2022

Community Health Needs Assessment

Report for Arkansas Children's Northwest

Arkansas Children's Northwest

LETTER TO THE COMMUNITY

Let's take a minute to think about three children in Northwest Arkansas on a typical school day.

The school bell rings to start the day, and the first child feels an ever-familiar pang in his stomach—he's hungry and unsure if he will have dinner tonight. Another child turns 4 today and is due for her immunizations, but her mom can't afford to take off work to get her to the doctor. And the last—he moves from classroom to classroom with an overwhelming feeling of sadness but doesn't know who to turn to for help.

Unfortunately, this is the reality for far more than three children in Northwest Arkansas.

The Arkansas Children's Northwest Community Health Needs Assessment (CHNA) is conducted every three years. Through data collection, analysis and deep listening with community leaders, parents, teachers, and healthcare and public health providers, we gain a better understanding of the health needs facing children in the community we serve.

The 2022 CHNA identified three primary priorities, all of which were exacerbated by the COVID-19 pandemic:

Behavioral & Mental Health
Immunizations
Food Insecurity

In addition to these primary priorities, CHNA participants shared recurring concerns about poverty and finances as a barrier to accessing care, which have been identified as intersecting needs in the community.

The enclosed report documents the CHNA process, findings and primary priorities. It provides helpful insights into some of the most prevalent health issues facing Arkansas families. Arkansas Children's Northwest uses these findings to inform programs and outreach efforts across the state, and I encourage you to do so as well.

Together, we can make Arkansas a safer and healthier place to be a child.

Marcy

Marcy Doderer, FACHE
President and CEO
Arkansas Children's

> *We champion children by making them better today and healthier tomorrow.*
>
> *Arkansas Children's Mission*

EXECUTIVE SUMMARY

For Arkansas Children's to achieve its mission, it is critical to have a deep understanding of the ongoing health needs of children in the communities served. The process of primary and secondary data collection, analysis, and prioritization, allowed us to engage in robust community listening to inform the 2022 Community Health Needs Assessment (CHNA) for Arkansas Children's Northwest (ACNW). ACNW defines its community as all children under age 18 in a 15-county area of Northwest Arkansas, which includes 251,028 children from birth to 18 years of age. These 15 counties are: Baxter, Benton, Boone, Carroll, Crawford, Franklin, Johnson, Logan, Madison, Marion, Newton, Pope, Scott, Sebastian, and Washington.

From June 2021 through April 2022, Arkansas Children's Community Engagement staff worked with Boyette Strategic Advisors on a multi-faceted approach to engage stakeholders and communities, in addition to reviewing secondary data sources for both the Arkansas Children's Northwest and Arkansas Children's Hospital Community Health Needs Assessments. This team also consulted members of the Natural Wonders Partnership Council, and other child health subject matters experts, as reviewers.

The four major assessment components included:

- Twenty-two focus groups with parents/caregivers of children, educators, community leaders, and medical providers.
- Forty-one key informant interviews with child health thought leaders and subject matter experts.
- A digital survey of 201 parents in Northwest Arkansas, statistically significant for the 15-county area.
- A comprehensive review of child-specific data from local, state, and national sources.

The identified child health needs were prioritized using a scoring process developed for this assessment. Each health need identified through research and stakeholder input was analyzed based on quantitative factors of scope, severity, community priorities, and health disparities. In addition, qualitative factors included: how health issues connected to the Arkansas Children's Strategic Plan, ACNW's ability to impact the need, and the ability to measure success. This report provides a detailed examination of the methodology used to complete this assessment, as well as both primary and secondary data that were reviewed to identify current children's health needs in Northwest Arkansas.

Prioritized Health Needs for the 2022 ACNW Community Health Needs Assessment

Primary Priorities:	Secondary Priorities:	Sustaining Activities:
Behavioral & Mental Health	Infant Health	Obesity
Immunizations	Child Abuse & Neglect	Injury Prevention
Food Insecurity	Access to Care	
Intersecting Need: Poverty & Finances		

This report summarizes and frames each of the identified health needs, in each of the categories, starting with the Primary Priorities. This CHNA will be used to inform ACNW's plans to improve children's health, including the 2023–2025 Implementation Strategy. This will guide efforts and commitment of resources over the next three years to make measurable improvements in the health of children in Northwest Arkansas. This assessment also fulfills the triennial IRS requirement of non-profit hospitals.

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Arkansas Children's Northwest: Needs Assessment

ASSESSMENT

This report is the 2022 Community Health Needs Assessment for Arkansas Children's Northwest (ACNW). It includes prioritized health needs and findings relevant to all children from ages birth to 18 years old, living in a 15-county area of Northwest Arkansas, which is the community ACNW serves.

Arkansas Children's Community Engagement, Advocacy, and Health Division, with Boyette Strategic Advisors, conducted the 2022 Northwest Arkansas assessment. A wide variety of public health and child health stakeholders reviewed and vetted the methods, data, prioritization process, and findings of the assessment.

PURPOSE & SCOPE

The 2022 ACNW Community Health Needs Assessment is the second report created for the hospital. The 2019 report was the first ACNW Community Health Needs Assessment completed.

In addition to satisfying the federal tax-exemption requirements as laid out in the Affordable Care Act (ACA), the purpose is to provide a snapshot of child health in the state. The goals of this Community Health Needs Assessment (CHNA) are to:

1) Identify and prioritize the top health needs for children in Northwest Arkansas (the community served by ACNW).
2) Inform the Arkansas Children's strategic initiatives that improve child health by using a social-determinants-of-health framework.
3) Inform the efforts of organizations and agencies that serve children in Northwest Arkansas.

COMMENTS

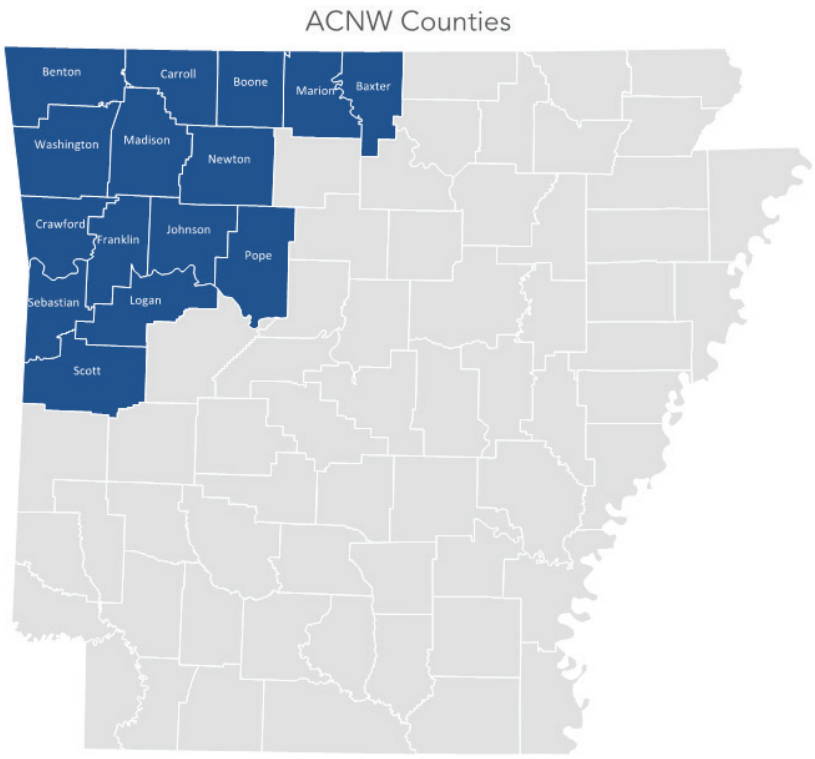
- Comments on the 2022 Community Health Needs Assessment may be emailed to CHNA@archildrens.org.

- The 2019 ACNW Community Health Needs Assessment was available as a printed document and widely available to the public on the Arkansas Children's website (https://www.archildrens.org/resources/community-needs-assessment). There were no written comments received for the 2019 needs assessment.

> *Food insecurity, access to care, transportation, poverty, parental education—all those contribute to the health of a child. Arkansas Children's can't be the solution for all of them, but they can take a lead in some areas and be supportive in others. Collaboration with other organizations will be important.*
>
> *Healthcare Community Leader*
> *Key Informant*

COMMUNITY DEFINITION

Arkansas Children's Northwest serves the region's pediatric population—all children from birth to age 18 in 15 northwest counties in the state. This private, nonprofit hospital has worked to not only meet the health needs of all Northwest Arkansas children, but to also support efforts to improve the overall health and well-being of our youngest residents.



Arkansas Children's Northwest is part of the state's only pediatric health system and treats children from across the state and surrounding areas. The total population of Arkansas children from birth to age 18 in the 15-county region is 251,028, which is an increase from the 2017 population of 205,767. The region's total population has increased from 900,282 in 2010 to 1,034,764 in 2021.

Northwest Arkansas's median household income of $52,206 is higher than the state median of $49,048 but below the US median of $64,730, while per capita income in the region is $28,620. The region reports 13% of its population ages 25+ does not have a high school diploma, while 26% of residents have earned a bachelor's degree or higher.

INCOME

$52,206
Median Household Income

$28,620
Per Capita Income

$102,893
Median Net Worth

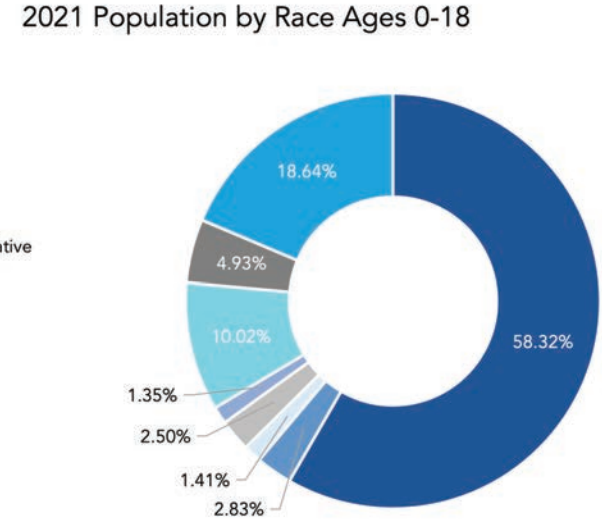
EDUCATION

13%
No High School Diploma

33%
High School Graduate

28%
Some College

26%
Bachelor's/Grad/Prof Degree



CHNA PROCESS OVERVIEW

Arkansas Children's Community Engagement team worked with Boyette Strategic Advisors on this CHNA. The stakeholder engagement process and secondary data collection occurred from June 2021 through April 2022. In addition to quantitative secondary data collection, a total of 808 participants in Arkansas provided their perspectives on the most important child health issues.

The following details the stakeholder participation in this process:

- Parents/caregivers, medical providers, educators, and community leaders participated in 19 virtual focus groups. Forty participants were specifically from Northwest Arkansas. Additionally, four groups were conducted in Spanish, one of which was held in Northwest Arkansas.
- Eight key informant interviews with participants from Northwest Arkansas were conducted to gather critical input from subject matter experts and thought leaders across the state.
- An online survey was conducted using a consumer panel of 606 Arkansas parents and caregivers who are the healthcare decision makers for their children and who do not work in healthcare. Two hundred and six of those participants were from Northwest Arkansas.
    - The survey for the 2019 CHNA was conducted by telephone, but the survey partner recommended an online survey as the preferred method for the 2022 report, given growing issues with telephone methodology.
- A Northwest Arkansas Community Health Survey, conducted by the Northwest Arkansas Council in 2021, was provided to ACNW and included in the ACNW CHNA analysis.
- Child health stakeholders reviewed each component of the CHNA, such as the parent survey questions and focus group guide. Many of these stakeholders supplied input through their work as part of the Natural Wonders Partnership Council.

Stakeholder Participation

Group	Engagement Type	Participants	NWA Participants
One-on-One Interviews	Key Informants	41	8
Focus Groups	Community Leaders (3 groups)	10	0
	Educators (4 groups)	18	6
	Medical Providers (3 groups)	14	2
	Parents/Caregivers (5 groups)	58	17
	Spanish-lanuage Parents/Caregivers (4 groups)	61	15
Online Survey	Parents/Caregivers	606	206

Following completion of all data collection and analysis, 10 themes emerged for further discussion. These themes, along with key data points to support each, were shared with the CHNA advisory group composed of senior leadership within the Arkansas Children's health system. A custom scoring algorithm was developed based on weighted scoring of all factors to determine priority ranking of the issues.

The initial themes shared with the advisory group included the following:

- Access to Care: Oral Health & Immunizations
- Behavioral & Mental Health
- Child Abuse & Neglect
- First 2,100 Days of Life
- Food Insecurity & Obesity
- Immunizations & Vaccine Confidence
- Parent Support & Education
- Poverty & Finances
- Safety & Injury Prevention
- Telehealth

After discussion with the Advisory Group, early themes were refined and further explored to confirm that critical needs had been identified. At that point, profiles of each of the revised needs were shared with the Advisory Group, who then implemented the scoring algorithm to prioritize the needs.

Following is the resulting list of priorities:

- Behavioral & Mental Health
    - Suicide Prevention
- Immunizations
- Food Insecurity
- Infant Health
    - Infant Mortality
    - Teen Pregnancy
- Child Abuse & Neglect
- Access to Care
    - Telehealth
    - Oral Health
- Childhood Obesity
- Injury Prevention

During this process, the advisory group and the CHNA team identified Poverty & Finances as an intersecting need. Arkansas has long been near the bottom of poverty and income rankings, despite concerted efforts to positively impact income and reduce poverty. This, in addition to the clear intersection of poverty with every other children's health issue, is why the group identified it as an intersecting need.

METHODS

The Arkansas Children's Northwest team reviewed all IRS requirements for this CHNA and developed a revised and thorough process for collecting and analyzing all primary and secondary data needed to make informed decisions about the current children's health needs in Northwest Arkansas. Quantitative data were used to help validate and frame health needs that were mentioned during the qualitative data collection process. More than 250 stakeholders, including parents/caregivers, subject matter experts, and community leaders, provided qualitative input for this report.

SECONDARY QUANTITATIVE DATA COLLECTION

Boyette Strategic Advisors used several subscription databases, which provided access to more current demographic estimates than are available through public data sources such as the U.S. Census Bureau. For this report, Boyette used demographic, income, and employment data from Esri Business Analytics Online, which enhances publicly available data and provides estimates for the current year, along with projections for many data points for five years forward.

In addition to the demographic and economic data accessed through Esri, this report includes analytics from many other local, state, and national data reviewed as part of this process. This includes local data from Arkansas Children's Hospital and research studies focused on specific diseases or groups. State-level data were examined from the Arkansas Department of Health, the Arkansas Department of Human Services, Arkansas Advocates for Children and Families, and Aspire Arkansas/Arkansas Community Foundation as well as other state agency and nonprofit organization sources. Some of these data also included detail at the county level, which allowed for a deeper analysis of the 15-county Northwest Arkansas region.

The CHNA team accessed national data sets that included the Annie E. Casey Foundation's *Kids Count Data Center*; the Centers for Disease Control and Prevention; the Youth Risk Behavior Survey; United Health Foundation's *America's Health Rankings Annual Report* and *Health of Women and Children Report*; National Survey of Children's Health; and University of Wisconsin and Robert Wood Johnson Foundation (RWJF) *County Health Rankings*. Every effort was also made to access data specific to children's health needs; however, in limited cases, adult data were accessed to assist in developing a clear picture of particular issues.

PRIMARY QUALITATIVE DATA COLLECTION

PARENT & CAREGIVER DIGITAL SURVEY

ACH contracted Klein & Partners, a healthcare-focused market research firm, to design and field a digital parent survey to collect comprehensive data from parents and caregivers in the state. While the 2019 parent/caregiver survey was conducted by telephone, the survey for this report was fielded digitally in order to avoid emerging limitations with telephone methodology. The survey was designed to gather parent/caregiver perspectives on a variety of issues that potentially impact children's health and well-being.

Methodology: The online survey was fielded between August 26 and September 16, 2021, to respondents across Arkansas, with a total of 606 respondents, 206 of whom were from Northwest Arkansas. To ensure a valid and representative sample, data were weighted by county, income, education, and ethnicity. The sample included parents or caregivers who are the healthcare decision-makers for their children and do not work in healthcare. At right is a demographic profile of statewide and regional respondents.

Key Findings: One overarching concern surfaced through the parent survey—the need for more mental health services for children. Parents said COVID-19 has negatively impacted children's mental health much more than their physical health.

Parent Survey Demographic Profile

Demographic Profile	Total for Arkansas	NW Arkansas
2+ Children	55%	7%
Average age of oldest child	10	10
Moms	78%	75%
College degree	22%	13%
Average parent age	37	37
Average # of household members	3.7	3.7
Marital Status		
Married	55%	60%
Single	15%	13%
Separated/divorced	15%	11%
Living together	13%	12%
Widowed	2%	2%
Race/Ethnicity		
Caucasian	77%	81%
African American	17%	7%
Hispanic	6%	10%
Median income	$39,197	$40,509
Health Insurance		
Medicaid (AR Kids First)	53%	44%
Group	29%	37%
Individual	9%	9%
Exchange	4%	3%
No insurance for children	2%	3%
Employment Status		
Employed full-time	44%	43%
Homemaker	19%	21%
Out-of-work but looking	8%	6%
Employed part-time	8%	7%
Self-employed	7%	6%
Out-of-work and not looking	4%	4%
Retired	3%	3%
Student	2%	4%

The top five concerns Northwest Arkansas parents have for their children include mental health issues; poor parenting; bullying; poverty and finances; and contagions/cold/flu. Analysis of the data indicated that mental health and financial challenges seem to go hand-in-hand and impact children's health. Additionally, there appears to be a correlation between households with children with chronic and/or serious acute situations and domestic violence/abuse, possibly the result of emotional and financial stress of these serious and/or ongoing medical situations contributing to parent stress.

Following are additional findings:

- Moms have the highest level of concern about their children's safety, whether it is preventable injuries or threats such as bullying or school violence.
- Half of parents surveyed must take unpaid time off of work to take their children in for healthcare services.
- Northwest Arkansas parents surveyed were confident about childhood vaccinations (66%), but fewer parents had confidence in the COVID-19 vaccine. Only 31% of parents were not at all hesitant about the COVID-19 vaccine, while 37% were "very hesitant" about the COVID-19 vaccine. For comparison, 40% of parents surveyed were not at all hesitant about the yearly flu vaccine.

Top Problems Related to Children's Health & Well-Being						
Problem	**Rank 1**	**Rank 2**	**Rank 3**	**Rank 4**	**Rank 5**	**Top 5 Ranking**
Bullying	8%	9%	8%	16%	6%	44%
Poverty & Finances	8%	7%	11%	9%	6%	38%
Poor Parenting	7%	9%	6%	5%	14%	35%
Mental Health Issues	9%	10%	11%	5%	8%	40%
Child Abuse	5%	6%	4%	6%	8%	26%
Affordable Health Insurance	12%	3%	6%	5%	4%	30%
Obesity/Lack of Exercise	5%	5%	5%	8%	3%	28%
Poor Nutrition	4%	6%	8%	2%	6%	27%
Drugs	3%	5%	5%	3%	6%	24%
Food Insecurity	2%	6%	7%	4%	4%	22%
Lack of Affordable Housing	3%	11%	2%	6%	3%	25%
Violence/Guns	2%	3%	3%	4%	3%	15%
Lack of Regular Health Visits	4%	3%	3%	4%	3%	16%
Access to Quality Healthcare	7%	4%	4%	3%	5%	27%
Contagions/Cold/Flu	5%	6%	2%	2%	3%	21%
Poor Educational Opportunities	3%	2%	3%	4%	5%	17%
Vaccination Issues	5%	2%	1%	4%	1%	16%
Systemic Racism	2%	2%	2%	3%	6%	15%
Suicide	3%	3%	5%	4%	4%	20%
Lack of Healthcare Services	3%	3%	5%	2%	3%	14%

KEY INFORMANT INTERVIEWS

Subject matter experts and other key stakeholders participated in interviews conducted via Zoom by Boyette Strategic Advisors in July and August 2021. A total of eight of 41 key informants were from Northwest Arkansas. Key informants included medical providers, educators, policy officials, ACNW senior leadership, and community leaders. Questions used for the interviews were centered on the conditions that impact health, or social-determinants-of-health, but also provided opportunities for the interviewees to share their thoughts about a variety of potential needs and concerns. Interviews also included an opportunity for key informants to share their thoughts on any COVID-19 impacts to children's health that may surface over the next three to five years. The questions that guided these conversations are included in the appendices.

Methodology: Boyette completed an initial analysis of the interviews by identifying key themes that emerged over the course of all conversations. All interview notes were organized in a spreadsheet format that allowed for quantifying the frequency and depth of concerns about each of the needs. A series of intersecting factors also surfaced as the themes were analyzed. Boyette provided a summary of findings from the interviews to the Arkansas Children's team, including quotes from key informants that illustrated the perspectives that were common across most of the interviews.

Key Findings: Poverty & Finances was an intersecting issue that surfaced as a concern related to a variety of children's health needs, including Behavioral & Mental Health, Food Insecurity, Parental Support, and Access to Care. Key informants also discussed the cultural and language challenges that exist with the region's large Hispanic and Marshallese populations, in addition to the specific challenge of health literacy. Additionally, many of those interviewed also expressed concern about a lack of transportation and the cost of travel to access healthcare resources from more rural areas of the region. Some public policy issues also surfaced, particularly related to immigration status, which was thought to prevent some families from seeking care and assistance.

Key informants agreed that the full long-term impacts of COVID-19 pandemic are not known. Many did express concerns about mental health impacts of the precautions taken because of the pandemic; developmental delays resulting from virtual education; and missed immunizations, as parents were hesitant to visit doctors' offices at the height of the pandemic and were uncomfortable about vaccines in general because of media coverage about COVID-19 vaccine hesitancy.

FOCUS GROUPS

A series of focus group virtual conversations were held via Zoom to seek input from parents/caregivers, educators, medical providers, and community leaders. A total of 19 focus groups engaged 161 stakeholders, including four groups that were conducted in Spanish. Each 60-minute conversation was recorded to ensure that all comments were captured for analysis. Two team members led the focus groups—one who facilitated the discussion and one who captured comments and identified themes. In addition, four Spanish-language focus groups were offered to parents and caregivers. Those in-person discussions were held intentionally in four different regions of the state: DeQueen (Southwest Arkansas), Warren (Southeast Arkansas), Little Rock (Central Arkansas), and Springdale (Northwest Arkansas).

Participant Recruitment: In an effort to ensure broad participation from diverse stakeholders across the state, a participant recruitment strategy was employed. This strategy involved contacting a list of potential partner organizations requesting they contact their members or stakeholders and invite them to participate in the appropriate focus groups. These partners were given a draft email with an embedded QR code and the flyer found at right to facilitate their outreach. Both the Alchemer online survey tool and Calendly were utilized to capture participant registration. Each registered participant was required to provide their county of residence as they registered for the focus group, which allowed the Boyette team to ensure a broad geographic representation.

Focus Group Guide: A focus group guide was developed that provided structure to the discussions. It included a full script of the introductory information to be provided to each group about why they had been invited to join the conversation and how the information would be used to help identify and address children's health needs in Arkansas. It also included the instant poll questions that were inserted in the conversation intermittently. Conversations opened with some general questions about their thoughts about the status of children in Arkansas, followed by more specific exploration around the social-determinants-of-health, access to and quality of clinical care, physical environment, social and economic factors impacting health, and health behaviors. Each topic provided opportunities for the facilitator to probe deeper to get full perspectives from participants. Each focus group closed with participants having the opportunity to share ideas of how they would improve children's health if unlimited resources were available. The focus group guide is found in the appendices.

Methodology: A combination of inductive and deductive analysis for the focus group discussions was used. During the focus groups, verbatim notes were captured, with a recording of the conversation as a backup. Additionally, themes that emerged across multiple groups as well as any group dynamics that may have influenced comments were noted.

Using those initial themes, comments and responses were coded into preliminary categories. Additional themes or "sub-themes" that surfaced were then added to the categories. The themes and comments were organized in a spreadsheet format with multiple tabs for themes related to the particular audience in the focus group. While focus groups included people from all across the state, participant comments were also analyzed separately for those from Northwest Arkansas. A summary of high-level findings was developed, along with a complete narrative report of the focus groups' data.

