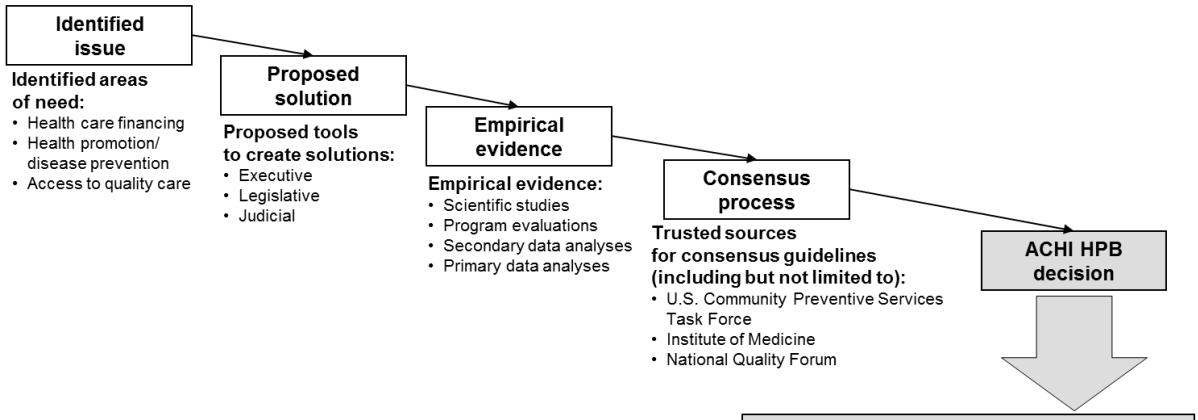
Health Policy Board
Policy Positions & Statements
(positions updated October 1, 2016)

ACHI's mission is to be a catalyst for improving the health of Arkansans through evidence-based research, public issue advocacy, and collaborative program development. Its vision is to be a trusted health policy leader committed to innovations that improve the health of Arkansans.

The ACHI Health Policy Board consists of 21 members from across the state who bring diverse perspectives and interests in health. As part of its standing work, the Health Policy Board, aided by ACHI staff, identifies and establishes strategic priorities, provides direction and guidance, and serves as a forum for the exchange of ideas. The Health Policy Board uses a decision support tool in determining its level of engagement around specific policy issues (shown below). Through informed discussions, the Health Policy Board guides and sets policy recommendations to benefit the citizens of the state, thus allowing ACHI to serve as an independent voice articulating the needs of Arkansans.

ACHI Health Policy Board: Decision Support Document



On-going ACHI staff activities:

Proactive
- Identify needs
- Develop proposals
- Engage collaborative partners
- Develop methods to improve policy development

Responsive
- Respond to external requests for information/analyses
- Respond to external requests for proposal development

Monitoring
- Scan for opportunities and vulnerabilities
- Tracking health indicators

Defensive
- Raise awareness of potential threats

ACHI Health Policy Board decision making process considerations:
- Impact assessment (Arkansas health impact and ACHI's ability to effect change)
- Support, oppose, or remain silent
- Level of engagement (see table below)
- Specific to a topic (e.g., fluoridation) or an action (e.g., support a specific House bill)

Level of engagement

Support proposal	Neutral	Oppose proposal
Policy position	—	Policy position
Position statement	—	Position statement
Letter of support	—	Letter of opposition
Board testimony	—	Board testimony
Public support	—	Public opposition

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Summary of ACHI Health Policy Board Positions & Statements (*click anywhere on list to go directly to statement*)

37. To support and encourage those policies that create built environments that support healthy lifestyles.

Teen Pregnancy in Arkansas

38. To support efforts and develop statewide strategies to reduce teen pregnancy.

Legalization of Medical Marijuana

39. Medical marijuana should be subject to approval by the FDA and made available only under appropriate clinical supervision.

Consensus Guidelines

ACHI focuses its policy work on evidence-based recommendations. Credible and recognized national efforts exist to critically review the scientific and empiric evidence for select health promotion and disease prevention activities. ACHI has opportunities to improve policy and programs within the state by incorporating this evidence in public and private dialogue. Thus, the ACHI staff and ACHI Health Policy Board have reviewed national bodies of evidence and recommendations to form a basis of health policy positions.

1. Adhere to recommendations from the U.S. Preventive Services Task Force and the U.S. Task Force on Community Preventive Services.

Health Policy Board Position Statement

The Health Policy Board formally adopted recommendations from the U.S. Preventive Services Task Force and the U.S. Task Force on Community Preventive Services as policy positions of the Board. The recommendations advanced serve as the threshold or default policy position for the Health Policy Board. (May 2006)

Issue/Status

The U.S. Preventive Services Task Force (USPSTF) is an independent panel of non-federal experts in prevention and evidence-based medicine and is composed of primary care providers. Under sponsorship of the Agency for Healthcare Research and Quality (AHRQ), the USPSTF conducts scientific evidence reviews of a broad range of clinical preventive health care services and develops recommendations for primary care clinicians and health systems. The mission of the USPSTF is to evaluate the benefits of individual services based on age, gender, and risk factors for disease; make recommendations about which preventive services should be incorporated routinely into primary medical care and for which populations; and identify a research agenda for clinical preventive care. Its recommendations are published in the form of "Recommendation Statements" (www.uspreventiveservicestaskforce.org).

The Task Force on Community Preventive Services is an independent, non-federal, volunteer body of public health and prevention experts that provides evidence-based findings and recommendations about community preventive services, programs, and policies to improve health. The fifteen Task Force members are appointed by the director of the Centers for Disease Control and Prevention (CDC) and represent a broad range of research, practice, and policy expertise in community preventive services, public health, health promotion, and disease prevention. Task Force members' recommendations help inform the decision making of federal, state, and local health departments; other government agencies; communities; health care providers; employers; schools; and research organizations (see www.thecommunityguide/org/index.html). Task Force findings are published on *The Community Guide* website at www.thecommunityguide.org/about/conclusionreport.html along with their annual Community Preventive Services Task Force Report to Congress at www.thecommunityguide.org/annualreport/2013-congress-report-full.pdf.

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For specific issues, the Health Policy Board elevates its level of engagement to a policy statement or beyond (as noted in the chart on p. 1), depending on the impact of the issue addressed. Current policy statements that reflect elevated engagement by the ACHI Health Policy Board are listed below. Position statements are organized by topic areas that span the range of ACHI's health policy agenda, including overall health and health care systems, disease prevention and health promotion, health care financing, and access to quality care. The ACHI Health Policy Board has adopted the following policy position statements, which are detailed in the following pages.

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Tobacco Prevention/Cessation

2. Improve health by reducing use of all tobacco products.

Health Policy Board Position Statement

The ACHI Health Policy Board's position is that all tobacco use is detrimental to good health. (September 2008)

Issue/Status

Smoking kills more people than alcohol, AIDS, car accidents, illegal drugs, murders, and suicides combined, with thousands more dying from other tobacco-related causes such as fires caused by smoking and smokeless tobacco use. Of all the children who become new smokers each year, almost a third will ultimately die from it. In 2010, 3,200 Arkansan children under the age of 18 became new daily smokers.[1] Smoking harms nearly every organ in the body and accounts for a large prevalence of disease and disability. The adverse health effects from cigarette smoking account for an estimated 4,900 deaths annually in Arkansas and approximately 400,000 people die from their own cigarette smoking each year in the United States. Smokers lose an average of 13 to 14 years of life because of their smoking.[2]

Annually in Arkansas:[1]

- 177,000 children are exposed to secondhand smoke;
- $812 million is spent in annual health care costs directly caused by smoking;
- $242 million is the portion covered by the state Medicaid program;
- $1.4 billion is lost in smoking caused productivity losses.

Scientists now know that disease risk surges even higher after someone smokes for about 20 years. Research shows that those who quit by age 30 could have their health returned to a condition nearly as good as that of a nonsmoker's. Quitting smoking has immediate as well as long-term benefits, reducing risks for diseases caused by smoking and improving health in general.[3,4]

With the implementation of the *Arkansas Clean Indoor Air Act of 2006* and the tobacco tax increase of 2009 (see below), coupled with tobacco control activities within the Arkansas Department of Health, the state has experienced steady reductions in tobacco use. The 2012 Behavioral Risk Factor Surveillance System (BRFSS) demonstrated an overall smoking rate of 25 percent in Arkansas, with a male smoking rate of 27.5 percent and the

[1] Campaign for Tobacco-Free Kids. The Toll of Tobacco in Arkansas, June 2013. Available at www.tobaccofreekids.org/facts_issues/toll_us/arkansas, accessed 10/07/13.
[2] Campaign for Tobacco-Free Kids. Toll of Tobacco in the United States of America. July 2013. Available at www.tobaccofreekids.org/research/factsheets/pdf/0072.pdf, accessed 10/07/13.
[3] U.S. Department of Health and Human Services. *A Report of the Surgeon General: How Tobacco Smoke Causes Disease: What It Means to You.* U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2010. Available at www.cdc.gov/tobacco/data_statistics/sgr/2010/consumer_booklet/pdfs/consumer.pdf, accessed 10/07/13.
[4] U.S. Department of Health and Human Services. How Tobacco Smoke Causes Disease: The Biology and Behavioral Basis for Smoking-Attributable Disease: A Report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2010. Available at www.surgeongeneral.gov/library/reports/tobaccosmoke/full_report.pdf, accessed 10/07/13.

female smoking rate at 22.8 percent.[5] Additionally, according to the 2012 Arkansas Tobacco Quitline Evaluation Report, 15,648 Arkansans registered for tobacco cessation intervention services during 2012 up from 11,024 in 2011. The national standard/goal for cessation is the "30-day point prevalence measured at 7 months" and this goal should be 30 percent. Arkansas's FY2010 30-day point prevalence measured at 7 months was 27.5 percent for those in the multiple call/nicotine-replacement therapy (NRT) and 24.4 percent in the single call/NRT.[6]

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3. Reduce exposure to secondhand smoke.

Health Policy Board Position Statement

The ACHI Health Policy Board's position is that to decrease disease and death associated with exposure to secondhand smoke, local and statewide efforts to prohibit smoking entirely within public spaces, such as workplaces, shopping malls, restaurants, bars, and taverns should be implemented. (January 2006)

Issue/Status

The 2009, Institute of Medicine publication*, Secondhand Smoke Exposure and Cardiovascular Effects*, notes that smoking bans are effective at reducing heart disease associated with exposure to secondhand smoke. In addition, it reviews available scientific literature to assess the relationship between secondhand smoke exposure and acute coronary events. The authors, experts in secondhand smoke exposure and toxicology, clinical cardiology, epidemiology, and statistics, find that there is about a 25 to 30 percent increase in the risk of coronary heart disease from exposure to secondhand smoke. Their findings agree with the 2006 Surgeon General's Report conclusion that there are increased risks of coronary heart disease morbidity and mortality among men and women exposed to secondhand smoke. Additionally the 2006 Surgeon General Report states that there is a casual relationship between maternal exposure to secondhand smoke during pregnancy and low birth weight, sudden infant death syndrome, and other pediatric aliments including respiratory/ lung function, and middle ear disease. There is no risk-free level of exposure to secondhand smoke, and only eliminating smoking in indoor spaces fully protects nonsmokers from exposure to secondhand smoke. The Arkansas Department of Health states that secondhand smoke is the third-leading cause of preventable death with approximately 575 Arkansans dying each year from someone else's smoke. [7]

Arkansas passed the *Arkansas Clean Indoor Air Act of 2006*, which prohibits smoking in all public places, but allows exemptions (e.g., private workplaces with fewer than three employees; designated guest smoking rooms in hotels/motels; retail tobacco stores, businesses, or storage facilities; supervised smoking areas in long-term facilities; restaurants and bars licensed by the State of Arkansas that prohibit persons less than 21 years of age from entering the premises; and designated smoking areas on the gaming floor of any franchisee of the Arkansas Racing Commission).

The ADH Secondhand Smoke Survey 2010 notes that more than 80 percent of Arkansans believe restaurants and bars would be healthier for employees and customers if they were all smoke free and would support a state law banning smoking in all indoor workplaces including bars and restaurants. More than 60 percent of Arkansas adults would support laws that made all hotel and motels completely smoke-free.[8]

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[5] Centers for Disease Control and Prevention (CDC). *Behavioral Risk Factor Surveillance System Survey Data.* Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2011 & 2012.

[6] Bennett C, Thiedig D. 2012 Arkansas Tobacco Quitline Evaluation. Little Rock, AR: Survey Research Center, UALR Institute of Government, January 2013. Available at www.healthy.arkansas.gov/programsServices/tobaccoprevent/Documents/Quitline%20Reports/2012ARTobaccoQLEvaluation.pdf, accessed 10/07/13.

[7] Arkansas Department of Health. Clean Indoor Air Act, 2006. Available at www.healthy.arkansas.gov/programsServices/environmentalHealth/arcleanair/Pages/default.aspx, accessed 10/07/13.

[8] Ali T. 2010 Arkansas Secondhand Smoke Survey (SHS). Arkansas Department of Health March 2011. Available at www.healthy.arkansas.gov/programsServices/tobaccoprevent/Documents/reports/ArkansasSecondHandSmokeSurvey.pdf, accessed 10/07/13.

4. Reduce smoking and tobacco use through higher taxes on tobacco products.

Health Policy Board Position Statement

The ACHI Health Policy Board adopted a position in March 2001 that higher taxes are most effective at reducing smoking and that taxes should be raised simultaneously on all tobacco products to avoid product substitution. In November 2005, the Board also adopted a policy stating that it supported an increase in the excise tax on tobacco products and updated that position in January 2006: *To reduce tobacco use, particularly initiation of tobacco use among young people, the prices of all tobacco products should be increased through enhanced tax strategies.* (adopted November 2005; updated January 2006)

Issue/Status

A reduction in taxes and therefore prices of tobacco products correlates with an uptake in youth smokeless tobacco initiation and use. However, Arkansas's taxes on cigarettes and smokeless tobacco are lower than the national average. To increase tobacco excise taxes in Arkansas, a legislative initiative must be passed by two-thirds of legislators.

With legislative and executive level support, Act 180 of 2009 (*Arkansas Tobacco Tax*) raised the tax on a pack of cigarettes by 56 cents from $0.59 per pack to $1.15 per pack and increased the tax on smokeless tobacco from 32 percent of manufacturer's price to 68 percent manufacturer's price. This tax rate was effective on and after March 1, 2009.

