

State Health Improvement Plan 2021-2025



**Arkansas Department of Health (ADH)
and ADH State Partners**

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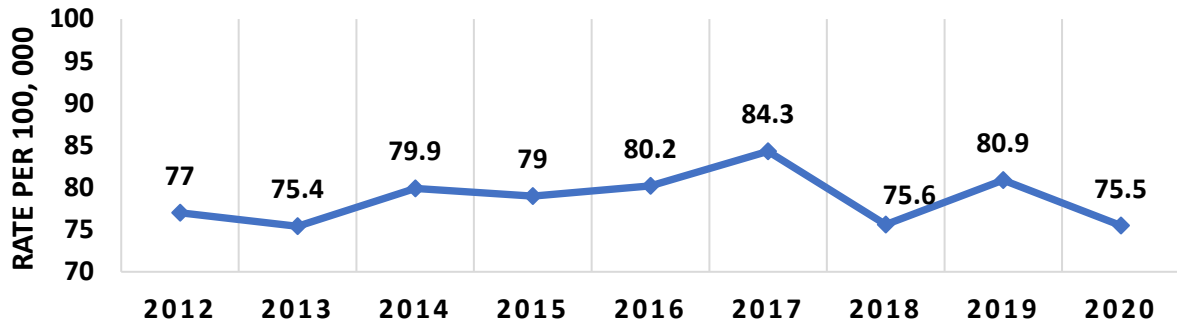
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PRIORITY AREA: ACCESS TO CARE
ARKANSAS STATE HEALTH IMPROVEMENT PLAN

About the Data

AGE-ADJUSTED ACUTE MYOCARDIAL INFARCTION (AMI) MORTALITY RATE, ARKANSAS



Data Source: CDCP, National Center for Health Statistics. National Vital Statistics System, Mortality 2012-2020

How are we doing on the data?

When asked how Arkansas adults are doing relative to the trendline data for the indicator, the stakeholders stated the following:

- There has been a very slight increase in the percentage of adults in Arkansas dying from AMI from 2014 to 2020.

Story Behind the Curve

Stakeholders identified the following negative factors promoting AMI death in Arkansas adults.

- Chronic Disease
- COVID-19 is not on this year's data
- Cultural factors for diet as well
- Data source (from death certificate)
- Diet
- Lack of education to identify the signs and symptoms (s/s)
- Lack of access to primary or acute care; not available or can't pay or is not a priority or working hours or organization they work for
- Fewer people want to go to the hospital
- Less time to engage
- Not calling 911: lack of trust in the system
- Obesity
- Particulate matter in the air
- Physical activity
- Rural/access to care: long time for the ambulance to get there, terrain, coverage, transportation, road conditions Shortages of Emergency Medical Services (EMS)/slow EMS response time
- Smoking
- Substance abuse

Stakeholders identified the following positive factors that are preventing AMI death in Arkansas adults.

- Awareness of the signs and symptoms of heart attack/education efforts
- Change in insurance aspects and its relation to income tax that has increased the coverage
- Clean Air Act
- Efforts to quit smoking; smoking be well program
- EMS education and distance from Per Cutaneous Intervention (PCI) hospitals
- Infrastructure similar to stroke
- Make access to care easy in clinical settings
- Mobile health units
- Prevention education and education to understand the s/s
- Screenings
- Smoking rates going down
- STEMI program at ADH; focused on the outcomes/clinical care
- Urban areas with multiple hospitals/ more hospitals in metropolitan areas per capita but the distribution may be a problem

Are there any factors creating disparities?

- Yes
- Rurality: doesn't have access to screenings
- Education
- Preventive services
- Minority population
- Culture of the cases
- Cultural competency of providers
- Lack of diverse workforce
- Broadband reception/technology
- Digital literacy
- Equipment and places to get BP checked

Partners

Stakeholders identified the following potential partners to strengthen the positive factors or address the negative factors influencing the rate of AMI mortality for Arkansas adults.

- American Heart Association (AHA)
- Hospital Association
- Arkansas Department of Education (ADE): to educate on the s/s as kids, gate keeper idea; Preventive education as kids
- Non-medical organizations: faith-based organizations, access points for telemedicine, ambulance associations, EMS associations, school nurses' association
- Insurance companies
- Employers: wellbeing programs that could be focused on prevention
- Voluntary fire departments: so that they know the signs
- Firefighters Association
- Community partners

- Nail salons, hair salons, barbershops
- Other providers such as dentists, behavior providers, psychologists,
- Local stores: Walgreens, Kroger
- Community leaders
- Pharmacies
- University of Arkansas for Medical Sciences – Institute for Digital Health and Innovation (UAMS-IDHI)
- Municipal league
- County government

What works/Solutions

Stakeholders proposed the following potential solutions to strengthen the positive factors or address the negative factors, impacting how adult Arkansas access AMI care.

- Community fairs
- Local level education
- Good relationship with the community and the leaders
- Get involved with the Municipal leagues
- County health officers' education and training
- Staffing issues: help with staff shortage
- A policy that every county has access to broadband for telehealth
- AMI prevention and intervention
- Federal level cap on the medicines
- Reimbursements on BP monitoring
- Policy to help hospitals survive: Many hospitals are on the verge of closure in rural Arkansas; Prospective Payment System (PPS) hospital are the ones that are struggling the most
- OFF THE WALL: Rely less on technology and electronics to schedule appointments. Just make care walk-in. Going to clinics, doctor office visits without having to wait on the phone calls from the doctor's office, welcome door: trying to meet people where they are. Make times flexible, adjustment of time, expand on the services you have to offer.
- Home-based care
- Telehealth resource centers
- Train community health workers
- Remote patient monitoring: Blood Pressure (BP), glucose
- Better shared data
- Criteria to meet the doctor: reduce them
- OFF THE WALL: stress, increase self-awareness, recognizing stress level and take rest. Not only for individuals but also employers. Being able to open up to the employers, collective stress source: finances, education, health literacy; communication across the board: help individuals connect to the doctors/psychologists if they are stressed
- Involve social workers and other professions

Strategies

The following strategies were prioritized on 9.13.22 because they ranked highest across four criteria: Impact, Feasibility, Specificity, and Value.

- Engage state policy makers to protect the solvency of Arkansas hospitals, particularly those in rural parts of the state and/or that are primarily funded by PPS
- Expand telehealth medicine with the specialization capacity for AMI mitigation, especially in under-resourced part of the state
- Promote education at a local level, especially with the support of trained Community Health Workers (CHWs), through outreach and messaging at community events (health fairs, etc.)

While the following strategies were not prioritized by the group at 9.13.22 work session, they are included here for future collaboration.

- Advocate for change at the federal level that would set a cap on the cost of medicines that reduce the risk of AMI
- Increase the possibility for patients to access care by encouraging hospital systems to adapt their scheduling systems so that walk-in appointments are possible
- Launch a statewide program that promotes walking and/or active living
- Provide reimbursements for BP monitoring

Work Plan for First Strategy: Engage state policy makers to protect the solvency of Arkansas hospitals, particularly those in rural parts of the state and/or that are primarily funded by Prospective Payment Systems (PPS).

Action Step	Lead	Due
Establish a rural emergency hospital designation	ADH	12/31/22
Review Medicaid inpatient/outpatient rates for sufficiency to provide equal access	DHS	12/31/22
Explore policies supporting requirements for rural hospital board education and administration	ACHI	12/31/22
Conduct analysis of hospital’s capacity to address AMI (STEMI capability)	ADH	12/31/22

Work Plan for Second Strategy: Expand telehealth medicine with the specialization capacity for AMI mitigation, especially in under-resourced part of the state.

Action Step	Lead	Due
Engage with non-participating hospitals to start using Pulsara to encourage usage.	ADH	12/2023
Raise awareness of/promote Pulsara/promote define protocols		
Determining funding/training needs		
Connect with the AR Hospital Association		
Engage legislative partners		
Address the potential roadblock of ensuring reliable broadband		

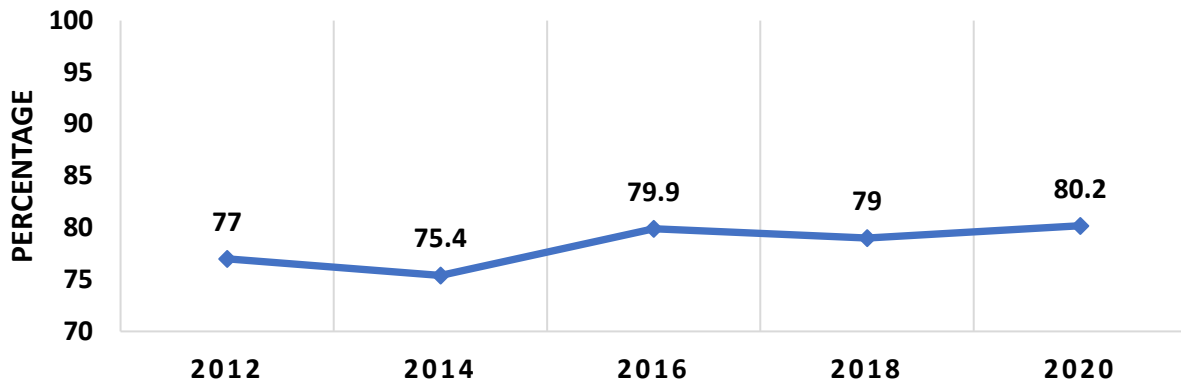
Work Plan for Third Strategy: Promote understanding at a local level through education and outreach at community events (health fairs, etc.), including through the engagement of Community Health Workers trained about the risks of AMI and how to access prevention and intervention supports.

Action Step	Lead	Due
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Develop materials/content that CHWs can utilize on prevention practices, i.e., Cardiopulmonary Resuscitation (CPR) training, etc.	ADH	
Access a comprehensive guide to identify where CHWs are deployed, who to talk to about engaging CHW resources, etc.		
Partner with existing CHW networks, resources or supports. Alternatively, engage the accreditation organization serving the state		
Identify which CHWs that would have the capacity to conduct this type of outreach and/or messaging		
Build capacity for CHWs around AMI prevention		
Identify how CHWs can be reimbursed through insurance providers for their services as a profession		
Percent of CHW certification		
Percent decrease of mortality related to CHW intervention		
Increase usage of CHW across health care systems by 30% in two years		

About the Data

ADULTS WHO VISITED DENTAL CLINIC FOR ORAL HEALTH CARE RELATED ISSUES



The data source is the Arkansas Behavioral Risk Factor Surveillance System (BRFSS), and this is a self-report. The outcome measure describes the percentage of adults in Arkansas who were treated for oral health care at a dental clinic within the past year.

There is data connected to claims that would not include those individuals accessing care at free clinics. ACHI has a report that shows those who have health insurance that file a claim for dental health care.

How are we doing on the data?

When asked how Arkansas adults are doing relative to the trendline data for the indicator, the stakeholders stated the following:

Things are staying the same, static

- 4 out of 10 adults did not visit the dental clinic in the past year
- Extrapolating from the 2020 census data, this is roughly 700,000 adults in the state

Story Behind the Curve

Stakeholders identified the following positive factors helping Arkansas adults to access a dental care visit in the past year.