Four quantitative questions that were used during the focus groups through Zoom polling allowed focus group participants to respond and see immediate results. The quantitative questions aligned with similar questions from the parent/caregiver survey and were placed throughout the focus groups to introduce new discussion topics.

Key Findings: The instant poll questions provided a limited amount of quantitative data from the focus groups. From those poll questions, the top five children's health concerns across all audiences included abuse (child and/or domestic), access to quality healthcare, poverty and finances, food insecurity/poor nutrition, and bullying. Those topics align well with themes that were identified through key informantinterviews and findings from the digital parent survey. In response to general questions about children's health, the most common responses involved access to care, mental health, food insecurity and nutrition, and parent education and support.

As with other stakeholder input, poverty and finances was identified as an underlying contributor to many of the concerns expressed by focus group participants. Many discussed barriers to accessing care that were driven by poverty. For example, a lack of transportation; working parents without the ability to miss work; a lack of understanding of available resources; and providers that do not accept Medicaid were all mentioned. Rurality as an access issue was mentioned in relationship to poverty, because length of time to travel and the associated costs to travel were perceived as a barrier to care for some families.

Medical providers expressed deep concerns about behavioral and mental health. Virtually all medical providers mentioned a lack of mental health providers, saying it is difficult to get a timely appointment as a result. The providers who are primary care providers also said that they often have to provide some level of mental healthcare because patients come in with mental health issues, and a timely appointment with a mental health provider is not available. Some suggested that additional training for primary care physicians related to mental health treatment options might be important.

While the Spanish-language focus group participants discussed many of the same concerns as those that emerged in other groups, there was a much greater focus on language barriers with medical professionals and concerns about immigration status that can interfere with access to care. Poverty and lack of available employment were also mentioned in all four Spanish-language groups. Participants also said that there is an overall lack of information and resources, particularly in more rural areas.

FINDINGS

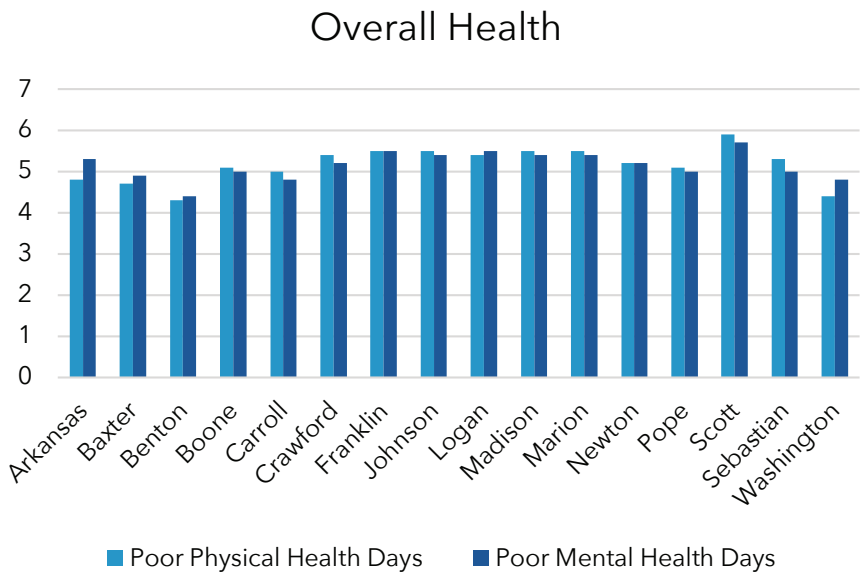
All qualitative and quantitative data were reviewed and analyzed individually, as well as across all results to determine any differences or outliers. This analysis led initially to early themes related to children's health needs in Arkansas. Some additional review and deeper data analysis, combined with conversations with the CHNA Advisory Group, resulted in a list of needs that were then prioritized using a process of both qualitative and quantitative measures. Below is a summary of broad measures of health that were identified early in the process, followed by detail about the scoring process used to determine priorities.

INTRODUCTION TO FINDINGS

While the 2022 Arkansas Children's Northwest CHNA identifies specific community health needs, there was also an analysis and review of the measures of overall health of children in Northwest Arkansas. Various health and other non-profit organizations track a multitude of data points that contribute to children's health. While some of these take a broad look at the overall status of children and the different contributing factors that result in positive or negative impacts on health, many are available only at the state level. This document provides an overview of those broad measures of children's health in Arkansas and, where possible, provides a summary of related data for the 15-county Northwest Arkansas region.

- The *2021 KIDS COUNT® Report* ranks Arkansas 50th for the number of children who have encountered two or more adverse childhood experiences (ACES). Arkansas's percentage is 11% above the US average, with nearly one third of children included in this category.
- According to the 2020 National Survey of Children's Health, Arkansas ranks 43rd for the percentage of children with special healthcare needs. The state rate of 22.3% is about 3.5% greater than the US.
- The same survey ranks the state's children's health status at 44th, with 88.5% of children ages 0–17 in excellent or very good health.

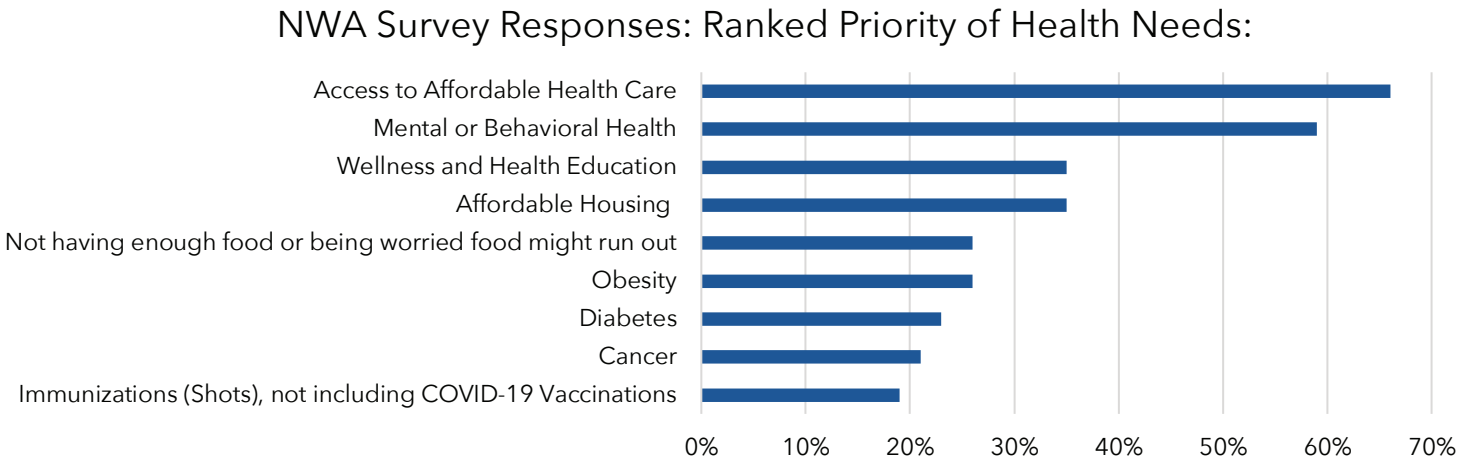
While county-level data are not available for Overall Children's Health Status, the Robert Wood Johnson Foundation County Health Rankings reports the percent of total population that is in poor or fair Health. The state average is 23%. The ACNW counties range from 20% in Benton County to 30% in Scott County.



This report also includes the number of Poor Physical Health Days and Poor Mental Health Days in the past month. The graph illustrates the data for the ACNW counties.

Arkansas Children's Northwest: Needs Assessment

The "Community Health 2021 Survey for the Northwest Arkansas Collaborative" is one of the specific stakeholder sources for the ACNW Community Health Needs Assessment. This survey was sponsored by the Northwest Arkansas Council and led by Mercy Hospital Northwest Arkansas, with 17 healthcare and community partners, including Arkansas Children's Northwest. This community health survey explores the health needs of adults, as well as families and their children. The final sample included 2,231 respondents from four counties: Benton, Carroll, Madison, and Washington. The results of this community survey supplemented the Northwest Arkansas responses of the Arkansas Children's CHNA parent survey. In the NWA community survey, when asked to select the three most important things for healthcare to address, the top three responses were access to affordable care, mental health, and wellness and health education (detail in graph below).



PRIORITIZING FINDINGS

ACNW used a rating and weighting index to prioritize the community health needs that were identified by the research components of the CHNA. This unique index tool was developed by the Arkansas Children's Community Engagement team and Boyette Strategic Advisors.

Each health need identified through research and stakeholder input was further analyzed based on the following factors:

- Scope (12%) – consideration of how widespread the need may be among Arkansas children.
- Severity (20%) – addresses the types of outcomes resulting from this need if nothing is done to further address the need.
- Community Priority (20%) – focuses on findings from stakeholder input and which needs were identified by a majority of stakeholder groups.
- Health Disparities (3%) – consideration of the need and its effect by race, community size, and economic factors.
- Connection to Arkansas Children's (AC) Strategic Plan (10%) – focuses on how a given need aligns with the AC Strategic Plan.
- Critical Leadership and Other Considerations (10%) – provides for key AC staff and medical providers to apply their expertise to the topic.
- Ability to Impact (15%) – considers whether the need is currently being addressed by Arkansas Children's or another entity and the likelihood of success if Arkansas Children's chooses to become involved or increase their efforts.
- Ability to Measure Success (10%) – determines how effective a program or service is in addressing a particular need using existing metrics or available data to create a meaningful metric.

Rating and Weighting Index for 2022 Community Health Needs Assessment											
	Factors Determined by Data (*55 pts*)					Factors Determined by Discussion (*45 pts*)					
Community Health Needs	Scope	Severity	Community Priority	Health Disparities	Pre-Total	Connection to Arkansas Children's Strategic Plan	Critical Leadership and other Considerations	Ability to Impact	Ability to Measure Success	Pre-Total	Overall Total
Point Value for Factor	12 points	20 points	20 points	3 points		10 points	10 points	15 points	10 points		

The first four factors in the rating index have significant data to inform the scores. All of these data were collected for the CHNA and utilized to arrive at the scoring of the Scope, Severity, Community Priority, and Health Disparities factors. Given the need for data analysis and the more objective considerations, these four factors were scored by the Community Engagement team and the consultant team.

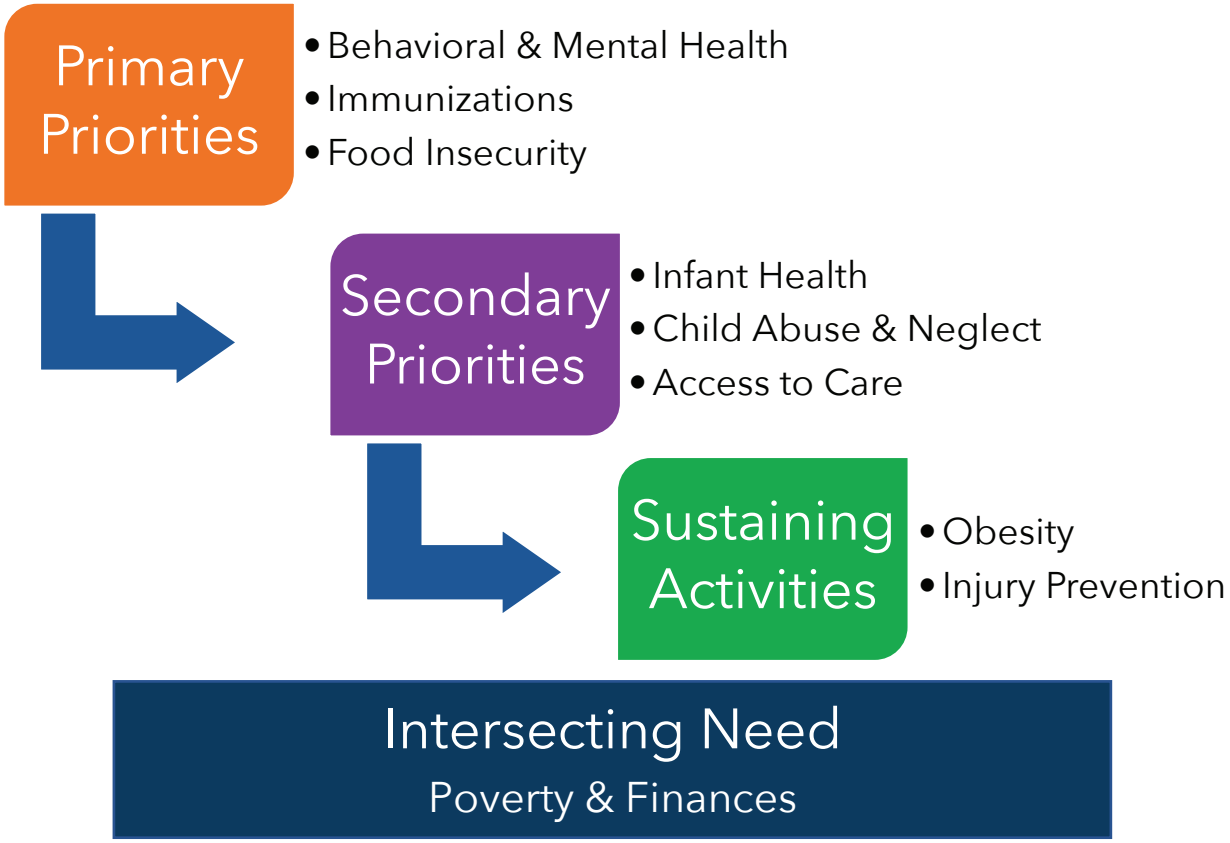
The final four factors required expertise and historic knowledge of the various issues. For that reason, the CHNA advisory group scored the Connection to the Strategic Plan, Critical Leadership and Other Considerations, Ability to Impact, and Ability to Measure Success factors.

Prior to scoring, working group members had the opportunity to participate in three information sessions about CHNA findings. A third of those meetings included a thorough overview of the rating process. Additionally, a two-page summary of each identified need was provided and included a description of the need, any pertinent data used to identify the need, and current or potential options to address the need.

PRIORITIZED HEALTH NEEDS

Using the rating methodology described previously, the identified health needs were scored. The scoring resulted in identification of three tiers of priorities. In addition, the determination that Poverty & Finances is an intersecting need.

Using the scoring results, ACNW will work to address the following prioritized health needs over the next three years:



Arkansas Children's Northwest: Needs Assessment

Primary Priorities for the 2022 Arkansas Children's Northwest Community Health Needs Assessment

Primary Priorities

- Behavioral & Mental Health
- Immunizations
- Food Insecurity

Primary Priorities: Behavioral & Mental Health

OVERVIEW

The mental and behavioral health of Arkansas children was one of the most significant topics identified in the Community Health Needs Assessment. The serious impacts of children's poor behavioral and mental health result from risky behaviors, family dynamics, missed developmental milestones, and learning and developmental disabilities. In a September 2021 article, Marcy Doderer, CEO of Arkansas Children's, was quoted as saying, "*Trying to understand how, as an industry and as a society, we can best address the mental, emotional, and behavioral health needs of kids is becoming an urgent topic for solutions*."

Arkansas ranks very poorly in child mental health national rankings. The most common mental disorders diagnosed in childhood include attention-deficit/hyperactivity disorder (ADHD), anxiety, and behavior disorders. [1] Additionally, Arkansas children are more likely to encounter adverse childhood experiences (ACEs) than children in other states. ACEs include all types of abuse, neglect, and other traumatic experiences. [2]

According to America's Health Rankings 2021 Annual Report from the United Health Foundation, Arkansas ranks 48th for ACEs, with 22.5% of children under age 18 experiencing two or more stressful or traumatic events that may have a long-term impact on their health and well-being. [3] Additionally, death by suicide among Arkansans ages 15 to 24 is high and ranked 37th nationally while continuing to increase in recent years. [4]

The scoring process described in the Findings section of this report used key data points to determine priority order for each of the identified needs. The metrics used to prioritize Behavioral & Mental Health can be found in the Appendix.

BEHAVIORAL & MENTAL HEALTH AT A GLANCE

3,241:1
NORTHWEST ARKANSAS RATIO OF POPULATION TO MENTAL HEALTH PROVIDERS

50th
CHILDREN RECEIVING DEVELOPMENTAL SCREENINGS

22.5%
OF CHILDREN IN ARKANSAS EXPERIENCE TWO OR MORE STRESSFUL TRAUMATIC EVENTS (THAT MAY HAVE A LONG-TERM IMPACT ON THEIR HEALTH)

22.6%
ARKANSAS TEENS WERE BULLIED ON SCHOOL PROPERTY

26.9/100,000
NORTHWEST ARKANSAS SUICIDE DEATHS PER 100,000

1 in 3
ARKANSAS CHILDREN SERIOUSLY CONSIDERED ATTEMPTING OR MADE A PLAN TO ATTEMPT SUICIDE

INTERSECTING NEEDS

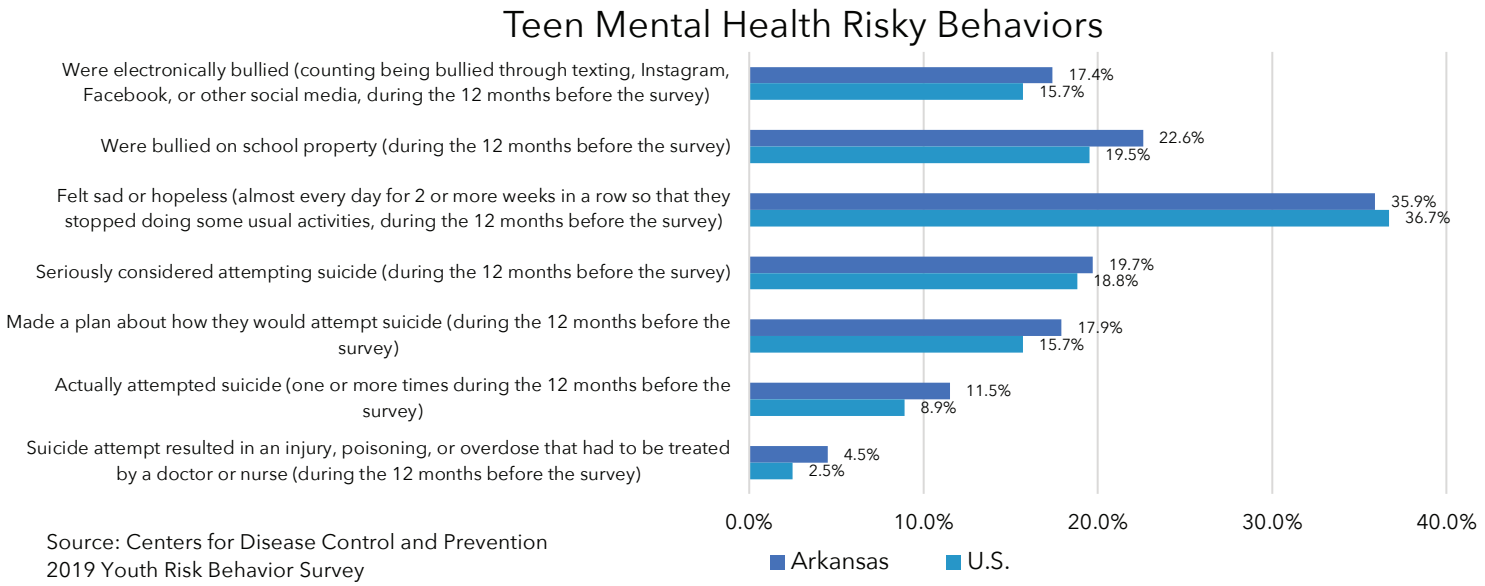
The Centers for Disease Control and Prevention (CDC) describes children's mental health disorders as "serious changes in the way children typically learn, behave, or handle their emotions, which cause distress and problems getting through the day." [5] Children with ADHD, anxiety, autism, substance use, and self-harm are among the childhood disorders that require behavioral and/or mental health treatment. Many of these disorders are chronic conditions that last a long time. Without treatment, these disorders will lead to problems at home, in school, and in forming healthy relationships. [6]

A variety of incidents, behaviors, and experiences contribute to mental health disorders in children and teens. A concerning number of children in Arkansas engage in or experience risky behaviors related to mental health. According to the CDC's Youth Risk Behavior Survey 2019, Arkansas children are more likely to experience or participate in the following risky behaviors that may impact mental health:

- Subject of bullying
- Experienced sexual violence
- Took prescription pain medicine without a doctor's prescription; used inhalants, heroin, methamphetamines, or ecstasy
- Had first drink of alcohol before age 13

The number of children and teens who plan, attempt, or die by suicide as a result of their mental illness is staggering. Nearly one in five Arkansas teens have seriously considered attempting suicide in the last 12 months, according to the CDC 2019 Youth Risk Behavior Survey. A suicide rate of 21.9 per 100,000 Arkansans ages 15 to 24 equates to more than 650 deaths per year.

According to the Annie E. Casey Foundation's *2021 KIDS COUNT® Report*, a study examining the validity of healthy days as a summary measure for county health status found that counties with more unhealthy days were likely to have higher unemployment, poverty, percentage of adults who did not complete high school, mortality rates, and prevalence of disability than counties with fewer unhealthy days. Each of these impacts also lead to poorer mental health, creating a difficult-to-break cycle.



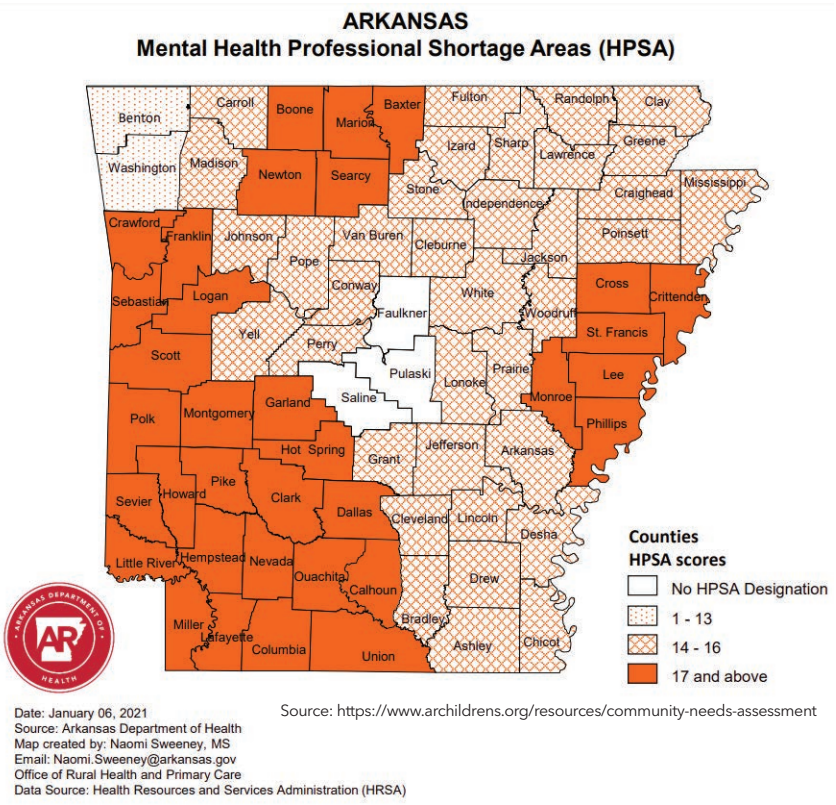
Source: Centers for Disease Control and Prevention
2019 Youth Risk Behavior Survey

SECONDARY QUANTATIVE DATA

Significant secondary data was identified and considered in determining whether Behavioral & Mental Health should be considered as a child health need in this CHNA. Following are data points that support the inclusion of this child health need.

- The state average ratio of population to mental health providers is 420:1, which is higher than the national average of 270:1. However, the 15-county NWA region is significantly higher at 3,241:1. Franklin County had the highest disparity in the state at 17,720:1. (RWJF County Health Rankings).

