



# 2016 ARKANSAS Chronic Disease Communication Kit



# A Communication Kit on Chronic Disease in Arkansas, 2016

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This communication kit is provided by...



Arkansas Chronic Disease Coordinating Council and  
Arkansas Department of Health, Chronic Disease Prevention and Control



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# HOW TO USE THIS KIT

## Get Involved

Arkansas needs your help combating chronic diseases. Coalitions and partnerships are the foundation for creating preventive chronic disease solutions. Basically anyone can become involved – individuals, employers, legislators, health care professionals, organizations, and educational institutions. This kit contains information about coalitions in Arkansas whose work is the prevention, treatment and cure of chronic diseases. The hope is that the kit will prompt you to contact the coalition of your choice for further information on how to help, based upon your role in Arkansas.

## What is a Communication Kit?

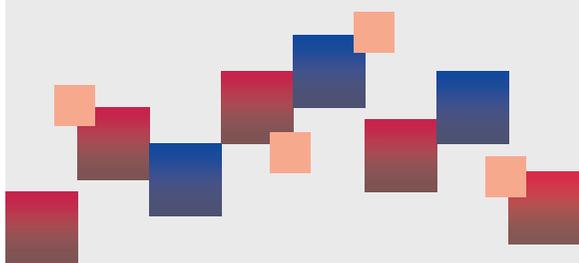
This communication kit was created by the Chronic Disease Coordinating Council (CDCC) and the Arkansas Department of Health (ADH) Chronic Disease Prevention and Control (CDPC) Branch. The CDPC Epidemiology and Surveillance Domain provides annual data for this toolkit. The CDCC, which was founded in 2008, is comprised of ADH program managers, as well as chronic disease coalition chairs and representatives of organizations in Arkansas which have the shared mission of combating chronic diseases.

*Healthy People 2020: Arkansas's Chronic Disease Framework for Action* guides the CDCC's efforts and provides a means for assessing progress and performance. This evidence-based framework, founded upon the national framework for improving population health, *Healthy People 2020*, can be accessed on the [ADH website](http://www.healthy.arkansas.gov/programsServices/chronicDisease/Initiatives/Documents/HP2020/ARHP2020ChDzbooklet.pdf) at <http://www.healthy.arkansas.gov/programsServices/chronicDisease/Initiatives/Documents/HP2020/ARHP2020ChDzbooklet.pdf>.

## Chapters

This kit is to serve as an informational resource for CDCC members as well as others across Arkansas with an interest in chronic disease prevention and treatment. The kit is organized by chapters about each of the CDCC member coalitions. Because of the interconnectedness of root causes for some chronic diseases, as well as recommended practices for prevention and treatment, there is overlap – we like to think of it as synergy! – among the coalitions and their activities as they work collaboratively toward the same goals.

One notable aspect of this communication kit: The information within are tools that can only work as hard as the one who holds them. Use these tools to help reduce the impact of chronic disease and their risk factors in Arkansas.



# INTRODUCTION

## What is Chronic Disease?

Chronic Disease  
Coordinating Council



A chronic disease is an illness that lasts a long time, at least three months or more according to the US Center for Health Statistics. Many chronic diseases require health care management for effective, long-term treatment. Diabetes, heart disease, hypertension, cancer, osteoporosis, Alzheimer's and asthma are examples of chronic diseases. <sup>1</sup>

**The Arkansas Chronic Disease Coordinating Council is a collaborative body providing leadership to prevent and control chronic diseases.**

The Council works by encouraging focus and collaboration among various sectors and through the development of overarching goals and recommended strategies for the prevention and management of chronic diseases in the state.

## MISSION

CDCC Mission: To increase the quality and years of healthy life for all Arkansans by reducing the burden of chronic disease through leadership and collaborative action impacting policy, system and environment changes.

## GOALS

1. Increase the percentage of Arkansans of all ages who engage in regular physical activity.
2. Promote tobacco cessation among Arkansans of all ages.
3. Improve access to screening and health care services for all chronic diseases in rural and underserved areas.
4. Educate and inform the public on health issues related to community partnerships, prevention, screening, treatment, outreach, and control of chronic diseases.
5. Develop and implement a legislative agenda to support the policy and fiscal needs of chronic disease activities.
6. Support the development of communities that promote life-long physical activity, healthy nutrition and tobacco free environments.

<sup>1</sup>[http://www.nationalhealthcouncil.org/NHC\\_Files/Pdf\\_Files/AboutChronicDisease.pdf](http://www.nationalhealthcouncil.org/NHC_Files/Pdf_Files/AboutChronicDisease.pdf)

## ARKANSAS CHRONIC DISEASE STATE PLAN

The Council has released "**Healthy People 2020: Arkansas's Chronic Disease Framework for Action**" designed to guide the efforts of participating agencies, organizations, and coalitions, and to help build relationships that can reduce the impact and costs of chronic disease in Arkansans. It is the goal of the Arkansas Chronic Disease Coordinating Council that this *Framework for Action* will continue to foster even greater partnerships, alliances, and coordinated activities within the state.

You can find the document at the following website address:

<http://www.healthy.arkansas.gov/programsServices/chronicDisease/coalition/Pages/default.aspx>

With this website you will also find information about the council and coalitions. You will be able to search and identify objectives, lead coalitions and activities toward each objective. You may also submit a comment or question to any of the coalitions involved.

## MEMBERSHIP

The Chronic Disease Coordinating Council is a partnership of organizations consisting of program managers for Arkansas Department of Health chronic disease programs, chairs of various chronic disease coalitions, and select organizations.

### Coalition Members:

1. Arkansas Cancer Coalition
2. Arkansas Coalition for Obesity Prevention (ArCOP)
3. Arkansas Diabetes Advisory Council
4. Arkansas Oral Health Coalition
5. Arkansas Wellness Coalition
6. Arkansas Tobacco Control Coalition (ArTCC)
7. Heart Disease and Stroke Coalition
8. Project Prevent Youth Coalition (PPYC)

## Supporting Organizations

- Arkansas Center for Health Improvement
- Arkansas Disability and Health Program
- Arkansas Foundation for Medical Care
- Arkansas Literacy Councils
- Arkansas Department of Human Services, Division of Medical Services
- Arkansas Minority Health Commission
- Arthritis Foundation Southeast Divisional Region, Arkansas
- Community Health Centers of Arkansas, Inc.
- Hometown Health Improvement
- UAMS Fay W. Boozman College of Public Health

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# ARKANSAS: HOSPITALIZATIONS FOR LEADING CHRONIC & ACUTE DISEASES

Table 1. Hospitalization Rates for Leading Chronic and Acute Diseases  
Arkansas, 2004-2013