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5. E-Cigarettes regulated similar to other smoking tobacco products.

Health Policy Board Position Statement

The ACHI Health Policy Board's position is that electronic cigarettes are a nicotine-delivery device and therefore addictive and should be regulated in a manner similar to other tobacco products. (January 2014)

Issue/Status

Electronic cigarettes, commonly known as e-cigarettes, are battery-powered devices producing a vapor of nicotine, flavorings, and other chemicals. They are designed to mimic behaviors similar to smoking cigarettes, cigars, and other tobacco products. Electronic cigarettes are currently being marketed as both a harm-reduction device for current smokers and a less harmful alternative to traditional smoking even though there is no evidence to support either.

Safety and effectiveness of e-cigarettes has not been fully studied, therefore, consumers of e-cigarette products currently have no way of knowing whether e-cigarettes are safe for their intended use, how much nicotine or other potentially harmful chemicals are being inhaled during use, or if there are any benefits associated with using these products.

Although e-cigarettes do not produce tobacco smoke, they do contain nicotine and other potentially harmful chemicals. Nicotine is a highly addictive drug and recent research suggests nicotine exposure may prime the brain to become addicted to other substances. Also, testing of some e-cigarette products found the vapor to contain known carcinogens and toxic chemicals (such as diethylene glycol—antifreeze), as well as potentially toxic metal nanoparticles from the vaporizing mechanism. The health consequences of repeated exposure to these chemicals are not yet clear.[9]

Analyst Bonnie Herzog of Wells Fargo Securities estimated that sales of e-cigarettes "will be $1.7 billion by the end of the year." The number of adults using e-cigarettes has increased dramatically over the last few years, doubling since 2010.[10] E-cigarette experimentation and recent use doubled among U.S. middle and high school students during 2011–2012, resulting in an estimated 1.78 million students having ever used e-cigarettes as of 2012.

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[9] National Institute on Drug Abuse. Drug facts: electronic cigarettes (e-cigarettes). 2013. http://www.drugabuse.gov/publications/drugfacts/electronic-cigarettes-e-cigarettes. Last accessed November 5, 2013.

[10] King BA, Alam S, Promoff G, Arrazola R, Dube SR. Awareness and ever use of electronic cigarettes among U.S. adults, 2010–2011. Nicotine Tob Res 2013;15:1623–7.

Moreover, in 2012, an estimated 160,000 students who reported ever using e-cigarettes had never used conventional cigarettes.[11] This is a serious concern because the overall impact of e-cigarette use on public health remains uncertain. Important to note is the potential negative impact of nicotine on adolescent brain development, as well as the risk for nicotine addiction and initiation of the use of conventional cigarettes or other tobacco products.[12]

E-cigarettes that are not marketed for therapeutic purposes are currently unregulated by the Food and Drug Administration, and in most states there are no restrictions on the sale of e-cigarettes to minors. With the increasing popularity of e-cigarettes and the undetermined impact on public health, states are beginning to enact regulations to ban or limit their sale as an alternative to traditional smoking tobacco products. The 89th Arkansas General Assembly passed Acts 1451 and 1099 banning the sale of electronic cigarettes to minors and prohibiting the use of electronic cigarettes on public school property, respectively.

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6. E-Cigarettes for therapeutic purposes only.

Health Policy Board Position Statement

The ACHI Health Policy Board's position is that, if available at all, electronic cigarettes should only be available via prescription as a means of harm reduction for individuals who currently smoke cigarettes and have no plan to quit smoking. (January 2014)

Issue/Status

Electronic cigarettes, commonly known as e-cigarettes, are battery-powered devices producing a vapor of nicotine, flavorings, and other chemicals. They are designed to mimic behaviors similar to smoking cigarettes, cigars, and other tobacco products. Electronic cigarettes are currently being marketed as both a harm-reduction device for current smokers and a less harmful alternative to traditional smoking even though there is no evidence to support either.

Safety and effectiveness of e-cigarettes has not been fully studied, therefore, consumers of e-cigarette products currently have no way of knowing whether e-cigarettes are safe for their intended use, how much nicotine or other potentially harmful chemicals are being inhaled during use, or if there are any benefits associated with using these products.

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[11] Centers for Disease Control and Prevention. Notes from the field: Electronic cigarette use among middle and high school students – United States, 2011-2012. Morbidity and Mortality Weekly Report 2013; 62: 729-730.
[12] Dwyer JB, McQuown SC, Leslie FM. The dynamic effects of nicotine on the developing brain. Pharmacol Ther 2009;122:125–39.
[13] King BA, Alam S, Promoff G, Arrazola R, Dube SR. Awareness and ever use of electronic cigarettes among U.S. adults, 2010–2011. Nicotine Tob Res 2013;15:1623–7.
[14] Centers for Disease Control and Prevention. Notes from the field: Electronic cigarette use among middle and high school students – United States, 2011-2012. Morbidity and Mortality Weekly Report 2013; 62: 729-730.
[15] Dwyer JB, McQuown SC, Leslie FM. The dynamic effects of nicotine on the developing brain. Pharmacol Ther 2009;122:125–3

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Obesity Prevention/Reduction

While tobacco use has been a national health concern for decades, the emergence of obesity is becoming the major disease prevention focus in the United States. Obesity has been linked to heart disease, type II diabetes, high blood pressure, and a host of other chronic and life-threatening conditions. A recent study estimated that the overall burden of obesity has become an equal, if not greater, contributor to the burden of disease than smoking.[16] Mortality data attribute tobacco use and poor diet/physical inactivity as the top two causes of death among adults in the United States. In 2000, the leading causes of death were tobacco (435,000 deaths; 18.1% of total U.S. deaths), poor diet and physical inactivity (400,000 deaths; 16.6%), and alcohol consumption (85,000 deaths; 3.5%).[17] With the increase in obesity, it may soon become the leading cause of preventable death in the United States. However, the majority of deaths linked to obesity and resulting health costs for treatment are preventable if positive and immediate action is taken.

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7. Increase access to safe and secure places for physical activity.

Health Policy Board Position Statement

To increase access to safe and secure places for physical activities, the ACHI Health Policy Board recommends that schools and communities voluntarily enter into joint use agreements to expand access to physical activity. (July 2005; updated January 2009)

Issue/Status

School gyms and public facilities and spaces are often not open to the public during non-school hours because of concerns about liability, security, and maintenance costs. At the same time, many Arkansas adults engage in no or limited physical activity on a regular basis—contrary to recommendations of health authorities. In fact, 31 percent of adult Arkansans reported that they did not participate in any physical activities during the past month in a 2011 survey.[18]

Joint Use Agreements (JUAs) represent an opportunity to extend the use of recreational facilities to the public for physical activity. JUAs raise awareness and provide information, technical assistance, and model contracts and agreements, with elective participation by schools and communities.

The Arkansas Department of Education currently manages a JUA grant program that has awarded 123 grants totaling $1.2 million to Arkansas school districts since 2010. To qualify for funding JUAs must include a partnership between a school and local agency, organization or business, with the school acting as the fiduciary agent. The 89th General Assembly enacted Act 1507 to promote the public health and well-being of communities through shared use of public school facilities.[19]

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[16] Jia H, Lubetkin EI. Trends in Quality-Adjusted Life-Years Lost Contributed by Smoking and Obesity. American Journal of Preventive Medicine. 2010;38(2):138-144.
[17] Mokdad AH, Marks JS, Stroup DF, Gerberding JL. Actual Causes of Death in the United States, 2000. JAMA. 2004;291:1238-1245.
[18] National Center for Chronic Disease Prevention & Health Promotion, CDC. Prevalence and Trends Data, Arkansas 2011. BRFSS. Available at apps.nccd.cdc.gov/brfss.
[19] Act 1507 of the 89th Arkansas General Assembly. Available at www.arkleg.state.ar.us/assembly/2013/2013R/Acts/Act1507.pdf

8. Increase school-based physical activity to reduce childhood obesity.

Health Policy Board Position Statement

In July 2005, the ACHI Health Policy Board, based on review of proposed Arkansas Department of Education rules and regulations, took a position recommending 30 minutes of vigorous physical activity daily for all students in grades K through 12. *All school students should be required to participate in at least 30 minutes of daily physical activity.* (reaffirmed January 2009)

Issue/Status

Due to societal changes and environmental safety concerns, adolescents today have sedentary lifestyles, which contribute to obesity and other unhealthy conditions. Only forty percent of high school reported participating in physical activity 60 minutes or more on five or more days in the past seven days.[20] Frequently, educational achievement criteria focus only on academic requirements involving sedentary activity. Yet, new powerful evidence indicates that children with higher physical fitness levels also evidence greater academic achievement.[21]

Legislation in 2007 amended state policies to eliminate all physical activity requirements in middle and high schools and left 60 minutes of physical education (PE) a week in middle schools and 0.5 PE credits required for high school graduation. Retention of policies for elementary students requiring 150 minutes of physical activity (90 minutes of physical activity and 60 minutes of physical education) per week remained intact. Physical activity differs from physical education, as it is not a curriculum course but a set of actions that help children avoid long periods of sedentary activity and promote lifelong habits to maintain appropriate physical activity during waking hours. The Arkansas Child Health Advisory Committee recently re-committed to working with school administrators to get physical activity requirements back in middle and high schools.

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9. Increase awareness of food calorie and nutrition information to optimize restaurant purchasing decisions.

Health Policy Board Position Statement

The ACHI Health Policy Board recommends that Arkansas require restaurant chains with 10 or more units nationally to display to consumers at the point of purchase, the number of calories for standard menu items identical to the federal menu labeling requirements that are part of the Patient Protection and Affordable Care Act. (January 2009)

Issue/Status

More Americans eat out now than in the past, and do so frequently. Unfortunately, studies show that eating out is associated with obesity because individuals consume more calories, fat, saturated fat, and sugar and fewer fruits and vegetables when eating out than when eating at home. [22] Studies have also shown that people are not aware of how many calories are in meals purchased in restaurants. [23] The National Academies' Institute of Medicine recommends that restaurant chains "provide calorie content and other key nutrition information on menus and packaging that is prominently visible at point of choice and use" (2006). The Food and Drug Administration, Surgeon General, U.S. Department of Health and Human Services, National Cancer Institute, and American Medical Association also recommend providing nutrition information at restaurants. By providing point-of-purchase information on nutrition and calories, individuals can make better informed choices about their nutritional intake.[24] Currently, Arkansas does not have standard menu labeling requirements.

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[20] Arkansas Youth Risk Behavior Survey Report, 2011. Available at www.arkansascsh.org/tinymce/filemanager/files/2011%20YRBS%20Booklet.pdf.

[21] Wittberg, Northrup, & Cottrell, 2012. Children's Aerobic Fitness and Academic Achievement: A Longitudinal Examination of Students During Their Fifth and Seventh Grade Years. Am Journal of Public Health.

[22] Pomeranz JL, Brownell KD. Legal and public health considerations affecting the success, reach, and impact of menu-labeling laws. American Journal of Public Health. 2008 Sep;98(9):1578-1583.

[23] Roberto CA, Haynos AF, Schwartz MB, Brownell KD, White MA. Calorie estimation accuracy and menu labeling perceptions among individuals with and without binge eating and/or purging disorders. Eating and Weight Disorders. 2013 May:1-7.

[24] Roberto CA, Schwartz MB, Brownell KD. Rationale and evidence for menu-labeling legislation. American Journal of Preventive Medicine. 2009 Dec;37(6):546-551.

By requiring restaurants to display nutritional information, consumers would be enabled to exercise personal responsibility and make informed choices for their diets. There are several ways in which a mandate may occur: legislation, administrative rule, or executive order. Several states have already adopted this policy change.

As part of the federal Patient Protection and Affordable Care Act of 2010[25], national chains will be required to list calorie counts and other nutrition information on the menu boards of chain restaurants, similar retail food establishments or adjacent to each food offered in vending machines. Establishments with 20 or more locations nationwide must post calories "in a clear and conspicuous manner," along with "a succinct statement concerning suggested daily caloric intake," — presumably, the 2000-kcal-per-day standard that the Food and Drug Administration (FDA) uses for the "Nutrition Facts" on packaged foods.

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10. To implement healthy food and beverage procurement policies.

Health Policy Board Position Statement

The ACHI Health Policy Board recommends that state and local governments adopt and implement healthy procurement policies for all foods and beverages sold or provided through government-run programs and facilities. (November 2013)

Issue/Status

In 2010, 47.9 percent of all food spending (more than $594 million), was for food consumed away from home.[26] Americans have access to food on a daily basis through government-run and/or -operated buildings and facilities, at work, at school and in child care settings, in recreational and entertainment settings, and in other locations (e.g., institutional facilities, military bases). Yet many of these locations are often overlooked as critical in affecting Americans' access to healthy, affordable foods that are recommended by the Dietary Guidelines for Americans. Given that foods consumed outside of the home represent approximately 34 percent of the energy intake of children and adolescents[27] and almost half of all food purchased is consumed outside of the home, it is crucial to focus on healthy and affordable food options being made available where food is frequently purchased. [26] There is a positive relationship between eating behaviors and access to healthy foods.28 Studies have found that individuals with access to a greater selection of healthy foods consume more fresh produce and other healthful items.[29] Increasing consumption of the foods and beverages recommended by the Dietary Guidelines will depend heavily upon their availability and affordability.

State and local governments are providers of food and should not be overlooked as part of the food environment. Programs range from food purchases for public worksites, health care facilities, senior centers, and military bases to foods sold in vending machines in city parks and other public places. Research has shown that interventions that improve access to healthy foods, including changes in cafeterias and ensuring that publicly run worksites, schools and child care centers offer foods and beverages aligned with the Dietary Guidelines for Americans, are effective in increasing the consumption of healthy options and are essential to making the healthy choice the default choice.[30,31]

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[25] Food Labeling; Nutrition Labeling of Standard Menu Items in Restaurants and Similar Retail Food Establishments. (Proposed rule.) RIN 0910-AG57. Fed Reg 2011;76(66):19192. Available at http://www.gpo.gov/fdsys/pkg/FR-2011-04-06/pdf/2011-7940.pdf#page=2, accessed 10/21/13.