- Expanded coverage happened in 2014 and might be pushing up the percentage
- Patients have an established relationship with a dental provider
- Individuals who live in more urban areas of the state likely have more access to providers
- Financial means to go to the dentist
 - Dental coverage or some other type of access
 - No or low-cost provider
 - Disposable income
- Because it is not limited to preventative care, pain might be driving these numbers

- AR Mission for Mercy (MOM) annual event provides services to Arkansans across the state
- Once you value oral health that stays with you through your life
- Transportation
- Flexibility of work schedules - employers offering some type of sick leave to employees
- General Practice Residency (GPR) advanced training program

Stakeholders identified the following negative factors preventing Arkansas adults from accessing a dental care visit in the past year.

- AR dental practices are only about 80% as busy to pre-pandemic
 - Lower numbers might be related to challenge of running at full capacity
- COVID-19 fog (okay to not to return to business as usual)
- Fear
 - Sound of the drill
 - Feel of injection
 - Negative experiences
- Shame/guilt of not going was a big factor
 - Patients don't want to be judged (worst thing a provider could do is to scold someone)
 - Not going to the dentist exacerbated by the pandemic
- Money
 - Cost associated with care
- Time
- Transportation in rural areas presents a deep challenge for people wanting to access care
 - Most people in rural parts of the state understand that they will have to drive to access services

Partners

Stakeholders identified the following potential partners to strengthen the positive factors or address the negative factors, impacting how adult Arkansas access dental care.

- ADH including Hometown Health- outreach and education
- Arkansas State Dental Association
- Arkansas Dental Hygiene Association
- Arkansas Department of Human Services
- Arkansas Hospital Association - discussion related to use of emergency rooms for non-emergency dental treatments
- Arkansas State Board of Dental Examiners
- Arkansas Transportation Association
- Arkansas Medical, Dental Pharmaceutical Association (AMDPA)
- Critical Access Hospitals/Rural Health care systems (linkage to care/medical dental integration)
- Dentists
- Employers and Hygienists Federally Qualified Health Centers (FQHCs)

- Insurance
- Literacy partners (adult illiteracy in the Delta region is high, which often prevents adults from understanding medical history forms or brochures)
- Lyon College
- Medical schools/providers - educate non-dental providers on oral/systemic link
- Office of Oral Health
- Providers
- Public transit organizations - can there be a partnership to help get people to appointments
- School-Based Health Centers (some see adults)
- School nurse association or school nurse organization can provide a direct link to students who help them learn about health care – and can perhaps kids can engage their parents into improving dental health for the family

What works/Solutions

Stakeholders proposed the following potential solutions to strengthen the positive factors or address the negative factors, impacting how adult Arkansas access dental care.

- Attract new dentists to rural areas that are underserved
- Co-locate medical/dental services
- Continue to build and expand the oral health coalition
- Data collection for services provided to individuals that are not tied to claims
- Development of dental school that will train professionals at the state level (One Health/Lyon College) and then rotate sites for new dental school - strategically placed in underserved areas
- Engage care coordinators that create an integration between medical and dental care providers (bi-directional referrals, appointment reminders, “warm handoffs”)
- Evaluate the cost of dental school/student loans compared to reimbursements for services - value based care instead of fee for service
- Focus on preventive education - educate more on the concept of oral health is preventive care and the value of dental care (including ties to systemic conditions)
- Engage Pharmacist groups for referrals to dental care Enhance adult Medicaid coverage
- Expanded scope of practice to allow licensed professionals to serve in underserved areas at the top of their licensure
- Expanded hours of service and/or allow for walk-in availability for individuals who do not have the flexibility to take time off work
- Incorporate programs into dental colleges on mental health, openness of talking with patients and easing fears
- Incentivize service in rural areas - perhaps including loan payment
- More AR MOM events
- More accessible platform for the public related to appointment scheduling among Medicaid providers

- Patient education on insurance benefits - to understand that "having insurance" doesn't mean that all their care needs are covered
- Build robust oral health mobile unit for rural areas
- Promote stronger levels of health literacy on dental insurance and navigating the health/dental care system
- Provide better insurance benefits (Medicaid and commercial) with higher annual limits
- Promote programs/techniques that ease a dental care visit-sedation, nitrous oxide, mental health visits to cope with fear
- Promote employer-based sick leave policies to support time away for dental care
- Provide education to dentists that help them develop better, long-term relationships with their clients.
- Provide oral health resources to Physical therapy and occupational therapy
- Provide transportation to dental visits/expecting funding from some grant to fund the community-based organization so they could secure vehicle, insurance, drivers, and vehicle maintenance
- Rural Health Public Health Campaign on Oral Health
- Social media campaigns
- Start to build a pipeline with students engaging at earlier age in the field of oral health
- Survey dentists to get average cost for check-up/cleaning to provide uninsured with an expected estimate
- Tele dentistry to screen before the actual appointment- assists in easing fear of patients.
- To achieve a higher dental IQ, Arkansas should concentrate on transportation and significant public education outreach.
- Well-funded public education programs
- Work with Historically Black Colleges & Universities (HBCUs) to identify potential Black, Indigenous and People of Color (BIPOC) students to foster a pipeline in oral health

Strategies

The stakeholders prioritized the four following strategies to increase the percentage of adult Arkansas accessing dental care. The strategies were prioritized over other strategies based on scoring across four criteria: Impact, Feasibility, Specificity, and Value.

- Engage HBCUs to identify potential BIPOC students to foster a pipeline in oral health
- Expand the hours of service and/or allow for walk-in availability for individuals who do not have the flexibility to take time off work
- Focus on preventive education - educate more on the concept of oral health is preventive care and also the value of dental care (including ties to systemic conditions)
- Start to build a pipeline with students engaging at earlier age in the field of oral health

Work Plan for First Strategy: Focus on preventive education - educate more on the concept of oral health is preventive care and also the value of dental care (including ties to systemic conditions)		
Action Step	Lead	Due
Educate side effects of medication/dry mouth.	DOH/OOH	06/2023
Basic communication about brushing and flossing	All	12/2023
Engage medical doctors, dentists, and clinics for side effect conversation	OOH	06/2023
Bisphosphonate class	Medical Group	06/2023
Utilizing school systems for education	ADE	12/2023
Address policy to implement oral risk assessment/screenings in schools	Legislators, ADE	12/2023
Message about prevention is cheaper than treatment down the road	All	12/2023
Connect with the pharmacist association	DOH/OOH	03/2023
Work Plan for Second Strategy: Shift or expand the hours of service and/or allow for walk-in availability for individuals who do not have the flexibility to take time off work.		
Action Step	Lead	Due
Identify providers willing to do it		
Get the marketing out		
Create enough incentives to make it attractive to both patients and doctors		
Identify which incentives that helped to promote visits during COVID-19 and then figure out how to utilize those		
Support the viability of "Floating" hygienists		
Promote the flexibility of a floating hygienists		
Identify retail partner to participate in floating hygienist opportunity		
Develop a pilot effort to learn what works and discern what scalability could look like		
Work Plan for Third Strategy: Work with HBCU to identify potential BIPOC students to foster a pipeline in oral health.		
Action Step	Lead	Due
Collaborate with Arkansas Minority Health Commission (AMHC) for HBCU contacts	OOH	12/2023
Mentor potential dental professional students	AMDPA	Ongoing
Develop and host Dental Camp event (similar to Pharmacy Camp @ UAMS/Harding e.g.)	AMDPA/OOH	12/2023
Develop/find/disseminate promotional materials specific to BIPOC students	AMDPA/OOH	6/2023
Participate in career days on HBCU campuses	OOH	Ongoing

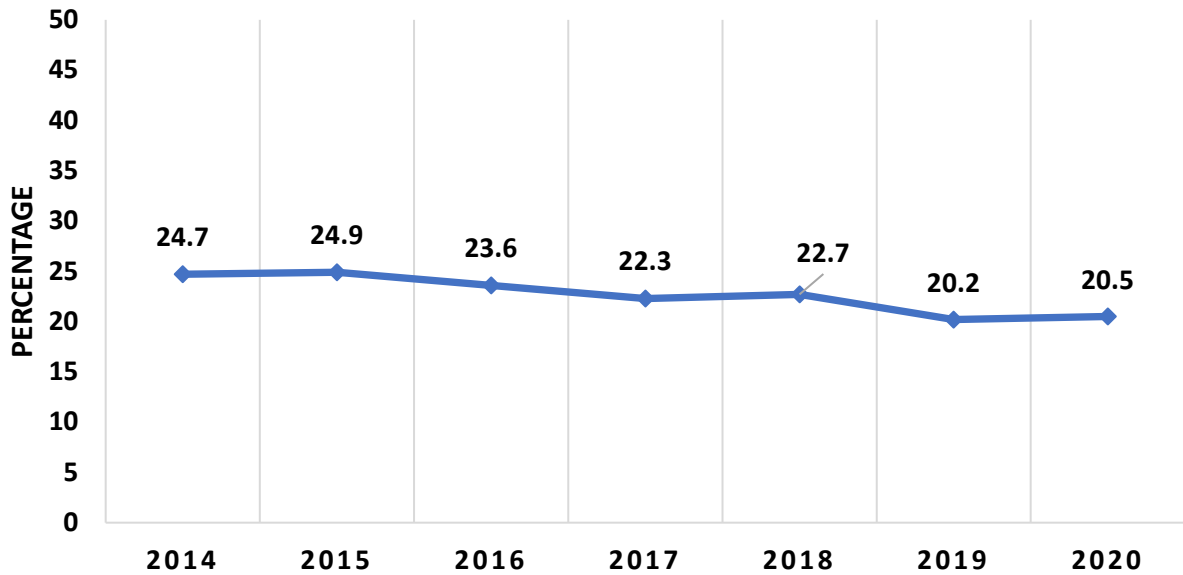


**PRIORITY AREA: ADDICTION, MENTAL
HEALTH, AND SUICIDE**

ARKANSAS STATE HEALTH IMPROVEMENT PLAN

About the Data

**ADULTS WHO ARE CURRENT SMOKERS,
ARKANSAS**



How are we doing on the data?

When asked how Arkansas adults are doing relative to the trendline data for the indicator, the stakeholders stated the following:

- Slight decrease over the years.

Story Behind the Curve

Stakeholders identified the following negative factors promoting Arkansas adults to smoke:

- Cigarettes cheaper than vaping
- Cultural factors
- Easy access to tobacco products
- Hard to join a quit group during the pandemic Increased vaping switching to cigarettes
- Mental health/drug users use more
- Peer pressure
- Relatively low taxes
- Stress of COVID-19 pandemic
- Tobacco companies

Stakeholders identified the following positive factors preventing Arkansas adults from smoking:

- Increase in vaping
- Low regulation
- Anti-smoking campaigns

- Be Well Quitline - docs refer to it
- Decreased social acceptance
- Non-smoking rules
- Marijuana use increase
- Businesses give incentives or even don't let you work there

Stakeholders also surfaced the following factors that contribute to health inequities:

- Certain age groups more acceptable
- Menthol cigarettes
- Places that allow only 21 and up can still smoke
- Tobacco companies targeting minority communities

Partners

Stakeholders identified the following potential partners to strengthen the positive factors or address the negative factors influencing the rate of Arkansas adults who are current smokers.

