Community Health Needs Assessment

and Three-year Community Benefit Plan

May 2013

Preface

This Community Health Needs Assessment has been produced for Arkansas Children's Hospital by Arkansas Advocates for Children and Families. This report was prepared by Anna Strong, MPH, MPS, Director of Healthcare Policy for Arkansas Advocates for Children and Families.

This report was prepared under contract from Arkansas Children's Hospital. Overall ACH coordination of this report was provided by Scott Gordon, LCSW, Executive Vice President.

For further information or to request a copy of this report, contact Arkansas Children's Hospital via email at naturalwonders@archildrens.org or via telephone at 501-364-9916.

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ACH Community Health Needs Assessment, 2012 Tax Year

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Executive Summary

New Internal Revenue Service (IRS) requirements formalize and require periodic community health needs assessments for nonprofit hospitals. This requirement formalizes the "state of child health in Arkansas" reports that the Natural Wonders Partnership Council has produced in past years, facilitated by Arkansas Children's Hospital.

For its first community health needs assessment (CHNA), the hospital communicated with public health experts, government agencies, and a wide variety of stakeholders from various communities to determine needs related to children's health in Arkansas. Special emphasis was placed on reaching out to low-income families and educators in determining issues affecting children. Data collection efforts included the following:

- Secondary data on child health issues
- Eight focus groups
- Twenty-four key informant interviews
- A phone survey of 1,000 households

After compiling and analyzing data, common themes were identified and prioritized by need and the number of sources in which they were mentioned. Five topics arose as high-priority:

- Access to care
- Food insecurity
- Sexual health
- Obesity
- Intentional Injury.

The second-ranking set of needs included parenting skills, unintentional injuries, oral health, immunizations, and substance use. Lower-priority needs that were mentioned in one or two data sources included homelessness and housing insecurity, poverty, early childhood education, mental health, health literacy, disparities faced by Arkansas's growing Hispanic population, low high-school graduation rates, and asthma.

As the hospital determines its community benefit investment strategy for the coming years, this needs assessment will provide a roadmap to guide the way to changing the health of Arkansas children for the better.

Introduction and Purpose

Arkansas Children's Hospital (ACH) is a private, nonprofit institution and is the only pediatric medical center in the state. The hospital treats children from every county in the state and some from neighboring areas. It works broadly in Arkansas to meet the health-related needs of children and improve children's health status. Since 2006, the Natural Wonders Partnership Council has periodically assessed the state of Arkansas children's health and made recommendations for policy and programmatic changes that positively impact child health. This Partnership of state agency representatives, clinical leadership, and other organizations that serve children meets regularly to coordinate strategic initiatives that improve health and quality of life for Arkansas children and families. New Internal Revenue Service (IRS) requirements formalize and require periodic needs assessments and community benefit implementation plans, much like the Natural Wonders efforts, for nonprofit hospitals.

This report is the hospital's Community Health Needs Assessment (CHNA) which will serve as the foundation for an implementation plan that directs the hospital's community benefit work. Through community benefit, the hospital uses "time, talent, and resources" to improve the lives of Arkansas children and their families. Past community benefit efforts in which the hospital has engaged, based on identified needs in the Natural Wonders assessments, include the Injury Prevention Center, mobile dental vans and statewide oral health outreach, support of HealthTeacher.com in Arkansas schools, home visiting expansion, and strengthened community partnerships. This needs assessment should be viewed in conjunction with the hospital's community benefit report, which highlights community investments including research, graduate medical education, subsidized care, and other subsidized community engagement programs. This report comprehensively examines current data-driven and community-identified health needs and prioritizes them, building a firm foundation upon which to strengthen community benefit work for Arkansas Children's Hospital.

Community Definition

For the purposes of this community health needs assessment, the hospital must define the community it serves. Arkansas Children's Hospital uses both a geographic and demographic definition: it serves children who live in the state of Arkansas. Though the hospital serves some adult patients in its burn unit and with pediatric chronic conditions, and a few out-of-state patients for particular health conditions, the majority of those it serves fall into the community defined by this report.

Arkansas children come from diverse communities, ranging from Northwest Arkansas's booming business industry to the persistent poverty of the Mississippi Delta. Racial and ethnic subcultures also vary across the state including a growing Hispanic population in the north and west to a larger African-American population in the south and east. The hospital serves all who need its services regardless of race, religion, or inability to pay. The hospital also places special emphasis on the lower-income neighborhood surrounding its main campus and works to improve quality of life for the children and families who live there.

The hospital's full-time physical locations include:

- Main campus in central Little Rock, which includes the ACH Research Institute
- Outpatient clinic in west Little Rock
- Centers for Children in Lowell
- Centers for Children in Jonesboro

In addition, the hospital offers 21 regional clinics across the state on a periodic basis. Telemedicine units are in place for almost 30 on-campus locations, connecting the UAMS Department of Pediatrics and ACH to dozens of off-campus providers. These telemedicine units allow the hospital to connect to remote sites in real time for various specialties including neonatology, emergency medicine, pediatric intensive care, burn, genetics, cardiology, and asthma education.

Methodology and Data Limitations

Primary and secondary data collection informed the comprehensive needs assessment. Researchers collected statistical data regarding demographics and health status from various sources, including the U.S. Census Bureau, the Annie E. Casey Foundation Kids Count Data Center, Arkansas state agencies, the Youth Risk Behavior Survey, Arkansas Children's Hospital, and state-based or neighborhood-focused research by local organizations. Most data was examined at the state level, but a number of indicators lent themselves to county-level analysis. Racial or age breakdowns were another way to examine the health of specific populations within the state. National comparisons and trends over time helped highlight areas that were improving, declining, or were lagging far behind the nation.

Over the course of several months, researchers conducted eight focus groups with parents, educators, and community members to discuss child health in Arkansas. Twenty-four interviews with thought leaders and subject-matter experts drilled into specific issues on child health. The Natural Wonders Partnership Council, comprised of agency leaders and professionals invested in child health, also had an opportunity to give feedback to the researchers. A phone survey of 1,000 Arkansas households examined perceptions about needs, challenges, and assets related to the health of children, statistically significant to the congressional district level. Secondary data were examined for trends, common themes, and regional disparities. Certain questions were compiled into quantitative results.

After data collection was complete, researchers noted areas of highest need, especially those found to be important in both qualitative and quantitative results. Poor national rankings, significant deviation from national averages, or areas that have shown declining trends were given priority. A matrix detailing the most significant needs found from a variety of data sources summarizes results.

Limitations Throughout the data collection and prioritization process, areas where data was not available were noted. Of particular note, chronic disease data for children is not tracked at the state level through the Arkansas Department of Health outside of school nurse survey completed by approximately one-quarter of school districts. Specifically, data on pediatric type 2 diabetes, high cholesterol, elevated blood pressure, asthma, sleep disorders, and other factors related to chronic disease are lacking at the state level, and recently-updated data is lacking on many more indicators. Health care providers and public health professionals should be working to update screening recommendations and population-level data collection for chronic disease risk factors in children. In the short term, the Youth Risk Behavior Survey could be updated to collect this type of data for high school students, or all schools could be required to participate in the school nurse survey. A state-level all-payer claims database would also allow a much more comprehensive examination of claims data for children rather than the analysis of limited Medicaid data available today.

A limitation to the telephone survey conducted for the needs assessment was the population surveyed. In order to access cell phone data, registered voter files were used. Of the population who responded to the survey, only 30 percent had children less than 18 years of age living in their home. This could limit respondents' knowledge of the health needs of children.

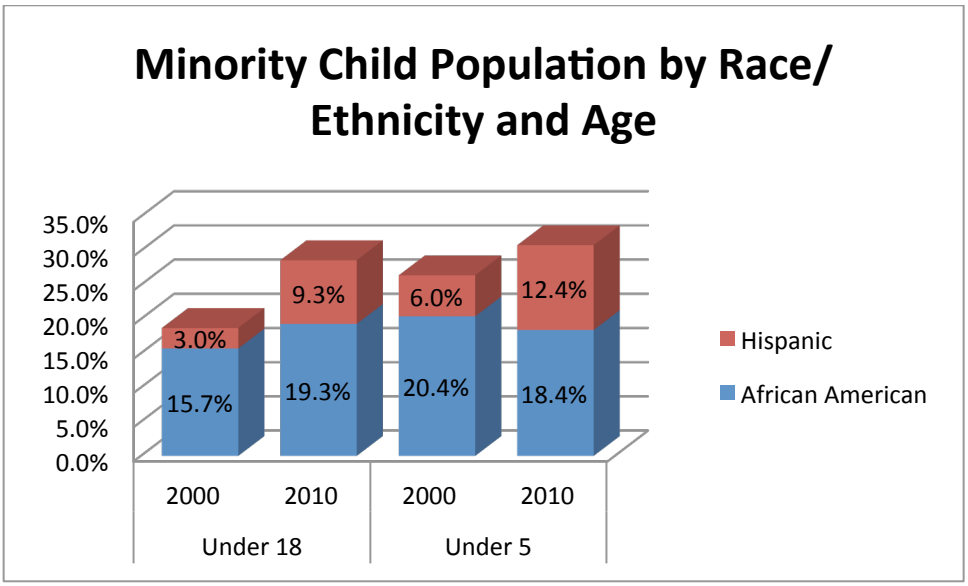
Secondary Data Analysis

In an effort to analyze the current health status of Arkansas children, secondary statistical data were examined. Data describing Arkansas demographics and exploring social determinants of health helped set a context for an analysis of statistics regarding health outcomes for children. A variety of data sources were used, including the Annie E. Casey Kids Count Data Center, the U.S. Census, the Arkansas Department of Health, the Youth Risk Behavior Survey, and several local organizations' publications. A full data appendix is available.

Demographics and Social Determinants of Health

In assessing the health of children in the state of Arkansas, demographic considerations and social determinants of health play a major role.

Population Arkansas's population is 2.9 million, with 710,223 children under age 18 (24.3%). This is a decrease in the child population of 1.1 percentage points from 2000, when 25.4% of the state's population were under age 18. Conversely, the percent of the population made up of elderly Arkansans has grown from 14% in 2000 to 14.4% in 2010.[1] The median age has increased from 36.0 years to 37.4 in the past decade, indicating a shift toward an older population base.[2] The state's minority child population is growing and changing, as the following graph shows.



Source: Annie E. Casey Foundation Kids Count Data Center

Arkansas has an estimated 9,000 non-citizen children living below 200 percent of the federal poverty level.[3] In fact, Arkansas ranked fourth in the nation in growth of its foreign-born population from 2000-2010 with 82 percent growth.[4] Arkansas also has one of the largest Marshallese communities in the United States, with about 4,300 Northwest Arkansas residents hailing from the Marshall Islands.[5]

Poverty and Basic Needs Arkansas ranks fourth in the nation for its overall poverty rate of 18.7%.[6] Children fare worse, with 26.8% of children under age 18 living in poverty in 2010 – a 23% increase from 2000.[7] The Annie E. Casey Foundation's Kids Count Ranking for Economic Well-Being in Arkansas is 39th in the nation.

Child Poverty in Arkansas, 2010	
Children under 18 in Poverty	26.8%
•African Americans	46.4%
•Hispanics	39.0%
•Whites	19.9%
Children under 5 in poverty	30.9%

Source: AR Advocates for Children and Families, Child Poverty Update, 2012

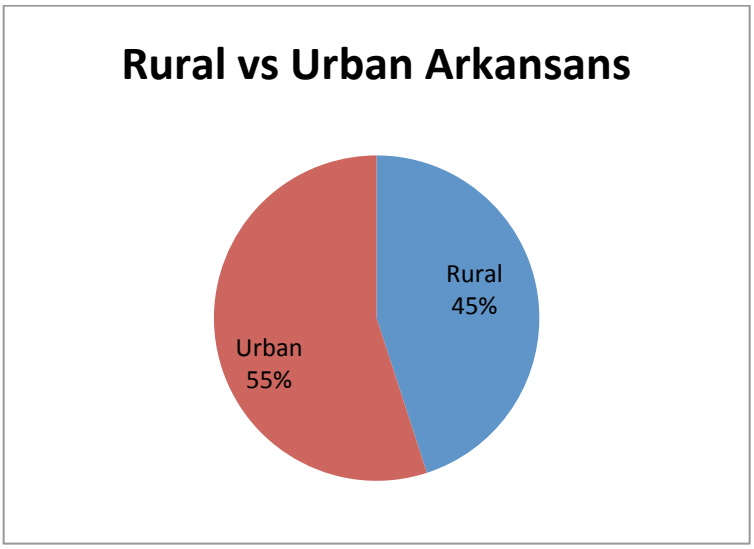
Poverty affects families' ability to save for unpredicted or future expenses, especially in easy-to-access savings. More than a quarter of Arkansas households are "asset poor," and more than half lack sufficient liquid assets that can be accessed easily if needed.[8]

With a median household income of $38,413, many children live in households unable to provide for basic needs.[9] WIC nutrition assistance ensures that more than 90,000 mothers, infants, and children have foods to encourage healthy development.[10] More than 300,000 children are enrolled in the Supplemental Nutrition Assistance Program (SNAP), and one in five households is food insecure.[11] Arkansas ranks last in the nation for food security, with only 14.7% of Americans being food insecure nationally.[12] Arkansas children experience a food insecurity rate of 27.8%, and an ongoing survey of Arkansas Children's Hospital emergency room patients showed that 18% were food insecure.[13]

Food Insecurity in Arkansas	
Food Insecurity, all households, 2011	19.2%
Very low food security, 2011	7.6%
Child food insecurity rate, 2010	27.8%

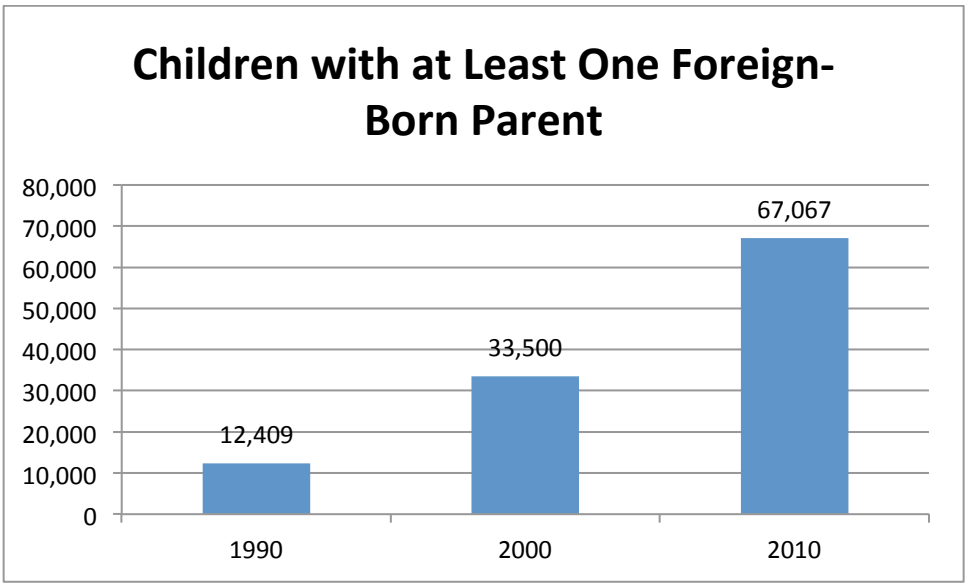
Source: USDA Household Food Security in the U.S.; Feeding America Map the Meal, 2010