- All 15 Northwest Arkansas counties are designated as Health Professional Shortage Areas (HPSA) for mental health professionals. Health Resources and Services Administration determines a HPSA with three scoring criteria:
    1) Population-to-provider ratio
    2) Percent of population below 100% of the federal poverty level (FPL)
    3) Travel time to the nearest source of care outside of the HPSA



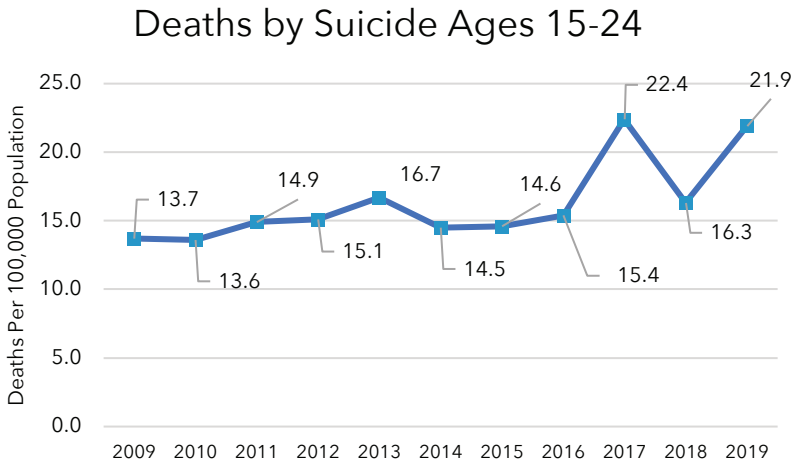
Source: https://www.archildrens.org/resources/community-needs-assessment

- The 2020 National Survey of Children's Health ranks Arkansas at 50th for children receiving developmental screenings, with the state percentage approximately 16% lower than the national average.

- A common underlying condition and/or symptom of mental health disparities is attention deficit disorder (ADD)/ADHD, and the *2021 KIDS COUNT® Report* ranks Arkansas 42nd for the percentage of children with ADD/ADHD, almost 3% higher than the national average.

- The state ranks 47th in percentage of children with emotional, behavioral, or developmental conditions, according to the *2021 KIDS COUNT® Report*, with about 7% more Arkansas children identified as experiencing emotional, behavioral, or developmental conditions than the national average.

- According to the 2021 United Health Foundation America's Health Rankings, the number of Arkansas children that die by suicide is 21.9 per 100,000, which is significantly more than the national rate of 13.9 per 100,000, and places Arkansas's national ranking at 37th.
- The Arkansas rate of death by suicide is 19 per 100,000 population (for all age groups), which is higher than the national rate of 14. The NWA regional rate is almost double the US average coming in at 26.9 per 100,000. Newton County has the highest rate in the region at 37 per 100,000, with Franklin and Marion counties both at 30 deaths.



Source: United Health Foundation America's Health Rankings 2021

- Approximately 35% of adults report living in households with children who felt nervous, anxious, or on edge more than half the days in the past two weeks in Arkansas.

STAKEHOLDER ENGAGEMENT

Multi-faceted stakeholder engagement provided a framework for identifying community priorities. Following is a summary of findings from stakeholder engagement related to Behavioral & Mental Health.

Children's mental and behavioral health was one of the most significant topics identified with all stakeholders (surveys, focus groups, key informants), and it was mentioned more than 50 times.

> *With mental health there is a lack of resources for depression, anxiety, and developmental disabilities.*
>
> *NWA Key Informant*

KEY INFORMANT FEEDBACK

- Several key informants discussed the high incidence of adverse childhood experiences (ACEs) in Arkansas and the potential long-term impact they may have on children's mental health.
- A number of key informants expressed concern that the COVID-19 pandemic may result in the need for even more resources to address mental health issues in children.
- As one NWA stakeholder said, "I have seen an uptick around behavioral health in kids, especially during COVID, while isolated from friends and doing virtual school. I also have heard of more parents reaching out to seek counseling for their children more than ever before."

- Concern about access to mental healthcare was also voiced by many key informants, who pointed out that early access and intervention could result in prevention or mitigation of factors impacting children's mental health.

FOCUS GROUP FEEDBACK

- Some educators mentioned the importance of school-based mental health programs, with some districts adding social workers to help address the issue. They emphasized the difficulty in finding mental health professionals, particularly in rural areas.

- Several parent focus group participants discussed the fact that many mental health providers don't accept Medicaid patients.

- Medical providers participating in focus groups discussed their concerns about how frequently they find themselves treating a child's mental health issues without appropriate training. One said they would like to see a program where primary care physicians could reach out to mental health providers for quick answers without having to wait for a return call. Others suggested investing in training primary care providers to assess mental health needs and provide preliminary care.

PARENT SURVEY RESULTS

- Survey findings from the Arkansas Children's 2022 CHNA parent survey illustrates the importance of child mental health. Parent respondents from Northwest Arkansas ranked mental health as the most important issue in children's health, behind poverty/finances, with 40% of respondents including mental health as a top five issue.

- Additionally, 58% of parents identified the number of children who have mental health issues as a serious problem.

NORTHWEST ARKANSAS COMMUNITY HEALTH SURVEY

- Mental & Behavioral Health was the single most significant health issue identified with Northwest Arkansas stakeholders in the 2021 Community Health Survey for The Northwest Arkansas Collaborative.

- According to the 2021 Community Health Survey for The Northwest Arkansas Collaborative, area residents identified Mental & Behavioral Health as the most important health issue, followed by COVID-19 and diabetes. These are issues that affect adults as well as children, and this is important because the health issues of adults impact children through their parents, families, and communities.

> *There is a stigma around mental health help, and even when resources are there, many parents don't know how to access them.*
>
> *NWA Community Leader Focus Group Participant*

HEALTH DISPARITIES

In addition to identifying general children's health needs, it is critical to understand any impacts that occur only with certain populations of children. The process for identifying and measuring health disparities is included in the Findings section of this report.

According to the National Survey of Children's Health, Black non-Hispanic children have the highest rate of having one or more mental, emotional, developmental, or behavioral (MEDB) problems at 33.6%, followed by White non-Hispanic children at 31.1%. Only 15% of Hispanic children are reported to have one or more MEDBs.

When examining regional data, disparities exist related to three areas of concern: rural, racial, and economic. All five counties defined as rural for which data are available have a higher ratio of population to mental health providers than the state. Two of the five counties with the highest non-White population have a higher rate than the state average. Four of five counties with the greatest poverty rates also have higher ratios than the state rate of 420:1.

Disparities in Behavioral & Mental Health

Source: Arkansas Department of Health

RURAL DISPARITY		
County	**County Ratio**	**AR Ratio**
Newton	3,880:1	420:1
Scott	3,430:1	420:1
Madison	660:1	420:1
Marion	8,350:1	420:1
Franklin	17,720:1	420:1
RACIAL DISPARITY		
Benton	440:1	420:1
Crawford	2,110:1	420:1
Johnson	370:1	420:1
Sebastian	280:1	420:1
Washington	260:1	420:1
ECONOMIC DISPARITY		
Franklin	17,720:1	420:1
Johnson	370:1	420:1
Marion	8,350:1	420:1
Newton	3,880:1	420:1
Scott	3,430:1	420:1

The data for ratio of population to mental health professionals at the county and state levels are sourced from 2021 County Health Rankings.

Primary Priorities: Immunizations

OVERVIEW

There is a clear link between immunization rates and the decrease of certain diseases. According to the Healthy People initiative, vaccines are among the most cost-effective clinical preventive services and are a core component of any preventive-services package.

Arkansas has made great strides in recent years in advancing childhood immunizations. In 2010, just 58.9% of 2-year-old children were vaccinated, but the percentage has steadily increased since that time. In 2019, for the first time, immunized Arkansas children exceeded the national average percentage of vaccinated children. The state currently ranks 23rd nationally, with 76.3% of 2-year-olds in Arkansas fully immunized for all doses of the recommended combined 7-vaccine series. Immunization rates for 2-year-olds is the national standard metric for comparing rates. There is a shift toward use of this standard metric, although in some cases, immunization rates for 19–35 month children are the data available. Even with these recent strides in fully immunized children, Arkansas still has ground to cover, when compared to the healthiest state (Massachusetts, 92.7% fully immunized). Additional work to provide vaccines to areas with limited access, to ensure providers offer vaccines, and to address misinformation about vaccines, can help Arkansas continue to improve our rates.

IMMUNIZATIONS AT A GLANCE

23rd

ARKANSAS RANK OF 2-YEAR-OLDS WHO ARE IMMUNIZED

62.2%

PERCENTAGE OF ARKANSAS CHILDREN 19–35 MONTHS OF AGE WHO RECEIVED ALL RECOMMENDED DOSES OF CHILDHOOD VACCINES

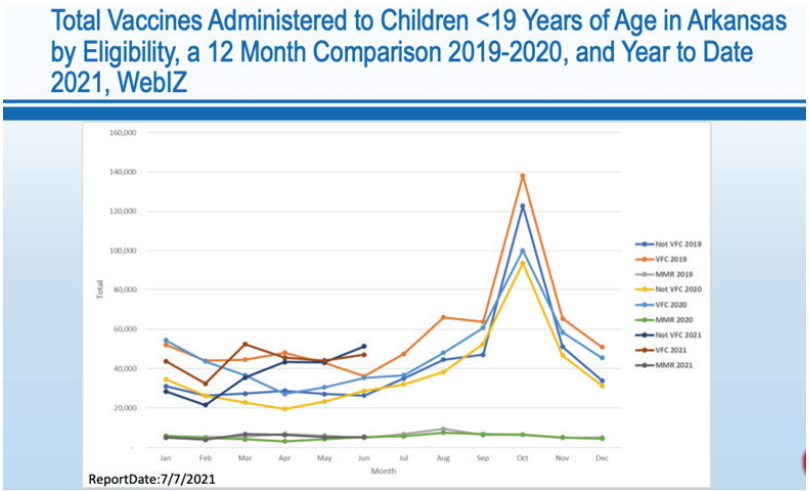
4 Counties

NORTHWEST ARKANSAS COUNTIES WITH ONLY ONE VACCINE FOR CHILDREN (VFC) PROVIDER

5 Counties

IN NORTHWEST ARKANSAS WITH IMMUNIZATION EXEMPTION RATES OF MORE THAN 20%

The COVID-19 pandemic negatively affected immunization coverage. Health officials and medical providers observed a delay in some families seeking well-child care, which likely played a part in the lag for recommended vaccines administered in early 2020–21. Through partnerships between healthcare providers, insurance companies, pharmacists, public interest groups, and others, work was done in the fall of 2020 to focus on ensuring children could catch up on their vaccine series. The graph below shows the increase in the vaccines administered from September through November of 2021.



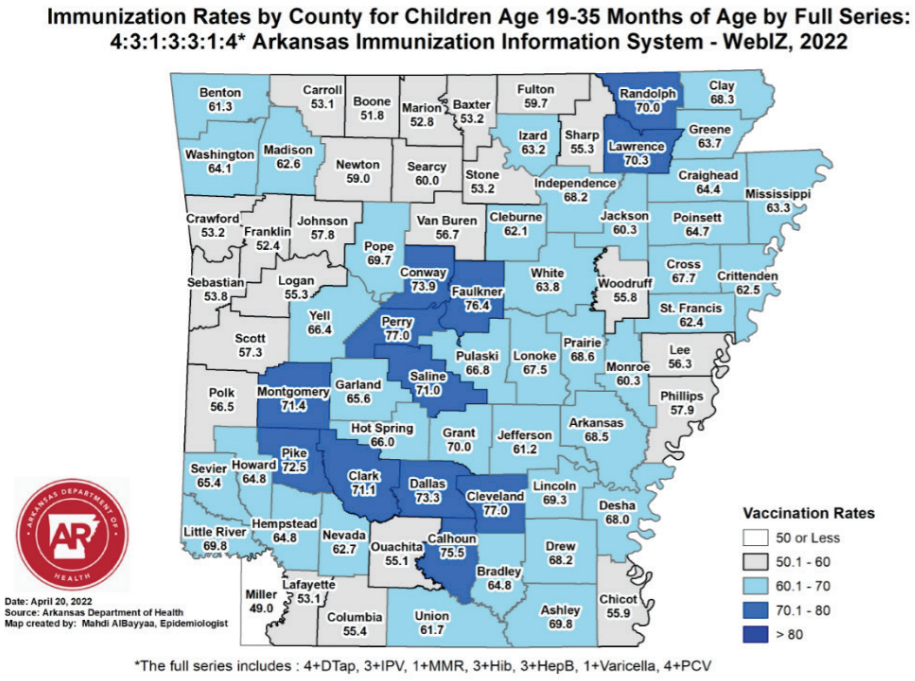
There are a growing number of philosophical exemptions filed annually. This may result in more cases of measles, mumps, chicken pox, and whooping cough. [7] In addition, hesitancy and mistrust of vaccinations plays an important role in informing the complex issue of Immunizations. It is still unclear how the hesitancy around the COVID-19 vaccine, a critical component of ending the pandemic, may play a role in affecting attitudes about other vaccines.

According to the National Immunization Survey conducted by the CDC, Black non-Hispanic children had the lowest immunization rate at 58.1%. However, Hispanic children in Arkansas had the highest rate at 72.6%, followed by children of other or multiple races at 72.2%. Children living at less than 133% of the federal poverty line have the lowest immunization rate based on poverty rates at 62.7%, while 86.2% of children who are greater than 400% of the Federal Poverty Line are immunized. [8]

The scoring process described in the Findings section of this document utilized certain key data points to determine priority order for each of the identified needs. The metrics utilized to prioritize Immunizations can be found in the Appendix.

INTERSECTING NEEDS

There is a clear link between immunization rates and the presence of certain diseases. Unvaccinated children may spread disease to other children, but immunizations have decreased most childhood diseases by more than 95%. It has been estimated that childhood vaccinations of children born between 1994 and 2013 would prevent 322 million cases of disease, with 732,000 premature deaths due to vaccine-preventable diseases. [9] The following diseases have been reduced by >99% to 100% through the use of vaccines: [10]



Arkansas Department of Health

- Diphtheria
- Measles
- Polio
- Rubella
- Congenital rubella syndrome
- Smallpox

Childhood immunization programs result in a high return on investment. For example, each birth cohort vaccinated with the routine immunization schedule (this includes DTaP, Td, Hib, Polio, MMR, Hep B, and varicella vaccines) results in the following outcomes:

- Saves 33,000 lives
- Prevents 14 million cases of disease
- Reduces direct health care costs by $9.9 billion
- Saves $33.4 billion in indirect costs [11]

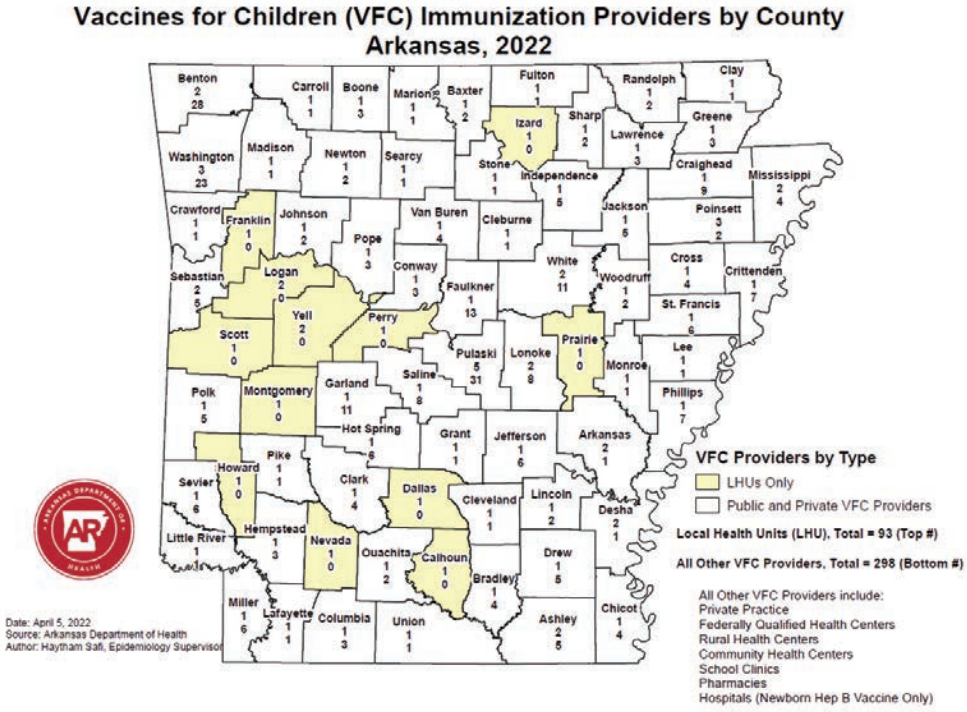
Adherence to immunization schedules for children help prevent the following 14 illnesses or diseases:

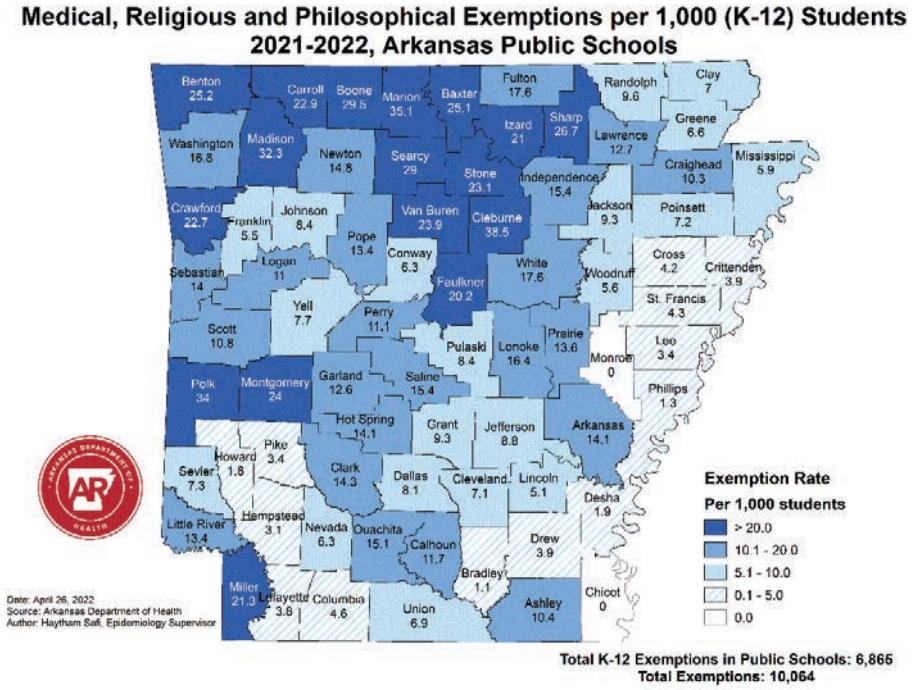
- Chickenpox
- Hepatitis A
- Measles
- Polio
- Rubella
- Diphtheria
- Hepatitis B
- Mumps
- Pneumococcal
- Tetanus
- Haemophilus influenzae type b
- Influenza
- Pertussis
- Rotavirus

SECONDARY QUANTITATIVE DATA

Significant secondary data were identified and considered in determining whether Immunizations should be considered as a child health need in this CHNA. Following are data points that support the inclusion of this child health need.

- The state immunization rate for children age 19–35 months of age is 62.22%. This is one of the most important immunization metrics since it captures the important series of vaccinations that children should receive early in life.
- For children 19–35 months old, there is one county in Arkansas with a rate below 50% (Miller County). Twenty-three counties have a rate below 60%.
- For families with inability to pay, the Vaccines for Children (VFC) program provides childhood vaccines at no cost. Children under 19 years of age qualify if they are Medicaid-eligible, uninsured, underinsured, or an American Indian or Alaska Native. The 2022 VFC map shows the number of providers in each county. An eligible child can receive VFC vaccines through a participating healthcare provider or their local health unit.[12]
- Twenty-nine Arkansas counties have two or fewer vaccine providers who participate in the VFC program, limiting the availability of this important access program.





- Arkansas has three types of exemptions for required vaccines: medical, religious, and philosophical. Only a few other states in the US have the philosophical exemption; most states only have medical and religious exemptions.

- The state map shows the exemption rates in each county. The northwest counties that ACNW serves have some of the highest exemption rates in the state.

STAKEHOLDER ENGAGEMENT

Multi-faceted stakeholder engagement provided a framework for identifying community priorities. Following is a summary of findings from stakeholder engagement related to Immunizations.

Immunizations was one of the most significant topics identified with all stakeholders (surveys, focus groups, key informants), having been mentioned more than 50 times.

KEY INFORMANT FEEDBACK

- Several key informants expressed concern that the COVID-19 pandemic has likely had a negative impact on the rate of childhood vaccinations in the state. They cite two reasons for their concerns: first, children missed well-care visits during the pandemic; and second, the national conversation around safety of the COVID-19 vaccine may also cause families to question the safety of other vaccines.

- One person interviewed suggested that Arkansas might see a measles outbreak as a result of children missing immunization milestones during the COVID-19 pandemic.

- Some schools have hosted "catch-up" immunization clinics since schools re-opened following the COVID-19 closings. Some have used school resource officers to go to students' homes to get permission forms signed.

> *"We have 12 counties where the Health Department is the only VFC provider in the county. If a child has Medicaid, they have to go to the Health Department for vaccines after already going to the physician for well care."*
>
> *Public Health Key Informant*

FOCUS GROUP FEEDBACK

- Some focus group participants believe that parents are often burdened with so many challenges—from food insecurity to paying the electric bill. This may cause them to not have a focus on well-care and, specifically, on immunizations.

- Parent participants in focus groups said that vaccine clinics in schools will help ensure that more children are immunized. Some said that they don't have transportation to get their children to the doctor or an immunization clinic.

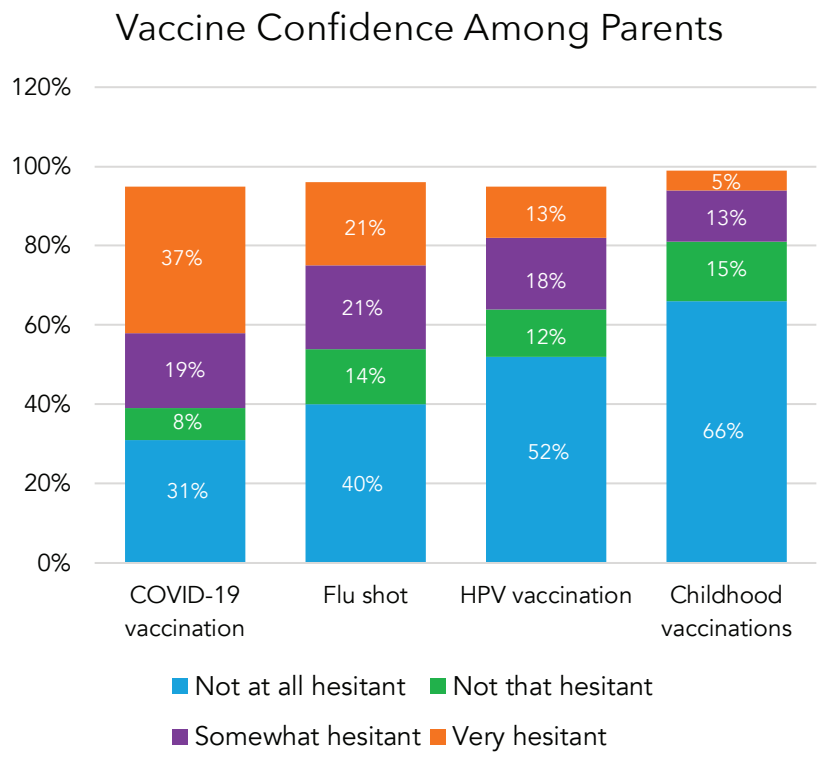
Primary Priorities: Immunizations

PARENT SURVEY RESULTS

- Northwest Arkansas parents surveyed as part of the CHNA process have confidence in childhood vaccinations, with 78% saying they were not hesitant to give their children the typical childhood vaccines. However, that hesitancy level increases for the HPV and flu vaccines, with the COVID-19 vaccine reflecting the highest hesitancy rate at 55%.

NORTHWEST ARKANSAS COMMUNITY HEALTH SURVEY

- Ninety percent of parent respondents said their children are up to date on immunizations, with an additional 5% saying they were not currently up to date, but they have plans to get their children immunized.



HEALTH DISPARITIES

In addition to identifying general children's health needs, it is critical to understand any impacts that occur only with certain populations of children. The process for identifying and measuring health disparities is included in the Findings section of this report.