- Churches
- Doctor's offices
- Hospitals
- Lobbyist entities (outside of ADH)
- Medical and nursing schools
- Mental health/rehab facilities
- Other ADH programs
- Policy makers
- Prevention coalitions
- Schools

What works/Solutions

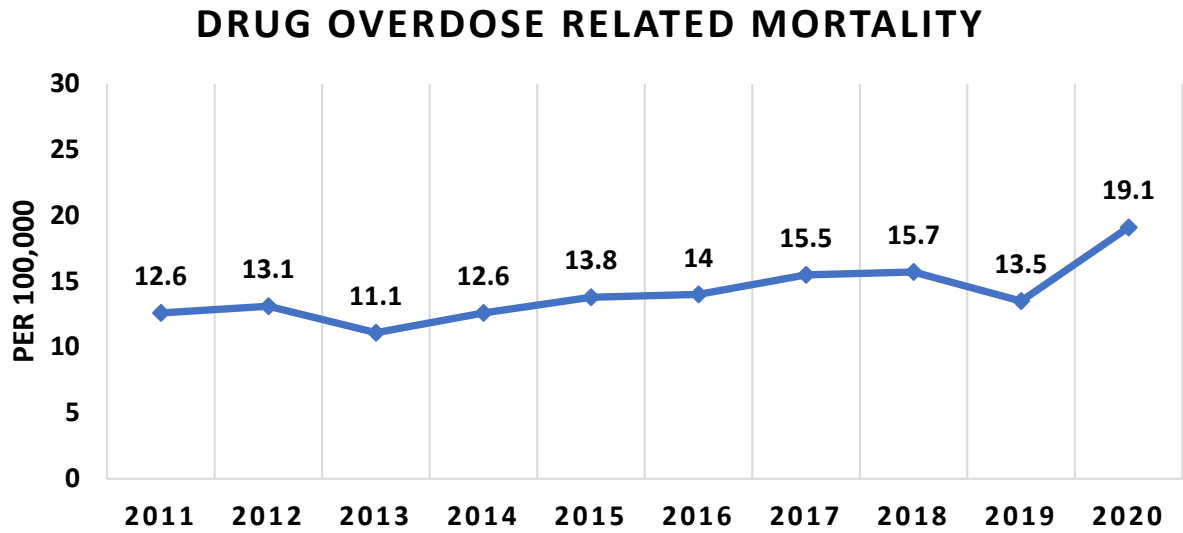
Stakeholders identified the following solutions to strengthen the positive factors or address the negative factors influencing the rate of Arkansas adults who are current smokers.

- Implement an awareness campaign for older adults.
 - Commercials with real people who quit.
- Educate about health problems such as coughing, etc.
 - From real people talking about how you might have to quit more than once.
- Eliminate smoking in movies
- Enact a tax-price increase
- Engage in early education
- Ensure that all retailers across the state are publicizing the Be Well Quitline number
- Engage dentist offices or veterinarian offices to publicize the Be Well Quitline number
- Make youth smoke grapevines first
- Outfit smoking products with an anti-smoking buzzer, personal smoke detector i.e., annoying noise

<ul style="list-style-type: none"> • Provide CT scans for lungs • Solicitation of Tik-Tok influencers • Talk to adults about influence on kids and grandkids- family connection 		
Strategies		
<p>Stakeholders prioritized the following strategies because they ranked highest across four criteria: Impact, Feasibility, Specificity, and Value.</p> <ul style="list-style-type: none"> • Conduct targeted outreach and education to children and youth about the dangers of tobacco use • Engage businesses (such as retailers and medical offices) and public sector organizations (such as veterans’ services) to publicize the Be Well Quitline number or other anti-smoking messaging • Initiate an ad campaign for older adults with multiple messaging strands (influence on family; quitting might take more than one time; health problems that result from smoking, etc.) 		
Work Plan for First Strategy: Conduct targeted outreach and education to children and youth about the dangers of tobacco use.		
Action Step	Lead	Due
Heighten the focus on Red Counties, targeting children from communities of color for smoking prevention		
Assess the data related to this issue with a focus on Red Counties		
Assess how many youths are educated		
Determine if additional partners would be useful in taking this to scale (see comment)		
Identify if there are other media/social media outlets that messaging should target		
Assess if there are messaging styles/formats that could be helpful in AR		
Work Plan for Second Strategy: Engage businesses (such as retailers and medical offices) and public sector organizations (such as veterans’ services) to publicize the Be Well Quitline number or other anti-smoking messaging.		
Action Step	Lead	Due
From a community perspective, leverage Hometown Health within ADH to assist with getting the information out		
Identify new partners at a community level who can be involved in Hometown Health		
Identify a representative from Veterans’ Services to be part of this effort		
Hire a state epidemiologist focused on Tobacco that can create data maps to help inform the strategy		
Engage the AR Cooperative Extension Programs (engaged in agriculture, very entrenched at a county level), could be a great ally (they do Lunch and Learns)		
Engage State Chamber of Commerce and local Chambers of Commerce		

Work Plan for Third Strategy: Initiate an ad campaign for older adults with multiple messaging strands (influence on family; quitting might take more than one time; health problems that results from smoking, etc.)		
Action Step	Lead	Due
Clarify the importance of quitting for adults 65+		
Develop messaging on the importance of quitting for adults 65+		
Partner with UAMS Centers on Aging		
Develop partnership with American Association of Retired Persons (AARP)		
Identify additional partners or places where seniors congregate (AARP, doctor's offices, senior centers, churches, bingo halls, etc.)		
Engage the AR Cooperative Extension Programs (engaged in agriculture, very entrenched at a county level), could be a great ally (they do Lunch and Learns)		

About the Data



The data source is CDC WONDER, an interactive dataset from CDC. This includes all the ICD-10 codes where the death was related to drugs: 1) accidental death (based on drug type), 2) murder by drug, and 3) intent was unknown.

In Arkansas, for accidental, it went from 11.1 (2019) to 16.1 (2020), an increase of almost 50%. We went from 388 total drug-overdose deaths in 2019 to 546 total drug overdose deaths in 2020. (There was almost no difference in the other two categories) The data is age-adjusted and so it is comparable across years. The national data also shows a similar type of increase from 2019 to 2020. Non-opioid-related drug overdose deaths were the main contributors on a national level (i.e. Fentanyl, etc.)

The number one drug that Arkansas will overdose on is Methamphetamines. With Fentanyl, we are seeing that is poly drug-related death. Methamphetamines were the leading cause up till 2019, but it has now been overtaken by Fentanyl.

How are we doing on the data?

When asked how Arkansas adults are doing relative to the trendline data for the indicator, the stakeholders stated the following:

- It's getting worse over time with a very sharp spike from 2019 to 2020.
- The data dipped in 2019. The data also dipped in 2014.

Story Behind the Curve

Stakeholders identified the following negative factors contributing to drug-related overdose deaths amongst adults in Arkansas.

- Perfect storm during COVID-19
 - Increased importation of Methamphetamine and Fentanyl (evidenced by a large increase in seizures at state borders)
 - Decrease in services

- Shift in focus and efforts to address COVID-19 also meant a shift away from focusing on drug-related issues in the state
- Increased isolation and stress might have contributed to increased use
- More people forced to be alone while using and not able to save each other in the event of an overdose
- Ever increasing potency of the drugs that are available mean that there is no such thing as "safe use"
 - Older strategies to mitigate overdose may not be effective
- Poly-drug addiction and/or use will require a different type of counteracting measures
 - When we look at deaths as an outcome, we don't have anything like Naloxone for Fentanyl or Methamphetamine
- Stigma related to drug ensures that the issue is not addressed in a positive, sympathetic transparent way that promotes treatment Undercounts are likely due to the illicit nature of abuse

Stakeholders identified the following positive factors restricting drug-related overdose deaths amongst adults in Arkansas.

- Under reporting
 - Shame connected to drug use
 - Rural communities are close-knit
- Naloxone promotion and utilization
- First responders are trained
- Expanding capacity in community Naloxone
- Outreaching/engaging with communities that typically shy away from first responders

Partners

Stakeholders identified the following potential partners to strengthen the positive factors or address the negative factors influencing the rate of drug-related overdose deaths amongst adults in Arkansas.

- Families, especially those that are struggling with addiction
- School districts
- Public libraries
- Businesses such as bars and nightclubs
- Faith-based Facilities
- City leaders
- Drug courts
- Food banks
- Homeless shelters

What works/Solutions

Stakeholders identified the following solutions to strengthen the positive factors or address the negative factors influencing the rate of drug-related overdose deaths amongst adults in Arkansas.

- Destigmatizing substance use as a moral failure
- Ensure everyone is released from treatment with Naloxone

- Family engagement, education, and training
- Free or low-cost Naloxone to chronic opioid users
- Mental health support
- Peer recovery counselors in every emergency room in the state
- Place Naloxone in community locations like where defibrillators are located
- Rapid detection of potential clusters using surveillance practices
- Stop and/or disrupt the supply chain to prevent the ready access to these drugs
- Wound care/Safe Syringe programs/recovery

Strategies

Stakeholders prioritized the following strategies because they ranked highest across four criteria: Impact, Feasibility, Specificity, and Value.

- Conduct outreach, education, training, and engagement for families of substance users that help them to understand how to support their loved ones and also maintain family safety
- Design and deliver (traditional and social media that destigmatizes substance use as a moral failure in order to alleviate the shame associated with seeking treatment
- Ensure everyone who participates in and is released from treatment has a supply of Narcan (targets treatment and what happens when people discharge from treatment/incarceration)

Work Plan for First Strategy: Broaden the distribution of Narcan (Naloxone) to at risk individuals:

- Ensure everyone who participates in and is released from treatment has a supply of Narcan (targets treatment and what happens when people discharge from treatment/incarceration)
- Co-locate Narcan with facility first aid boxes (defibrillator boxes)
- Adjust the law so Naloxone can be made available after hospital discharge (ED and in patient)

Action Step	Lead	Due
Adjust the law so Narcan can be made available as broadly as possible. <ul style="list-style-type: none"> • Hospital discharge (in patient) • In buildings • In public areas (schools) • Crisis stabilization units 		
Ensure everyone who participates in and is released from treatment has a supply of Narcan (targets treatment and what happens when people discharge from treatment/incarceration) And individuals who are served by crisis stabilization units.		
Secure Funding to support efforts for Naloxone purchases to support the larger effort. (Develop sustainability for long-term funding)		

Priority Area: Addiction, Mental Health, and Suicide

Partner with Department of Human Services (DHS) to ensure availability of Narcan to state funded facilities		
Identify and partner with private treatment facilities		
Outreach to schools (Higher Ed and K-12) to include Narcan in nurse's offices and college buildings		
Implement vending machine-style distribution in area where risk is high		
Find out regulations on emergency resources (defibrillator and fire extinguisher) in buildings to advocate for/or require including Narcan as a required element		
Work Plan for Second Strategy: Conduct outreach, education, training, and engagement for families of substance users that helps them to understand how to support their loved ones and also maintain family safety.		
Action Step	Lead	Due
Work Plan for Third Strategy: Design and deliver traditional and social media that destigmatizes substance use as a moral failure in order to alleviate the shame associated with seeking treatment.		
Action Step	Lead	Due
Get all parties to the table for a coordinated messaging campaign (ADH, DHS, AR Opioid Recovery Partnership, Arkansas Center for Health Improvement (ACHI), Criminal Justice Institute (CJI), AR Drug Director's Office, University of Arkansas at Little Rock (UALR) MidSouth, Substance Use Disorder (SUD) Peers, Recovery Program, Department Offices of Communications)	Kirk Lane (AORP)	3/31/2023
Identify point person for each partner organization	Kirk Lane (AORP), Haley Ortiz ADH	3/31/2023
Identify plans for funding stream(s)	Jacob Smith, Kirk Lane, DHS	8/1/2023
Research what media is already being used	ADH Overdose Data to Action Program Manager (OD2A)	2/1/2023
Decide on a final messaging/media campaign	Jacob Smith (ADH)	5/31/2023