Arkansas ranks 48th in the nation in child homelessness, and almost 14,000 children were homeless in 2010.[14] A quarter of Arkansas households pay more than 50% of their income in rent, and 51% of Arkansas children are housing-insecure.[15] The majority of Arkansans own their own home (67%), but 6.4% of households have no vehicle.[16] More Arkansans live in urban areas than rural.[17]



Source: U.S. Census Bureau, 2010 Census

More than one in three children live in a single-parent family, and almost 68,000 Arkansas grandparents live with their grandchildren.[18] In state fiscal year 2012, more than 1,300 children were in the care of a relative other than a parent.[19] A growing number of children have at least one foreign-born parent.[20] More than seven percent of families speak a primary language other than English.[21]



Source: AACF Critical Generation: Improving the well-being of children of immigrants in Arkansas

In 2011, 71 percent of Arkansas children had at least one risk factor for poor health, school or developmental outcomes.[22] The Annie E. Casey Foundation's Kids Count Ranking for Family and Community is 45th in the nation. [23]

Education The Annie E. Casey Foundation ranks Arkansas 34th in the nation for education.[24] Arkansas is behind the nation in the number of adults with Associate's, Bachelor's, and Graduate or Professional degrees.[25]

Education of Adults over 25	Arkansas	United States
Less than high school	16.9%	14.4%
High School	35.1%	28.4%
Some College	22.3%	21.3%
Associate's Degree	6.1%	7.6%
Bachelor's Degree	13.0%	17.7%
Graduate or Professional	6.5%	10.5%

Source: U.S. Census Bureau, 2009-2011 American Community Survey

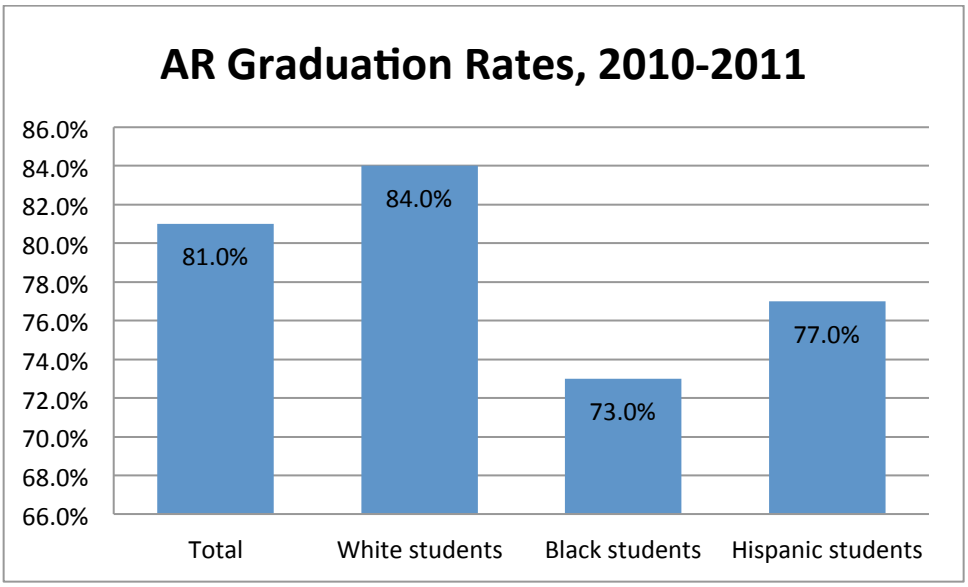
Education begins early, and children need quality child care from day one. Currently, the state has more than 177,000 slots in licensed child care provider facilities, with 14 percent of these meeting high quality measures outlined in the Arkansas Better Chance (ABC) or ABC for School Success programs. About 8,300 children receive assistance for child care with about 2,000 additional subsidized spots opening soon for qualified children.[26]

Not enough Arkansas children receive early childhood education, with 52% of Arkansas children not attending preschool. The state fares slightly better than the national average of 54% of children not attending preschool.[27] Especially for younger children, access can improve for low-income-eligible pre-k in programs such as Arkansas Better Chance, Arkansas Better Chance for School Success, and Head Start.[28]

Children eligible for ABC, ABCSS, or Head Start who are enrolled in quality pre-k	
4-year-olds	80.0%
3-year-olds	47.0%
0- to 3-year-olds	2.2%

Source: Arkansas Advocates for Children and Families. Pre-K: Access to Success in Arkansas (2012)

Quality pre-k can help improve long-term education outcomes, an area where Arkansas needs improvement. In Arkansas, just 30% of fourth-graders are proficient in reading, and 29% of eighth graders are proficient in math.[29] Arkansas's high school graduation rate is 81%, and disparities exist by race.[30] Additionally, fourteen percent of the Arkansas population lacks basic prose literacy skills, a strong risk factor for low health literacy skills.[31]

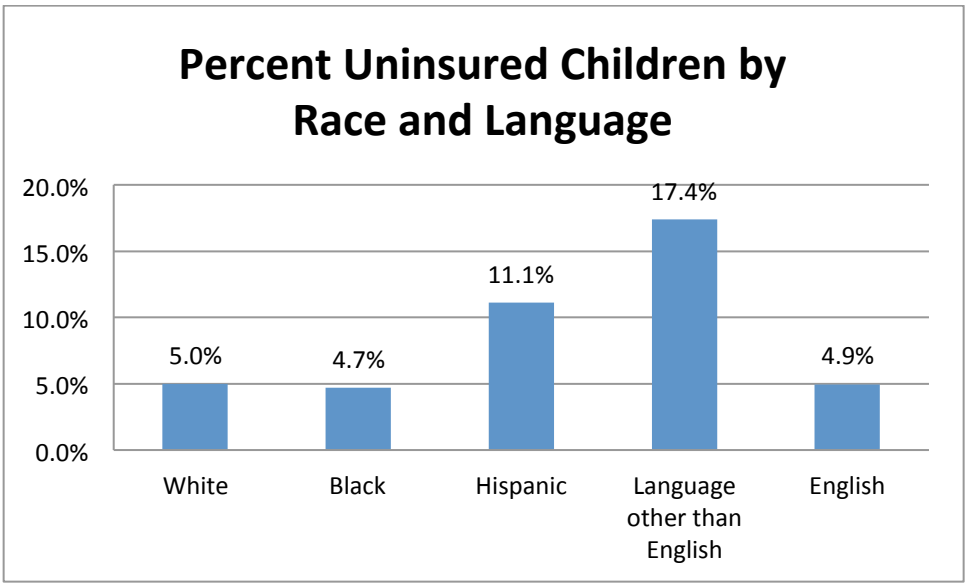


Source: US Department of Education, SY2010-11 Four-Year Regulatory Adjusted Cohort Graduation Rates

Access to Health Coverage and Health Care Services Thanks to the ARKids First program, the number of uninsured children in Arkansas has decreased dramatically since 1997, from 22 percent to just 6 percent in 2011. However, 45,500 children remain uninsured. The income demographic with the highest uninsured rate is for children just above the income cap for ARKids First, 200-250% FPL. Race and household language breakdowns highlight additional disparities, especially for Arkansas children whose families speak a language other than English.[32]

Percent Uninsured Children in Arkansas by Federal Poverty Level	
<100% FPL	**7.1%**
100 - <200% FPL	**8.1%**
200 - <250% FPL	**9.0%**
250 - <400% FPL	**4.1%**
>400% FPL	**2.0%**

Source: PRB analysis of 2011 American Community Survey PUMS, U.S. Census Bureau



Source: PRB analysis of 2011 American Community Survey PUMS, U.S. Census Bureau

Access to health care can be a challenge for Arkansas children. All but two Arkansas counties are entirely or partially medically underserved and 19 counties are dental health professional shortage areas.[33] Primary care health professional shortage areas affect 18.9% of the population, and 62.4% of Arkansans live in a mental health professional shortage area.[34] Twelve community health center organizations provide health care and dental services to the underserved in Arkansas, including children, through 75 sites.[35]

Six percent of children in Arkansas who receive ARKids First or Medicaid do not have an assigned primary care physician (more than 24,000 children).[36] While the ConnectCare program helps families find providers with open Medicaid spots, anecdotal evidence suggests some families have difficulty finding open appointments for Medicaid-covered patients. A primary care physician helps ensure children have a medical home to connect them to the services they need and monitor their health status. While many unassigned children still visited a physician or had a primary care provider in the past, some transition caused them to be without guaranteed access to needed care.

Of children enrolled in the Medicaid program, only 47 percent received *all* of the well-child preventive screenings they should have in 2011. Overall, sixty-two percent of the screenings that should have occurred were actually provided. Nationally, 87 percent of required screenings occurred.[37]

Home visiting programs work with pregnant women, parents, and children in their own home and in group settings. Home Visitors assist parents in anticipating child development stages, developing skills and confidence to serve as their child's first teacher as well as chief protector and nurturer. A 2010 survey from the Arkansas Home Visiting Network showed that 31 home visiting programs serve more than 10,000 families.[38] Most programs in the network currently employ one of nine evidence-based models (or two promising models) to work with families. Arkansas's capacity for home visiting programs is being strengthened through a Maternal, Infant, and Early Child Home Visiting program grant designed to expand and evaluate home visiting efforts.

Health Status

The Annie E. Casey Foundation ranked Arkansas 37th in the nation for child health in its most recent report. Risk factors and health outcomes contribute to this low rank.

Pregnancy and Childbirth Many Arkansas children are at risk from the time they are in the womb. Arkansas's teen birth rate for women ages 15-19 is 52.5 per 1,000 in 2010. While this is a marked reduction from 2007's rate of 60.1 per 1,000, it still ranks us 48th in the nation. The national average is 34.3 teen births per 1,000 births. [39]

A significant percentage of all live births are to teenagers. Again, while the data shows improvement, much work remains to ensure teenagers are not becoming mothers.

Teen and Unmarried Births	2011	2009
Percent of all live births to teens under 20	12.6%	14.6%
Percent of all live births to teens under 18	3.6%	4.4%
Percent of births to unmarried women	44.8%	45.4%

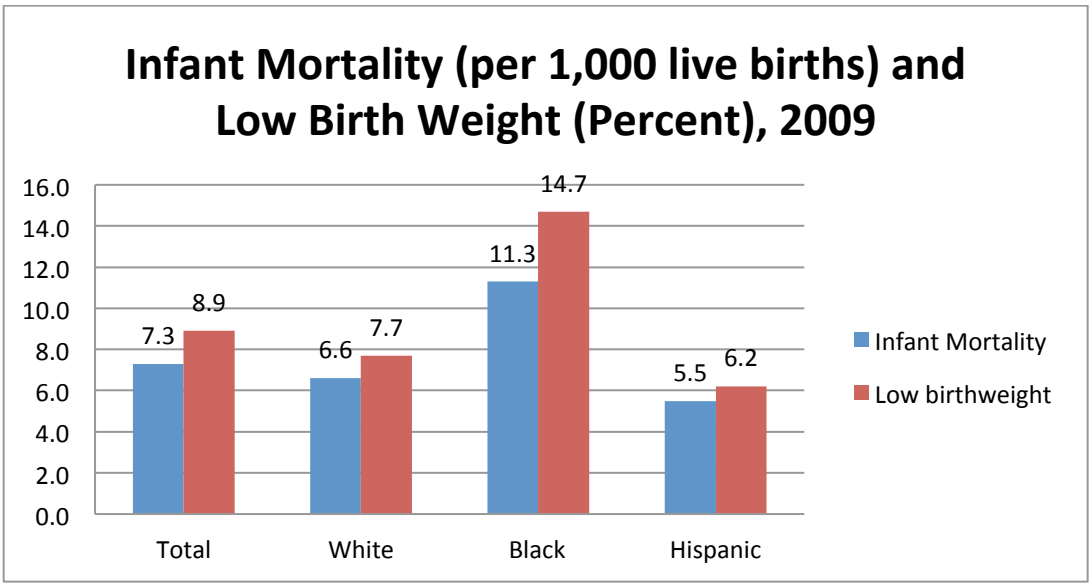
Source: AR Department of Health, Current Birth data

Sixty-six percent of high school students are engaged in sexual activity by the 12th grade, and pregnancy is not the only potential outcome.[40] Sexually transmitted diseases are most prevalent in adolescents and young adults, with the majority of cases affecting 15 to 24-year-olds.[41] Sixty-five Arkansans between the ages of 13 and 24 contracted HIV in 2011.[42]

Sexually Transmitted Infections by Age, 2011			
	Chlamydia	**Gonorrhea**	**Syphilis**
Total Number of Cases	16,047	4,687	349
Ages 5-14	209 (1%)	48 (1%)	48 (1%)
Ages 15-19	5,976 (37%)	1,444 (31%)	106 (30%)
Ages 20-24	6,051 (37%)	1,692 (36%)	73 (21%)

Source: AR Department of Health, AR STD Annual Report, 2011

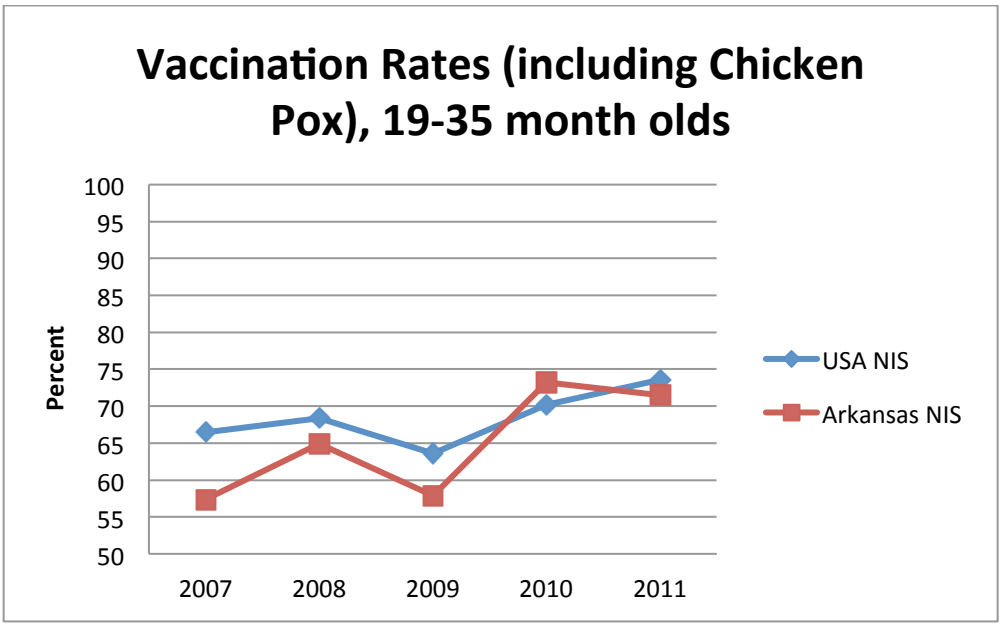
These and other risk factors contribute to Arkansas's high infant mortality rate and low birth weight percentage. Only 78.9 percent of births had first-trimester prenatal care in 2011, and 13 percent of babies were born pre-term.[43] An analysis of 2009 data examines infant deaths and low birth weight babies by race.[44]



