

HEALTH POLICY BOARD POSITIONS

ACHI Health Policy Board Positions: 2010

Tobacco Use

1. Reduce health care and business costs related to tobacco use.

Issue/Status

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 438,000 deaths, or nearly 1 of every 5 deaths, each year in the United States. People who start smoking in their teens (as more than 70 percent do), and continue to do so for two decades or more will die 20–25 years earlier than those who have never smoked, thus losing some of the most productive years of their lives. Quitting smoking has immediate as well as long-term benefits, reducing risks for diseases caused by smoking and improving health in general.

Arkansas's taxes on cigarettes and smokeless tobacco are lower than the national average; a comparison with surrounding states is shown in the table below. Reduction in taxes and therefore prices of tobacco products correlates with an uptake in youth smokeless tobacco initiation and use.

Tax rate	AR	TX	OK	MS	LA	MO	TN
Cigarettes (\$/pack)	\$1.15	\$1.41	\$1.03	\$.68	\$0.36	\$0.17	\$0.62
Smokeless (% of price)	68%	110%	60%	25%	20%	10%	6.6%

Increase and maintain an Arkansas tobacco excise tax/smokeless tobacco tax to comport with the national average.

To increase tobacco excise taxes, a legislative initiative must be passed by two-thirds of the legislators.

Health Policy Board Position

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 increase in the excise tax on tobacco products. In January 2006, the Board adopted the following position: *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.* This position was maintained for the 2009 Session. With legislative and executive level support, Act 180 of 2009 raised the tax on a pack of cigarettes by 56 cents from 59¢ per pack to a rate of \$1.15 per pack and increased the tax on smokeless tobacco from 32% of mfp to 68% mfp. This tax rate was effective on and after March 1, 2009.

In addition, the ACHI Health Policy Board recommends the following:

All Master Settlement Agreement (MSA) funds should be used to improve and optimize the health of Arkansans.

MSA 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 MSA funds.

MSA funds should be invested in solutions that work effectively and efficiently in Arkansas.

ACHI is a nonpartisan, independent, health policy center that serves as a catalyst to improve the health of Arkansans.



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Arkansas Health Information Exchange and Technology

Support the adoption of an HIE system that will allow important health information exchange between providers, payers, hospitals and patients.

Issue/Status

ACHI leads the strategic planning process with the assistance of private contractors, state partners and current staff. The state received notification of the award of \$7.9 million for the HIE Cooperative Agreement Program on February 12, 2010 with an official notification/start date of February 8, 2010. Legislative approval was obtained during the 2010 fiscal session for the \$600,000 state matching funds needed for the Cooperative Agreement. No HIT Coordinator has been named to date, and Frank Scott from the Governor's office is the Acting HIT Coordinator. The Surgeon General continues to chair the state's HIT Executive Committee and Task Force.

Health Policy Board Position

The ACHI Health Policy Board supports the state's adoption of an HIE system that will allow important health information to be exchanged between providers, payers, hospitals and patients. Whenever possible, both health information exchange and health information technology should be used as resources to improve access to care, clinical application of care, and to measure the quality of care that is delivered.

ACHI Health Policy Board Positions: 2009

Obesity Prevention

Mortality data attribute tobacco use and obesity as the top two causes of disease-related death among adults in the United States today. While tobacco use has been on the national radar screen for decades, the recent emergence of obesity-related deaths will soon overtake tobacco for the number one spot. Obesity has been linked to heart disease, type II diabetes, high blood pressure, and a host of other chronic and life-threatening conditions. However, the majority of deaths linked to obesity and resulting health costs for treatment are preventable if positive and immediate action is taken.

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

Issue/Status

School gyms and public facilities and spaces are not open to the public during non-school hours because of concerns about liability, security and maintenance costs. Yet in Arkansas, many adults engage in no or limited physical activity on a regular basis, contrary to recommendations of health authorities: 27% of whites, 36% of black, and 38% of Latino adults do not engage in any physical activity. Less than half of adults engaged in regular daily physical activity (46%, white; 43%, black; 40%, Latino).¹

Several options exist to encourage or require joint use agreements for public school properties.

