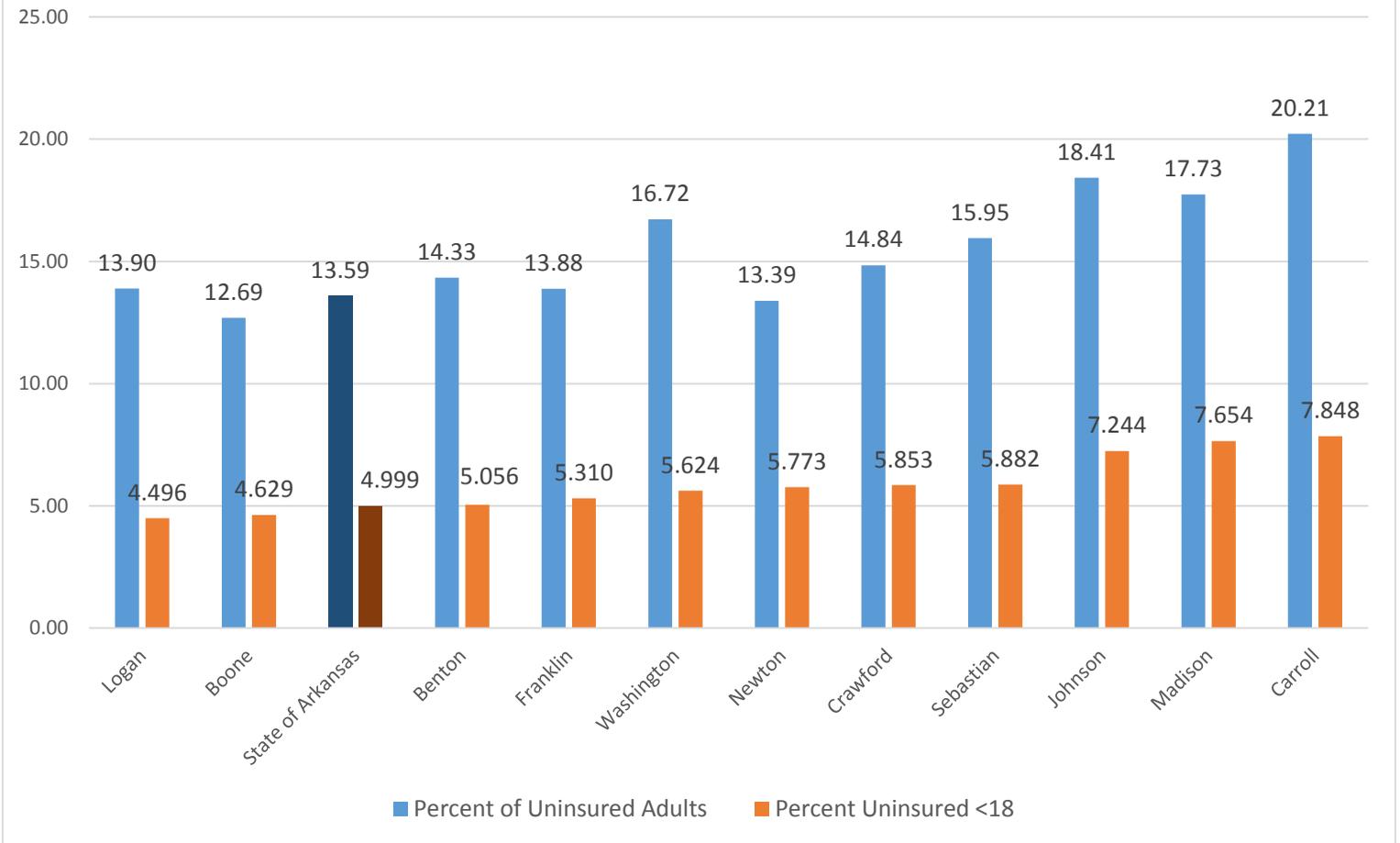
After the Arkansas Medicaid Expansion legislation, the rate of uninsured kids in Arkansas fell from 6 percent (2013) to just 4 percent (2016).⁶ Most recently, the rate of children without health insurance has ticked up slightly, but overall the downward trend in insurance rates for children in Arkansas has been strong. In Northwest Arkansas, the percentage of children who do not have health insurance tends to be above state averages. Nine out of the 11 counties in Northwest Arkansas have child insurance rates higher than the Arkansas average.

Statewide, there are health insurance coverage disparities for kids with different racial and ethnic backgrounds. White children in Arkansas, for example, are uninsured at a rate of 3 percent and Hispanic children go uninsured at a rate of 9 percent.⁷ Children with behavioral and developmental disabilities also face additional barriers to care. See the “Mental Health and Substance Use” Priority Health Needs Profile for more information about the new PASSE (Provider-Led Arkansas Shared Savings Entities) model that Arkansas is introducing for Behavioral Health and Intellectual/Developmental Disability beneficiaries.



Health Insurance Coverage in Northwest Arkansas

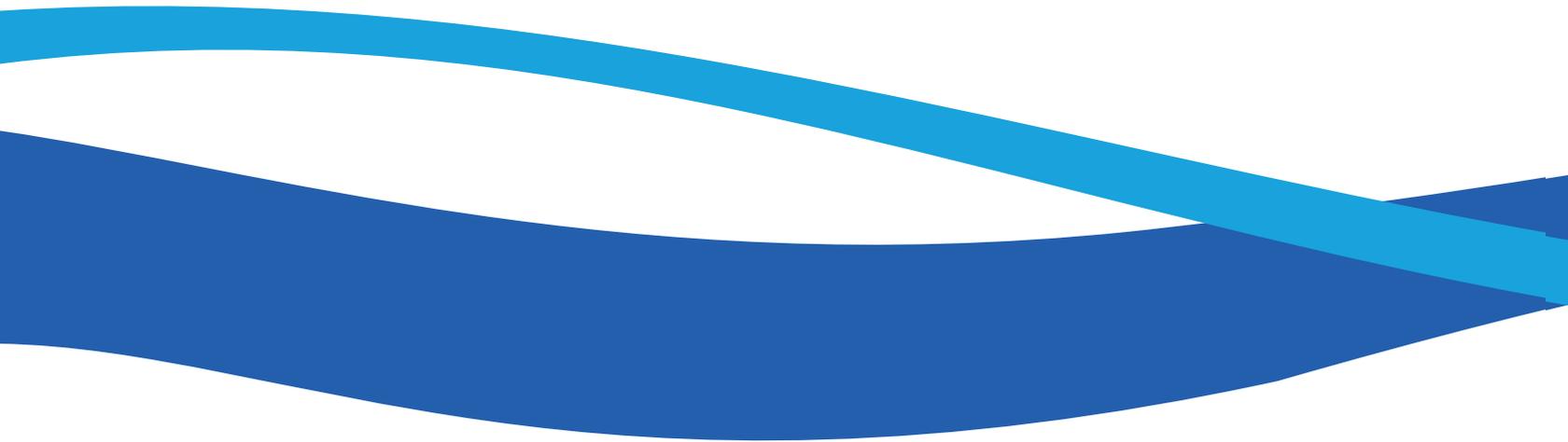
Source: County Health Rankings (2015)



Access points and School Based Health Centers (SBHCs):

Northwest Arkansas families report having a hard time finding primary care professionals. School Based Health Centers (SBHCs) offer a convenient solution, by putting healthcare services providers where kids already spend most of their day: their schools.⁸ Arkansas has 31 state-funded SBHCs and over 23,000 students have enrolled or consented to use these centers.⁹ During the 2017-18 school year, Arkansas SBHCs billed 5,601 medical encounters, 6084 mental health encounters, and 2,538 EPSDT exams.¹⁰

From March 2018 to February 2019, ACNW had 2,050 admissions. Outpatient visits during that time totaled 45,088, including 19,133 emergency department visits. The top five specialty clinics by volume were Ear, Nose and Throat, Orthopedic, Neurology, Pulmonary, and Hematology/Oncology. The top three reasons for visiting the hospital for primary care were for well child visits, establishing care, and cough. These chief complaints reflect all 2018 visits from these patients, which are not necessarily all Emergency Department visits.



Mental Health and Substance Use

Mental health and substance use problems include depression, anxiety, suicide, tobacco, alcohol, and illicit drug use. These issues affect entire families, not just individual parents or children. Children living in households with untreated mental health or substance use problems are more prone to Adverse Childhood Experiences (ACEs) and their profound lifelong health effects.

Leading metric: Student Drug Use
Northwest Arkansas: 20.4%
Arkansas: 20%

Mental Health and Substance Use

KEY INFORMANT FEEDBACK

“The PASSE, the PASSE, the PASSE... We have very clear examples of states that have done this [The PASSE] really well, and states that have done this as bad as you can imagine, and it doesn’t seem like we are really taking many of those lessons.”

“Another issue is going to be trying to get our arms around the behavioral health and mental health issues. That continues to be an increased concern of the different partners who come to the table. That gets away from what we have traditionally seen as core public health.”

“All together in the hotel room, [it is] traumatizing mentally to live in these conditions.”

Key informants connected problems with mental health most frequently to language or cultural barriers and rural isolation. The general lack of affordable mental health providers was a common theme. Some key informants saw technology (via telemedicine) as a potential solution to areas with few mental health providers. Key informants also mentioned the importance of parental mental health to the safety as well as physical and behavioral development of the child. Several key informants also expressed concern about the future implementation of the PASSE for children with disabilities and behavioral disorders.

FOCUS GROUP FEEDBACK

“I have seen resources for tobacco cessation in clinics but not drugs.”-Benton County parent

“It’s a lot easier to get drugs than mental health.”-Washington County parent

“The perceived reduced risk of vaping is huge.”-Crawford County provider

“I think we are all familiar with the opioid use increase, and the lack of mental health providers across the state. It’s a challenge to say the least. There aren’t residential places where people can go to get assistance. It turns into neglect of the child.”-Washington County provider

Participant 1: “I think everyone of us has someone who was involved in that [drug abuse]. I’ve lost a brother-in-law to it.”

Participant 2: “My brother.”

Participant 3: “Cousin.”

Participant 4: “My own kid.”

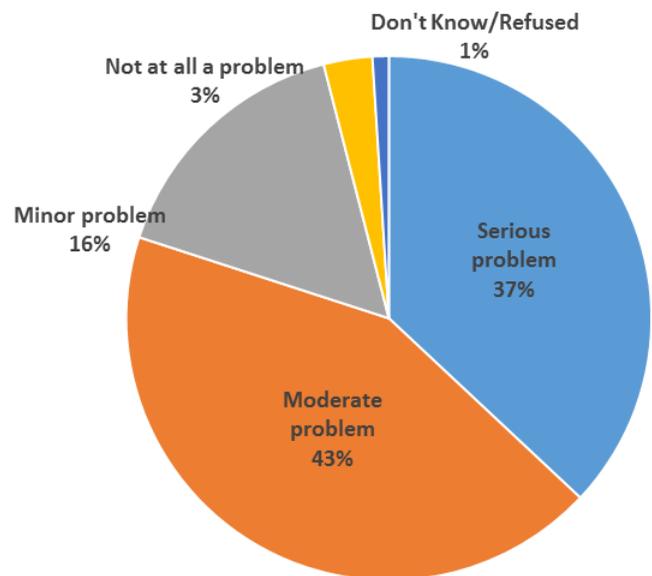
-Logan County consumer focus group

Providers have seen an increase in depression, anxiety, and suicidal ideations in children and believe these are tied to parental absence due to work demands and the rise of social media. There are resources at school, but they are insufficient for the magnitude of the problem since there are few mental health and substance abuse treatment facilities in the region. Participants report that there is more awareness now around mental health than in previous years, although stigma remains. The language barrier for minority populations makes mental health care even harder to access. Minorities also report bullying and discrimination at school.

PHONE SURVEY RESULTS

Mental Health was the fourth most severe community problem as ranked by phone survey data. A large majority of parents (80 percent) said that the number of children with a mental health issue (such as anxiety, depression, or suicidal thoughts) was either a serious or moderate problem. Only 3 percent said that it was not at all a problem. Parents showed strong support for in-school mental health services. When asked how important it was that schools provide basic mental health services, 94 percent of parents said it was either very or moderately important. Eighty-three percent said that it was very important, and only 2 percent said it was not at all important. Parents were also asked about the number of children and adolescents who use E-cigarettes, Juuls, and other vaping products. Seventy one percent said that the use of these products by children was a serious or moderate problem. Only 5 percent said that it was not at all a problem.

How serious a problem is "the number of children who have mental health issues such as anxiety, depression, or suicidal thoughts?"



CROSS CUTTING FACTORS:

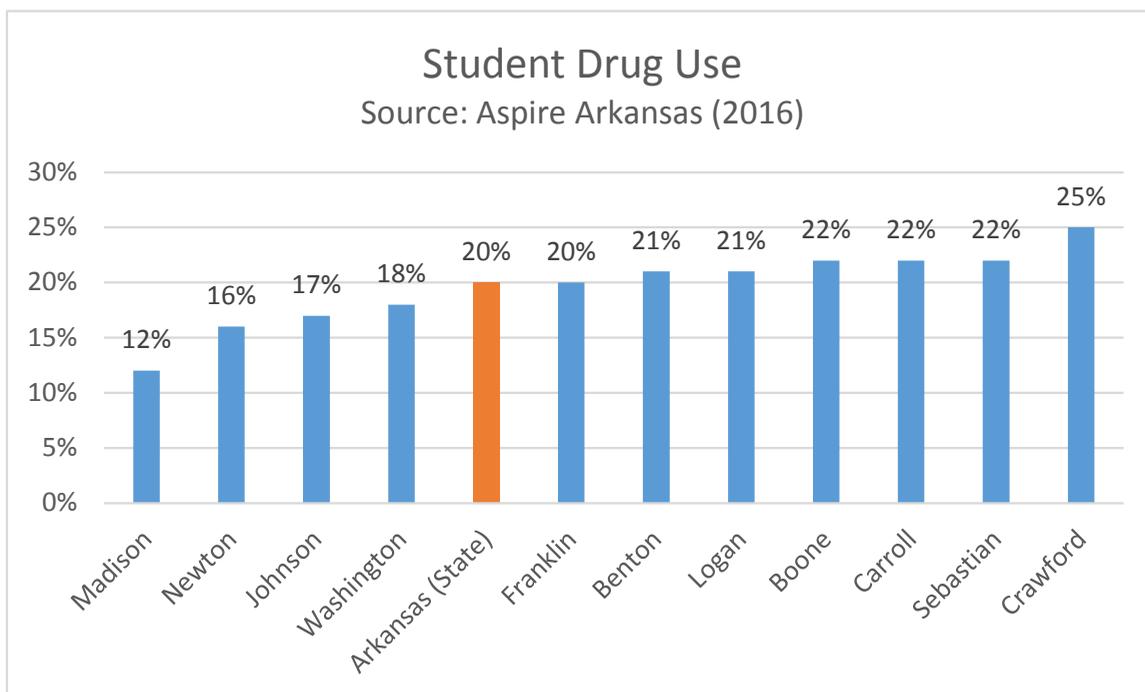
(Themes identified by parents, providers, and key informants as root causes of mental health and substance use issues.)

- **Technology:** Many focus groups reported concerns that social media and technology were damaging to the mental health of children in their communities.
- **Substance use:** Participants described parental substance use problems (including opioids) that are detracting from the physical and mental health of kids. They also mentioned an increase in vaping by teens.
- **Adverse Childhood Experiences:** Providers and consumers reported increasing awareness of childhood trauma as contributing to mental health issues in children. They also were concerned about how parent's ACE scores could affect their parenting ability and their children's behavioral development.