[26] IOM - http://www.iom.edu/Reports/2012/Accelerating-Progress-in-Obesity-Prevention.aspx

[27] Poti, J. M., and B. M. Popkin. 2011. Trends in energy intake among U.S. children by eating location and food source, 1977-2006. *Journal of the American Dietetic Association* 111(8):1156-1164.

[28] Larson, N. I., M. T. Story, and M. C. Nelson. 2009. Neighborhood environments: Disparities in access to healthy foods in the U.S. *American Journal of Preventive Medicine* 36(1):74-81.

[29] Treuhaft, S., and A. Karpyn. 2010. *The grocery gap: Who has access to healthy food and why it matters.* Oakland, CA and Philadelphia, PA: PolicyLink and The Food Trust.

[30] IOM. 2009. *Local government actions to prevent childhood obesity.* Washington, DC: The National Academies Press.

[31] Ritchie, L. D., S. Whaley, K. Hecht, K. Chandran, M. Boyle, P. Spector, S. Samuels, and P. Crawford. 2012. Participation in the Child and Adult Care Food Program is associated with more nutritious foods and beverages in childcare. *Childhood Obesity.* In press.

In 2010, the U.S. Department of Health and Human Services (HHS) and the U.S. General Services Administration (GSA) began a collaboration to create the Health and Sustainability Guidelines for Federal Concessions and Vending Operations. The goal of the Guidelines is to assist contractors in increasing healthy food and beverage choices and sustainable practices at federal worksites. By applying the Dietary Guidelines for Americans to food service operations, this collaboration demonstrate HHS and GSA commitment to promoting a healthy workforce and can serve as a model for state and local procurement policies.[32]

By instituting nutrition standards for all foods purchased with government dollars, local and state authorities can reduce the calories consumed by their citizens across a variety of environments, model healthier eating, and potentially drive reformulation as food and beverage manufacturers respond to new product specifications. Beyond federal programs, state and local governments often are relatively large purchasers of food. They purchase or contract with restaurant/food service operators to supply the foods sold in employee cafeterias, schools and child care centers, public hospitals, senior centers, parks, and numerous other facilities.[33]

State and local government implementation of healthy food and beverage procurement policies is an important step toward making the changes necessary to create a healthier environment in which Americans live, work, and play.

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11. Increase worksite wellness policies and programs.

Health Policy Board Position Statement

The ACHI Health Policy Board recommends that all Arkansas businesses in both the public and private sectors voluntarily implement worksite wellness policies and programs as part of a statewide strategy to address high adult obesity rates and improve the health of Arkansans. (November 2013)

Issue/Status

Arkansas is currently ranked 3rd nationally in adult obesity and was the only state to have a significant increase in adult obesity from 2011 to 2012.[34] Obesity and associated health problems have a negative economic impact on businesses and communities. The annual health care costs of obesity are projected to be as high as 147 billion dollars a year[35] and medical expenses for obese employees are estimated to be 42 percent higher than for a person with a healthy weight.[36]

Employees spend a quarter of their lifetime at the workplace,[37] which makes it an ideal place to implement strategies to address the obesity epidemic. Encouraging active living and healthy eating in the workplace is a strategy listed in the Institute of Medicine's recommendations outlined in its 2012 publication *Accelerating Progress in Obesity Prevention.* Potential actions discussed in this IOM publication are:

- increasing opportunities for physical activity as part of a wellness promotion program;
- providing access to and promotion of healthful foods and beverages; and
- offering health benefits that provide employees and their dependents coverage for obesity-related services and programs.

Research shows that medical costs decrease $3.27 and absenteeism costs fall by about $2.73 for every dollar spent on wellness programs.[38] Workplace obesity prevention programs can be an effective way for employers to reduce obesity and lower their health care costs, lower absenteeism, and increase employee productivity.

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[32] Centers for Disease Control. Health and sustainability guidelines for federal concessions and vending operations. http://www.cdc.gov/chronicdisease/resources/guidelines/food-service-guidelines.htm. Accessed: November 7, 2013.
[33] IOM. 2010. *Strategies to reduce sodium intake in the United States.* Washington, DC: The National Academies Press.
[34] F as in Fat http://healthyamericans.org/report/108/
[35] Finkelstein, EA, JG Trogdon, JW Cohen, and W Dietz. 2009. Annual medical spending attributable to obesity: Payer- and service-specific estimates. *Health Affairs*; 28(5):w822-w831.
[36] http://www.cdc.gov/leanworks/
[37] Goetzel, RZ, TB Gibson, ME Short, BC Chu et al. 2009. First-year results of an obesity prevention program at the Dow chemical company. *Journal of Occupational and Environmental Medicine*; 51(2): 125-138.
[38] Baicker, K, D. Cutler, Z Song. Workplace wellness programs can generate savings. 2010. *Health Affairs*; 29(2):304-311.

12. Increase the number of medical facilities and clinics that adopt Baby-Friendly Hospital policies.

Health Policy Board Position Statement

The ACHI Health Policy Board recommends that all Arkansas medical facilities, prenatal services, and community clinics adopt policies consistent with the Baby-Friendly Hospital Initiative. (November 2013)

Issue/Status

Research suggests that initiation, longer duration, and exclusivity of breastfeeding provide a protective effect that can reduce the risk of childhood and adolescent overweight or obesity.[39]

Breastfeeding has been endorsed as a strategy for obesity prevention by the Institute of Medicine, the Centers for Disease Control and Prevention (CDC), the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and the Endocrine Society.[40] Significant gaps remain, however, in both breastfeeding initiation and maintenance. According to the CDC, only 57.7 percent of infants born in Arkansas during 2010 were ever breastfed compared to the national average of 76.5 percent.[41]

In 1991, the World Health Organization and the United Nations Children's Fund launched the Baby-Friendly Hospital Initiative to ensure that all hospitals and birthing centers offer optimal breastfeeding support. In 1997, Baby-Friendly USA was established as the national authority for the Baby-Friendly Hospital Initiative in the United States.

A team of global experts developed *Ten Steps to Successful Breastfeeding* consisting of evidenced-based practices that have been shown to increase breastfeeding initiation and duration. Baby-Friendly hospitals and birthing facilities must adhere to the Ten Steps to receive and retain a Baby-Friendly designation.[42] Certification is entirely voluntary and based on the hospitals' reports.

The Ten Steps to Successful Breastfeeding:

1. Have a written breastfeeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in the skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within one hour of birth.
5. Show mothers how to breastfeed and how to maintain lactation, even if they are separated from their infants.
6. Give infants no food or drink other than breast-milk, unless medically indicated.
7. Practice rooming in, allowing mothers and infants to remain together 24 hours a day.
8. Encourage breastfeeding on demand.
9. Give no pacifiers or artificial nipples to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them upon discharge from the hospital or birth center.

Giving birth in a Baby-Friendly hospital has been associated with a greater likelihood of breastfeeding initiation.[43] There is also a relationship between the number of Baby-Friendly steps in place and successful breastfeeding. In

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[39]Harder, T., R. Bergmann, G. Kallischnigg, and A. Plagemann. 2005. Duration of breastfeeding and risk of overweight: A meta-analysis. *American Journal of Epidemiology* 162(5):397-403.

[40] IOM APOP http://www.iom.edu/Reports/2012/Accelerating-Progress-in-Obesity-Prevention.aspx

[41] CDC. *Breastfeeding report card—United States, 2013.* http://www.cdc.gov/breastfeeding/pdf/2013BreastfeedingReportCard.pdf (accessed November 2, 2013).

[42] Baby-Friendly USA. Ten steps to successful breastfeeding. http://www.babyfriendlyusa.org/about-us/baby-friendly-hospital-initiative/the-ten-steps. Accessed: November 7, 2013.

[43] Merewood, A., S. D. Mehta, L. B. Chamberlain, B. L. Philipp, and H. Bauchner. 2005. Breastfeeding rates in US baby-friendly hospitals: Results of a national survey. *Pediatrics* 116(3):628-634.

one study, mothers who experienced none of the ten Baby-Friendly steps were eight times less likely to continue breastfeeding to six weeks than were mothers experiencing at least five steps.[44]

While some hospitals in Arkansas have made progress toward meeting some of the ten steps to becoming Baby-Friendly there are currently no hospitals in Arkansas that are certified as Baby-Friendly. Strategies aimed at increasing breastfeeding initiation and maintenance are crucial to increasing the impact of breastfeeding on obesity prevention.

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Oral Health

13. Reduce untreated caries and dental decay through fluoridation.

Health Policy Board Position Statement

In addition to the ACHI Health Policy Board's support of all U.S. Task Force on Community Preventive Services recommendations, the Board specifically has taken a position to support legislation mandating statewide fluoridation of public water supplies. *All public water supplies should be fluoridated.* (reaffirmed January 2009)

Issue/Status

Oral health is integral to one's overall general health.[45] Although preventable, tooth decay is a chronic disease affecting all age groups. In fact, it is the most common chronic disease of childhood.[46] The burden of this disease is far worse for those who have limited access to prevention and treatment services. Left untreated, tooth decay can cause pain and tooth loss. Among children, untreated decay has been associated with difficulty eating, sleeping, learning, and maintaining proper nutrition. Untreated decay and tooth loss among adults can also have negative effects on one's self-esteem and employability. In the U.S., tooth decay affects one in four elementary school children, two of three adolescents, and nine out of ten adults.[47]

The most comprehensive data on children and adults in Arkansas was collected in 2010 by the Arkansas Department of Health.[48]

Among children and adolescents:

- 64 percent had evidence of current or past cavities (caries experience);
- 29 percent had untreated cavities;
- 27 percent were in need of routine care; and
- 4 percent were in need of urgent care.

Among older adults:

- a significant proportion of older adults were missing five or more teeth;
- female respondents were more likely to have all their natural teeth missing as compared to males; and
- 23.3 percent of adults 65 and older in Arkansas reported that they had lost all of their permanent teeth, compared with 16.9 percent in the U.S.

The U.S. Task Force on Community Preventive Services strongly recommends community water fluoridation for reducing tooth decay. For the many studies reviewed, there was a median 29 percent reduction in tooth decay

[44] DiGirolamo, A. M., L. M. Grummer-Strawn, and S. Fein. 2001. Maternity care practices: Implications for breastfeeding. *Birth* 28(2):94-100.
[45] Centers for Disease Control and Prevention. Fluoridation of drinking water to prevent dental caries. Morbidity and Mortality Weekly Report, 48 (1999): 933-40.
[46] Truman, BI; Gooch, BF; Suleman, I; et al, and the Task Force on Community Preventative Services. Reviews of evidence on interventions to reduce dental caries, oral pharyngeal cancers and sports-related craniofacial injury. *American Journal of Preventive Medicine* 23 (2002), 1S: 1-84.
[47] U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General, Executive Summary.* Rockville, MD. National Institute of Dental and Craniofacial Research, National Institutes of Health.
[48] Arkansas Department of Health, Office of Oral Health, 2010.

among children and adolescents. Water fluoridation is much cheaper than dental treatments. Costs for fluoridating water can vary from $0.50 to $3.00 per-person per-year.

The 2011 Arkansas General Assembly passed SB 359 guaranteeing access to fluoridated water for all persons on water systems serving 5,000 or more customers. Signed into law by Governor Mike Beebe as Act 197 of 2011, the statute will increase the percentage of Arkansans whose water systems are fluoridated from 65 percent to almost 87 percent. (Note: A total of 88 percent of the state's population is served by public water systems; the remainder are served by springs or wells.) Of the 34 water systems affected by the legislation, seven are fluoridating and two more will come on line by the end of 2013. (Source: Carol Amerine, Arkansas Dept. of Health, Office of Oral Health).

As of October 2013, 65.7 percent of Arkansans are receiving fluoridated water – up from 64 percent. The remaining water systems are at various stages of developing fluoridation implementation plans and applying to Delta Dental Foundation for funding. The Foundation has pledged to spend at least $2 million to help communities purchase equipment needed to implement fluoridation. The State Board of Health is taking steps to assure all remaining water systems comply with the law.

As a result of the passage of Act 197, ACHI will continue to monitor the percentage of Arkansas residents on community water systems receiving the benefits of water fluoridation. ACHI will support efforts to build and maintain adequate capacity and infrastructure within ADH, including the Office of Oral Health, the Division of Engineering, the State Health Laboratory, and Information Technology, to support fluoridation continuation and new community start-ups. Additionally, ACHI will support ongoing oral health collaborations focused on promoting community water fluoridation and securing adequate funding for sustaining community fluoridation.

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14. Prevent dental caries through access to fluoride varnishes.

Health Policy Board Position Statement

The ACHI Health Policy Board recommends that all children and adolescents have access to fluoride varnishes to prevent dental caries. (January 2011)

Issue/Status

Fluoride varnishes applied professionally two to four times a year can substantially reduce tooth decay in children.[49] Fluoride is a mineral that prevents dental caries and can be applied topically to tooth enamel as a preventive agent. Fluoride varnish is brushed or "painted" on the enamel. This type of application is especially useful for young patients and those with special needs who may not tolerate fluoride trays. Children who benefit the most from fluoride are those at highest risk for decay. Risk factors include a history of previous cavities, a diet high in sugar or carbohydrates, orthodontic appliances, and certain medical conditions such as dry mouth.[50] Additionally, many children in Arkansas do not have the benefit of fluoridated water.

In 2011, Act 90 was enacted to allow physicians and nurses to provide fluoride varnish to a child's teeth after having received appropriate training on patient risk assessment and fluoride varnish application. As of June 2013, Arkansas Medicaid does not provide reimbursement for caries prevention services by non- dental professionals.

In support of Act 90, ACHI will continue to promote and monitor the efforts of physicians, nurses, and other licensed health care professionals to apply fluoride varnish to children's teeth during primary care visits.