Source: Unpublished data from Dr. Nugent of NCHS linked birth/Infant Death files, AR Department of Health, 2009

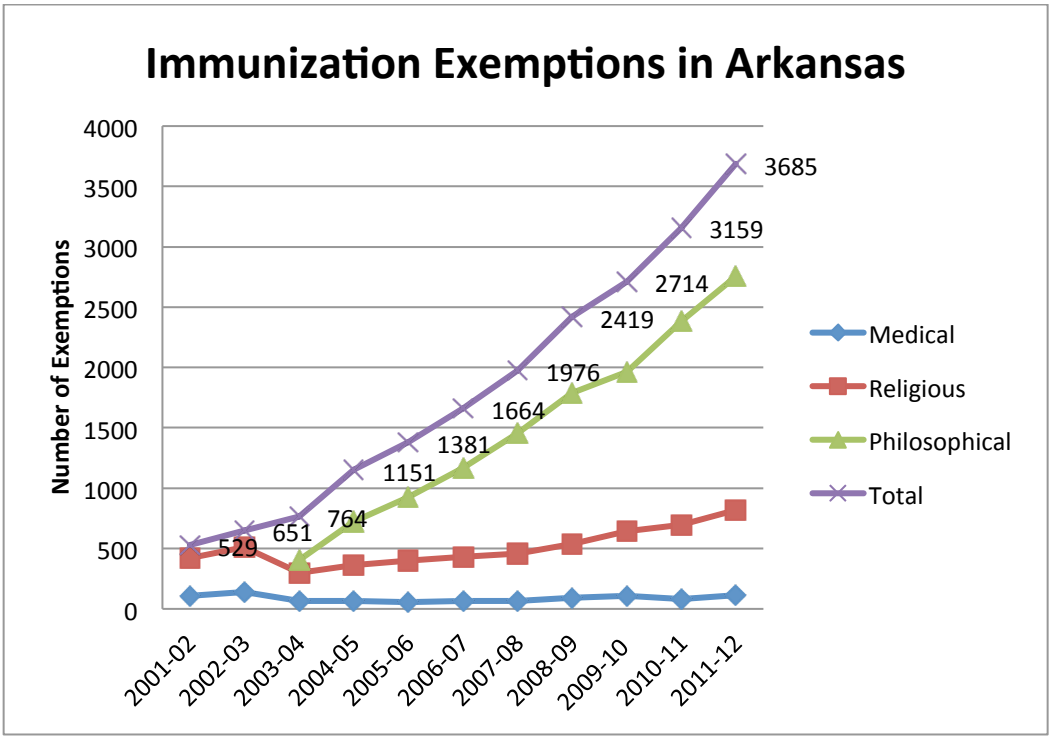
Newborn screening has been successful in Arkansas, with 98.5 percent of babies born in Arkansas in 2011 receiving a metabolic screening; 77 disorders were detected through these screens in the same year.[45] Four infants per 100 live births in Arkansas will be diagnosed with a birth defect, or 1,500 children per year. Congenital heart defects are the most commonly diagnosed birth defect.[46] Across the age spectrum, one in five Arkansas children has special health care needs (19.8%).[47]

Immunizations Arkansas children mirror the nation in vaccination compliance rates. In 2011, the rate of full vaccination compliance, including chicken pox (varicella) for 19-35 month olds was 71.5 percent in Arkansas and 73.6 percent for the nation. Arkansas has made significant progress in vaccinating children, increasing the rate from just 57.4 percent in 2007.[48]



Source: Dr. Haytham Safi report pulled from National Immunization Survey. Arkansas Department of Health.

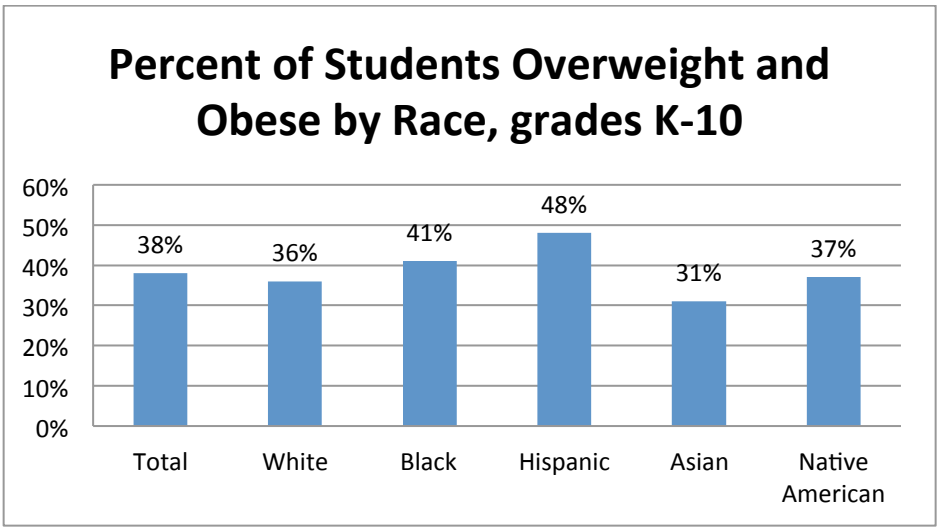
In 2011-2012, almost 3,700 children were granted an exemption due to medical, religious, or philosophical reasons. Since philosophical exemptions began in 2003-2004, they have increased rapidly and comprise 75 percent of all exemptions. While less than 1 percent of all Arkansas children are granted exceptions, close to thirty percent of children are not fully immunized.[49]



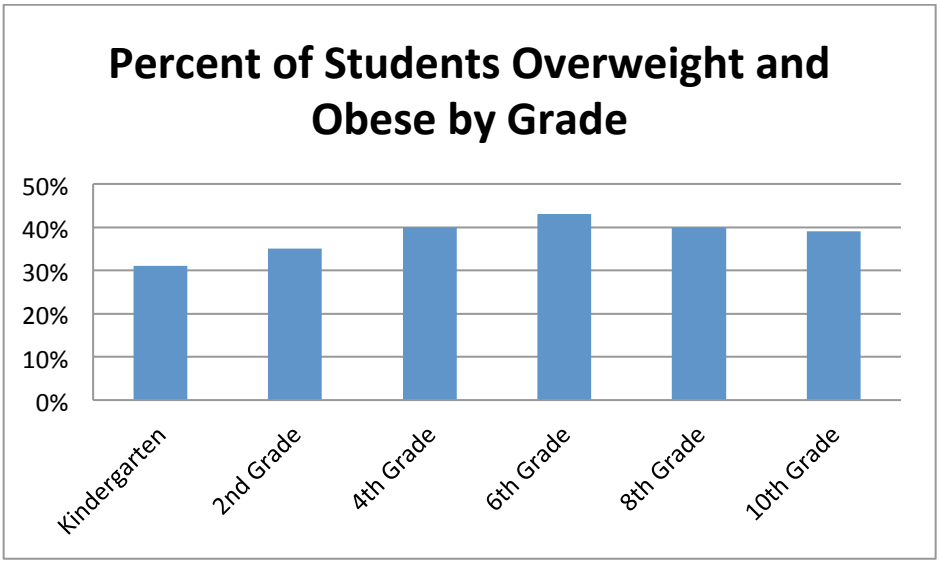
Source: Dr. Haytham Safi report pulled from National Immunization Survey. Arkansas Department of Health.

Obesity and Chronic Disease National data shows that Arkansas children have higher overweight and obesity rates than most states in the nation. Overweight is defined as a Body Mass Index (BMI) at or above the 85th percentile, and obesity is at or above the 95th percentile. Nationally, 31.7 percent of children are overweight or obese, but 37.5 percent of Arkansas children are in this category. Arkansas ranks 44th in obese children and 41st in overweight children.[50]

Arkansas has measured BMI rates in all schoolchildren since 2003. Trends in the data have not changed significantly over the past decade, with overall overweight and obesity rates peaking in the 6th and disparities affecting black, Hispanic, and Native American students. For the 2011-2012 school year, 83 percent of all Arkansas public school children were screened, and 38 percent were found to be overweight or obese, aligning with national surveys.[51] For tenth graders, the overweight and obesity rate was 39 percent, which is interesting when compared to a self-reported study showing that just 29 percent of high school students felt slightly or very overweight.[52]



Source: Assessment of childhood and adolescent obesity in Arkansas, year 9 (2011-2012)



Source: Assessment of childhood and adolescent obesity in Arkansas, year 9 (2011-2012)

Health behaviors are important factors in chronic disease and obesity. Healthful eating, adequate physical activity, and limiting sedentary activities help avoid health issues. Arkansas children fare worse than the nation in eating fruits and vegetables, being active, and watching television for long hours. Females fall behind males in physical activity rates as well.[53]

Health-Related Behaviors	AR	US
Children who ate fruit/vegetables 3+ times per day in past 7 days	12%	15%
Children who were active 1+ hour per day, 5 times in past week	40%	50%
•males	52%	60%
•females	29%	39%
Children who watch 3+ hours of TV on school day	32%	32%

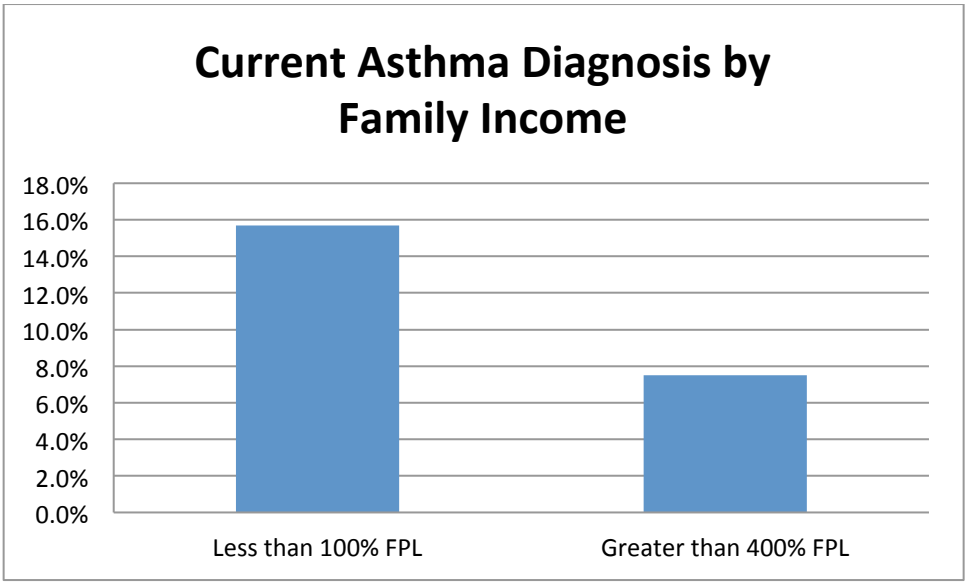
Source: Youth Risk Behavior Survey, 2011 (state and national)

Despite significant risk factors for adult chronic disease, Arkansas does not track obesity-related disease in children. Nationally, type 2 diabetes prevalence is growing in 10 to 19-year-olds, but Arkansas's rates are unknown.[54] High cholesterol, elevated blood pressure, and heart disease data are not available at the state level for children, either. Other chronic disease rates in children are also difficult to find; newborn screenings provide an approximate rate for the population.

Arkansas Children's Hospital (ACH) patient data shows that more children with chronic, complex conditions are being hospitalized, while fewer "healthy" children are admitted with acute illness. Arkansas is not alone in this trend; aggregate data from other children's hospitals shows that between 2004 and 2010, hospitals experienced the largest growth in children with life-long chronic conditions that affected two or more body systems or were complex in nature. ACH data showed that children with government payers had higher overall patient days than non-government payers, indicating a possible association between lower incomes and poor health. Children with two or more body system conditions are increasingly covered by government payers. Conditions such as cerebral palsy, chromosomal abnormalities, congenital heart disease, and bronchopulmonary dysplasia dominate the group of patients with complex, chronic conditions. [55]

Asthma Local studies have been conducted to assess the burden of asthma in Arkansas. Fifteen percent of Arkansas children have ever had asthma, and black children experience a higher rate than the population with 17.9 percent of children having been diagnosed. In families where someone smokes but not inside the home, 19.9 percent of children have had asthma.[56]

Of children who currently have asthma (12.3 percent of children), more males than females, and more black children than white, have an existing diagnosis. Income appears to be a factor as well for current asthma diagnoses. [57]



Source: Burden of Asthma in Arkansas: Biddle et. al. (2011)

Local research shows that rural children had more asthma complications than urban, including recurrent trouble breathing, chest tightness, recurrent cough, and repeated bronchitis.[58] Additionally, predominantly minority, low-income, rural schoolchildren experience symptoms consistent with undiagnosed and uncontrolled asthma.[59] High school students were current smokers had higher prevalence of asthma attack or episode (9.6 percent) than those who did not (7.3 percent).[60]

Oral health Arkansas improved its Oral Health Ranking from the Pew Center on the States from an F in 2010 to a C in 2011, thanks to legislation that improves community health and access to care for oral health care. Five counties in Arkansas lack a dentist, and only about a third of Arkansas dentists accept Medicaid or ARKids First, making access difficult for some rural or low-income children. Only 65 percent of Arkansans' water systems are fluoridated, leaving many without an important tool for reducing poor oral health.[61]

Children in Arkansas continue to struggle to access the preventive and restorative oral health care they need. Thanks to mobile dental vans and other outreach spearheaded by Arkansas Children's Hospital, the number of children with sealants has increased from 17 percent in 2008 to 27 percent in 2010.[62] Disparities continue to exist for racial minorities.