Substance use:

In general, drug use by adolescents in Arkansas has been going down, following a national trend. Students in Arkansas are less likely now to try substances like cigarettes and alcohol, and if they do they are waiting longer to try them.¹¹ The rate of Northwest Arkansas student drug use is 20.4 percent¹², marginally above the rate for Arkansas as a whole (20 percent).¹³

Most counties in Northwest Arkansas have some mental health professional shortage areas.¹⁴ Statewide, Arkansas DHS served 1,517 substance abuse clients under age 18 and 22,256 mental health clients under 18 in fiscal year 2017.¹⁵



E-cigarettes:

The CDC identifies e-cigarettes as the reason for increasing nicotine usage among children in the United States. From 2017 to 2018, the rate of use of tobacco products (including e-cigarettes) increased by 38.3 percent.¹⁶ The use of e-cigarettes is also on the rise in Arkansas schools. 42.7% of 12th grade males and 36.1% of 12th grade females reported ever using e-cigarettes, and a majority of 12th grade students (55.4%) said it was easy to get e-cigarettes.¹⁷ The 2017 Arkansas Prevention Needs Assessment reports that there have been major increases in e-cigarette use across grades for males and females, and that younger and younger kids are trying e-cigarettes.¹⁸

Access to mental health care providers:

All counties in Northwest Arkansas are at least partly in a mental health care professional shortage area; Carroll and Madison counties are the only two in the region that are entirely within a shortage area.¹⁹ Logan County has the highest ratio of people per mental health providers in the region, with 4,358 people for every mental health professional.²⁰ Washington County has the least people per mental healthcare provider, with 287 people per mental health professional.²¹

High schoolers in Arkansas report high rates of depression and suicide related thoughts and activity. Forty percent report feeling regularly sad or hopeless and 26 percent reported making a plan about how they would attempt suicide in the past year.^{22,23} Sixteen percent report actually attempting suicide at least once in the past year.²⁴

Adverse Childhood Experiences (ACEs):

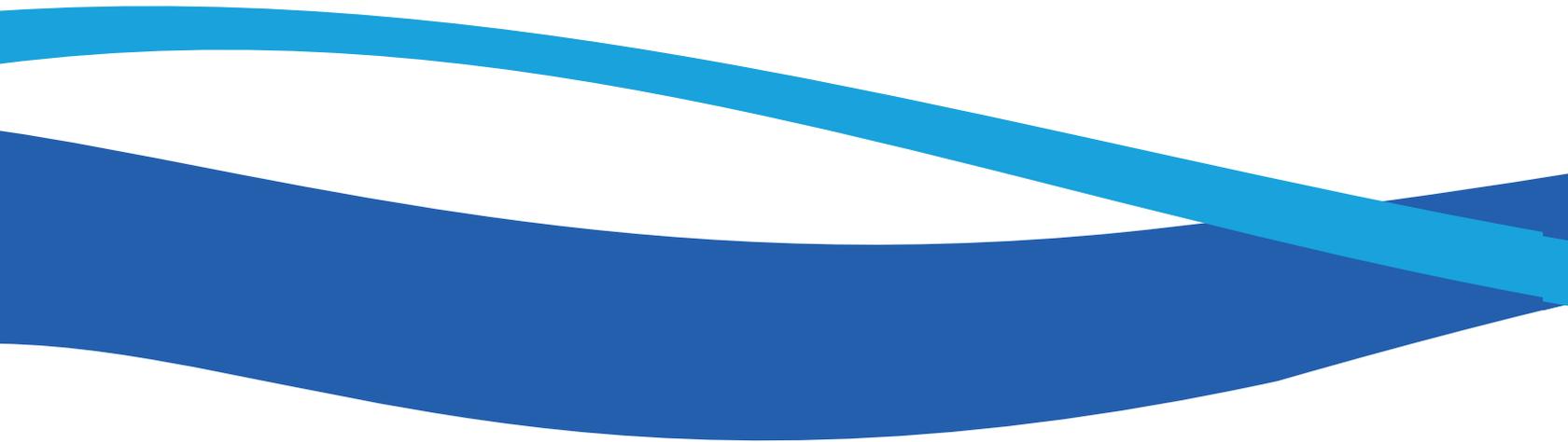
Arkansas children are more likely to have at least one adverse childhood experience compared to other kids in the US.²⁵ These traumas include having a parent incarcerated, extreme economic hardship, neighborhood violence, domestic violence, mental illness or drug abuse in the family, divorce or parental separation, and death of a parent. There were 14,280 cases of domestic violence services in 2017, of which 5,386 were children.²⁶ There were 47 domestic violence related homicides in 2017, of which 15 were children.^{27,28}

Research has found a connection between ACE scores and increased need for health services later in life. These childhood traumas have been connected to poor physical health outcomes (such as diabetes and stroke) as well as poor mental and behavioral health outcomes (such as mental distress and depression). Identifying childhood trauma rates anticipates certain future health care needs in the community.

The PASSE:

In 2017 the Arkansas Legislature enacted a new Medicaid-managed care program called the PASSE (Provider Led Shared Savings Entities) with the goal of coordinating health care services for Medicaid beneficiaries of Behavioral Health, Intellectual, or Developmental Disability services.²⁹ Arkansas Advocates for Children and Families (AACF) interviewed stakeholders about the PASSE, and found several major concerns:³⁰

- **Assessment Issues:** Initial assessments were delayed, and stakeholders worry the assessors themselves may not be neutral or well qualified. Consumers may be overburdened by the lengthy beneficiary questionnaire (up to 400 questions) and some have challenged the appropriateness of the assessment tool.
- **Consumer Education Gaps:** Consumers have questions about navigating the PASSE, and some have worried that calls from assessors are scams.



Social Issues

Social issues that impact child health include poverty, low-quality and unstable jobs, housing instability, and low educational attainment. These issues are intertwined with child health, the wellbeing of parents, and the health and economic success of communities.

Leading metric: Child Poverty
Northwest Arkansas: 23%
Arkansas: 27%

Social Issues

KEY INFORMANT FEEDBACK

"I was talking to a woman today about how much being poor costs her... By the time she gets to payday she has to pay late fees and has to factor that into her budget. How that impacts her kids, and what she is able to provide for them and do with them. It was disheartening to listen to her blame herself."

"Any family who is scared to get healthcare because of political talk - that is inequitable."

"We're seeing more stress, more people being apprehensive of taking care, of food or housing, of medical needs... the fear in communities based on what is happening nationwide is affecting them."

"We have a transportation system but it doesn't meet the need... That's been a challenge for families with health appointments, because there's not a set public transportation system."

The number one theme brought up during discussions of poverty and social issues related to housing and safe living environments. Key informants repeatedly cited the physical environment as critical to child health (prevention of injuries, asthma, stress, and mental health etc.).

Many participants also discussed the limited mobility of low-income and rural residents. Discrimination, lack of trust, and fear were also reported as issues preventing people from accessing care and resources, particularly among immigrant and marginalized groups. Several informants reported qualified families foregoing needed benefits like SNAP because of fears of future legal or political repercussions. This added to the mental and economic strain on families.

FOCUS GROUP FEEDBACK

"[People] can't accept a promotion or a raise because they lose benefits."-Crawford County Provider

"There should be an agency to help parents lower the cost of daycare, you can take them somewhere, but it's a lot, like as much as we earn."-Benton County Parent

"Since women have gone into the workforce and wages haven't grown as far as buying power, parents are working more than they were 40 years ago... Wages have fallen as far as the ability to purchase."-Washington County Provider

"Housing, rent is going up, parents come in with complaints that the heater isn't working, they have to pay more rent or pack up and move again."-Washington County Provider

Participants report that poverty impacts the provision of care and quality of life, with low-income families experiencing housing insecurity and living in unhealthy housing conditions. Some participants think income inequality contributes to disparities, while others attribute the root cause to the drug epidemic. Substance abuse is a major health topic and some believe it is caused by untreated mental health issues.

The economic health of communities was reported by focus group participants to be related to physical and especially emotional health of families. Participants mentioned income impacting physical environment, quality of life, unhealthy habits, and vices.

FOCUS GROUP FEEDBACK CONTINUED

Children were said to be left unattended for long hours due to parents' tough work schedules and long commutes. This was also said to impede taking kids to their medical appointments. Participants report that it is still hard for some segments of the population to gain quality employment.

Participants report that it is hard to get ahead because when one earns more, they no longer qualify for benefits. Participants suggest an incentive transition system, so people can rise through the ranks without having to sacrifice benefits. The cost and limited availability of daycares also play a role in preventing people from working. Participants report parents work odd shift hours and many times they don't have access to resources due to their work schedule.

PHONE SURVEY RESULTS

Poverty was ranked as the second most severe community problem by parents who participated in the phone survey. A large majority of parents (78 percent) said that the number of children experiencing the negative effects of poverty was either a serious or moderate problem. Only 3 percent said it was not at all a problem. A quarter of parents surveyed reported that they did not have paid time off from their job that allowed them to take their children to receive medical services. Parents were also asked "Poverty is associated with many poor health outcomes for children. Would you support or oppose a tax break for working families to make ends meet?" Ninety percent strongly or somewhat supported a tax break for working families.

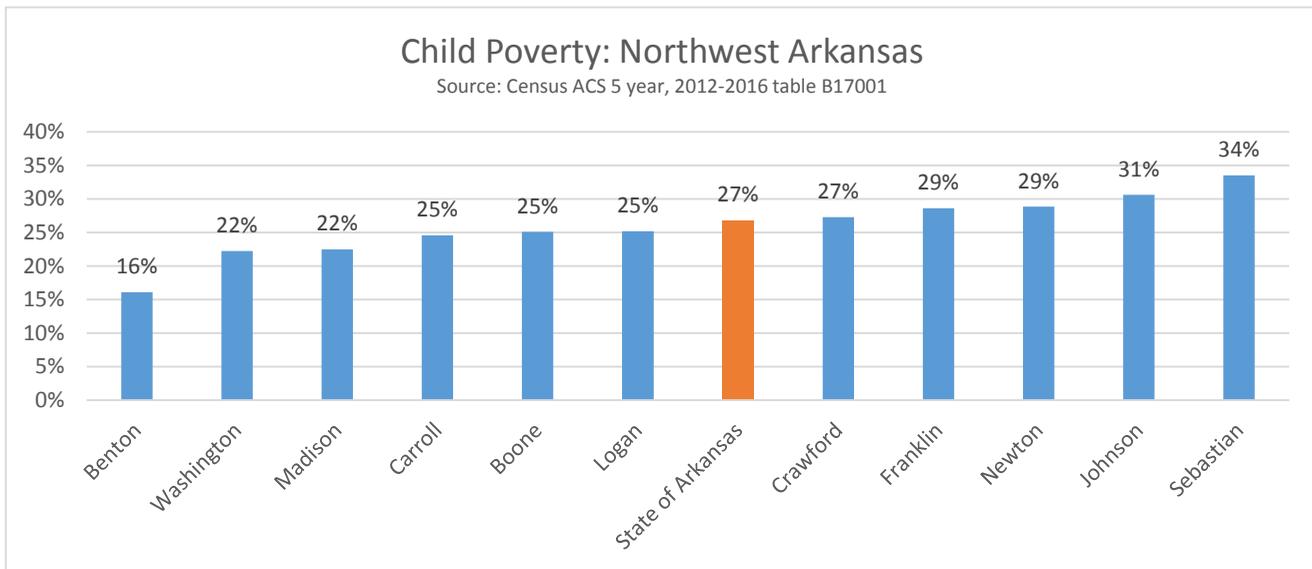
CROSS CUTTING FACTORS:

(Themes identified by parents, providers, and key informants as root causes of social issues.)

- **Discrimination based on Language, Culture, or Race:** There remain cultural divides across racial lines in Arkansas, including access to employment opportunities. Some groups are also hesitant to use benefits because of fear of legal repercussions due to political changes.
- **Housing and Environmental Quality:** Income was reported as strongly tied to ability to live in "good" neighborhoods with more resources and less crime. Prices for housing have gone up, pushing people out of some areas. Low-quality housing was seen as unsafe or unhealthy.
- **Transportation:** Families have limited access to both services and opportunities for employment when their transportation is lacking. Issues with transportation and work hours also make getting kids to healthcare appointments and checkups more difficult.

Child poverty:

Arkansas is a high poverty state, with 165,000 children living below the federal poverty line.³¹ Arkansas child poverty rates are higher than national average (19 percent) but are declining (from 28 percent in 2010 to 24 percent in 2016).³² Forty-six percent of African American children live in poverty in Arkansas, more than twice the rate of their white peers (21 percent). Hispanic children fall in the middle, living in poverty at a rate of 39 percent.³³ The child poverty rate in Northwest Arkansas (23 percent)³⁴ is lower than the state average (27 percent).³⁵ However, disparities remain. About 33 percent of Black and Hispanic children in Northwest Arkansas live in poverty, compared to about 15 percent of white children.³⁶



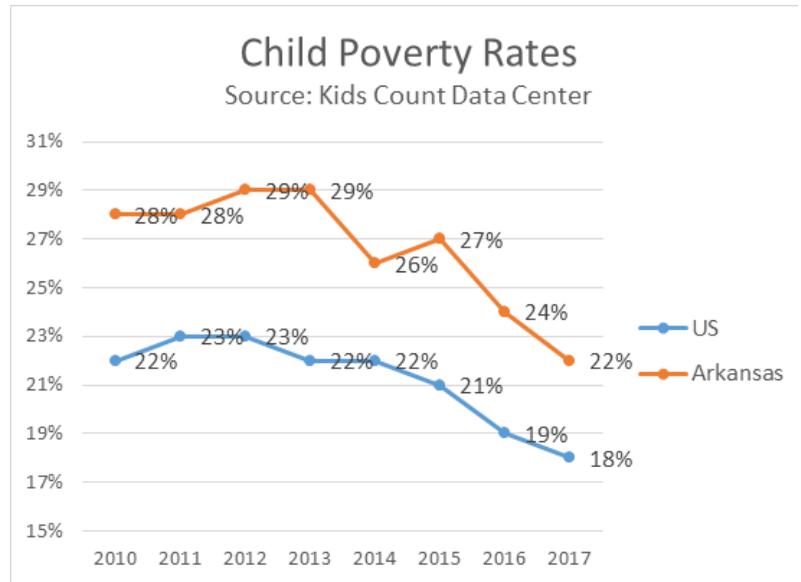
Housing and physical environment:

Arkansas ranks relatively well for housing cost burden for homeowners (11th) and housing cost burden for renters (13th).³⁷ However, about one third of Arkansans rent instead of own³⁸, and Arkansas is the only state that does not ensure that landlords maintain reasonable living standards with a “warranty of habitability”.³⁹ Fifteen percent of Arkansans live with at least one housing problem: overcrowding, high housing costs, or lack of kitchen or plumbing; in Northwest Arkansas that percentage ranges from just 10 percent in Logan County to 19 percent in Washington County.⁴⁰

Good housing, crime-free streets, and fresh air all contribute to a healthy living environment. Arkansas has a violent crime rate of 470 per 100,000.⁴¹ In Northwest Arkansas, violent crime is relatively low, with rates ranging from 193 in Johnson County to 595 in Sebastian County.^{42,43,44} Air pollution is also not consistent across all counties in Arkansas. The highest particulate matter concentrations are in Central Arkansas (Pulaski, Lonoke, Jefferson, and Saline Counties), the lowest is in Northwest Arkansas (Newton County). Overall, Arkansas has a fine particulate matter density of 10.1 per cubic meter.

Employment:

Between 2010 and 2016, the economic growth of urban areas of Arkansas has greatly outpaced that of their rural counterparts.⁴⁵ In rural Arkansas, employment in 2016 was still below pre-recession era numbers.⁴⁶ However, three of the twelve best performing county level economies were in Northwest Arkansas (Benton, Carroll, and Washington counties). Benton county in particular stands out for its 26 percent employment growth from 2010-2016.⁴⁷ During this time, however, nearby Newton County had employment rates decrease by 7.1 percent.⁴⁸



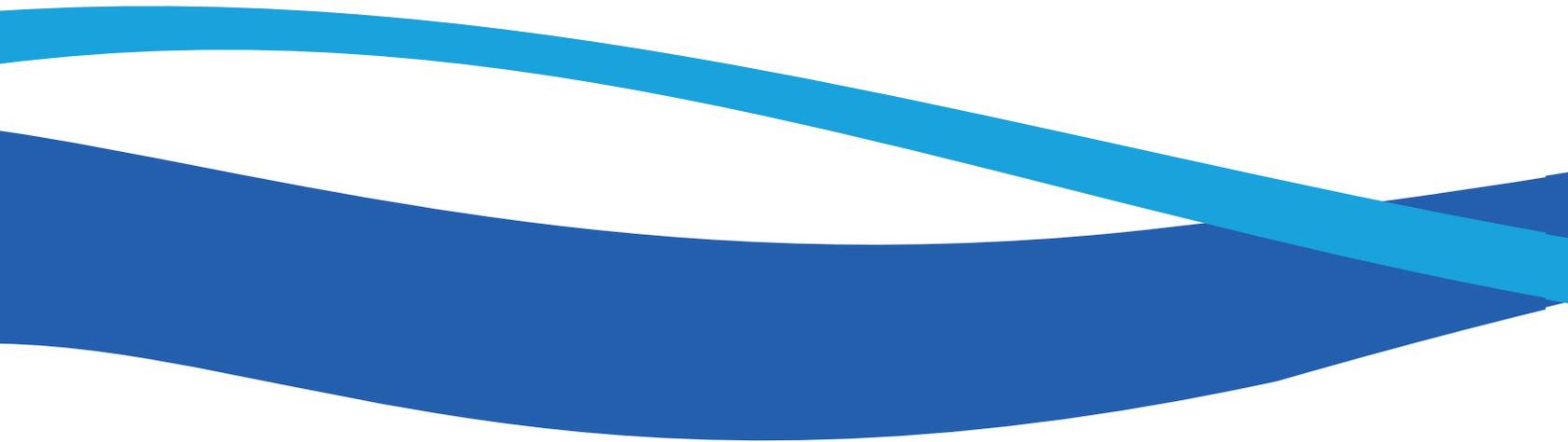
Median household income for Arkansas is about \$42,000 a year. For Northwest Arkansas, it ranges from about \$59,000 a year (Benton County) to just \$33,000 a year (Newton County).⁴⁹ Benton County, in addition to having the highest median household income, also has the lowest unemployment rate for the region (2.2 percent).⁵⁰ Thirty-one percent of children in Arkansas live in families where their parents don't have full time, year-round jobs.⁵¹ The mean travel time to work for Arkansans is 21.6 minutes. For the Northwest Arkansas region that time ranges from 18.7 minutes in Sebastian County to 33.7 minutes in Newton County.⁵²

Race, ethnicity, and language:

Economic factors differ greatly by race and ethnicity in Arkansas. Children whose first language was not English are less likely to have health insurance that protects families from catastrophic expenses. These children are uninsured at a rate of 9.5 percent, higher than the non-insurance rates of children who speak English as a first language (4 percent).⁵³ In Arkansas, 1.4 percent of children (ages 5-17) speak Spanish at home.⁵⁴ In Northwest Arkansas, that number is usually higher, reaching its highest at 4.1 percent in Washington County.⁵⁵ There are also instances of higher-than-average rates of Asian and Pacific Islander languages spoken at home for children in Northwest Arkansas. For Arkansas as a whole, just 0.2 percent of kids aged 5-17 speak an Asian or Pacific Islander language at home.⁵⁶ Several Arkansas counties stand out with higher rates, such as Washington (.9 percent), Logan (.7 percent), and Sebastian (.6 percent).⁵⁷

Family type:

Children in Arkansas are a little more likely to live in single parent households compared to the national average (38 percent and 35 percent respectively).⁵⁸ Female-headed households in Arkansas with children under 18 live in poverty at 46.8 percent, much higher than the national average for this type of household (39.7 percent).⁵⁹ Central Arkansas has the lowest rate of poverty for single parent households (37.9 percent), and Northwest Arkansas is next lowest (48.2 percent).⁶⁰



Parenting Supports

Children need capable, loving parents who can support them physically, mentally, emotionally, and financially. Supporting parents and primary caregivers means giving them the tools to improve their parenting or caregiving skills (such as parenting programs, home visiting programs, and teen parenting support) and creating a community network of resources and supports outside the family home.