According to the National Immunization Survey conducted by the CDC, Black non-Hispanic children have the lowest immunization rate at 58.1%. However, Hispanic children in Arkansas have the highest rate at 72.6%, followed by children of Other or Multiple races at 72.2%. Additionally, children living at less than 133% of the federal poverty line have the lowest immunization rate based on poverty rates at 62.7%, while 86.2% of children who are living at greater than 400% of the federal poverty line are immunized. [13]

Immunization Rates by County
Children Ages 19–35 months, 7 Series Vaccination Rate

Source: Arkansas Department of Health

RURAL DISPARITY		
County	**County**	**AR**
Franklin	52.4%	62.22%
Madison	62.6%	62.22%
Marion	52.76%	62.22%
Newton	58.97%	62.22%
Scott	57.32%	62.22%
RACIAL DISPARITY		
Benton	61.31%	62.22%
Crawford	53.15%	62.22%
Johnson	57.81%	62.22%
Sebastian	53.8%	62.22%
Washington	64.09	62.22%
ECONOMIC DISPARITY		
Franklin	52.4%	62.22%
Johnson	57.81%	62.22%
Marion	52.76%	62.22%
Newton	58.97%	62.22%
Scott	57.32%	62.22%

In examining 2022 immunization rates for children ages 19–35 months for Northwest Arkansas, disparities exist in each of the three types reviewed: rural, racial, and economic. Four of the five counties defined as rural have a lower rate of childhood immunization than the state rate of 62.22%. Additionally, four of the five counties with the highest non-White population have a lower rate than the state average. All five of the counties with the greatest poverty rates also have lower rates of immunization than the state rate of 62.2%.

The data for immunization rates at the county and state levels are provided by the Arkansas Department of Health.

Primary Priorities: Food Insecurity

OVERVIEW

Feeding America, the largest hunger-relief organization in the United States, defines food insecurity as a lack of consistent access to enough food for every person in a household to live an active, healthy life. [14] In many Arkansas families, food insecurity is multi-faceted and can encompass lack of resources, including access to fresh and healthy foods, or to a grocery store. While there are organizations all across Arkansas working to address food insecurity, the challenge often goes beyond just availability of food. Almost 18% of the population of Arkansas is facing food insecurity.

Food insecurity and hunger are not the same. For many families, food is available, but it may be processed, high in fats and carbohydrates, and lacking in nutritional value. [15] The healthier food choices are often more expensive, and require additional time to prepare and, have a limited shelf life, and are very difficult to source. SNAP, Supplemental Nutrition Assistance Program (formerly known as food stamps), is a federal program providing low-income Americans with assistance to feed themselves and their families. SNAP benefits are not intended to cover families' full monthly food cost. To ensure their families have enough food, many low-income families depend on local food pantries in addition to SNAP benefits.

Many families struggle not just with food insecurity, but also issues like affordable housing, medical costs, and poverty. Children in these families are faced with both the mental and physical impacts to their brains and bodies, which are still developing. Food insecurity in children is associated with anemia, asthma, depression and anxiety, cognitive and behavioral problems, and a higher risk of hospitalization. [16]

There is also an educational component to the issue of food insecurity that introduces families to key concepts such as how to shop and prepare nutritious meals, even when on a budget. Programs that address these components of hunger and food insecurity may positively impact the diet of food-insecure families who are receiving assistance but may not be maximizing healthier food options.

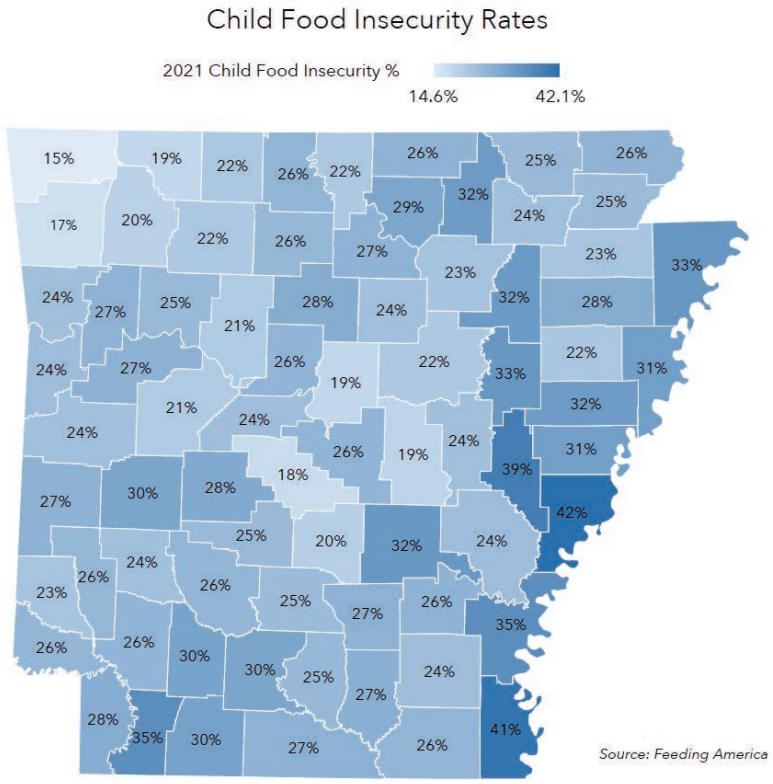
FOOD INSECURITY
AT A GLANCE

16.4%
PERCENTAGE OF NORTHWEST ARKANSAS'S POPULATION FACING FOOD INSECURITY

45,370
FOOD-INSECURE CHILDREN IN NORTHWEST ARKANSAS

50th
ARKANSAS'S RANK FOR POPULATION THAT IS FOOD-INSECURE

33%
ARKANSAS HOUSEHOLDS WITH CHILDREN WHO DO NOT GET ENOUGH TO EAT



The scoring process described in the Findings section of this report utilized key data points to determine priority order for each of the identified needs. The metrics utilized to prioritize Food Insecurity can be found in the Appendix.

Food Insecurity Rate by County in Northwest Arkansas

Source: Map the Meal Gap 2021

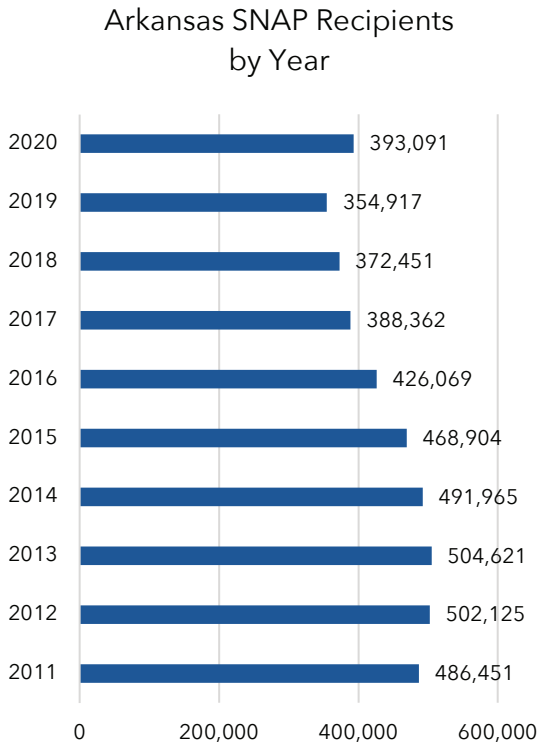
Baxter	17.4%	Madison	17.3%
Benton	13.1%	Marion	19.8%
Boone	17.3%	Newton	17.5%
Carroll	15.8%	Pope	18.1%
Crawford	17.9%	Scott	19.6%
Franklin	21.4%	Sebastian	19.3%
Johnson	20.3%	Washington	15.8%
Logan	19.9%		

INTERSECTING NEEDS

Food insecurity is closely related to a variety of health needs and concerns, particularly when families have difficulty accessing fresh, healthy foods.

Families may opt for unhealthy, processed foods because they are less expensive and more readily available. This has resulted in a clear link between food insecurity and obesity, which is explored in depth in another section of this report. According to the National Institute of Diabetes and Digestive and Kidney Diseases, "access to and ability to afford healthy foods and safe places to be active" are among the factors that contribute to excess weight gain in both children and adults. [17]

Additionally, families with low income or those living in poverty are much more likely to face food insecurity. That connection goes beyond a family's ability to afford food. It is also impacted by where they live, with many low-income neighborhoods, even in urban areas, not having a nearby full-service grocery store. These food deserts result in families purchasing what they can find in a convenience store or market. Those same neighborhoods may not have parks or playgrounds for children to be more active, which can also contribute to obesity. Even when a space is available for physical activity, it may not be considered safe for children.



SNAP, Supplemental Nutrition Assistance Program (formerly known as food stamps), provides assistance to low-income families. SNAP is a temporary, short-term solution for individuals and families, in most cases. According to the Arkansas Hunger Relief Alliance, on average, SNAP participants stay on the program less than a year. SNAP benefits are delivered monthly to eligible participants through electronic debit (EBT) cards that can be used to purchase groceries. Most grocery stores in Arkansas accept SNAP. The SNAP program is funded through the United States Department of Agriculture and is administered in Arkansas through the Arkansas Department of Human Services.

SECONDARY QUANTITATIVE DATA

Significant secondary data were identified and considered in determining whether Food Insecurity should be considered as a child health need in this CHNA. Following are data points that support the inclusion of this child health need.

- In Northwest Arkansas, only Benton, Carroll, and Washington counties have a food insecurity rate lower than the state average of 17%.
- A total of 220,691 children in Arkansas received SNAP benefits in 2021, according to the Arkansas Department of Human Services 2021 Statistical Report. That represents almost 52% of the total 18-and-under population in the state.
- According to the *2022 State of WIC Report*, 60% of infants born in Arkansas participate in WIC—Women, Infants, and Children supplemental nutrition, a federal program which provides supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.
- Arkansas ranks 21st for households with children who did not eat enough because food was unaffordable, according to *2021 KIDS COUNT® Report*.
- Arkansas ranks 49th for food sufficiency among children, with 59.3% of children having access to sufficient food, compared to the national average of 69.8%, according to a United Health Foundation Health of Women and Children Report 2021.
- Feeding America reports that in 2021, 6.6% of Arkansas children experienced very low food security, which is a decrease from 7% in 2020.

Primary Priorities: Food Insecurity

STAKEHOLDER ENGAGEMENT

Multi-faceted stakeholder engagement provided a framework for identifying community priorities. Following is a summary of findings from stakeholder engagement related to Food Insecurity.

Food insecurity was a major topic of discussion in both focus groups and one-on-one interviews. Additionally, parents, both in focus groups and those who participated in the parent survey, indicated that food insecurity is a significant problem when addressing children's health in Arkansas.

KEY INFORMANT FEEDBACK

- More than 53% of key informants interviewed for the CHNA mentioned food and nutrition among the issues negatively impacting children's health in Arkansas. There were nearly 100 mentions of food and nutrition among focus group participants.
- One key informant said there are problems with access to healthy foods both in rural and in urban areas. Several stakeholders said many urban areas don't have a nearby full-service grocery.
- A key informant from Northwest Arkansas pointed out the difficulty for some families to access SNAP benefits, which would help food-insecure families access more nutritional foods.
- Another Northwest Arkansas key informant talked about a new resource opening in Springdale, which will have culturally diverse food boxes for families, including fresh produce and protein.

> *"SNAP helps us address food needs. But we also make it difficult for families to get SNAP benefits. Why not let kids get the nutrition they need without making it harder than it has to be?"*
>
> *Hunger Relief*
> *NWA Key Informant*

FOCUS GROUP FEEDBACK

- A medical provider in one of the focus groups pointed out two of the major barriers to healthier eating—the first being a need to teach parents more about nutrition, as well as how to prepare fresh foods. The second is that many people know how to eat better, but they can't afford the fresh ingredients to prepare healthy meals.
- Participants in Spanish-language focus groups expressed concern about a lack of places to shop for groceries as well as limited access to safe areas for outdoor activities. Some also believe that children need to be better educated about nutrition and that more food pantries aimed at providing culturally appropriate food choices for immigrants and diverse communities would be helpful.

- A medical provider who participated in a focus group said that it's a struggle to help feed a family and set them up for success, because they know what the healthy foods are, but they can't afford them. Instead, families purchase frozen foods and fast food because it is less expensive.

- In a community leader focus group, participants discussed the cost of eating healthy and accessing food. They said access to quality nutrition is an on-going issue, which is impacted by food deserts with nothing but small general merchandise stores, liquor stores, and convenience stores for grocery shopping in a neighborhood. To make matters worse, transportation is often a challenge for families, so traveling further to get to a better food source may be difficult.

> *For the most part, kids in Arkansas, while not underfed, are lacking the nutritious foods necessary to develop to the best of their abilities.*
>
> *NWA Key Informant*

PARENT SURVEY RESULTS

- Almost a quarter of Northwest Arkansas parents who responded to the Arkansas Children's CHNA parent survey say that food insecurity is one of the top five problems impacting children's health in their community.

- Forty-one percent of surveyed Northwest Arkansas parents said the nutritional quality and healthiness of food served in their children's school cafeteria is excellent or very good, which was slightly below the statewide percentage of 45%.

HEALTH DISPARITIES

In addition to identifying general children's health needs, it is critical to understand any impacts that occur only with certain populations of children. The process for identifying and measuring health disparities is included in the Findings section of this report.

According to America's Health Rankings, funded by United Healthcare, the prevalence of food insecurity is more than two times greater in non-Hispanic Black and Hispanic households than in non-Hispanic White households. Additionally, the same data show that lower-income households (those below 185% of the poverty threshold) have a higher rate of food insecurity than higher-income households experience. [18]

Disparities in Food Insecurity in Northwest Arkansas

Source: Map the Meal Gap 2021, Feeding America

RURAL DISPARITY		
County	**County Rate**	**NWA Rate**
Newton	17.5%	16.4%
Scott	19.6%	16.4%
Madison	17.3%	16.4%
Marion	19.8%	16.4%
Franklin	21.4%	16.4%
RACIAL DISPARITY		
Benton	13.1%	16.4%
Crawford	17.9%	16.4%
Johnson	20.3%	16.4%
Sebastian	19.3%	16.4%
Washington	15.8%	16.4%
ECONOMIC DISPARITY		
Franklin	21.4%	16.4%
Johnson	20.3%	16.4%
Marion	19.8%	16.4%
Newton	17.5%	16.4%
Scott	19.6%	16.4%

In examining data specific to Northwest Arkansas, disparities exist related to all three areas of concern: rural, racial, and economic. All five counties defined as rural have a higher rate of food insecurity than the 15-county region. Three of the five counties with the highest non-White population have a higher rate than the regional average. All five counties with the greatest poverty rates also have higher food insecurity rates than the regional rate of 16.4%.

The data for county and regional food insecurity rates is from Map the Meal Gap 2021, by Feeding America.

Secondary Priorities for the 2022 Arkansas Children's Northwest Community Health Needs Assessment

Secondary Priorities

- Infant Health
- Child Abuse & Neglect
- Access to Care

Secondary Priorities: Infant Health

OVERVIEW

There are countless ways to assess the overall health needs of children from birth through their teen years. Pediatric providers understand the importance of the first 2,100 days of a child's life—when their brains are rapidly developing and the services provided have maximum impact on the developing child. Getting a healthy start in life is crucial to children having a bright future. This need considers measures of health related to pregnancy and birth to ensure Arkansas is doing everything possible for children to have a healthy start in life.

Infant mortality is defined as the number of babies who die before they reach their first birthday. Arkansas's infant mortality rate has fluctuated between 6.9 infant deaths per 1,000 live births and 7.9 infant deaths per 1,000 live births since 2008, with the most recent rate at 7.7 infant deaths per 1,000 live births. The Northwest Arkansas infant mortality rate is 5.4 infant deaths per 1,000 live births. High infant mortality may indicate that other health problems exist in the community. Arkansas reduction activities include maternity and family planning clinics; newborn screening; home visiting services; and educating families on safe sleep. [19]

INFANT HEALTH AT A GLANCE

5.4/1,000
INFANT DEATHS PER LIVE BIRTHS

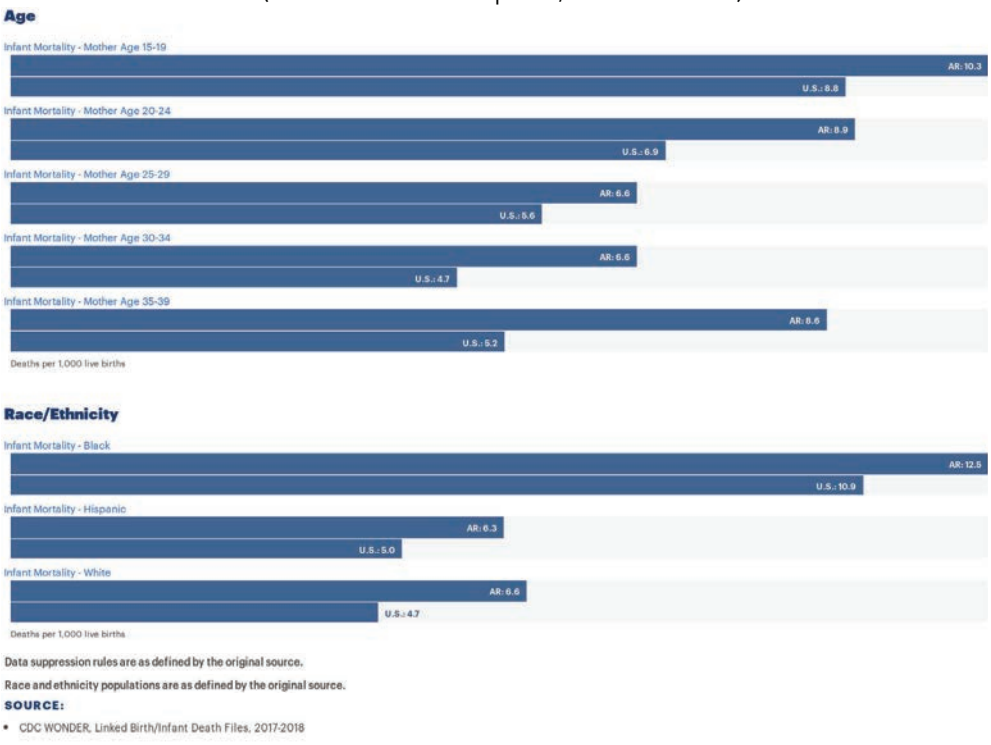
7.6%
NORTHWEST ARKANSAS'S PERCENTAGE OF LOW BIRTHWEIGHT BABIES

50th
ARKANSAS'S RANK FOR NUMBER OF TEEN BIRTHS

38.6/1,000
NUMBER OF BIRTHS PER 1,000 TEEN GIRLS IN NORTHWEST ARKANSAS ANNUALLY

18%
TEEN BIRTHS TO WOMEN WHO ARE ALREADY MOTHERS

Many health disparities exist with infant mortality due to societal factors and social determinants likely beyond the control of the mother. The graph below shows the racial disparity that exists for Black mothers who experience a higher infant mortality rate at 12.5 infant deaths per 1,000 live births. The infant mortality rate for Black mothers in Arkansas also exceeds the national rate for Black mothers (10.9 infant deaths per 1,000 live births). Additionally, when comparing infant mortality rates by the age of the mother, the highest rate occurs for mothers age 15–19 at 10.3 infant deaths per 1,000 live births. The second highest rate is for mothers age 35–39 at 8.6 infant deaths per 1,000 live births. These data show the interconnection of infant mortality and teen births.



Although Arkansas ranks 50th in the nation for teen births per 1,000, the state has made significant progress over the last decade. The *2021 KIDS COUNT® Report* shows 30 teen births per 1,000, compared to 50 per 1,000 in 2011. The Northwest Arkansas rate is 38.6 teen births per 1,000. The ranking for Arkansas did not improve

during that time because other states decreased teen births at higher rates. The US rate of teen births dropped from 26 per 1,000 to 17 per 1,000 during the same period.

The scoring process described in the Findings section of this report used key data points to determine priority order for each of the identified needs. The metrics used to prioritize Infant Health can be found in the Appendix.

Secondary Priorities: Infant Health

INTERSECTING NEEDS

Challenges associated with infant health are often the result of teen births, low birthweight, lack of prenatal care, and maternal health complications. The most critical outcome is infant mortality, or the death of a child before his or her first birthday.

Top Five Causes of Infant Deaths [20]

- Birth defects
- Pre-term birth & low birthweight
- Sudden unexpected infant death (SUID)
- Maternal complications of pregnancy
- Unintentional injuries

Teen pregnancy results in children who are more likely to be at risk for low birthweight and infant mortality, in addition to being at risk for less cognitive stimulation and being less prepared for school. This often leads to lower school achievement. They may also have behavioral problems and chronic medical conditions, in addition to becoming a teen mother. [21]

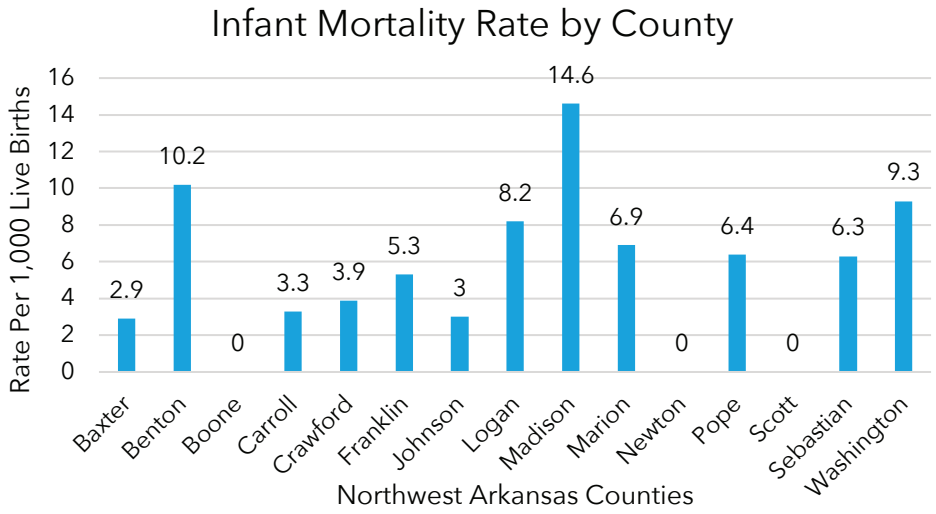
Northwest Arkansas also has a higher percentage of repeat teen births, which usually occur among teens aged 18–19 years. Infants born from a repeat teen birth are often born too small or too soon, which can lead to more health problems for the baby. In addition, teen mothers often have pregnancy complications at a much higher rate than older women. Complications include the following: [22]

- Three times more likely to develop anemia and deliver preterm
- Two times more likely to develop hypertensive problems
- Infant mortality is higher in infants born to teen mothers
- Greater frequency of low maternal weight gain, anemia, and sexually transmitted diseases

SECONDARY QUANTITATIVE DATA

Significant secondary data were identified and considered in determining whether Infant Health should be considered as a child health need in this CHNA. Following are data points that support the inclusion of this child health need.

- The state ranks 50th in number of teen births per 1,000, according to the *2021 KIDS COUNT® Report,* with 30 teen births per 1,000, compared to just 17 per 1,000 nationally. Northwest Arkansas has 38.6/1,000 teen births annually.



Source: *2021 KIDS COUNT® Report*

- Arkansas's infant mortality rank is 38th in the country, with a rate of 6.9%, compared to 5.6% at the national level.
- 17% of infant deaths result from pre-term birth or low birthweight. [23]
- 63% of teen mothers receive some type of public benefits within the first year after their children are born.
- Only about 50% of teen mothers receive a high school education by age 22, while nearly 90% of women who have not given birth as a teen have received a high school diploma.
- At least one-third of parenting adolescents (both males and females) are themselves the products of adolescent pregnancy.
- Birthweight is also an important indicator of future health. For this metric, Arkansas ranks 42nd, with 12.6% of babies born at a birthweight lower than 5.5 pounds. This compares to 11.7% of births in the US.

Secondary Priorities: Infant Health

STAKEHOLDER ENGAGEMENT

Multi-faceted stakeholder engagement provided a framework for identifying community priorities. Following is a summary of findings from stakeholder engagement related to Infant Health.

Infant health was not discussed significantly by stakeholders (surveys, focus groups, key informants), but data demonstrate the importance of addressing this children's health need.

KEY INFORMANT FEEDBACK

- Many of the key informants interviewed believe early intervention is key to addressing prenatal care, infant mortality, and a healthy start to a baby's life, with several suggesting expansion of home visit programs.
- One key informant also mentioned the strong link between teen pregnancy and poverty, which also affects access to care. Another interviewee expanded on the access-to-care issue by saying that Arkansas has a very high occurrence of women who receive little or no prenatal care, saying that health deserts in the state have little or no maternal and child healthcare.
- Other key informants discussed the lack of reproductive health education in Arkansas schools and believe that would help decrease the frequency of teen pregnancy in the state.

