



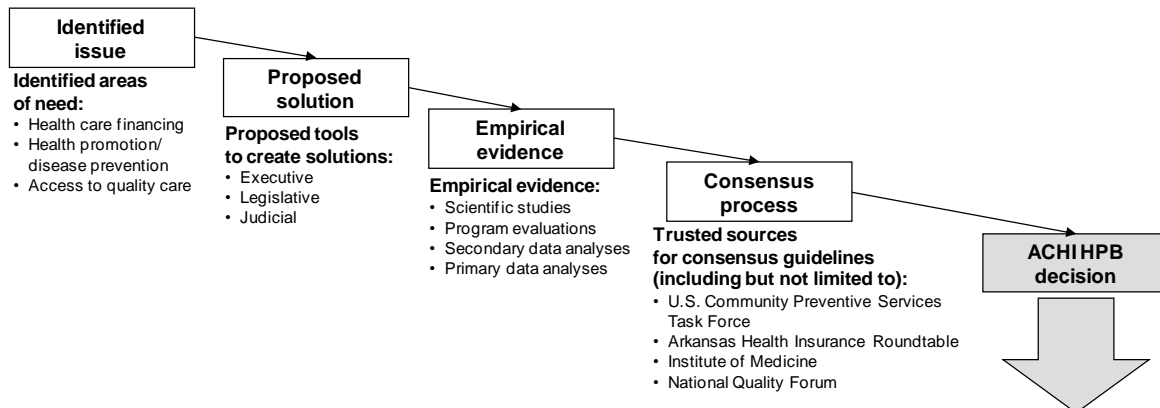
Health Policy Board

Policy Positions & Statements

(updated 1/13/11)

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.



- 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

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



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ACHI Health Policy Board—Policy Positions

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 recommendation to form a basis of health policy positions.

Recommendations from the U.S. Preventive Services Task Force and the U.S. Task Force on Community Preventive Services

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, whose members are appointed by the Director of the Centers for Disease Control and Prevention (CDC). Task Force members oversee the prioritization process for which systematic reviews are conducted; participate in development and refinement of review methods; serve as members of individual review teams; and consider the findings of all reviews and issue recommendations and findings to help inform decision making about policy, practice, research, and research funding in a wide range of U.S. settings (www.thecommunityguide.org/index.html). Findings are published in the Community Guide (www.thecommunityguide.org/about/Conclusion_Report_071210.pdf).

Health Policy Board Position

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)

ACHI Health Policy Board—Position Statements

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. In addition, the ACHI Health Policy Board has made the following policy position statements.

Health System Financing

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

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

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 9, 1999)¹

- *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.*

Arkansas Health Information Exchange (HIE) and Technology (HIT)

2. Support the adoption of information technology to support access and quality.

Issue/Status

The American Recovery and Reinvestment Act of 2009 provides funding opportunities for states to expand use of health information technology (HIT). Included is a four-year cooperative agreement program designed to allow states to use federal funds to develop Health Information Exchange (HIE) capacity. The state and federal intent for an interoperable HIE system will ultimately allow health information to follow individuals whenever and wherever they engage the health care system. This will improve access to and quality of health care services throughout Arkansas, leading to reduced inefficiencies and avoidable costs, improved patient care and individual decisions, and better health outcomes.

The Arkansas HIE project, steered by Arkansas Surgeon General, Dr. Joe Thompson, at the request of Governor Mike Beebe, was staffed by the Arkansas Center for Health Improvement (ACHI) and fueled by leaders in the health and technology professions through formation of an HIT taskforce and executive committee. An application for federal dollars was completed through the project and Arkansas was awarded \$7.9 million for the HIE cooperative agreement program. The HIE taskforce then worked to develop strategic and operational plans, and establish mechanisms for putting the HIE system in place. As part of the process, project leader, Ray Scott, was

¹ 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

named State HIT Coordinator and a new office of Health Information Technology was established for the day-to-day coordination of this important effort.