Leading metric: Infant Mortality
Northwest Arkansas: 6.28
Arkansas: 7

Parenting Supports

KEY INFORMANT FEEDBACK

"[Services] are better in Northwest Arkansas than they are in rural Arkansas; there are way more options and service providers, way more types of service. You get into other parts of the state and those things become nonexistent. You should be getting help and support, but because of where you live we cannot help you."

"School communications with Marshallese parents is a concern. Many parents do not understand the education system and have difficulty communicating with teachers."

Key informants saw a lack of education as the most important factor driving parent supports in Arkansas. They recognized the need for parent supports in the form of parenting education including traditional classes. They also saw a need for improved environmental factors to allow parents to succeed. Lack of affordable childcare, substance use in the community, language and cultural barriers, and unsafe living environments were all listed as obstacles to effective parenting. Some participants also identified issues with inefficiencies within DHS.

FOCUS GROUP FEEDBACK

"I think there is a stigma with the parenting classes because a lot of times they are court ordered."-Washington County Provider

"The education and support we are giving to students, we should give to parents."-Crawford County Provider

"We need a place for childcare that is accessible financially and we can trust, because most of the Hispanic people will say 'oh I know this lady who takes care of children' and we are not like Americans that can go see their records, many people do not have legal documentation so we don't know their backgrounds. Sometimes for saving money and financial need, we expose our children [to danger] and you realize it when it's too late." -Benton County Parent

Participants mentioned that the community would benefit from early childhood education, safe and affordable daycares, after school care as well as affordable community centers and extra-curricular activities. This would help to take some pressure off parents, who are overextended due to work demands. Churches are said to have helped a lot previously, but people would like to see more community collaboration with neighbors helping each other.

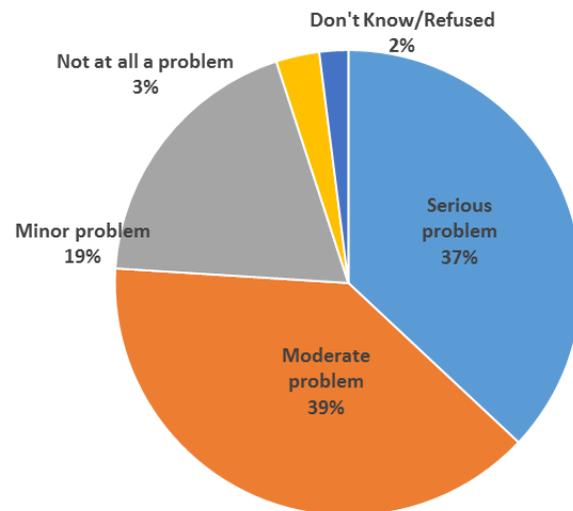
Participants frequently note that parents would benefit from education. They said that education needs to start with the parents so they can teach the kids, and some suggested these classes could be provided at schools. However, families also report a lack of awareness about existing resources, and a stigma around parenting classes because of court mandates.

PHONE SURVEY RESULTS

During phone survey interviews, parents were asked about the number of parents who have poor or inadequate parenting skills and support. Poor parenting skills was ranked as the fourth most severe community problem by phone survey participants. Seventy-six percent of respondents said poor parenting was a serious or moderate problem. Only 3 percent of respondents felt this was not a problem.

When asked about their own interest in attending a class that would help manage behavioral, developmental, or emotional problems with their children, the majority of parents (51 percent) said they were either somewhat or very interested. 31 percent said they were not at all interested in this type of parenting classes. Parents showed moderate interest in parent-child therapy services. Forty-nine percent said they were either very or somewhat interested in these services, while 35 percent said they were not at all interested. Relatively fewer parents were interested in home visiting services. Fifty-seven percent said they were not at all interested in being part of a home visiting program for parents of newborns and young children, though this may be skewed by the inclusion of parents with older children. Only 27 percent said they were very or somewhat interested.

How serious a problem is "the number of parents who have poor or inadequate parenting skills and support?"



CROSS CUTTING FACTORS:

(Themes identified by parents, providers, and key informants as root causes of parenting issues.)

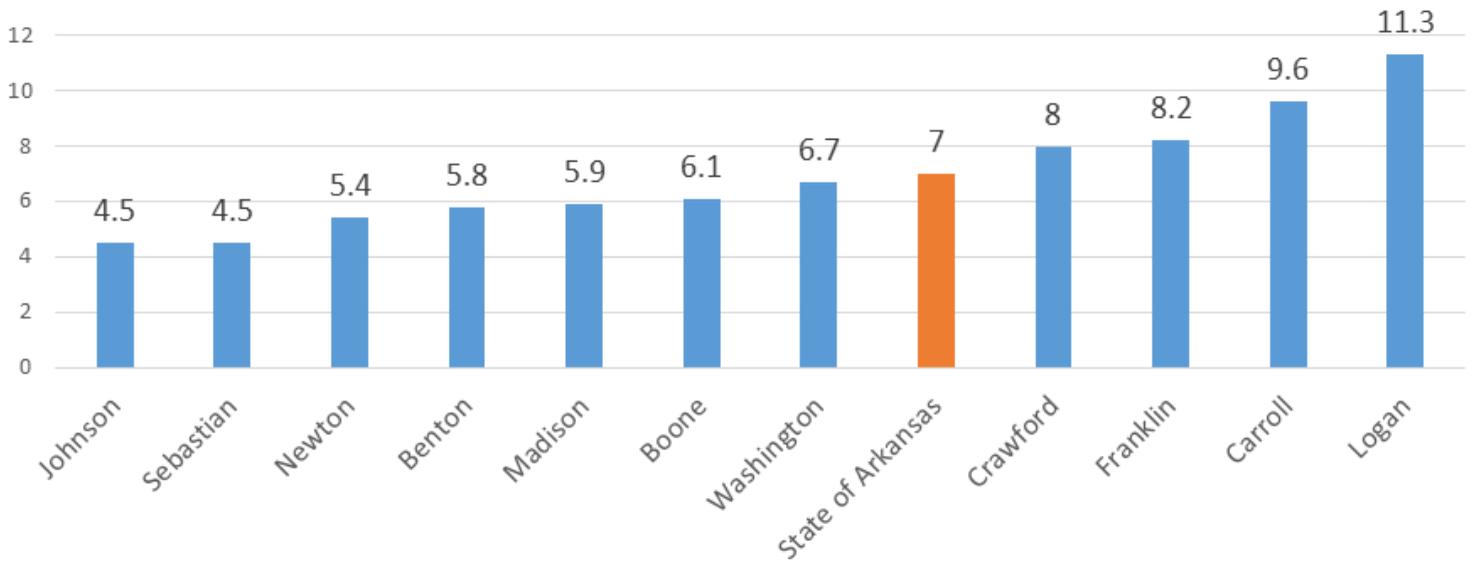
- **Health Education:** The foremost cross cutting topic for parenting supports was a desire for more parenting classes.
- **Discrimination based on Language, Culture, or Race:** Hispanic and Marshallese parents report a lack of affordable, safe daycare and afterschool options for their children. Language and cultural barriers increase the difficulty of obtaining care and accessing resources.
- **Transportation and Rural Isolation:** Parents without access to reliable transportation are reported to have a harder time making parent teacher conferences and other activities related to parenting.

Infant mortality:

Arkansas is among the worst states for rates of infant mortality, ranking 46th out of 50 states according to Aspire Arkansas. Rates of infant mortality have plateaued over recent years in Arkansas, while national rates have gone down. Northwest Arkansas’s Infant Mortality rate is 6.28⁶¹ (out of 1,000), which is lower than the Arkansas rate (7).^{62,63}

Infant Mortality Rate: Northwest Arkansas (per 1,000)

Source: Aspire Arkansas 2016



Parenting needs for infants and toddlers:

Arkansas Advocates for Children and Families and the Arkansas Campaign for Grade Level Reading identified 4 important supports for parents of children aged 0-3: Prenatal Care, Paid Family Leave, Economic Support, and Home Visiting:⁶⁴

- Prenatal care: 12.7 percent of babies in Arkansas are born pre-term. Expanding access to prenatal care can improve the health of mothers and infants, and reduce pre-term births.
- Paid Family Leave: Although Arkansas recently passed legislation providing paid maternity leave for certain state-employees, there is no state-wide paid leave program. Such a program would improve the health and recovery time of children, and “Just a few extra weeks of paid leave is also connected to a significant reduction in infant deaths.”
- Economic Support: Arkansas has high and persistent child poverty rates. Unlike most other states, Arkansas does not have a state Earned Income Tax Credit program that would target financial assistance to working families with low-incomes.
- Home Visiting: This is a crucial strategy for supporting vulnerable parents of young children in Arkansas. This includes programs like Parents as Teachers (PAT) and HIPPIY (Home Instruction for Parents of Preschool Youngsters).

Parenting needs across the state:

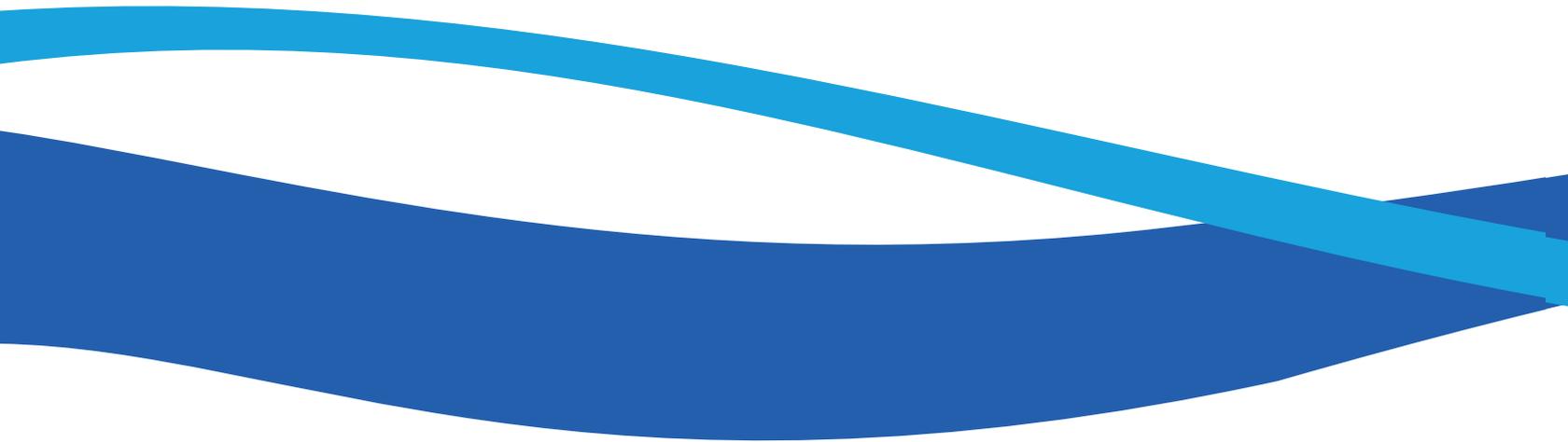
The Natural Wonders Partnership Council collaborated with Child and Family Evaluation Services in 2018 to develop a report of available resources for parents in select locations across Arkansas. One of the target communities examined was Springdale, in Northwest Arkansas. The needs reported for this community were: supports for parents with Adverse Childhood Experiences, and adequate, quality parenting classes for parents who are court mandated them and for parents who are divorced or separated. Overall, this report identified several unmet needs for supporting parents:⁶⁵

- A lack of parenting courses available in Arkansas despite numerous certified trainers. Very few parenting classes use evidence-based curriculum courses.
- Although home visiting is present across all regions of Arkansas, not all parents have access. Home visiting services in Arkansas reach about 7,000 kids at any given time, far less than the true number of children under age five living below the poverty line.
- The report also identified the special needs associated with Arkansas’s high rates of Adverse Childhood Experiences. The ARBEST (Arkansas Building Effective Services for Trauma) has recently increased the number of clinicians that can offer evidence-based mental health therapy services to children with ACEs. However, the need greatly outweighs the supply of services. About 480 ARBEST providers are in training, but there are thousands of children every year who experience new traumas (54 percent of kids in Arkansas have at least one ACE).

Child welfare:

The Arkansas Department of Health reports 9,364 cases of true child maltreatment, 5,113 children in foster care, and 451 young people committed to youth services centers in Arkansas in fiscal year 2017.⁶⁶

	Total true reports of child maltreatment	Total children in foster care	Children in foster care: African American	Children in foster care: Hispanic	Children in foster care: White
Benton	349	335	7	40	262
Boone	109	158	0	3	145
Carroll	5	108	1	17	90
Crawford	152	268	1	7	223
Franklin	43	99	0	6	86
Johnson	85	105	5	12	82
Logan	78	81	0	3	69
Madison	4	162	13	4	126
Newton	15	18	0	0	16
Sebastian	330	1093	86	83	697
Washington	444	467	23	47	13
Source: 2017 Kids Count Data Center					



Child Obesity

Child Obesity is most often defined in terms of excessive Body Mass Index (BMI) for the child's height and age. An elevated BMI carries risk of current and life-long health issues. Children with healthy weights require healthy food options, safe places to play and exercise, and a community-based approach to family health.

Leading metric: Child Obesity Rate
Northwest Arkansas: 20.8%
Arkansas: 22.2%

Child Obesity

KEY INFORMANT FEEDBACK

“Many communities don’t have safe places to play outside. In some communities, it’s not safe to walk to school.”

“We can say yes there is a playground, but what about the street you have to travel on to get there?”

“In some areas where the kids live the easiest option is fast food.”

Key informants cited a need for increased safe places for kids to play and exercise. Dangerous streets or sidewalks and crime were barriers to kids going outside, walking, or riding their bikes. These concerns were echoed in the focus group discussions as well.

Key informants also mentioned a need for transportation to recreational opportunities for kids. Many also listed a lack of easily accessible or affordable healthy food options. They said that neighborhoods often have a variety of fast food options, or even liquor stores, but few healthy, affordable choices.

FOCUS GROUP FEEDBACK

“I think the environment touches many issues, by not having security in the parks, the children have to stay indoors, that will make them more likely to be glued to cell phones, tables, TVs and as a consequence, brings about obesity, right?”

-Benton County Parent

“Health education is not part of the standardized testing that we do and it got pushed to the wayside. We are not teaching health in schools even though a large part of future jobs will be health related.”

-Washington County Provider

“Policy change needs to happen to make time for PE and health education.”

-Washington County Provider

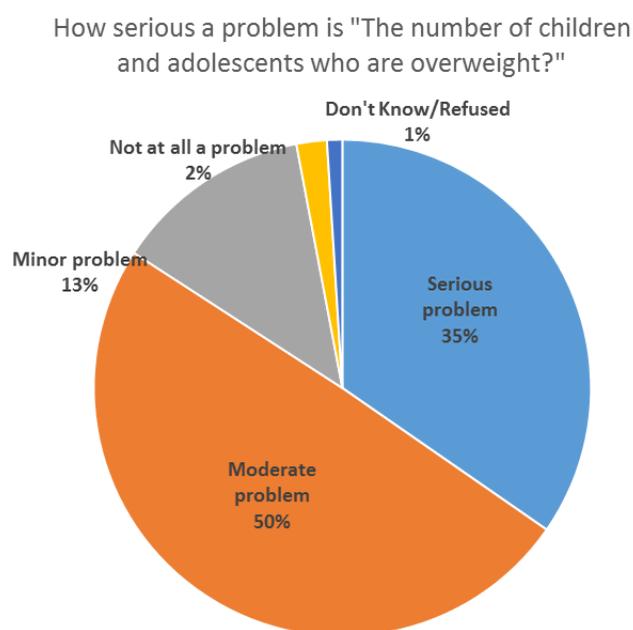
Participants noted a lack of safe spaces for children to play, and connected that to health problems. They also connected a lack of affordable child care to problems with parents securing employment. Issues like neighborhood safety, lack of nearby parks, and unsafe sidewalks all reportedly deterred children from going outdoors and being more active. Participants would like to see more affordable recreation centers where children can play.

Participants discussed the need for better education on nutrition and healthy habits in the school systems as well as for parents so they can prepare healthy meals. The quality of the food offered at school is an issue for many and some say it builds unhealthy eating habits. The availability of healthy foods was a concern as well as time to prepare healthy meals. Participants expressed a need for legislators to make policy changes to allow children more time for physical activity and health education at school.

PHONE SURVEY RESULTS

Parents recognized child obesity as a problem in Arkansas. This issue was ranked as the most severe community problem in the phone survey, and was the third most commonly mentioned “number one community problem”. Eighty-five percent of parents said that the number of children and adolescents who are overweight is either a serious or moderate problem. Only 2 percent said it was not at all a problem.

When asked about GoNoodle (program used by schools that provides movement breaks in the classroom for kids to get them up and moving) 25 percent of parents said that their children use the program. Sixty-one percent said they did not, and 10 percent said they did not know.