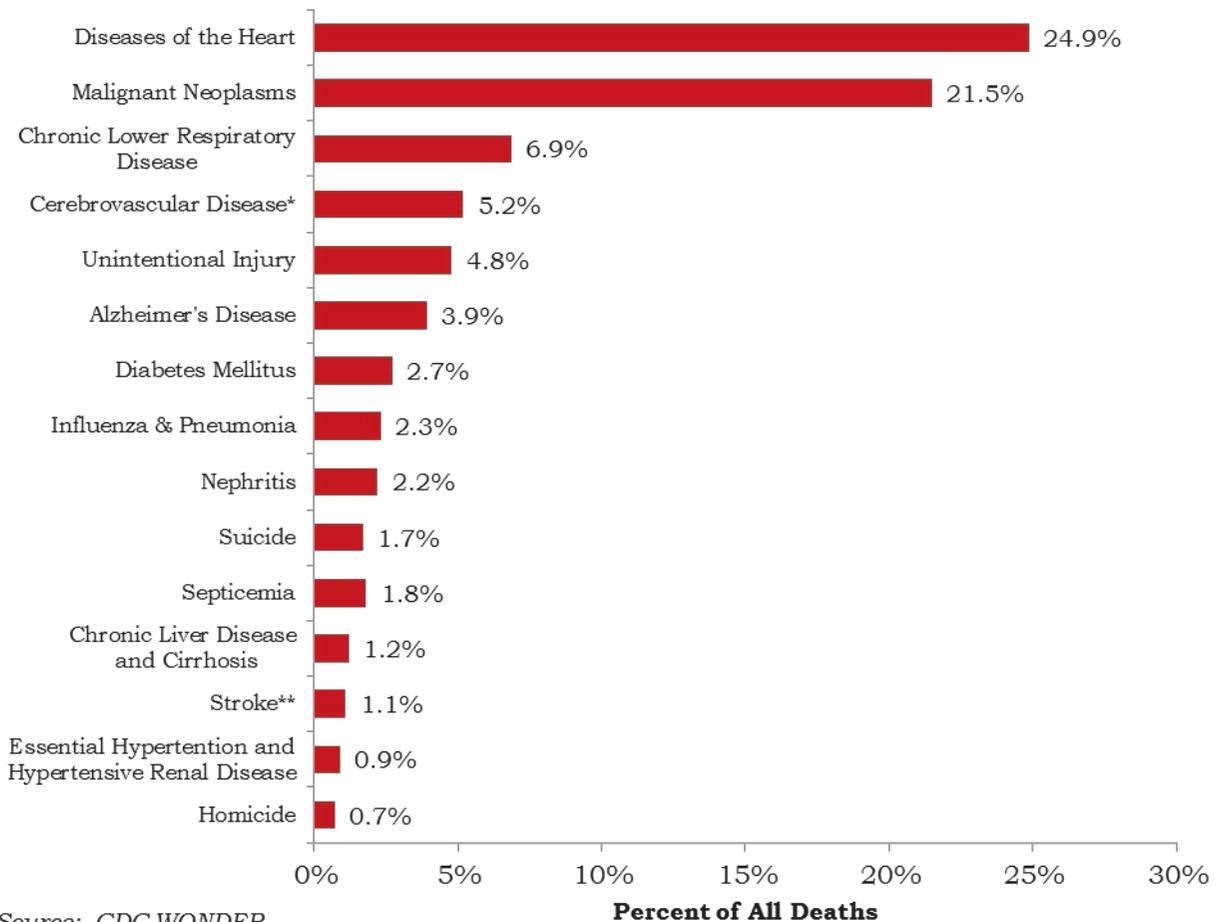
| Cause  | 2004  | 2005  | 2006  | 2007  | 2008  | 2009  | 2010  | 2011 | 2012 | 2013 |
|--|-------|-------|-------|-------|-------|-------|-------|------|------|------|
| Unintentional Injury*  | 113.8 | 113.0 | 110.9 | 107.0 | 106.6 | 104.5 | 101.2 | 99.1 | 97.2 | 91.8 |
| Coronary Heart Disease*  | 87.6  | 81.9  | 81.6  | 76.2  | 72.9  | 63.7  | 63.3  | 60.7 | 58.9 | 52.3 |
| Influenza & Pneumonia*   | 62.4  | 67.5  | 59.9  | 61.8  | 63.5  | 60.7  | 51.6  | 52.1 | 50.1 | 47.9 |
| Septicemia*  | 18.5  | 20.9  | 22.0  | 22.3  | 23.8  | 25.7  | 28.8  | 30.2 | 34.0 | 40.1 |
| Malignant Neoplasms**  | 46.2  | 46.5  | 46.1  | 46.8  | 45.7  | 45.4  | 44.3  | 44.3 | 44.3 | N/A  |
| Chronic Lower Respiratory Disease*   | 38.7  | 42.3  | 36.7  | 36.2  | 39.6  | 40.7  | 38.6  | 38.0 | 38.1 | 37.4 |
| Stroke*  | 37.2  | 35.6  | 34.3  | 32.5  | 32.0  | 32.0  | 32.2  | 32.1 | 33.4 | 31.4 |
| Diabetes Mellitus*   | 20.2  | 20.5  | 20.6  | 20.5  | 20.9  | 19.9  | 20.3  | 21.0 | 20.2 | 20.5 |
| Kidney Disease*  | 8.2   | 9.1   | 9.7   | 11.7  | 12.8  | 12.7  | 14.4  | 17.3 | 19.5 | 19.0 |
| Primary (essential), Secondary Hypertension & Hypertension with Complications* | 12.3  | 11.8  | 12.1  | 11.6  | 10.1  | 10.5  | 10.4  | 9.7  | 9.8  | 9.5  |
| Alzheimer's Disease*   | 6.9   | 7.2   | 7.6   | 7.4   | 8.1   | 8.3   | 8.4   | 7.5  | 5.8  | 6.0  |

\*Healthcare Cost and Utilization Project online query system (HCUPnet); \*\*CDC Wide-ranging Online Data for Epidemiologic Research (CDC WONDER). Rates are per 10,000 Arkansas population for all diseases. Population estimates were obtained from UALR Institute for Economic Advancement State Level Population Estimates 2004-2013. N/A= data not available for specific year. Septicemia is a body's life-threatening response to an infection and includes hospital acquired infections (HAI). Chronic Lower Respiratory Disease (CLRD) comprises three major diseases - chronic bronchitis, emphysema, and asthma. Stroke hospitalizations include ischemic and hemorrhagic strokes, and transient ischemic attacks (TIAs). Kidney Disease includes kidney disease secondary to diabetes, autoimmune disorders, infections, and toxins. Primary (essential) and Secondary Hypertension: Primary (essential) hypertension is high blood pressure due to no identifiable cause. Secondary hypertension includes high blood pressure due to kidney disease and other secondary causes. Hypertension with Complications include malignant hypertension (extremely high blood pressure that develops rapidly), hypertensive encephalopathy, hypertension with cardiac failure, and hypertension with renal failure.

- Hospitalization rates are reliable indicators of the status of chronic and acute diseases. These rates are relevant to the understanding of healthcare access and utilization for persons with chronic and acute diseases. A major public health goal is to reduce hospitalization rates and increase outpatient care.
- These rates for major chronic diseases such as coronary heart disease, malignant neoplasms, stroke, and hypertensive diseases show decreases over the past decade (Table 1). Declines in these rates indicate a shift from the hospital-centric model to the population-centric model, which is based on reducing the tremendous costs of hospitalization and investing in the lowest-possible cost settings such as patient-centered medical homes in which quality care can be delivered.