Oral Health Factors, children	
Children with Sealants	27%
•Non-white	20%
Children in need of routine dental care (2010)	26.6%
Children with current or past dental caries (2010)	64.0%
•Non-white	69.0%
Children with untreated caries (2010)	29.0%
•Non-white	33.0%
Arkansas teens who use smokeless tobacco (2010)	15.0%
•White males	31.0%

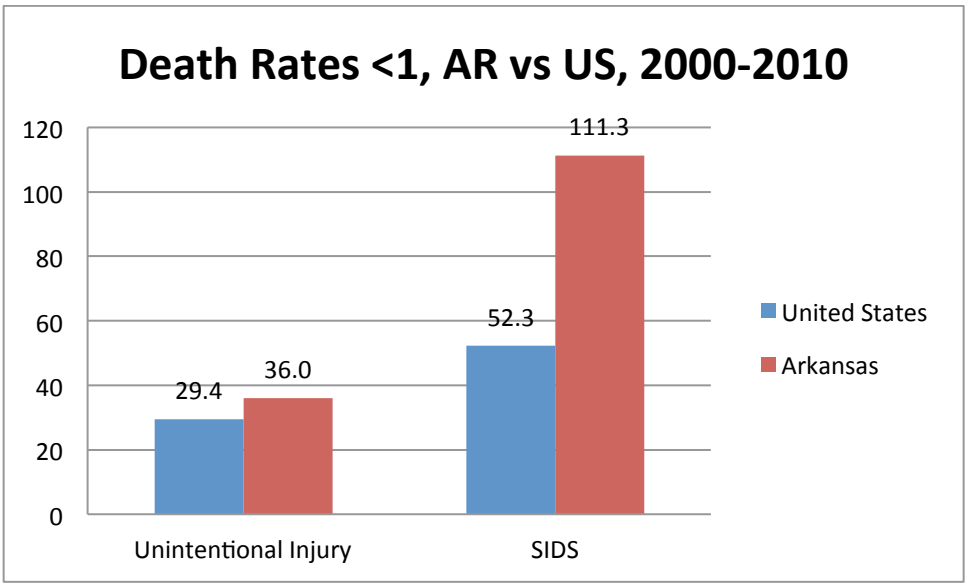
Source: AR Department of Health, Oral Health in Arkansas, 2012

Unintentional Injuries and Risky Behavior Unintentional injury is the leading cause of death for Arkansans ages one to 44.[63] The child death rate in Arkansas for children ages one to 14 is 26 per 100,000 children, significantly higher than the national average of 18 per 100,000 children. For ages 1 to 19, the child/teen death rate is 37 per 100,000 compared to a national average of 27 per 100,000.[64]

Unintentional Injury mortality for children ages 0-19 in 2010 was 15.83 per 100,000 children compared to 26.43 per 100,000 in 2000. This represents a 40 percent reduction over the past decade in deaths due to unintentional injury. Leading causes of death for children and infants both include unintentional injury, including Sudden Infant Death Syndrome (SIDS) for infants.[65] Arkansas's SIDS death rate for infants is more than double the national rate.

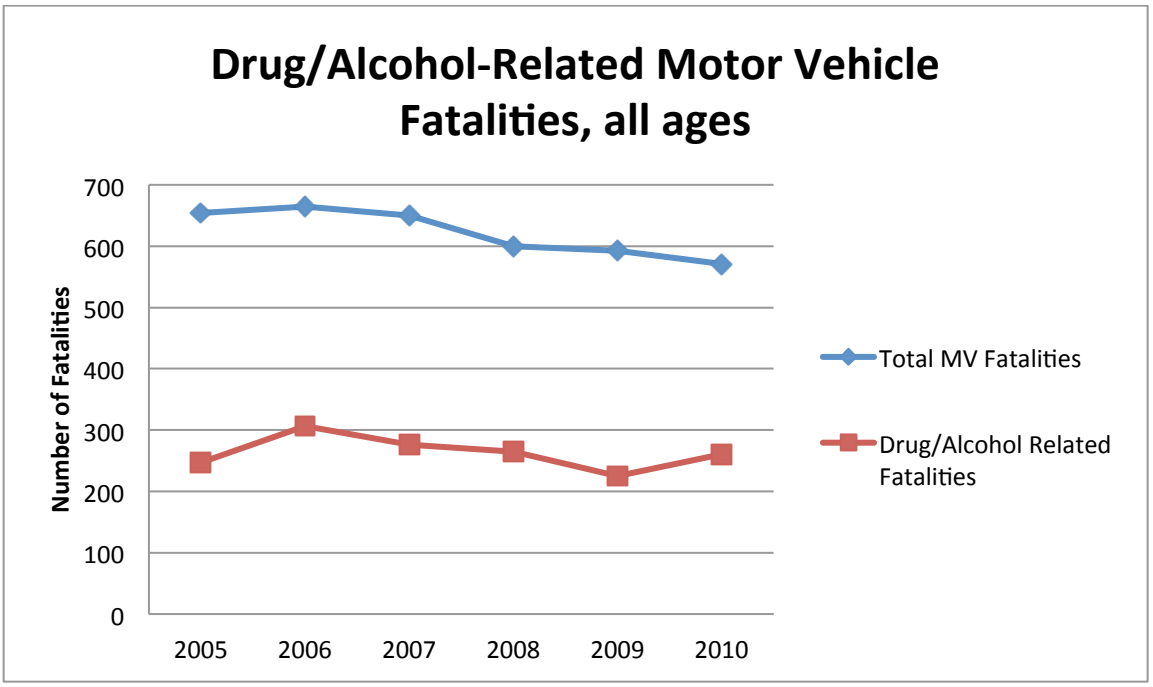
Leading Causes of Death, Arkansas, 2000-2010	Ages 1-18	Infants <1
First	Unintentional Injury	Congenital Anomalies
Second	Homicide	SIDS
Third	Malignant Neoplasms	Short Gestation
Fourth	Suicide	Maternal Pregnancy Complication
Fifth	Heart Disease	Unintentional Injury

Source: CDC, WISQARS database



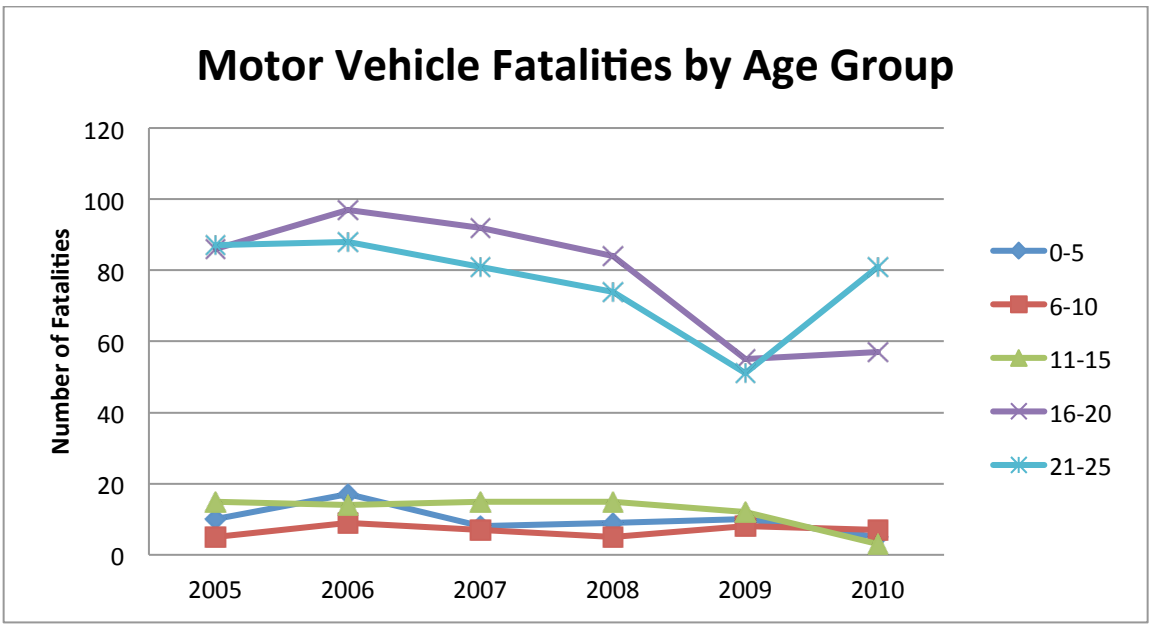
Source: WONDER, Centers for Disease Control and Prevention

Motor vehicle fatalities are a leading cause of unintentional injury deaths in Arkansas, and alcohol and drugs played a role in 46 percent of fatal vehicle injuries in 2010.[66]



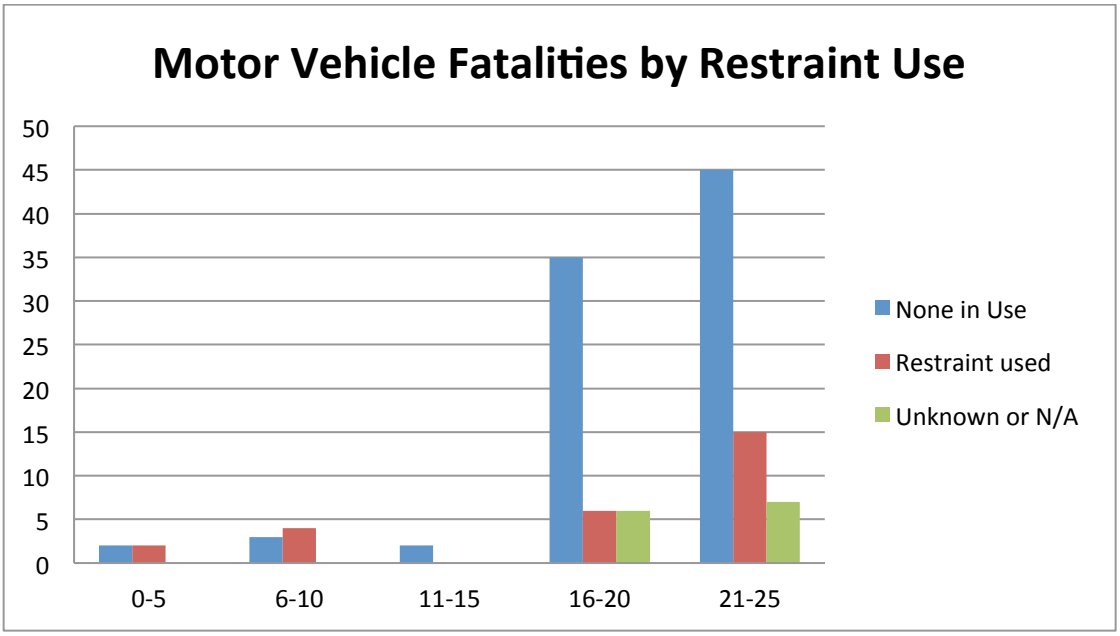
Source: Arkansas State Police Arkansas 2010 Traffic Crash Statistics

Young drivers have seen a decrease in recent years for the number of motor vehicle fatalities, although drivers aged 21-25 saw a spike in 2010. [67]



Source: Arkansas State Police Arkansas 2010 Traffic Crash Statistics

Additionally, seatbelt and car seat use plays an incredible factor in motor vehicle fatalities. In 69 percent of fatalities for ages 0-25, no restraint was used.



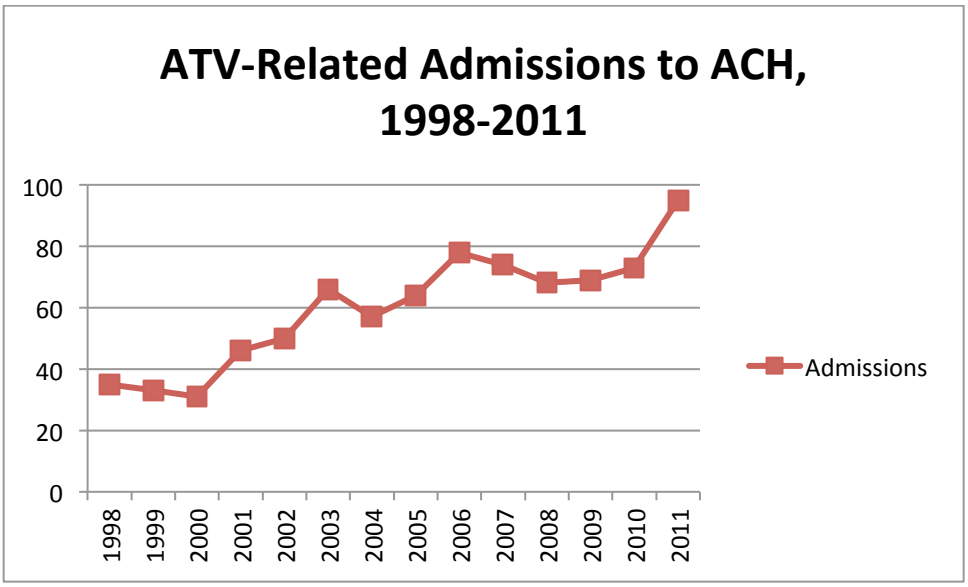
Source: Arkansas State Police Arkansas 2010 Traffic Crash Statistics

Recent legislation that strengthened teen driving laws appears to have improved health outcomes for teen drivers, saving 32 lives in 2010 compared to 2008.[68]

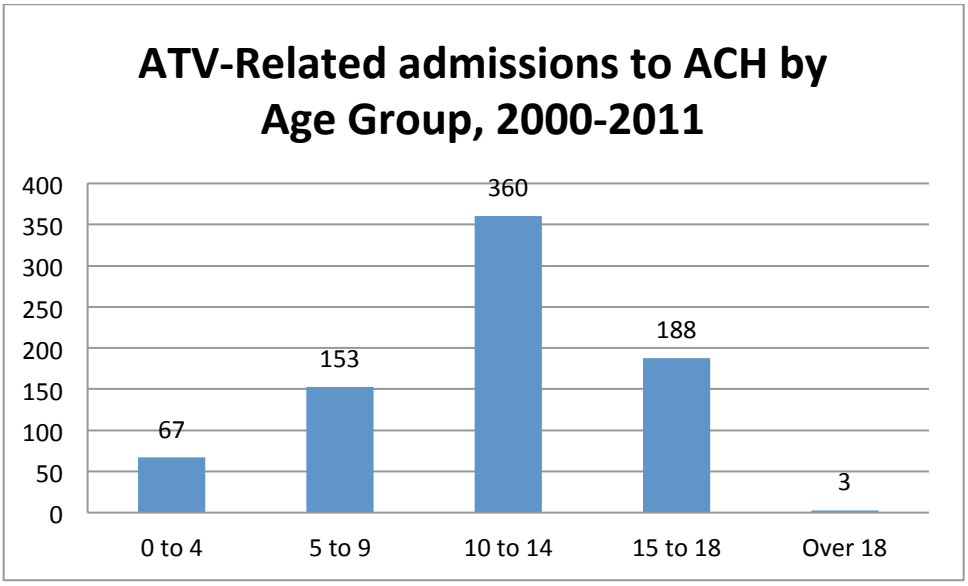
Graduated Driver License Outcomes, 2008-2010	
Reduction in rate of crashes for 16 year olds	22%
Reduction in fatalities involving teen drivers	59%
Reduction in single-vehicle fatal crashes for teen drivers 16-18	52%
Number of lives saved in fatal crashes involving teen drivers	32 lives
Reduction in crashes between 11 p.m. and 4 a.m.	76%
Reduction in crashes involving 5 or more passengers	20%

Source: AR Center for Health Improvement, Graduate Driver License Fact Sheet

Road vehicles are not the only risky vehicle for children. All-Terrain Vehicles (ATVs) were responsible for 95 admissions to the Arkansas Children's Hospital in 2011, up from 31 admissions in 2000. Children ages 10 to 14 have the largest number of admissions.[69]



Source: Arkansas Children's Hospital Injury Prevention Center



Source: Arkansas Children's Hospital Injury Prevention Center

The ATV –related death rate for children ages 0-18 is more than double the national rate at .73 per 100,000 compared to .3 per 100,000 nationally.