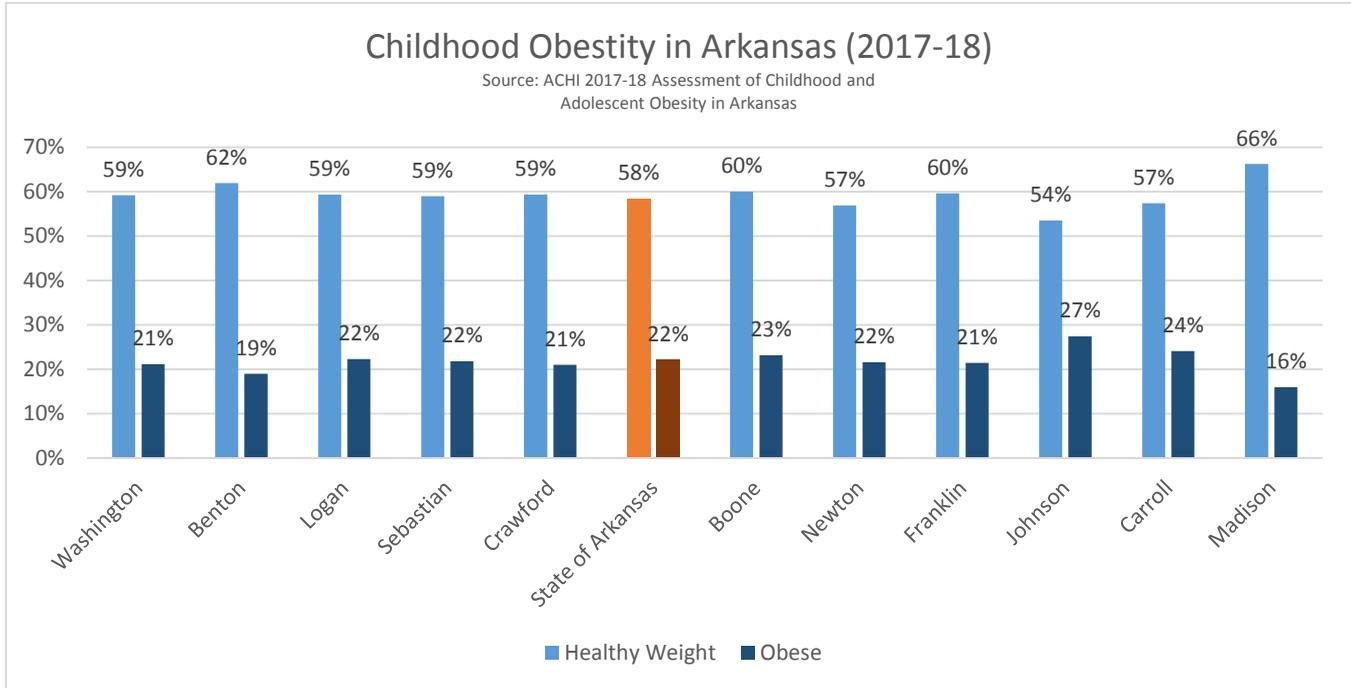
CROSS CUTTING FACTORS:

(Themes identified by parents, providers, and key informants as root causes of child obesity.)

- **Health Education:** There is a desire for a two-generation approach to teaching healthy eating habits, nutrition, and cooking.
- **Housing and Environmental Quality:** A lack of safety in neighborhoods and a lack of parks and recreational activities is preventing children from exercising and going outdoors according to focus group and key informant discussions.

Child obesity rates:

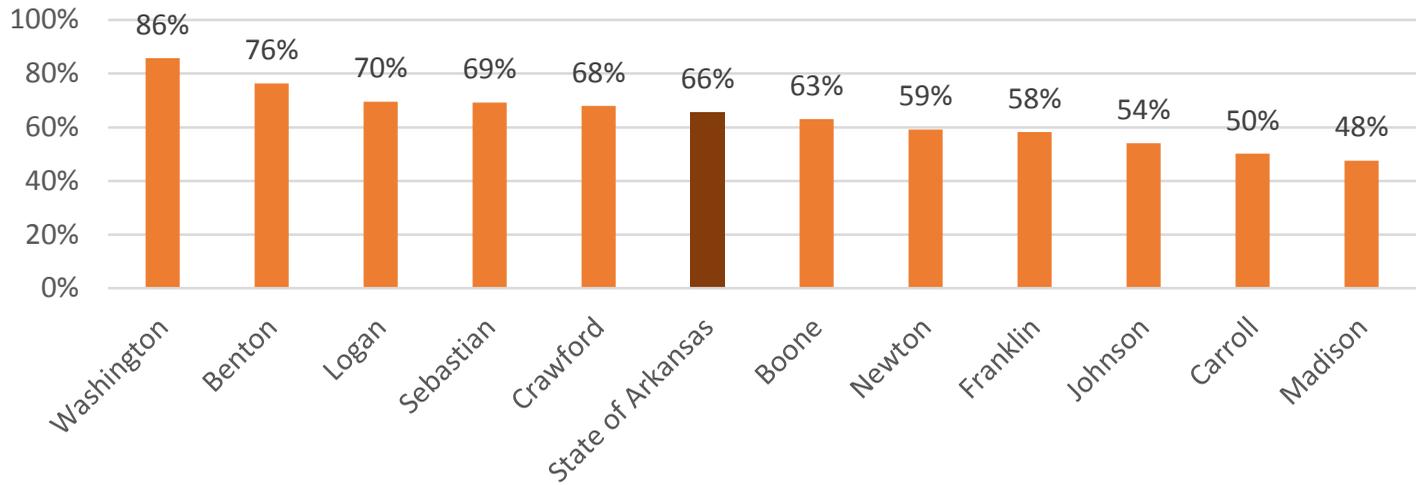
Arkansas has the highest rate of high school obesity in the nation (21.7 percent).⁶⁷ Arkansas overall child obesity rates (ages 0-18) range from a low of 16 percent in Madison County to about double that in Bradley County (31 percent).⁶⁸ They also vary by race, with racial and ethnic minority groups like Hispanic and African American children more likely to experience obesity. Northwest Arkansas has a child obesity rate (for grades K-10) of 20.8 percent⁶⁹, slightly lower than the state average of 22.2 percent.⁷⁰



Arkansas Child Obesity by Race and Age Group			
Source: ACHI 2017-18 Assessment of Childhood and Adolescent Obesity in Arkansas http://www.achi.net			
Child obesity by race and ethnicity		Child obesity by age group	
White	19.60%	Kindergarten	15.30%
Black	25.40%	2nd Grade	19.80%
Hispanic	30.30%	4th Grade	23.90%
Asian	13.10%	6th Grade	24.90%
Native American	21.80%	8th Grade	24.70%
		10th Grade	25.30%

Percent of population with adequate access to locations for physical activity

Source: RWJF Analysis of 2010 and 2016 data from: Business Analyst, Delorme map data, ESRI, & US Census Tigerline Files

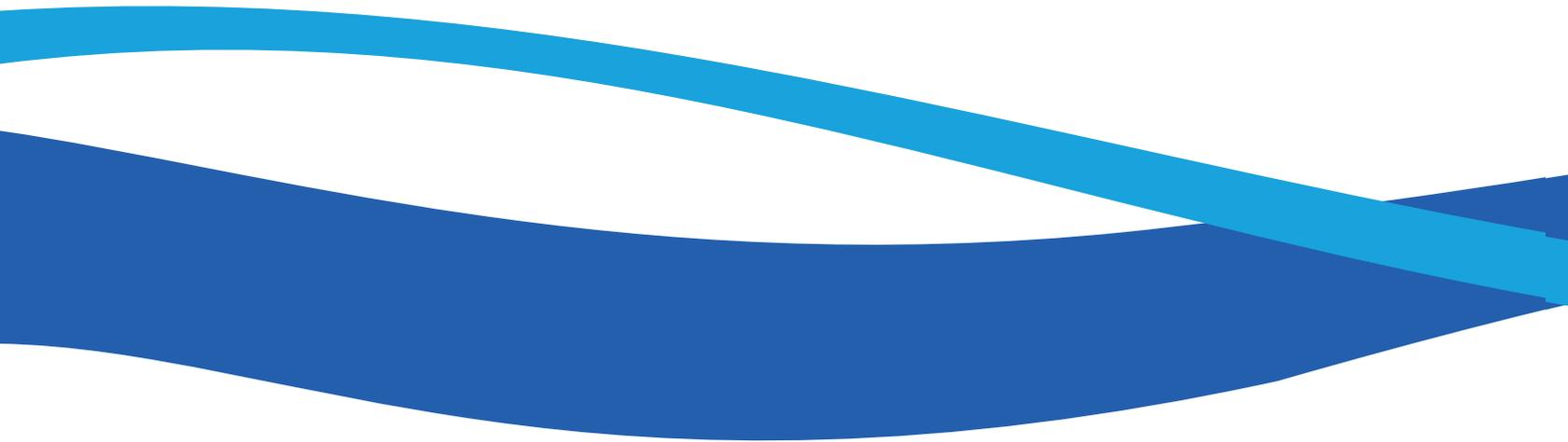


Proximity to places to exercise:

Overall, 66 percent of Arkansans live half a mile or more from a park or recreational facility.⁷¹ Only about one in 5 (21.4%) high school students in Arkansas get an hour or more of daily exercise.⁷² Options for places to exercise in Northwest Arkansas range from a low of 48 percent in Madison County to 86 percent in Washington County.⁷³ Six out of the 11 counties in Northwest Arkansas are below the state average for access to places to exercise.

Diet:

Maintaining a quality, nutritious diet is a problem in general for Arkansans, 255,000 (or 8.9 percent) of whom have limited access to healthy foods.⁷⁴ Thirty-two percent of Arkansas youth drink one or more sodas every day (compared to 19 percent nationally). Some Arkansas youth (12 percent) drink three or more sodas daily. Fourteen percent of children in Arkansas don't regularly eat vegetables (compared to 7 percent nationally).



Food Insecurity

Children who do not have consistent access to a nutritionally adequate diet are considered food insecure. These children and their families often make difficult tradeoffs, sometimes foregoing health care, to afford food. Children who go without needed food also are more likely to struggle to pay attention in school and face additional health problems.

Leading metric: Child Food Insecurity
Northwest Arkansas: 21%
Arkansas: 23%

Food Insecurity

KEY INFORMANT FEEDBACK

“Some folks see SNAP and food pantries as enabling versus helping. People don’t know enough of the story of the working poor to know this is not so. We need to do more to help some folks understand what the poor and working poor are experiencing.”

“Many of the kids in the rural areas of Northwest Arkansas have very limited resources. Some come to school without a winter coat. Some come to school on Monday, having not eaten on the weekend. Contrary to popular belief, there is a lot more poverty in Northwest Arkansas than anyone is aware of or cares to admit exists.”

One of the primary barriers to adequate nutrition that key informants brought up was a fear of signing up for benefits. Some families, particularly mixed immigration status families, were hesitant to use programs like SNAP for fear of future legal repercussions that could put their citizenship in jeopardy.

Educating parents and kids on healthy nutrition options was a priority. Some families were also said to have less access to healthy options because of living far from grocery stores and having limited access to transportation. Certain parts of town often have a much different selection of retail options, with lower-income neighborhoods reportedly having much higher rates of fast food restaurants, liquor stores, and places to buy tobacco than healthy food options.

FOCUS GROUP FEEDBACK

“When you have parents who are striving to pay bills or keep food and the lights on, they are not getting healthcare themselves, the last thing they are concerned about is if their kid ate something they shouldn’t have, they aren’t going to limit access to social media and devices because that’s a break for them. To have healthy kids we have to have adults who are healthy.”

- Washington County Provider

“Our food banks are constantly calling on our local churches because they are always empty.”

-Logan County Parent

“Healthy food needs to be more economical, families do want to eat better but it is expensive.”

-Washington County Provider

“A lot of people fall on that line where they can’t afford school lunch, but they don’t qualify [for free and reduced lunch].”-Washington County Parent

Participants reported that food insecurity is high in the region, with many relying on the assistance of food pantries. Participants also state that many children are caught between being unable to afford lunch and not qualifying for free or reduced price meals at school.

The Marshallese focus group participants mentioned they have a saying “even if you don’t work, you still eat,” reflecting community support and reliance during times of financial hardship. Participants would like to see an increase in nutritional education at schools for kids and also for schools to provide information for parents.

FOCUS GROUP FEEDBACK CONTINUED

Families also say they need better access to healthy foods. They report that it is easier, faster, and more economical to buy unhealthy food on the go than to prepare a healthy meal at home. Participants say that in order for health habits to change, healthy food needs to be affordable and that we must take into consideration the time it takes to prepare healthy meals.

PHONE SURVEY RESULTS

Most parents (75 percent) said that the number of children who are often hungry was either a serious or moderate problem. Only 3 percent said it was not at all a problem. Parents are more divided on their opinions of the nutritional quality of the food served in their child's school. Fifty-six percent said that the food was either excellent or good, and 44 percent said that it was fair or poor. Their opinions of the nutritional quality of food served in pre-school or daycare was more favorable. 75 percent said that food at daycare or pre-school was either excellent or good. Eight percent rated this food as poor.

Parents were supportive of the prospect of Arkansas developing regulations to increase the standards of the nutritional quality of meals served in pre-schools. Ninety-three percent said they would somewhat or strongly support such a measure, and only 3 percent said they would not at all support it. Parents were not as supportive of the idea of attending a class to teach them how to shop for and prepare affordable healthy meals. Forty-seven percent said they were not at all interested and only 12 percent said they were very interested.

CROSS CUTTING FACTORS:

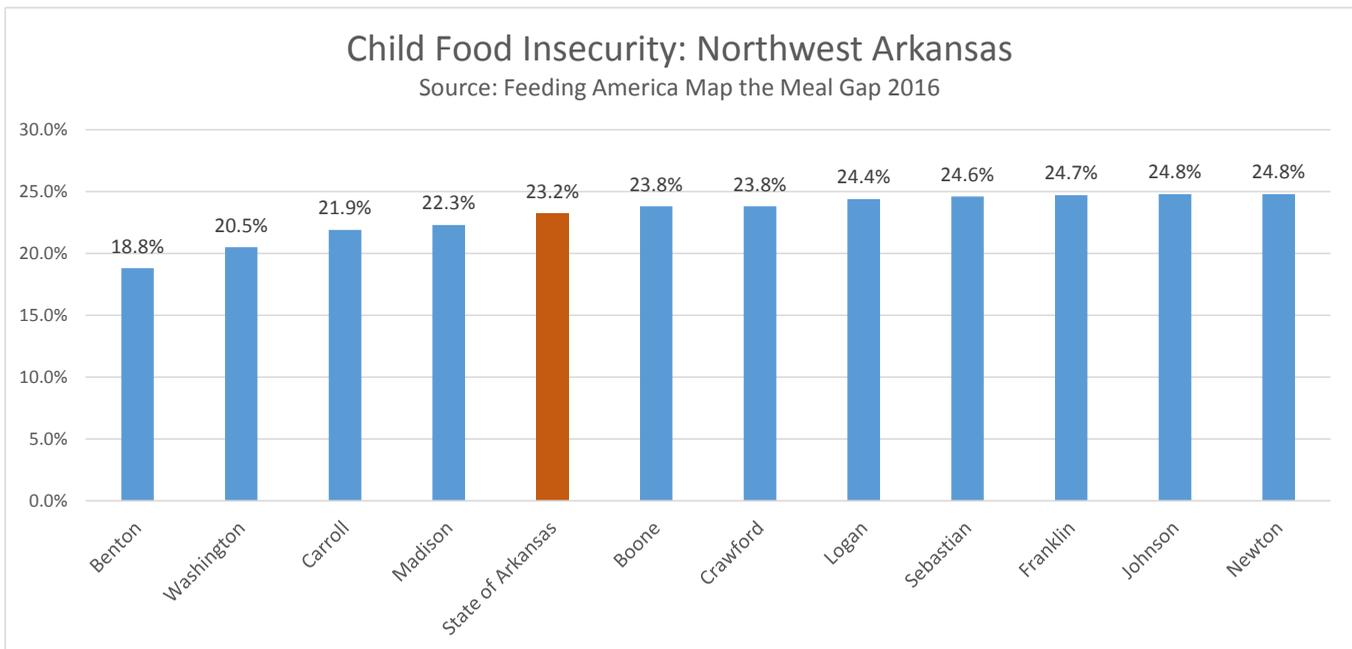
(Themes identified by parents, providers, and key informants as root causes of food insecurity.)

- **Health Education:** Participants again saw a need for a two-generation style approach to health education for nutrition and healthy cooking. Some also suggested increased education on gardening.
- **Transportation and Rural Isolation:** Location is a major issue reported by providers and parents in relation to access to healthy food. Many communities, or certain areas within communities, have much more restricted access to grocery stores.
- **Discrimination based on Language, Culture, or Race:** Cultural divides that dictate income and neighborhood in Arkansas communities also influence access to grocery stores and healthy food options. Some groups are also hesitant to use benefits because of fear of legal repercussions or deportation.