# ARKANSAS: LEADING CAUSES OF DEATH

**Figure 1. Fifteen Leading Causes of Death, Arkansas, 2014**

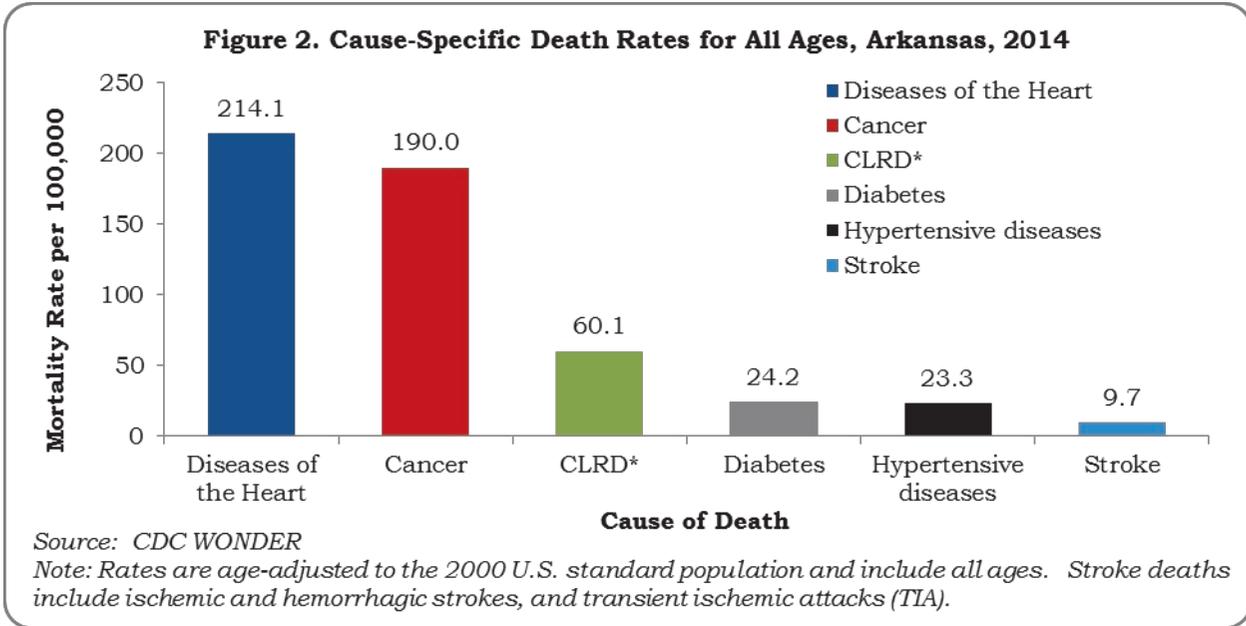


Source: CDC WONDER

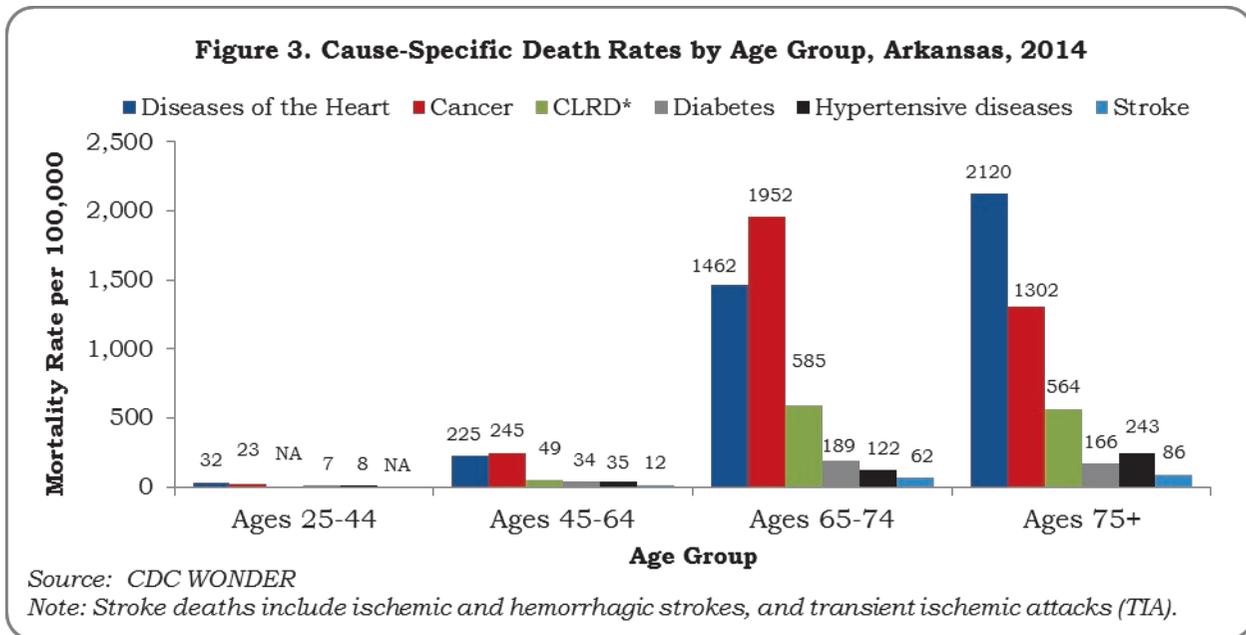
Note: Deaths include all ages. \*Cerebrovascular Disease deaths include all cerebrovascular diseases and stroke. \*\*Stroke deaths include ischemic and hemorrhagic strokes, and transient ischemic attacks (TIA).

- Despite reductions in hospitalization rates, chronic diseases such as heart disease, malignant neoplasms (invasive cancers), chronic lower respiratory disease, cerebrovascular disease, and diabetes mellitus accounted for over 60% of Arkansas’s deaths totaling to 18,600 deaths in 2014 (Figure 1).
- These death rates are indicative of persons who had low or delayed access to the healthcare system.

# CHRONIC DISEASE SNAPSHOT



- In 2014, more people died from diseases of the heart than any other chronic disease, followed closely by cancer (Figure 2).

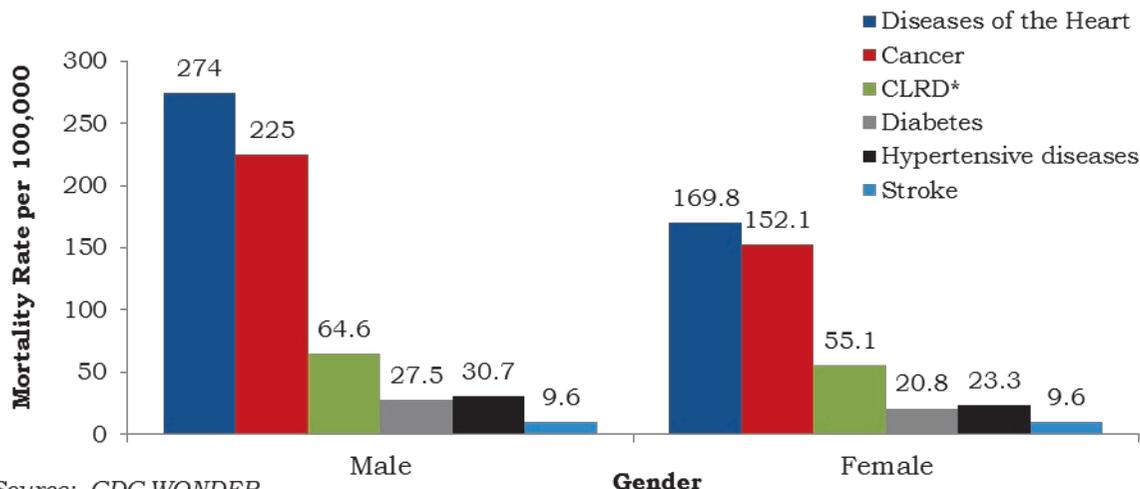


- When examining cause-specific death rates by age groups, deaths due to chronic diseases were highest for people over 75 years of age in 2014. Younger age groups were also affected indicating that significant healthy lifestyle changes are needed to lower their rates of dying from chronic diseases (Figure 3).

\*CLRD: Chronic Lower Respiratory Disease, refer page 4

# CHRONIC DISEASE SNAPSHOT

**Figure 4. Cause-Specific Death Rates by Gender, Arkansas, 2014**

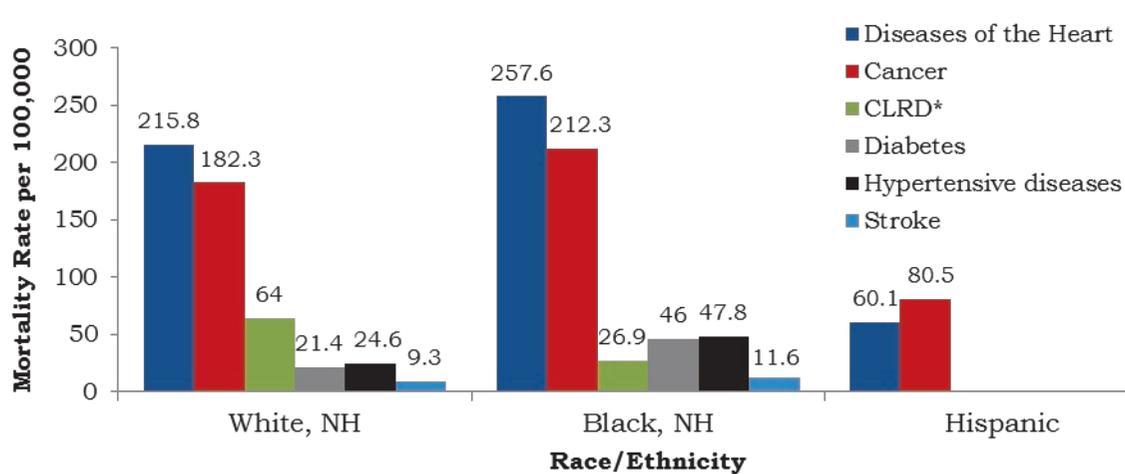


Source: CDC WONDER

Note: Rates are age-adjusted to the 2000 U.S. standard population and include all ages. Stroke deaths include ischemic and hemorrhagic strokes, and transient ischemic attacks (TIA).

- Arkansas’s males show higher rates of death from heart disease, cancer, CLRD\*, hypertensive diseases, and diabetes compared to females (Figure 4).

**Figure 5. Cause-Specific Death Rates by Race/Ethnicity, Arkansas, 2014**



Source: CDC WONDER

Note: Rates are age-adjusted to the 2000 U.S. standard population and include all ages. Stroke deaths include ischemic and hemorrhagic strokes, and transient ischemic attacks (TIA).

- Blacks show higher death rates from major chronic diseases than Whites and Hispanics, with the exception of CLRD. Hispanic numbers for CLRD\*, diabetes, hypertensive diseases and stroke were too small for calculation of rates. Diseases of the heart were the leading causes of death for Whites and Blacks in 2014, while cancer was the leading cause of death for Hispanics (Figure 5).

\*CLRD: Chronic Lower Respiratory Disease, refer page 4

# COALITIONS



Arkansas Cancer Coalition



Arkansas Wellness Coalition



Arkansas Coalition for Obesity Prevention (ArCOP)



Arkansas Diabetes Advisory Council



Heart Disease and Stroke Coalition



Arkansas Oral Health Coalition



Arkansas Tobacco Control Coalition (ArTCC)



Project Prevent Youth Coalition (PPYC)

# ARKANSAS CANCER COALITION



The Arkansas Cancer Coalition (ACC) is a network of cancer control partner organizations formed in 2000.