Health Policy Board Position Statement

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. (March 2010)

Tobacco Use

3. Improve health and reduce health care and business costs related to tobacco use.

Issue/Status

Smoking kills more people than alcohol, AIDS, car accidents, illegal drugs, murders, and suicides combined, with thousands more dying from spit tobacco use. Of the roughly 400,000 kids who become new regular, daily smokers each year, almost a third will ultimately die from it. In 2007, 3,400 Arkansan kids under 18 became new daily smokers. 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 nearly 1 of every 5 deaths, each year in the United States. People who start smoking in their teens (as more than 70% do), and continue to do so for two decade lose an average of 13 to 14 years of life because of their smoking.²

Annually in Arkansas:³

- 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

Quitting smoking has immediate as well as long-term benefits, reducing risks for diseases caused by smoking and improving health in general.⁴

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

In 2009, the Institute of Medicine conducted a comprehensive review of the impact of smoke-free legislation. The IOM publication, *Secondhand Smoke Exposure and Cardiovascular Effects*, 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% 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 ailments including respiratory/ lung function, and middle ear disease. There is no risk-free level of exposure to secondhand

² <http://www.tobaccofreekids.org/research/factsheets/pdf/0072.pdf>

³ <http://www.tobaccofreekids.org/reports/settlements/toll.php?StateID=AR>

⁴ <http://www.surgeongeneral.gov/tobacco/2008>

smoke, and only eliminating smoking in indoor spaces fully protects nonsmokers from exposure to secondhand smoke.

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 the legislators.

Arkansas Clean Indoor Air Act of 2006: Arkansas passed legislation to prohibit 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.

Arkansas Tobacco Tax 2009: With legislative and executive level support, Act 180 of 2009 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% of manufacturer's price to 68% manufacturer's price. This tax rate was effective on and after March 1, 2009.

Impact on Tobacco Use in Arkansas: With the implementation of the 2006 Clean Indoor Air Act and the Tobacco Tax increase of 2009, coupled with tobacco control activities within the Arkansas Department of Health, the state has experienced steady reductions in tobacco use. The 2009 BRFSS demonstrated an Arkansas overall smoking rate of 21.5%, which is down from 22.3% in 2008. This moves us from 8th to 11th in national smoking prevalence. The male smoking rate is 21.0% and the female smoking rate is 21.9%. Additionally, according to August 2010 Arkansas Quitline Evaluation Report, 16,942 Arkansans registered for tobacco cessation interventions in FY2010 (approximately 2.8% of AR smokers). The national standard/goal for cessation is the "30-day point prevalence measured at 7 months" and this goal should be 30%. Arkansas's FY2010 30-day point prevalence measured at 7 months was 36.1% for those in the multiple call/nicotine-replacement therapy (NRT) and 31.7% in the single call/NRT.

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)

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 increase in the excise tax on tobacco products. In January 2006, the Board adopted the following position statement: *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.*

Obesity Prevention

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.⁵ 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 US deaths), poor diet and physical inactivity (400,000 deaths; 16.6%), and alcohol consumption (85,000 deaths; 3.5%).⁶ 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.

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

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. Yet in Arkansas, many adults engage in no or limited physical activity on a regular basis, contrary to recommendations of health authorities—30% of adult Arkansans reported that they did not participate in any physical activities during the past month in a 2009 survey.⁷

Several options exist to encourage or require public school properties to be available for use by the public or organizations; these agreements are known as “joint use agreements” or JUAs.

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.

The Arkansas Department of Education currently manages a \$400,000 grant program for joint use agreements with the first round of applications released in April 2010. Schools could apply for Cycle I and/or Cycle II receiving \$5,000 per cycle. Applications could be made by any agency, organization or school, but the school must act as the fiduciary agent. Nine of 19 applications were funded in the first cycle and second-round applications are due to the Office of Coordinated School Health on September 13, 2010. Based on the response and quality of the applications, the intention is to release another round of applications before the end of the 2010 calendar year.

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)

5. Increase school-based physical education (PE) to reduce childhood 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. Frequently, educational achievement criteria focus only on the academic requirements which are provided through 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.