ACH serves as the pediatric level I trauma center for the state, taking the most critically-injured children. In 2011, the hospital received 963 hospital transfers through the trauma system, and 823 had been receive in the first three quarters of 2012. Emergency Medical System referrals to ACH totaled 149 in 2011, and 2012 was outpacing that with 167 by October. ACH also treats child and adult burn victims; it saw 163 in 2011 and had treated 165 in 2012 with 10 weeks left in the year.

Other behaviors put youth at risk. Of high school students, more than a quarter rode with someone who had been drinking, and a third had consumed alcohol in the past month. One in five Arkansas

students had carried a weapon in the past month, and substance use is also prevalent in a significant portion of high school students.[70]

Risky Behaviors	Arkansas	United States
Riding with someone who was drinking	26%	24%
Students who carried a weapon last 30 days	21%	17%
Students who ever attempted smoking	51%	45%
Students who drank alcohol last 30 days	34%	39%
Students who took prescription drugs not prescribed for them	18%	21%
Rarely or Never wore a seatbelt	14%	8%
Drove while drinking in past 30 days	8%	8%

Source: Youth Risk Behavior Survey, 2011 (state and national)

Smoking rates for youth in Arkansas have dropped significantly for Arkansas youth in the past decade although students still try smoking at a higher rate than the national average, at 51 percent in Arkansas versus 45 percent nationally.[71] Males continue to smoke at a significantly higher rate than females.[72]

Cigarette use, high school students	2010	2000
Current cigarette use	23.5%	35.8%
•males	27.8%	37.5%
•females	18.7%	33.7%

Source: Arkansas Department of Health; AR Youth tobacco Survey, 2010

Drug Use is another issue affecting far too many Arkansas youth, with a third of high school students using marijuana at least once and thirty percent of teachers believing drug and alcohol abuse is a top health issue for students.[73]

Drug-related Risk Factors	Arkansas	United States
Students who used marijuana one or more times in their life	33%	40%
Students who used any form of cocaine one or more times in their life	4%	7%
Students who inhaled paint/sprays or sniffed glue one or more times in their life	13%	11%
Students who used methamphetamines one or more times in their life	6%	4%
Students who were offered, sold, or given illegal drugs on school property in past year	26%	26%
Percent teachers who thought alcohol and drug abuse pressing health issue	30%	n/a

Source: Youth Risk Behavior Survey, 2011 (state and national) and May 2012 annual survey of HealthTeacher users; 226 respondents or 7.8% response rate from Arkansas teachers.

Behavioral Health In Arkansas, one in five children has at least one developmental, emotional, or behavioral condition.[74] High school students in Arkansas mirror national trends for behavioral health risk factors, although disparities exist by sex and race/ethnicity. Notably, 22 percent of students were bullied at school in the past year.[75] Teachers in Arkansas identified bullying as the most pressing health issue facing Arkansas students, with sixty-six percent of teachers listing it as the number one issue in 2012.[76]

Behavioral Health Risk Factors	Arkansas	United States
% feel sad, hopeless	28%	29%
% seriously considered suicide	14%	16%
•Females	18%	19%
•Hispanic	18%	17%
% kids made plan for suicide	13%	13%
•Hispanic	22%	14%
% attempted suicide	10%	8%
Students bullied at school in last 12 months	22%	20%
Students who considered suicide past 12 months	14%	16%

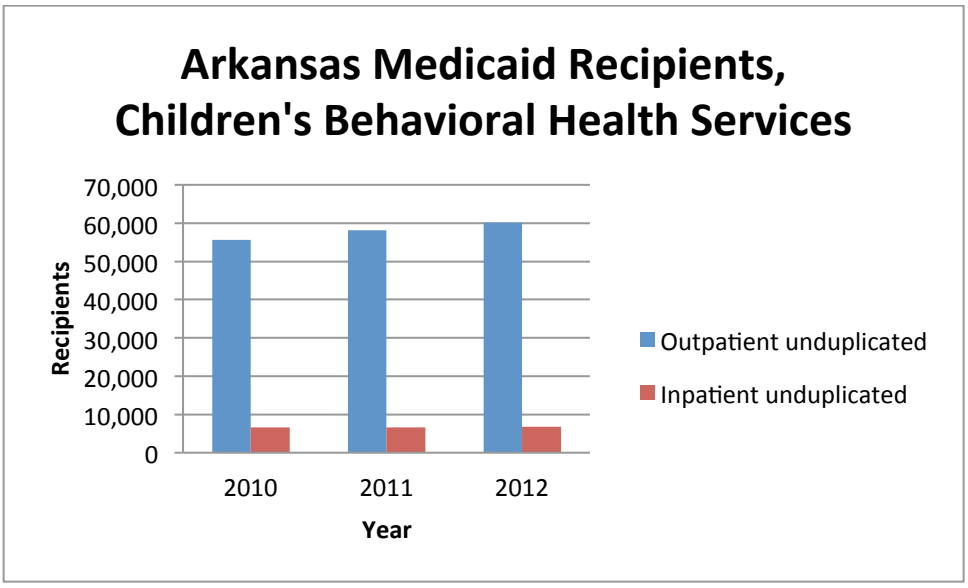
Source: Youth Risk Behavior Survey, 2011 (state and national)

Arkansas's mental health system serves many youth who need services, whether within schools, outpatient settings, or inpatient services.

Arkansas mental health system data , SFY 2007-2011	
Recipients under age 5	19,740
Expenditures under age 5 (state dollars)	$46.2 million
Cost per Recipient under age 5	$2,342
Recipients age 5-18	250,280
Expenditures age 5-18	$1.8 billion
Cost per Recipient age 5-18	$7,270

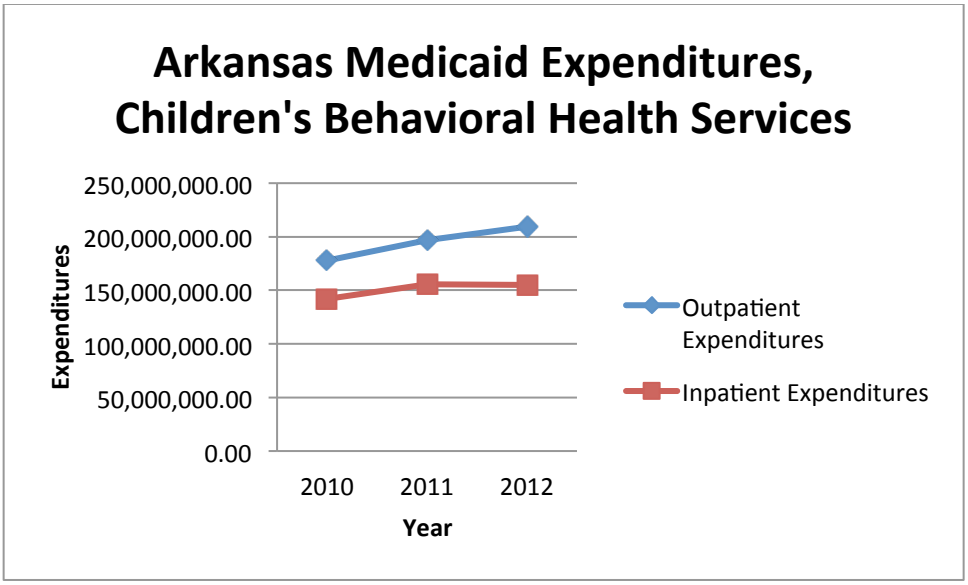
Source: DHS legislative joint auditing report, June 22, 2012

The number of children receiving Medicaid behavioral health services has increased slightly in the past several years. The number of children receiving outpatient services is growing more quickly than children receiving institutional care, a sign that community-based services are being utilized over inpatient settings.[77]



Arkansas Department of Human Services Medicaid Claims data, special run, 2013.

Expenditures for children's behavioral health are also growing significantly, with $31.7 million more in services provided in 2012 than in 2010. However, the majority of expenditures are in outpatient care; as recently as 2006, inpatient care was outpacing outpatient services.[78]



Arkansas Department of Human Services Medicaid Claims data, special run, 2013.

The Children's Behavioral Health Care Commission (BHCC) works at the system-level to address issues within the mental health and substance use disorder arena. One priority of this group is to implement standard outcome assessments, which it has done for patients in Rehabilitative Services for Persons with Mental Illness (RSPMI) agencies. In 2011, more than 86,000 surveys were completed by patients and caregivers, a 50 percent rate of completion. The surveys showed high satisfaction with RSPMI services. Progress on several other initiatives was outlined in the BHCC Annual Report to the Governor in 2011.[79]

Violence and Child Welfare System Arkansas has worked for many years to strengthen the state's child welfare system. In 2012, 10,927 children in Arkansas were involved in substantiated reports of abuse or neglect, and 7,793 were in the foster care system. Sixty-four percent of child maltreatment assessments were completed in a timely manner (within 30 days) compared to just half in 2009.[80]

Promise Neighborhood

The Central Little Rock Promise Neighborhood (CLRPN) is an effort to replicate the public-private partnerships modeled in the Harlem Children's Zone to provide children in a fixed geographic area "whatever it takes" to help them grow up to be healthy, well-educated, productive adults. Arkansas Children's Hospital's main campus is located in the midst of the neighborhood and provides primary care to many neighborhood children. The hospital is invested in outcomes for children in the neighborhood surrounding it.

Originally funded by a U.S. Department of Education Promise Neighborhood Program planning grant, the CLRPN is led by the University of Arkansas at Little Rock, Arkansas Children's Hospital, Central Arkansas Library System, City of Little Rock, Little Rock Preparatory School, Little Rock School District, New Futures for Youth, and UAMS. A comprehensive needs assessment was published for the neighborhood in 2011, covering educational, health, neighborhood safety, and other data specific to the zip codes in the CLRPN. A few highlights from the CLRPN needs assessment that call for the involvement of ACH include the following indicators.

Access to health care and parenting skills:

- 23% of households surveyed think of the emergency room as the first place they take a sick child, rather than a doctor's office or clinic
- 57% of parents have not participated in a formal parenting class

Birth data:

- 16% of births to women in the CLRPN were to mothers 19 or younger (2007-2009)
- 52% of mothers giving birth in the CLRPN had not completed high school (200-2009)
- 23% of babies born in the CLRPN weighed 5 pounds or less at birth; 38% of these low birth weight babies weighed 4 pounds or less (2007-2009)

Nutrition and physical activity:

- 38% of households said children consumed fruit only 2-5 times per week
- 23% of households said children never participated in 60 minutes of physical activity at a time
- Almost 50% of students in some CLRPN schools have an unhealthy Body Mass Index

Neighborhood safety:

- 59% of children do not feel safe at school
- 11% of juveniles aged 9-17 were victims of violence (2009-2010)
- 2% of juveniles were arrested for violent crimes and 1% were arrested for drug-related crimes
- 2% of students were homeless and 1% in foster care

Parent Data

Undeniably, parents and caregivers have an immeasurable impact on their children. Unfortunately, in Arkansas, parents do not always model ideal health and well-being for their children. While this report does not delve specifically into parental issues, a few statistics are worth noting given their potential impact on children.

- **Poverty**: 17 percent of non-elderly adults and 12 percent of elderly adults were in poverty in 2010.[81]
- **Family Violence**: In 2010, 21 females were murdered by males in single victim homicides, ranking the state 19th. In 2007, the state was fourth in the nation for this type of murders. In 2009, a one-day survey indicated that more than 600 victims were served in emergency shelters or housing, or received services including legal advocacy.[82]
- **Drug and Alcohol Use**: Arkansas ranks 42nd in alcohol consumption for person 18 and older, but 6th in cigarette use for adults. Though cocaine use rates in Arkansas are typically lower than the national average, methamphetamine use is higher.[83]
- **Mental Health**: In 2010, 13 percent of adults reported that their mental health was not good for 14 of the past 30 days.[84]
- **Chronic disease**: In 2010, 67 percent of adults were overweight or obese, and 10 percent reported being diagnosed with diabetes. In 2009, 39 percent of adults reporting having high blood cholesterol, and 34 percent reported having high blood pressure. [85]
- **Insurance Status**: One in four non-elderly adults have no health insurance (26 percent). Adults who have no health coverage can lack access to preventive care and treatment that can help them be healthy, engaged parents.
- **Healthy behaviors**: In recent years, 30 percent of adults reported having engaged in no physical activity in the past month; 80 percent consumed fewer than 5 fruits and vegetables a day, and many did not receive routine screenings such as prostate cancer screening (57%), pap smears (25%), or mammograms (31%).[86]

Parents with less-than-optimal health or environmental factors may be less able to provide their children with the opportunity to achieve the best health possible. As it relates to health behavior and parenting skills, an investment can be made in the well-being of the entire family unit through educational efforts.

Community Feedback

Several methods of primary data collection were used to take the considerations of the community served by Arkansas Children's Hospital into account. Researchers conducted eight focus groups with parents and educators around the state, interviewed nearly two dozen subject matter experts in children's health and well-being, and conducted a phone survey of 1,000 Arkansas households. Preliminary results of the needs assessment were presented to the Natural Wonders Partnership Council as an opportunity to suggest additional data, ask questions, and identify emerging issues. The following analysis of each type of community feedback highlights common themes.

Focus Groups

Eight focus groups examining community members' perspectives on children's health were held across the state of Arkansas in August and September 2012, hosted by Arkansas Advocates for Children and Families. The communities covered by the focus groups included Batesville, Forrest City, Gurdon, Lavaca, Little Rock, Jonesboro, and Springdale. Local organizations including school based health centers, health departments, and churches took the lead on recruiting participants to the sessions in all locations but Little Rock. One Little Rock group was held in the Promise Neighborhood, and the other extended invitations to community members invested in child well-being through Arkansas Advocates for Children and Families.