Priority Area: Addiction, Mental Health, and Suicide

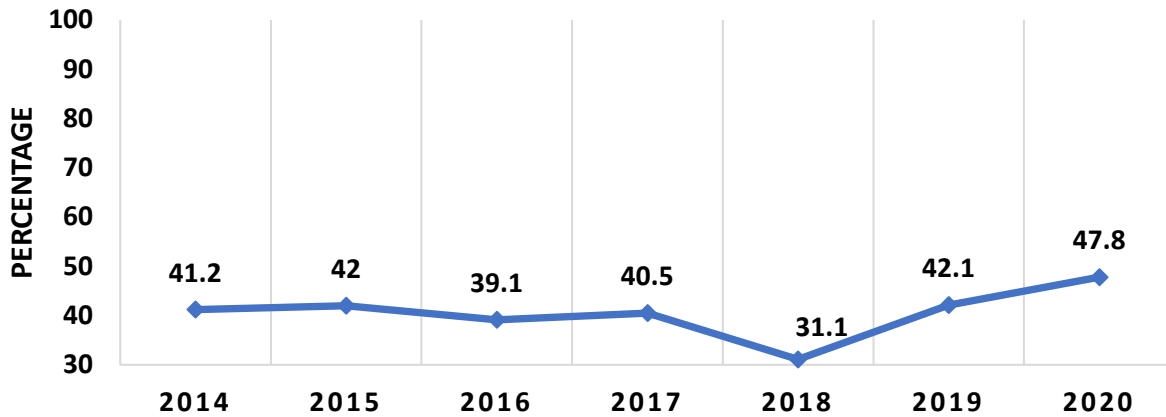
Develop plan for each partner and begin placement in free media platforms, such as Facebook, Instagram, Twitter	ADH Overdose Data to Action Program Manager (OD2A)	6/30/2023
Track Reach of Messaging/Media Campaign	Wanda Simon	12/31/2023



**PRIORITY AREA: INFECTIOUS DISEASE
TRANSMISSION AND VACCINATIONS**
ARKANSAS STATE HEALTH IMPROVEMENT PLAN

About the Data

ADULTS 18+ RECEIVING ANNUAL INFLUENZA VACCINATION, ARKANSAS



How are we doing on the data?

When asked how Arkansas adults are doing relative to the trendline data for the indicator, the stakeholders stated the following:

- 2020 went up and need more data for the uptick in the current rise

Story Behind the Curve

Stakeholders identified the following positive factors promoting Arkansas adults to get their annual influenza vaccination.

- Health Care workers mandates with large employers in rural areas
- Long-term Care requires flu shots
- Waivers required
- Education
- COVID-19 pandemic
- Convenience/most pharmacists/community events/school clinics
- Jails/prisons (incarceration sites) may help with the rise in data

Stakeholders identified the following negative factors preventing Arkansas adults from getting their annual influenza vaccination.

- Misinformation and bottom-up strategy with small cities, rural and local governments
- Developing partnership
- Racial and ethnic disparities with gate keepers
- COVID-19 contamination
- Wording of "immunization" instead of "vaccine"
- Imagery
- Efficacy
- Medicaid reimbursement issues
- Vaccine administration fees

Are there any factors creating disparities?

- Lack of confidence, vaccine deserts, access in rural areas, anti-science information and hesitancy

Partners

Stakeholders identified the following potential partners to strengthen the positive factors or address the negative factors influencing the rate of Arkansas adults who get their annual influenza vaccination.

- Chambers of Commerce (state/local)
- Doctors/pharmacist/veterinarian care provider is key
 - Engage the front-line worker
- Local business organizations
- Nuclear Factor 1B for policy adoption
 - allowing mandates
 - engage local events
 - educational process- teach science and education
- NICU - could help to provide free vaccines
- Non-traditional entities such as AR Farm Bureau/American Association of Retired Persons
 - Vaccination with infection control training; communication mass media
- Religious leaders

What works/Solutions

Stakeholders identified the following solutions to strengthen the positive factors or address the negative factors influencing the rate of Arkansas adults who get their annual influenza vaccination.

- Create health insurance incentives for state employees and teachers, and county/city staff
- For residents who are homebound, utilize a mobile unit that can take vaccinations to them
- Incentivize vaccinations, particularly for population groups with higher non-vaccination rates
- Increase awareness and understanding about the importance of vaccinations with targeted messaging, including social media influencers
- Leverage the resources of the statewide partners collaborating with the AR SHIP to promote vaccinations amongst their clients and through their respective networks

Strategies

Stakeholders prioritized the following strategies because they ranked highest across four criteria: Impact, Feasibility, Specificity, and Value.

- For residents who are homebound, utilize a mobile unit that can take vaccinations to them
- Incentivize vaccinations, particularly for population groups with higher non-vaccination rates
- Leverage the resources of statewide partners collaborating with the AR SHIP to promote vaccinations amongst their clients and through their respective networks

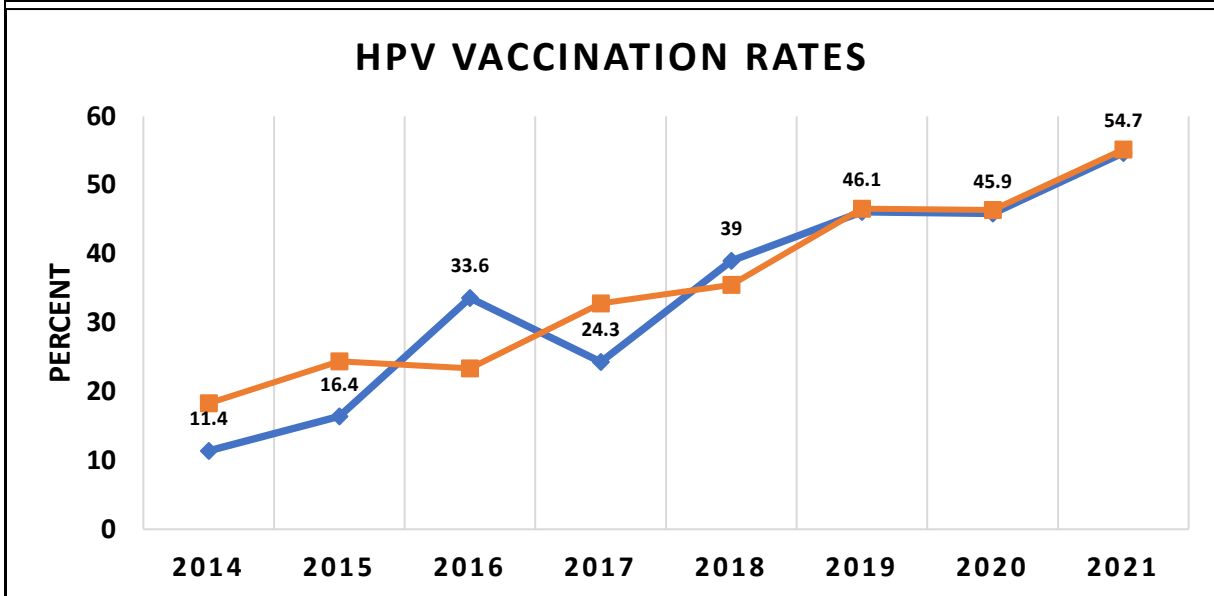
Priority Area: Infectious Disease Transmission and Vaccinations

Work Plan for First Strategy: For residents who are homebound, utilize a mobile unit that can take vaccinations to them.		
Action Step	Lead	Due
Apply the lessons learned from the mobilization effort for the COVID-19 vaccine to the flu vaccine		
Explore organization who may be providing mobile immunization services		
Explore collaborations among nurses (homebound coordinators), pharmacies, and other entities to reach residents and deliver vaccine services (need to consider compensations, funding, etc.)		
Connect with programs such as Meals on Wheels, faith-based programs, In-Home Service programs and other who have mobile services not necessarily vaccine-related		
Utilize nurse volunteers and other health care professional (licensed) within the faith-based community		
Connect with community groups/non-profit organizations doing outreach - e.g., ADH Office of Health Disparities Elimination (OHDE), Hometown Health Improvement (HHI), Arkansas Minority Health Commission (AMHC), American Heart Association (AHA), NW Arkansas Council (Ryan Cork) to join effort of AR SHIP partners to reach homebound population.		
Work Plan for Second Strategy: Conduct outreach, education, training, and engagement for families of substance users that helps them to understand how to support their loved ones and also maintain family safety.		
Action Step	Lead	Due
Determine what is meant by “incentivize” - access, availability, or an actual incentivize that has a financial component		
Think through the feasibility for each incentive (fishing license, lottery tickets, etc.)		
Conduct an analysis for costs associated with each type of potential incentive		
Determine if there are partners or champions would be able to absorb the costs and/or dissemination		
Defining the target population[s] (Delta, red counties, specific, regional)		
Conduct deeper analysis to understand health equity, especially for people in rural parts of the state		
Work Plan for Third Strategy: Leverage the resources of statewide partners collaborating with the AR SHIP to promote vaccinations amongst their clients and through their respective networks.		
Action Step	Lead	Due

Priority Area: Infectious Disease Transmission and Vaccinations

Develop a list of partner organizations, or people, and who would need to be engaged to communicate to clients that participate in their services		
Develop (or utilize pre-existing) messaging on the value added of flu vaccines		
Disseminate vaccination messaging/information to partner organizations so they can distribute that to their clients and/or contact lists		
Revive Influenza Workgroup and recruit new members?		11/2022
Develop recommendations that the state would send to local health units, where they can create local partnerships (i.e., local utilities, etc.)		

About the Data



The data source for the HPV Vaccination Rate is the Centers for Disease Control and Prevention. Human papillomavirus (HPV) vaccines are vaccines that prevent infection by certain types of human papillomavirus (HPV). It is estimated that HPV vaccines may prevent 70% of cervical cancer, 80% of anal cancer, 60% of vaginal cancer, 40% of vulvar cancer, and show more than 90% efficacy in preventing HPV-positive oropharyngeal cancers.

Data is from the National Immunization Survey (Teen Vax View) - these are reflective of the child being up to date at that point in time they were surveyed.

How are we doing on the data?

When asked how Arkansas adults are doing relative to the trendline data for the indicator, the stakeholders stated the following:

- Things are getting better
- Lower rate in males; however, the gap between females and males is narrowing (getting better but still a gap)

Story Behind the Curve

Stakeholders identified the following positive factors helping females and males 13-17 years to get the HPV vaccination:

- Arkansas Chapter, American Academy of Pediatrics did an outreach project on this pre-COVID!
- Cost is covered by public and private payors
- More common/information is out there
- Not a new vaccine anymore so people are more comfortable with it in general
- School nurses (SN) in schools/districts PreK-12 grades advocate for HPV vaccine with parents. SN are a proven trusted source for parents.
- Vaccines for Children program shares data with practices
- We have been pushing the message of HPV vaccine is cancer prevention

- Word of mouth among parents is creating familiarity with the vaccine among the public

Stakeholders identified the following negative factors preventing females and males 13-17 years from getting the HPV vaccination:

- Lack of provider training on importance of HPV in cancer prevention; motivational interviewing/effective messaging
- Low rates of wellness child checkups for school aged children.
- Religious views surrounding HPV vaccine and sexual activity especially for those under 18
- Multi-dose series requires multiple touchpoints which are not always easy to schedule/remember for adolescents
- Myths and misinformation about the HPV vaccine
- Myths around sexual activity (if you pay to get the HPV done that it leads to sexual activity at an earlier age due to increased desire)
 - belief that it will cause promiscuity/that their child will not have risk factors outside of marriage
 - misunderstanding among parents/kids of what actually "counts" as sexual encounters.
- Not a school required vaccine, so providers don't always recommend it
- Overall vaccine fatigue is leading to a decrease in vaccine rates in other areas (flu, vaccine, etc.)
- Perceived safety concerns
- When a physician does not recommend a vaccine, it will not be on parents or caretaker's radars

Partners

Stakeholders identified the following potential partners to strengthen the positive factors or address the negative factors influencing the HPV vaccination rates amongst females and males ages 13-17 in Arkansas.