⁵ 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.

⁶ Mokdad AH, Marks JS, Stroup DF, Gerberding JL. Actual Causes of Death in the United States, 2000. *JAMA*. 2004;291:1238-1245.

⁷ National Center for Chronic Disease Prevention & Health Promotion, CDC. Prevalence and Trends Data, Arkansas 2009. BRFSS. Available at apps.nccd.cdc.gov/brfss.

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 was the traditional curriculum requirement of physical education.

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. This position was reaffirmed in January 2009: *All school students should be required to participate in at least 30 minutes of daily physical activity.*

6. 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.

As part of the federal Patient Protection and Affordable Care Act of 2010, in March 2011, national chains will be required to listing calorie counts on the menu boards of chain restaurants or adjacent to each food offered in vending machines and in retail stores. 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.

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 according to guidelines recommended by national authorities. (January 2009)

Dental Problems

7. Reduce untreated caries and dental decay.

Issue/Status

Oral health is integral to one's overall general health.⁸ Although preventable, tooth decay is a chronic disease affecting all age groups. In fact, it is the most common chronic disease of childhood.⁹ 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 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.¹⁰

The most comprehensive data on children and adults in Arkansas was collected in 2008 by the Arkansas Department of Health.¹¹

Among children and adolescents:

- 56% had evidence of current or past cavities (caries experience)
- 24% had untreated caries (cavities)
- 18% were in need of routine care
- 8% were in need of urgent care

Among older adults:

- 23% of adults 65 years and older in Arkansas reported they had lost all of their permanent teeth, compared to 19% in the U.S.

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 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

Fluoride varnishes applied professionally two to four times a year can substantially reduce tooth decay in children.¹² 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

⁸ Centers for Disease Control and Prevention. Fluoridation of drinking water to prevent dental caries. *Morbidity and Mortality Weekly Report*, 48 (1999): 933-40

⁹ 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

¹⁰ 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.

¹¹ Arkansas Department of Health, Office of Oral Health, 2008.

¹² 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

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.¹³ Additionally, many children in Arkansas do not have the benefit of fluoridated water.

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

Application of dental sealants to 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 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 recommend school sealant programs and issued a strong endorsement for dental sealants in 2001.¹⁴ 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.¹⁵

Health Policy Board Position Statement

The US 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)*

Child Health and Mortality

8. 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's 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.¹⁶ Compared to other states, Arkansas ranks in the top five with 29 deaths per 1000 children 1–14 years of age.¹⁷ 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 country have similar type commissions. A special task force studied the issue in

¹³ Fluoride. American Academy of Pediatric Dentistry – AAPD Publications. Retrieved 12/12/2010 at <http://www.aapd.org/publications/brochures/fluoride.asp>

¹⁴ http://www.cdc.gov/OralHealth/Topics/dental_sealant_programs.htm#3

¹⁵ http://www.ada.org/prof/resources/pubs/jada/reports/report_sealants.pdf

¹⁶ Arkansas Department of Health, Center for Health Practice, Health Statistics Bureau

¹⁷ <http://www.statehealthfacts.org/comparetable.jsp?ind=61&cat=2&sub=18&yr=16&typ=3&sort=n&o=a>

2008 and recommended 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 Statement

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. (January 2009)

9. 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.

- As of school year 2010, 41 school districts are identified as Coordinated School Health (CSH) schools through a CDC grant program (\$700,000/yr). Included in these 41 districts, 20 districts also receive funding from the Arkansas Department of Health Tobacco Prevention and Cessation Program for tobacco prevention focus (\$1M/yr).
- Nine school districts are starting Wellness Centers on campus and have received \$2M in funding from Arkansas general revenue. These CSH Wellness Centers will have quality school-based mental health programs implemented by January 1, 2011.
- Dental hygienist provides quality oral health education in CSH fourth grades around the state of Arkansas from CDC grant attained by Arkansas Oral Health Coalition.
- The CSH program (joint venture between Arkansas Department of Education and Department of Health) is currently implementing a work plan approved and funded by the National State Boards of Education to improve child nutrition in Arkansas. CSH reports to the Arkansas State Board of Education monthly.
- ACHI has developed a CSH evaluation tool and will be delivering the annual CSH state evaluation report due spring 2011.