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[49] Marinho VCC, Higgins JPT, Logan S, Sheiham A. Fluoride varnishes for preventing dental caries in children and adolescents. Cochrane Database of Systematic Reviews 2002, Issue 3. Art. No.: CD002279. DOI: 10.1002/14651858.CD002279

[50] Fluoride. American Academy of Pediatric Dentistry – AAPD Publications. Retrieved 12/12/2010 at http://www.aapd.org/publications/brochures/floride.asp

15. Prevent dental caries through access to dental sealants for children.

Health Policy Board Position Statement

The U.S. Task Force on Community Preventive Services has endorsed and highly recommends that sealants be applied through school-based programs. *The ACHI Health Policy Board recommends that all children have access to dental sealant application.* (January 2009)

Issue/Status

Application of dental sealants for children under the age of 18 years is a preventive health measure that prevents dental caries. Reimbursement for sealants has two issues. First, Medicaid, as insurance provider for most of the state's children, will reimburse for either sealants or treatment of caries but not both, which has become problematic in determining appropriate treatment. Second, reimbursement for such application is limited to only dentists. Pediatricians would like to be included as a provider of this preventive measure and be reimbursed for such. Dental sealants do not supplant the need for fluoride. They protect permanent molars where cavities in children and adolescents are most likely to occur. The Centers for Disease Control and Prevention and the Task Force on Community Preventive Services recommend school sealant programs and issued a strong endorsement for dental sealants in 2001.[51] Additional evidence supports sealants as a preventive measure for caries as well as protection against future caries even when treated after a tooth is affected by caries.[52] In Arkansas, there are 1051 dentists who can apply sealants and 1,419 hygienists for a total of 2,470 health care providers trained to apply sealants.

In 2011, Act 89 was enacted to authorize dental hygienists to perform dental hygiene procedures for persons in public settings without the supervision of a dentist. The Arkansas Department of Health (ADH) promulgated rules and regulations for the *Collaborative Care Dental Hygiene* program in June 2014. ADH rules and regulations have "prioritized" school based collaborative care by need. This was established with a tier system developed largely on student population and the percentage of free and reduced lunches within a given school. A collaborative effort must attempt to address schools in order of priority. ADH reserves discretion in making that determination.

In support of Act 89, ACHI will promote and monitor provision of assessment and preventive dental services to underserved populations by collaborative practice dental hygienists, working closely with the Department of Health to remove barriers that impede these efforts.

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Child Health and Mortality

16. Obtain comprehensive determination of causes of death in children.

Health Policy Board Position Statement

The ACHI Health Policy Board recommends continued support of the Arkansas Infant & Child Death Review Program to inform development of preventive measures to reduce the high rate of infant, child, and teen mortality. (adopted January 2009; updated January 2014)

Issue/Status

According to records from the Arkansas Department of Health,[53] in 2010 there were 460 deaths among Arkansas children ages 0–17 years. Children under the age of 1 year were disproportionately represented at 57 percent of these deaths with the remaining 43 percent of deaths occurring in children ages 1 through 17. Of the infant deaths that were ruled "sudden unexplained infant death," approximately 43 percent listed a specific contributory cause such as co-sleeping or wedging. Transportation deaths were responsible for 25 percent of all accidental deaths. Drowning, at 14.5 percent, makes up the second largest cause of accidental death. Suicide and homicide claimed a total of 25 lives and made up 2 percent and 3 percent of these deaths, respectively.
Catalyzed by the passage of Act 1818 of 2005, *An Act To Create The Arkansas Child Death Review and For Other Purposes*, the state convened a special task force in 2008 to study the issue and recommended the development of

[51] http://www.cdc.gov/OralHealth/Topics/dental_sealant_programs.htm#3
[52] http://www.ada.org/prof/resources/pubs/jada/reports/report_sealants.pdf
[53] Arkansas Department of Health, Vital Statistics (2010 and 2011).

the Arkansas Infant and Child Death Review Program. Between 2000 and 2010, Arkansas had the fifth highest death rate in the U.S. for all causes of deaths among those ages 0–17.[54]

Formally organized in 2011, the Arkansas Infant & Child Death Review Program is administered by the Department of Pediatrics of the University of Arkansas for Medical Sciences and Arkansas Children's Hospital and supported by a contract with the Arkansas Department of Health, Family Health Branch. The mission of the Infant & Child Death Review Program is to improve the response to infant and child fatalities, provide accurate information as to how and why Arkansas children are dying, and make recommendations to reduce the number of preventable infant and child deaths in our state. The Program has trained multidisciplinary, local-level teams across the state to conduct legislatively required reviews of all unexpected infant and child deaths in Arkansas. To date, there are three active local level review teams that review infant and child deaths in 14 counties:

- Faulkner County Team (Faulkner, Conway, Van Buren, Perry and Pope)
- Sebastian County Team (Sebastian, Scott, Logan, Franklin, Crawford, Johnson and Yell)
- Washington County Team (Washington and Benton)

Additionally, four teams were under development to initiate reviews starting in FY 2014. The findings from reviews are utilized to identify system-based barriers to infant and child health and safety; enhance public awareness through the examination of issues that affect health, safety, and prevention; and recommend policy, organizational, and community prevention initiatives.

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17. Adopt a statewide coordinated school health system.

Health Policy Board Position Statement

The ACHI Health Policy Board recommends adoption of a statewide coordinated school health system. (January 2009)

Issue/Status

The goal of Coordinated School Health (CSH) is to improve the health, education, and well-being of our children through collaborative partnerships, policy changes, and program planning. It is an effective system that connects health and academics to ensure students are ready to learn and teachers are able to teach. CSH addresses inadequate physical activity; unhealthy dietary behaviors; sexual behaviors that may result in HIV infection, STDs, and unintended pregnancies; alcohol and other drug use; tobacco use; and behaviors that result in intentional injuries (violence and suicide) and unintentional injuries (motor vehicle crashes)—all risk factors determined by the Centers for Disease Control (CDC) to have the most detrimental effect on children and adolescents. CSH in Arkansas is funded by CDC and a partnership between Arkansas Department of Education and Arkansas Department of Health. While state agencies are coordinating resources and struggling to grow the program, additional state support is necessary to grow the program as needed.

The following is an overview of CSH in Arkansas:

- As of school year 2013, 53 school districts are identified as CSH schools with only seven districts receiving funding from the Arkansas Department of Health Tobacco Prevention and Cessation Program for tobacco prevention focus— down from 20 in previous years due to a change in the grant program.
- The Arkansas Department of Education has funded 21 School-Based Health Centers (SBHCs) with each school set to receive $500,000 over a 5-year period from Arkansas general revenue. Thirteen of the SBHCs are currently operating, seven are renovating, and one returned funding. Ten of the SBHCs are established and last quarter had 5,198 students enrolled. All SBHCs offer physical and mental health services, three offer optometry services, and five offer oral health services.
- ACHI has released three annual evaluation reports on CSH. The latest report was released in summer 2013 and showed that CSH schools experience a significantly lower rate of disciplinary actions than schools that are not implementing CSH.

Additional programming that addresses the health of students in schools in Arkansas includes the following:

[54] Centers for Disease Control and Prevention, WONDER Online Database, 2013

- Through the Natural Wonders Partnership Council (NWPC) the Partnership for School Health Council (PSHC) was established. The PSHC is currently constructing a strategic plan for improving the health of children through the public school system. PSHC also serves as an advocate for statewide coordinated school health policy.
- Arkansas Children's Hospital (ACH) has purchased an on-line health education curriculum, HealthTeacher.com, which aligns with state standards. ACH has offered this to all public schools in Arkansas free of charge.
- Assistance for schools determining budget and Medicaid challenges and opportunities is now provided by staff at Medicaid in the Schools dedicated to CSH and SBHCs.
- As of April 2013, there are 5,909 schools across the country and 11 schools in Arkansas certified through the HealthierUS Challenge program. This voluntary certification program was established in 2004 to recognize schools participating in the National School Lunch Program that have created healthier school environments through the promotion of nutrition and physical activity.
- The Fresh Fruit and Vegetable Program provides all children in participating schools with a variety of free fresh fruits and vegetables throughout the school day. It is an effective and creative way of introducing fresh fruits and vegetables as healthy snack options.
- Alternative breakfast models are being implemented in schools across Arkansas. These models break down barriers that cause low participation rates in the School Breakfast Program and are creative, low-cost ways of increasing school breakfast participation.
- The Alliance for a Healthier Generation's goal is to reduce the prevalence of childhood obesity by 2015 by creating healthier schools and healthier students nationwide. The Alliance collaborates with school staff, parents, students, and community members to transform schools into healthy campuses.
- The USDA-funded, Delta Garden Study, is designed to show how building new gardens—complete with greenhouses, budding crops and composting areas—can help adolescents cultivate green thumbs, log more physical activity, eat healthier, and connect with their schools.
- Environmental and Spatial Technology (EAST) is an education model focusing on student-driven service projects accomplished through the combined use of teamwork and cutting-edge technology. The EAST National Service Project Theme for the 2013-2014 school year is Health and Wellness.
- The Arkansas Joint Use Agreement (JUA) Grant is a competitive application process made possible and supported by Governor Mike Beebe and the Arkansas tobacco excise tax created by Arkansas Act 180 of 2009. These funds aid schools in adoption and implementation of joint use policy and the formation of collaborative partnerships with local community resources with the intent of maximizing resources while increasing opportunities for physical activity.
- Safe Routes To School is a federal-aid highway program administered in Arkansas by the Arkansas State Highway and Transportation Department (AHTD). The purpose of the program is to enable and encourage children, including those with disabilities, to walk and bicycle to school; to make bicycling and walking to school a safer and more appealing transportation alternative, thereby encouraging a healthy and active lifestyle from an early age; and to facilitate the planning, development, and implementation of projects and activities that will improve safety and reduce traffic, fuel consumption, and air pollution in the vicinity of schools.
- The Smart Nutrition Active People-Education (SNAP-Ed) Program is a partnership between the University of Arkansas Cooperative Extension Service (UACES), the Arkansas Department of Health, the Arkansas Department of Human Services, and the USDA Food and Nutrition Service. The goal of SNAP-Ed is to provide educational programs that help Supplemental Nutrition Assistance Program (SNAP) participants and those eligible for SNAP make healthier food choices and adopt active lifestyles that are consistent with the Dietary Guidelines for Americans and USDA Food Guidance System.

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Injury Prevention

18. Reduce preventable deaths and injuries related to motorcycle crashes with non–helmeted riders.

Health Policy Board Position Statement

The ACHI Health Policy Board had taken a position (January 2007) to support legislative attempts to require protective head gear while riding motor vehicles. The Board reaffirmed this decision in adopting the following statement: *The ACHI Health Policy Board supports legislation requiring helmet use by motorcycle, motor scooter, and moped operators* (reaffirmed January 2009) *and operators of all-terrain vehicles* (November 2010).

Issue/Status

In 2011, 4,612 motorcyclists died on America's roads, a 2 percent increase over those killed in 2010. In 2011, motorcycle deaths comprised 14 percent of total highway deaths, despite motorcycle registrations representing only about 3 percent of all vehicles in the country.[55]

On a per vehicle mile basis, motorcyclists are more than 30 times more likely to die in a crash than occupants of cars, and five times more likely to be injured. Head injury is the leading cause of death in motorcycle crashes. Helmets are estimated to be 37 percent effective in preventing fatal injuries to motorcycle riders. NHTSA estimates that helmets saved the lives of more than 1,600 motorcyclists in 2011. If all motorcyclists had worn helmets, an additional 703 lives could have been saved. In 2011, 20 states, the District of Columbia, and Puerto Rico required helmet use by all motorcyclists.[56]

A previous Arkansas State law mandating universal helmet use was repealed in 1997 and by May 1998 observed helmet use had dropped from 97 percent compliance to just 52 percent. Arkansas's current motorcycle regulations specify "protective headgear unless the person is 21 years of age or older," but every motorcycle driver is required to wear "protective glasses, goggles or transparent face shields." After the universal helmet law was repealed, Arkansas emergency medical service providers noted that motorcycle fatalities increased by 21 percent. These same medical providers also recorded a significant increase in head injuries and in the average medical treatment costs per accident.[57]

In addition to injuries sustained from motorcycles, injuries sustained by children as a result of using all-terrain vehicles (ATVs) continue to increase, especially in states with rural communities. According to the Children's Safety Network, those under the age of 16 years are four times more likely to sustain ATV-related injuries that require a visit to the emergency department than riders aged 16 years and older. Factors such as children's physical size, strength, coordination, and maturity level can lead to unsafe situations.[58]

During 2012, Arkansas Children's Hospital admitted 95 children with ATV-related injuries. Ages of children involved ranged from 6 months to 21 years and the children resided in counties all over Arkansas. Injuries included concussions (i.e. brain injury), spinal fractures, fractures of arms, legs and pelvis and serious internal injuries. Sadly, some of these injuries resulted in death.[58]

Since 1987, the American Academy of Pediatrics (AAP) has had a policy about the use of motorized cycles and all-terrain vehicles by children. Recommendations are made for public, patient, and parent education by pediatricians; equipment modifications; the use of safety equipment; and the development and improvement of safer off-road

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[55] National Highway Traffic Safety Administration. Traffic Safety Facts: 2001 Data – Motorcycles. [DOT HS 811 765] U.S. Department of Transportation, NHTSA's National Center for Statistics and Analysis, May 2013. Available at http://www-nrd.nhtsa.dot.gov/Pubs/811765.pdf, accessed 10/07/13.

[56] National Highway Traffic Safety Administration. NHTSA Reminds Motorists to Safely 'Share the Road' with Motorcyclists. [NHTSA 11-13, press release] NHTSA, May 2013. Available at http://www.nhtsa.gov/About+NHTSA/Press+Releases/NHTSA+Reminds+Motorists+to+Safely+'Share+the+Road'+with+Motorcyclists, accessed 10/07/13.

[57] Bledsoe GH, Li G. Trends in Arkansas motorcycle trauma after helmet law repeal. Southern Medical Journal. 2005 Apr;98(4):436-40. Available at http://www.ncbi.nlm.nih.gov/pubmed/15898519.accessed 10/02/2013.

[58] "April is declared All-terrain Vehicle Safety Month in Arkansas." Central Region Hometown Health Newsletter, 2013;1(1):5.

trails and responsive emergency medical systems. In addition, the AAP strengthens its recommendation for passage of legislation in all states prohibiting the use of 2- and 4-wheeled off-road vehicles by children younger than 16 years. Current Arkansas law prohibits use by children under 12 except under direct supervision of an adult, on parent's land or with permission of land owner.[59,60]

To reduce the number of preventable deaths and injuries related to motorcycle accidents among non-helmeted riders, helmet use should be legislatively mandated for those operating all motorcycles, motor scooters, and mopeds on public roads.

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19. Reduce motor vehicle crashes related to alcohol.