> *"For child/maternal health, 36 counties in Arkansas are considered health deserts. So, you ultimately have populations in our state that are receiving no healthcare. Arkansas is third in the US for pregnancies that had little to no prenatal care."*
>
> *Parent Focus Group Participant*

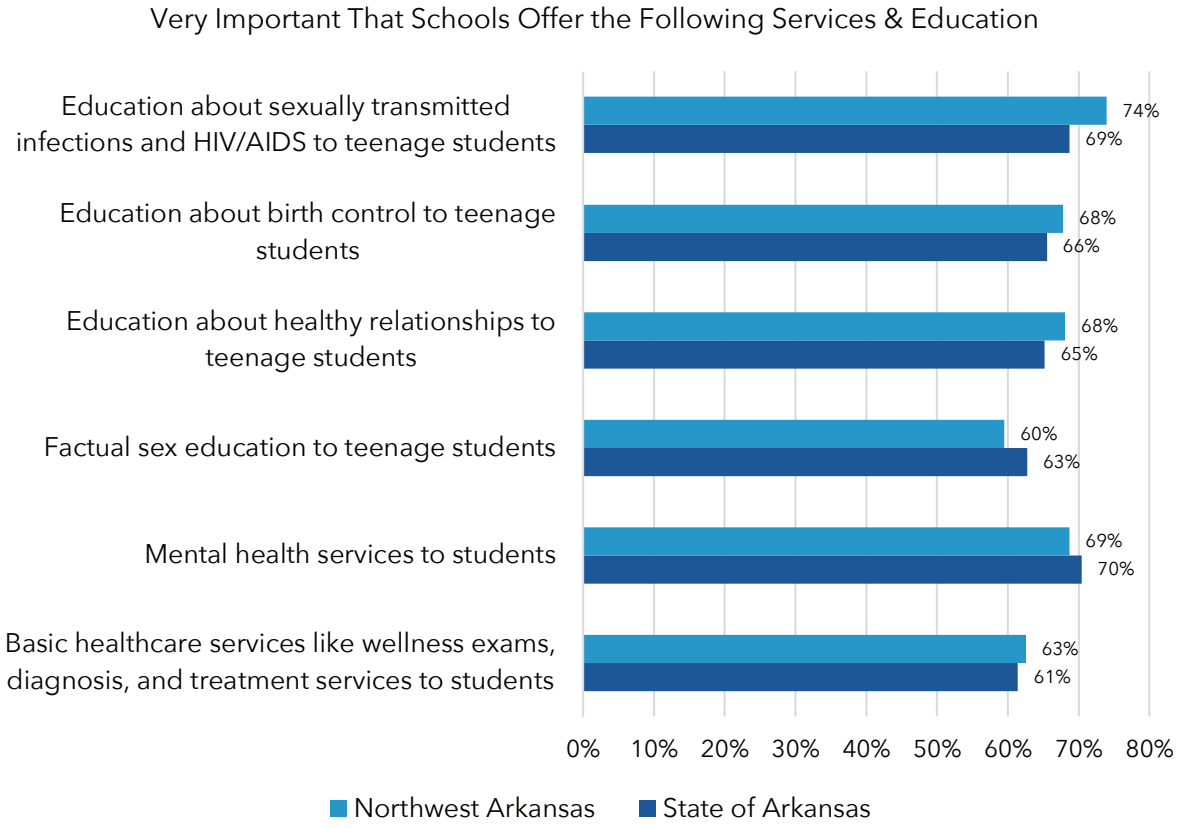
FOCUS GROUP FEEDBACK

- Focus group participants discussed the need for improved prenatal care for teens, believing this would help decrease infant mortality and low birthweights.
- Some educators pointed to teen pregnancy rates and lack of prenatal care as one thing preventing Arkansas children from living a healthy life.

PARENT SURVEY RESULTS

- Parents surveyed as part of the Arkansas Children's 2022 CHNA process indicated they are very interested in schools providing factual reproductive health education, including information about sexually transmitted infections, birth control, and healthy relationships, to their children. Parents surveyed also indicated support of mental health services and basic wellness and diagnostic services being offered at school.

- Forty-two percent of parents participating in the CHNA parent survey viewed the number of infants who die unexpectedly before their first birthday as a serious children's health problem.



HEALTH DISPARITIES

In addition to identifying general children's health needs, it is critical to understand any impacts that occur only with certain populations of children. The process for identifying and measuring health disparities is included in the Findings section of this report.

According to the *2021 KIDS COUNT® Report*, Black teens had the highest rate of teen births at 45 per 1,000 in 2019, while Hispanic or Latino teens had a teen birth rate of 34 per 1,000 in the same year. Asian/Pacific Islander teens also had a rate of 34 per 1,000 in 2019. However, in 2016 to 2018, Hispanic or Latino girls had a rate that was significantly higher than the Asian/Pacific Islander rate. Likewise, births to Black mothers have a higher infant mortality rate than any other race, followed by Hispanic or Latino births.

In examining regional infant mortality data, disparities information is limited. Two of the five counties defined as rural have a higher rate of infant mortality than the state. None of the five counties with the highest non-White population have a higher rate than the state average. One of the five counties with the greatest poverty rates also has higher rates of infant mortality than the state rate of 7.6 infant deaths per 1,000 live births.

Infant Health

Source: Aspire Arkansas & County Health Rankings 2021

	Infant Mortality		Teen Births	
County	**County**	**NWA**	**County**	**NWA**
RURAL DISPARITY				
Newton	5.2	7.6/1,000	42	36/1,000
Scott	4.9	7.6/1,000	51	36/1,000
Madison	10.8	7.6/1,000	49	36/1,000
Marion	7.7	7.6/1,000	43	36/1,000
Franklin	7.3	7.6/1,000	35	36/1,000
RACIAL DISPARITY				
Benton	6.6	7.6/1,000	26	36/1,000
Crawford	5.5	7.6/1,000	39	36/1,000
Johnson	5.7	7.6/1,000	38	36/1,000
Sebastian	6.8	7.6/1,000	38	36/1,000
Washington	7	7.6/1,000	26	36/1,000
ECONOMIC DISPARITY				
Franklin	7.3	7.6/1,000	35	36/1,000
Johnson	5.7	7.6/1,000	38	36/1,000
Marion	7.7	7.6/1,000	43	36/1,000
Newton	5.2	7.6/1,000	42	36/1,000
Scott	4.9	7.6/1,000	51	36/1,000

For teen births, disparities exist related to all three areas of concern: rural, racial, and economic. Four of five counties defined as rural have a higher rate of teen births than the state. Three of five counties have a higher rate than the state average. Four of five counties with the greatest poverty rates also have higher rates of teen births than the state rate of 36/1,000.

The data for infant mortality at the county and state levels is provided by Aspire Arkansas, while county and state teen pregnancy data are from County Health Rankings 2021.

Secondary Priorities: Child Abuse & Neglect

OVERVIEW

Arkansas ranks poorly by most measures of childhood abuse and neglect. The annual Child Maltreatment report series, sourced from the National Child Abuse and Neglect Data System (NCANDS) managed by the Department of Health and Human Services, provides comprehensive reporting on child maltreatment for the nation. Each state has its own definitions of Child Abuse & Neglect based on standards set by federal law. At a minimum, Child Abuse & Neglect is defined as: "*Any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act, which presents an imminent risk of serious harm.*" (Child Maltreatment 2020, ix)
Data about abuse and neglect is limited to what is reported, which affects addressing the problem and prevention efforts. In 2020, the Arkansas Department of Human Services, Division of Children and Family Services (DCFS), received more than 31,000 reports of child maltreatment through the Arkansas Child Abuse Hotline. The map titled "Child Abuse Hotline Calls Per 1,000 Population 0–18" shows the rate of hotline calls compared with child population. The graphic titled "Volume and Description of Child Maltreatment Reports" describes the process to investigate potential child abuse from the initial report to the determination.

CHILD ABUSE & NEGLECT AT A GLANCE

1,885
TOTAL SUBSTANTIATED REPORTS OF CHILD MALTREATMENT IN NORTHWEST ARKANSAS

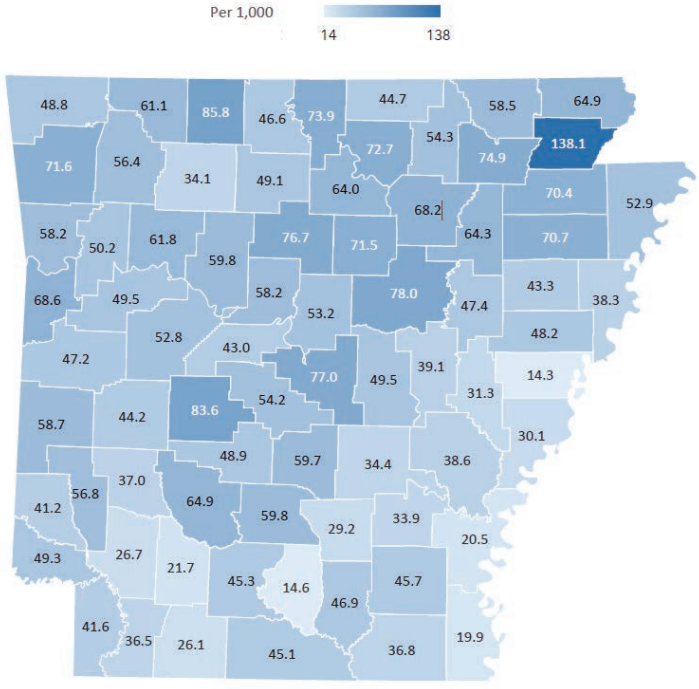
12/1,000
ARKANSAS CHILDREN WHO ARE CONFIRMED VICTIMS OF MALTREATMENT

47th
ARKANSAS'S RANK FOR CHILDREN SUBJECT TO INVESTIGATIVE REPORT

4,391
ARKANSAS CHILDREN IN FOSTER CARE IN 2020

37
ARKANSAS VICTIMS OF CHILD ABUSE WHO DIED IN 2020

Child Abuse Hotline Calls Per 1,000 Population 0-18



Investigations by DCFS determined that 22% of those reports were substantiated, the determination given after the research and review process. There were more than 9,000 children involved in those substantiated reports. Northwest Arkansas had 1,885 substantiated reports of maltreatment, with Madison County having the highest rate at 13.4/1,000. [24]

Many victims of Child Abuse & Neglect are placed in foster care following a substantiated determination of maltreatment against someone in the home. Neglect is the top reason for Arkansas children to be placed in foster care, and physical abuse the fourth most common reason. Experts in-state and nationwide are concerned about the lack of reporting during the COVID-19 pandemic, when schools and daycares were closed, and children had less time around mandatory reporters.

The information included in this section includes the best available data about Child Abuse & Neglect in Arkansas. According to in-state child abuse-prevention experts, Child Abuse & Neglect goes unreported in areas of the state. This occurs because of many reasons, including cultural perceptions of what qualifies as child abuse, and other concerns that prevent some types of abuse and maltreatment from being reported. This lack of reporting

affects the ability to make regional comparisons, as well as decreases the ability to have robust, population-level data about Child Abuse & Neglect in different counties throughout Arkansas.

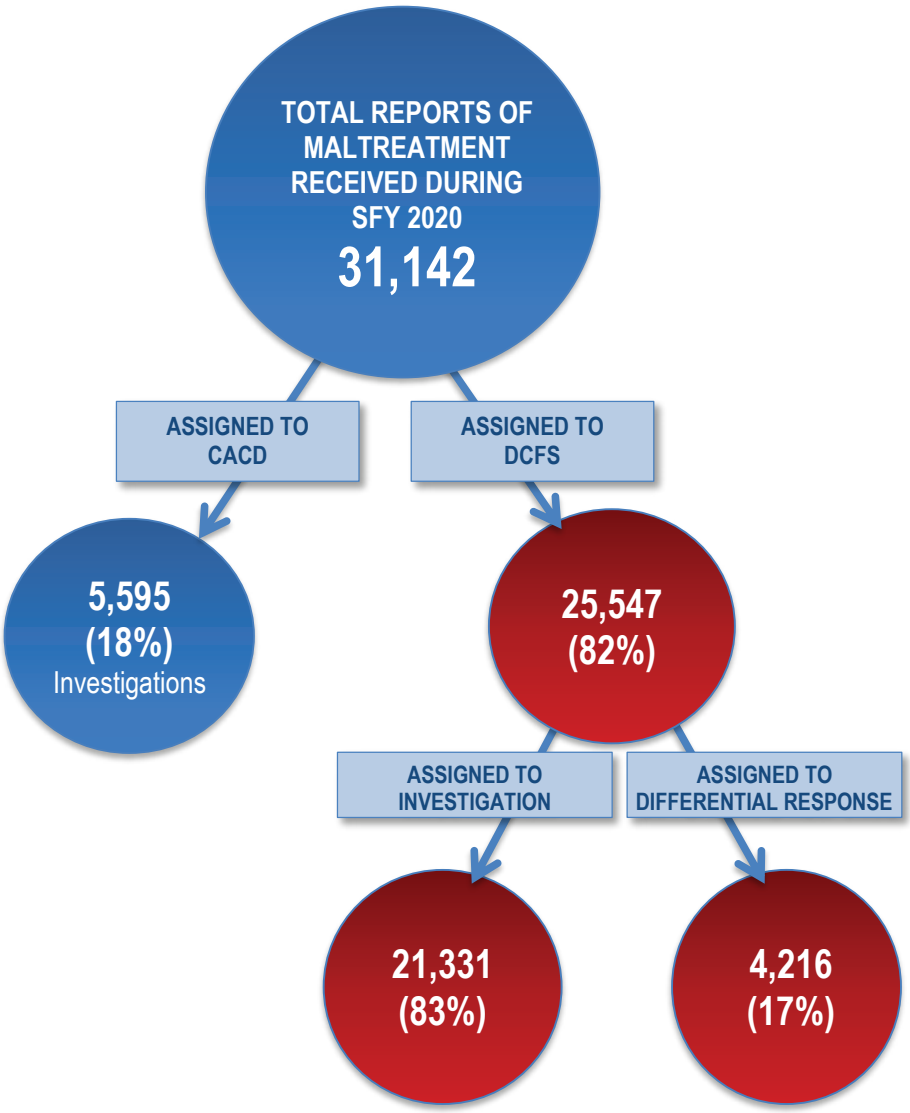
The scoring process described in the Findings section of this report used key data points to determine priority order for each of the identified needs. The metrics used to prioritize Child Abuse & Neglect can be found in the Appendix.

Volume and Description of Child Maltreatment Reports

Arkansas Division of Children and Family Services (DCFS)
State Fiscal Year 2020 (July 1, 2019 – June 30, 2020)

Volume of Incoming Reports

Maltreatment Reports Received During SFY 2020



Of the 31,142 reports of child maltreatment accepted by the Arkansas Child Abuse Hotline during State Fiscal Year (SFY) 2020, 82 percent were assigned to DCFS and 18 percent were assigned to the Crimes Against Children Division (CACD) of the Arkansas State Police, which is responsible for investigating the most serious allegations of maltreatment.

Of the reports assigned to DCFS, 83 percent were assigned for an investigation and 17 percent were handled through Differential Response (DR).

DR allows the Division to respond to specific, low-risk maltreatment reports through a family assessment and provision of services rather than a traditional investigation.

The following types of allegations can qualify for DR:

- Inadequate Supervision if children are at least five
- Environmental Neglect if children are at least three
- Medical Neglect if children are at least thirteen
- Lock Out if children are at least ten
- Inadequate Food, Inadequate Shelter, Inadequate Clothing, and Educational Neglect with no age restrictions
- Certain allegations of abuse where the incident occurred at least one year prior to the report date

Arkansas Division of Children and Family Services

Sourced from: "Annual Report Card for Arkansas, State Fiscal Year (SFY) 2020 (July 1, 2019–June 30, 2020)"

- Produced for the Arkansas Department of Health and Human Services by NCCD Children's Research Center

INTERSECTING NEEDS

Child Abuse & Neglect is closely connected to other children's health needs. Some victims of abuse suffer from immediate physical injuries, but their reactions may have lifelong or intergenerational impacts, including physical, psychological, and behavioral effects.

Abuse or neglect may impact physical development of a child's brain, which later leads to psychological problems, including low self-esteem and high-risk behaviors like substance abuse. A 2019 report by the Child Welfare Information Gateway indicates that children who are victims of child abuse may also be affected by other adverse childhood experiences (ACEs), such as parental substance abuse, domestic violence, and poverty.

Physical abuse also may result in long-term physical health consequences, with victims at a higher risk for future health problems. These problems may range from malnutrition to diabetes and vision and oral health issues. [25]

Some children also suffer psychological consequences that result in educational difficulties, depression, and low self-esteem. They may also have diminished cognitive skills, attachment and social difficulties, and post-traumatic stress. All of these issues put an additional burden on the already inadequate behavioral and mental health system.

Parental drug use and child neglect also are common co-occurring conditions within families. Children who grow up in a home with parents who are addicted to drugs or alcohol are three times more likely to suffer physical, sexual, and emotional abuse. This abuse may come from a parent or from exposure to others who abuse them. [26]

Arkansas Mandatory Reporters

- Child care or foster care workers
- Coroner
- Daycare center worker
- Dentist
- Dental hygienist
- Domestic abuse advocate
- Domestic violence shelter employee or volunteer
- Department of human services employee
- Contract workers for division of youth services of department of human services
- Foster parent
- Judge
- Law enforcement official
- Licensed nurse
- Medical personnel
- Mental health professional
- Osteopath
- Peace officer
- Physician
- Prosecuting attorney
- Resident intern
- School counselor
- School official
- Social worker
- Surgeon
- Teacher
- Court-appointed special advocate program staff or volunteer
- Juvenile intake or probation officer
- Clergy member
- Child advocacy center or child safety center employee
- Attorney ad litem
- Sexual abuse advocate or volunteer
- Rape crisis advocate or volunteer
- Child abuse advocate or volunteer
- Victim/witness coordinator
- Victim assistance professional or volunteer
- Employee of crimes against children division of the Arkansas State Police
- Employee or volunteer of reproductive healthcare facility

While placement in foster care is necessary at times to protect children who have been neglected or abused, the Arkansas Department of Human Services Division of Children and Family Services is continuing to develop and fund family- and parent-strengthening services such as home visiting and positive parenting instruction. These interventions work with the family and the child(ren) to keep them safe, while helping parents and caregivers learn additional skills for caring for their children.

Secondary Priorities: Child Abuse & Neglect

SECONDARY QUANTITATIVE DATA

Significant secondary data were identified and considered in determining whether Child Abuse & Neglect should be considered as a child health need in this CHNA. Following are data points that support the inclusion of this child health need.

- Northwest Arkansas had a total of 1,885 substantiated reports of child maltreatment in 2018.
- Madison County had the highest rate of substantiated reports of maltreatment per 1,000 children in Northwest Arkansas at 13.4. Benton County had the lowest rate in the region at 4.6/1,000.
- The state ranks 34th in number of children who are confirmed victims of maltreatment, according to the *2021 KIDS COUNT® Report*. Twelve out of every 1,000 Arkansas children experience maltreatment, which is higher than the national rate of nine in every 1,000 children.
- The *2021 KIDS COUNT® Report* ranks Arkansas at 47th for children subject to investigative reporting, with the state rate being 78 out of every 1,000 children, which is much higher than the US rate of 47 in every 1,000 children.
- The number of children in foster care has declined from 5,113 in 2017 to 4,391 in 2020. The Arkansas Department of Human Services is deploying a variety of interventions with families where abuse or neglect may have occurred in an effort to keep more children in their homes safely.

Substantiated Reports of Child Maltreatment

Source: Arkansas Department of Human Services & Aspire Arkansas

County	Rate Per 1,000 Children
Baxter	10.9
Benton	4.6
Boone	16.1
Carroll	9.6
Crawford	8.3
Franklin	10.4
Johnson	5
Logan	9.8
Madison	13.4
Marion	11.4
Newton	9.4
Pope	7.8
Scott	8.8
Sebastian	8.4
Washington	5.7

STAKEHOLDER ENGAGEMENT

Multi-faceted stakeholder engagement provided a framework for identifying community priorities. Following is a summary of findings from stakeholder engagement related to Child Abuse & Neglect.

KEY INFORMANT FEEDBACK

- Some key informants expressed concern that prevention programs are needed to break a cycle of abuse. Additionally, some believe that abused children are more likely to grow up to abuse their own children.
- Stress on families resulting from the COVID-19 pandemic may result in a higher rate of child abuse. Some key informants are concerned that child abuse may have occurred but gone unreported while schools were closed during the pandemic, with children being isolated with family or other caregivers and not around mandated reporters.
- One key informant mentioned the high incidence of adverse childhood experiences (ACEs) in Arkansas and the need for intervention with families that have suffered a high level of ACEs to prevent further abuse.

> *"I worry about child abuse during COVID. There is evidence that maltreatment is happening in homes that will never be reported by school officials because kids are not in school. That contributes to the cycle because there is not intervention when that needs to happen."*
>
> *Attorney*
> *NWA Key Informant*

FOCUS GROUP FEEDBACK

- In an instant poll, almost 30% of focus group participants identified abuse (either child or domestic) as their greatest concern when thinking about children's health in the state of Arkansas.
- Abuse (either child or domestic) tied for the leading concern along with Access to Care. There were more than 50 mentions of abuse among focus group participants.
- When asked what resource/service is the most important to children's health, addressing abuse (either child or domestic) was the second most-identified important resource/service among focus group participants.

PARENT SURVEY RESULTS

- When asked about the top five health problems facing their communities, 44% of NWA parents identified bullying as one of their top five concerns and was identified as the number one issue by 8% of parents.

- In the same NWA parent survey, issues of Child Abuse & Neglect account for three of the top six issues identified: bullying (44%), poor parenting (35%), child abuse (27%).

HEALTH DISPARITIES

In addition to identifying general children's health needs, it is critical to understand any impacts that occur only with certain populations of children. The process for identifying and measuring health disparities is included in the Findings section of this report.

According to the Arkansas Department of Human Services, Division of Children and Family Services *2020 Annual Report Card*, 65% of children who are involved in verified reports of maltreatment are White, while 18% are Black, and 7% are Hispanic. [27]

In examining regional data, there is no evidence of disparities related to rural, racial, or economic factors. One of five counties defined as rural has a higher rate of child maltreatment than the state. None of the five counties with the highest non-White population has a higher rate than the state average. None of the counties with the greatest poverty rates have higher rates of child maltreatment than the state rate of 12.3/1,000.

Substantiated Reports of Child Maltreatment

Source: Aspire Arkansas

RURAL DISPARITY County	County Rate	NWA Rate
Newton	9.4	12.3/1,000
Scott	8.8	12.3/1,000
Madison	13.4	12.3/1,000
Marion	11.4	12.3/1,000
Franklin	10.4	12.3/1,000
RACIAL DISPARITY		
Benton	4.6	12.3/1,000
Crawford	8.3	12.3/1,000
Johnson	5	12.3/1,000
Sebastian	8.4	12.3/1,000
Washington	5.7	12.3/1,000
ECONOMIC DISPARITY		
Franklin	10.4	12.3/1,000
Johnson	5	12.3/1,000
Marion	11.4	12.3/1,000
Newton	9.4	12.3/1,000
Scott	8.8	12.3/1,000

The data for substantiated reports of child maltreatment at the county and state levels are provided by Aspire Arkansas.

Secondary Priorities: Access to Care

OVERVIEW

Access to Care was a child health need mentioned by virtually every stakeholder participating in the process. This is a broad category and has been explored from a general perspective, in addition to two specific needs categories: Telehealth and Oral Health.

Telehealth has been in use for a number of years, but this method of delivering medical care has taken on increased significance and exposure during the COVID-19 pandemic. In fact, federal waivers were issued to enhance insurance coverage for telehealth during the pandemic. [28] Despite increased use, availability and affordability of the technologies needed for telehealth delivery are still severely lacking in areas of Arkansas that perhaps have the greatest access challenges due to rural locations and a lower-income population. [29]

Oral health and dental care have been an ongoing need for Arkansas children for several years. While improvements have been made, it is clear that more can be done. Some key informants were concerned that many children have not received preventive dental care in the last two years, in part due to fears related to COVID-19. Additionally, Arkansas continues to face long-term challenges of a lack of dentists in the state, with even fewer providers available to families insured through Medicaid.