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

- Through \$700,000/yr grant funding from the Arkansas Tobacco Settlement Commission, 56 schools (22 K–2 buildings, 24 3–6 buildings, and 10 middle schools) focus on physical education using the SPARK curriculum, Fitnessgram, and PE4Life. Also, Arkansas Children’s Hospital purchased Health Teacher.com curriculum for these schools and others (total value, \$130,000). Pre-K will be added in the 2011-12 grant year.
- Arkansas Department of Human Services has hired a policy analyst to address policy issues to maximize the funding potential and minimize current policy barriers.
- Assistance for schools determining budget and Medicaid challenges and opportunities is now provided by staff at Medicaid in the Schools dedicated to CSH and CSH Wellness Centers.

Health Policy Board Position Statement

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

Motor Vehicle Crash Harm

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

Issue/Status

Twenty states and the District of Columbia have motorcycle helmet laws that require all riders to wear a helmet. Twenty-seven states have a motorcycle helmet law that only require some riders to wear a helmet. Arkansas is one of these 27 states. Three states (Illinois, Iowa, and New Hampshire) do not have a motorcycle helmet law.

Helmets are estimated to be 37% effective in preventing fatal injuries to motorcycle riders and 41% for motorcycle passengers; NHTSA estimates that helmets saved the lives of 1,829 motorcyclists in 2008.¹⁸

A previous Arkansas State law mandating universal helmet use was repealed in 1997 and by May 1998 observed helmet use had dropped from 97% compliance to just 52%. 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%. These same medical providers also recorded a significant increase in head injuries and in the average medical treatment costs per accident.

In addition to injuries sustained from motorcycles, injuries sustained by children as a result of using all-terrain vehicles (ATVs) continues to increase, especially in states with rural communities. In 2009 alone, seven children in Arkansas were killed in ATV-related crashes. Arkansas Children's Hospital (ACH) admits approximately 75 children to its trauma unit annually for severe injuries. These two statistics do not account for the children who are treated at their family physician or local hospital for less severe injuries.¹⁹

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 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.^{20,21}

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 Statement

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 Board reaffirmed this decision in adopting the following

¹⁸ Traffic Safety Facts: 2008 Data, NHTSA, DOT HS 811159

¹⁹ Children's Safety Network. ATV Safety in Arkansas: Disseminating the Message to Rural Communities. Arkansas Children's Hospital, April 2010 (available at www.childrensafetynetwork.org; accessed 10/18/10).

²⁰ American Academy of Pediatrics. All-Terrain Vehicle Injury Prevention: Two-, Three-, and Four-Wheeled Unlicensed Motor Vehicles. *Pediatrics* 2000;105(6).

²¹ American Pediatric Surgical Association Trauma Committee position statement on the use of all-terrain vehicles by children and youth. *Journal of Pediatric Surgery* 2000;44:1638-1639.

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 (adopted November 2010).*

11. 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 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.

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.* This position was reaffirmed in January 2009.

Health Care Insurance Coverage

12. Increase health insurance coverage for Arkansans.

Issue/Status

Among Arkansas's, 2.7 million people, almost 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% of the state's residents are uninsured, more than 90% 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% of whom do not have coverage. The statistics are even more daunting for those aged 19 to 44 years—30% are estimated to be uninsured and rates of uninsurance are even higher for certain geographic and demographic groups.

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.

The Patient Protection and Affordable Care Act (PPACA) of 2010 provides avenues for insurance coverage for uninsured Americans. In Arkansas, this will be particularly helpful to adults between the ages of 19 and 64 years. In a graduated cycle of enrollment between 2010 and 2014, currently uninsured adults will find a path for receipt of 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.