Health Policy Board Position Statement

In November 2007, the ACHI Health Policy Board adopted a policy: *The ACHI Health Policy Board supports enhanced restrictions to eliminate any open containers of alcohol inside a motor vehicle.* (reaffirmed January 2009)

Issue/Status

Most states do not allow open containers of alcohol in moving vehicles. While Arkansas law prohibits the operator of a vehicle from consuming alcohol while the vehicle is in motion, it allows passengers to consume. Thus, if open containers of alcohol are found in a vehicle when stopped by police, enforcement becomes difficult if at least one passenger is present.

Additionally, by failure to implement stricter open container laws, Arkansas has lost and continues to lose access to federal highway funds under the Transportation Equity Act for the 21st Century (TEA-21). All but 11 states have an outright ban on open containers in vehicles. Alaska, Louisiana, Tennessee, and Wyoming have partial bans whereas Arkansas, Connecticut, Delaware, Mississippi, Missouri, Virginia, and West Virginia actually allow passengers to drink.

Legislative action can be taken to amend the existing law to allow penalty for all occupants of a vehicle in which an open container of alcohol is detected. This law would discourage consumption of alcohol by drivers and passengers.

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Health Care System

20. Maintain critical support for programs leading to health improvement.

Health Policy Board Position Statement

The ACHI Health Policy Board adopted the following positions related to expenditures of Arkansas's share of Master Settlement Agreement (MSA) funds (February 1999):[61]

- *All funds should be used to improve and optimize the health of Arkansans.*
- *Funds should be spent on long-term investments that improve the health of Arkansans.*
- *Future tobacco-related illness and health care costs in Arkansas should be minimized through use of funds.*
- *Funds should be invested in solutions that work effectively and efficiently in Arkansas.*

Issue/Status

To improve and maintain the health status of Arkansans, those in the state must have adequate access to programs that prevent disease and promote health, be able to access affordable health care services, and have

[59] American Academy of Pediatrics. All-Terrain Vehicle Injury Prevention: Two-, Three-, and Four-Wheeled Unlicensed Motor Vehicles. Pediatrics 2000;105(6).
[60] American Pediatric Surgical Association Trauma Committee position statement on the use of all-terrain vehicles by children and youth. Journal of Pediatric Surgery 200-;44:1638-1639.
[61] Health Policy Board of the Arkansas Center for Health Improvement. *Position Paper on Spending the Tobacco Settlement Funds in Arkansas.* ACHI: Little Rock, AR. February 9, 1999.

available to them high-quality prevention and treatment. ACHI has monitored the Arkansas Tobacco Settlement Commission meetings and biennial reports to the General Assembly.

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21. Pursue health care reform that expands access for all Arkansans to high-quality, affordable, evidence-based care.

Health Policy Board Position Statement

The ACHI Health Policy Board recommends the pursuit of health care reform that expands access for all Arkansans to high-quality, affordable, evidence-based care. (March 2010)

Issue/Status

Arkansas has high rates of uninsurance and chronic disease, but opportunities to obtain meaningful access to needed high-quality health care are improving. The ACHI Health Policy Board has concluded that given the present status of the U.S. health care system, taking no substantive reform action is unacceptable. Additionally, any reform that is implemented must be empirically based in order to most efficiently address health care system needs.

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22. Provide enhanced transparency of access, quality, and cost information to support patient, provider, payer, employer, and other stakeholder decision-making as it relates to health care service selection.

Health Policy Board Position Statement

In March 2012, the ACHI Health Policy Board adopted a position statement to improve the quality and efficiency in health care delivery, and to enhance and increase the use of health information technology. In May 2013, the ACHI Health Policy Board replaced this position statement with the following statement that emphasizes transparency of health care-related data.

The ACHI Health Policy Board supports strategies that increase the responsible reporting, application, and transparency of access, quality, and cost information to inform patients, providers, and payers about the performance of providers, payers, and other components of the Arkansas health care system. (May 2013)

Issue/Status

Receipt and delivery of high-quality and efficient health care requires the collection, analyses, and availability of data that provide information on access, quality, and costs of care. Concurrently, the practice of medicine is not an exact science and is subject to patient variation and actuarial risks that require intentional methodological rigor and judicious release of provider specific information.

Broad health care system transformation includes many integrated components, including but not limited to the following:

- The Arkansas Payment Improvement Initiative and its modification of payment strategies to align payments with outcomes
- The adoption of electronic medical records by a majority of primary care providers
- The authorization and use of the State Health Alliance for Records Exchange (SHARE)
- The need for providers to have available information to improve the clinical quality and efficiency of care
- The application of appropriate risk stratification methodology to mediate underlying socio-economic status variation
- The increasing demand by patients for information regarding their health, their risks, their care, and their providers

To some degree, all components require enhanced information transparency that includes access, quality, and cost of care. The ACHI Health Policy Board recommends the development of strategies that will support the responsible reporting, application, and transparency of access, quality, and cost information to inform patients, providers, and payers about the performance of the Arkansas health care system.

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Health Care System Financing

23. Align financial incentives to achieve health outcomes, adopt new financing, payment, and reimbursement policies and mechanisms.

Health Policy Board Position Statement

The ACHI Health Policy Board recommends that the state, payers, and providers adopt strategies that align financial incentives to achieve health outcomes and to adopt new financing, payment, and reimbursement policies and mechanisms. (March 2012)

Issue/Status

Changes to health provider practice structure and patterns would be incomplete without changes to the method and manner in which providers are compensated. Reimbursement streams must be developed to compensate patient-centered, team-based care so that everyone shares in the resulting savings.[62]

Financing goals should incentivize providers and practice sites to adopt more comprehensive, coordinated, team-based care; implement and fully utilize health information technology; comply with quality-based outcome measures; and develop and maintain practices in rural or underserved areas. Additionally, reimbursement strategies should build on methods that promote accountability and flexibility and reflect the capacity of providers to meet certain goals.

Strategies recommended by the ACHI Health Policy Board to achieve the goals noted above include the following:

- Payers should contribute a per member per month (PMPM) payment for care management and coordination of services.
- Model base rate for PMPM payment after the level of coordination necessary to maintain status quo in a healthy, adjusted population (time and cost).
- Create population-level methodologies for differential payments to practices where the social determinants of health and patient non-compliance issues have a disproportion impact on outcomes.
- Align provider incentives to achieve specific outcomes using a tiered/risk adjusted methodology.
- Use a shared savings model as an incentive to reduce unnecessary emergency room and readmission costs.
- Incentivize providers to reinvest in areas that will best support their patients through tax reform, e.g., tax credits for transportation access, health literacy programs.
- Use bundled episodic payments to encourage the use of care coordination activities, to improve health outcomes, and reduce unnecessary utilization.
- Provide differential payments for services provided in rural or underserved areas (site specific).
- Encourage providers to apply for Attestation for the Medicare and Medicaid EHR Incentive Program.
- For episodes requiring hospitalization, specialty care or procedures, hospitals should contract with primary care providers to provide services to optimize outcomes.

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Health Care Coverage

Among Arkansas's, 2.9 million people, more than half a million individuals do not have health insurance coverage. Surveys conducted by national organizations, as well as by ACHI, document that lack of health insurance is a pervasive condition impacting every community in Arkansas. The picture is not uniformly bleak—although approximately 17 percent of the state's residents are uninsured, more than 90 percent of children and almost all over the age of 65 years have either public or private health insurance. The key group of individuals who continue to face challenges in obtaining health insurance are those aged 19 to 64 years, 25 percent of whom do not have coverage. The statistics are even more daunting for those aged 19 to 44 years—30 percent are estimated to be uninsured and rates of uninsurance are even higher for certain geographic and demographic groups.

[62] Magie, S. "Physician's Perspective." Little Rock, AR: University of Arkansas for Medical Sciences Center for Rural Health Retreat.. 2011. Presentation.

For uninsured and underinsured individuals and families the negative impact is immediately felt in their diminished fiscal and physical well-being. The impact is also realized by employers who must cope with a work force that is not optimally healthy; absenteeism and decreased productivity increase business costs. Health care providers are forced to limit services as they are increasingly less able to cost-shift expenses related to care for the uninsured. State and federal governments, often used as a resource of last resort for those needing care or coverage, have less discretionary ability to provide coverage.

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24. Increase health insurance coverage for Arkansans by optimizing coverage expansion to uninsured adults as authorized by the Patient Protection and Affordable Care Act of 2010 and the Health Care Independence Program waiver.

Health Policy Board Position Statements

The ACHI Health Policy Board recommends that Arkansas optimize coverage expansion via the Patient Protection and Affordable Care Act and the Health Care Independence Program to offer coverage to low-income uninsured adults and pursue continued funding for the program during the 3-year approval of the waiver demonstration. (adopted January 2012; updated January 2014)

The ACHI Health Policy Board recommends that its level of engagement in coverage via the Health Care Independence Program be at the highest level of involvement. (January 2014)

Issue/Status

The Patient Protection and Affordable Care Act (PPACA) of 2010 is intended to provide avenues for insurance coverage for uninsured Americans. In Arkansas, this will be particularly helpful to adults between the ages of 19 and 64 years. As an incentive to comply with the individual mandate, the PPACA provides subsidies for low-income uninsured to purchase health insurance. To enable states to expand Medicaid, the PPACA requires that the federal government pay for 100 percent of the cost of care for the Medicaid expansion to 138 percent of the federal poverty level for three years beginning in 2014 with a gradual reduction ending at 90 percent of the costs in 2020 and thereafter.

As eligibility requirements change and enrollment into health plans becomes available in a progression of changes between 2010 and 2014, currently uninsured adults will be able to obtain coverage; by 2014 all uninsured will be able to be served in federal or private insurance programs. This will be a large improvement for Arkansans to have fiscal coverage but does not allay the access issues of not enough primary care physicians to attend to all those insured. Federal grant funds are being funneled to the states in competitive grant proposals to attend to infrastructure needs that the new demand for care will cause.

Subsequent to the PPACA's passage into law, 26 states' attorneys general brought suit in federal court challenging the authority of Congress to pass the Act. In particular, the challenges focused on whether Congress had the authority to mandate that individuals purchase health insurance coverage and whether Congress could require states to expand eligibility to their Medicaid programs for low-income adults as a condition of states' ability to participate in the overall Medicaid program. On June 29, 2012, the U.S. Supreme Court held in *NFIB v. Sebellius* that Congress does have the constitutional authority to mandate individual purchase of health insurance coverage but does not have the authority to require states to expand Medicaid eligibility to uninsured adults as a condition of continued receipt of existing Medicaid funding. States have the elective capacity to expand or not expand.

Despite the 100 percent then 90 percent federal subsidy of the Medicaid expansion, a number of state governors have said that they will not expand their respective Medicaid programs to low-income uninsured adults. Analyses from ACHI and Arkansas DHS indicate that approximately 250,000 presently uninsured Arkansans aged 19–64 years would become eligible for coverage through Medicaid if the program is expanded under PPACA.

Rather than pursue a traditional Medicaid expansion as envisioned by PPACA, Arkansas took a much different approach to covering very low-income Arkansans. The Arkansas Health Care Independence Act of 2013 authorized the state to use federal funding for premium assistance to allow low-income individuals to purchase private plan coverage through the Health Insurance Marketplace. The Health Care Independence Program authorized by the

Act must be reauthorized for 2017 and future years and must be funded yearly by the Arkansas legislature. The federal government has approved the program via a waiver demonstration for a period of three years.

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25. Modify the state RFP process to award "scoring points" for bid respondents providing health care coverage as a benefit to employees.

Health Policy Board Position Statement

The ACHI Health Policy Board recommends modification of the state RFP process to award "scoring points" for bid respondents providing health care coverage as a benefit to employees. (January 2009)

Issue/Status

Most health insurance is obtained as an employment benefit. For all businesses, health insurance contributions comprise a substantial percentage of the cost of doing business. Thus, among businesses who submit competitive bids to contract with the State of Arkansas and are selected based on lowest cost, those who do not provide health insurance as a benefit can keep their costs lower and therefore may enjoy a competitive bid advantage over employers who do offer health insurance. By modifying the state bid process to reward businesses that provide health insurance coverage, business will be incentivized to offer coverage.

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Coordination and Quality of Health Care Services

26. Improve quality of care for Arkansans, promote coordination across the continuum of care.

Health Policy Board Position Statement

The ACHI Health Policy Board recommends formal care coordination training and education and deployment of care coordinators for population-based management of preventive care and chronic disease in primary care settings, care transitions across care settings, and within episodes of care. (March 2012)

Issue/Status

Through the Arkansas Payment Improvement Initiative (APII), Arkansas's public and private insurers are transitioning to an episode-based payment structure and providing per member per month payments to primary care physicians to promote team-based care through patient-centered medical homes. The purpose of the initiative is to incentivize patient-centered, high-quality health care that fits Arkansans' needs. Taking steps such as coordinating care, improving efficiency, and eliminating low-value services will dramatically improve the patient experience.

While care coordination is integral to the APII approach, the need for it is exacerbated by the fast-approaching expansion of insurance coverage, which will increase demand for services at all levels. Care coordination will maximize the capacity of an already-strained health care workforce, but no formal training and education for care coordination currently exists in Arkansas.

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27. Improve delivery of health care to trauma victims.

Health Policy Board Position Statement

The ACHI Health Policy Board supports continued development and implementation of a statewide coordinated trauma system and improved hospital participation at higher levels. (adopted January 2009; updated January 2014)

Issue/Status

Trauma systems help ensure appropriate local treatment for accident victims in a more timely and cost-effective manner, lessening avoidable disability and death. Passed during the 2009 General Session, Act 393 amended the Trauma System Act to clarify the procedures for funding Arkansas's trauma care system, including procedures for grants to emergency medical system care providers and ambulance providers; Level I, Level II, Level III, and Level IV trauma centers; rehabilitation service providers; quality improvement organizations; trauma regional advisory councils; command communication networks; and injury prevention programs. The act became effective on July 1,

2009. As of 2013, there remain Arkansas hospitals that do not participate in the trauma system, and several hospitals participate a lower trauma system levels, although they meet minimum requirements to participate at higher levels.

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28. Increase access to quality mental health / substance abuse care for children and pregnant women.