- Committee on Immunization Practices (CIP), Association of Professionals in Infection Control (APIC) and Infectious Disease groups
- American Cancer Society
- Arkansas Chapter, American Academy of Pediatrics
- Arkansas pediatricians, family physicians
- AR School Nurses Association, School-based health Centers
- Community Health Nurses (CHNs)
- Childcare advocates
- College athletes/arts drama students promote immunization
- Dept of Education
- Department of Health- sponsor HPV health month and campaigns
- Doctors
- Faith-based community leaders
- Particularly evangelical leaders
- Influencers - broadcast the condition and vaccine efficacy
- Maternal and Child Health (MCH) advocates - Sponsor HPV health months

- Medicaid - for improved immunization rates
- Parents
- ADH - vaccines for children program for outreach/data sharing
- School district parent-teacher organizations
- Payors - put quality metrics around HPV vaccines
- Clinics - help incentivize electronic medical records to automate outreach
- Dental community/Arkansas State Dental Association/Hygienists Association
- University health centers (not for age 13-17, but older kids who missed it previously)

What works/Solutions

Stakeholders identified the following solutions to strengthen the positive factors or address the negative factors influencing the HPV vaccination rates amongst females and males ages 13-17 in Arkansas.

- Ask AR School Nurse Association what strategies work best to reach students and families
- Contact faith-based leaders by mail/in person; offer training
- Create an app for developmental milestones (call it something else) for adolescents. Include all needed immunizations that are recommended.
- Education to Dental providers about counseling patients that HPV vaccine is cancer prevention for oropharyngeal cancers
- Engage AR American Academy of Pediatrics (AAP) to train pediatricians on motivational interviewing or HPV Roundtable strategies for improving rates
- Enlisting dental providers in effort to counsel patients on getting HPV vaccine
- Get more dentists/hygienists to discuss HPV vaccine with patients/parents
- Grants for outreach (AR Pediatricians - but can't travel/use time without funding, plus data helps us do that effectively)
- Grants to practices upgrading Electronic Medical Records (EMRs) for automated text outreach to patients for HPV reminders (and other vaccines)
- Have college health system broadcast HPV and vaccination on campus platforms and health events throughout the school year
- Identify influencers in low-rate counties who can do grassroots outreach, such as moms' groups on Instagram
- Increase outreach through various organizations and partners
- Joint educational venture with school health, Parent Teacher Association (PTA), and public health to focus on the issue and make educational resources user friendly and readily available
- Make a part of sexual health education at family planning and local health unit clinics for all patrons; require for school attendance.
- Start vaccinating kids at age 9 so that they complete the series by age 14
- Utilize social media platforms to make available and more prominent

Strategies

The following strategies were prioritized by the stakeholders because they ranked highest across four criteria: Impact, Feasibility, Specificity, and Value.

Priority Area: Infectious Disease Transmission and Vaccinations

- Deliver education to Dental providers to better counsel patients that HPV vaccine is cancer prevention for oropharyngeal cancers
- Engage providers (school nurses, etc.) and provider support organizations (AR AAP to train pediatricians on motivational interviewing or HPV Roundtable strategies for improving rates
- Increase the capacity for automated text outreach (including grants to upgrade EMR, etc.) to patients for HPV reminders (and other vaccines)
- Start vaccinating kids at age 9 so that they complete the series by age 14

Work Plan for First Strategy: Deliver education to Dental providers to better counsel patients that HPV vaccine is cancer prevention for oropharyngeal cancers.

Action Step	Lead	Due
Engage the Arkansas State Dental Association/Hygiene Association on patient-related HPV educational opportunities for providers	ADH OOH/ADH Family Health	Summer 2023
Develop a framework or method for opening HPV vaccine conversation with patients during preventive visits (frame it as head/neck cancer prevention)	ADH OOH/ADH Family Health	Summer 2023
Develop HPV vaccine information insert/card for patients (take home bag) [framed as head/neck cancer prevention]	ADH OOH/Immunize AR	Spring 2023
Promote/Distribute Educational information in waiting/exam rooms	ADH OOH/Immunize AR	Summer 2023
Engage Dental Assistantship programs on the addition of curriculum vaccine information/oral cancer/education strategies	ADH OOH/ADH Family Health	FALL 2023

Work Plan for Second Strategy: Engage providers (school nurses, etc.) and provider support organizations (AR American Academy of Pediatrics) to train pediatricians on motivational interviewing or HPV Roundtable strategies for improving rates.

Action Step	Lead	Due

Work Plan for Third Strategy: Leverage the resources of statewide partners collaborating with the AR SHIP to promote vaccinations amongst their clients and through their respective networks.

Action Step	Lead	Due
Explore funding opportunities (federal, state, philanthropic) to incentivize technology upgrades for vaccine outreach to patients	ADH, ARAAP	August 2023
Explore payer quality measures, Healthcare Effectiveness Data and Information Set (HEDIS) or other incentives to encourage completion of HPV series	ARAAP, payers	

Priority Area: Infectious Disease Transmission and Vaccinations

ADH - talk with Local Public Health/Greenway lead about what capabilities EMR has for text reminders, how we currently do appt reminders, etc.	ADH- Joel	End of 2022
Contact AR Academy of Family Physicians (AFP) to discuss this issue and their perceptions of how their members' clinics are dealing with and succeeding at this issue of text reminders for vaccinations	ADH, Dr. Joel/Bala	End 2022
Engage AR Children's regarding collaboration with their Community Health Needs Assessment immunization strategies	ARAAP	End of 2022
Contact AR Pharmacist Association to discuss this issue and their perceptions of how their members' clinics are dealing with, succeeding at this issue of text reminders for vaccination	ImmunizeAR, APA	
Work Plan for Fourth Strategy: Start vaccinating kids at age 9 so that they complete the series by age 14.		
Action Step	Lead	Due
Messaging for providers (including school nurses, Vaccine for Children (VFC) providers, pharmacies etc.) including the cancer prevention message		12/2022
Secure support of AR AAP, AR AFP, ImmunizeAR, ADH, American Pharmacists Association (APA), American Cancer Society		
Social media messaging		
Automated text messages letting parents know their child can get the vaccine at age 9		
Creative TikTok message		
Publications of professional associations - articles, ads etc. (AAFP, AAP, APA etc.)		
(Barrier) Lack of providers/lack of access to the vaccine		
(Barrier) Vaccine hesitancy/misinformation		

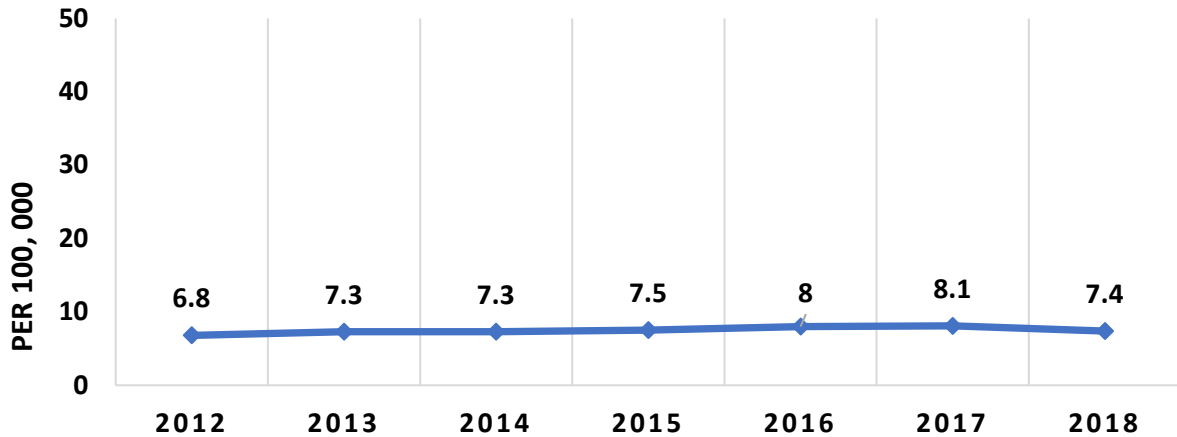


**PRIORITY AREA: MATERNAL & INFANT
HEALTH**

ARKANSAS STATE HEALTH IMPROVEMENT PLAN

About the Data

CHILDREN WHO DIED BEFORE THEIR FIRST BIRTHDAY, ARKANSAS



How are we doing on the data?

When asked how Arkansas adults are doing relative to the trendline data for the indicator, the stakeholders stated the following:

- From 2013 through 2015 the rate remained relatively unchanged
- The rate increased in 2016 and peaked in 2017 at 8.1 deaths per 1,000 births
- The rate decreased from 8.1 in 2017 to 7.4 in 2018
- Regardless of the reduced infant mortality rate in 2018, Arkansas still ranks highest out of all 50 states

Story Behind the Curve

Stakeholders identified the following negative factors that may be contributing to infant mortality in Arkansas.

- Access to care, overall and prenatal care
 - Health care coverage through employers or affordable care options
- Access to contraception
- Age - births to women less than 20 years old or greater than 40 years old (35 years or older at the time of pregnancy strong correlation for mother and baby)
- Availability to "good" insurance not helping
- Access to Obstetrics/Gynecology (OB/GYN) - many providers not providing OB/GYN care in smaller communities/maternal care deserts, distance to provider and outcomes. Further they must drive for appt, the worse they are
- Perinatal deaths - surviving babies during neonatal care going home and lack of support at home
- Black babies have higher infant mortality when compared to whites or Latinos. In 2017, the infant mortality rate for blacks was 12.6, compared to 6.9 for whites, and 6.2 for Latinos.

- Black babies die at greater rates than whites, in part because they have low birth weights twice as often.
- Child abuse and neglect
- Co-morbid conditions occurring in disadvantaged populations - preeclampsia, gestational diabetes, etc.
- Educational attainment - Data suggests that women with less than a 12th grade education face higher risks for infant mortality
- Genetic anomalies - leading cause of infant death
- Health literacy, including understanding the importance of prenatal care
- High stress environment - perhaps stress weathering, increases stress and negative outcomes
- Housing insecurity
- Pregnant women experiencing at least one health problem while pregnant
- Mental health
- Physical health of the mother during pregnancy, including health risks associated with obesity
- Sexual violence leading to pregnancy
- Substance abuse addiction, including smoking cigarettes
- Teenage birth rate
- Unintended pregnancy

Stakeholders identified the following positive factors that may be preventing or reducing infant mortality in Arkansas

- ACH - worked hard with National Institute for Children Health Quality (NICHQ) alliance and nurse alliance, working with hospitals Decrease of elective deliveries
- Good preventative care early/prenatal care.
- Home visiting program efforts increasing awareness of the importance of prenatal care
- Increased access to Long-Acting Reversible Contraception (LARC)
- Increased access to Mirena and Nexplanon. Dr. Manning secured funding for placing device immediately. Supreme Court issue - overall population has increased information with this issue/misinformation (example: Plan B is NOT illegal). Governor and other efforts to improve education. More people now trying to figure out where access is located.
- Mitigating risks posed from unintended pregnancy - elective deliveries and C-sections

Partners

Stakeholders identified the following potential partners to strengthen the positive factors or address the negative factors impacting the infant mortality rate in Arkansas.