## MISSION

Our mission is to facilitate and provide partnerships to reduce the human suffering and economic burden from cancer for the citizens of Arkansas.

## GOALS

**Provide** an overview of cancer control in Arkansas

**Strengthen** and sustain the cancer control partnership and support network

**Direct** goals and strategies in the Arkansas Cancer Plan

## WHAT CDC SAYS

The Center for Disease Control and Prevention (CDC) reports that cancer is the second leading cause of death in the United States, exceeded only by heart disease.

Cancer risk can be reduced by avoiding tobacco, limiting alcohol use, limiting exposure to sun, tanning beds and other carcinogens, eating a diet rich in fruits and vegetables, maintaining a healthy weight, being physically active, and seeking regular medical care.

Screening also can help find cervical, colorectal, and breast cancers at an early, treatable stage. The human papilloma virus (HPV) vaccine helps prevent some cervical, vaginal, and vulvar cancers. The hepatitis B vaccine can reduce liver cancer risk.

## PROMISING INTERVENTIONS

The ACC provides funding for projects that support the Arkansas Cancer Plan. In collaboration with the ACC and in support of the Arkansas Cancer Plan, the Arkansas Department of Health's Comprehensive Cancer Control helps to expand the reach of the health care system related to screening and reducing the burden of cancer. Equal access is increased through mobile vans. Quality-driven care ensures quality screenings.

## STATE PLAN

The ACC has a detailed plan, titled "Arkansas Cancer Plan: A Framework for Action" that reflects many of the objectives sought in the "Arkansas Healthy People 2020: Framework for Action." The Cancer Plan supports overarching goals three and four of the Arkansas Healthy People 2020 Framework.

## HOW TO GET INVOLVED

Committees and work groups meet regularly to discuss and implement strategies on how best to move the mission of the Arkansas Cancer Coalition forward and meet the goals and objectives established by the Arkansas Cancer Plan. If you are interested in joining a coalition committee, please contact [info@arcancercoalition.org](mailto:info@arcancercoalition.org).

Evaluation Committee  
Summit Planning Committee  
Communications Committee  
Breast Cancer Work Group  
Skin Cancer Work Group  
Lung Cancer Work Group  
Prostate Cancer Work Group

## HOW TO GET INVOLVED CONTINUED

Breast Cancer Work Group  
Cervical Cancer Work Group  
Colorectal Cancer Work Group  
Survivorship Work Group  
Palliative Care Work Group

## RESOURCES

American Cancer Society—Arkansas  
[www.cancer.org](http://www.cancer.org)

American Lung Cancer in Arkansas  
[www.lung.org](http://www.lung.org)

Arkansas Cancer Coalition  
[www.arcancercoalition.org](http://www.arcancercoalition.org)

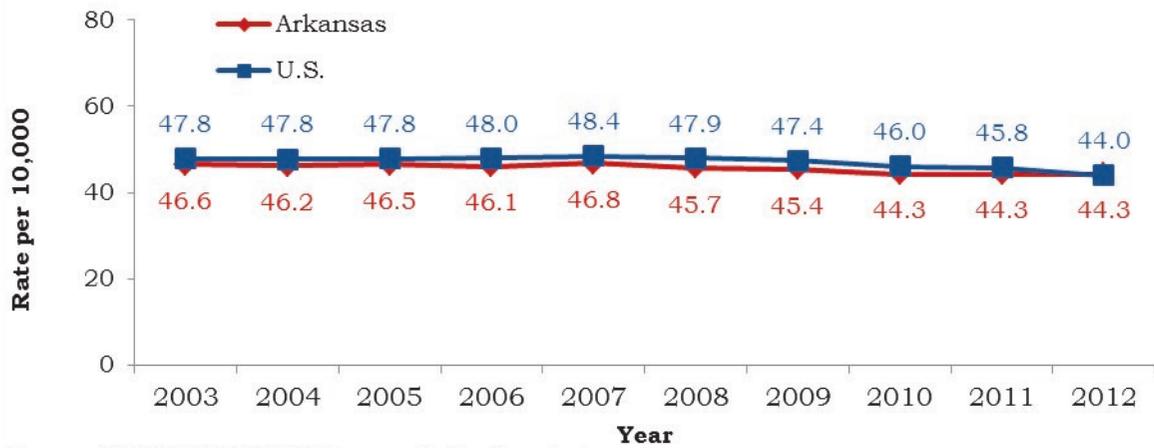
Arkansas Department of Health, BreastCare  
[www.ARBreastCare.com](http://www.ARBreastCare.com)

Arkansas Department of Health  
Comprehensive Cancer Control  
[www.healthy.arkansas.gov](http://www.healthy.arkansas.gov)

Centers for Disease Control and Prevention  
[www.cdc.gov/cancer](http://www.cdc.gov/cancer)

Susan G. Komen  
[www.komen.org](http://www.komen.org)

**Figure 6. Incidence of Malignant Neoplasms (Invasive Cancers), Arkansas and United States, 2003-2012**

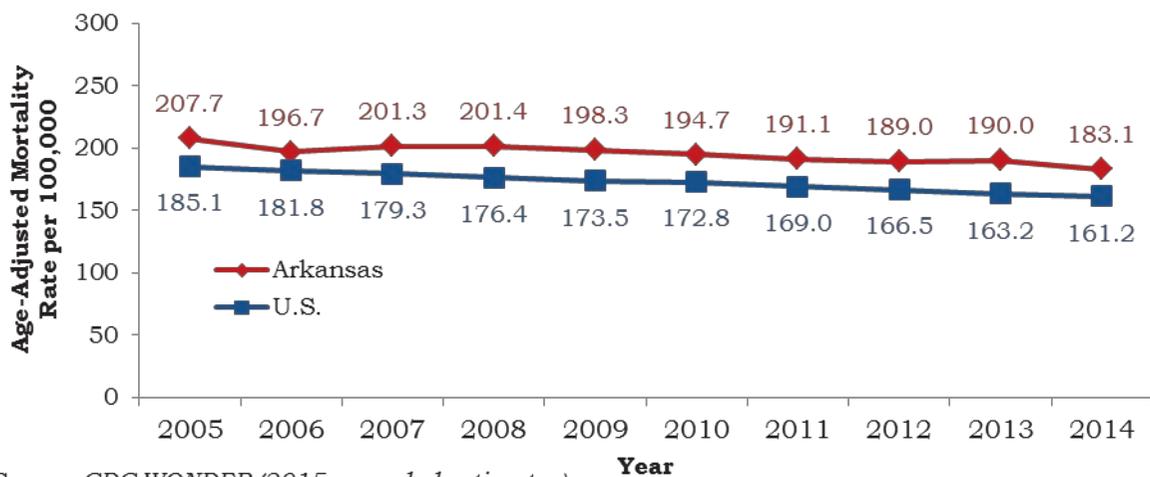


Source: CDC WONDER (2015 amended estimates)

Note: Rates are age-adjusted to the 2000 U.S. standard population. Includes all cancer sites.

- The incidence rates (occurrence of new cases) of malignant neoplasms (invasive cancers) decreased from 46.6 per 10,000 in 2003 to 44.3 per 10,000 in 2012. Arkansas’s and U.S. rates show comparable declines (Figure 6).

**Figure 7. Mortality Rates for Malignant Neoplasms (Invasive Cancers), Arkansas and United States, 2005-2014**

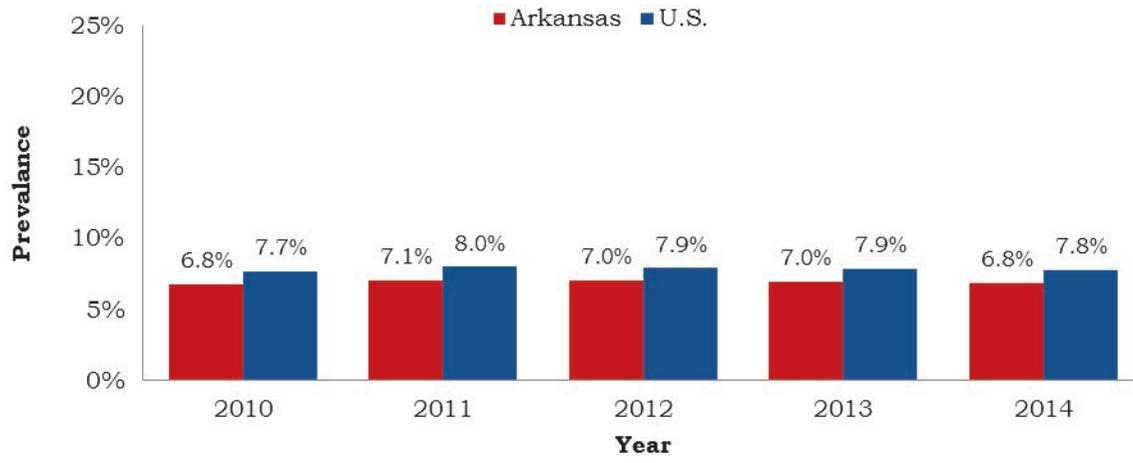


Source: CDC WONDER (2015 amended estimates)

Note: Rates are age-adjusted to the 2000 U.S. standard population. Includes all cancer sites.