Food insecurity rates:

In Arkansas, 23.2 percent of children are food insecure.⁷⁵ The number of food insecure kids in Arkansas had plateaued at around 200,000 for several years before finally edging down. The current number of food insecure children (about 163,000) is a 19 percent decrease from 2015.⁷⁶ The rate of food insecure children is also going down in Arkansas, dropping from 26.3 percent in 2014 to 23.2 percent in 2016.⁷⁷

In the Northwest region of the state, there are 43,550 children living with food insecurity. In this region, child food insecurity is slightly lower (21 percent) than in Arkansas overall, but still higher than the US average (17.5 percent).⁷⁸ Child food insecurity in Northwest Arkansas ranges from a low of 19 percent in Benton County, to 24.8 percent in Newton and Johnson Counties.⁷⁹



Nutrition assistance:

In Northwest Arkansas there are over 23,000 kids under age 6 who rely on SNAP (the Supplemental Nutrition Assistance Program), and nearly 33,000 total kids (under age 18) who use the program.⁸⁰ Fourteen percent of Arkansas families received SNAP benefits over the last year.⁸¹ During that time, over 145,000 kids in Arkansas also benefited from SNAP.⁸² Still, about 255,000 Arkansans (or 8.9 percent) have limited access to healthy foods.⁸³

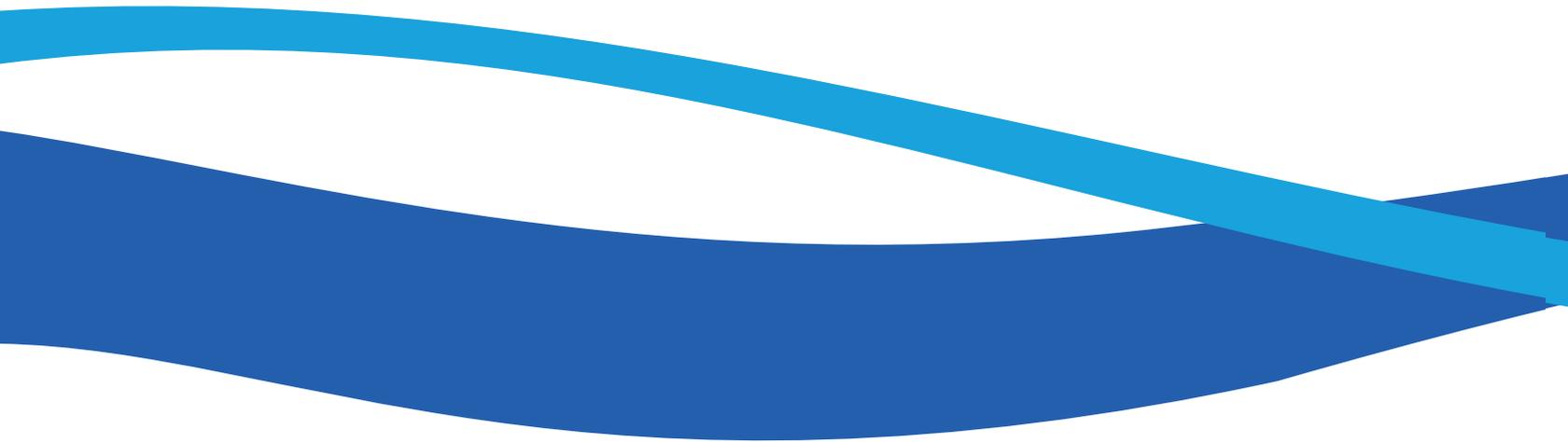
Access to food:

The average rate of people in Arkansas who have limited access to healthy foods is 9 percent.⁸⁴ This means that 9 percent of the population in Arkansas is low-income and lives too far from a grocery store (More than 10 miles if rural, more than one mile if urban). Newton County stands out in the Northwest region as having a relatively high rate (21 percent) of its population with limited access to healthy foods.⁸⁵ Other counties in Northwest Arkansas are near or below the state average for limited access to healthy foods.

School breakfast and lunch:

Sixty-four percent of Arkansas children are eligible for free or reduced price lunch.⁸⁶ In Northwest Arkansas, that rate ranges from just 46 percent in Benton County to 81 percent in Logan County.⁸⁷ As one of the most rural states in the country, Arkansas faces additional barriers to providing school breakfasts for kids.⁸⁸ Despite this, Arkansas is showing improvement in school meal participation. According to the 2017-18 School Breakfast Scorecard from the Food Research and Action Center (FRAC), Arkansas is now ranked 6th in the nation for school breakfast participation. This report shows that 65.7 percent of low-income students in Arkansas who participate in school lunch also participate in school breakfast programs. This represents an increase of nearly 2 percentage points from the previous year. Arkansas was ranked 8th (63.8 percent participation) for the previous school year.

	Households with SNAP benefits in the past 12 months	Children 0-6 on SNAP	Children 0-18 on SNAP	Children eligible for free or reduced lunch	Child food insecurity rate	Food insecure children (rounded)	Limited Access to healthy foods (number)	Limited Access to healthy foods (Percent)
Source:	ACS table DP03 (2012-2016)	DHS Annual Statistical Report SFY2017		RWJF,NCES 2015-16	Map the Meal Gap 2016	RWJF analysis of USDA Food Environment Atlas 2015		
Arkansas (State)	14%			64%	23.2%	163,800	254970	9%
Benton	7%	4796	6995	46%	18.8%	12,530	11738	5%
Boone	16%	1296	1690	57%	23.8%	1,970	3822	10%
Carroll	11%	779	1208	71%	21.9%	1,350	1047	4%
Crawford	15%	2164	3172	66%	23.8%	3,700	4855	8%
Franklin	15%	554	932	58%	24.7%	1,050	660	4%
Johnson	15%	1096	1586	76%	24.8%	1,570	742	3%
Logan	16%	820	1210	81%	24.4%	1,200	1098	5%
Madison	11%	542	771	67%	22.3%	830	1894	12%
Newton	17%	195	336	73%	24.8%	390	1776	21%
Sebastian	16%	4779	6748	65%	24.6%	7,680	4678	4%
Washington	9%	6072	8149	60%	20.5%	11,280	12307	6%



Oral Health

Oral health is connected to the health of the whole child. Ideal oral health is achieved when children and adolescents are free from chronic mouth and facial pain, tooth decay, tooth loss, and other mouth and gum diseases. Healthy environments, nutrition, and appropriate dental treatment all reduce family costs of care, and lead to longer term improvements in education and general health.

Leading metric: Ratio of Population to Dentists
Northwest Arkansas: 3316:1
Arkansas: 2218:1

Oral Health

KEY INFORMANT FEEDBACK

“It’s difficult to innovate or focus on new initiatives when political capital is used to keep important public health efforts in place. Especially things like water fluoridation which has been established in many places for decades but is under threat in Arkansas.”

“From the socioeconomic standpoint, if you have a limited budget and you are looking at how you are going to pay utilities, get food, dental care is probably not even on the table.”

Key informants felt there was a general lack of understanding of the importance of oral health among community members and healthcare providers. There was concern that oral health was seen as a separate and less important part of child well-being. Key informants also lamented the lack of education and understanding that parents have about the importance of child dental health, especially among very young children.

Parents are said to put off dental care for fear of expense, even if they do have dental insurance. Some systemic concerns were also mentioned regarding slow progress with legislative changes at the state level. This included legislation related to fluoridation as well as resistance to changes in scope of practice by some health care providers who are concerned about competition.

A lack of dental care providers, especially in rural areas of the state, was another major concern. This was particularly true for pediatric dentists, who are even more concentrated in the urban regions of Arkansas. This compounded the transportation issues that already pose a barrier to families accessing dental care.

FOCUS GROUP FEEDBACK

“I’ve had a child this year whose teacher handed him a toothbrush and he didn’t know what to do with it and I teach 4th grade.” – Logan County Parent

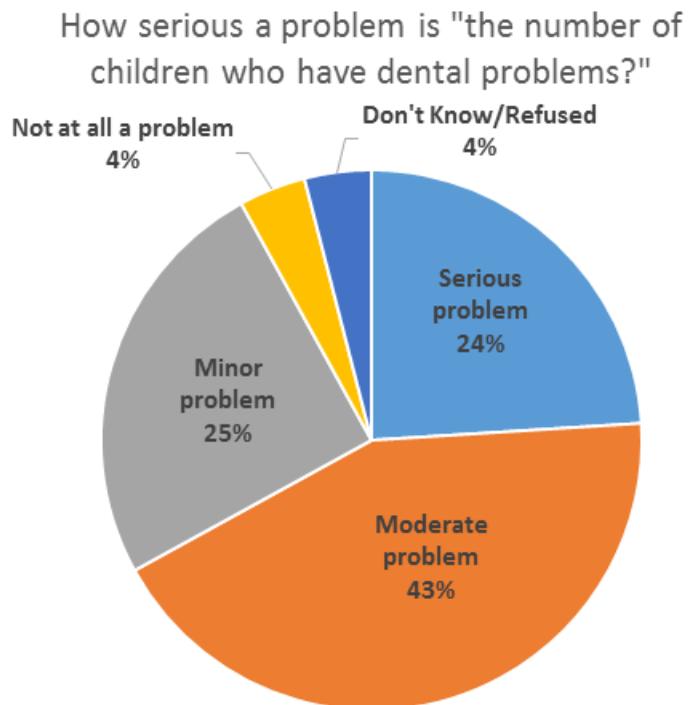
“We need some of them [parents] to understand that dental care really is important to your overall health, they don’t link the two.” -Logan County Parent

Providers report that dental health is not a priority for parents. Dental care offered at schools is helpful but it would be better if it started earlier. For many people transportation issues and matters of lost work days prevent them from taking their children to the dentist (home visiting programs, childcare facilities, etc.).

There is also a reported lack of awareness that dental care is covered by ARKids First. It is hard to predict upfront costs, especially for the uninsured, and this causes families to forego preventive checkups.

PHONE SURVEY RESULTS

The number of children who have dental problems is considered a serious or moderate problem by 67 percent of parents. Just 4 percent said that it was not at all a problem. Some parents (6 percent) report that their child has missed school due to a toothache.



CROSS CUTTING FACTORS:

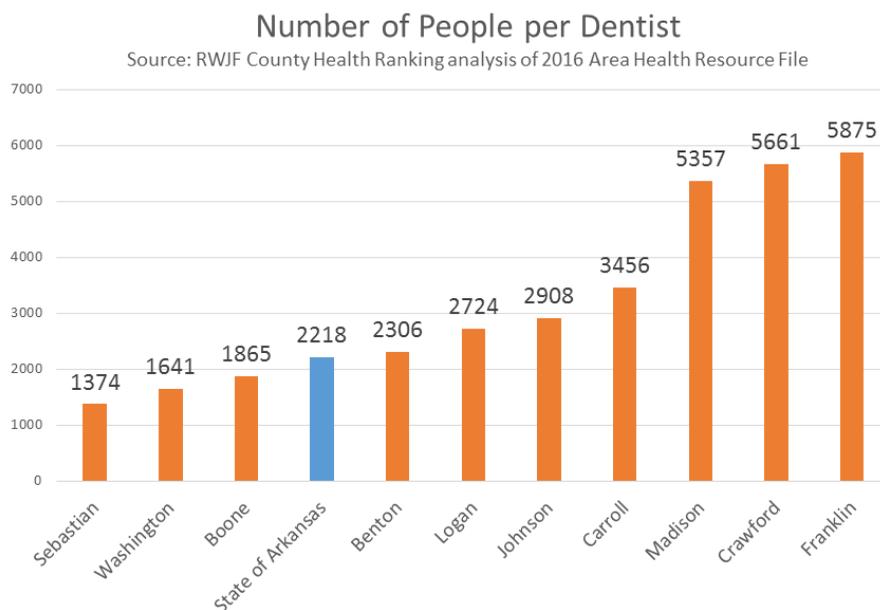
(Themes identified by parents, providers, and key informants as root causes of oral health issues.)

- **Health Education:** There is a reported lack of awareness of basic dental care among kids and their parents, especially regarding the relationship between dental care and overall health. There is also a lack of awareness about when children need to start seeing the dentist and other health care system navigation issues.
- **Transportation and Rural Isolation:** Like many other services, parents without access to reliable transportation are reported to have a harder time making dental appointments. This is an additional barrier in rural areas where there are fewer dental providers and some have limited slots for publicly insured patients.

Availability of dentists:

Overall in Arkansas there are about 2,218 people for every dentist.⁸⁹ In Northwest Arkansas, there are fewer dentists per capita, with a ratio of 3,316 to 1.⁹⁰ This can make things especially difficult for parents trying to find pediatric dentists in the region.

The Arkansas Department of Health recommends that a baby’s first dental checkup happen within the first year of life. However, many parents in Arkansas have trouble accessing dental care for their very young children because of a lack of pediatric dentists. In Northwest Arkansas, only Franklin and Sebastian Counties aren’t in a dental health care professional shortage area.⁹¹



Preventive dental sealants:

More kids in Arkansas are receiving preventive dental procedures called “dental sealants” to protect their teeth from cavities. In 2010, 27 percent of third graders in Arkansas had them, and in 2016 that figure went up to 43.4 percent. That is well above the Healthy People 2020 United States goal of 28.1 percent.⁹² Arkansas benefits from some progressive laws related to preventive dental services. For example, if they have a collaborative practice agreement, hygienists are allowed to go into schools to do cleanings, apply fluoride varnish, place sealants, and even take X-rays for kids who haven’t had a prior dental exam. However, Medicaid still does not reimburse for portable dentistry which has become important to reaching rural parts of Arkansas.⁹³

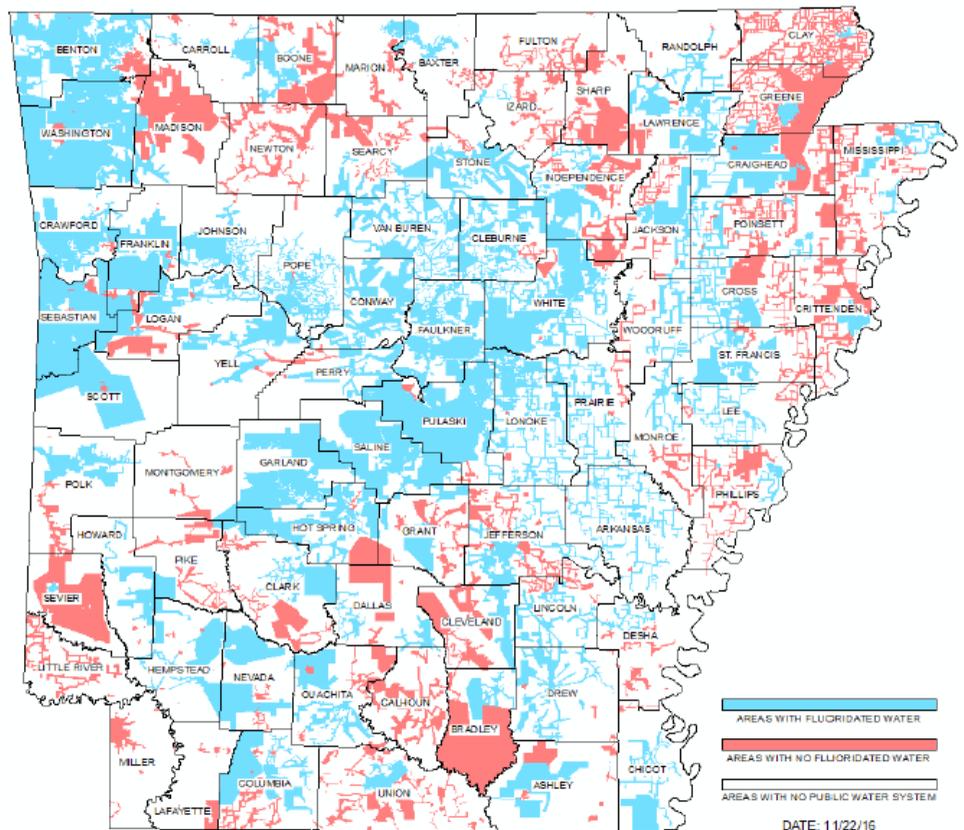
Fluoridated Water Systems in Arkansas, 2016

Fluoridated water:

Not all public water systems in Arkansas have access to fluoridated water, and some families use other sources for water like wells. Kids in Arkansas who drink mostly city or county water show less evidence of dental decay (62.3 percent) compared to those who consume mostly well water 65.7 percent, or mostly bottled water (70.5 percent).⁹⁴ Eighty-six percent of Arkansans have access to fluoridated drinking water, which is up from 64.7 percent in 2010.⁹⁵

Tooth decay:

Arkansas kids had lower rates of tooth decay in 2017 (12.6 percent) compared to 2012 (18.8 percent). Kids in Arkansas are also less likely now to have untreated dental issues or dental decay. In 2010, 29 percent of Arkansas third graders had a cavity or dental decay that was not treated. In 2016 that percentage dropped to 18.7, which is below the Healthy People 2020 target for the United States (25.9 percent).⁹⁶ Arkansas was ranked 36th for the percentage of Medicaid children who received a sealant on a permanent molar in the most recent (2013) state-level analysis by the American Dental Association. In that year, Arkansas was at 12 percent while the US rate was 14 percent.



Disparities:

A 2016 screening of Arkansas third graders found that 64 percent had evidence of dental decay or cavities. This varied by race group, with 73.1 percent of African American third graders in Arkansas showing evidence of dental decay, 69.1 percent of Hispanics, and 59.6 percent of whites.⁹⁷ African American children in Arkansas are less likely to be referred for urgent dental care (0.6 percent) compared to whites (2.3 percent) and Hispanics (3.3 percent) African American children in Arkansas, however, are more likely to be found to have early dental needs (24.4 percent) compared to whites (16.8 percent) and Hispanics (16.2 percent).⁹⁸



Immunizations

Without proper immunizations, children are vulnerable to dangerous childhood diseases, complications, and even premature death. It is critical that Arkansas children and adolescents receive the proper recommended schedule of vaccinations and that their parents receive educational materials about the timing and nature of these vaccinations.

Leading metric: 7 Vaccination Series (19-35 months)
Northwest Arkansas: 58.5%
Arkansas: 66.6%

Immunizations

KEY INFORMANT FEEDBACK

“They [parents] don’t always have reliable information. They may be influenced to pay attention to information that is not science-based. I would love to see more health education, so they don’t deny vaccinations.”

“Community beliefs about immunizations have impacted immunization rates in the region. More parents are opting out. It’s made kids and families more vulnerable to disease.”

Many key informants are troubled by the potential harm from lower rates of childhood vaccinations. Most saw a need for more education for parents who were unsure about immunizing their children. They recognized that parents are faced with an increasing amount of misinformation that makes choosing the best option for their children more difficult.

Language barriers were also seen as a potential problem for informing parents on the importance of vaccinations. A lack of transportation and public transportation options were also considered barriers to families getting scheduled immunizations for their children.

FOCUS GROUP FEEDBACK

*“They only got them [immunizations] to come into school and they didn’t get them after that age.”
-Logan County Parent*

“There are no excuse [philosophical] exemptions now for immunizations, somebody needs to work on that.” -Washington County Provider

“We have a lot of parents who won’t take their kids [to be immunized].” -Washington County provider

The low level of immunization in the Northwest Arkansas area is identified as a problem by both providers and parents, with some stating that no excuse or philosophical exemptions and misinformation spread through social media contribute to the problem.

School-based measures are important in getting children immunized, but participants expressed that this could be improved upon by reaching children before they enter public schools. Providers commented that before they touch the school system, many kids are not checked in on to see if their immunizations are up to date. Participants also report that social media is contributing to misinformation about immunizations and inflating the perceived dangers.