Health Policy Board Position Statement

The ACHI Health Policy Board supports establishment of a Governor's Commission on Child Mental Health that will make recommendations regarding development and implementation of a mental health / substance abuse system of care (SOC). (January 2009)

The ACHI Health Policy Board also supports the use of tobacco tax monies to fund quality mental health and substance abuse treatment for children and pregnant women. (November 2010)

Issue/Status

Many policy makers and leaders in Arkansas acknowledge that delivery of and access to mental health and substance abuse care is often problematic. Importantly and most acutely, there is a need for services to address the increasing number of children diagnosed with mental health problems or substance abuse. In response, many of these leaders are calling for the state to invest in a system of care that provides coordination, research, and response to families whose children suffer from these conditions.

Act 1593 of the 2007 Regular Session established the principles of a system of care for behavioral health care services for children and youth as the public policy of the state. Act 1593 created a Governor-appointed Children's Behavioral Health Care Commission, which was appointed in August 2007. The commission has 20 representatives of youth, families, advocates, providers, and other critical stakeholders. The act requires the Department of Human Services, under the advisement of the commission, to:

- ensure that children, youth and their families are full partners in all aspects of the system of care;
- revise Medicaid rules and regulations to increase quality, accountability and appropriateness of Medicaid reimbursed behavioral health care services;
- define a standardized screening and assessment process designed to provide early identification of conditions that require behavioral health care services; and
- develop an outcomes-based data system to support an improved system of tracking, accountability, and decision-making.

Aligning with current efforts in payment improvement and delivery system redesign, DHS has advanced a Behavioral Health Transformation proposal[63] that incorporates a health home model and new behavioral health services. The goals of the behavioral health home are to deliver integrated care management in a manner that facilitates quality care and positive outcomes by:

- providing clients with integrated care coordination within and across behavioral health, medical health, developmental disabilities, long-term supports, and other systems; and
- ensuring effective treatment of behavioral health conditions, including pharmacy effects.

In addition to care management, the new behavioral health system will reimburse new, tier-specific services to deliver necessary care.

Tier 1: Time-limited, office-based services with no preauthorization required. Services could be provided by licensed practitioners with private offices or offices in schools, physician offices, health centers, and behavioral health clinics.

Tier 2: More intensive services coordinated by the health home and provided in home- and community-based settings.

[63] Health Care Payment Improvement Initiative. Behavioral Health Transformation (Preliminary Draft). September 2013. Available at www.paymentinitiative.org/referenceMaterials/Documents/DHS%20BH%20Transformation%20Oct%202013.pdf, accessed 10/07/13.

Tier 3: Most intensive services coordinated by the health home and provided in home- and community-based settings. This includes residential services, if needed.

The Patient Protection and Affordable Care Act will provide one of the largest expansions of mental health and substance use disorder coverage in a generation. Beginning in 2014 under the law, all new small group and individual market plans will be required to cover ten essential health benefit categories, including mental health and substance use disorder services, and will be required to cover them at parity with medical and surgical benefits.

The Affordable Care Act and its implementing regulations, building on the Mental Health Parity and Addiction Equity Act, will expand coverage of mental health and substance use disorder benefits and federal parity protections in three distinct ways: (1) by including mental health and substance use disorder benefits in the essential health benefits; (2) by applying federal parity protections to mental health and substance use disorder benefits in the individual and small group markets; and (3) by providing more Americans with access to quality health care that includes coverage for mental health and substance use disorder services.[64]

In 2001, the Arkansas Department of Human Service (DHS) Division of Behavioral Health Services (DBHS) submitted an application to the Substance Abuse and Mental Health Services Administration (SAMHSA) for the Expansion of the Comprehensive Community Mental Health Services for Children and Their Families Grant. The purpose of the grant was to plan the implementation, expansion, and sustainability of the statewide Children's System of Care (SOC). DBHS was awarded $724,676 in 2012 to support their two-year project. As a result of this grant, DBHS took a multi-faceted approach to plan for the expansion of family-driven, youth-guided, and culturally competent SOC across the state by emphasizing the training and certification of service providers. Additionally, they developed outcome measurements to ensure efficacy and infrastructure for financial sustainability. Implementation of this program is expected to begin in July of 2015.

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29. Rebalance long-term care in Arkansas to compress morbidity.

Health Policy Board Position Statement

The ACHI Health Policy Board recommends that the state adopt programmatic and reimbursement long-term care policies that support individuals who desire to reside in their own homes and communities as long as possible. Evidence shows that these programmatic and reimbursement changes in the program would save the state money. (January 2011)

Issue/Status

Aging population: While some 48.6 million Americans lack health insurance, 240 million Americans are uninsured for long-term care. This situation has the potential to create significant problems in the years ahead as a growing and aging population puts increasing strain on system capacity and financial resources.[65]

Even under the most optimistic disability scenario, which assumes that disability rates fall by 1 percent per year, the size of the disabled older population will grow by more than 50 percent between 2000 and 2040. Joining this group as major users of the long-term care system are individuals under age 65 with a disability.[66] Using census data, *Arkansas 2020* projected the actual and percentage growth in population as forecasted within each age category from 2000 to 2020. The largest growth is expected to occur within the population aged 55–74 years.

[64] Beronio K, Po R, Skopec L, Glied S. "Affordable Care Act Expands Mental Health and Substance Use Disorder Benefits and Federal Parity Protections for 62 Million Americans." *ASPE Issue Brief.* U.S. DHHS, Office of the Assistant Secretary for Planning and Evaluation, February 2013. Available at aspe.hhs.gov/health/reports/2013/mental/rb_mental.cfm, accessed 10/07/13.
[65] *Healthy States/Healthy Nation: Essays for a New Administration and a New Congress,* by Members of the Reforming States Group co-published by the Reforming States Group and the Milbank Memorial Fund, May 2009. .
[66] Balhous C, Greenstein R. Social Security Shortfall Warrants Action Soon. PEW Economic Policy Group: Fiscal Analysis Initiative. November 2010.

Specifically, from 2000 to 2020, the population of Arkansans 65 or older and 85 or older will increase by nearly 40 percent.[67]

Figure 1: Actions to Rebalance Long-Term Care

- Empower consumers and their families to make informed decisions about long-term care options and to easily access existing health and long-term care choices
- Enable consumers to remain in their homes with a high quality of life for as long as possible through the provision of home-and community-based services, including supports for family caregivers and nursing home diversion
- Expedite eligibility for home- and community-based services
- Encourage evidence-based health promotion and disease prevention (for example, health enhancement opportunities focusing on chronic illness management and training to prevent falls)
- Develop innovative, consumer-friendly combinations of housing and services (for example, adult family homes and assisted living)
- Educate and train health care professionals and workers to provide person-centered care in all settings across the continuum (ambulatory, acute, home- and community-based, assisted living, and long-term care)
- Support the training, recruitment, and retention of an adequate number of health care professionals and direct care workers—from geriatricians to in-home attendants
- Promote individual and government planning for long-term care
- Increase coordination between acute and chronic care
- Improve the quality of care across all settings

Adopted from Reforming States Group and the Milbank Memorial Fund[68]

Economic profile: The potential costs of this population shift are significant. In fiscal year 2012, Arkansas Medicaid spending for long-term care totaled more than $834 million, 18 percent of all Medicaid expenditures. In SFY09, there were ~22,000 recipients with an average expenditure per recipient of $32,509. These individuals live in the approximately 227 nursing facilities and 41 intermediate care facilities for the mentally retarded that are licensed to provide long-term care services in Arkansas.[69]

Non-institutional choices are offered through Medicaid Independent Choices option extended to Medicaid-eligible adults with disabilities (age 18 or older) and the elderly who require personal care but prefer to stay in their own homes.[70] Data from an independent evaluation indicated that consumers who directed their own care were less likely to use nursing homes and hospitals than their counterparts who received in-home care from an agency.[71] SFY09 expenditures for this program were $15.6 million representing ~3,000 recipients with an average expenditure per recipient of $5,200.[72]

According to John Selig, Director, Arkansas Department of Human Services, the crucial challenges facing Arkansas's long-term care system are ensuring sustainable financing, a skilled long-term care workforce, and the availability of quality services. To meet this challenge, our long-term care system needs to be "rebalanced." Rebalancing refers to shifting the reliance for long-term support from institutional services to those that will keep patients at home in

[67] Arkansas 2020. A report on the changing demographics and related challenges facing Arkansas' state government in 2020.Produced in 2007 for Senator Shane Broadway and the 86th General Assembly of the State of Arkansas.
[68] *Healthy States/Healthy Nation: Essays for a New Administration and a New Congress,* by Members of the Reforming States Group co-published by the Reforming States Group and the Milbank Memorial Fund, May 2009.
[69] Arkansas Medicaid Program Overview: State Fiscal Year 2009. Arkansas Department of Human Services: Division of Health Services. 2009.
[70] Choices in Living for Arkansans with Long-Term Care Needs. Arkansas's Long Term-Term Care System: Planning for the Future. Arkansas Department of Human Services. undated
[71] Grabowski DC. The Cost Effectiveness of Noninstitutional Long Term Care Services: A Review and Synthesis of the Most Recent Evidence. Med Care Res Rev 2006 63:3. DOI:10.1177/1077558705283120
[72] Arkansas Medicaid Program Overview. : State Fiscal Year 2009. Arkansas Department of Human Services: Division of Health Services. 2009.

their community. Succinctly stated, the overall long-term care goal for state organizations engaged in rebalancing is to provide good-quality long-term care services to clients that are delivered quickly and in forms and at locations that patients prefer.[73] National groups have made recommendations about how to achieve this goal (see Figure 1).

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30. Advance end-of-life directives in Arkansas.

Health Policy Board Position Statements

The ACHI Health Policy Board encourages all individuals to complete advance directives and to clearly communicate their end-of-life desires to family members and caregivers. In an effort to empower Arkansans to express their needs and expectations surrounding end of life issues, the Health Policy Board recommends exploring methods of public engagement and end-of-life education for health providers and the general public. (January 2013)

Issue/Status

The health care system in Arkansas can improve on its job of addressing end-of-life decisions and protecting the right of personal autonomy. In the presence of a terminal condition with no possibility of recovery, most Americans would prefer comfort care in their home or in a hospice rather than in a hospital setting.[74] At times, choices directing end-of-life decisions are not thoroughly discussed, and hospice care is not optimally utilized. In some instances, major medical efforts are made to extend life, even if these interventions serve only to extend the dying process. Some maintain that physicians are not well prepared to conduct difficult decisions regarding comfort or aggressive treatment.

There are available mechanisms for Arkansans to express their end-of-life wishes. Arkansas law provides for "advance directives" to govern decisions pertaining to life-sustaining treatment. Advance directives are legal documents that protect a patient's right to refuse or request medical treatment in the event the patient becomes terminally ill or permanently unconscious. Advance directives also allow the designation of a health care proxy who has authority to make decisions on behalf of the patient when the circumstances arise. Palliative care and hospice providers are uniquely positioned to communicate with patients and families about health care interventions. Utilizing these resources will help better educate individuals about their end-of-life options.

During the 2013 General Assembly, Act 1264 of 2013 (An Act To Create The Arkansas Health Care Decisions Act; To Protect Patients' Rights To Make Their Own Health Care Decisions; To Promote Advance Directives; To Provide Legal Protection For Patients' Rights; And For Other Purposes) was passed. The act requires the Department of Health to create universal forms for do not resuscitate and other end-of-life medical instructions including advance directives.

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Health Care Workforce

31. Improve and expand Arkansas's health care workforce to meet present and projected needs of Arkansans.

Health Policy Board Position Statement

The ACHI Health Policy Board recommends the prioritization and development of a strategic framework for all policy decisions related to workforce development and decisions of authority and scope of practice for health care professionals. (November 2010)

[73] Kane R, Kane R, Kitchener M, Priester R, Harrington C. State Long-Term Care Systems: Organizing for Rebalancing. Topics in Rebalancing State Long-Term Care Systems, Topic Paper No. 2.Submitted to the Division of Advocacy and Special Programs Centers for Medicare & Medicaid Services CMS Project Officer, Dina Elani. December, 2006

[74] Gomes B, Calanzani N, Curiale V, McCrone P, Higginson IJ. Effectiveness and cost-effectiveness of home palliative care services for adults with advanced illness and their caregivers. Cochrane Database Syst Rev. 2013 Jun 6;6:CD007760. doi: 10.1002/14651858.CD007760.pub2.

Issue/Status

Examination of the Arkansas health care workforce availability and distribution demonstrates clear limitations for consumer access. With the Patient Protection and Affordable Care Act (PPACA), fiscal barriers to accessing care will be addressed while provider availability and access may be more negatively affected by both increased utilization demand and potentially reduced provider participation. Because availability, access, and quality of services delivered have been shown to directly affect health outcomes, a need for a strategic framework to meet growing consumer demands is self-evident. This framework should include:

- consensus among health care providers and consumers to provide the best access, service coverage, and health care delivery for Arkansans;
- consideration of geographic access and racial diversity of provider availability;
- level of provider education and experience in addition to educational cost and time requirements for training;
- scope of practice and medical review and oversight requirements; and
- quality of care monitoring and disclosure requirements to consumers.

Health care workforce development efforts within the state and from other states with similar challenges provide options that should be systematically explored to employ non-physician providers when and where needed to address availability and meet access needs across the state. Legislative and Board decisions that historically have been conducted in isolation should be subject to an integrated review and impact assessment on health care availability, service, utilization, costs, and quality of care.

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32. Meet existing and future needs for primary care, increase primary care capacity by fostering team-based care.

Health Policy Board Position Statement

The ACHI Health Policy Board recommends the development of team-based models that define team members, core competencies, practice roles, training needs, and outcome metrics for care teams, including non-traditional providers in primary care settings, while assuring that patient safety and quality of care are protected in the assignment of clinical roles on the team. (March 2012)

Issue/Status

Access to quality care for Arkansans will continue to deteriorate because of a number of factors, including an aging population, static health care practitioner pipeline, increasing disease burden, and a heightened demand for services from a newly insured population. Many health care professions require years of training. Expanding education and training will ensure adequacy in the long term but will not solve the state's immediate needs. Consequently, Arkansas must look to expand the capacity of the existing primary care workforce and ensure the availability of and access to services provided to Arkansans.

New delivery models that embrace team-based care—such as patient-centered medical homes (PCMH)—are becoming more widespread practice in Arkansas. Through the Comprehensive Primary Care initiative and a broader roll-out of PCMH by invested Arkansas payers, there has been proactive movement towards utilizing activities to improve patient care, decrease costs, and relieve providers overburdened by excess demand. Team-based care models are supported by enhanced roles for non-physician practitioners.