The scoring process described in the Findings section of this report used key data points to determine priority order for each of the identified needs. The metrics used to prioritize Access to Car topics of Oral Health and Telehealth can be found in the Appendix.

ACCESS TO CARE AT A GLANCE

41st

ARKANSAS'S RANK FOR CHILDREN RECEIVING CARE IN A WELL-FUNCTIONING SYSTEM

6%

ARKANSAS CHILDREN WITHOUT HEALTH INSURANCE

50th

ARKANSAS'S BROADBAND ECOSYSTEM, INCLUDING SPEED AND LOW-COST ACCESS

6

NORTHWEST ARKANSAS COUNTIES WITH LOWER BROADBAND COVERAGE THAN THE STATE AVERAGE

9

NORTHWEST ARKANSAS COUNTIES HAVE A SHORTAGE OF DENTISTS (DENTAL HPSA)

48th

ARKANSAS'S RANK FOR CHILDREN WITH TEETH IN VERY GOOD OR EXCELLENT CONDITION

INTERSECTING NEEDS

There are many factors that impact access to healthcare services that overlap with other CHNA needs areas, including availability of insurance, poverty, transportation, and access to specialty care when needed. The impacts of a lack of access are broad, with potential impacts on physical health, mental health, oral health, and cognitive development. Many of these issues are explored in greater depth in other identified needs areas of this report.

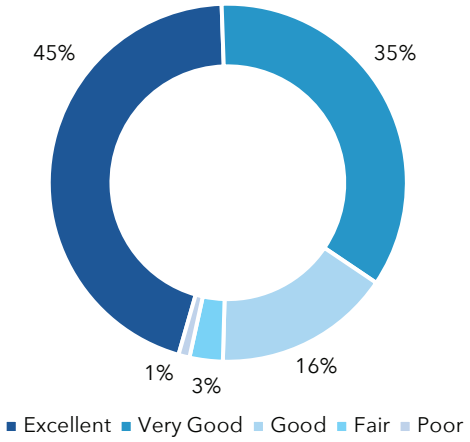
Access to care is a critical component of clinical care, with a focus on access to timely and regular health services. It also includes availability of health insurance and access to specialty healthcare providers. The highest-quality and most efficient way to ensure access to care is through medical home care—patient-centered, accessible care—managed by a primary care physician.

The American Academy of Pediatrics has identified the qualities important in effective medical home relationships:

- Accessible
- Family-centered
- Continuous
- Comprehensive
- Coordinated
- Compassionate
- Culturally effective

Having a medical home not only ensures high-quality primary care for children, but additionally, ensures children who need specialty referrals or care coordination will get the attention needed. [30] Based on responses to the National Survey of Children's Health, approximately 324,000 children receive comprehensive care within a medical home. [31]

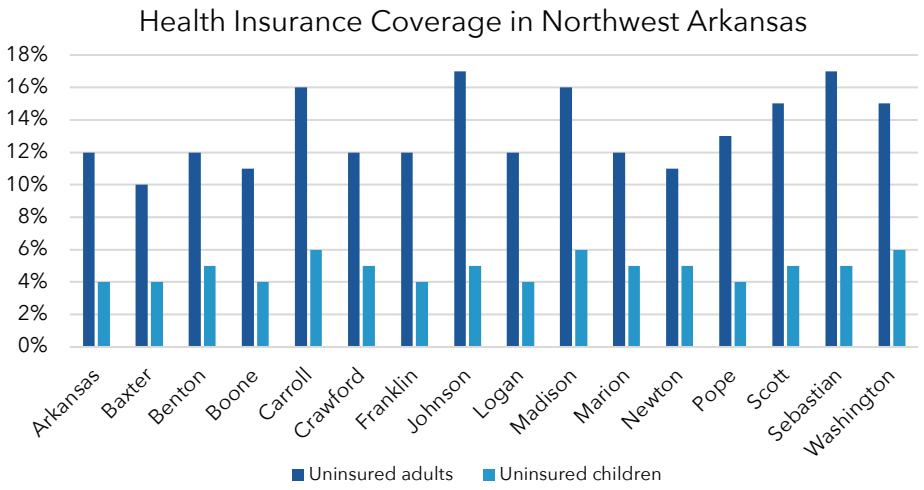
Quality of Healthcare Children Receive from Primary Care Provider



SECONDARY QUANTITATIVE DATA

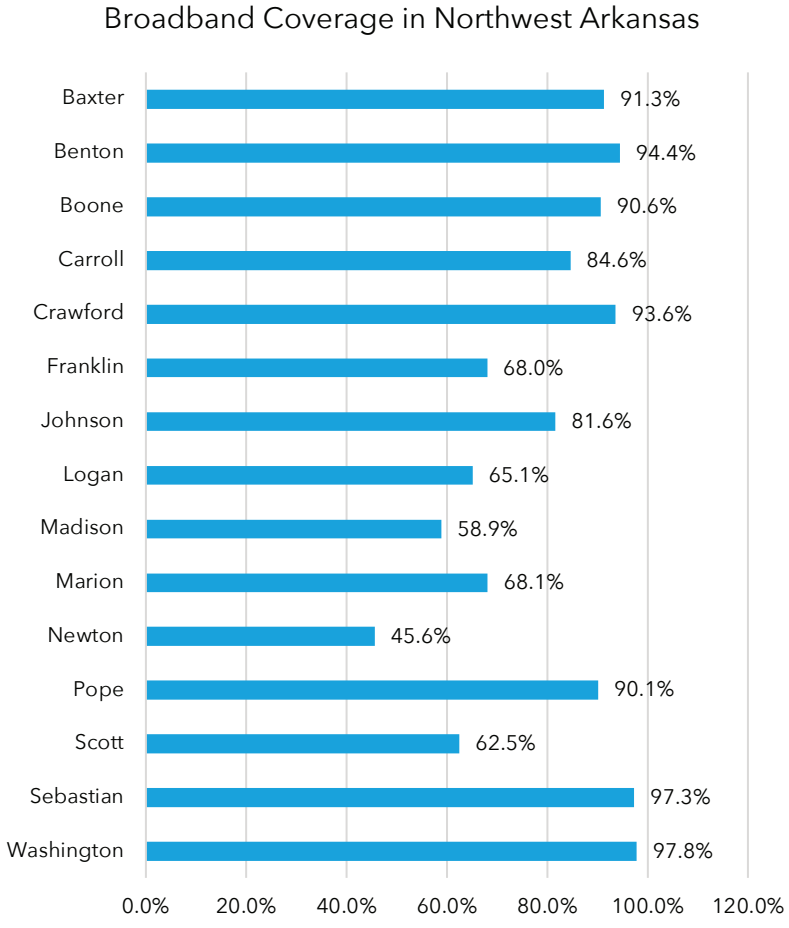
Significant secondary data were identified and considered in determining whether Access to Care, including Oral Health and Telehealth, should be considered child health needs in this CHNA. Following are data points that support the inclusion of these child health needs.

- Arkansas has been a leader in providing health insurance for children through the ARKids First health insurance program and ranks 31st in the nation for children without health insurance.



- The state's rural geography makes it challenging to find specialist care when needed. While Arkansas ranks 32nd nationally, only 22.4% of respondents to the National Survey of Children's Health indicated it is difficult or very difficult to access specialty care.

- The National Survey of Children's Health also evaluates whether children receive care in a well-functioning healthcare system. Arkansas ranks 41st, with 17.3% of children receiving care through a system that provides children with a medical home; access to medical and dental care; available insurance; no unmet needs; and teens prepared to transition to adult healthcare. This compares to 18.1% of children in the US.

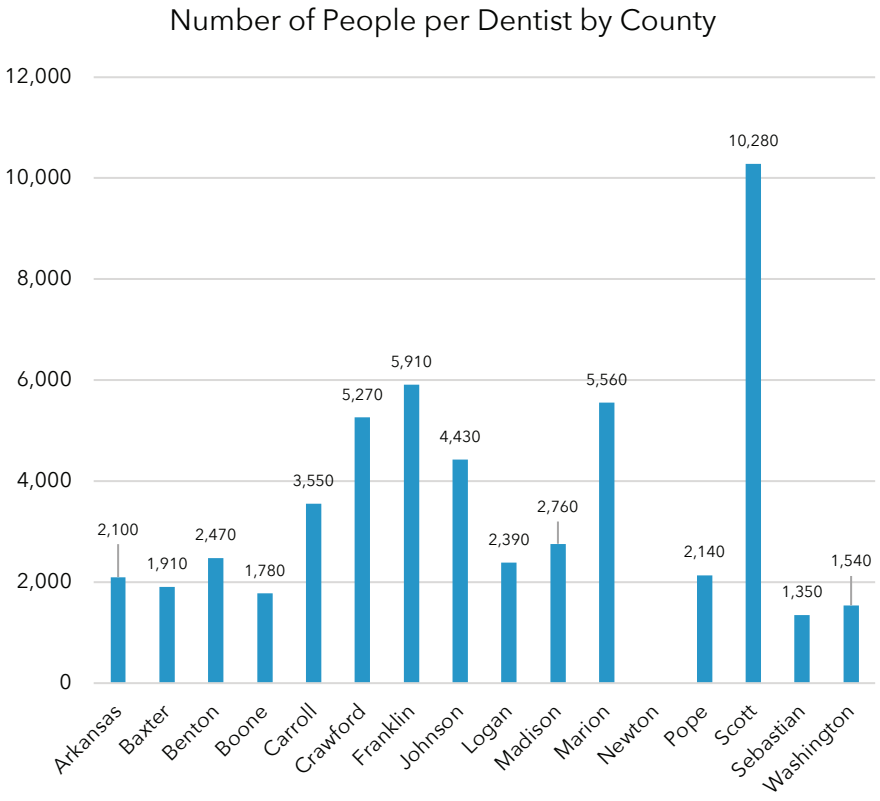


- BroadbandNow, a research organization monitoring broadband expansion across the US, has ranked Arkansas 50th for broadband access. This ranking is based on availability of broadband, low-cost access to services, and the average speed available.

- The *2021 KIDS COUNT® Report* ranked Arkansas 47th for households that have both internet access and a computer available for educational uses. While telehealth is a different-use case, typically a device and internet access are necessary to have a telehealth visit.

- The *2021 KIDS COUNT® Report* places Arkansas at 48th for children with teeth in "very good or excellent condition." Arkansas has 74% of its children receiving that evaluation, while the US total is 79%.

- Some counties in Northwest Arkansas are facing a significant shortage of dentists who provide care. Arkansas averages 2,100 people per dentist. Baxter, Boone, Sebastian, and Washington counties have a lower number of people per dentist than the state average, while Crawford, Franklin, Marion, and Scott counties have more than 5,000 people per dentist.

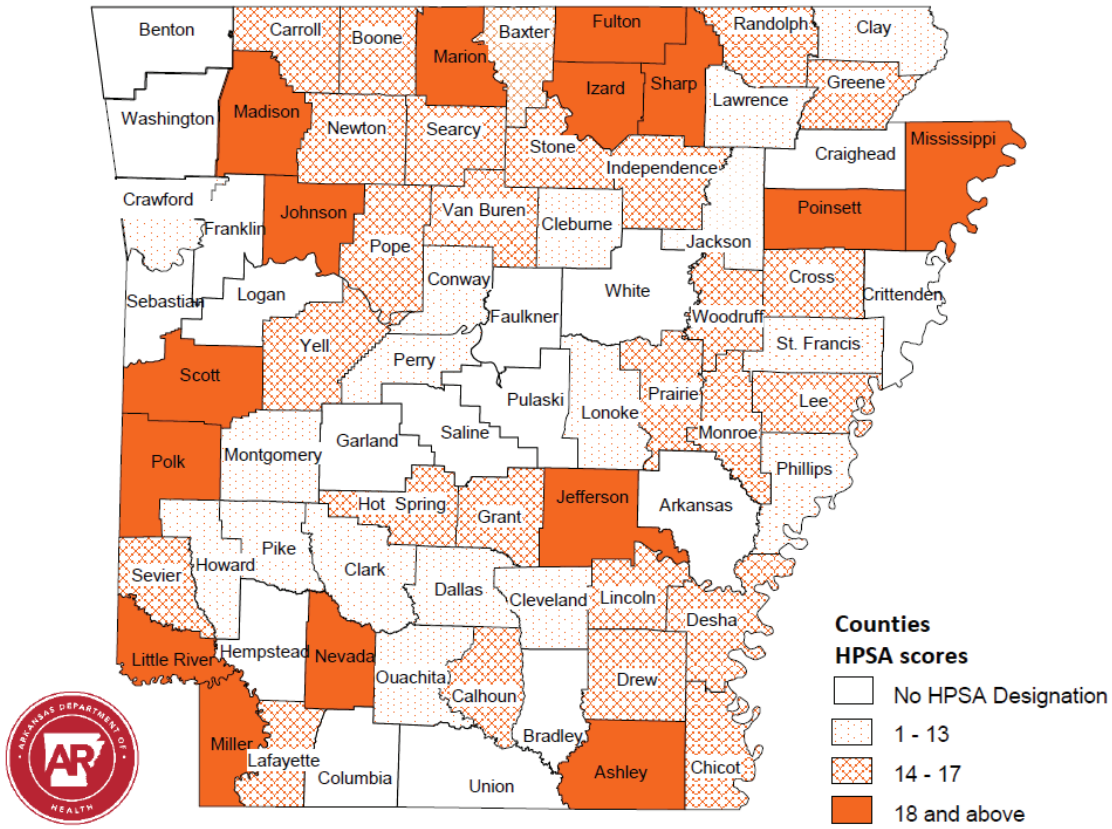


Source: BroadbandNow.com

- Some of the counties with highest dental HPSA are in Northwest Arkansas, including Johnson, Madison, and Marion. HRSA determines a HPSA with three scoring criteria: population-to-provider ratio, percent of population below 100% of the federal poverty level, and travel time to the nearest source of care outside of the HPSA designated area.

- Additionally, Arkansas ranks 42nd for children who received preventive dental care in the past year, with 76% of children receiving that care, compared to 80% in the US, according to the *2021 KIDS COUNT® Report*.

ARKANSAS
Dental Health Professional Shortage Areas (HPSA)



Date: January 06, 2021
Source: Arkansas Department of Health
Map created by: Naomi Sweeney
Email: Naomi.Sweeney@arkansas.gov
Office of Rural Health and Primary Care
Data Source: Health Resources and Services Administration (HRSA)

STAKEHOLDER ENGAGEMENT

Multi-faceted stakeholder engagement provided a framework for identifying community priorities. Following is a summary of findings from stakeholder engagement related to Access to Care.

Access to care was one of the issues receiving the greatest amount of input from stakeholders (surveys, focus groups, key informants), while data also demonstrates the importance of addressing this children's health need.

Key Informant Feedback

- Some key informants expressed concerns about the limited number of dentists who will accept patients on Medicaid. While the number of providers is already too low to meet demand, this limitation makes it very difficult for children on Medicaid to have routine access to oral health services.
- Key informants also discussed the challenges of access to care for parents who have jobs, pointing out that primary care, dental care, and vaccinations are part of a health system that is not designed to consider parents' work responsibilities.
- While Arkansas children have a high rate of being insured, key informants said just because a high number of children are insured doesn't mean there are not still access-to-care issues. Some mentioned medical providers often do not want to engage with patients who have a government-funded insurance plan. Others suggested this issue is even greater for dental health than for primary care access.
- One key informant suggested access issues go beyond availability of care, saying, "We are lacking in services and access to services and even education for parents and caregivers to know when or how to look for services."

> *"Primary care is where children's health needs are met. If we could resolve that, we could make a lot of inroads in improving children's health."*
>
> *Pediatrician*
> *Key Informant*

> *"Dental is always seen as a luxury. It is one of those things that can be overlooked. But it gets really expensive when you do that."*
>
> *Oral Health*
> *Key Informant*

Secondary Priorities: Access to Care

Focus Group Feedback

- Some focus group participants mentioned the connection between food insecurity—lack of fresh, healthy foods—and children with unhealthy teeth, primarily because of the sugar intake and a lack of milk, which contains calcium.
- Telehealth was also discussed by focus group participants, with some believing telehealth will provide easier access to families who live in very rural areas or have no transportation.
- Another focus group participant said telehealth "is a good alternative, but many parents are new to learning how to use Zoom." They elaborated that there is a learning curve to telehealth that providers need to acknowledge, and even widely used products like Zoom can cause confusion because not all parents are comfortable with using these or have experience.

> *Internet is a huge issue. If a family can't access in-person care, they may not have internet service to access telehealth.*
>
> *Educator*
> *NWA Key Informant*

Parent Survey Results

- The Arkansas Children's CHNA parent survey revealed 27% of parents in the Northwest Arkansas region believe that access to quality healthcare is a problem facing the community. That compares to 19% of parents statewide identifying that as an issue. An additional 15% of Northwest Arkansas parents included lack of healthcare services as a top five problem related to children's health and well-being.
- The CHNA parent survey showed 33% of Northwest Arkansas parents believe the number of children who have dental issues is a serious problem, with another 33% citing it as a moderate problem.
- The Arkansas Children's CHNA parent survey results show 30% of respondents in Northwest Arkansas have little or no interest in online virtual doctor visits, compared to 25% statewide.
- The CHNA parent survey showed 19% of parents say their child has missed school due to a toothache, with this percentage being much higher (41%) among parents with a child with an acute or chronic condition.

HEALTH DISPARITIES

In addition to identifying general children's health needs, it is critical to understand any impacts that occur only with certain populations of children. The process for identifying and measuring health disparities is included in the Findings section of this report.

According to Arkansas 3rd Grade Basic Screening Survey 2019–2020, Black and Hispanic students are more likely to have dental problems than are White children. In that survey, 72.4% of Hispanic students and 68.3% of Black students had decay experience, compared with 61.1% of White students. Black students also had the highest rate of untreated decay at 29.5%, with White children at 19.6% and Hispanic students at 17.0%. Additionally, a greater percentage of Black children need dental treatment when compared to White and Hispanic students.

Access to Care

Source: County Health Rankings 2021 & Broadband Now

	Oral Health		Telehealth	
County	**County**	**NWA**	**County**	**NWA**
RURAL DISPARITY				
Newton	N/A	2,100:1	45.60%	69.20%
Scott	10,280:1	2,100:1	62.50%	69.20%
Madison	2,760:1	2,100:1	58.90%	69.20%
Marion	5,560:1	2,100:1	68.10%	69.20%
Franklin	5,910:1	2,100:1	68.00%	69.20%
RACIAL DISPARITY				
Benton	2,470:1	2,100:1	94.40%	69.20%
Crawford	5,270:1	2,100:1	93.60%	69.20%
Johnson	4,430:1	2,100:1	81.60%	69.20%
Sebastian	1,350:1	2,100:1	97.30%	69.20%
Washington	1,540:1	2,100:1	97.80%	69.20%
ECONOMIC DISPARITY				
Franklin	5,910:1	2,100:1	68.00%	69.20%
Johnson	4,430:1	2,100:1	81.60%	69.20%
Marion	5,560:1	2,100:1	68.10%	69.20%
Newton	N/A	2,100:1	45.60%	69.20%
Scott	10,280:1	2,100:1	62.50%	69.20%

In examining regional oral health data, some level of disparity exists related to all three areas of concern: rural, racial, and economic. Four of the five counties defined as rural have a higher ratio of population to dentists than the state. (No data were available for one of the counties.) Three of the five counties with the highest non-White population have a higher ratio than the state average. Four of the five counties with the greatest poverty rates also have higher ratios for population to dentists than the state rate of 2,100:1, with one county having no data available.

For telehealth, disparities exist related to two of the three areas of concern: rural and economic. All of the five counties defined as rural have a lower rate of broadband availability than the state. None of the counties have a higher rate than the state average. Four of the five counties with the greatest poverty rates also have lower rates of broadband access than the state rate of 69.2%.

The data for oral health at the county and state levels is provided by County Health Rankings 2021, while county and state broadband access data is from Broadband Now.

Sustaining Activites for the 2022 Arkansas Children's Northwest Community Health Needs Assessment

Sustaining Activities

- Obesity
- Injury Prevention

Sustaining Activities: Obesity

OVERVIEW

Approximately 20% of Arkansas children ages 10–17 are identified as obese, according to the 2020 National Survey of Children's Health, and 14% of Arkansas children are identified as overweight. The definitions used identify children between the 85th and 95th percentile Body Mass Index (BMI)-for-age as overweight, with children at or above the 95th percentile BMI-for-age characterized as obese. Johnson County has the highest rate of overweight and obese children in Northwest Arkansas at 41.6%, while Madison County has the lowest in Northwest Arkansas, at 33.7%. Arkansas ranks 46th in the percentage of obese children and teens, according to the 2020 National Survey of Children's Health, with almost 5% more Arkansas children identified as obese than the national average.

In 2003, the Arkansas General Assembly led the country and approved the first state-level legislation to address obesity among school-age children in the state. That legislation established the Child Health Advisory Committee (CHAC) to make recommendations related to nutrition and physical activity in schools.

Additionally, it required healthier foods and beverages and confidential reporting of every public school student's weight status to parents and/or guardians every two years. [32] In 2007, the screening requirements were amended to assess children in kindergarten and even-numbered grades 2 through 10. Since that time, the Arkansas Center for Health Improvement (ACHI) has annually published the *Assessment of Childhood and Adolescent Obesity in Arkansas* report. The data are reported at both the individual school and the school district levels. Some students are not assessed during the annual assessment due to a variety of reasons, including absenteeism and parent refusal. Details of those reasons are provided in the table on the following page.

OBESITY AT A GLANCE

46th

ARKANSAS'S RANK FOR CHILDREN AND TEENS WHO ARE OBESE

1 IN 5

ARKANSAS CHILDREN ARE OBESE

51%

ARKANSAS CHILDREN AND TEENS WHO DO NOT EXERCISE REGULARLY

44%

ARKANSAS 8TH GRADE STUDENTS WHO ARE OVERWEIGHT OR OBESE

32.2%

INCREASE IN HEALTHCARE COSTS FOR CHILDREN WHO ARE OVERWEIGHT OR OBESE

43.2%

AFRICAN AMERICAN STUDENTS IN ARKANSAS WHO ARE OVERWEIGHT OR OBESE

The scoring process described in the Findings section of this report used key data points to determine priority order for each of the identified needs. The metrics used to prioritize Obesity can be found in the Appendix.

INTERSECTING NEEDS

Obesity is a multi-faceted health outcome that can be impacted by (lack of) physical activity; consuming foods high in calories but low in nutrients; cultural norms and practices; stress; lack of access to healthy foods; and food insecurity. Many of the factors that affect obesity in childhood are areas in which Arkansas also ranks behind other states.

Food insecurity, which is covered in depth in a separate needs profile, often plays a significant role in obesity. Many who are food-insecure in Arkansas have access only to predominantly low-nutrient, processed foods.

According to the National Institute of Diabetes and Digestive and Kidney Diseases, "access to and ability to afford healthy foods and safe places to be active" are among the factors that contribute to excess weight gain in both children and adults. [33]

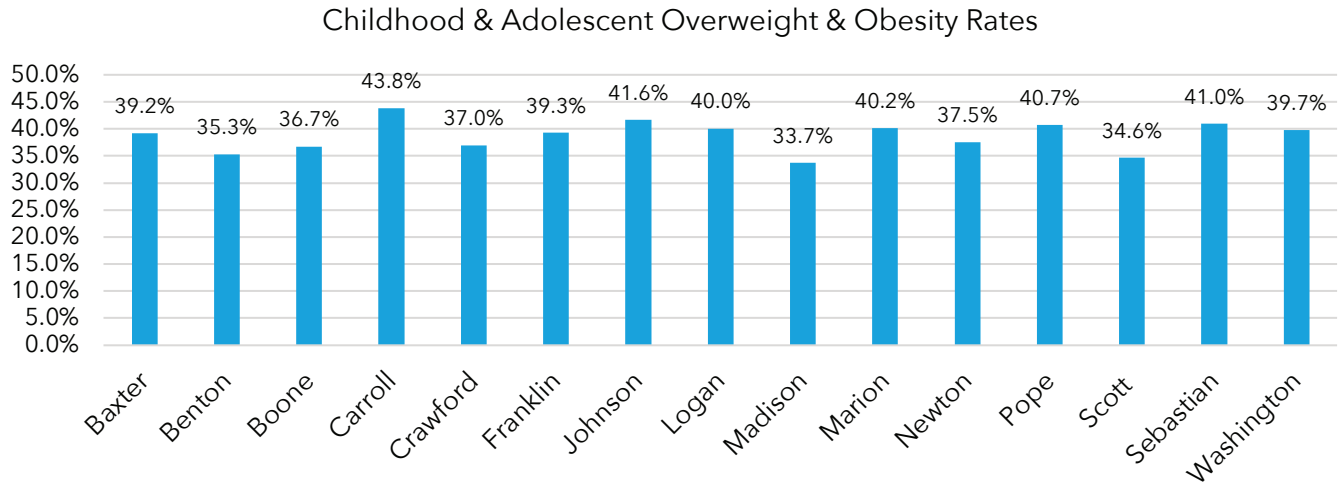
A lack of physical activity is another factor that contributed to childhood obesity. Families living at or near the poverty line may live in areas that do not include parks, playgrounds, and other public spaces for children to play and remain active. Some areas may have outdoor space, but parents are concerned about the safety of the area. In an effort to encourage more physical activity for children, the Arkansas General Assembly passed legislation in 2019 requiring elementary schools to offer 40 minutes of recess time per day. [34]

SECONDARY QUANTITATIVE DATA

Significant secondary data were identified and considered in determining whether Obesity should be considered as a child health need in this CHNA. Following are data points that support the inclusion of this child health need.