- Invasive cancer mortality (death) rates in both the state and the nation have declined during the past decade; however, cancer mortality rates in Arkansas have consistently been higher than for the nation overall (Figure 7).
- Cancer prevention and control efforts are directed toward increasing the early detection of invasive cancers and preventing death.

**Figure 8. Prevalance of Cancer\* among Medicare Beneficiaries, Arkansas and United States, 2010-2014**

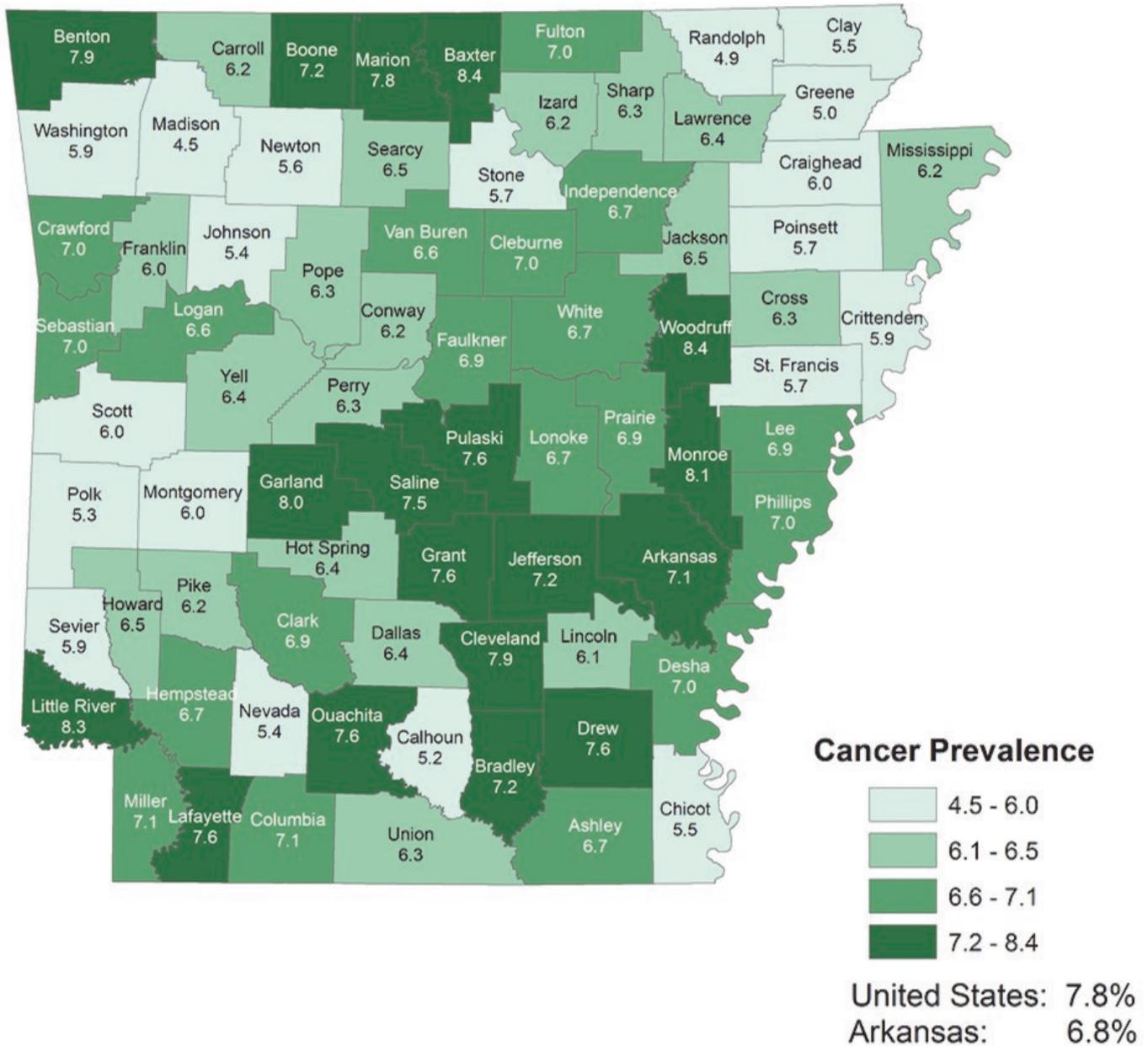


Source: Centers for Medicare and Medicaid Services, 2010-2014.

\*Includes Breast, Colorectal, Lung, and Prostate Cancer

- Electronic Medical Records (EMR) data show the prevalence of cancer among Medicare beneficiaries has remained constant over time for both Arkansas and the U.S. (Figure 8).
- In 2014, the prevalence of cancer among the Medicare population was 6.8% for Arkansas and 7.8% for the United States (Figure 8).
- Figure 9 (page 13) shows that although Arkansas's cancer prevalence among Medicare beneficiaries is lower than that of the U.S., one-fourth of the state's counties have a higher than the state's average cancer prevalence.

**Figure 9. Prevalence of Cancer\* Among Medicare Beneficiaries  
Arkansas, 2014**



\*Includes Breast, Colorectal, Lung, and Prostate Cancer

Date Created: January 16, 2016

Source: Centers for Medicare & Medicaid Services

Author: Brandy Sutphin, CPH, MPH, Chronic Disease Epidemiology Section



# ARKANSAS COALITION FOR OBESITY PREVENTION



The Arkansas Coalition for Obesity Prevention (ArCOP) is a true Coalition – a group of people, or groups who have joined together for a common purpose. The Coalition is an alliance of individuals, government agencies, nonprofit organizations, private businesses, and membership organizations working towards improving the health of Arkansas communities by increasing physical activity and healthy eating to reduce and prevent obesity.

## LEADERSHIP

ArCOP is led by an Executive Team comprised of the officers, workgroup chairs, and members-at-large. The Executive Team provides guidance for the overall Coalition and coordinates policy issues, strategy development, research and evaluation among the workgroup teams. The 4 main workgroup teams include: Access to Healthy Foods, Built Environment, Early Childhood and Schools, and Worksite Wellness.

## MISSION

ArCOP's mission is to improve the health of all Arkansas communities by increasing physical activity and healthy eating to reduce and prevent obesity.

## VISION

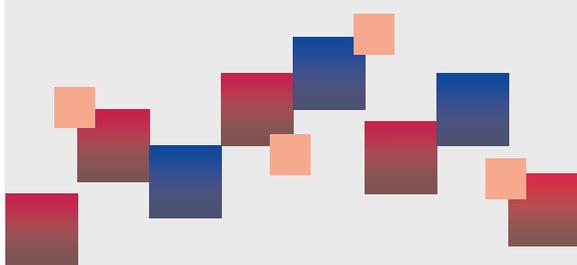
ArCOP envisions a day when all Arkansans value and practice healthy lifestyles through created and supported opportunities for physical activity and healthy eating.

## GOAL

ArCOP's goal is to increase the percentage of Arkansans of all ages who have access to healthy and affordable food and who engage in regular physical activity.

## GROWING HEALTHY COMMUNITIES

Growing Healthy Communities (GHC) is an initiative of the Arkansas Coalition for Obesity Prevention (ArCOP) to promote changes in communities across the state. Since 2009, the Coalition has been helping Arkansas communities build capacity to reduce obesity by increasing access to physical activity and healthy foods, as well as implementing environmental and policy changes that support healthy living.



## GROWING HEALTHY COMMUNITIES

Beginning in December 2014, all Arkansas communities applied to receive recognition for their efforts towards healthier practices and policies. In this first year, ArCOP has designated three recognition levels:

- Emerging Communities – Communities/teams that are just getting started or re-started
- Blossoming Communities – You have a few wins under your belt and are a little wiser than when you started
- Thriving Communities – Your community is “there” and, while you can always do more, you have seen (and can demonstrate) statistical change.