Description of a Healthy Child

To ground the rest of the discussion, the first part of the focus group was spent describing what a healthy child would look like. In all sites, a comprehensive picture of a healthy child was developed. Participants talked about physical, mental, and oral health. They described a need for healthy eating, exercise, and adequate sleep. They mentioned the need to be loved, happy, safe, and supported. They talked about having confidence, social skills, and skills for dealing with pressure and conflict.

Key Concerns Regarding Child Health in Your Community

Focus group participants were asked to talk about the health concerns they have regarding the children in their community. Following a robust discussion in each site, the participants were asked to vote on their top two concerns. The following is a list of the key issues that were raised:

- Access to Healthy Food – In both rural and urban areas, some participants felt they live in food deserts. Either grocery stores were far away, or the stores located in the communities offered limited selections of affordable, healthy food.

- Social Norms and Role Models Regarding Teen Pregnancy – In several communities, teenage pregnancy is viewed as an acceptable social norm, and participants felt that television shows glorify young motherhood. Additionally, young people look to celebrities rather than local community members as role models.

- Parents Not Parenting - Almost every site talked about parents who are still children themselves, not engaged in their children's lives, raising their children in unstable environments, and abusing drugs and alcohol.

- Family Violence – Several communities discussed children growing up in homes where they witness their family members being emotionally and physically abused and can experience the abuse themselves. Stigma keeps families from talking about the abuse and getting physical and mental health services.

- Health Insurance – ARKids is viewed as a great resource for those children who are enrolled. However, children in families whose incomes fall just over the eligibility limits and children who do not have legal access to the program do not enjoy its benefits.

Report Card on Health Conditions and Services in Your Community
Each participant was asked to fill out a "report card" on health conditions and available health services in 11 categories. These categories were drawn from the "Natural Wonders" reports. Participants were asked to rate each category as A, B, C, D, or F. The following table summarizes the grades given by all focus group participants.

Category	Grade	Category	Grade	Category	Grade
Health Literacy	D	**Insurance Coverage**	D	**Prenatal Care**	C
Immunizations	C+	**Mental Health**	C-	**Teen Pregnancy**	D
Infant Mortality	D	**Obesity**	D	**Tobacco Use**	D
Injury Prevention	C	**Oral Health**	C		

Statewide, all categories averaged either a C or a D, with the highest score for immunizations and the lowest score for obesity. Scores across the sites varied somewhat. No site gave an A to any category. Six of the eight sites gave a B to immunizations; two gave a B to prenatal care, and two gave a B to infant mortality. One site gave a B to mental health, most likely because of their school based health center. Four sites gave obesity an F, and another three sites gave obesity a D. Both insurance coverage and teen pregnancy received one F and six D's; health literacy received one F and four D's.

What Can ACH do to Help in Your Community?
Participants were asked what ACH could do to help child health in their communities. The following is a summary of the ideas that came up most frequently.

- Health Education – Almost every site mentioned a need for help with health education, primarily for teens and adults, related to topics such as teenage pregnancy and eating healthy food on a budget. People felt frustration with traditional education methods that do not seem to be reaching the parents. Perhaps strategies should meet young parents where they are – through the use of celebrities they admire or through their cell phones.

- Satellite Clinic/Telemedicine – One of the biggest issues in rural communities is not having access to a pediatrician, a specialist, a dentist, or a mental health professional. Several communities expressed a desire to have either a satellite clinic or more use of telemedicine to provide access to the full array of health care professionals.

Participant Demographics
Just over 100 individuals participated in the eight focus groups. The overwhelming majority (92 percent) were women. There was a fairly even distribution across age groups (26 percent between 18 and 35, 36 percent between 36 and 49, 34 percent between 50 and 64, and three percent 65 or older).

The racial and ethnic makeup of the groups mirrored the state's demographics (58 percent Caucasian, 38 percent African-American, and four percent Hispanic.) A little over half of participants (56 percent) had children living at home. Almost all (98 percent) of those children had health insurance.

Interviews

To explore the status of child health in Arkansas, Arkansas Advocates for Children and Families interviewed twenty-three key stakeholders who were chosen based on their depth of knowledge of the issue. Stakeholders included health care providers, community leaders, government employees and educators with specialties ranging from broader state-wide policy, to services offered by ACH, UAMS and ADH, to smaller, local community service providers. Each participant was asked the same set of questions which were developed to ascertain the major health issues in the state and prompt suggestions for how Arkansas Children's Hospital can contribute to alleviating these problems.

Defining a Healthy Child

All participants in this research were primarily asked to offer their definition of a "healthy child." Though answers varied slightly, participants agreed that a healthy child was one whose physical, mental, emotional and developmental needs were being met. He or she has a medical and dental home, regular well-child visits, proper immunizations, a nutritious diet, gets plenty of exercise and has a supportive family and community environment. This child receives a quality education that most likely began before kindergarten and in which he or she has plenty of support. While many participants agreed that, based on this definition, many children in Arkansas are indeed healthy, there are a large number of children who are not.

Child Health Concerns and Causes

Primary health concerns that emerged from this research include obesity, poor dental health, teenage pregnancy, lack of immunizations, access to mental/behavioral health services, childhood injury, and tobacco/substance abuse. Obesity was the most commonly stated health concern. Poverty and a lack of health literacy were the most commonly stated reasons behind child health issues in the state. Time and time again, participants expounded on how low socioeconomic status directly correlates to the health of a child. Several participants emphasized that unemployed parents created significant barriers to optimal child health.

- *Food deserts and Food Literacy*: Reasons given for the epidemic of childhood obesity in Arkansas ranged from the lack of health food stores or the availability of only fast food options, creating "food deserts" in the many rural areas of the state to the minimizing of recess time in the school day to the culture of computer gaming. A major reoccurring theme, however, was the idea that many parents lack the knowledge on how to prepare healthy foods or believe that healthy foods are too expensive to purchase.

- *Transportation and Access to Providers*: Lack of transportation necessary to take a child to the doctor or travel to Arkansas Children's Hospital was frequently mentioned as a barrier to care, especially if special services were unavailable. Arkansas is a very rural state, and many towns lack pediatricians, obstetricians and other specialists, thus creating the necessity for parents to drive hours in many instances in order to secure services for their child or to deliver a baby. Even if service providers do exist in these communities, there is a capacity at which they accept

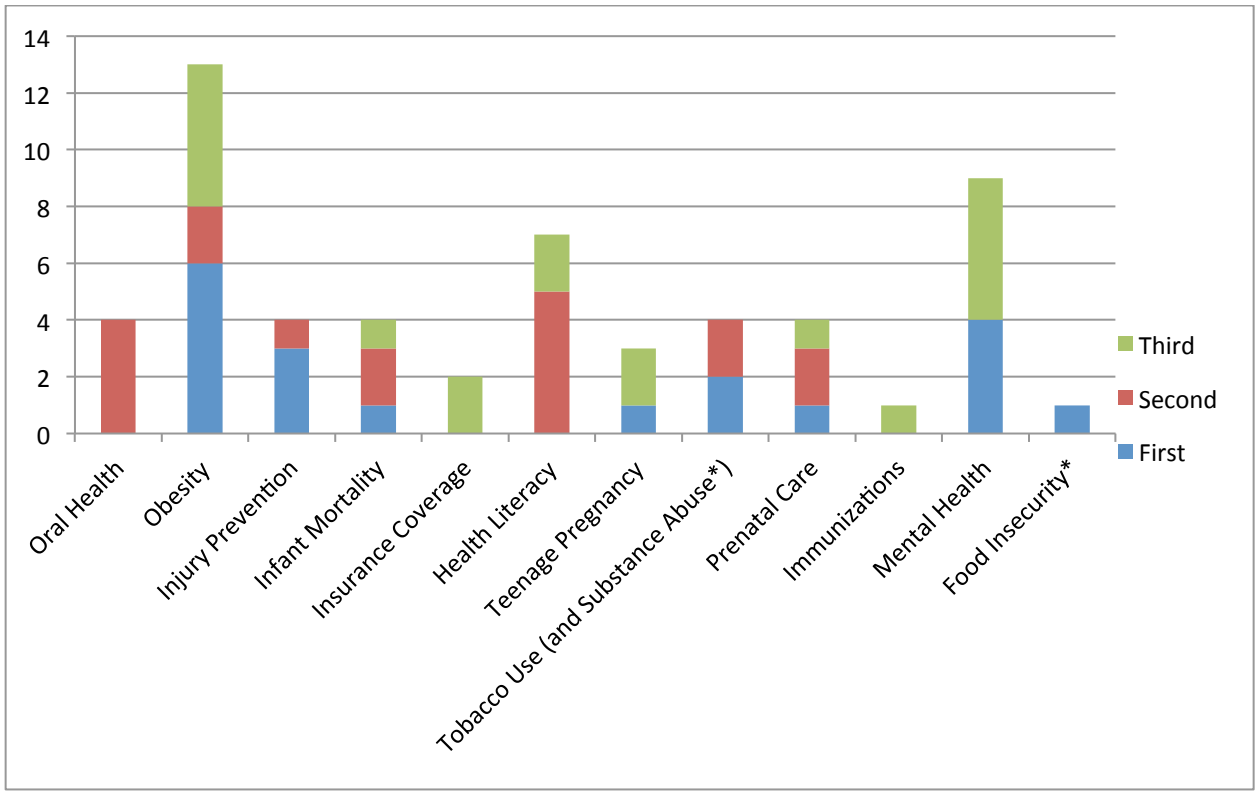
ARkids First patients. There can be a long waiting list to get an appointment. The fact that there are few, if any, dentists in many communities who accept ARkids First was also mentioned.

- *Time Off and Prioritizing*: Time off from work is not always available to low-income families as stated by many interview participants, creating the impossible choice for parents to take their child for a check-up with the potential consequence being a reduction in pay or even loss of a job. Priorities for many families living in poverty include feeding their children and keeping a roof over their family's heads rather than worrying about the types of food they children are eating or prioritizing well-check-ups.

- *Culture and Perception of the Healthcare System*: The culture of poverty was also discussed thoroughly in these interviews regarding its implications on child health. A barrier to preventing teenage pregnancy in some communities lies in the fact that in many families it is considered the norm. Additionally, there is a permeating culture in rural areas that does not rely on the health-care system. Children are told to "buck up" if they have a toothache because that is how their parents dealt with pain growing up. In some instances, there is also a fear or lack of trust in the healthcare system, particularly within predominantly African-American communities. Taking a child to the doctor, especially when they are healthy, is seen as an unnecessary hassle that will only result in losing money and time or potentially drawing the attention of DHS.

- *Health Literacy*: A lack of knowledge and resources on how to maintain the health of their children is a permeating challenge for many parents, as well as the root cause behind childhood illness and injury discussed by many participants. The importance of parent, child and healthcare provider education was listed as a key element to addressing every health concern mentioned.

Primary Health Concerns



Interview participants were shown the above list of issues and asked to rank the first, second and third most serious or pressing health-related issues regarding child health in Arkansas.

What Can Be Done?

After discussing challenges, interviewees were asked about their suggestions for improving some of the issues they felt affected children's health. Some of the most common ideas are detailed below.

Education and Resources

Community outreach and education were prevalent themes throughout these interviews. The importance of educating parents on the effects of threats such as second-hand smoke, childhood obesity, and poor dental hygiene and maintenance was stressed, as was the importance of educating parents on child safety. The need for health literacy was also applied to addressing teenage pregnancy in the state. Educational outreach needs to extend to youth in all areas of health – including reproductive health, nutritional health, and mental health.

Resources are an essential component to this as well. Parents need to be educated on the importance of nutrition for their children but also given the resources to make nutrition a reality for their families through, for example, healthy cooking classes. Additionally, many participants interviewed emphasized the need for education and resources to be provided to parents whose children have mental, emotional and/or behavioral health issues.

Creating a Culture of Health and Support

To promote healthcare in the state, interviewees expressed a need to establish a culture of supporting families. Initiatives like Home Visitation that involve meeting parents where they were and providing

them with support and resources were praised. Healthcare providers need to be educated on the social norms of a community and provide resources and services in Spanish.

Emphasizing the importance of healthcare should be a priority from the family level to the business community and all the way to the state-wide level. Outreach to businesses should stress the importance of child health, emphasizing the need for supportive policies on taking time off for a sick child. Additionally, state leaders should become actively involved in the promotion of child health and safety across the state.

Finally, a culture of support should be evident through health care provider practices. An often-mentioned example of this would be extended clinic hours and weekend options for well-child visits to give parents more flexibility and options.

Developing Partnerships

Interviewees stressed the need for continued formation of partnerships to address the issues of child health in the state. These partnerships ranged from local (ex: working with the neighborhood around ACH to build a grocery store that could be used by patients and employees of the hospital) to statewide partnerships between ACH and local care providers, creating a constant communication of the health needs and status of all communities. Partnerships should be created between organizations addressing food insecurity and obesity specialists, and other health concerns should be addresses from all angles. Additionally, partnerships with state-wide and local businesses are needed, as well as neighborhood groups to address the lack of jobs in the state.

School-Based Health Centers

Another reoccurring recommendation coming out of these interviews was to increase the number of school-based health clinics around the state. These clinics provide children and parents with immediate care, without the need for taking time out of work. Having a clinic in the school also meets families where they are and emphasizes the essential pairing of education and health.

Continued Outreach

Though many participants praised the work of Arkansas Children's Hospital, they stressed the need for continued outreach. Dental vans were necessary in every community and should be extended to children of all ages. Health care providers should be dispatched to all areas of the state to provide education to children, parents, teachers and healthcare providers to establish a state-wide network of education and care.

Phone Survey

A telephone survey of 1,003 registered voters was conducted from November 7 – December 4, 2012 by Opinion Research Associates, Inc. [87] A large portion of the survey replicated a 2007 statewide survey conducted for the 2008 Natural Wonders report, giving points of comparison for change perceptions of the public. Statistical significance was achieved at the state and congressional district levels.

Respondent Demographics	
Age group	*Percentage*
18-24	3%
25-34	9%
35-44	15%
45-54	23%
55-64	23%
65+	27%
Educational Background	
Some high school or less	7%
High School	24%
Some college	33%
College graduate	36%
Income	
Less than $20,000	12%
$20,000-$50,000	46%
More than $50,000	29%
No answer/Don't know	13%
Race/Ethnicity	
White/Caucasian	82%
Black/African-American	16%
Other or Refused	2%
Sex	
Male	46%
Female	54%

Source: Opinion Research Associates, Inc. A Survey of Arkansas Public Opinion on Children's Health Issues. (2012).

An open-ended question asking respondents about the two most pressing issues facing children highlighted the impact of obesity and related issues. Obesity, good nutrition, or physical activity was the first concern mentioned by 35 percent of those surveyed. Thirteen percent mentioned irresponsible parenting first, and 10 percent mentioned lack of health insurance.