1. Awareness raising and provision of information, technical assistance, and model contracts and agreements, with elective participation by schools and communities.
2. Legislative and/or executive branch support to encourage voluntary establishment of JUAs.
3. Legislative and/or executive branch support with statutory language describing JUA parameters.
4. Legislatively required establishment of JUAs by schools and communities.

Health Policy Board Position

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.

¹ Healthy People 2010 Health Status Report

3. Increase school-based physical education (PE) to facilitate reduction of child obesity.

Issue/Status

Due to changes in lifestyle and environmental safety concerns, adolescents today have sedentary lifestyles, which contribute to obesity and other health conditions. Just over half of adolescents (59% of whites and 51% of blacks) engage in moderate physical activity and only about one quarter participate in daily school physical education.¹ Frequently, the attention given to the reauthorization of the No Child Left Behind Act focuses only on the criteria that suggest academic offerings that require sedentary activity. Yet, new powerful evidence indicates that children learn and perform better and achieve more when they have a balance of physical activity to sedentary time in the academic day.

Legislation in 2007 amended state policies to eliminate all but minimal physical activity requirements in grades 7–12. 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 helps children avoid long periods of sedentary activity and promotes lifelong habits to maintain appropriate physical activity during waking hours. Inclusive in the attainment of the 150 minutes were the traditional curriculum requirement of physical education.

Health Policy Board Position

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. This position stands for 2009—*All school students should be required to participate in at least 30 minutes of daily physical activity.*

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

Issue/Status

More Americans eat out now than in the past, and we 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. Studies have also shown that people are not aware of how many calories are in their meals purchased in restaurants. 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. Currently, Arkansas does not have standard menu labeling requirements.

By requiring restaurants to display nutritional information, consumers would be enabled in exercising personal responsibility and 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 exercised this policy change.

Health Policy Board Position

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 according to guidelines recommended by national authorities.

Dental Problems

5. Reduce untreated caries and dental decay.

Issue/Status

Oral diseases and conditions afflict more persons than any other disease in the United States. Oral diseases can cause difficulty speaking, chewing, and/or swallowing and those who suffer from them may have a loss of self esteem. Treatment can often be very costly and those afflicted often have decreased economic productivity through lost work and school days. Dental caries is the most common chronic childhood disease, disproportionately afflicting low-income ethnic-minority children, the very same children who have the least access to dental care and the highest disease levels. In Arkansas, dental surveys show that tooth decay is a major problem. In 2006, 57% of third-grade children had a cavity, 27% attend school with untreated caries, and 10% of children had emergency dental needs. In addition, one state survey indicated that almost one in four Arkansans over the age of 40 years has lost all of his or her teeth. The US Task Force on Community Preventive Services strongly recommended community water fluoridation for reducing tooth decay. For the many studies reviewed, there was a median 29% reduction in tooth decay 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.

Options for mandating fluoridation of public water supplies are state legislation mandating fluoridation of all public water systems, changes in State Board of Health rules and regulations, county-level referendum, or executive order.

Health Policy Board Position

The ACHI Health Policy Board has taken a position to support all US Task Force on Community Preventive Services recommendations and specifically has taken a position to support legislation mandating statewide fluoridation of public water supplies. This position stands for 2009—*All public water supplies should be fluoridated.*

Maximize application of dental sealants to children under the age of 18 years as a preventive health measure.

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 for 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. CDC and The Task Force on Community Preventive Services recommends school sealant programs and issued a strong endorsement for dental sealants in 2001.² Several new papers reveal that the evidence supports sealants as a preventive measure for caries as well as protects against future caries even when treated after tooth is affected by caries.³

Health Policy Board Position

The ACHI Health Policy Board has taken a position to support all US Task Force on Community Preventive Services recommendations. The Task Force has endorsed and highly recommends that sealants be applied through school-based programs. *The HPB recommends that all children have access to dental sealant application.*

² http://www.cdc.gov/OralHealth/Topics/dental_sealant_programs.htm#3

³ http://www.ada.org/prof/resources/pubs/jada/reports/report_sealants.pdf

Child Health and Mortality

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

Issue/Status

Infant mortality and child mortality rates are excessively high in Arkansas. In 2006, 359 Arkansas infants died before their first birthday; resulting in an infant mortality rate of 8.8 per 1000 live births. Arkansas' infant mortality rate is higher than 39 other states and the rate for African-American infants in Arkansas is more than twice as high as it is for whites.⁴ Compared to other states, Arkansas ranks in the top five with 29 deaths per 1000 children 1–14 years of age.⁵ The Kaiser Foundation reveals that teens between the age of 14 and 18 years fare comparatively as their younger counterparts with Arkansas ranking in the top ten of states with high mortality rates for teens.