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33. Meet existing and future needs for primary care, enhance roles for non-physician practitioners.

Health Policy Board Position Statement

Many health care professions require years of training, and expanding education and training—though it will ensure adequacy in the long term—will not solve the state's immediate needs. Consequently, the ACHI Health Policy Board's position is that *Arkansas must look to expand the capacity of the existing primary care workforce and ensure the availability of and access to services provided to Arkansans by deploying APNs and PAs as primary care providers.* (March 2012)

Issue/Status

Expanding coverage and increasing delivery of team-based care are likely to entail a growing role in the health system for advanced practice nurses (APNs), physician assistants (PAs), and other non-physician clinicians. Experience suggests that APNs (a term encompassing nurse practitioners, nurse midwives, nurse anesthetists, and clinical nurse specialists) and PAs can perform some of the same services as doctors, with equivalent results, and can be trained in less time and at less expense. Practice boundaries are defined and enforced through professional credentialing boards and state licensing and scope-of-practice laws, reinforced by the reimbursement policies of public and private payers.

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Health Information Technology

34. Improve quality and efficiency in health care delivery, and support the adoption of information technology and meaningful connection to SHARE across all Arkansas providers.

Health Policy Board Position Statement

In March 2010, the ACHI Health Policy Board developed a position statement encouraging the adoption of information technology to improve access and quality through the exchange of information between providers, payers, hospitals, and patients. In May 2013, the following position statement updated the original statement.

The ACHI Health Policy Board supports the state's adoption of a coordinated and integrated health information system that will allow important health information to be exchanged between providers, payers, hospitals, pharmacies, and patients, and also allow this information to be utilized to assess quality of care and public health trends. Whenever possible, all components of Arkansas's health information systems should be used as resources to continuously improve access to care, clinical application of care, and to measure the quality of care that is delivered. (adopted March 2010; updated May 2013)

Issue/Status

Health information exchange systems (HIE) include a variety of technologies and technology systems, including electronic medical records (EMRs), patient personal health records, clinical decision support systems, computerized physician order entry for medications, telemedicine equipment and connections, and personal health devices. The goal of health information exchange systems should be to provide timely access to patient information and (if standardized and networked) communicate health information to other providers, patients, and insurers. Creating and maintaining such systems is complex. However, the benefits can include dramatic efficiency savings, greatly increased safety, and health benefits.

The ACHI Health Policy Board recommends the development of strategies that will:

- support providers in operating in the new Arkansas health care delivery system to increase the use of the statewide health information exchange (Statewide Health Alliance for Records Exchange [SHARE]);
- onboard all hospital systems to SHARE (inclusive of transmission of admission/discharge/transfer data, lab values, radiology, and transcribed documents);
- support all Arkansas primary care practices in adoption of EMR systems that interface with SHARE (inclusive of ability to consume and transmit data [push/pull] to SHARE) to allow providers to manage a patient's complete care experience;
- allow cross-system provider access to real-time clinical data for patient engagement and management to improve health outcomes;
- align SHARE's capabilities and resources with the Arkansas Payment Improvement Initiative's episode- and population-based delivery system redesign so providers experience a single point of connection/entry to manage patient health information and to best manage the quality and cost outcomes of their care;
- support statewide availability of telemedicine technology to optimize delivery of quality health care to underserved areas; and

- enhance opportunities to increase and support the use of information by consumers to improve their health and quality of care.

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Immunizations

35. Increase flu vaccination rates in Arkansas, especially among pregnant women.

Health Policy Board Position Statement

All Arkansans over the age of six months, especially high-risk populations like pregnant women, should receive an annual flu vaccination. (November 2014)

Issue/Status

Each year, one in five—an average of 62 million—Americans get the flu. Between 3,000 and 49,000 Americans die (depending on the severity of the season) and 226,000 are hospitalized annually from the flu. The flu contributes to about $10.4 billion in direct health care costs and high worker absentee expenses.[75]

According to the Arkansas Department of Health's 2013 report, "Arkansas's Big Health Problems and How We Plan to Solve Them" flu and pneumonia are ranked number eight as a leading cause of death in Arkansas.[76] In fact, flu is the only infection-related cause of death that could be prevented by widespread utilization of the vaccine. During the 2013-2014 flu season, 76 Arkansans, including two pregnant women, lost their lives after contracting the flu. This represents a spike compared with previous years.

An analysis by the Trust for America's Health finds that overall flu vaccination rates remain low in the United States. In Arkansas, 47 percent of all individuals (children and adults) were covered by the flu vaccine. It is important to note, however, that among adults 18-64 years of age the vaccination coverage rate was lower, at 37 percent.[75]

The Centers for Disease Control and Prevention and the College of Obstetrics and Gynecologists recommend that pregnant women receive a flu shot as soon as the current season vaccine is available or as early in the season as possible regardless of gestational age. Flu vaccination helps protect women during pregnancy and their babies for up to 6 months after they are born. One study showed that giving flu vaccine to pregnant women was 92 percent effective in preventing hospitalization of infants for flu.[77] Unfortunately, during the 2009-2010 flu season, less than half of women who had a baby in Arkansas, or 46.7 percent, got the flu shot.[78]

Under the Affordable Care Act, new group or individual health plans are required to cover vaccines that are recommended by the Advisory Committee on Immunization Practices (ACIP) with no co-payments or other cost-sharing requirements (when delivered in-network).[79] This includes the flu vaccine for adults and children.

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[75] Trust for America's Health. "Issue Brief: As Flu Season Ramps Up, Adults 18-64 Years Old Least Likely to Get Flu Shots." January 2014. Available at http://healthyamericans.org/report/112/. Accessed 11/06/2014.
[76] Arkansas Department of Health. *Arkansas's Big Health Problems and How We Plan to Solve Them: State Health Assessment and Improvement Plan*, Arkansas Department of Health, 2013.
[77] Centers for Disease Control and Prevention (CDC). "Key Facts about Seasonal Flu Vaccine." Available at http://www.cdc.gov/flu/protect/keyfacts.htm. Accessed November 6, 2014.
[78] Arkansas Department of Health. "Flu Shots for Women During and After Pregnancy: Information about Arkansas Women." Available at http://www.healthy.arkansas.gov/programsServices/healthStatistics/PRAMS/Documents/PregwomanAR8.pdf, Accessed 11/06/2014.
[79] Centers for Disease Control and Prevention. "Finding and Paying for Vaccines." Available at http://www.cdc.gov/vaccines/adults/find-pay-vaccines.html, Accessed November 6, 2014.

Prescription Drug Monitoring Program

36. Support for the Arkansas Prescription Drug Monitoring Program and other efforts.

Health Policy Board Position Statement

To prevent opioid pain reliever (OPR) overprescribing, decrease nonmedical use and overdoses, and to lower the costs associated with OPR misuse, the ACHI Health Policy Board recommends full participation by providers in the Prescription Drug Monitoring Program (PDMP) in Arkansas and complete connectivity among all surrounding states. The Board also recommends the prioritization of the five focus areas as identified in the state plan. (March 2015)

Issue/Status

Opioid pain relievers (OPRs) are prescription drugs that are effective in providing pain relief but are extremely addictive and pose a risk to those who take OPRs for medical and nonmedical use.[80] Individuals who are OPR dependent often have multifaceted social, physical, or behavioral health needs that result in high costs of care[81] and other societal ills. Prescription OPRs present a two-fold issue: overprescribing and misuse. Increasingly, misuse of prescription OPRs is leading to unnecessary deaths.

In the United States, deaths from prescription drug overdose have been steadily rising over the past decade. In Arkansas, the number of deaths from prescription drug abuse has doubled since 1999 when the rate was 4.4 per 100,000 people[82] to 13.1 per 100,000 people in 2008.[80] Deaths from prescription drug overdose and a myriad of other negative impacts can and should be prevented. One strategy to address the problem of overprescribing and misuse is the creation of a state-based Prescription Drug Monitoring Program (PDMP) that interacts with other PDMPs across state lines.

Forty-nine states, including Arkansas, currently utilize PDMPs to aid in monitoring inappropriate dispensing of OPRs with the ultimate goal of patient safety, but prescriber participation is low and, therefore, overprescribing remains a risk. According to a National Prescription Audit performed in 2012, Arkansas is in the top ten states for the number of OPR prescriptions at 116 prescriptions per 100 people.[80]

Limited use of the PDMP system against the backdrop of rising drug abuse has prompted 22 states to mandate prescribers query their systems before writing prescriptions for controlled substances.[83] Arkansas does not currently have such a mandate, but health care professionals and public health officials are searching for ways to increase participation as well as to link Arkansas's PDMP system to all surrounding state databases.

The Arkansas Prescription Drug Abuse Plan was developed in March 2013, with leadership from the Arkansas Department of Health, to provide a comprehensive approach to addressing the problem of overprescribing and misuse of OPRs. The plan identifies five major areas of focus: (1) prevention and education, (2) PDMP operation, (3) data improvement/evaluation, (4) secure prescription drug disposal, and (5) treatment and recovery.

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[80] Paulozzi L, Mack K, Hockenberry J. "Variation among States in Prescribing of Opioid Pain Relievers and Benzodiazepines — United States, 2012." *Journal of Safety Research*, 2014; 51:125-9.

[81] Moses K, Klebonis J. "Designing Medicaid Health Homes for Individuals with Opioid Dependency: Considerations for States." *Center for Health Care Strategies*, January 2015. Accessed February 2, 2015, http://www.chcs.org/resource/designing-medicaid-health-homes-individuals-opioid-dependency-considerations-states/.

[82] Trust for America's Health. "Prescription Drug Abuse: Strategies to Stop the Epidemic 2013." Washington, DC: *Trust for America's Health*, October 2013. Available at http://healthyamericans.org/assets/files/TFAH2013RxDrugAbuseRpt16.pdf; accessed March 2, 2015.

[83] The National Alliance for Model State Drug Laws. "States that Require Prescribers and/or Dispensers to Access PMP Database in Certain Circumstances." Charlottesville, VA: *The National Alliance for Model State Drug Laws*, June 2014. Available at http://www.namsdl.org/library/4475CD3E-1372-636C-DD2E5186156DFB6F/; accessed February 19, 2015.

Built Environment

37. To support and encourage those policies that create built environments that support healthy lifestyles.

Health Policy Board Position Statement

The ACHI Health Policy Board's position is that health should be included in all policies that impact community design and construction. (January 2016)

Issue/Status

According to the Centers for Disease Control and Prevention (CDC), the way communities are designed and built can affect the physical and mental health of those individuals who live, work, and play there. Healthy community design decreases dependence on automobiles, provides opportunities for people to be physically active and socially engaged, and allows people to age in place.[84] Healthy communities also have location-efficient housing; opportunities for interaction with music, arts, and culture; clean air, soil, and water; environments free of excessive noise; job opportunities and a thriving economy; and socially cohesive and supportive relationships, families, homes, and neighborhoods.[85] Healthy community design has many health benefits. It promotes physical activity, improves air quality, lowers risk of injuries, increases social connection and sense of community, and reduces contributions to climate change.

Currently, less than half of all adults and three in 10 high school students in Arkansas get the recommended daily amounts of physical activity.[86] From 2011 to 2012, among children aged 0–17, asthma rates ranged from six percent among Latino children, seven percent among white children, to 13 percent among African-American children. Among 9th−12th graders, the rates were approximately 24 percent, and among adults, 13 percent had asthma.[87] Approximately 10 Arkansans die each week on Arkansas roads due to motor vehicle accidents, most of which are preventable. Motor vehicle crashes contribute to a large amount of hospitalizations, 78.51 per 100,000.[88]

"Walk Scores" for Arkansas cities are considered very low, ranging from 37 in Searcy to 2 in Bella Vista, on a scale where 100 is a "walker's paradise" and 0-24 is almost totally car-dependent.[89] Within some cities, neighborhoods have high scores due to mixed-use developments with housing, shopping, office buildings, and restaurants.[90]

Policy Recommendations

There is strong evidence that addressing safe, secure accessibility to destinations that support peoples' lives (e.g., employment, grocery stores, physical activity, health care, etc.), active transportation, green space and vegetation,

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[84] "Healthy Community Design." *U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), National Center for Environmental Health, Division of Emergency and Environmental Health Services*, 2008. Available at http://www.cdc.gov/healthyplaces/docs/Healthy_Community_Design.pdf; accessed January 4, 2016.

[85] Rudolph L, Caplan J, Ben-Moshe K, Dillon L. "Health in All Policies: A Guide for State and Local Governments." Washington, DC and Oakland, CA: A*merican Public Health Association and Public Health Institute,* 2013. Available at https://www.apha.org/~/media/files/pdf/factsheets/health_inall_policies_guide_169pages.ashx; accessed January 4, 2016.

[86] "Nutrition, Physical Activity and Obesity Data, Trends and Maps." [web site] Atlanta, GA: *U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), National Center for Chronic Disease Prevention and Health Promotion, Division of Nutrition, Physical Activity and Obesity*, 2015. Available at http://www.cdc.gov/nccdphp/DNPAO/index.html; accessed January 4, 2016.

[87] Maulden J, Phillips M. "The State of Asthma in Arkansas 2013." Little Rock, AR: *University of Arkansas for Medical Sciences*. Available at http://www.uams.edu/phacs/reports/Asthma%20Report%20FINAL.pdf; accessed January 4, 2016.

[88] "Creating Conditions in Arkansas Where Injury is Less Likely to Happen…." *Arkansas Department of Health*, June 2014. Available at http://www.healthy.arkansas.gov/programsServices/injuryPreventionControl/injuryPrevention/Documents/InjuryPrevention/CreatingConditions.pdf; accessed January 5, 2016.

[89] "Cities in Arkansas." *Walk Score,* 2016. Available at https://www.walkscore.com/AR/; accessed January 7, 2016.