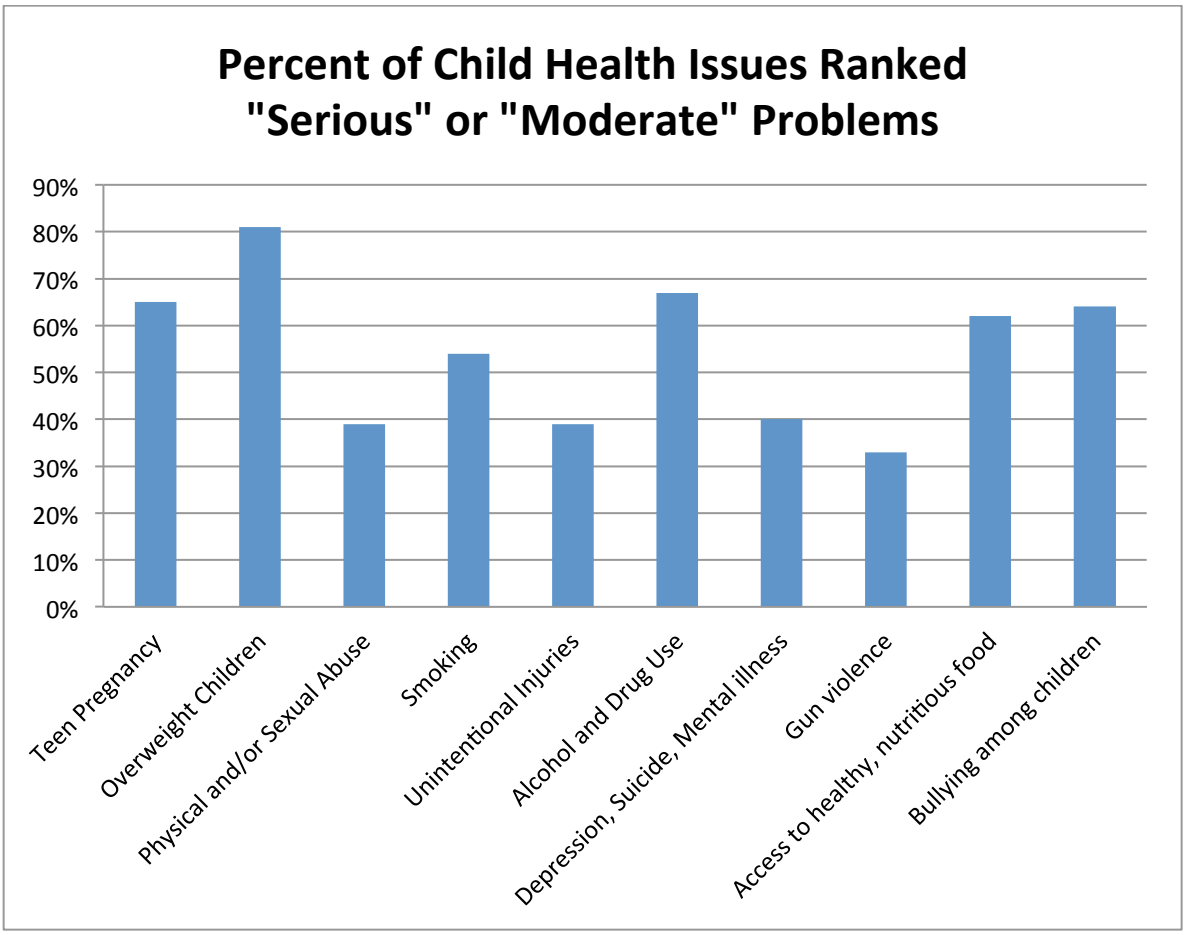
Parents were asked to rate their community on various issues. (Answers of don't know or no response not shown)

Community Issue, 2012	Excellent or Good	Average	Below Average or Poor
Availability of dental care for children	59%	21%	14%
Having enough doctors who take care of children	58%	22%	18%
Having the ability to take care of children with learning disorders	36%	27%	23%
Quality of education	63%	24%	12%
Having adequate pre-school for 3- and 4-year olds	42%	26%	14%
Having adequate quality childcare for infants and toddlers	35%	29%	16%
Having the ability to take care of children with discipline problems or disorderly behaviors	26%	28%	29%
Providing a safe environment for children	58%	28%	12%
Availability of home visiting programs for new and expectant parents	14%	17%	18%

Source: Opinion Research Associates, Inc. A Survey of Arkansas Public Opinion on Children's Health Issues. (2012).

Since the 2007 survey, communities have improved significantly on access to dental care for children and having the ability to take good care of children with learning disorders. Respondents perceive that good or excellent access to adequate pre-k for 3- and 4-year olds or quality child care is similar in 2012 as in 2007. Communities still struggle to handle children with discipline problems with 57 percent of respondents giving this indicator a rating of average or below. The majority (51 percent) of respondents answered "don't know" regarding the availability of home visiting programs, indicating the need to better advertise availability of these resources for parents.

The next set of questions asked about how serious problems were in communities, with rankings of "serious" or "moderate" shown in the below table.

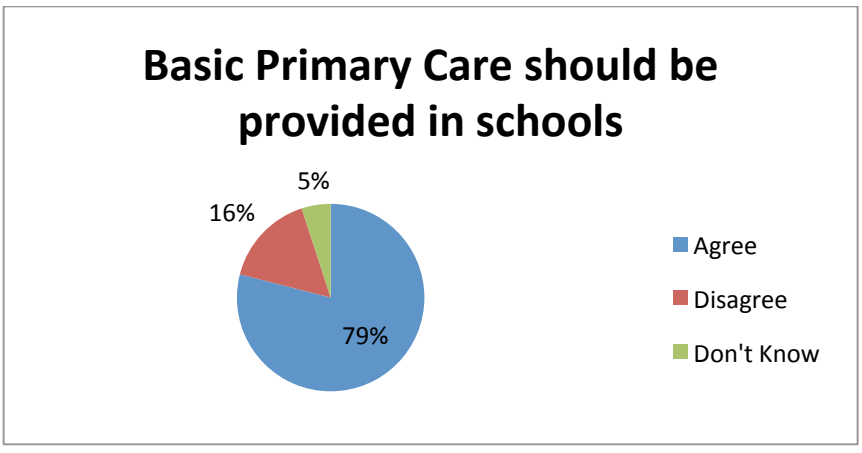


Source: Opinion Research Associates, Inc. A Survey of Arkansas Public Opinion on Children's Health Issues. (2012).

A few noted changes from 2007 survey results include

- Decrease in **smoking** being considered serious or moderate from 66% to 54%
- Decrease in **alcohol and drug use** being considered a serious problem from 45% to 28%

Many respondents felt that **access to health care** was more difficult for minority children (44%) and low-income children (62%). However, 79% of respondents felt that basic primary **health care services should be provided in schools**, a factor that can help improve access to care for all children.



Source: Opinion Research Associates, Inc. A Survey of Arkansas Public Opinion on Children's Health Issues. (2012).

New teen driving laws that were implemented in recent years receive very favorable opinions from survey respondents.

Favorability of Teen Driving Laws	Favor strongly or somewhat	Oppose strongly or somewhat
Graduated Driver Licenses	88%	11%
Primary Seat Belt Laws	84%	15%
Law regulating cell phone use while driving	97%	3%

Source: Opinion Research Associates, Inc. A Survey of Arkansas Public Opinion on Children's Health Issues. (2012).

Of respondents who had children in their home who were under 18 years of age, several issues emerged.

- 74% of caretakers agree (strongly or somewhat) that they can **afford medical care**, services, and medications their children need.
- 22% of caretakers are concerned that their **children may be overweight**, compared to 78% who are not concerned about this issue.
- 66% of respondents feel **emergency medical care** available to their child is "good" or "excellent." 27% feel emergency care is average.
- 50% of respondents' children have private **health insurance**, while 38% have ARKids First or Medicaid. Statistically, the surveyed population may be different from the state population, in which approximately 55% of children are enrolled in Medicaid or ARKids First.
- 27% of caretakers reported that their child had a chronic condition.
- 76% of caretakers prefer for their child to be seen at Arkansas Children's Hospital rather than other facilities if their child has a serious health issue

Natural Wonders Partnership Council

As a final avenue for feedback from the community, a two-hour presentation and discussion of preliminary needs assessment results, including primary and secondary data findings, was conducted with the Natural Wonders Partnership Council. This group of medical professionals, state agency leaders, and private child-focused nonprofits gave excellent feedback and suggestions for strengthening the needs assessment. While not a facilitated discussion, this was an opportunity for professionals to suggest additional data sources, areas of need, or concepts that could be part of the hospital's implementation plan.

Existing Resources to serve children

In addition to the ACH facilities and health care providers that have been mentioned, a host of resources and partnerships are available to help meet the needs of children across the state. Broadly, Arkansas's **changing health care system** aims to provide high-quality, lower-cost care to all Arkansans; specific initiatives include the Payment Improvement Initiative, health workforce development, improved opportunities for health care coverage, a medical records exchange system (SHARE), and efforts to strengthen medical homes for those with special health needs.

Schools go far beyond education, providing meals, after-school programs, and even health care through 15 school-based wellness centers to children. Arkansas's **investment in pre-k** programs means that children enter school ready to learn. The state provides funds to schools, based on the percent of students who qualify for free- or reduced-lunch, to help close the achievement gap for low-income students. This source of revenue can be used to improve educational outcomes, fund school health initiatives, or offer out-of-school time activities. The **Office of Coordinated School Health**, jointly supported by the Departments of Education, Health, and Human Services, helps schools develop the infrastructure to integrate health into the school environment, including the creation of additional school-based health centers. One way they help encourage health literacy is through the use of **HealthTeacher.com** and other health education curricula that are sponsored by ACH.

The **Injury Prevention Center at ACH** provides education, awareness, advocacy, and research to help reduce the number of unintentional injuries in the state. The state's **Trauma System**, provided for in 2009 legislation, has moved forward in developing a strong system of emergency care in the state. Hospital trauma-designation levels, improved emergency medical services infrastructure, and a new system for ensuring patients are transported to the most appropriate hospital(s) as quickly as possible are saving lives. **Telemedicine** efforts such as the ANGELS program and PedsPlace use telemedicine to consult with and train physicians to improve outcomes for infants. **Children and youth with special health care needs** are the focus of the System Improvement Project, which seeks to address system-wide health care issues that would help them receive timely, coordinated, family-centered care.

Programs that reach children where they are remain important. In addition to school-based health, **home visiting programs** go into the homes of at-risk families to ensure children grow up with parents who encourage their health and educational development. Mobile health care services, such as the three **mobile dental vans** at ACH or the state's Seal-the-State program, bring needed oral health care to underserved areas. The ACH Community Outreach staff help ensure that car-seats are installed correctly and that children practice fire safety, in addition to other activities.

Partnerships are also vital to continued health improvement for children in Arkansas, and the hospital works in collaboration with a host of them. The Natural Wonders Partnership Council and its subgroups on food insecurity, infant mortality, school health, and teen pregnancy help align the strengths of partner organizations to achieve systems-level change. The Children's Behavioral Health Care Commission does similar work specific to children's mental and emotional health needs. Advocacy groups such as Arkansas Advocates for Children and Families work in the public policy arena through coalitions, such as the Kids Count Coalition and the Finish Line Coalition, among others. The Arkansas Minority Health Commission ensures all minority Arkansans have access to health care that is equal to the care provided to other citizens of the state and seeks ways to provide education, address issues and prevent diseases and conditions that are prevalent among minority populations. Arkansas's Poverty Task Force, originally conceived through legislation, continues to suggest broad-reaching strategies to combat the high poverty rate in Arkansas.

Analysis and Prioritization

After examining a plethora of data, highest-priority needs were identified. The matrix below organizes the highest-priority needs from each data source (secondary data, focus groups, interviews, and phone survey) by the number of sources that cited them as high-need areas. Five topics arose as priorities in all four areas: access to care, food insecurity, sexual health, obesity, and intentional injuries. Parenting skills, unintentional injuries, oral health, immunization, and substance use were all prioritized in three of the four sources. These ten areas should receive a high level of attention from ACH as the hospital chooses its community benefit investments. Here, ACH should examine whether other organizations are addressing these needs or if the hospital could have a large impact by investing (or continuing to invest) in these areas.

Those issues that received a score of two or one may not have been highlighted in various sources, but they were of high importance where mentioned and should not be overlooked. With these issues, the hospital should be keenly aware of areas in which no other statewide entities are helping develop infrastructure as a way to direct community benefit work.

Prioritized Needs					
Child Health Needs	**Data Analysis**	**Focus Groups**	**Interviews**	**Phone Survey**	**Total mentions**
Access to Care: health insurance, school-based health centers, parent time off, expanded clinic hours, providers who accept ARKids First and Medicaid, satellite specialty clinics statewide, well-child screens	1	1	1	1	4
Food Insecurity: food deserts, affordability	1	1	1	1	4
Sexual Health: teen pregnancy, sexually transmitted infections in adolescents	1	1	1	1	4
Obesity: poor nutrition, physical activity	1	1	1	1	4
Intentional Injuries: Suicide, Family Violence, Bullying	1	1	1	1	4
Parenting Skills: general need for innovative education and outreach solutions to improve parenting skills, home visiting programs for at-risk families, tools for handling discipline problems or learning disorders		1	1	1	3
Unintentional injury: all-terrain vehicles, teen driving laws, infant mortality, low birth weight infants, sudden infant death syndrome	1		1	1	3
Oral health	1	1	1		3
Substance Use: tobacco, illegal drugs, alcohol	1	1		1	3
Immunization: low rate, exemptions	1		1	1	3
Homelessness or Housing Insecurity	1			1	2
Poverty, especially child poverty	1			1	2
Early Childhood Education for 0-3 year olds	1			1	2
Mental Health: Disparities by race and gender, access to care	1		1		2
Health Literacy: general health knowledge, nutrition, reproductive health, distrust of health system		1	1		2
Growing Hispanic Population: disparities in many areas	1				1
High School Graduation Rate: low graduation rate, disparities by race	1				1
Asthma: disparities by race, rural/urban disparities, access to care	1				1

Conclusion

As Arkansas Children's Hospital prepares to direct its community benefit work for the upcoming three years, this needs assessment should provide a comprehensive overview of the demonstrated and perceived needs for improving children's health in the state of Arkansas. It should help the hospital invest strategically in areas of most need or in places where resource or leadership gaps threaten forward progress. The hospital can build upon a solid infrastructure thanks to its Natural Wonders Partnership Council and its previous studies of children's health. Future investment in the health of Arkansas children will augment the successes of the Natural Wonders efforts, making measurable improvements in the health of the state's children and youth.