PHONE SURVEY RESULTS

Most parents said that they were not at all hesitant (69 percent) about childhood vaccinations. Some felt “not that hesitant” (13 percent) and others felt “somewhat hesitant” (13 percent). Six percent of parents reported being “very hesitant” about childhood vaccinations.

Parents were split on how important they saw the problem of lack of child vaccinations to be in their community. Forty-six percent said it is a serious or moderate problem, and 46 percent said it is a minor problem or not at all a problem. Eight percent said it is not at all a problem.

CROSS CUTTING FACTORS:

(Themes identified by parents, providers, and key informants as root causes of immunization issues.)

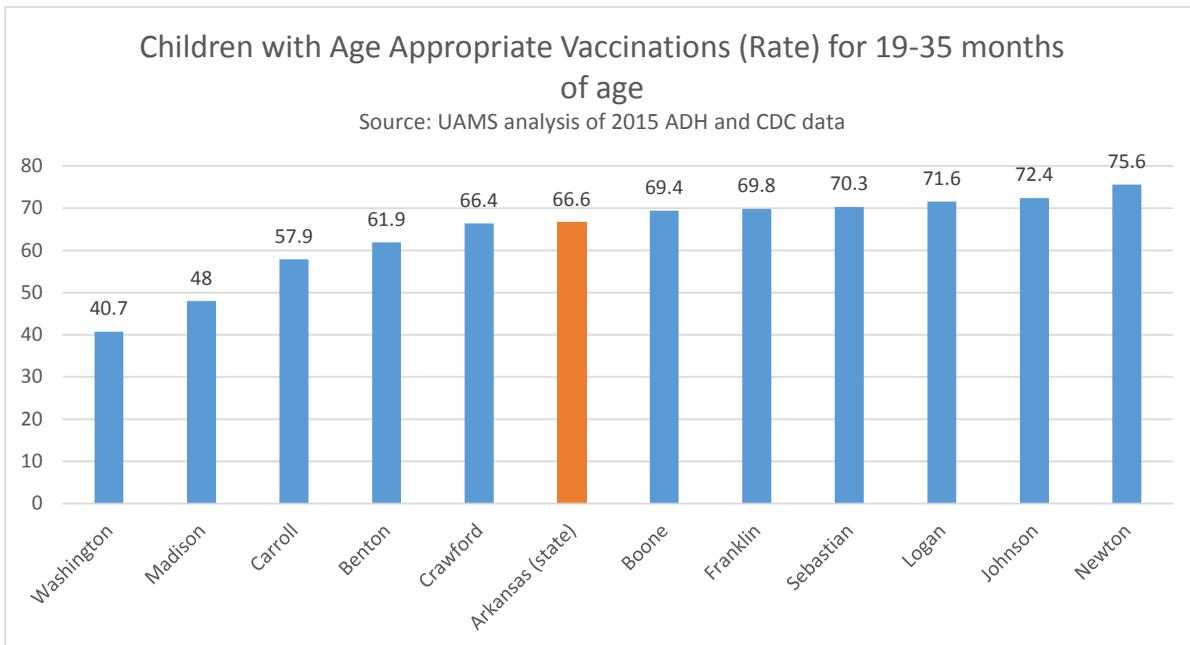
- **Technology:** The internet and social media reportedly play a role in changing perceptions of childhood vaccinations. Participants report that social media plays a big role in spreading misinformation, and that parents are unsure about what to believe.
- **Health Education:** Often at odds with technology are efforts to promote educational resources about child immunizations. Key informants, parents, and providers describe a recent change in the perceptions of the need for childhood vaccinations.

Vaccination rates:

Arkansas lags behind the US for vaccination rates in several areas. In particular Arkansas is below target for the 7-vaccine series for children ages 19-35 months, as measured by the CDC National Immunization Survey (NIS). Arkansas’s children get the full 7-vaccine series just 69.4 percent of the time, which is well below the Healthy People 2020 goal of 80 percent.⁹⁹

2017 Vaccination Rate among Adolescents, ages 13-17 years		
Source: CDC National Immunization Survey		
	US	Arkansas
≥1 Tdap	88.7	92.4
≥1 MenACWY	85.1	91.7
≥1 HPV	65.5	61.1
HPV UTD	48.6	35.2
Tdap = Tetanus, diphtheria, and pertussis vaccine MenACWY = Meningococcal vaccine HPV = Human papillomavirus vaccine UTD = Up-to-date		

In Northwest Arkansas, the rate is even lower, at 58.5 percent.¹⁰⁰ Some counties in Northwest Arkansas have particularly low rates of full 7-series vaccinations for kids 19-35 months. In Washington County it is just 40.7 percent.



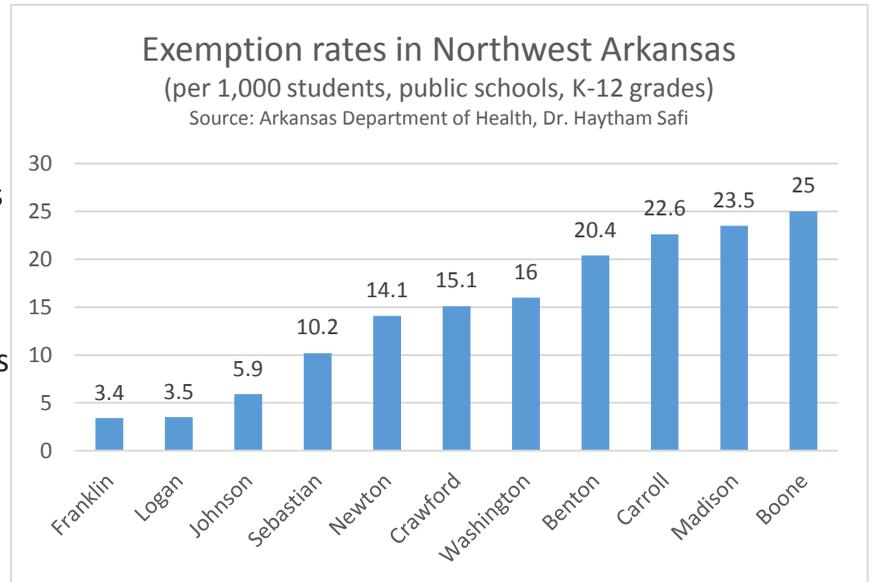
Flu prevention:

Arkansas is below the U.S. average for influenza vaccination coverage overall, and 228 people in Arkansas died during the 2017-18 flu season, including five children.¹⁰¹ Arkansas is not currently meeting any of the Healthy People 2020 goals for flu vaccinations in among children, and is behind the US average for all child and adolescent age groups in this category except for ages 5-12 years.¹⁰²

Vaccine hesitancy:

The World Health Organization (WHO) defines vaccine hesitancy as “a delay in acceptance or refusal of vaccines, despite availability of vaccination services”. Vaccines protect the health of children, but they also work to protect the health of other people in the community, even those without vaccinations. A growing number of Arkansas families are choosing not to vaccinate their children. This hesitancy may be due to:¹⁰³

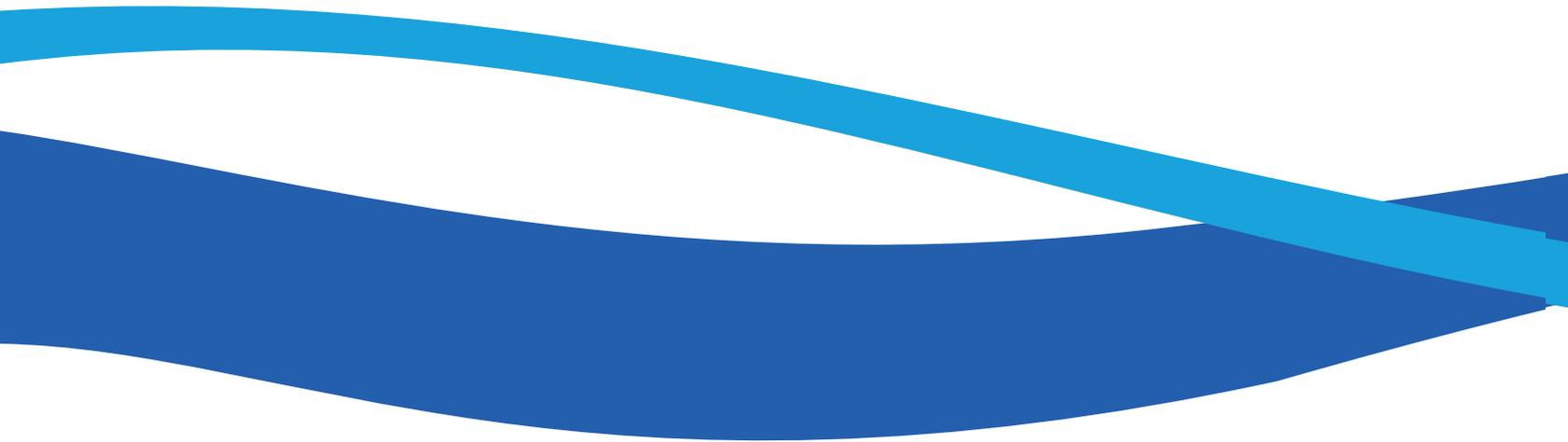
- **Complacency:** Families may feel that the risk of infection is low and therefore the vaccine is not needed.
- **Confidence:** Some families do not trust health care providers or organized medicine. Some are also fearful that vaccinations could be harmful to children.
- **Convenience and Freedom of Choice:** Some barriers like cost and location make vaccinations inconvenient. Some families also have ethical or religious concerns when deciding whether to vaccinate their children.



Act 999 of 2003 authorized the Arkansas Department of health to allow additional individual immunization exemptions.¹⁰⁴ In the 2017-18 school year, 7,595 students received exemptions from vaccination required by the Arkansas Board of Health for school attendance. About 2 percent of these exemptions were for medical reasons. The rest were for either religious (32 percent) or philosophical reasons (67 percent).¹⁰⁵

HPV (Human Papillomavirus) and cancer prevention:

HPV (Human Papillomavirus) is a group of viruses that can lead to cancers of the mouth, throat, vagina, cervix, and anus and other cancers in both men and women.¹⁰⁶ It is most commonly spread through sexual contact, and most people get HPV at some point in their lives. The CDC recommends that all kids get vaccinated for HPV at age 11 or 12 years to develop protection well before they have any exposure to the virus.¹⁰⁷ Cancers associated with HPV infections have been increasing over time, and Arkansas ranks 5th worst in the nation for rates of HPV-associated cancer (Arkansas' rate is 14.18 per 100,000).¹⁰⁸ Boys are much less likely than girls to get HPV vaccinations in Arkansas, even though 38 percent of HPV-associated cancer diagnoses in Arkansas are among males.¹⁰⁹



Reproductive Health

Positive reproductive health includes avoidance of sexually transmitted infections, low likelihood of teen births, and deterrence of sexual assault. These outcomes are driven by providing appropriate health education, giving male and female youth the tools they need to have healthy relationships, and providing access to comprehensive health care services for adolescents.

Leading metric: Teen Births per 1,000
Northwest Arkansas: 30.3
Arkansas: 33.5

Reproductive Health

KEY INFORMANT FEEDBACK

“The statistics for teen pregnancy really have improved for us, it’s just that we started in last place and we are still in last place. I think it’s the internet and the availability of information. In one sense they may be less sexually active, but in another sense they know more about contraception and are using it.”

Reproductive health was not a frequently mentioned priority for Key Informants. However, when reproductive health came up, participants also discussed the need for increased education, and acknowledged that although Arkansas is ranked low in the category, things have been steadily improving. Technology was seen as a driver of information about reproductive health, for good or bad. Kids have more access to information because of the internet, but they may not be accessing reliable or dependable resources to inform them about contraception or STI (Sexually Transmitted Infection) prevention.

FOCUS GROUP FEEDBACK

“Whenever I have to talk to my daughter when she is of age, I just don’t know. I don’t want to but I know she is going to [be sexually active]. People are set on their mindset of ‘you get married and then you have a baby’. But it doesn’t always happen like that. I would like to take a class to know how to talk to my child.” -Washington County Parent

“In school, our brief discussion of sex-ed was just ‘don’t do it’, I don’t know if schools were getting more funding to teach abstinence. And that was detrimental to kids my age.” -Washington County Parent

“You have a lot of conservative families that don’t address sex-ed issues... The conservative families are not as open to it.” -Independence County Parent

Previous efforts to teach abstinence rather than STI (Sexually Transmitted Infection) and pregnancy prevention were seen as ineffective. The topic of reproductive health remains taboo and some parents stated they would like a class to inform them about how to approach the topic with their children. Participants feel families would benefit from parenting education and healthy habits education.

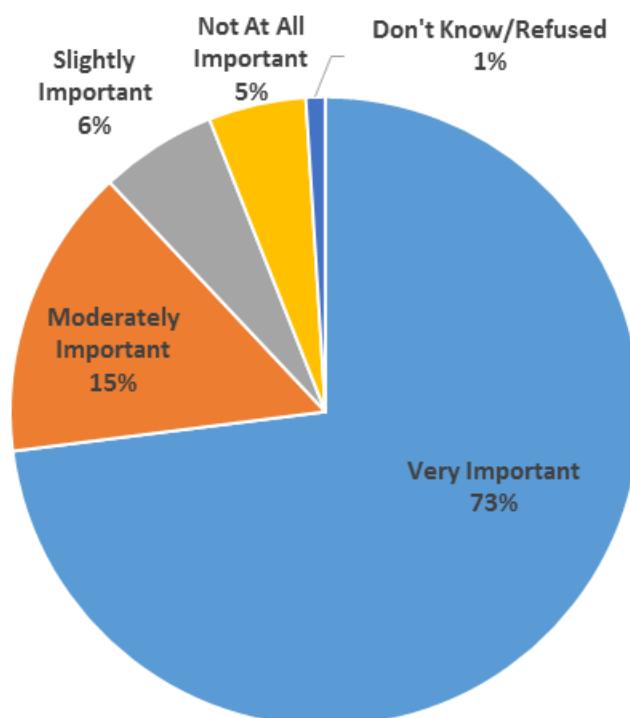
Focus group participants reported a widespread lack of education about reproductive health for teens; in many communities this is still seen as a taboo subject. Participants perceive that there is some sex education in schools but say it is very basic, and does not address the issues kids want to talk about so they turn to peers and the internet for answers. Groups said that birth control is very expensive and hard to access for uninsured teens, and that others lose coverage when they reach age 18.

PHONE SURVEY RESULTS

Most parents (52 percent) said that teen pregnancy was a serious or moderate problem. Only 5 percent said it was not at all a problem. Parents were very supportive of the idea of reproductive health education in the school setting. Parents felt very strongly that it is important for schools to provide factual sex education to teenage students. Eighty-nine percent said that it was either very important or moderately important. Seventy-four percent felt that it was very important, and only 4 percent said that it was not at all important. Parents were similarly supportive of healthy relationship education in schools, with 92 percent saying it is very or moderately important.

Parents also were strongly supportive of schools providing education about birth control to teenage students. Eighty-eight percent said that it was either very or moderately important, and just 5 percent said that it was not at all important. Finally, education on STIs in schools was almost universally considered either very important or moderately important (94 percent) by parents. Only 2 percent said that this was not at all important.

Parent Support of Schools Educating Teenage Students about Birth Control



CROSS CUTTING FACTORS:

(Themes identified by parents, providers, and key informants as root causes of reproductive health issues.)

- **Health Education:** Many discussions on reproductive health-focused around increasing education and conversations between parents and teens. Some saw lingering social taboos and cultural expectations as a barrier to adequate reproductive health education.