Although the state used to have a child fatality review committee functioning within the Department of Health, currently no such group exists. These committees assess circumstances relating to child fatalities which can inform and prepare interventions that could avoid untimely death for children. This information is vital for the prevention of child abuse, as well as avoidable fatal injuries. A commission would issue annual reports documenting the types and kinds of death suffered by children and determine preventive actions to reduce/avoid such deaths in the future. All but three states in the county have similar type commissions. A special task force has studied the issue over the last year and is recommending that the state have such a group again. No decision as to where to locate it has been determined. Suggestions are the Arkansas Department of Health, the Commission on Child Abuse and Domestic Violence, the Injury Prevention Center or another independent contractor. State funds for administration of the commission will be needed.

The administrative branch of government could convene such a group and support within context of present budget or ask for additional support; the legislature could authorize and mandate a specific state agency to convene and manage a committee; or the Governor could appoint a body within one of his administrative agencies.

Health Policy Board Position

The ACHI Health Policy Board recommends creation of a standing child fatality review committee to inform development of preventive measures to reduce the high rate of infant, child, and teen mortality.

7. Implement coordination of child health.

Issue/Status

Coordinated school health programs are emerging as a promising practice for delivery and maintenance of public health improvement among school age children and their families. Minimal coordinated school health programs exist in the state and are supported primarily on federal or private funds. While state agencies are coordinating resources and struggling to grow the programs, additional state support is necessary to grow the program as needed.

Health Policy Board Position

The ACHI Health Policy Board recommends adoption of a statewide coordinated school health system.

⁴ Arkansas Department of Health, Center for Health Practice, Health Statistics Bureau

⁵ <http://www.statehealthfacts.org/comparetable.jsp?ind=61&cat=2&sub=18&yr=16&typ=3&sort=n&o=a>

Tobacco Use

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Motor Vehicle Accident Harm

9. Allow primary enforcement of seat belt laws.

Issue/Status

On average in 2006, every week in Arkansas, more than 12 people died and 47 people suffered incapacitating injuries because of traffic crashes.⁶ Among those fatally injured in passenger vehicles, 68% were not using safety

⁶ Highway Safety Office. Arkansas 2006 Traffic Crash Statistics. Little Rock, AR: Arkansas State Police; 2007.

restraints compared with only 32% who were restrained.⁷ Only 2 out of 3 Arkansans routinely use their safety belts.

Arkansas currently has a secondary safety belt law, meaning that citations for not wearing a safety belt can only be written if a vehicle is stopped for another reason. Primary laws are more readily enforced than secondary laws and the average safety belt use rate in states with primary laws was 10 percentage points higher than in states without primary laws in 2005 (84 versus 73 percent safety belt use).⁷ To reduce preventable deaths and injuries related to lack of seat belt usage, the Arkansas state legislature should pass a primary seat belt law.

Health Policy Board Position

By adopting recommendations of the Task Force on Community Preventive Services, the ACHI Health Policy Board supports primary seat belt law enforcement legislation. The following recommended position statement comports with this prior HPB decision. *The ACHI Health Policy Board supports legislation to allow primary enforcement of seat belt laws.*

10. Reduce preventable deaths and injuries related to motorcycle accidents with non-helmeted riders.

Issue/Status

Helmets reduce the risk of death by 29% and are 67% effective in preventing brain injuries to motorcycle riders.⁸ In 1997, Arkansas repealed mandatory helmet usage by most riders. For 1998, the National Highway Transportation and Safety Administration reported that helmet use declined from 97% to 52% and motorcycle operator fatalities increased by 21% in Arkansas.

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.