## INCREASED ACCESS TO HEALTHY FOODS

Maintaining a healthy diet is difficult for families who don't have convenient access to affordable healthy foods. In too many neighborhoods, families are surrounded by high calorie, low nutritional value options with minimal if any access to affordable healthy foods, including fresh fruits and vegetables. Improving local access to healthy foods can include strategies such as:

- Implementing community gardens, Farmer's Markets, and Farm to School Program
- Providing education about healthy, affordable food preparation through the Cooking Matters and Shopping Matters programs
- Promoting breastfeeding for at least one year after birth and supporting mothers who choose to breastfeed.

## LOCAL POLICY CHANGE

Local policy-makers have direct control over decisions that shape neighborhood activity environments. Choices like where to place a school, what kinds of businesses to welcome and how much to invest in public transit and crime prevention can have a significant impact on community health. Policymakers have many options that can positively change the community environment so that the healthy choice is the easy choice for families.

Healthier environments produce healthier people. And healthier people produce greater economic outputs, consume fewer healthcare resources and lead better, longer lives.

## INCREASED ACCESS TO PHYSICAL ACTIVITY

A lack of physical activity is one of the leading contributors to obesity and poor health. In many neighborhoods, there are not sufficient safe places for walking, bike riding or physical play. Our community environments must change so that all families have access to safe places to be physically active. Communities have a front-line role when it comes to the community environment. Several options that local governments can take to increase access to physical activity include:

- Plan, build, and maintain a network of sidewalks and street crossings that connect schools, parks, and other destinations
- Adopt community policing strategies that improve safety and security of streets and park use, especially in higher-crime neighborhoods
- Collaborate with schools to develop and implement a Safe Routes to Schools program to increase the number of children safely walking and bicycling to school
- Build and maintain parks and playgrounds that are safe and attractive for playing, and in close proximity to residential areas
- Institute policy standards for play space, physical equipment, and duration of play in preschool, afterschool, and childcare programs.

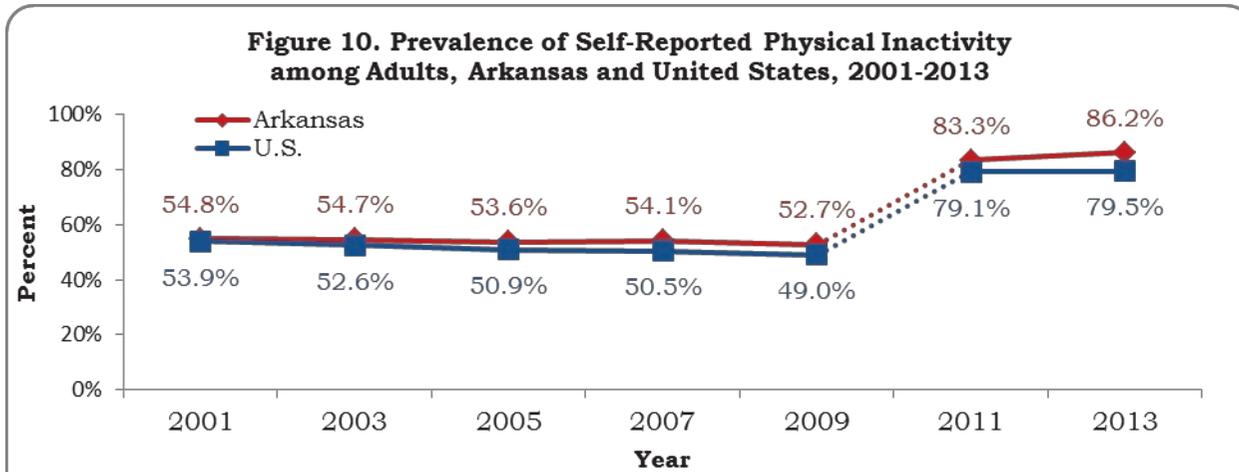
## CONTACT US

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**On Twitter:** #AROBESITY

**On Facebook:** <https://www.facebook.com/arkansasobesity>

**Online:** <http://www.arkansasobesity.org/>



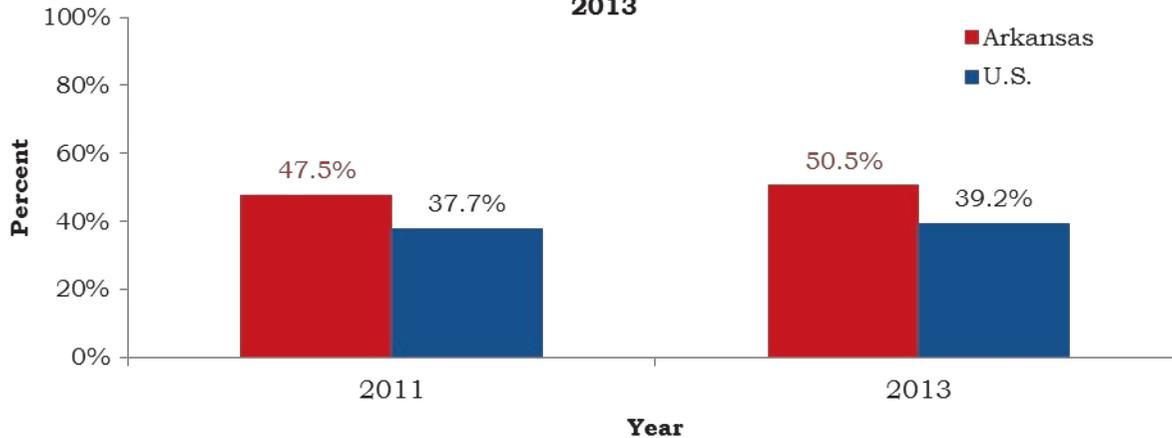
Source: Behavioral Risk Factor Surveillance System, CDC

Notes: Data from 2001-2009 represent the percent of adults who did not meet the 1995 physical activity guidelines. 2011-2013 data represent the percent of adults who did not meet the 2008 Physical Activity Guidelines for Americans. 2011 data are not comparable to prior years. The U.S. prevalence is the median of the states and Washington, D.C. The physical activity module is asked every odd year. New estimates will be available in 2016.

..... Indicates different weighting procedures and the inclusion of cellular telephones for years beginning with 2011. The data for 2011 and after are not comparable to previous years.

- Arkansas and the U.S. made little progress in reducing levels of physical inactivity from 2001-2009 based on Centers for Disease Control and Prevention (CDC) and the American College of Sports Medicine (ACSM) 1995 adult physical activity guidelines recommendations of at least 30 minutes a day of moderate-intensity physical activity on five days a week (Figure 10).
- In 2008, the U.S. Department of Health & Human Services released more flexible guidelines allowing a person to accumulate 150 minutes over a week in various ways, rather than being restricted to 30 minutes on five days a week. These guidelines added participation in strengthening exercises on at least two days per week to the minimum recommended guidelines.
- The percentage of Arkansas adults who did not meet the minimum recommended physical activity guidelines was 83.3% in 2011 and 86.2% in 2013, following release of the 2008 recommendations (Figure 10).

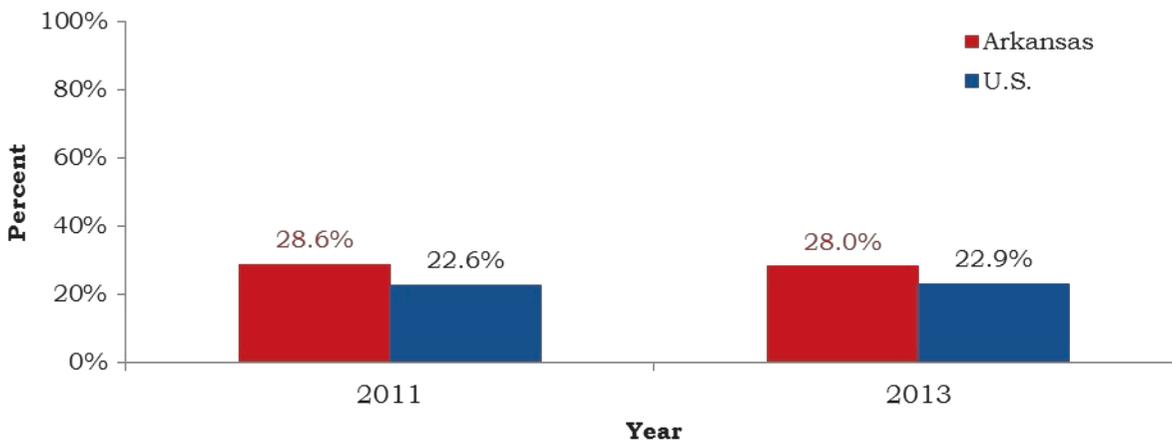
**Figure 11. Prevalence of Self-Reported Low Consumption of Fruits (Less Than 1 Serving/day), among Adults, Arkansas and United States, 2011 & 2013**



Source: Behavioral Risk Factor Surveillance System, CDC and Arkansas Department of Health  
 Notes: The U.S. prevalence is the median of the states and Washington, D.C. The fruits and vegetable module is asked every odd year. New estimates will be available in 2016.