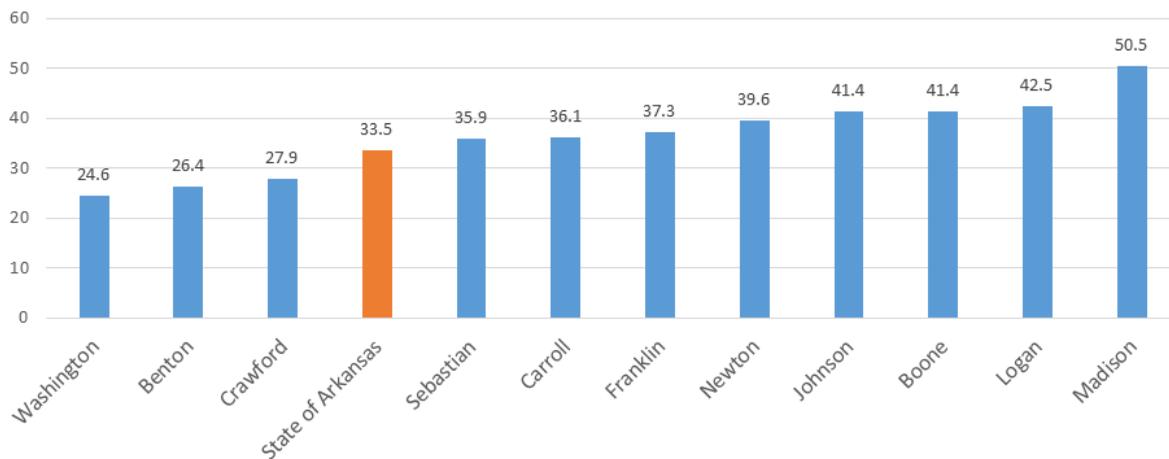
Teen births:

Arkansas has the highest teen birth rate in the nation, though the numbers have been improving (dropping 52 percent from 1991 to 2015).¹¹⁰ Northwest Arkansas teen birth rates have been just below the state average since 2007. In 2016, the state average was 33.5 teen births per 1,000, and Northwest Arkansas was 30.3.¹¹¹ In the Northwest Arkansas region, Madison County has the highest teen birth rate (50.5), while Washington has the lowest (24.6).¹¹²

Young moms are less likely to receive prenatal care in Arkansas. Just 56.7 percent of mothers aged 15-19 had any first trimester prenatal care (compared to 67.8 percent for mothers of all ages).¹¹³ Prenatal care in the first trimester, however, increased overall from 68.4 to 70.1 percent in Arkansas from 2016 to 2017.¹¹⁴ In the Northwest Arkansas region, low birthweight rates range from 9.8 percent (Logan County) to 6.1 percent (Boone County).¹¹⁵

Northwest Arkansas Teen Birth Rates

Source: 2016 Kids Count Data Center



Healthy relationships:

Nineteen percent of high schoolers in Arkansas report being physically forced to have sexual intercourse when they didn't want to.¹¹⁶ Reports of rape increased from 9.7 percent of high schoolers in Arkansas in 2011 to 19.2 percent in 2017.¹¹⁷

Health education:

High schoolers in Arkansas are much less likely than other students across the nation to use any kind of pregnancy prevention method. About one in five sexually active high schoolers in Arkansas didn't use any method to prevent pregnancy the last time they had sexual intercourse; the US average rate is lower at 13.8 percent.¹¹⁸ Arkansas does not require information on contraception, sexual orientation, negative outcomes of teen sex, healthy decision making, family communication, or condoms in school sex education courses.¹¹⁹

Attitudes toward teen pregnancy:

Researchers from UAMS and the Clinton School of Public Service held 12 focus groups across Arkansas in 2018. These focus groups included teens and parents of teens, and centered on discussions of their attitudes towards teen pregnancy prevention.¹²⁰

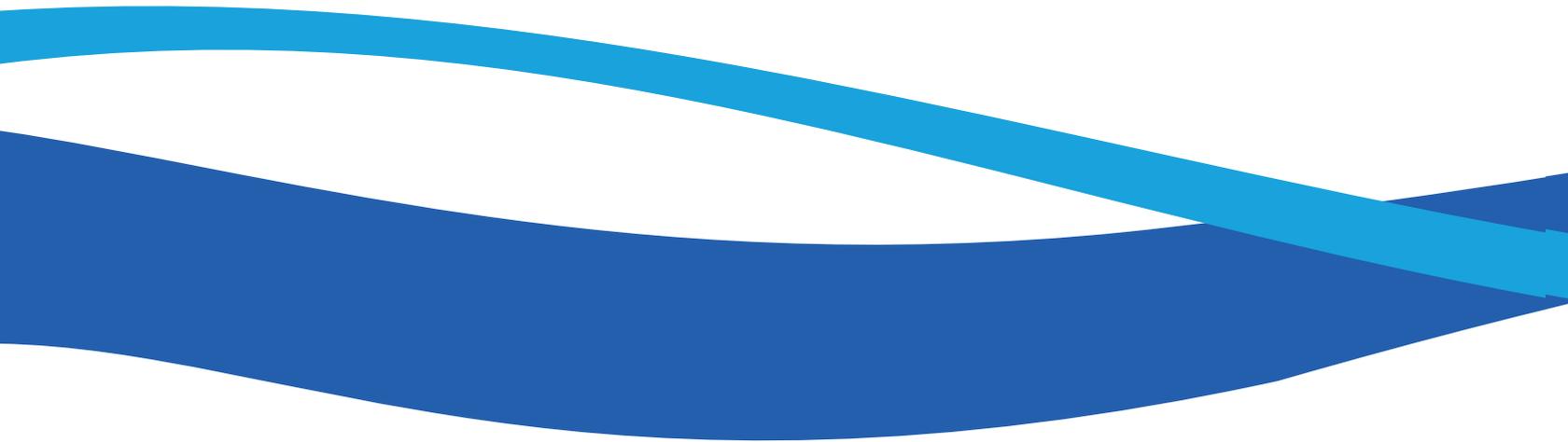
Their research found that parents felt uneasy discussing these topics with their teens, put off the conversations, and hoped or assumed that they received pregnancy prevention information from school or other sources. Parents, like teens, felt skeptical about the safety and effectiveness of some types of contraception including IUDs. Teens in particular reported inadequate understanding of contraception options. They also reported imbalanced access to contraception, for instance citing that boys were given condoms while girls were not.¹²¹

The key needs that arose suggested that teens and their parents both want better communication about pregnancy prevention, and parents in particular needed help feeling empowered to have these conversations. The report finds that parents “need to know how to have this conversation in a way that does not feel like they are condoning sex” and teens “desire a conversation about teen pregnancy prevention and/or contraception that is open and honest with someone they trust.”¹²²

Sexually Transmitted Infections (STIs):

Children in Arkansas are vulnerable to sexually transmitted infections, especially in the older teen years. Chlamydia is one of the more common STIs, and the number of total cases is increasing in most regions of the state. Southwest and Southeast Arkansas were the only regions to see small decreases in total Chlamydia cases.

Northwest Arkansas STI Counts All Ages (2016)		
Source: Source: ADH STI Annual Report		
	Northwest Arkansas Cases 2015	Northwest Arkansas Cases 2016
Chlamydia	3,853	4,032
Gonorrhea	631	880
Early Syphilis	25	31



Child Injury

Child injuries are most often predictable and preventable. Common child injuries include burns, falls, drowning, motor vehicle or recreational vehicle crashes, suffocation, poisoning, suicide, and homicide.

Leading metric: Injury-related Child Deaths
Northwest Arkansas: 18.14*
Arkansas: 25

Child Injury

KEY INFORMANT FEEDBACK

“In injury prevention physical environment is key, we need to make sure kids live in safe and healthy homes with safety equipment and free of chemical and physical hazards. That is clearly a key issue.”

“The rural nature of our state really puts our kids at risk of injury, you are farther [away] from care if you get hurt...There are all kinds of injury hazards that are more risky in rural environments.”

Key informants said that child injury education, though important, was not enough on its own. Parents were also said to need a safe and peaceful living environment as well as mental health services to succeed. Some key informants also expressed frustration with slow progress on child injury prevention laws at the state level.

FOCUS GROUP FEEDBACK

*“The older kids are taking care of themselves.”
-Logan County Parent*

“This is how we discipline our kids, we spank them because according to the Bible, if you love your child this is what you must do.” -Washington County Parent

“When we discipline them, they [other people] are seeing abuse.” - Washington County Parent

Parents report that most of the problems arise from unsafe play areas or limited access to play areas, sidewalks, or parks. Providers say parents are afraid to use social services because DHS will inspect their homes and take children away because of inadequate or unsafe living environments. Participants report that they would like to see more done in child abuse prevention.

CROSS CUTTING FACTORS:

(Themes identified by parents, providers, and key informants as root causes of child injury)

- **Housing and Environmental Quality:** Unsafe houses that are near busy streets were a common safety concern for focus group participants and key informants alike. Neighborhoods were also frequently reported as “unsafe” because of crime.
- **Transportation:** Rural isolation is a factor that makes life riskier in some ways for children and adults, who have farther to travel to a hospital during an emergency.
- **Health Education:** Best practices for child safety like safe sleep environments and car seats are critical elements of community knowledge that need to be sustained.

* Data for Franklin and Newton counties were excluded because of small sample size.

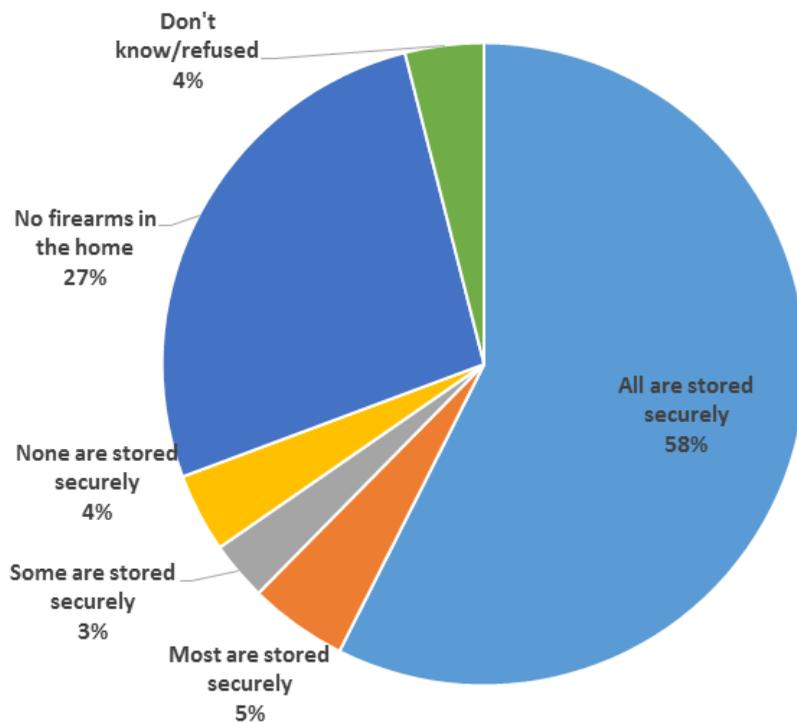
PHONE SURVEY RESULTS

Parents were split on how severe of a problem child injury is in their communities. Forty-eight percent said it was either a serious or moderate problem, while 45 percent also said it was a minor problem or not at all a problem.

When asked about firearms in the home, 27 percent said there were no firearms in the home. Seven percent of parents said that either none or only some of their firearms are stored securely, 58 percent said all are stored securely, and 5 percent said most are stored securely.

Most parents said that their child under the age of one slept in a crib or bassinet (67 percent). Ten percent said that they co-sleep with their infant. The rest reported that their child under one slept in a car seat, swing or bouncy seat (5 percent), a couch, chair or sofa (5 percent), or an adult bed (14 percent).

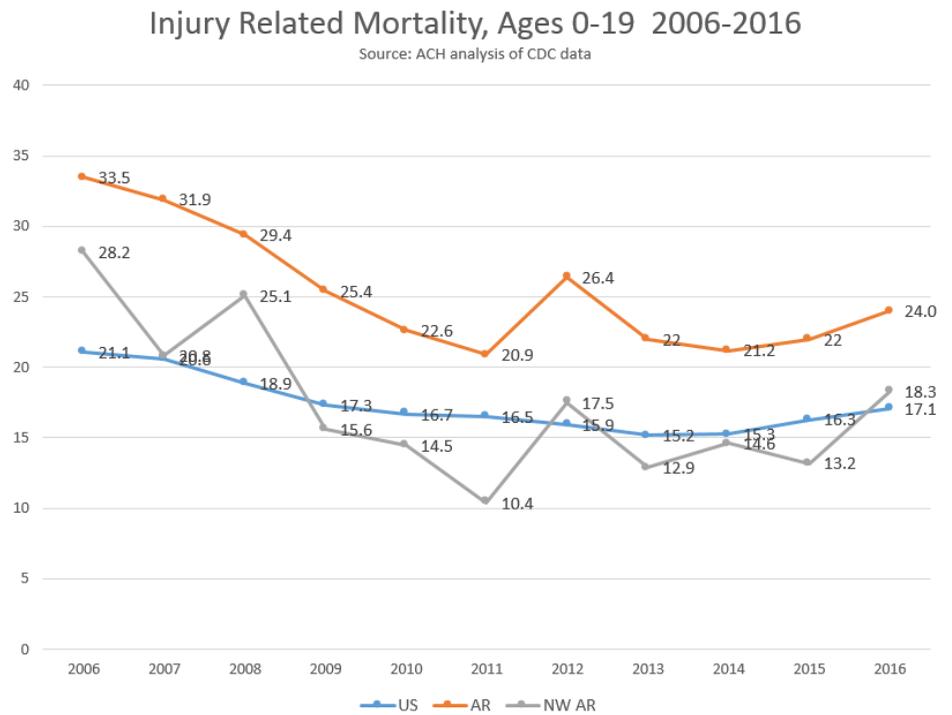
Parent Reports of Firearm Storage in the Home



Secondary Data: Child Injury

Leading causes of child and teen deaths:

Injury-related child deaths are often preventable, and the rate of these types of deaths has been trending down in Northwest Arkansas and the rest of the state. The top three leading causes of death for ages 1-18 in Arkansas are Unintentional Injury, Suicide, and Homicide. For children less than one year of age, SIDS (Sudden Infant Death Syndrome), which is injury related, is the second leading cause of death.¹²³ Unintentional Injury accounts for 39 percent of all child deaths in Arkansas.¹²⁴



Arkansas: Leading Causes of Death		
Source: CDC WISQUARS database, 2015-2017 all races, both sexes		
Rank	<1 year	1-18 years
1	Congenital Anomalies	Unintentional Injury
2	SIDS	Suicide
3	Short Gestation	Homicide
4	Unintentional Injury	Malignant Neoplasms
5	Maternal Pregnancy Comp.	Congenital Anomalies
6	Placenta Cord Membranes	Heart Disease
7	Circulatory System Disease	Cerebrovascular
8	Homicide	Chronic Low. Respiratory Disease
9	Respiratory Distress	Diabetes Mellitus
10	Influenza & Pneumonia	Influenza & Pneumonia

Suicide:

Teen Suicide is less common in Northwest Arkansas (12.6 per 100,000) than in the rest of the state (14.9 per 100,000).¹²⁸ The Arkansas Infant and Child Death review program conducts in-depth reviews on unexpected deaths for children under 17 in order to aid in the development of interventions to prevent future injury-related deaths. The 2018 Arkansas Infant and Child Death Review found that Firearms accounted for 71 percent of suicide deaths statewide (among children under 18).¹²⁹ The AICDR also found that the majority of suicide deaths among children in Arkansas (71 percent) occurred in children ages 15-17 during that year.¹³⁰

Firearms:

While motor vehicle-related teen deaths have been trending down in Arkansas, firearm-related deaths (for ages 0-18) have been increasing steadily. Firearm-related child deaths have been rising much faster in Arkansas than in the nation as a whole. In 2007, US and Arkansas child firearm-related deaths per 100,000 for ages 0-18 were 2.87 and 3.64 respectively.¹³¹ By 2017, the US rate had increased slightly to 3.32 and the Arkansas rate had more than doubled, increasing to 5.64.¹³²

Preventive measures:

Arkansas has a Graduated Driver License law as of 2009 which requires extra supervision, cell phone restrictions, passenger limitations, and curfews for young drivers. Motor vehicle deaths for ages birth to 19 in Arkansas have dropped from 7.87 in 2012 to 6.18 in 2017, although Arkansas is still above the national average of 5.64.¹²⁵

The Arkansas Department of Health promotes safe sleep practices which can reduce infant fatalities. Babies should be placed “alone, on their backs, and in a crib”.¹²⁶ They also recommend securing pools with four foot fences and with self-latching gates to prevent drowning as well as installing smoke alarms in furnace and sleep areas.¹²⁷

This needs assessment is an important step toward building on Northwest Arkansas's previous achievements in child health. Staff offer thanks to the key informants, providers, and parents (and their children) who took time out of their schedules to help the team gain a greater understanding of child health needs. The following section describes the current assets supporting child health, as well as a summary of the most commonly suggested options for improving child health during community discussions.

A. COMMUNITY RESOURCES TO SUPPORT CHILD HEALTH

The needs assessment outlines a broad range of child health issues that need help. Thankfully, a similarly extensive variety of resources exist to improve child health in Arkansas, and ACNW will convene a group of community partners to develop collaborative plans to improve child health. Schools, parents, caregivers, and a variety of organizations are engaged in defining the issues through this CHNA and addressing child health through their daily work.

- Arkansas Children's Hospital and Arkansas Children's Northwest
- Arkansas Department of Health
- Arkansas Department of Education
- Arkansas Department of Human Services
- Arkansas Minority Health Commission
- The Arkansas Coalition for Obesity Prevention
- The Arkansas Food Bank and the Northwest Arkansas Food Bank
- The University of Arkansas for Medical Sciences
- The University of Arkansas's College of Public Health
- The Clinton School of Public Service
- Advocacy organizations including Arkansas Advocates for Children and Families, the Hunger Relief Alliance, the Northwest Arkansas Workers Justice Center, and the Hispanic Women's Organization of Arkansas
- Health policy organizations including the Arkansas Center for Health Improvement and the Arkansas Support Network
- Health care providers including pediatricians, family practice physicians, and nurses
- Health researchers
- The Arkansas Oral Health Coalition
- The Arkansas Immunization Action Coalition
- The Arkansas Foundation for Medical Care (AFMC)
- The network of Arkansas School-Based Health Centers and the School-Based Health Alliance of Arkansas
- Nonprofit organizations providing direct services
- Membership organizations including the American Academy of Pediatrics, the Arkansas Hospital Association, pharmacy representatives, and dentist representatives
- Community Health Centers of Arkansas
- Behavioral health agencies
- Dental insurance companies and providers
- Private health insurance companies
- Faith community representatives
- Low-income legal services
- Private foundations and the Arkansas Community Foundation
- The Arkansas Campaign for Grade-Level Reading
- Private industries ranging from pharmaceutical companies to chambers of commerce
- Parents

B. CHILD HEALTH ASSETS FROM FOCUS GROUPS AND KEY INFORMANTS

During focus group and key informant conversations, participants discussed what they saw as the most important assets that are currently supporting child health in their communities. These are important considerations for planning how to build on past progress.

Child health assets mentioned at Focus Groups: Participants in the focus groups mentioned the newly constructed Arkansas Children’s Hospital in the Northwest as a major benefit to their community health. The new hospital was seen as important to increasing the availability of services and specialists. Other efforts to bring health services to the communities, like mobile health units, were viewed very positively.

Participants also mentioned that nutrition initiatives like Cooking Matters have been great assets to educate not only children, but also parents in healthy eating habits. Parenting education, home health visits, and family health and safety education for children five and younger were mentioned as valuable services by focus group providers.

Similar to the key informant responses, focus group participants said that positive collaboration among community partners has a tangible impact on child health. Other community health assets include churches and faith-based organizations, that are stepping in to fill service gaps. Some faith groups provide mentoring, tutoring, and after-school programs to help working families. Churches and food banks are also providing assistance to Arkansans suffering from food insecurity.