Health Policy Board Position

The ACHI Health Policy Board has taken a position (January 2007) to support legislative attempts to require protective head gear while riding motor vehicles. The following 2009 position statement is in keeping with this earlier decision of the HPB: *The ACHI Health Policy Board supports legislation requiring helmet use by motorcycle, motor scooter, and moped operators.*

11. Reduce teen motor vehicle death/trauma rates.

Issue/Status

Arkansas teens have rates of motor vehicle death that are nearly twice as high as the United States overall. Motor vehicle crashes are the leading cause of death for teens making up 78% of total Arkansas teen fatalities from 1999-2005.⁹ Graduated driver licensing¹⁰ is a system designed to delay full licensure while allowing beginners to obtain their initial experience under lower-risk conditions. The three stages of GDL are:

- Supervised learning period— After passing a qualifying test, a young driver is then allowed to drive ONLY with a supervising adult in the car for a given period of time or minimum number of hours. Only after they meet the criteria can they earn an intermediate license.
- Intermediate license— At this stage the young driver no longer has to drive with supervision. However, they must continue to follow restrictions. These restrictions include following a curfew, not using a cell phone, and limiting the number of passengers in the car. These restrictions vary by state.

⁷ National Highway Traffic Safety Administration. Traffic Safety Facts: Laws. Washington, D.C.: National Highway Traffic Safety Administration; 2006.

⁸ NHTSA, 2001.

⁹ ACH Injury Prevention Center, Graduated Driver Licensing Fast Fact Sheet. Little Rock, AR: Arkansas Children's Hospital. 2008.

¹⁰ Insurance Institute for Highway Safety. Graduated Driver Licensing (GDL). 2008.

- Full-Privilege license— At this stage the driver meets the age and any other requirements to earn an unrestricted driver’s license. These requirements vary by state.

A study supported by NHTSA and the Centers for Disease Control and Prevention released in July 2006 found that GDL programs can reduce fatal crashes for 16-year-old drivers by an average of 11 percent. The Insurance Institute for Highway Safety (IIHS) has evaluated state licensing systems and found that the length of the learning period and the duration and strength of restrictions in the intermediate license phase are credited in the reduction of injury and fatality.

Current Arkansas law allows 14 year olds to obtain permits to drive if accompanied by a licensed driver 21 years of age or older; those aged 16–18 have some restrictions and must be accompanied by an adult for six months after licensing. The state also allows exemptions for those aged 14 and 15, commonly known as “hardship” licenses.

Legislative restrictions on vehicle operation based on age, passenger number, time of day, and cell phone usage are expected to reduce teen motor vehicle death and trauma.

Health Policy Board Position

In November 2007, the ACHI Health Policy Board adopted a position: *The ACHI Health Policy Board supports expansion of the graduated drivers license currently in place to consider additional restrictions on drivers under the age of 17, i.e. raising the age to obtain learner’s permit; night driving restrictions; passenger restrictions; and longer periods requiring a teen driver to be accompanied by an adult with an active driver’s license. For 2009, The ACHI Health Policy Board supports graduated automobile license restrictions on drivers under the age of 17.*

12. Reduce motor vehicle crashes related to alcohol.

Issue/Status

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

Additionally, by failure to implement stricter open container laws. Arkansas has and continues to lose access to federal highway funds under the Transportation Equity Act for the 21st Century (TEA-21).

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

Health Policy Board Position

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. This position stands for 2009.*

Health Care Insurance Coverage

13. Increase health insurance coverage for Arkansans.

Issue/Status

Arkansas families who earn less than 200% of the federal poverty limit (FPL) are eligible to enroll their children in the ARKids program, which provides health care coverage. Currently, 70,000 children in Arkansas are estimated to be without health care coverage and 44,000 of those live in households earning less than 200% of the FPL.^{11 11}

¹¹ Medicaid Report – Arkansas Advocates fro Children and Families

Additionally, private sector family coverage continues to erode as families drop insurance because of cost and as businesses are no longer able to offer insurance benefits to their employees.

One prime example of the erosion of coverage in the state is within the state operated and funded Arkansas Public School Employee health insurance plan. The plan's fiscal stability is imperiled because of increased utilization by members, low levels of participation, and cost of plan operation. Currently, many members cannot continue to participate in the plan because of increasing costs of coverage. Thus, those who are "healthy" and eligible opt out of the plan or go to the private market for coverage, leaving only the chronically ill in the plan. Because of limited state funds for the plan, the members' share of the premium continues to grow, causing more members to drop coverage. This results in a "death spiral" for the insurance plan, where costs continue to increase because of adverse risk selection in the insured pool.