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Community Benefit
Three-year Plan

May 2013

FY14-FY16
Arkansas Children's Hospital (ACH)
Community Benefit Plan

I. Executive Summary

A. Reason for plan—

Arkansas Children's Hospital [ACH] has long maintained an interactive relationship with our state's population and leaders. In the recent past, the ACH Board of Directors has asked senior management to take a more deliberate approach to working to improve the status of children's health in Arkansas. At an ACH Board Retreat the question "what are we doing for the kids in Dumas?" asked by Clinton School Dean Skip Rutherford, set the stage for the comprehensive review of children's health issues in our state and the initiation of the Natural Wonders Partnership Collaboration [NWPC]. Since this effort began in 2006, ACH has continued to expand its' role as a key institutional leader bringing people and organizations together to engage in collaborative efforts to improve the health of our children. The NWPC has grown from a few agencies and organizations to over 35 groups and more than 45 members. The philosophy of ACH is to serve as an impartial convener, active supporter of programs and efforts in many areas impacting children's health, and a leader in key areas of activity important to children and their families. The NWPC now supports working groups in nine key areas.

As the Internal Revenue Service [IRS] began to develop new guidance for not-for-profit hospitals related to their Community Benefit associated with their tax-exempt status, ACH found itself in the forefront of this activity through its' earlier efforts with Natural Wonders. The continued refinement of the IRS guidance has allowed us to further develop the Natural Wonders program and to include a comprehensive Community Health Needs Assessment [CHNA] to serve as the foundation of our initial three year plan designed to meet the IRS requirements and to further develop our outstanding community engagement to improve the health status of our children.

B. ACH Community Benefit Structure and Function

1. ACH Board Charter for Community Development Committee
2. Community Development Committee adoption of 3 year planning process.
   a) FY14-FY16
   b) FY17-FY20
3. Community Development Committee review and adoption of plan followed by ACH Board adoption of plan – June 2013.
4. Annual Review of plan with Community Development Committee and ACH Board of Directors.

II. FY14-FY16 ACH Community Benefit Plan

A. CHNA identified several areas in which ACH has already assumed a leading role or in which ACH could assume a key role in addressing. These areas include, for the FY14-FY16 period, the following:

1. Intentional Injuries
2. Parenting Skills
3. Unintentional Injury

4. Oral Health
5. Childhood Immunization
6. Early Childhood Education for 0-3 years old
7. Health Literacy for Children

B. CHNA identified several areas in which ACH is best addressed in collaboration with others at the community level. Thus, the plan of the hospital is to work through the Natural Wonders Partnership Council (NWPC) to support the work of others in addressing these issues. ACH does provide specialty care, research and education services in many of these areas to assist in meeting these needs. These areas for the FY14-FY16 period include:
   1. High School Graduation Rate
   2. Mental Health
   3. Food Insecurity
   4. Sexual Health
   5. Substance Abuse
   6. Access to Care
   7. Obesity
   8. Asthma Care
   9. Homelessness

C. CHNA identified an area, which is beyond the scope and resource of ACH to make significant positive impact. Thus, this area will not receive action planning or resource allocation in the FY14-FY16 Plan. This area is:
   1. Poverty involving children.

D. There are certain elements of the robust Community Benefit Plan which transcend any single program, but are essential to the success of any mature planning and program implementation process. Thus, as ACH begins the work of implementing its initial 3 year plan, time, talent and other resources will be allocated to these elements. For the FY14-FY16 plan, these include:
   1. Program Evaluation Process for various plan elements [as identified in Section III A.1]
   2. Short, intermediate, and long-term goal development.
   3. Community Benefit Management to include coordination of:
      a) Community Benefit Plan
      b) Natural Wonders Partnership Council
      c) Bates Center for Improving Child health

III. Community Benefit Plan Elements by fiscal year.

A. FY14
   1. Programs – continuing efforts with potential expansion of some activities should the budget permit such activity. All funding decisions will depend on hospital finances and will be reflected in the final ACH Budget for FY 14 as approved by the ACH Board of Directors in June 2013.
      a) Injury Prevention Center (IPC)
         1) Current Programs: Safe Driving, Baby Safety Showers, ATV Safety, etc.
         2) Statewide Injury Prevention Program (SIPP)
         3) Infant Death Review Teams

b) **Health Teacher**—117 Districts, 662 schools, and 301,000 students
   1) Add GoNoodle.com
   2) Add AwesomeUpstander.com

c) Mobile Dental Vans
   1) Central: Year 4 of 5 with Ronald McDonald Charities of Central Arkansas and Delta Dental of Arkansas. Serving 14 schools/year, 2 groups in summer. Treating 794 students/year with $370,178 in dental value.
   2) Northwest: Year 3 of 5 with Ronald McDonald Charities of Arkoma and Tyson, and Delta Dental of Arkansas. Serving 21schools/year, 4 groups in summer, treating 602students/year with $306,785 in dental value.
   3) South: Year 2 with Delta Dental of Arkansas and Ottenheimer Foundation. Serving 14 schools/year, 4 groups in summer, treating 814 students/year with $405,981 in dental value.

d) **Seal the State**: Statewide dental sealant initiative focusing on elementary children who have no dental home or have not seen a dentist in over one year. Does not treat children who have private insurance. Program visits on average include 36 schools/year and evaluate 1,300 children. Annually 1,100 students have 3800 teeth sealed actually sealed.

e) **Maternal, Infant, Early Childhood Home Visiting (MIECHV):** This is a $6.1 Million annual contract to ACH from the Arkansas Department of Health to implement this Federal program in Arkansas. Through the Arkansas Home Visiting Network (AHVN) ACH is managing the expansion of three evidence-based home visiting models: 1) Promising Program, 2) an Arkansas Home Visiting Training Institute for all home visiting programs in the state, and 3) an aggressive program evaluation agenda.

f) **Home Instruction for Parents of Pre-School Youngsters (HIPPY):** ACH has, since 1990, managed this home visiting program for families with children aged 3-5 as a pre-literacy, early child development program. Currently, over 5,000 families in Arkansas are enrolled in this program.

g) **Healthy Baby Coalition:** This group, led by Arkansas Department of Human Services though funded in a major part by ACH, seeks to provide "just in time" information about pre-natal care, child nutrition and early childhood development to expectant and newly-delivered mothers. In the most recent period (year?) reviewed, approximately 30,000 Happy Birthday Baby Books (2 volumes) were distributed through a variety of public and private service agencies/practices.

h) **Central Little Rock Promise Neighborhood (CLRPN):** In response to needs of children and families in the immediate neighborhood surrounding the hospital, ACH has become a partner with other local entities to develop the CLRPN. Through collaborative efforts, working with a Neighborhood Advisory Board, the CLRPN partners are working to improve the health, literacy, and general quality of life for the children of this neighborhood. From improved access to pre-natal care, through early childhood development in the initial three years of life, through formal education and post high school training/education, the CLRPN is working to help children achieve their fullest potential. The immediate role played by ACH includes system leadership, financial support (with other partners) of the CLRPN infrastructure, and various programmatic services.

i) **ACH/Wal Mart/Central Arkansas Legal Services/Legal Aid of Arkansas Medical/Legal Partnership:** This is a pilot program initiated by Wal Mart and Legal Aid of Arkansas in cooperation with ACH to provide pro bono legal support to patient families on issues regarding access to various services and programs related to the needs of patients and their families. As this program matures, opportunities for it to grow will be explored.

j) **12th Street Corridor Development**: In FY14 the expansion study of the 12th Street Corridor, funded by ACH, will be completed. ACH will, in FY14, join as a member of the 12th Street Corridor Oversight Group and will work to assist in the prioritization of activities designed to improve the quality of life for residents this area adjoining the ACH Campus

k) For all programs currently in operation, programmatic goals are being developed and will be organized and attached to this plan as practical. Complex programs such as the Injury Prevention Center have multiple goals associated with aspects of the Center and are included in their annual plan. Other programs, such as MIECHV, have specific Federal Benchmarks which are included in their annual plan document.

2. Programs and Partnerships to be considered for initiation or expansion in FY14 include:
   a) **Development of a Coordinated School Wellness Center in Franklin Elementary** in partnership with the Little Rock School District and Children's International.
      1) This will be a medical center operated along the lines of the Wakefield Dental Clinic sponsored, in part, by ACH. Franklin is one of the five Children's International elementary schools and will serve as a health hub for all five schools. ACH anticipates providing 12-16 hours of APN and/or MD time weekly as well as minimal clinic equipment and supplies. This will be the first Arkansas Coordinated School Health Wellness Center in an urban setting and in Pulaski County. Franklin is a CLRPN School.
   b) **Central Arkansas Library System (CALS) Children's Library**: The opening of the Children's Library in March 2013 offers many collaborative opportunities to ACH. Located in the CLRPN just west of ACH, this facility will employ cutting edge programming to enrich the lives of Little Rock children. In FY14 active planning between ACH and CALS leaders will begin focus to opportunities for enhanced collaborative between these two entities.
   c) As a part of a plan to **expand HealthTeacher.com** statewide to all Arkansas public schools, FY14 is envisioned to include 128 districts, 505 schools, and 211,238 additional students. Based on our experience with implementing this program, we anticipate achieving 45% active school in year 1 (FY14); 60% active schools in year 2 (FY15), and 80% active schools in year 3 (FY16).
3. Community Benefit/NWPC Infrastructure
   a) Program Evaluation Process Development
   b) CHNA follow-up
   c) Natural Wonders Volume 4 update

IV. FY15 Community Benefit Plan

A. The second year of the ACH Community Benefit Plan will be highlighted by focus in three general areas:

1. Continued implementation of existing programs with appropriate modifications.
2. Initial review of efforts initiated in FY14 with special focus on those activities near the hospital campus, i.e. CLRPN and 12th Street Corridor. Modification of efforts will occur in response to these reviews.
3. Application of Program Evaluation process across all Community Benefit efforts, applying the recommendation and systems developed in FY14.

B. It is not anticipated that any new program efforts will be undertaken in FY15. Potential expansion of HealthTeacher.com and Coordinated School Health School Wellness Centers with the Little Rock School District are possible.

C. One major event anticipated for the Fall of CY14 (FY15) is a state conference on the Status of Children's Health. Envisioned as a two-day meeting in September-early October 2014, this will be an opportunity to share with state leaders, contenders for political office, professional leaders and clinical practitioners the status of children's health in Arkansas, the major improvements initiated and demonstrated, as well as major gaps/needs remaining. This will be an opportunity for ACH and its' leadership team, to bring focus and potential support for political, business, and healthcare sectors to bear on the needs of children and families in Arkansas.

D. Plans for the second CHNA will be developed in FY15 with effort to begin in the summer of CY15 (FY16 start).

V. FY16 Community Benefit Plan

A. This fiscal year is the final year of the initial three year plan and will consist of two main components:
   1. Continued implementation and evaluation of existing Community Benefit Programs as well as associated NWPC efforts.
   2. Creation of a Community Benefit summary report of efforts linked to updated data analysis to begin determination of the impact of ACH Community Benefit efforts. This report will lead, in the second half of FY16, to a new three-year plan for ACH Community Benefit activities.

B. During FY16, coordinated planning between ACH Natural Wonders/Community Benefit efforts and the efforts of the Bates Center will focus on how to achieve better health and better value for the children of Arkansas. Close collaboration among Bates Center leadership, ACH Natural Wonders/Community Benefit leadership, and the NWPC will drive this effort. Review and endorsement by the ACH Board Community Development Committee will affirm this activity.

APPENDIX A

Initial ACH Community Health Needs Assessment Details

Data sets reviewed include the U.S. Census Bureau, the Annie E. Casey Kids' Count Dana Center, Arkansas state agencies data bases, the Arkansas Statistical Abstract, the Youth Risk Behavior Survey, Arkansas Children's Hospital Pediatric Health Information System, and a variety of local organization research.

Focus Groups [8] were held in Batesville, Forrest City, Gurdon, Lavaca, Jonesboro, Springdale, and two in Little Rock [one general and one in the Promise Neighborhood]. Generally these groups included parents, school officials, community leaders and elected officials. Anonymity was assured as a means of obtaining honest and frank input. Thus, specific names will not be published.

Key Stakeholder Interviews were held with 23 individuals. These included:

- Sip Mouden: Executive Director of Arkansas Community Health Centers
- Dr. Paul Halverson: Director, Arkansas Department of Health
- Dr. Vic Snyder: Associate Medical Director, Arkansas Blue Cross/Blue Shield
- Dr. Tom Kimbrell: Commissioner, Arkansas Department of Education
- Dr. Martha Phillips: Professor, Fay Boozman College of Public Health
- Amy Rossi: Sr. Vice President, Arkansas Foundation for Medical Care
- Diana Courson: Associate Director, Arkansas State University, Childhood Services
- Joey Miller: Chief Operating Officer, White River Health Center
- Beatrice Shelby: Executive Director, Boys, Girls, Adults Community Development Center, Marvell, AR
- Dr. Mary Aitken: Professor of Pediatrics and Director, Injury Prevention Center at ACH
- Carol Maxwell: Director of Social Work, ACH
- Michelle Justus: Director, Disease Prevention and Health Promotion, Arkansas Center for Health Improvement
- Brenda Million: Vice President, Nursing Services, St. Bernard's Hospital, Inc.
- Sherri Jo McLemore: Executive Director, Arkansas Children's Trust Fund
- Brad Planey: Associate Branch Chief, Family Health Branch, Arkansas Department of Health
- Michael Hadley: Business Leader and member, Ronald McDonald Children's Charity of ARKOMA
- Joyce Soularie: Vice Chair, Arkansas Children's Behavioral Health Care Commission
- Becky Hall: Director, Delta Area Health Education Center, UAMS
- Tonya Russell: Director, Division of Childcare and Early Childhood Education, Arkansas Department of Human Services
- Dr. Eddie Ochoa: Associate Professor of Pediatrics, UAMS
- Debbie Rushing: Section Chief, Tobacco Prevention & Cessation Programs, Arkansas Department of Health
- James "Skip" Rutherford, Dean, William J. Clinton School of Public Service
- ACH Ambassadors [group interview with former and current patients of ACH...names not published to maintain confidentiality]

A telephone survey of 1000 randomly selected families (250 from each of the state's four Congressional Districts) was conducted. Questions focused on various topics related to the status of children's health and access to care matters.

APPENDIX B

The final Community Benefit Budget will be included in the FY 14 ACH Budget Package.

APPENDIX C

Coordination of ACH Community Benefit
With the
Bates Center for Child Health Improvement

I. Creation of the Bates Center sets the stage for integration/coordination of efforts to both improve guidelines/safety of clinical care with efforts to improve the health status of Arkansas children, thus reducing the need for interventional care. All this can take place within the context of improving the value of services provided, whether inside an ACH Clinic/Hospital program on in a community-oriented effort engaged by ACH.

II. During FY14 both the Bates Center and the ACH Community Benefit process will be developing guiding principles to accomplish their goals.

For more information,
visit archildrens.org
or call (501) 364-9916