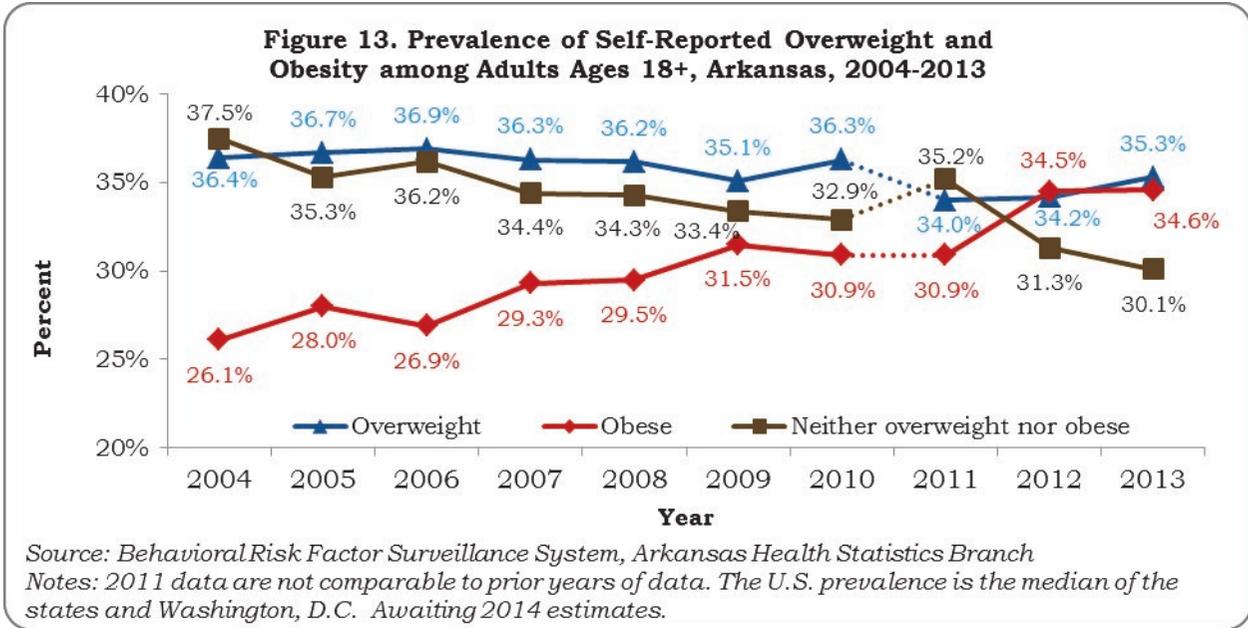
- In 2011 47.5% of Arkansas adults reported consuming less than one serving of fruit per day, compared to 37.7% of U.S. adults. This rose to 50.5% in Arkansas and 39.2% in the U.S. for 2013 (Figure 11).

**Figure 12. Prevalence of Self-Reported Low Consumption of Vegetables (Less Than 1 Serving/day) among Adults, Arkansas and United States, 2011 & 2013**



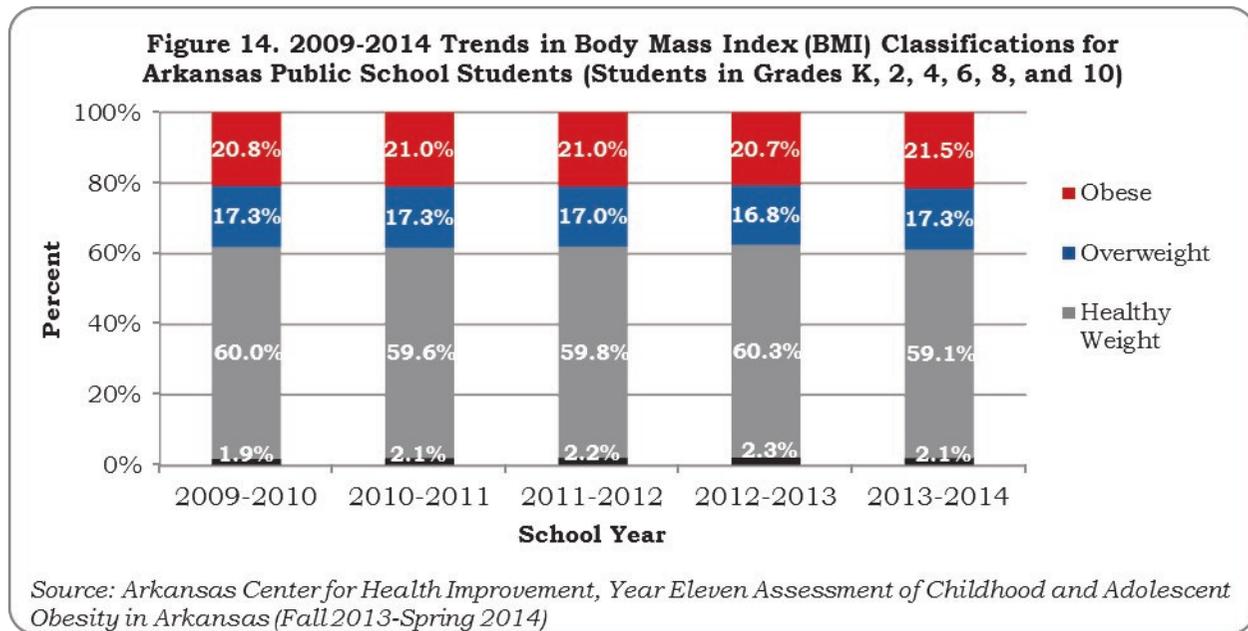
Source: Behavioral Risk Factor Surveillance System, CDC and Arkansas Department of Health  
 Notes: The U.S. prevalence is the median of the states and Washington, D.C. The fruits and vegetable module is asked every odd year. New estimates will be available in 2016.

- In 2013, 28.0% of adults in Arkansas reported consuming less than one serving of vegetables per day, compared with 22.9% of U.S. adults (Figure 12). Other evidence also shows the inadequate consumption of fruits and vegetables increased in Arkansas during the last 10 years compared to the U.S (figure not displayed).



..... Indicates different weighting procedures and the inclusion of cellular telephones for years beginning with 2011. The data for 2011 and after are not comparable to previous years.

- The self-reported prevalence of overweight (body mass index or BMI = 25.0-29.9) was relatively unchanged and the prevalence of obesity (BMI ≥30.0) increased steadily from 2004 to 2010 in Arkansas. Normal weight prevalence has decreased over time. In 2013, over two-thirds (69.9%) of Arkansas’s adults were either overweight at 35.3%, or obese at 34.6% (Figure 13).



- Body mass index (BMI) screenings from select public school students in grades K, 2, 4, 6, 7, and 10 show the percent of obese and overweight students increased slightly between 2009 and 2014. During the 2013-2014 school year, 38.8% of students were either obese or overweight (Figure 14).

# ARKANSAS WELLNESS COALITION



The Arkansas Wellness Coalition (AWC) is a voluntary effort of the health care and employer communities to improve the health and well-being of all Arkansans through the use of nationally recognized, peer-reviewed clinical guidelines for physician, consumer, and employer education. These principles will be used by all coalition members and will focus on disease entities and/or healthy lifestyles.

## MISSION

A **voluntary** partnership of the health care and employer communities to improve the health and well-being of all Arkansans through the use of nationally recognized, peer-reviewed clinical guidelines for physician, consumer, and employer education.

## GOALS

**Consolidate** efforts to improve quality of care and health outcomes for certain high-cost, high-risk diseases and promote healthy lifestyles

**Enhance** consistency and efficiency of care by providing common core principles

**Develop** materials to support implementation of nationally recognized standards of care

## MAJOR PROJECTS

The Arkansas Wellness Coalition completes one nationally accepted care guideline and one enhancement of a previous guideline annually based on health issues prevalent among residents in the state.