Expand the ARKids program eligibility to cover additional children.

By increasing ARKids income eligibility to 250% FPL, coverage options would be expanded to include 7,000 presently uninsured children. Alternatively, by increasing the ARKids income eligibility threshold from 200% to 300% FPL, coverage would be expanded to 14,000 presently uninsured children. To accomplish either of these legislative initiatives, upfront state funding is required to draw down federal match dollars.

Health Policy Board Position

The ACHI Health Policy Board recommends expanding the ARKids program eligibility to cover additional children.

Expand non-custodial child health insurance coverage.

The state could support enhanced steering of ARKids eligible children by the Arkansas Office of Child Support and Enforcement (OCSE). Further, implementation of an OCSE coverage mandate for non-custodial children >200% FPL could be supported.

Health Policy Board Position

The ACHI Health Policy Board recommends expanding non-custodial child health insurance coverage.

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

Most health insurance is obtained as an employment benefit. However, in Arkansas, only one in three small businesses offers health insurance to their employees. 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.

Health Policy Board Position

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.

System of Care

14. Improve delivery of health care to trauma victims.

Issue/Status

Arkansas does not presently have a centralized and coordinated statewide trauma care system. In other states, this type of system helps ensure appropriate local treatment for accident victims in a more timely and cost-effective manner, lessening avoidable disability and death. At present, Arkansas has neither a trauma care system nor designated trauma center hospitals. Such hospital designation can facilitate coordination of trauma victim transportation from accident sites and remote health care facilities to other facilities equipped for appropriate treatment.

Establish a coordinated trauma system in Arkansas through multi-phased implementation.

The establishment of a trauma system is the most optimal choice for any proposed legislation, but incremental implementation is also an option to consider. With the funding to implement a statewide trauma system “Dashboard” is the first step toward a coordinated trauma system. Adding components such as a statewide trauma registry and limited number of trauma designated hospitals with a plan for geographic distribution of centers. Legislation that dedicates funding to implement and administer a statewide trauma system, along with a trauma registry would be the recommendation.

Health Policy Board Position

The ACHI Health Policy Board, supports development and implementation of a statewide coordinated trauma system.

Enhance and improve access to health care services

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

Issue/Status

Many policy makers and leaders in Arkansas acknowledge that delivery of and access to mental health and substance abuse care is problematic for many. 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

Establish a standing Governor’s Commission on Child Mental Health to develop a “system of care” for delivery of mental health and substance abuse services to Arkansas children and pregnant women.

This Commission can be established by executive order and / or through legislation.

Health Policy Board Position

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).

16. Improve access to safety net health care services through community health centers

Issue/Status

For many Arkansans, access to quality health care is difficult. While this is true for the over 500,000 uninsured Arkansans, it is also true for many insured Arkansans without ready access to a traditional hospital or health care provider. For these individuals and families, the Community Health Centers of Arkansas serves as a safety net.

Establish appropriate funding to ensure stability of CHC network.

Through the CHC Executive Director, the CHC Board has issued a statement that the network requires \$5M in one time funding in order to support attainment of new infrastructure. Additionally, the CHC network will require approximately \$20M annually in order to maintain current service levels. This funding requirement can be satisfied through legislative action.

Health Policy Board Position

The ACHI Health Policy Board recommends that the state designate appropriate funding to ensure stability of the Arkansas CHC provider network.

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

Issue/Status

Examinations of the present Arkansas health care workforce demonstrate an insufficient number and distribution of physicians, dentists, allied health professionals and nurses to meet current health care needs of Arkansans. Policy makers have issued predictions that this inadequacy will worsen in coming years.

Establish a Health Care Workforce Commission to develop a long-term strategic plan to strengthen and stabilize the delivery of primary care in Arkansas.

Establishment of this Commission can occur through executive order and / or legislation.

Health Policy Board Position

The ACHI Health Policy Board recommends the creation of a Health Care Workforce Commission to develop a staffing strategic plan for the state.

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