- Johnson County has the highest rate of overweight and obese children in Northwest Arkansas at 41.6%, while Madison has the lowest at 33.7%.
- Arkansas ranks 46th in percentage of obese children and teens, according to the 2020 National Survey of Children's Health, with almost 5% more Arkansas children identified as obese than the national average.
- The National Survey of Children's Health found that 7.5% of Arkansas parents have been told by a medical provider their child is overweight, compared to 8% of parents nationwide.
- Physical activity also factors into the obesity equation, and the *2021 KIDS COUNT® Report* ranks Arkansas at 34th for the percentage of children and teens not exercising regularly.
- More than one in four (26%) of Arkansas public school students are obese, with 27.8% of students in 10th grade classified as obese.
- Over 47% of Arkansas 8th grade students are either overweight or obese, according to the Arkansas Center for Health Improvement. Data from this source show the percent of obese children increases until high school and then remains steady.
- More than half (54.3%) of Arkansas Hispanic students are overweight or obese, with African American students at 49.3%. Asian students have the lowest rate of being overweight or obese at 34.4%.
- According to *America's Health Rankings* from the United Health Foundation, adult obesity in Arkansas has increased from 23.3% in 2000 to 36.4% in 2020. The highest rate of obesity since 1990 occurred in 2019 with a rate of 37.4%.

Sustaining Activities: Obesity



STAKEHOLDER ENGAGEMENT

Input from various stakeholder groups is a critical component of this CHNA. The process for stakeholder engagement is provided in the methodology section of this document. Following is a summary of findings from community engagement related to Obesity.

Obesity was discussed by stakeholders in both focus groups and one-on-one interviews. Additionally, parents, both in focus groups and those who participated in the parent survey, indicated that obesity is a significant concern when addressing children's health in Arkansas.

> *Understanding the long-term health impacts of poor nutrition on kids is critical. Poverty and nutrition share identical indicators of need. Unfortunately, calories are cheap.*
>
> *Hunger Relief*
> *Key Informant*

KEY INFORMANT FEEDBACK

- More than 53% of key informants interviewed for the CHNA mentioned food and nutrition among the issues negatively impacting children's health in Arkansas. There were nearly 100 mentions of food and nutrition among focus group participants.
- One key informant expressed concern about nutrition and health, saying evidence shows that children who grow up without enough food are often obese adults because of the types of food available to them during childhood.
- Key informants also discussed ways to eliminate food insecurity in an effort to address overall health. One said, "You are what you eat. I would feed children healthy foods and make them move more."

> *What we are seeing now is an increase in diet-related diseases—diabetes, obesity, and other problems that arise over time.*
>
> *Hunger Relief*
> *NWA Key Informant*

FOCUS GROUP FEEDBACK

- One educator who participated in a focus group said there is a pilot curriculum that teaches children how to cook healthy foods, with directions, ingredients, and proper utensils sent home.
- Parents in focus groups discussed the importance of physical activity to help children achieve a healthy weight. One suggested children need 60 minutes of exercise daily, with others expressing concern about the impact obesity can have on children.

- Several parent focus group participants discussed the fact that many parents cannot afford to feed their children healthy foods, especially fresh fruits and vegetables. They also mentioned the role that food deserts play in feeding their children healthy foods, as well as the importance of exercise.

PARENT SURVEY RESULTS

- More than a quarter (27%) of Northwest Arkansas parents who responded to the CHNA parent survey say they know someone outside their household who has children who are very overweight or obese, and 10% of parents say they have a child who is very overweight or obese.

- Forty-one percent of surveyed Arkansas parents said the nutritional quality and healthfulness of food served in their children's school cafeteria is excellent or very good, which is important for children participating in the free and reduced lunch program.

HEALTH DISPARITIES

In addition to identifying general children's health needs, it is critical to understand any impacts that occur only with certain populations of children. The process for identifying and measuring health disparities is included in the Findings section of this report.

In examining regional data, only limited disparities exist related to rural, racial, and economic factors. One of the five counties defined as rural has a slightly higher rate of obesity in children than the region. Two of the five counties with the highest non-White population have a higher rate than the regional average. Two of the five counties with the greatest poverty rates also have higher childhood obesity rates than the regional rate of 40%.

The data for county and state food insecurity rates were sourced from the Arkansas Center for Health Improvement (ACHI) *Assessment of Child & Adolescent Obesity Report 2019*.

Obesity

Source: ACHI Assessment of Child & Adolescent Obesity 2019

RURAL DISPARITY		
County	**County**	**NWA**
Newton	37.50%	40%
Scott	34.60%	40%
Madison	33.70%	40%
Marion	40.20%	40%
Franklin	39.30%	40%
RACIAL DISPARITY		
Benton	35.30%	40%
Crawford	37.00%	40%
Johnson	41.60%	40%
Sebastian	41.00%	40%
Washington	39.70%	40%
ECONOMIC DISPARITY		
Franklin	39.30%	40%
Johnson	41.60%	40%
Marion	40.20%	40%
Newton	37.50%	40%
Scott	34.60%	40%

Sustaining Activities: Injury Prevention

OVERVIEW

Arkansas has made improvements over the past ten years, with improved positive safety behaviors to prevent injury. These include increases in the use of car seats and appropriate restraint for children of all ages in motor vehicles. The use of seat belts by teenagers has increased over the past 10 years. Additionally, there has been a decrease in teenage drivers having motor vehicle crashes with the introduction of the graduated driver's license program in 2009.

While certain injury rates in Arkansas are improving, the state still ranks negatively compared with national averages in most injury mechanisms. Although Arkansas has made progress, other states are improving at a faster rate. Sustaining current prevention efforts is imperative as new babies are born each day and new teens become drivers. Training and prevention around injury prevention initiatives must continue, because most new initiatives take a generation before behaviors become social norms.

INJURY PREVENTION AT A GLANCE

42nd

ARKANSAS'S RANK FOR CHILD AND TEEN DEATH RATE

35/100,000

CHILD AND TEEN ANNUAL DEATH RATE

50/100,000

ARKANSAS TEEN DEATHS BY ACCIDENT, HOMICIDE, OR SUICIDE

46.2%

ARKANSAS YOUTH WHO TEXTED OR EMAILED WHILE DRIVING IN THE PAST 30 DAYS

Arkansas ranks in the top five states for death rates of children ages 1 to 14 in addition to ranking poorly in the top 10 for death rates for teens between the ages of 14 and 17. Many of these deaths are preventable with adequate public education, access to safety devices, and additional intervention strategies. Emerging injury prevention issues that need concentrated focus are suicide prevention and firearm safety.

- Arkansas ranks 9th in the nation for homicide by firearms for ages 1–18 at a rate of 7.37 per 100,000. (CDC WISQARS, 2015–20)
- Arkansas ranks 9th in the nation for suicide by firearm for ages 9–18 at a rate of 11.17 per 100,000. (CDC WISQARS, 2015–20)

The chart below shows the leading causes of injury-related death by age group in Arkansas. The statistics are sourced from the Centers for Disease Control and Prevention (CDC) Web-Based Injury Statistics Query and Reporting System (WISQARS). The data cover a 19-year period in order to have accurate rates and percentages. An accurate rate cannot be determined from one or even four years of mortality data, because the rates are not reliable.

Leading Causes of Injury Related Death 0 to 18 Years, Arkansas, 2000-2019

Rank	Less than 1 (n=367)	1 to 4 (n=638)	5 to 9 (n= 379)	10 to 14 (n=498)	15 to 18 (n=1738)
1	Suffocation (169) 46%	Motor Vehicle Crashes (158) 25%	Motor Vehicle Crashes (149) 39%	Motor Vehicle Crashes (187) 38%	Motor Vehicle Crashes (870) 50%
2	Homicide (68) 19%	Drowning (124) 19%	Fire/Burn (58) 15%	Suicide (86) 17% (48% by firearm)	Suicide (301) 17% (57% by firearm)
3	Motor Vehicle Crashes (43) 12%	Homicide (114) 18% (9% by firearm)	Drowning (45) 12%	Homicide (45) 9% (82% by firearm)	Homicide (236) 14% (83% by firearm)
4	Poisoning (19) 5%	Fire/Burn (80) 12%	Firearm (39) 10% (70% unintentional)	Drowning (45) 9%	Drowning (86) 5%
5	All Other Injuries (68) 18%	Suffocation (43) 7%	Other Land Transport (16) 4%	Other Land Transport (26) 5%	Other Land Transport (36) 2%

The scoring process described in the Findings section of this report used key data points to determine priority order for each of the identified needs. The metrics used to prioritize Injury Prevention can be found in the Appendix.

Sustaining Activities: Injury Prevention

Childhood injuries and deaths span a wide range, from accidents at home to intentional injury. In addition to the effects of actual injuries, some preventable actions also result in long-term physical or emotional health impacts.

Child maltreatment and interpersonal violence are both likely to result in mental health issues that must be addressed. Other incidents such as vehicle accidents, concussions, firearm accidents, and water safety may all require significant physical care and rehabilitation, with some victims having lifelong medical problems as a result of these injuries.

Motor vehicle safety is among the most common and potentially most serious injuries involving children. Arkansas has a high rate of motor vehicle crashes and fatalities. Teen drivers have a higher rate of crashes, due in part to their inexperience, but also resulting from distracted driving.

Approximately 25% of motor vehicle crashes that result in teen deaths involve alcohol, with many more injured in crashes resulting from underage drinking. [35] Arkansas youth who abuse alcohol and drugs may require mental health and addiction treatment, in addition to addressing any injuries they may have experienced or inflicted on others as a result of the risky behaviors. Substance abuse also results in other long-term physical health problems, including heart disease, high blood pressure, and brain development.[36]

Injury Prevention Topics

RECREATIONAL SAFETY
- ATV safety
- Bicycle safety & helmets
- Concussions
- Dog bite prevention
- Hunting safety
- Hydration
- Pedestrian safety
- Playground safety
- Toy safety
- Water safety

HOME SAFETY
- Bathing safety
- Burn prevention
- Crying baby
- Fall safety
- Safe sleep for infants

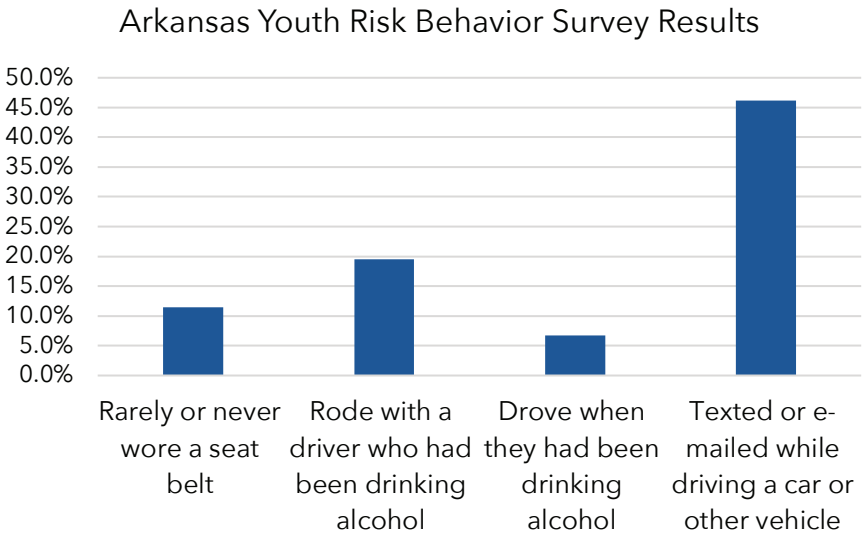
MOTOR VEHICLE SAFETY
- Car seats & booster seats
- Distracted driving
- Kids in hot cars
- Motorcycles
- Teen driving

INTENTIONAL INJURY
- Child maltreatment
- Firearm safety
- Interpersonal violence
- Suicide
- Youth violence

SECONDARY QUANTITATIVE DATA

Significant secondary data were identified and considered in determining whether Injury Prevention should be considered as a child health need in this CHNA. Following are data points that support the inclusion of this child health need.

- Arkansas ranks 42nd nationally for the overall child and teen death rate, according to the *2021 KIDS COUNT® Report*. Among children ages 1 to 19, 35 out of every 100,000 Arkansas children die, which is higher than the national rate of 25 per 100,000 children.
- The *2021 KIDS COUNT® Report* ranks Arkansas at 35th for teen deaths by accident, homicide, or suicide, with the state rate of 50 per 100,000 teens, which is higher than the US rate of 36 per 100,000 teens.



Source: *2021 KIDS COUNT® Report*

- According to the 2021 United Health Foundation America's Health Rankings, the number of Arkansas children that die by suicide is 21.9 per 100,000, which is significantly more than the national rate of 13.9 per 100,000 and places Arkansas's national ranking at 37th.
- Arkansas's child restraint use rate was 82.1% in 2021, which is a decrease from 88.2% in 2019.
- The child fatality rate in vehicle crashes in Arkansas is 3.09/100,000, compared to a US rate of 1.74/100,000, which ranks Arkansas 44th nationally.
- In 2018, 44% of all preventable child deaths in Arkansas were among children < 1 year of age, followed by 15–17 years of age at 24%. [37]
- Accidental deaths of children in 2018 totaled 68, with nearly half being the result of motor vehicle accidents. Drowning accounted for 13 deaths, and suffocation was the cause of 10 deaths. [38]
- Arkansas's unintentional death rate of 13.08/100,000 for children is much higher than the US average of 8.44/100,000.

Sustaining Activities: Injury Prevention

STAKEHOLDER ENGAGEMENT

Multi-faceted stakeholder engagement provided a framework for identifying community priorities. Following is a summary of findings from stakeholder engagement related to Injury Prevention.

Injury prevention was not discussed significantly by stakeholders (surveys, focus groups, key informants), but data demonstrate the importance of addressing this children's health need.

> *Children are not healthy and in a safe place in general in Arkansas. Children who get sick or injured get good care, but the overall health of children is poor to fair at best.*
>
> *Public Health*
> *Key Informant*

KEY INFORMANT FEEDBACK

- Several key informants expressed concerns about tobacco use and vaping, with some saying it seems to have been forgotten during the stress of the COVID-19 pandemic, but the issue remains.
- Key informants also discussed substance abuses, specifically opioids, as another risky behavior among Arkansas teens that is concerning.

FOCUS GROUP FEEDBACK

> *Drug use, especially marijuana, is so prevalent that it is being treated as not a big deal.*
>
> *Medical Provider*
> *Focus Group Participant*

- In the focus group instant poll, almost 20% of participants identified preventable injury topics such as: bullying, violence/guns, accidents, or drug use as their greatest concern when thinking about children's health in the state.
- Bullying, accidents, drug/alcohol abuse, and violence/guns combined were the fourth most important resources or services needed for children's health in Arkansas.
- More than 11% of focus group participants believe bullying, accidents, drug/alcohol abuse, or violence/guns were the most important needed resources in children's health.
- Community leaders participating in focus group discussions suggested bullying, both online and at school, is a disturbing issue that has both physical and mental impacts on children.
- Medical providers discussed tobacco use and vaping, along with substance abuse, as concerns. Some believe that significant drug use, particularly marijuana, is becoming culturally acceptable.

PARENT SURVEY RESULTS

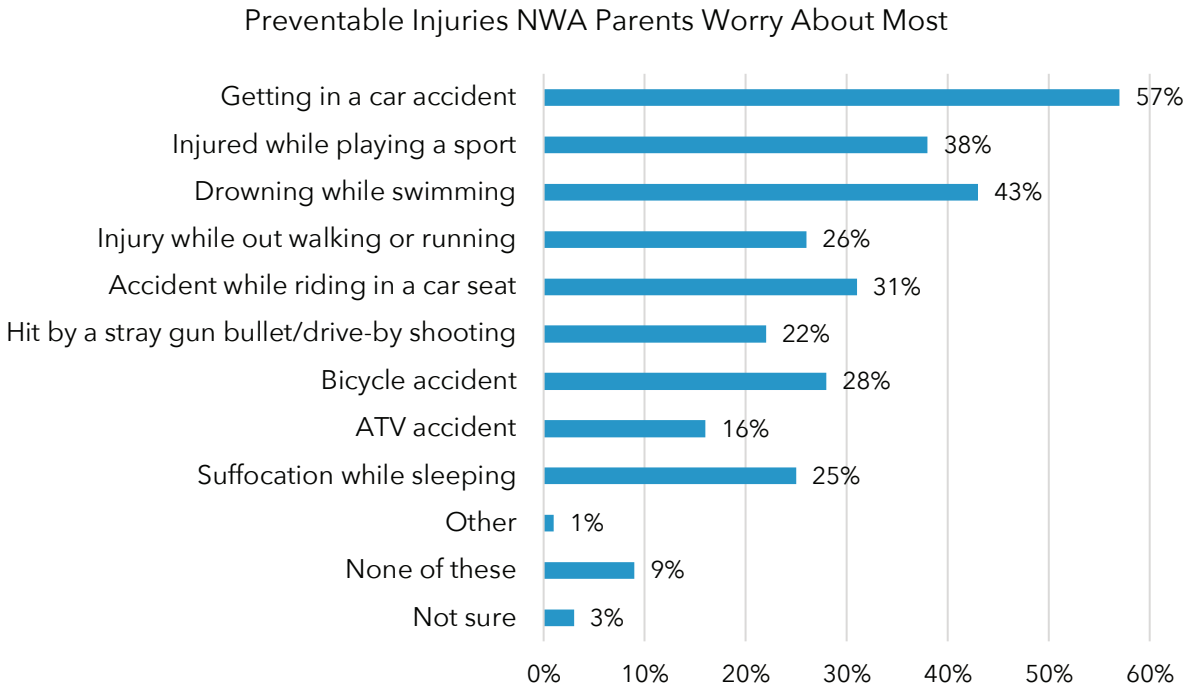
- Fifty-five percent of parents surveyed for the CHNA worry about their children being bullied or beaten up, while 51% are concerned about violence at school.
- Fifty-eight percent of parents also worry about their children being in a car accident, which ranked as the top preventable injury parents worry about the most. An additional 31% worry about an accident involving a car seat.

What types of violence, if any, do you worry about your child/children experiencing or witnessing?

Source: CHNA parent survey Northwest Arkansas Counties

Bullied/Beaten Up By Others	55%
Violence at School	51%
Cyberbullying	53%
Violence Between Adults	34%
Violence Seen Online or On TV	33%
Shot/Stabbed	25%
None of These	11%
Not Sure	2%

- Seventeen percent of Northwest Arkansas parents polled in the Arkansas Children's CHNA parent survey reported experiencing some form of domestic violence in their home. Additionally, 9% said their children have experienced some form of domestic violence.



Source: Statewide Parent Survey of Arkansas Children's 2022 CHNA Process

HEALTH DISPARITIES

In addition to identifying general children's health needs, it is critical to understand any impacts that occur only with certain populations of children. The process for identifying and measuring health disparities is included in the Findings section of this report.

According to the Arkansas Infant and Child Death Review Report 2020, there is no conclusive evidence there are any racial disparities for motor vehicle accidents resulting in death. In considering data for 2015 through 2018, the death rate was higher for White victims in 2015 and 2016, while there was a greater death rate for Black victims in 2017 and 2018. [39]

In examining motor vehicle crash data, regional disparities exist in two of the areas of concern: rural and economic. Five of five counties defined as rural have a higher rate of motor vehicle crash deaths than the state. None of the five counties with the highest non-White population have a higher rate than the state average. Four of the five counties with the greatest poverty rates also have higher rates of motor vehicle crash deaths than the state rate of 18/100,000.

Motor Vehicle Crash Deaths

Source: County Health Rankings 2021

RURAL DISPARITY		
County	**County**	**State**
Newton	29/100,000	18/100,000
Scott	30/100,000	18/100,000
Madison	26/100,000	18/100,000
Marion	28/100,000	18/100,000
Franklin	24/100,000	18/100,000
RACIAL DISPARITY		
Benton	10/100,000	18/100,000
Crawford	14/100,000	18/100,000
Johnson	12/100,000	18/100,000
Sebastian	12/100,000	18/100,000
Washington	12/100,000	18/100,000
ECONOMIC DISPARITY		
Franklin	24/100,000	18/100,000
Johnson	12/100,000	18/100,000
Marion	28/100,000	18/100,000
Newton	29/100,000	18/100,000
Scott	30/100,000	18/100,000

The data for motor vehicle crash deaths at the county and state levels were sourced from County Health Rankings 2021.


AIRBAG

Intersecting Need for the 2022 Arkansas Children's Northwest Community Health Needs Assessment

Intersecting Need

- Poverty & Finances

Intersecting Need: Poverty & Finances

OVERVIEW

By most measures, Arkansas consistently ranks as one of the poorest states in the nation. Lack of income and/or monetary resources affects the health outcomes of Arkansas children perhaps more so than any other single topic area reviewed. Economic stability is a key component of social determinants of health because of the significant connection between the financial resources of families and their health. It considers poverty, employment, food security, and housing stability in understanding how lack of financial resources truly impacts overall health.

Not only does quantitative data point to the seriousness of poverty in Arkansas, but virtually every stakeholder who provided input into this CHNA connected the dots between poverty and children's health. Arkansas's comparison of per capita income and the number of low-income working families with children both put the state at a rank of 49th. That results in 22% of the state's children currently living in poverty. While some measures of income and poverty are better in Northwest Arkansas than the state as a whole, the region has a higher poverty rate of children than the state.

Poverty & Finances intersect with every other children's health need in the state, from food insecurity to whether telehealth could be a potential solution to access-to-care issues. In fact, consideration of the social determinants of health reveals the cross-cutting issues of poverty:

- Clinical care – access-to-care issues are much more challenging for those children living in poverty or in low-income working families.
- Physical environment – living conditions, access to healthy food, lack of transportation, and unsafe neighborhoods all negatively impact children's health.
- Social and economic factors – lack of employment opportunities, access to supportive services, educational opportunities, and safety, all of which are critical to children's health, negatively impact low-income families.
- Healthy behaviors – exercise, a healthy diet, mental health and substance abuse treatment, and having trusted sources for information about children's health generally are much more challenging for families struggling financially.

The clear intersection of poverty and all other children's health needs in Arkansas, combined with the long-term nature of the state's place near the bottom of the financial ladder, is why Poverty & Finances is a foundational children's health need. Yet, the state's healthcare system is not positioned to have a significant impact on increasing family income and decreasing poverty rates.

The scoring process described in the Findings section of this report used key data points to determine priority order for each of the identified needs. The metrics used to prioritize Poverty & Finances can be found in the Appendix.