- Arkansas Children's Hospital - operates the largest NICU in the state and also conducts Infant Death Review, working with local hospitals and communities
- CHW - engage directly with women
- Doula - true grassroots in communities. example: church - gathering around the family. What is a doula - Where is a doula - Who is the right doula conversation?
- Medicaid

- Pharmacies - connection with provider, encouraging pharmacists to have discussion with providers - can I send this to you?
- Schools
- UAMS

What works/Solutions

Stakeholders proposed the following potential solutions to strengthen the positive factors or address the negative factors impacting the infant mortality rate in Arkansas.

- Address the lack of physical health knowledge in school
- Engage doulas especially on minority populations and on mental health
- Expand Home Visiting programming as a cost-effective way to address adverse childhood experiences (ACES) and other things going on in the home.
- Implement age-appropriate educational tools to increase understanding about physical health for young women
- Nursery Alliance - work with hospitals to provide standard quality of care. Transition occurs sooner rather than later.
- Offer lottery tickets as incentive to attend appointments
- Preconception Health
- Social determinant code that providers aren't using to bill for Medicaid (Z code 009 series?). Needs to be coded so as to know what to do next.
- Southeast hospitals collaborate and designate one to provide obstetric and gynecological services with support from UAMS (example Stuttgart, DeWitt). Residents assigned a site on a rotating basis, proximity to complicated deliveries. Center provides the telehealth. ANGEL had something like this, but not resident program. However, residents need to be trained full services.
- Two pregnant women plans through Medicaid. Life360 program. Low income and high risk.
- UAMS Neonatal Intensive Care Unit (NICU) - does follow-up care with nurses across the state.

Strategies

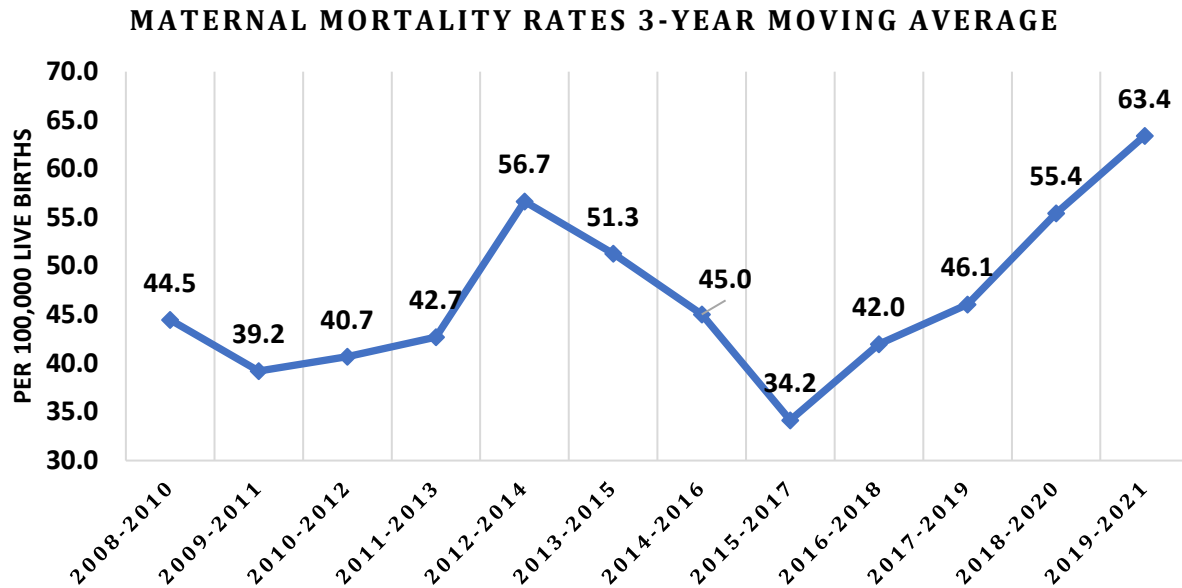
Stakeholders prioritized the following strategies because they ranked highest across four criteria: Impact, Feasibility, Specificity, and Value.

- Expand telehealth medicine specializing in maternal and infant care, especially in under-resourced parts of the state, that would engage trusted partners such as the AR Children’s Hospital Nursery Alliance or the University of Arkansas for Medical Sciences
- Promote the use of doulas amongst women of color as a cost-effective and culturally responsible form of maternal care
- Utilize and/or scale the use of Home Visiting Program models to increase awareness and understanding about the importance of maternal and infant health and how to access services, particularly in underserved communities

Work Plan for First Strategy: Expand telehealth medicine specializing in maternal and infant care, especially in under-resourced parts of the state, that would engage trusted partners such as the AR Children’s Hospital Nursery Alliance or the University of Arkansas for Medical Science..

Action Step	Lead	Due
Identify drivers of Social Media Marketing and associated risk factors that can be addressed via telehealth		
Identify sites of care		
Find qualified tele-presenters		
Engage state perinatal collaborative around mortality and morbidity on data, partnership, and/or leveraging resources		
Convene meeting between Drs. Manning/McElfish and ACH Nursery Alliance	SO	
Locate legislative money to expand bandwidth for adequate connectivity (partnering with leg affairs folks from UAMS, BCBS, ADH, etc.)	SO	
Target red counties with health equity focus		
Work Plan for Second Strategy: Promote the use of doulas amongst women of color as a cost-effective and culturally responsible form of maternal care.		
Action Step	Lead	Due
Establish a shared definition for what a doula is and the work which they do		
Identify physician champions		
Initiate a pilot project in Northeastern AR		
Increase partnerships		
Increase education of HC providers		
Increase education of consumers and communities		
Increase supply of doula services and distribution		
Determine payment source		
Increase policy and advocacy		
Work Plan for Third Strategy: Utilize and/or scale the use of Home Visiting Program models to increase awareness and understanding about the importance of maternal and infant health and how to access services, particularly in underserved communities.		
Action Step	Lead	Due
Develop partnership/resources: ADH, DHS, Arkansas Home Visiting Network (AHVN), birthing hospitals, Congressional Budget Office (CBOs), Blue Cross Blue Shield (BCBS)	Sheena	6/23
Create an implementation plan for ARHOMES and potential expansion of Maternal, Infant and Early Childhood Home Visiting program that strengthens the existing relationships and aligns their contributions	Tamara	12/23
Create awareness outreach campaign: AHA, Arkansas Foundation for Medical Care (AFMC)	Amie	6/23

About the Data



CDC National Center for Health Statistics (NCHS) and World Health Organization (WHO) maternal mortality definition: deaths of women while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes. Rates are calculated as the number of maternal deaths per 100,000 live births.

Ascertainment of maternal deaths was modified by a pregnancy checkbox in the 2003 revision of the U.S. Standard Certificate of Death. These estimates based on state of residence were furnished by the Centers for Disease Control and Prevention National Center for Health Statistics (CDC NCHS) and follow the 2018 coding method in which the pregnancy checkbox is not used for women 45 and over due to significant error rates in this age group. Five-year estimates are provided to improve precision and reportability. Changes are mitigated with five-year data where each estimate shares 80% (4/5) of the data with the next estimate. Standard statistical tests that assume independence should not be used when comparing overlapping 5-year estimates. For more information about the new maternal mortality release and changes in coding, please see

<https://www.cdc.gov/nchs/maternal-mortality/index.htm>

This measure is related to Healthy People 2030 objective MICH-04: Reduce maternal deaths.

Data Source: Centers for Disease Control and Prevention National Vital Statistics System, released by Maternal and Child Health Bureau. Federally Available Data (FAD). April 13, 2021; Rockville, MD: Health Resources and Services Administration

How are we doing on the data?

When asked how Arkansas adults are doing relative to the trendline data for the indicator, the stakeholders stated the following:

- Things are getting worse

- Did experience a dip (improvement) in 2015-2019
- Limited because of the small sample size and the small statistical difference

Story Behind the Curve

Stakeholders identified the following negative factors contributing to the maternal mortality rate in Arkansas.

- Access to care and resources
- Advanced maternal age pregnancy
- Chronic disease, untreated, undertreated, or not identified
- Decrease in education for the community, patients, providers?
- Increased health risks
 - Not able to carry the pregnancy as well
- In 2020 specifically, this could be related to COVID-19 related issues with access to and use of prenatal care and maternal health care
- Lot of moms today have heart problems, pre-existing conditions, and renal disease
- Seen all kinds of issues with COVID-19
- Substance misuse
- Very rare for medical programs to offer obstetrical care and training, this is related to potential malpractice (premiums exceed the amount a doctor will make for services)
- With AR having such a high rate of unintended pregnancy, young women do not know where to go or what to do - this is exacerbated in more underserved communities (50 percent!)

Stakeholders identified the following positive factors restricting the Maternal Mortality Rate (MMR) in Arkansas.

- Bills like HB1215-granting full practice authority to certified nurse midwives
- Continued focus from the media and the partner at this table ensures the issue and opportunities remain at the top
- Home visiting program and WIC providing services and education to pregnant and new mothers
 - There are three home visiting programs statewide that serve prenatal moms. However, there is a limit to the number of prenatal moms we can serve.
- Implementation of Antenatal and Neonatal Guidelines, Education and Learning System (ANGELS) program to support high risk pregnancies
- Maternity program through ADH serves as a stop gap for access
- Medicaid coverage for pregnancy
- Most health plans have special maternity programs and case management to support mothers and babies (BCBS, e.g.)
- Maternal Mortality Review Committee ensures a sustained focus on the issues related to MMR
- POWER Team travels the state to provide outreach and strengthen access

- Potential for the community health worker program being developed at UAMS to enhance access to care as a Small and Medium Sized Enterprise (SME) for new mothers
- Skilled, caring proactive providers
- Supportive/helpful/knowledgeable families
- Transfer of high-risk pregnancies to higher level birthing hospitals

Partners

Stakeholders identified the following potential partners to strengthen the positive factors or address the negative factors impacting the maternal mortality rate in Arkansas.

- American College of Obstetricians and Gynecologists (ACOG)-create unified message to help providers understand issues
- Arkansas Children’s Hospital Nursery Alliance-help with standardization of care with moms
- Arkansas Home Visiting Network-Healthy Families America, Nurse-Family Partnership, Following Baby Back Home, Parents as Teachers all enroll and serve prenatal families, encouraging prenatal doctor's visits and providing education.
- Arkansas faith network - Community education and outreach
- Arkansas Minority Health Commission, faith-based organizations - grassroots outreach and education for planned pregnancy and prenatal and maternal health care to general and minority populations
- AR Pharmacists Association - Providing education and contraception
- Community birth workers and smaller community-based organizations
- Arkansas Birthing Project
- Ujamaa Maternity Network
- County Health Officers-trusted messengers within the community
- Media to keep a light on the situation and updates from the work the organizations are doing and monitoring outcomes
- Medical specialty groups (Arkansas Medical Society (AMS), Arkansas Medical, Dental, and Pharmaceutical Association (AMDPA), Asian American and Pacific Islander (AAPI) Osteopathic (College of Osteopathic Medicine (COMs)-trainers of primary care providers, can potentially address maternity deserts
- Minority serving providers and groups - Advocacy and education
- Partners that we can engage to help are ADH, Arkansas State Board of Nursing (ASBN), AR Medical Board, ANGELS, Doulas, local media
- Politicians-passing policies and funding opportunities

What works/Solutions

Stakeholders identified the following potential solutions to strengthen the positive factors or address the negative factors impacting the maternal mortality rate in Arkansas.