The ACHI Health Policy Board has made the following statements about specific ways to expand coverage in Arkansas. (January 2009)

Expand the ARKids program eligibility to cover additional children: For 2008, the total uninsured number of children under 19 was 65,000 or 9% of this population. The number of uninsured kids aged <19 years and living at < 200% of the federal poverty level (FPL), making them eligible for ARKids First, was 43,000. The total number of uninsured children under 100% FPL was 20,000 and the total number of children uninsured between 100 and 199% FPL was 23,000. On average, 20,000 kids are dropped off of ARKids each year because of “red tape” (can’t locate, didn’t return a form, etc.)—this was determined by looking at closure data between 2007 and 2009.

When states increase income eligibility for programs, the majority of enrollees are children who were already eligible; this was reflected in the estimated cost of expansion. Funds provided by the Arkansas tobacco tax increase would provide insurance to 25,000 more uninsured children—not just to the 9,000 uninsured in the new income bracket. To accomplish either of these legislative initiatives, upfront state funding is required to draw down federal match dollars.²²

Act 435 for ARKids First expansion required the Department of Human Services to seek a Medicaid waiver to increase the eligibility level for ARKids First to 250% FPL and seeks parity of coverage under ARKids. It also included requirements for mental health care coverage. This Medicaid expansion was included in Governor Mike Beebe’s 2009 Healthcare Initiative which was funded from the tobacco tax increase. To date, no monies have been released to achieve this expansion.

Health Policy Board Position Statement

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

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 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.

13. Pursuit of health care reform that expands access for all Arkansans to high quality, affordable, evidence-based care.

Issue/Status

Arkansas has high rates of uninsurance and chronic disease, and fewer opportunities to obtain meaningful access to needed high quality health care. The ACHI Health Policy Board has concluded that given the present status of the US 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.

²² <http://www.aradvocates.org/assets/PDFs/Health-insurance-2010-r2.pdf>

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)

System of Care

14. Improve delivery of health care to trauma victims.

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.

Health Policy Board Position Statement

The ACHI Health Policy Board supports development and implementation of a statewide coordinated trauma system. (January 2009)

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

Issue/Status

Aging Population

While some 47 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.²³

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.²⁴ 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. Specifically, from 2000 to 2020, the population of Arkansans 65 or older and 85 or older will increase by nearly 40%.²⁵

Economic Profile

The potential costs of this population shift are significant. In 2009, Arkansas Medicaid spending for long-term care totaled more than \$718 million, 19 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.²⁶

²³ 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

²⁴ Balhous C, Greenstein R. Social Security Shortfall Warrants Action Soon. PEW Economic Policy Group: Fiscal Analysis Initiative. November 2010

²⁵ 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

²⁶ Arkansas Medicaid Program Overview: State Fiscal Year 2009. Arkansas Department of Human Services: Division of Health Services. 2009.

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 homes²⁷ 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.²⁸ SFY09 expenditures for this program were \$15.6 million representing ~3,000 recipients with an average expenditure per recipient of \$5,200.²⁹

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 the patient at home in 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.³⁰

National groups have made recommendations about how to achieve this goal (see 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 Fund³¹

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.

²⁷ 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

²⁸ 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

²⁹ Arkansas Medicaid Program Overview. : State Fiscal Year 2009. Arkansas Department of Human Services: Division of Health Services. 2009.

³⁰ 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

³¹ 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

Evidence shows that these programmatic and reimbursement changes in the program would save the state money. (January 2011)

Enhance and Improve Access to Health Care Services

16. 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.

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.

Under the Governor's health care plan of 2009, substance abuse treatment was a category for funding using tobacco tax dollars, which were allocated first to general revenue.

As noted above, the federal PPACA will affect a change in access to mental health/substance abuse services.

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. (adopted November 2010)

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

Issue/Status

Examination of the Arkansas health care workforce availability, distribution, and measureable availability 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.

Building off of the health care workforce development efforts within the state and from other states with similar challenges, the options available for consideration to employ non-physician providers when and where needed to address availability and meet access needs across the state should be systematically explored. 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.

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)

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