POVERTY & FINANCES AT A GLANCE

49th

ARKANSAS'S RANK FOR LOW-INCOME WORKING FAMILIES WITH CHILDREN

23.2%

NORTHWEST ARKANSAS CHILDREN LIVING IN POVERTY

49th

ARKANSAS'S RANK FOR PER CAPITA INCOME

30%

LOW-INCOME FAMILIES WITH CHILDREN IN ARKANSAS

$28,620

PER CAPITA INCOME IN NORTHWEST ARKANSAS, $1,800 MORE THAN STATE AVERAGE

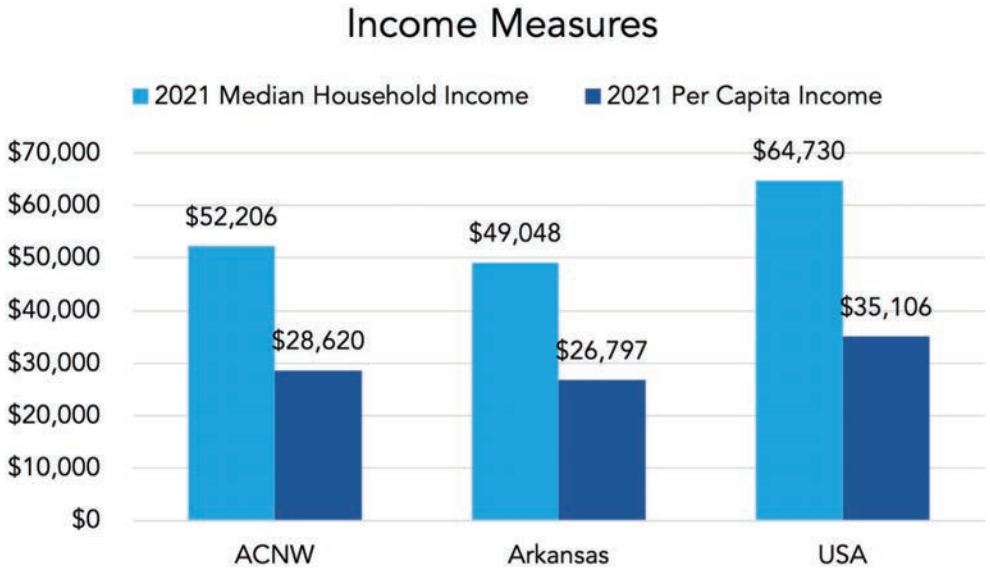
8

NORTHWEST ARKANSAS COUNTIES HAVE POVERTY RATES GREATER THAN THE STATE

SECONDARY QUANTITATIVE DATA

Significant secondary data were identified and considered in determining whether Poverty & Finances should be considered as a child health need in this CHNA. Following are data points that support the inclusion of this child health need.

- 23.2% of Northwest Arkansas children are living in poverty, compared to the state rate of 22%.
- Arkansas's poverty rate is 16.7%, compared to the national rate of 12.93% for 2021.
- The state ranks 49th in percentage of low-income working families with children, according to the *2021 KIDS COUNT® Report*. Thirty percent of Arkansas families are identified as low-income with children, which is 8% higher than the national average.



- The *2021 KIDS COUNT® Report* ranks Arkansas at 46th for children experiencing poverty, with the state percentage being 22%, which is 5% higher than the US average of 17%.
- According to the United Health Foundation America's Health Rankings 2021, Arkansas is the second poorest state by per capita income with an average per capita income of $26,797.
- The number of children living in poverty in Arkansas has declined from 28% in 2010 to 22% in 2019, according to *2021 KIDS COUNT® Report*.

Intersecting Need: Poverty & Finances

STAKEHOLDER ENGAGEMENT

Multi-faceted stakeholder engagement provided a framework for identifying community priorities. Following is a summary of findings from stakeholder engagement related to Poverty & Finances.

Poverty & Finances was one of the issues receiving the greatest amount of input from stakeholders (surveys, focus groups, key informants), while data also demonstrates the importance of addressing this children's health need.

KEY INFORMANT FEEDBACK

- Key informants also discussed the challenges of access to care for parents who have jobs, pointing out that primary care, dental care, and vaccinations are part of a health system that is not designed to consider parents' work responsibilities.

- One key informant discussed concerns about the disparity in care among those who do not have the financial resources to access care, saying, "One thing we know is tremendously impactful is family income and financial security. That's why you see so much disparity."

> *Poverty is the biggest obstacle in everything encompassing children's health.*
>
> *Physician & Community Leader*
> *Key Informant*

FOCUS GROUP FEEDBACK

- In a focus group instant poll, almost 20% of participants in the CHNA focus groups said affordability is their greatest concern when thinking about children's health in the state of Arkansas.

- Poverty & Finances was the third most identified concern following Access to Care and Child Abuse & Neglect. There were more than 50 mentions of Poverty & Finances among focus group participants.

- A common theme from the focus groups is that family economics is connected to almost every children's health topic area. As one medical provider put it, "Personal income is a huge determinant in whether families are equipped to care for their children." Another participant agreed, saying, "If a family struggles financially, it impacts their day-to-

> *As a whole, I think the majority of Arkansans are all suffering in terms of being able to make enough money just to survive and meet all their needs.*
>
> *Attorney*
> *NWA Key Informant*

day safety, food access and healthy options, ability to participate in physical activity through extracurricular activities, and time off from work to get healthcare and pay for that."

- Parents said they believe their stress levels related to not working or living in poverty have impacts on the health of their children. Some suggested that financial literacy education would help reduce stress.

> *If we could solve poverty, it would take care of a lot of things.*
>
> *Community Leader*
> *Focus Group Participant*

- A group of community leaders discussed their concerns about affordable housing. They said some families live in poverty-stricken environments in homes that are in unsafe condition. Children who are raised in those environments often grow up thinking this is the way they are supposed to live, making poverty generational, they said.

PARENT SURVEY RESULTS

- In the Arkansas Children's CHNA parent survey, when Northwest Arkansas parents were asked what level of interest they would have in attending a class on how to better manage the family's finances, 33% answered "very interested," 35% answered "somewhat interested," and 12% answered "a little interested."

- Poverty & Finances was the third most identified concern, following bullying and mental health issues, for Northwest Arkansas parents.

- Ninety percent of Northwest Arkansas parents in the Arkansas Children's CHNA parent survey indicated the number of children experiencing the negative effects of poverty is a problem, with more than half believing it to be a serious problem.

Intersecting Need: Poverty & Finances

HEALTH DISPARITIES

In addition to identifying general children's health needs, it is critical to understand any impacts that occur only with certain populations of children. The process for identifying and measuring health disparities is included in the Findings section of this report.

The *2021 KIDS COUNT® Report* shows there is a significant disparity in poverty levels by race. The poverty rate for Black children in Arkansas is 39%, compared to the overall state average of 22%. The poverty rate for Hispanic children is 27%, which is also greater than the state rate.

In examining regional data for per capita income, disparities clearly exist related to all three areas of concern: rural, racial, and economic. All five counties defined as rural have a lower per capita income than the region. Four of the five counties with the highest non-White population have a per capita income lower than the regional average. All of the five counties with possible economic disparities have lower per capita income than the regional average of $28,620.

Poverty & Finances

Source: Esri Business Analytics Online

RURAL DISPARITY County	County	Region
Newton	$21,386	$28,620
Scott	$19,169	$28,620
Madison	$25,553	$28,620
Marion	$23,618	$28,620
Franklin	$21,347	$28,620
RACIAL DISPARITY		
Benton	$35,398	$28,620
Crawford	$24,032	$28,620
Johnson	$20,912	$28,620
Sebastian	$26,320	$28,620
Washington	$28,146	$28,620
ECONOMIC DISPARITY		
Franklin	$21,347	$28,620
Johnson	$20,912	$28,620
Marion	$23,618	$28,620
Newton	$21,386	$28,620
Scott	$19,169	$28,620

The data for poverty at the state level were sourced from the *2021 KIDS COUNT® Report.* The county level data were sourced from Esri Business Analytics.

Looking Forward

- Review of 2020–2022 ACNW Implementation Strategy
- Engagement of Community Stakeholders
- Big Ideas from Community Stakeholders
- Authors & Acknowledgements

REVIEW OF 2020–2022 ACNW IMPLEMENTATION STRATEGY

The 2022 Arkansas Children's Northwest (ACNW) Community Health Needs Assessment (CHNA) identifies the most pressing child health needs in Northwest Arkansas and will inform the Arkansas Children's Northwest Implementation Strategy, due in the fall of 2022. The 2022 ACNW Implementation Strategy will connect with the work of the Natural Wonders Partnership Council and other partners working to improve child health throughout the state.

Formed in 2006, the Natural Wonders Partnership Council is a coalition of diverse child health organizations, nonprofits, agencies, and funders that work together to address the health needs of children in Arkansas. In recent years, Natural Wonders has strategically configured from 10 workgroups into five workgroups that cover overlapping health needs for children and their families. These five groups include: Mental Health & Well-being, Immunizations, First 2100 Days, Building Community Assets, and Healthy Relationships.

Arkansas Children's will continue to serve as the backbone entity for this group by planning, managing, and supporting Natural Wonders' efforts. The 2022 ACNW CHNA will inform the next goals and action plan for Natural Wonders, as it has for the previous three statewide needs assessments for Arkansas Children's Hospital (ACH). By coordinating and targeting efforts, ACH and Natural Wonders can make measurable improvements in child health.

The 2020–2022 ACNW Implementation Strategy created goals to address the needs identified in the 2019 ACNW Community Health Needs Assessment. Major accomplishments of the ACNW Implementation Strategy include:

- Responding to impact of the Covid-19 pandemic on children and their families in a variety of methods. As a system, Arkansas Children's responded by launching a statewide hotline, answered by clinical support staff responding to over 20,000 calls over a seven-month period. Arkansas Children's shared over 50,000 face masks that were donated by the community to children and families in need. Arkansas Children's senior leadership served in various capacities on local and statewide advisory boards, including a collaborative task force that has focused on providing resources for schools, educators, students, and families, as the state prepared for a return to safe, in-person learning.

- Implementing Arkansas Children's Resource Connect, a closed-loop referral platform to help connect families to organizations that can help meet their social needs at no cost or in low-cost ways. This system was launched in April 2021 for use by patients, families, and staff at Arkansas Children's Hospital and Arkansas Children's Northwest. Resource Connect helps staff address social needs in a clinical setting and provides connection to community resources. In addition, the site has an outward-facing component that allows for anyone, anywhere, to search for free and reduced-cost resources that help address and alleviate the social vulnerabilities that impact health. In the first three months of use (April–June 2021), over 350 searches occurred, with the most common searches being for food pantries, help to pay for utilities, and help to pay for housing.

- Responding to the food insecurity needs of children and their families around the state is an additional accomplishment from the past implementation strategy. Arkansas Children's Northwest is following best-practice models to help improve the food security of children and their families around the state. This process begins at the individual level, with screening programs to determine food insecurity needs at the individual and family levels. Patients are screened at most primary care appointments. Additionally, in June 2021, Arkansas Children's made a $1 million contribution to food banks and pantries around the state, including seven organizations in Northwest Arkansas. This contribution provided over 4.6 million meals to 315,867 children around the state. Additionally, ACNW is actively participating in the NWAR

Community of Practice, focused on addressing food insecurity in Northwest Arkansas, to seek new partnerships and equitable solutions for better health of children and families.

- ACNW made a financial contribution to Compassion House in Springdale, AR. Their program offers pregnant teens a safe place to live, empowering each resident with life skills, education, and support—to allow them to become productive parents and contributors in the community. In future years, the Arkansas Children's Injury Prevention Center will partner with Compassion House to provide activities, such as baby shower events, to provide education, training, and resources for pregnant and parenting teen mothers to keep their children safe, as well as car seat training events to provide education, training, and resources for pregnant and parenting teen mothers to keep their children safe.

ENGAGEMENT OF STAKEHOLDERS & COMMUNITY

This needs assessment outlines a broad range of child health issues. This needs assessment engaged individuals and organizations that represent the communities served. Many representatives of organizations are part of Natural Wonders Partnership Council. Schools, parents, caregivers, and a variety of organizations with an interest in these issues were engaged in defining the needs for this CHNA. Those organizations include:

- Arkansas Children's Hospital and Arkansas Children's Northwest
- Arkansas Department of Health
- Arkansas Department of Education Division of Primary and Secondary Education
- Arkansas Department of Human Services
- Arkansas Minority Health Commission
- The Arkansas Food Bank and the Northwest Arkansas Food Bank
- The University of Arkansas for Medical Sciences
- Arkansas Hunger Relief Alliance
- Arkansas Advocates for Children and Families
- Health policy organizations, including the Arkansas Center for Health Improvement
- Healthcare providers, including pediatricians, family practices physicians, and nurses
- Health researchers
- Immunize Arkansas
- The Arkansas Foundation for Medical Care (AFMC)
- Nonprofit organizations providing direct services
- Private health insurance companies
- Faith community representatives
- Low-income legal services organizations
- Private foundations like the Arkansas Community Foundation
- The Arkansas Campaign for Grade-Level Reading
- Private industries ranging from pharmaceutical companies to chambers of commerce
- Parents and caregivers
- Educators
- Community leaders

Looking Forward

BIG IDEAS

Many of the stakeholders engaged through focus groups and key informant interviews for this CHNA were asked how they would address children's health needs if they had unlimited resources. Following are ideas related to each of the prioritized needs that resulted from those conversations:

BROAD HEALTH NEEDS

- Establish a children's health board in every county to look at the entirety of children's health. These county-level boards could have money to administer and fund programs.
- Have a social worker and nurse in every school.

BEHAVIORAL & MENTAL HEALTH

- Increase the number of mental health providers—counselors, therapists, psychiatrists.

IMMUNIZATIONS

- A well-funded voice of public health could promote the importance of childhood immunizations.
- Expand the network of vaccine providers for children around the state.
- Consider having school-based health centers offer vaccine clinics more frequently.
- Provide information about immunizations in schools to educate parents using trusted information.

FOOD INSECURITY

- Overhaul the whole nutrition system so every child starts out with very nutritious first years.
- Provide fresh fruits and vegetables and establish community or school gardens.
- Create a daily or weekly impact point related to nutrition and cooking in schools.
- Actively work on curriculum for elementary-age children to maximize the impact seen with younger children before they establish regular habits.
- Explore additional funding sources for feeding organizations, such as a soda tax, which helps fund entities that are boots on the ground with this.

INFANT HEALTH

- Establish a home visiting program for the first year of life for every child and offer universal PreK.
- Create resources related to pre-birth maternity care, early intervention, home visiting, and post childbirth.
- Consider a more robust early-care program that would be similar to Head Start, with health intertwined.

ACCESS TO CARE

- Conduct physical and oral screenings in all schools using a mobile health and dental clinic.
- Explore having school doctors to supplement the work of school nurses.
- Expand access to community health workers and social workers and place them in pediatric clinics in schools.
- Ensure every child has access to preventative care.
- Establish a Hospital at Home® program with mobile hospitals going into the community.

CHILDHOOD OBESITY

- Provide more recess time and more PE in schools to get children up and moving. Also teach nutrition in health classes.
- Provide after-school care and summer programs to provide recreational time for children.
- Establish frequent impact points in schools for nutrition and cooking.
- Offer family and consumer science courses that focus on healthy eating.

POVERTY & FINANCES

- Establish a universal basic income so families of all children from birth to age 18 have income to support their needs.
- Implement a pilot program where people on government assistance could work their way to self-sufficiency.
- Ensure all families below the poverty line have the resources and support to rise above the poverty line.

AUTHORS & ACKNOWLEDGEMENTS

This document has been prepared to summarize the data analysis, stakeholder engagement, and findings related to Arkansas Children's Northwest's efforts to identify and understand the current children's health needs in Northwest Arkansas. This assessment has been completed by a hospital team, working together with Boyette Strategic Advisors, a Little Rock-based consulting firm. Boyette provided both qualitative and quantitative research support under the guidance of the hospital team. Boyette has experience in providing holistic strategic plans, workforce solutions, impact evaluations, corporate services, and general business consulting, allowing their team to see through each of those lenses to provide research, creative thinking, and implementation guidance to Arkansas Children's. This Community Health Needs Assessment (CHNA) has been prepared to satisfy the federal tax-exemption requirements of the Affordable Care Act, in addition to meeting specific planning objectives of Arkansas Children's Northwest.

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INTERNAL GROUPS

Arkansas Children's advisory group for 2022 Community Health Needs Assessment Process

A group of Arkansas Children's senior leadership, representing Arkansas Children's Hospital (ACH), Arkansas Children's Northwest (ACNW), and system-wide views, provided oversight and leadership for the CHNAs of both ACH and ACNW. The advisory group reviewed all needs assessment findings and participated in the process to identify the priority health needs.

Working Group for the 2022 Community Health Needs Assessment Process:

The working group included team members representing ACH, ACNW, and the system, with individual expertise from a variety of areas, including strategy, community engagement, process improvement, research, and clinical areas. The working group served many roles through the ACH and ACNW Community Health Needs Assessment processes. Specifically, the working group helped design, refine, and use the index tool to prioritize the needs for each assessment.

Appendix

APPENDIX TABLE OF CONTENTS:

Sections of Appendix:

- Index sources for each priority need

ACNW Prioritization Index Metrics for Index Factors		
Primary Priorities (Score Range: 70-85)		
FACTOR	**METRIC**	**SOURCE**
Behavioral & Mental Health (Total Score: 84)		
• **Scope**	• Children with Emotional, Behavioral or Developmental Conditions • Suicide-related Risky Behaviors (Considered, Planned, or Attempted Suicide)	*Source:* KIDS COUNTS 2021 *Source:* CDC Youth Risk Behavior Survey
• **Severity**	• Ratio of Population to Mental Health Providers	*Source*: 2021 County Health Rankings
• **Community Priority**	• AC CHNA Parent Survey & Discussions in Focus Groups and Key Informant Interviews	*Source*: Arkansas Children's Stakeholders
• **Health Disparities**	• Comparison of Ratio of Population to Mental Health Providers for Counties with a High Level of Poverty (financial), a Low Overall Population (rural), and a High Non-White Population (racial) • Total Suicides for Counties with a High Level of Poverty (financial), a Low Overall Population (rural), and a High Non-White Population (racial)	*Source*: Esri Business Analytics Online & 2021 County Health Rankings *Source:* Esri Business Analytics Online & 2021 County Health Rankings
Immunizations (Total Score: 74)		
• **Scope**	• Immunization Rates of Children 19-35 Months	*Source*: Arkansas Department of Health
• **Severity**	• Number of Counties with Two or Fewer Vaccine Providers	*Source*: Arkansas Department of Health
• **Community Priority**	• AC CHNA Parent Survey & Discussions in Focus Groups and Key Informant Interviews	*Source*: Arkansas Children's Stakeholders
• **Health Disparities**	• Comparison of Ratio of Population to Immunized Children (19-35 months) for Counties with a High Level of Poverty (financial), a Low Overall Population (rural), and a High Non-White Population (racial)	*Source*: Esri Business Analytics Online & Arkansas Department of Health
Food Insecurity (Total Score: 72)		
• **Scope**	• Food Insecurity Rate for Children in ACNW Service Area Counties	*Source:* Feeding America – Map the Meal Gap
• **Severity**	• Very Low Food Insecurity for Children	*Source:* Feeding America
• **Community Priority**	• AC CHNA Parent Survey & Discussions in Focus Groups and Key Informant Interviews	*Source:* Arkansas Children's Stakeholders
• **Health Disparities**	• Comparison of Ratio of Population to Rate of Food Insecurity for Counties with a High Level of Poverty (financial), a Low Overall Population (rural), and a High Non-White Population (racial)	*Source:* Esri Business Analytics Online & Aspire Arkansas/Feeding America

Secondary Priorities (Score Range: 60-69)		
FACTOR	**METRIC**	**SOURCE**
Infant Health		
Infant Mortality (Total Score: 61)		
• **Scope**	• Infant Mortality Rate	*Source:* CDC WISQARS
• **Severity**	• Sudden Unexpected Infant Death Rate (SUID)	*Source:* CDC WONDER
• **Community Priority**	• AC CHNA Parent Survey & Discussions in Focus Groups and Key Informant Interviews	*Source:* Arkansas Children's Stakeholders
• **Health Disparities**	• Comparison of Ratio of Population to Rate of Infant Mortality for Counties with a High Level of Poverty (financial), a Low Overall Population (rural), and a High Non-White Population (racial)	*Source:* Esri Business Analytics Online & Aspire Arkansas
Teen Pregnancy (Total Score: 66)		
• **Scope**	• Total Teen Births by County	*Source*: 2021 County Health Rankings
• **Severity**	• Low Birthweight Babies to Under 20-year-old Mothers	*Source*: March of Dimes Peristats
• **Community Priority**	• AC CHNA Parent Survey & Discussions in Focus Groups and Key Informant Interviews	*Source:* Arkansas Children's Stakeholders
• **Health Disparities**	• Comparison of Ratio of Population to Teen Births by County for Counties with a High Level of Poverty (financial), a Low Overall Population (rural), and a High Non-White Population (racial)	*Source:* Esri Business Analytics Online & 2021 County Health Rankings
Child Abuse & Maltreatment (Total Score: 60)		
• **Scope**	• Child Abuse Hotline Calls by County	*Source:* Arkansas Department of Human Services
• **Severity**	• True Reports of Child Maltreatment	*Source: Aspire Arkansas*
• **Community Priority**	• AC CHNA Parent Survey & Discussions in Focus Groups and Key Informant Interviews	*Source:* Arkansas Children's Stakeholders
• **Health Disparities**	• Comparison of Ratio of Population to True Reports of Child Maltreatment for Counties with a High Level of Poverty (financial), a Low Overall Population (rural), and a High Non-White Population (racial)	*Source:* Esri Business Analytics Online & Aspire Arkansas
Access to Care (Total Score: 60)		
Oral Health		
• **Scope**	• Percent of Students with Untreated Tooth Decay	*Source: Arkansas Department of Health Dental Health Report 2019-2020*
• **Severity**	• Ratio of People per Dentist	*Source:* 2021 County Health Rankings
• **Community Priority**	• AC CHNA Parent Survey & Discussions in Focus Groups and Key Informant Interviews	*Source:* Arkansas Children's Stakeholders
• **Health Disparities**	• Comparison of Ratio of Population to Ratio of People Per Dentist for Counties with a High Level of Poverty (financial), a Low Overall Population (rural), and a High Non-White Population (racial)	*Source:* Esri Business Analytics Online & 2021 County Health Rankings
Telehealth		
• **Scope**	• Percentage of Population with Broadband Access	*Source:* BroadbandNow

• **Severity**	• Adults Living in Households with Children Who Delayed Medical Care Because of the COVID-19 Pandemic	*Source:* KIDS COUNT 2021
• **Community Priority**	• AC CHNA Parent Survey & Discussions in Focus Groups and Key Informant Interviews	*Source:* Arkansas Children's Stakeholders
• **Health Disparities**	• Comparison of Ratio of Population to Percent of Broadband Access for Counties with a High Level of Poverty (financial), a Low Overall Population (rural), and a High Non-White Population (racial)	*Source:* Esri Business Analytics Online & Broadband Now

Sustaining Activities (Score Range: 50-59)		
Childhood Obesity (Total Score: 57)		
• **Scope**	• Children & Teens Who Are Obese	*Source:* Arkansas Center for Health Improvement Assessment of Childhood and Adolescent Obesity in Arkansas 2019
• **Severity**	• Overweight & Obese Students by Grade	*Source:* Arkansas Center for Health Improvement Assessment of Childhood and Adolescent Obesity in Arkansas 2019
• **Community Priority**	• AC CHNA Parent Survey & Discussions in Focus Groups and Key Informant Interviews	*Source:* Arkansas Children's Stakeholders
• **Health Disparities**	• Comparison of Ratio of Population to Obesity Rate by County for Counties with a High Level of Poverty (financial), a Low Overall Population (rural), and a High Non-White Population (racial)	*Source:* Esri Business Analytics Online & Arkansas Center for Health Improvement Assessment of Childhood and Adolescent Obesity in Arkansas 2019
Injury Prevention: Motor Vehicle Safety (Total Score: 53)		
• **Scope**	• Seatbelt/Car Seat Use	*Source:* National Traffic Safety & AC Injury Prevention Center
• **Severity**	• Child Fatalities in Traffic Crashes	*Source:* National Highway Traffic Safety Administration
• **Community Priority**	• AC CHNA Parent Survey & Discussions in Focus Groups and Key Informant Interviews	*Source:* Arkansas Children's Stakeholders
• **Health Disparities**	• Comparison of Ratio of Population to Motor Vehicle Crash Deaths for Counties with a High Level of Poverty (financial), a Low Overall Population (rural), and a High Non-White Population (racial)	*Source:* Esri Business Analytics Online & 2021 County Health Rankings

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