The newly approved minimum wage increase was mentioned by many focus group participants as a way to alleviate many of the socioeconomic factors that prevent children from achieving optimal health and participants reported feeling optimistic about the possible effects of increased wages.

Child health assets mentioned in Key Informant interviews: During interviews, key informants were asked to identify assets related to children’s health in their communities. Communication and collaboration among the many community partners were seen as a major asset in the area, with participants noting that although child poverty is high in the region, there are many existing resources to help alleviate the needs. These resources include nonprofit organizations, state entities like the Department of Education and the Health Department, and projects from private organizations all working in collaboration to meet the community health needs. School-based health initiatives in particular were consistently mentioned by participants. Key informants brought up a range of important school programs, from school-based health centers, to backpack programs, free and reduced-price lunch, oral health services, and joint use agreements.

The expansion of ARKids First Services to non-citizen children and to the Marshallese population were seen as major assets, especially for access to immunizations and dental care. Arkansas Children’s Hospital Northwest was also seen as a principal asset because it increases access to providers and specialty care and reduces travel burdens on parents. The Northwest Arkansas Food Bank also was identified as a key player in alleviating child hunger and developing nutritional policies for families to access healthy foods.

C. BIG IDEAS FOR CHILDREN'S HEALTH FROM FOCUS GROUPS

Focus group participants were asked to imagine funding a major child health improvement project. Below are brief summary descriptions of the ideas grouped by topic.

Recreational opportunities: The most common suggestion involved some type of recreational activity for children. These suggestions included outdoor activities like parks, community gardens, bike paths, fishing or hunting clubs, playgrounds, and pools. Participants also suggested indoor options like library activities, community centers, and after school activities. Participants were adamant about the need to keep kids, especially teenagers, busy. They also emphasized the need for these options to be affordable for all families. Many suggestions involved making free versions of currently available activities.

These suggestions were tied to several health outcomes. Participants thought these options would help to reduce obesity by increasing physical activity. They also envisioned recreational opportunities decreasing substance abuse and mental health issues by keeping kids “out of trouble”.

Health education: Increasing awareness and understanding of health issues was a very common suggestion from participants. Much of the time, they suggested training or classes for parents as well as kids. Suggested topics for parents included nutrition, cooking, parenting, and safety issues like co-sleeping. For youth, suggested education topics were more centered on reproductive health issues and drug and tobacco prevention.

Academic education: Like health education, academic education was a very common suggestion for improving child health. These suggestions were aimed at programming from an early age, with some participants proposing comprehensive early childhood education and free or reduced price childcare.

Mental health in schools: Participants focused on increasing the availability of counseling services, by offering them in the schools, providing them through telemedicine, increasing multilingual counselors, and generally increasing the number of mental health providers and facilities for youth.

Cultural awareness: Some groups expressed the need for broad community-based cultural awareness training, including for teachers. They saw this type of awareness training as important to protecting child mental health, especially for minority students. Participants also saw room for improved cultural awareness in hospital settings. They suggested that hospitals should have more interpreters as well as more documents translated into Marshallese. People said they are willing to go out of their way to get to “a facility that is culturally friendly”.

Access to food: Some direct options for nutrition assistance were suggested (like soup kitchens) while other participants suggested broader systemic solutions like better stores in the neighborhoods. Food for kids in schools was mentioned as a good option to help kids academically.

Access to healthcare: The most common problem for accessing healthcare was cost. Many participants suggested cost reduction initiatives like free clinics, reduced cost prescriptions, and affordable or free insurance. Another very common suggestion in this category was increased school-based health options. Participants wanted to see more medical professionals in schools, covering care from mental to dental and vision. Similarly, participants often discussed the success and convenience of mobile health units. They wanted to see more options for mobile health care.

Improving hospital logistics was also a common suggestion. Participants wanted to be able to have walk-ins instead of having to go to the Emergency Room. They also suggested evening hours for doctors to accommodate parent work schedules. Parents also suggested making it easier to transition from doctor to doctor, and the Connect Care system was seen as challenging.

Substance and Tobacco use prevention and treatment: Participants suggested rehabilitation facilities for people who have drug or alcohol abuse problems. This type of facility was suggested for both juveniles and adults. Furthermore, some participants thought more needed to be done to stop teenagers from using e-cigarettes or vaping.

Transportation accommodations: Participants saw transportation as a large barrier to both employment and income and access to healthcare. To address this, many suggested increased public transportation options and housing units for families visiting the hospital. Parents also thought that hospitals should be more understanding of parents' work schedules and the time they spend driving to the hospital. Some said that parents who have to take off work to get to an appointment, and are then told to come back in a few weeks will be discouraged and not return for care. Generally, better public transportation options were seen as a way to improve access to healthcare for kids.

D. COMMUNITY LEADER INPUT

In March of 2019, hospital staff presented data and qualitative data results to select community stakeholders in Northwest Arkansas. These community members included representatives from local organizations like nonprofits that serve youth, hospitals, and School-Based Health Centers. Hospital staff discussed results and incorporated their feedback and comments into the final product. During these discussions hospital staff also solicited "Bold Ideas" from the community members. These "Bold Ideas" (listed below) are a starting point for the ACNW Implementation Strategy.

- Increase School Based Care: Provide mental health services in schools at free or reduced cost and allow for school-based and community healthcare access.
- Reduce Language Barriers: Establish a Marshallese Interpreter Certificate Program, educate health professionals about language access, offer a bilingual phone line for appointments and financial counseling, increase translation of marketing materials, and provide bilingual health education. "There are a lot of issues that can be prevented if we communicate effectively."- Community Member.
- Improve Transportation: Improve public transportation resources and provide specific transportation for parents to take children to medical appointments and from Northwest Arkansas to Little Rock.
- Increase Health Education: Provide reproductive health education for students K-12 as well as parenting classes.
- Expand Parenting Services: Provide home visiting for ages 0-5 for at-risk families.
- Assess and Address Child Food Insecurity: Identify specific children with food insecurity and organize food banks at community centers.
- Assess and Address Adverse Childhood Experiences (ACEs): Create an ACE screener for pediatricians.
- Increase Vaccination Access: Include vaccination access in mobile primary care outreach.
- Advocate for Child Health Needs: Promote advocacy for attachment based mental health services and oral health for children 0-5.

APPENDICES:

Appendices are available online.

Appendix A: Secondary Data

- A1: Demographics
- A2: Access to Care
- A3: Obesity
- A4: Mental Health and Substance
- A5: Reproductive Health
- A6: Social Issues
- A7: Parent Supports
- A8: Food Insecurity
- A9: Child Injury
- A10: Immunization
- A11: Oral Health

Appendix B: Phone Survey

- B1: Survey Questions
- B2: Survey Demographics
- B3: Question Outcomes

Appendix C: Key Informant Interviews

Appendix C1: Key Informant Interview questions

Appendix D: Focus Groups

- D1: Focus Group Questions
- D2: Focus Group locations and participant counts
- D3: Focus Group Demographic Data
- D4: Focus Group Profiles by Region

Endnotes

- 1 ACS table B09001 2013-2017 5-Year Estimates
- 2 Kids Count Data Center analysis of 2016
- 3 Strauss, A. & Corbin, J. (1990). Basics of Qualitative Research: Grounded Theory Procedures and Techniques. Newbury Park, CA: Sage Publications.
- 4 Centers for Medicaid and Medicare services. CMS-416 report. Fiscal Year 2017
- 5 AACF and GLR 2017 "The Importance of Childhood Screenings"
- 6 Children's Health Watch policy action report: "Balancing Act - Countering High Health Care Costs to Promote Healthy Arkansas Families and Children" September 2018
- 7 Kids Count Data Center analysis of 2017 American Community Survey
- 8 Danna Schaffer, ADH School Based Health Center Advisor
- 9 Danna Schaffer, ADH School Based Health Center Advisor
- 10 Danna Schaffer, ADH School Based Health Center Advisor
- 11 Arkansas Prevention Needs Assessment 2017
- 12 Population weighted average of ASPIRE Arkansas data 2016
- 13 ASPIRE Arkansas data 2016
- 14 Ruralhealthinfo.org 2017
- 15 ADH 2017 Annual statistical report (pg 27)
- 16 CDC Vital Signs: "Tobacco Use By Youth Is Rising" February 2019
- 17 Arkansas Prevention Needs Assessment 2017
- 18 Arkansas Prevention Needs Assessment 2017
- 19 2017 Rural Health Info
- 20 2017 Rural Health Info
- 21 2017 Rural Health Info
- 22 2017 Youth Risk Behavior Survey - Arkansas High School Survey
- 23 2017 Youth Risk Behavior Survey - Arkansas High School Survey
- 24 2017 Youth Risk Behavior Survey - Arkansas High School Survey
- 25 2016-2017 National Survey of Children's Health; ChildHealthData.org
- 26 The Arkansas Coalition Against Domestic Violence
- 27 Data from Ashley Walker, Arkansas Coalition Against Domestic Violence
- 28 CDC Behavioral Risk Factor Surveillance System ACE Data page
- 29 AACF PASSE report, December 2018
- 30 AACF PASSE report, December 2018
- 31 AECF 2018 Kids Count Profile for Arkansas
- 32 AECF 2018 Kids Count Profile for Arkansas
- 33 AACF "Breaking Down Barriers" 2018
- 34 Population weighted average Census ACS 5 year, 2012-2016 B17002
- 35 Census ACS 5 year, 2012-2016 B17002
- 36 Arkansas Advocates for Children and Families "Child Poverty In Northwest Arkansas" September 2018
- 37 Prosperity Now - Arkansas scorecard
- 38 Prosperity Now Scorecard for Arkansas, 2014 data
- 39 Arkansas for Fair Landlord Tenant Laws. <http://fairpropertylaws.org/basics/>.
- 40 RWJF Comprehensive Housing Affordability Strategy (CHAS) data 2010-2014
- 41 RWJF County Health Rankings - Violent Crime 2012-2014
- 42 RWJF County Health Rankings - Violent Crime 2012-2014
- 43 RWJF County Health Rankings - Air Pollution Particulate Matter 2012
- 44 RWJF County Health Rankings - Air Pollution Particulate Matter 2012
- 45 University of Arkansas Division of Agriculture, "Rural Profile of Arkansas 2019"
- 46 University of Arkansas Division of Agriculture, "Rural Profile of Arkansas 2019"
- 47 University of Arkansas Division of Agriculture, "Rural Profile of Arkansas 2019"

48 University of Arkansas Division of Agriculture, “Rural Profile of Arkansas 2019”
49 Census table DP03 (2012-2016) American Community Survey 5-Year Estimates
50 Census table DP03 (2012-2016) American Community Survey 5-Year Estimates
51 AECF 2018 Kids Count Profile for Arkansas
52 Census table DP03 (2012-2016) American Community Survey 5-Year Estimates
53 AACF Health And Wealth 2018 Analysis of ACS PUMS 2016 data
54 Census 2012-2016 ACS table S1601, S1602, S1603 and S1604
55 Census 2012-2016 ACS table S1601, S1602, S1603 and S1604
56 Census 2012-2016 ACS table S1601, S1602, S1603 and S1604
57 Census 2012-2016 ACS table S1601, S1602, S1603 and S1604
58 Kids Count Data Center 2016
59 WFA Demographic Report 2018
60 WFA Demographic Report 2018
61 Population weighted average of ASPIRE Arkansas analysis of ASH and CDC 2015 data
62 ASPIRE Arkansas analysis of ASH and CDC 2015 data
63 Note: Kids Count and Aspire Arkansas infant mortality data vary slightly, Kids Count Uses Centers for Disease Control and Prevention and National Center for Health Statistics data while ASPIRE uses Arkansas Department of Health and Centers for Disease Control and Prevention data.
64 AACF and GLR 2018 “What do our Littlest Learners need to be School Ready?”
65 “Arkansas Parenting Support”, Children and Family Evaluation Services, Jan 2019.
66 ADH 2017 Annual Statistical Report
67 Stateofobesity.org
68 ACHI 2017-2018 Assessment of Childhood and Adolescent Obesity in Arkansas
69 Source: Weighted average by population of ACHI 2017-18 Assessment of Childhood and Adolescent Obesity in Arkansas
70 Source: ACHI 2017-18 Assessment of Childhood and Adolescent Obesity in Arkansas
71 Stateofobesity.org
72 Stateofobesity.org
73 RWJF Analysis of 2010 and 2016 data from: Business Analyst, Delorme map data, ESRI, & US Census Tigerline Files
74 RWJF Analysis of 2010 and 2016 data from: Business Analyst, Delorme map data, ESRI, & US Census Tigerline Files
75 Map the Meal Gap, Feedingamerica.org 2016
76 Source: Map the Meal Gap, Feedingamerica.org
77 Source: Map the Meal Gap, Feedingamerica.org
78 Map the Meal Gap, Feedingamerica.org 2016, NWA figure from population weighted average
79 Map the Meal Gap, Feedingamerica.org 2016
80 DHS Annual Statistical Report SFY2017
81 DHS Annual Statistical Report SFY2017
82 DHS Annual Statistical Report SFY2017
83 RWJF analysis of USDA Food Environment Atlas 2015
84 RWJF analysis of USDA Food Environment Atlas 2016
85 RWJF analysis of USDA Food Environment Atlas 2016
86 RWJF/ National Center for Education Statistics 2015-16
87 RWJF/ National Center for Education Statistics 2015-16
88 FRAC School Breakfast Scorecard 2017
89 RWJF County Health Ranking analysis of 2016 Area Health Resource File/National Provider Identification file
90 Population weighted average of RWJF County Health Ranking analysis of 2016 Area Health Resource File/National Provider Identification file
91 2016 www.ruralhealthinfo.org
92 AR Smiles: Arkansas Oral Health Screening 2016
93 Children’s Dental Health Project, “State Dental Screening Laws for Children: Examining the Impact” Jan, 2019

94 AR Smiles: Arkansas Oral Health Screening 2016
95 AR Smiles: Arkansas Oral Health Screening 2016
96 AR Smiles: Arkansas Oral Health Screening 2016
97 AR Smiles: Arkansas Oral Health Screening 2016
98 AR Smiles: Arkansas Oral Health Screening 2016
99 CDC Child Vax View
100 Source: UAMS and CDC data
101 "2017-18 Influenza Season Vaccination Coverage Dashboard." CDC. 2018. 23 Apr. 2019 <<https://www.cdc.gov/flu/fluview/reportshtml/reporti1718/reportii/index.html>>;
102 <https://www.healthy.arkansas.gov/programs-services/topics/influenza> and Dr. Dillaha presentation to Flu Prevention Workgroup 3/9/18 https://docs.wixstatic.com/ugd/14a95a_6e997bd6db5f420291c30a6de83fedec.pdf
103 World Health Organization. Report of the SAGE Working Group on Vaccine Hesitancy (2014) https://www.who.int/immunization/sage/meetings/2014/october/1_Report_WORKING_GROUP_vaccine_hesitancy_final.pdf (accessed May 6th 2019)
104 https://www.healthy.arkansas.gov/images/uploads/pdf/2018-2019_Childcare-School_Immunization_Exemption_Application_Packet.pdf
105 Arkansas Department of Health, Immunization section
106 CDC <https://www.cdc.gov/hpv/parents/whatishpv.html>
107 CDC <https://www.cdc.gov/hpv/parents/vaccine.html>
108 ADH Kristyn Vang, MPH: presentation to HPV Prevention Workgroup 1/17/19; Arkansas Central Cancer Registry. Trends in human papillomavirus (HPV)- associated cancers, Arkansas, 2001-2015. https://www.healthy.arkansas.gov/images/uploads/publications/HPV_Cancers_SAC_Presentation.pdf Revised April 12, 2019.
109 ADH Kristyn Vang, MPH: presentation to HPV Prevention Workgroup 1/17/19; Arkansas Central Cancer Registry. Trends in human papillomavirus (HPV)- associated cancers, Arkansas, 2001-2015. https://www.healthy.arkansas.gov/images/uploads/publications/HPV_Cancers_SAC_Presentation.pdf Revised April 12, 2019.
110 ACOG Unplanned Pregnancy Workgroups Summary 2018 (1000 Feathers)
111 Source: ADH analysis of 2007-2016 Health Statistics Branch Query System
112 2016 Kids Count Data Center
113 Arkansas Department of Health analysis of Health Statistics Branch Query System
114 NVSS Vital Statistics Rapid Release May 2018
115 RWJF / National Center for Health Statistics - Natality files 2010-2016
116 2017 Youth Risk Behavior Survey- Arkansas High School Survey
117 2017 Arkansas High School Survey Trend Analysis Report
118 Arkansas Department of Health analysis of Health Statistics Branch Query System
119 Guttmacher Institute
120 Marshal, Driver, Allison, "Attitudes Towards Teen Pregnancy Prevention Strategies", UAMS and the Clinton School of Public Service, December 2018
121 Marshal, Driver, Allison, "Attitudes Towards Teen Pregnancy Prevention Strategies", UAMS and the Clinton School of Public Service, December 2018
122 Marshal, Driver, Allison, "Attitudes Towards Teen Pregnancy Prevention Strategies", UAMS and the Clinton School of Public Service, December 2018
123 Source: CDC WISQARS database, 2015-2017 all races, both sexes
124 Source: CDC WISQARS database, 2015-2017 all races, both sexes
125 Source: CDC WISQARS database
126 Arkansas Infant and Child Death Review Report, 2017
127 Arkansas Infant and Child Death Review Report, 2017
128 University of Arkansas for Medical Sciences Public Health in Arkansas Communities Search. (2018). Teen Suicide Rate 2008-2013
129 Arkansas Infant and Child Death Review Report, 2017
130 Arkansas Infant and Child Death Review Report, 2017
131 Source: CDC WISQARS database
132 Source: CDC WISQARS database



Arkansas
Children's

HOSPITALS • RESEARCH • FOUNDATION