- Access to contraception at the time of birth
- Addressing maternal mental health
- Centering in pregnancy programs for group prenatal care
- Expanding Medicaid for postpartum care

- Expansion of Home Visiting Program to cover more prenatal moms in the state
- Partnering of Home Visiting programs with birthing hospitals to ensure what families are taught in the hospital translates to the home environment. Can also discuss birth spacing and birth control with the moms
- Get a no-fault insurance plan for providers (family med) who are properly trained and credentialed to offer coverage for OB services. This will be countered by the plaintiff attorney group but if you don't solve for malpractice, you don't solve for access.
- Improve maternal health care for incarcerated women
- Incorporate pharmacists throughout the state as paid providers for certain services including access to contraception (oral contraceptives). Best way to have "good" babies and mothers is to have both states be desired.
- The education is out and deliverable and is also being included in the education of pharmacists in our colleges of pharmacy here in Arkansas
- Jobs/works/training in schools to ensure kids graduating have opportunities to work. Teen pregnancy often 18-19 years old.
- Make sure women know the risks of advanced-age pregnancy while they are young and promote healthy lifestyles for all women
- Medicaid reimbursement for doula services
- Preconception health education
- Promote patient education within community to understand prenatal care
- Providing real sex ed in schools
- Rolling campaigns with constant messaging to address areas of concern e.g. campaign on heart disease in pregnancy, seat belt safety in pregnancy
- State should make it easier for granting independent practice authority for APRN which has the probability of increasing providers in the SE area of the state. A way to provide OB services in local hospitals such as Helena Regional (lost privileges ~Jan 2022); Postpartum coverage for 12 months instead of 6 weeks insured coverage for Doulas as well.
- Strengthen existing health programs like Medicaid and support reproductive health care (abortion access, sex education programs, and contraception coverage with education)

Strategies

Stakeholders prioritized the following strategies because they ranked highest across four criteria: Impact, Feasibility, Specificity, and Value.

- Ensure the continued health of the mother by promoting maternal mental health and also access to contraception at the time of birth.
- Expanding and educating on the availability of Medicaid for postpartum care (extend PP coverage to traditional Medicaid and facilitate transition to Qualified Health Plan (QHP) coverage for those eligible).
- Incorporate pharmacists throughout the state as paid providers for certain services including access to contraception (oral contraceptives). Best way to have "good" babies and mothers is to have both states be desired

Work Plan for First Strategy: Ensure the continued health of the mother by promoting maternal mental health and also access to contraception at the time of birth.		
Action Step	Lead	Due
Prenatal Care counseling should include a birth plan as well as follow-up linking to post-delivery care with a plan for birth control upon discharge. Should explain choices for permanent contraception (Tubal, Hysterectomy, etc.) as well as hormonal contraception such as progesterone only for nursing mothers, estrogen/progesterone combination, Intra Uterine Device (IUD), or implanted hormonal contraceptives	ACOG ADH	12/31/23
Options to obtain appropriate contraception should be explained at time of delivery prior to discharge. Linking care to your pharmacy provider before delivery.	ACOG ADH	12/31/23
Prenatal Care counseling should include follow-up for prenatal and postpartum mental health resources to help normalize mental health care and resources for expectant and new mothers.	ACOG ADH	12/31/23
ACOG and ADH create a review for providers of augmented service availability on early visits for pregnancy to develop appropriate longer-term plans post-delivery. Educational modules (tool kit) for providers and patients for mental health screenings as well as post-delivery contraception.		
Work Plan for Second Strategy: Expanding and educating on the availability of Medicaid for postpartum care (extend PP coverage to traditional Medicaid and facilitate transition to QHP coverage for those eligible).		
Action Step	Lead	Due
Campaign for education for mothers, partners, and providers	Public Private partnership (ADH, BlueCross, UAMS, Community partners)	
Access to mental health-Paranoid Personality Disorder, Primary Progressive Aphasia, Suicide	Walton Family Foundation	
Expand ADH Suicide hotline-988	Arkansas Department of Health	
Work Plan for Third Strategy: Incorporate pharmacists throughout the state as paid providers for certain services including access to contraception (oral		

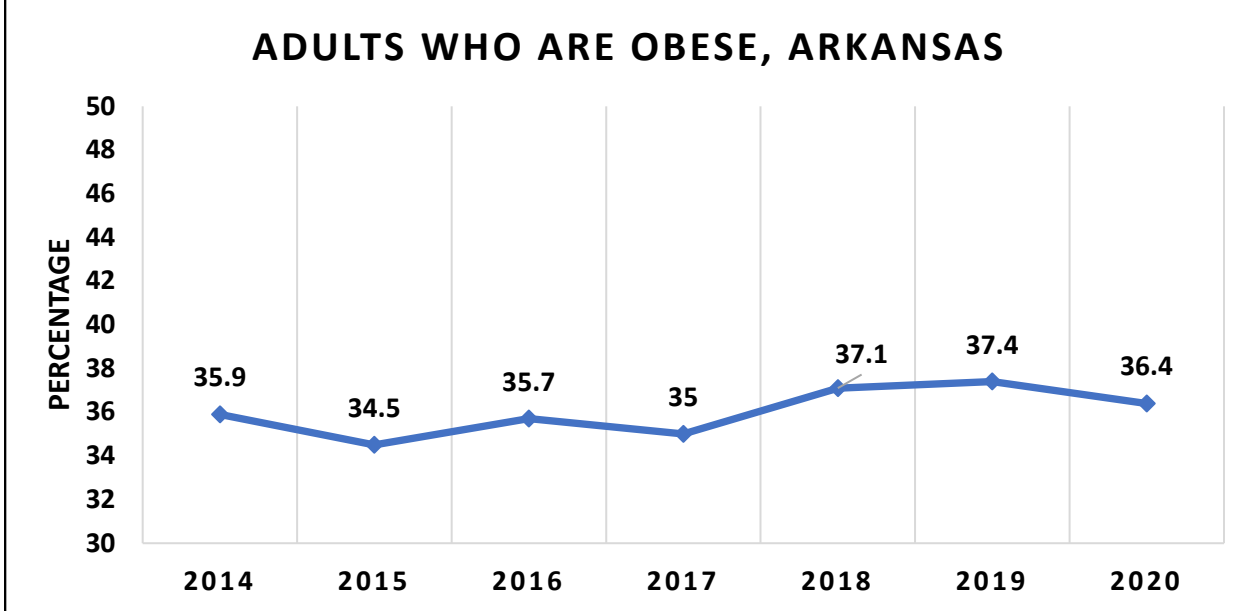
contraceptives). Best way to have "good" babies and mothers is to have both states be desired.		
Action Step	Lead	Due
BCBS initiated the innovation of adding pharmacists as paid providers through its systems, which includes any number of systemic changes (coding, billing, practice, etc.)	BCBS	12/22
Encourage expansion beyond BCBS for this coverage. (Medicaid, Private Insurance)		
Listing of participating providers on ADH website similar to vaccine availability.	ADH, Arkansas Pharmacists Association	
Monitor the claims of BCPs; correlate the decrease of births to contraceptives provided throughout the state		
For local providers, encourage (and help) them to identify other providers in the area who can provide bridge care	ARAP; ARFP	
Arkansas Academy of Family Practitioners and Pediatric Physicians to work with Arkansas Pharmacists Association to work together to plan bridges to care.		
Promote the usage of Folic Acid Supplementation for any woman of childbearing age who menstruates (could the state give this out?)	ADH	
Assess existing hospital records to understand where the concentration of deliveries (by race and equity) is happening (and type: vaginal vs. C-section), and then geographically determine the optimal location to establish Obstetrical Centers of Excellence (and to encourage those with fewer births to forgo the provision of care) and then organize transportation supports along this infrastructure	ADH	2/23
Needed services are difficult to access in areas of the state such as Stuttgart (Southeast Arkansas)		



PRIORITY AREA: OBESITY

ARKANSAS STATE HEALTH IMPROVEMENT PLAN

About the Data



How are we doing on the data?

When asked how Arkansas adults are doing relative to the trendline data for the indicator, the stakeholders stated the following:

- Data is showing a lower amount of obesity in Arkansas
- More than 50% of Arkansans have a BMI above 30
- There should be a data portal that connects data from doctors and clinics

Would be better to look at obesity data within each county vs. the whole state to better understand obesity in Arkansas

Story Behind the Curve

Stakeholders identified the following negative factors promoting obesity amongst Arkansas adults.

- COVID-19 prevented people from participating in normal physical activities
- Cultural differences
- Family structure and lack of cooking skills
- Financial factors
- Inflation has caused the price of healthier foods to go up
- Physical activity might be a lower priority for residents experiencing financial instability
- Lack of access to healthy foods
- Lack of bike trails
- Lack of community resources
- Lack of motivation
- Lack of parental guidance
- Lack of physical activity, more attention to television, and screen games
- Lack of sidewalks

• School system needs more healthy activities, and healthy options
Stakeholders identified the following positive factors preventing obesity amongst Arkansas adults.

- Access to more parks, trails, and physical activity outside
- "Breakfast after the Bell" program
- "Double up food bucks' program" offers financial support for buying healthy food such as vegetables and fruits
- Healthy nutrition in schools'
- Healthy foods in vending machines
- Hometown Health offers nutrition education in school systems
- More additional resources need to be aimed towards healthy eating and physical activity with promotions, programs, and interventions
- Nutrition education
- Promotion of physical activity
- United Methodist offers food programs

Partners

Stakeholders identified the following potential partners to strengthen the positive factors or address the negative factors influencing the rate of Arkansas adults who are obese:

- Arkansas Department of Health
- Business within local communities including grocery stores and convenience stores
- Chambers of Commerce
- Charitable foundations
- Faith-based networks
- Governor's office
- School districts and/or the state education agency
- WIC

What works/Solutions

Stakeholders identified the following potential partners to strengthen the positive factors or address the negative factors influencing the rate of Arkansas adults who are obese.