[90] Chamberlain J. "Walkability Ranking of Arkansas Cities and Neighborhoods." *Trails of Arkansas*, 2014. Available at http://trailsofarkansas.blogspot.com/2014/01/walkability-ranking-of-arkansas-cities.html; accessed January 7, 2016.

and water and air quality will help improve health.[91] The "Healthy Active Arkansas" 10-year plan for Arkansas includes several strategies within the Physical and Built Environment section:[92]

- Create communities that are denser and more connected and livable, incorporating mixed-use neighborhoods, safety, walkability and access to schools and other positive destinations, and healthy food options.
- Encourage design principles that support a statewide healthy highways policy.
- State, county, and local policymakers will create incentives to encourage denser, more walkable communities and multi-use developments.
- Create a shared community vision to develop and improve livability and economic vitality.

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Teen Pregnancy in Arkansas

38. To support efforts and develop statewide strategies to reduce teen pregnancy.

Health Policy Board Position Statement

The ACHI Health Policy Board recognizes that teen pregnancy is a significant economic and public health threat in Arkansas and supports efforts to develop statewide strategies to reduce teen pregnancy. (January 2016)

Issue/Status

Arkansas is one of the top 10 states in the United States with the highest overall teen birth rate.[93] In 2013, the teen birth rate was 43.5 per 1,000 births in Arkansas compared to 26.5 in the United States.[94]

Evidence suggests that teen pregnancy is both a significant public health issue and an economic concern for our state. For example, teen mothers are less likely to receive prenatal care, stay in or complete school, work or maintain economic self-sufficiency, or have children who are ready for school.[95] Increased risk of health complications for teen mothers and their babies include a nearly three times greater likelihood of developing anemia and delivering preterm.[96] The preterm birth rate for babies born to teen mothers is high: 14.7 percent of births for teenagers aged 15–17 compared with 12.6 percent of births for teens aged 18–19 and 11.4 percent of births for women aged 20 and over.[97] Being born preterm puts babies at greater risk of serious long-term illnesses, developmental delays, and death within the first year of life. The infant mortality rate is almost three times higher in infants born to teen mothers.[98]

Teen pregnancies and births are significant contributors to high school dropout rates. Only about 50 percent of teen mothers receive a high school education by age 22, while nearly 90 percent of women who have not given

[91] "Design for Health, Planning Information Sheet: Integrating Health into Comprehensive Planning." [Version 2.0] *University of Minnesota,* 2007. Available at http://designforhealth.net/wp-content/uploads/2012/12/BCBS_ISHealthCompPlanning_082307.pdf; accessed January 4, 2016.
[92] "Healthy Active Arkansas: A 10-year Plan for Arkansas." *Winthrop Rockefeller Institute,* Revised October 2015; available at http://www.healthyactive.org/assets/docs/_HAAplan_FINAL_WebView.pdf; accessed January 4, 2016.
[93] Ventura SJ, Hamilton BE, Mathews TJ. "National and State Patterns of Teen Births in the United States, 1940–2013." *National Vital Statistics Reports*; vol 63 no 4. Hyattsville, MD: *National Center for Health Statistics,* August 2014.
[94] Martin JA, Hamilton BE, Osterman MJK, Curtin SC, Mathews TJ. "Births: Final Data for 2013." *National Vital Statistics Reports*; vol 64 no 1. Hyattsville, MD: *National Center for Health Statistics*, January 2015.
[95] The National Campaign to Prevent Teen and Unplanned Pregnancy. (2013). "Counting It Up: The Public Costs of Teen Childbearing in Arkansas in 2010." Retrieved from: http://thenationalcampaign.org/why-it-matters/public-cost.
[96] Mahavarka SH, Madhu CK, Mule VD. "A Comparative Study of Teenage Pregnancy." *Journal of Obstetrics and Gynecology* 2009;33(2); 281-3432.
[97] "Arkansas: Teen Pregnancy." *National Conference of State Legislators,* 2014. Retrieved from: http://www.ncsl.org/research/health/teen-pregnancy-in-arkansas.aspx.
[98] Klein JD. "Adolescent Pregnancy: Current Trends and Issues." *Pediatrics* 2005; 116(1):281-6.

birth as a teen receive a high school diploma.[99] Of teen mothers who finish high school, only 2 percent finish college by age 30.[100] This can have a negative impact on future employment and future earnings.

The cost of teen births to taxpayers is substantial. This includes public sector healthcare costs, child welfare costs, and the indirect cost of lost revenue due to lower earnings and spending.[101] Between the years of 1991 and 2010, there were 126,788 children born to Arkansas teens, costing taxpayers approximately $3.3 billion.[102] In 2010 (the most recent year for which data are available), the annual public cost of teen childbearing in Arkansas was $129 million.[103]

Policy Options

The ACHI Health Policy Board supports options to avoid teen pregnancy through:

- Supporting Arkansas legislative efforts to examine teen pregnancy trends across the state and connect teens with available educational and healthcare resources (i.e., plan of action developed as a result of Arkansas House Bill 1534 and submitted to the Arkansas Department of Higher Education).
- Investing in evidence-based programs such as those found on the Office of Adolescent Health's website at http://www.hhs.gov/ash/oah/oah-initiatives/teen_pregnancy/db/tpp-searchable.html.
- Improving services and mechanisms to support teen mothers in acquiring an education and completing a degree.
- Improving and supporting access for teens to essential primary prevention strategies and services, including counseling strategies targeted toward sexual behavior and long-acting reversible contraception.
- Supporting research efforts to better understand the economic impact of teen pregnancy on families and on the state.
- Supporting education efforts to enhance health literacy and, in particular, education surrounding pregnancy avoidance in various venues.

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[99] Perper K, Peterson K, Manlove J. "Diploma Attainment among Teen Mothers." [Fact Sheet Publication #2010-01] *Child Trends*, 2010. http://www.childtrends.org/wp-content/uploads/2010/01/child_trends-2010_01_22_FS_diplomaattainment.pdf.

[100] The National Campaign to Prevent Teen and Unplanned Pregnancy. (2011). "Teen Pregnancy and High School Dropout: What Communities Can Do to Address the Issues." Retrieved from: https://thenationalcampaign.org/sites/default/files/resource-primary-download/teen-preg-hs-dropout-summary.pdf.

[101] The National Campaign to Prevent Teen and Unplanned Pregnancy. (2013). "Counting It Up: Key Data." Retrieved from: http://thenationalcampaign.org/resource/counting-it-key-data-2013.

[102] The National Campaign to Prevent Teen and Unplanned Pregnancy. (2013). "Counting It Up: The Public Costs of Teen Childbearing in Arkansas in 2010." Retrieved from: http://thenationalcampaign.org/why-it-matters/public-cost.

[103] The National Campaign to Prevent Teen and Unplanned Pregnancy. (2015). "Key Information about Arkansas." Retrieved from: https://thenationalcampaign.org/resource/key-information-about-us-states.

Legalization of Medical Marijuana

39. Medical marijuana should be subject to approval by the FDA and made available only under appropriate clinical supervision.

Health Policy Board Position Statement

The ACHI Health Policy Board's position is that cannabinoid medical therapeutics (i.e., medical marijuana) could have potential clinical benefits but as a pharmaceutical agent should be subject to approval by the FDA and made available only through standardized dosing and delivery mechanisms and under appropriate clinical supervision.

Issue/Status

Although nearly half of the states have legalized medical marijuana in some form, this legalization has occurred despite the U.S. Food and Drug Administration's (FDA) lack of approval of marijuana for medical treatment. Calls for legal paths for medical application of marijuana combined with federal and state restrictions on availability have generated initiated referenda for the electorate in Arkansas.

Medical marijuana, which may be identical in form to recreational marijuana, is material from the cannabis plant consisting of cannabinoids. The primary cannabinoids are tetrahydrocannabinol (THC), which is the psychoactive ingredient, and cannabidiol (CBD), which can neutralize the euphoric effect induced by THC.[104] Medical marijuana is not available from pharmacies; however, it can be purchased from state-approved dispensaries in a variety of preparations or grown by patients for the treatment of a myriad of illnesses.

Medical marijuana is federally classified as Schedule I under the Controlled Substances Act, which means it currently has no acceptable medical use, a high potential for abuse, and a lack of accepted safety for use under medical supervision. The FDA has not approved marijuana as safe or effective for the medical treatment of any disease or condition although the FDA does facilitate scientific research to continue to assess the safety and effectiveness of medicinal uses of marijuana. However, the FDA has approved synthetically-derived cannabinoids dronabinol (which has an identical chemical structure as THC), nabilone, and oral drabinol.

Scientific evidence supporting the medical use of marijuana and cannabinoids is very limited and varies considerably by disease or condition. The strongest evidence for the medical use of marijuana and cannabinoids is for chronic pain, neuropathic pain, and spasticity associated with multiple sclerosis. Small randomized clinical trials suggest CBD may reduce seizures in children with treatment-resistant epilepsy.[105]

Like all drugs, marijuana has potential risks. Acute effects associated with marijuana use include impaired short-term memory, impaired motor coordination, psychotic symptoms, and impaired judgment. Short-term use of marijuana doubles the risk of involvement in a motor vehicle crash.[106] Chronic effects from daily use include anxiety[107] and depression.[108] The method of use also affects the risk. Regular marijuana smoking increases the risk of breathing problems and lung infections.[109]

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[104] Hill, K. P. (2015). Medical marijuana for treatment of chronic pain and other medical and psychiatric problems: a clinical review. *JAMA*, 313(24), 2474-2483.

[105] National Institute on Drug Abuse. (2016). Retrieved from https://www.drugabuse.gov/about-nida/legislative-activities/testimony-to-congress/2016/researching-potential-medical-benefits-risks-marijuana

[106] Hartman, R. L., & Huestis, M. A. (2013). Cannabis effects on driving skills. *Clinical chemistry*, *59*(3), 478-492.

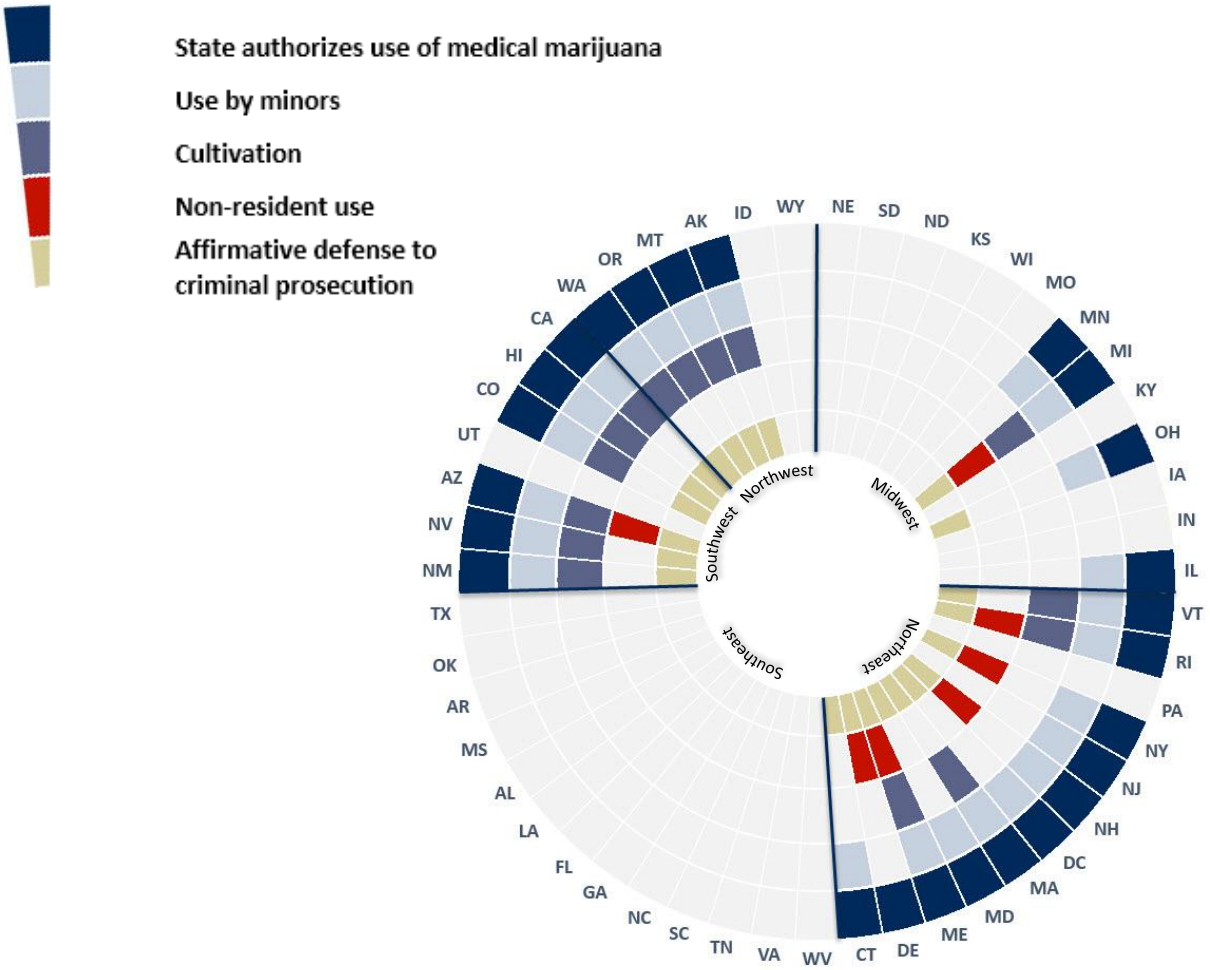
[107] Patton, G. C., Coffey, C., Carlin, J. B., Degenhardt, L., Lynskey, M., & Hall, W. (2002). Cannabis use and mental health in young people: cohort study. *BMJ*, 325(7374), 1195-1198.

[108] Crippa, J. A., Zuardi, A. W., Martín-Santos, R., Bhattacharyya, S., Atakan, Z., McGuire, P., & Fusar-Poli, P. (2009). Cannabis and anxiety: a critical review of the evidence. *Human Psychopharmacology: Clinical and Experimental*, 24(7), 515-523.

[109] Thompson, A. E. (2015). Medical Marijuana. *JAMA*, 313(24), 2508-2508.

Finally, cannabinoid medical therapeutics should not be exploited as an alternative to explicit decisions on the legalization of marijuana for recreational purposes. Legalization of marijuana for recreational purposes should be a societal decision weighing the short- and long-term risks and benefits.

Figure 1: Medical Marijuana Laws by State[110]



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[110] LawAtlas. (2016). Retrieved from http://lawatlas.org/query?dataset=medical-marijuana-patient-related-laws