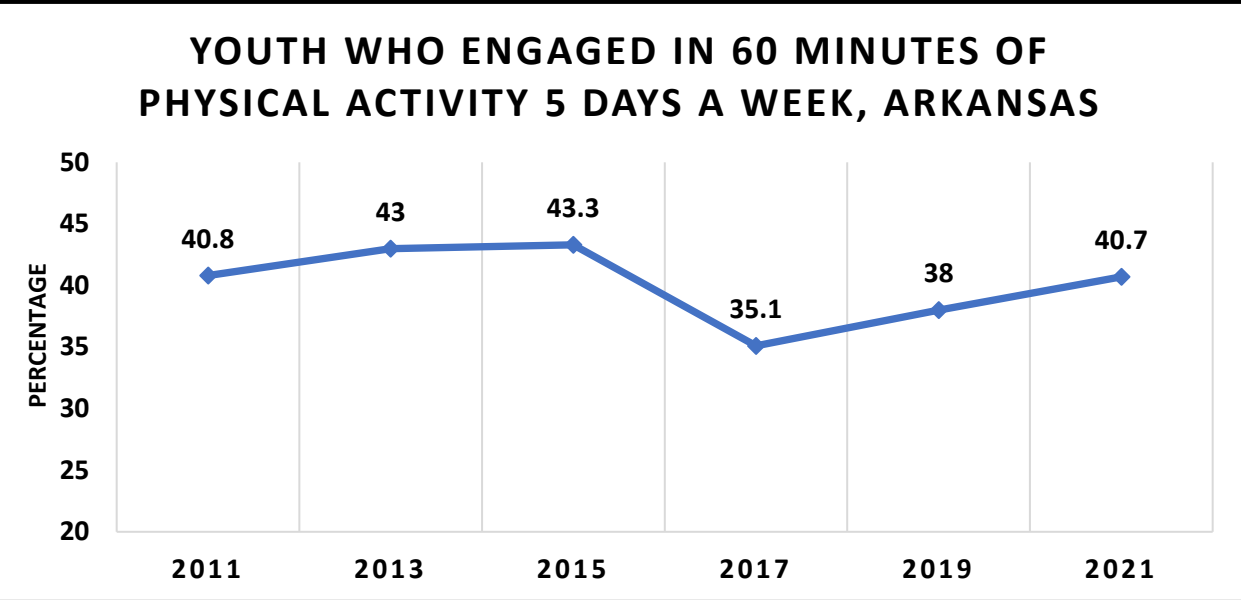
- Build bike trails, walking trails, or parks to promote more active living
- Develop and implement an early education curriculum that promotes health food choices
- Enact a lower tax rate for fresh foods and/or healthy foods
- Enact a policy that limits the number of convenience stores or discount retail stores in a county or zone
- Increase access to resources that promote healthy habits
- Increase recess time and physical activity in school system
- Initiate a state fund available to grocery stores or retail outlets that sell food to promote fresh produce and/or health foods – for example, placing healthy foods in checkout lines rather than sugary/salty snacks

<ul style="list-style-type: none"> • Launch a healthy food program specifically targeted towards students at higher education institutions • Make the cost of sugary drinks/unhealthy foods increasingly prohibitive by enacting a price increase for them • Promote local policy change that results in the limitation of how many fast-food restaurants can operate in a zone/county 		
Strategies		
<p>Stakeholders prioritized the following strategies because they ranked highest across four criteria: Impact, Feasibility, Specificity, and Value.</p> <ul style="list-style-type: none"> • Build bike trails, walking trails, or parks to promote more active living • Develop and implement an early education curriculum that promotes health food choices • Enact a lower tax rate for fresh foods and/or healthy foods 		
Work Plan for First Strategy: Build bike trails, walking trails, or parks to promote more active living.		
Action Step	Lead	Due
Evaluate existing infrastructure/policy to prioritize trail locations for maximum impact on active transportation Population reached Travel routes	Bryan	
Convene statewide active transportation/trail taskforce to engage partners	SHIP committee	
Develop/find employer/business recommendations to facilitate active transportation	Mike	
Work Plan for Second Strategy: Support the implementation of an early education curriculum that promotes health food choices.		
Action Step	Lead	Due
Get “Go NAPSACC” (Nutrition And Physical Activity Self-Assessment for Child Care) program into licensures of Pre-K and daycare centers as a requirement https://gonapsacc.org/	Katrina	6/30/23
Outreach to stakeholders who could help implement the program; State administrators, local area providers, local city officials; other organizations not currently involved	Mike	12/31/22 + ongoing
Identify areas of high need or no services, and assist with licensure process	Katrina	02/28/23
Develop evaluation plan/survey-based, providers, children, and families. Identify impacts and challenges.	Sharon and Jacquie	12/31/23
Work Plan for Third Strategy: Enact a lower tax rate for fresh foods and/or healthy foods.		
Action Step	Lead	Due
Convene key stakeholders for creation, input, and review of white paper.		
Define what are healthy foods	Mike T. Bryan M.	10/31/2022

Priority Area: Obesity

Create a white paper on the proposal that defines terms, includes cost analysis, potential impact, etc.	ACHI	12/31/2022
Work with legislators to identify other possible supporters		1/31/2023
Identify key sponsors for legislation		1/5/20223
Draft proposed legislation to proposed sponsors		1/31/2023
Legislative Session		1/17/2023

About the Data



The source is the Arkansas High School Youth Risk Behavior Survey. Data is reported every two years and ONLY reflects grades 9-12. The outcome measure describes the percentage of Arkansas youth who are doing any kind of physical activity that increased their heart rate and made them breathe hard some of the time, during the 7 days before the survey.

How are we doing on the data?

When asked how Arkansas adults are doing relative to the trendline data for the indicator, the stakeholders stated the following:

- Things took a downturn in 2017
- Things are getting better, heading in the right direction
- However, the 2021 data is only reaching the level of 2011 but has not yet caught back up to 2013 or 2015 (which were both the highest data points on the trendline)

Story Behind the Curve

Stakeholders identified the following positive factors promoting Arkansas youth to engage in 60 minutes of physical activity five days a week.

- Activity from summer programming might have an impact on the data, depending on the point in time of data collection
- Change in policy within the AR School System: Act 641 of 2019 requires Elementary School students have 40 minutes of physical activity daily
- Families are starting to get back out of the house as COVID-19 vaccination rates are going up and COVID-19 rates are going down
- Youth involved in sports or athletics participate in regular physical activity

Stakeholders identified the following negative factors preventing Arkansas youth from engaging in 60 minutes of physical activity five days a week.

- Body image might dissuade

- Cultural perceptions about who can exercise
 - Exercise advertisements present people who are more "normal"
 - Communities of color may not see a type of physical activity (e.g., hiking) as exercise that is available to them
- Family dynamics - if the parents or caretakers don't have the habit or culture of exercising, the behavior might get picked in the home. There might also be less support from parents or caretakers for youth who do want to exercise
- Organized sports come with a price tag to participate that might be prohibitive for some families
- Policy for High School physical activity is one semester of physical activity over the course of four years
- Students may have to choose other competing priorities over engaging physical activity
- Students might be drawn to more intellectually focused extracurricular pursuits
- Students who are not participating in a competitive sport (basketball, football, volleyball) might miss out on opportunities to engage in physical activity
- Screen time, including phones, computers, tablets, and/or TVs
- Varying levels of access to places to engage in physical activity, including school grounds, parks, etc.
 - Concerns over safety at public spaces to engage safely in physical activity

Partners

Stakeholders identified the following potential partners to strengthen the positive factors or address the negative factors influencing the percentage of youth who engage in 60 minutes of physical activity 5 days a week:

- 4-H Youth development programs related to physical activity
- ACH Community Engagement Team
- After School Programs-Boys' and Girls' Clubs- provide facility for engagement
- Arkansas Chapter of AAP (American Academy of Pediatrics)
- Arkansas Coalition for Obesity Prevention and other health organizations
- ADH Hometown Health Leaders
- Arkansas Department of Education, Athletic Clubs within school system
- Churches with family life centers
- Parents- provide transportation to physical activity programs
- Policy Makers (Local and State)- similar requirements for activity time during school day
- Arkansas Community Health Workers Association- help connect stakeholders to communities that are underserved and address barriers as advocates
- Summer Camp Programs- provide facility and infrastructure for physical activity programs
- School Representatives (teachers, staff, admin, and volunteers)
- Pediatricians -can help encourage parents to support the physical activity of their youth and educate on the importance of exercise
- School district administrators for joint use agreements for facilities
- Teenagers

- Parks and Recreation Centers- provide facility and infrastructure for physical activity programs

What works/Solutions

Stakeholders identified the following solutions to strengthen the positive factors or address the negative factors influencing the percentage of youth who engage in 60 minutes of physical activity 5 days a week:

- Blue and You Foundation grants to schools for athletic activities that are not school athletic team associated or Arkansas Activities Association (AAA) sanctioned (activity groups for fun)
- Community sponsor for a team to participate in organized sports (all kids paid for by one entity regardless of an individual child’s ability to pay)
- Business sponsor scholarships to fitness locations
- Faith-based exercise programs (may need to promote or identify funding sources specifically for this need)
- Family-based exercise programs; that encourage families or neighbors to move together (may need to promote or identify funding sources specifically for this need)
- Safe routes to schools (walking/biking)
- Have student mentors of all shapes and colors in community and school programs
- Have town or state celebrities come and visit a place that promote physical activity and print it in the local paper
- More community nights sponsored by local businesses where families come together and do physical activity and have drawings or t-shirts
- Non-traditional/unconventional and non-competitive physical activity programs to encourage movement through fun activities such as dancing, badminton, racquetball, gardening, hiking, trampolining, etc.
- Peer modeling/social support exercise programs to encourage movement among teens who struggle with body image or cultural barriers, using motivational coaches
- Provide access to gym after school hours with supervision for safety (joint use agreements)
- Schools have an organized club that focuses on being active as a group and varies the activities
- State and local policy (increase time for physical activity), system (make it the norm for all-inclusive activity) and environmental (increase access such as parks, fields to play) changes
- Tailor marketing that promotes the availability and accessibility of state parks to all high school aged-youth and their families
- Virtual exercise programs, where youth/families can exercise from their homes with a virtual coach or group (while considering barriers for rural residents with limited access to the internet)
- Work with local retailers to include real students modeling their clothes in their ads

Strategies

Stakeholders prioritized the following strategies because they ranked highest across four criteria: Impact, Feasibility, Specificity, and Value.

- Enact state and local policies that increase time for physical activity for high school youth which focuses on systems change (i.e., making it a norm that activities are inclusive for all youth regardless of weight or mobility) and environmental change (increase access such as parks, fields to play)
- Engage schools to provide access to facilities after school hours and to support organized clubs that focus on being active as a group and varies the activities (joint use agreements)
- Promote non-traditional/unconventional and non-competitive physical activity programs to encourage movement through fun activities such as dancing, badminton, racquetball, gardening, hiking, trampolining, etc.

Work Plan for First Strategy: Enact state and local policies that increase time for physical activity for high school youth which focuses on systems change (i.e., making it a norm that activities are inclusive for all youth regardless of weight or mobility) and environmental change (increase access such as parks, fields to play).

Action Step	Lead	Due
Identify policies that already exist at the state and local levels (i.e., mandatory breaks)		
Identify opportunities for new policies or policy changes (step counters for all students, look at Walk Across Arkansas program)		
Look at ways to build in competitiveness, school rivalries, PSAs to build awareness and knowledge of programs		
Implement Walkability assessments for communities		
Ensure options/solutions are inclusive of all youth and specifically identify programs that are appropriate for youth with weight or mobility challenges)		

Work Plan for Second Strategy: Engage schools to provide access to facilities after school hours and to support organized clubs that focus on being active as a group and varies the activities (joint use agreements).

Action Step	Lead	Due
Conduct planning session for project		
Engage district legal resources to create Memorandum of Understanding (MOU)/Joint use agreements for schools (part of this may exist already)		
Determine whether there is already a model/pilot program that exists and could be used to shared/leveraged		
Assessing community needs and mapping opportunities		

Work Plan for Third Strategy: Enact a lower tax rate for fresh foods and/or healthy foods.

Action Step	Lead	Due
Conduct planning session for project		

Identify existing programs that already exist that could be utilized for this program (green schoolyard, after school activities, etc.) focusing on whether the clubs currently include physical activity		
Assessing community needs and mapping opportunities		
Share best practices from statewide resources		
Prioritize strategies for local areas and partners		
Identify additional partnerships/resources		
Identify funding sources (grants, gifts, matching, etc.)		
Promote the natural resources of the state (parks, trails, etc.)		
Create standards for programs to meet the physical activity requirements		