The following guidelines have been distributed:

- Diabetes
- Cardiovascular disease
- Stroke
- Adult immunization
- Obesity
- Colon cancer
- Chronic kidney disease

Enhancements and/or updates include:

- ABCs of Diabetes
- ATP III Update
- JNC 7
- Diabetes – Numbers at a Glance
- Physical Activity Guidelines
- Choose My Plate.gov (based on 2010 Dietary Guidelines)

## MEMBERSHIP

The Arkansas Wellness Coalition is comprised of organizations and key health-care stakeholders with interest in improving the delivery of health care in Arkansas.

Members of the Coalition include:

- American Cancer Society
- American Heart Association
- Arkansas American Academy of Pediatrics
- Arkansas Blue Cross and Blue Shield
- Arthritis Foundation, Southeast Divisional Region
- Health Advantage
- Arkansas Department of Health
- Arkansas Children's Hospital
- Arkansas Foundation for Medical Care
- AstraZeneca
- Boehringer Ingelheim
- Centocor Ortho Biotech Services
- City of Little Rock
- Novo Nordisk
- Pfizer Pharmaceuticals
- QualChoice/QCA
- State of Arkansas Department of Finance and Administration Employee Benefit Division
- University of Arkansas for Medical Sciences

## OPERATING PRINCIPLES

- Educational programs will be developed based upon medical literature, state initiatives and nationally accepted standards of care.
- AWC members shall review projects and activities prior to their initiation.
- Topics will be selected by a consensus of the membership.
- Information shall not be released without the review and consent of the AWC.

## HOW TO GET INVOLVED

### *Membership or Financial Partnership*

Email:  
Bridget Johnson, Chair  
Bridget.Johnson@pfizer.com

Treg Long, Membership Chair  
Treg.m.long@cancer.org

### **Check the website at:**

[www.healthy.arkansas.gov/programsServices/chronicDisease/coalition/Pages/ArkansasWellness.aspx](http://www.healthy.arkansas.gov/programsServices/chronicDisease/coalition/Pages/ArkansasWellness.aspx)

# DIABETES ADVISORY COUNCIL

## Arkansas Diabetes Advisory Council

The Council represents public and private partners to promote education, awareness, and quality of care to reduce the burden of complications. The Council advocates for legislation, policies and programs to improve the treatment and outcome of people with diabetes in Arkansas.

### MISSION

The mission of the Council is to reduce the economic, social, physical and psychological impact of diabetes in Arkansas by improving access to care and enhancing the quality of services by linking and maintaining effective relationships statewide and implementing sound public health strategies.

### GOALS

**Increase** diabetes knowledge among patients and caregivers

**Expand** providers' cultural competency, diabetes knowledge and adherence to the American Diabetes Association (ADA) clinical practice guidelines

**Build** support and understanding among the general public regarding diabetes prevention, early detection and treatment methods in Arkansas

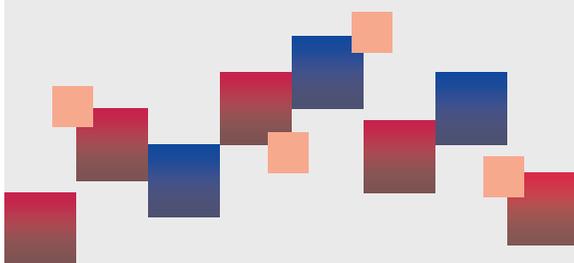
**Influence** and encourage businesses, health facilities, state agencies and state government/legislative branches to promote policies and programs that support diabetes prevention and control

### MEMBERSHIP

Membership consist of persons with diabetes (or their family members), nurse educators, dietitians, health educators, primary care providers, podiatrists, endocrinologists, epidemiologists, psychologists, pharmacists, community health centers, diabetes education programs, health plans, American Diabetes Association, Juvenile Diabetes Research Foundation, Arkansas Department of Health, consumer or sales groups, academic institutions, etc.

The DAC seeks members from a wide range of backgrounds and geographic locations from across the state to assist in meeting our goals and objectives.

Meetings are held quarterly (four times a year), the first Thursday of each quarter from 11:30 a.m.-1:00 p.m. Conference calling capability is available for those not able to travel to the Little Rock meeting location.



The Diabetes Advisory Council's work reflects many of the objectives sought in the "Arkansas Healthy People 2020: Framework for Action." The DAC's current plan of work calls for emphasis in the following areas: patient education, provider education, public education and policy-maker education. Subcommittees meet to solidify activities for the Council.

## Four Subcommittees:

### Patient Education

To increase diabetes knowledge among patients and caregivers to improve diabetes self-management behaviors and related health outcomes.

### Provider Education

Expand providers' cultural competency, diabetes knowledge and adherence to the American Diabetes Association clinical practice guidelines.

### Public Education

To build and support and understanding in the general public regarding diabetes prevention, early detection, and treatment methods in Arkansas.

### Policy-maker Education

To influence and promote policy decisions in business, health facilities, state agencies, and state government/legislative branches to promote policies and programs that support diabetes prevention and control.

## ACTIVITIES

The DAC provides a wide range of support services such as technical assistance, quality improvement and health promotions through media messages emphasizing:

- **Increased** awareness of diabetes and the importance of early detection and prevention of diabetes among residents of Arkansas
- **Increased** access to education for those identified with pre-diabetes
- **Improved** access to education and other resources necessary for diabetes self-management.

## DIABETES RESOURCES

[Helping your child manage diabetes at school](#)  
[Blood sugar and fears](#)  
[Learn Your Risk for Diabetes and Take Steps to Protect Your Health](#)

### CONSUMERS:

[Free and Reduced-Cost Diabetes Resources in Arkansas](#)  
[American Association of Diabetes Educators](#)  
[National Institutes of Health](#)  
[American Diabetes Association](#)  
[Family Support Network](#) (an online community for kids, families and adults with diabetes)  
[Juvenile Diabetes Research Foundation International](#)  
[ChooseMyPlate.gov](#)  
[Learning About Diabetes](#)  
[National Kidney Disease Education Program](#)  
[National Kidney Foundation - Chronic Kidney Disease](#)  
[Better Choices, Better Health with Diabetes](#)

### PRESCRIPTION ASSISTANCE PROGRAMS:

[RX Assist](#) (directory of patient assistance programs)  
[Partnership for Prescription Assistance](#)  
[NeedyMeds.org](#) (information on medicine and healthcare assistance programs)

### SPANISH SPEAKING:

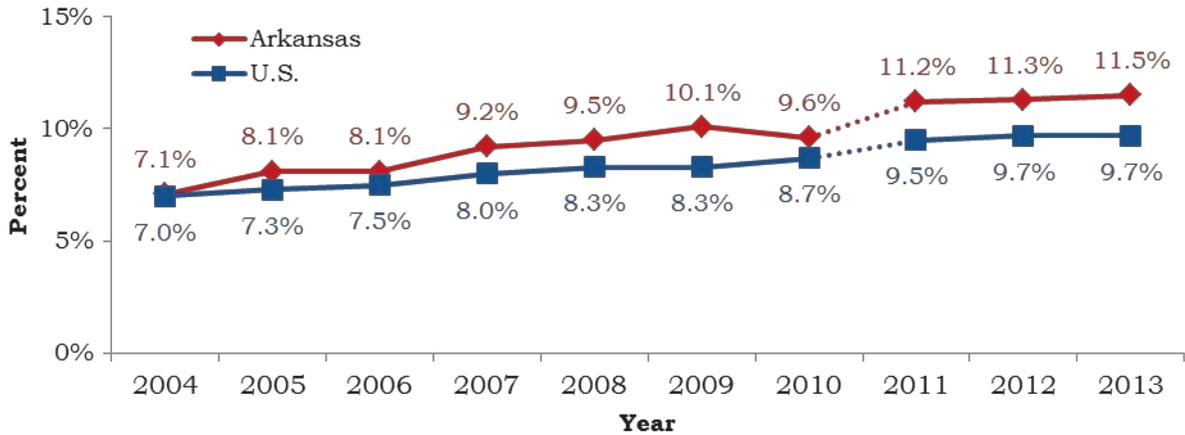
[National Alliance for Hispanic Health](#)

### PROFESSIONALS:

Outpatient Diabetes Self-Management Education Programs (DSME/ADA-Recognized/AADE-Accredited).

[Arkansas Chronic Illness Collaborative](#)  
[National Diabetes Education Program](#)  
[Joslin Diabetes Center](#)  
[American Diabetes Association](#)  
[American Dietetic Association](#)  
[Patient Education Handouts](#)  
[National Association of Chronic Disease Directors](#)  
[Standards of Medical Care in Diabetes](#)  
[STOP Diabetes](#)  
[Road to Health Toolkit](#)  
[Better Choices, Better Health with Diabetes](#)  
<http://www.healthy.arkansas.gov/programsServices/chronicDisease/diabetesPreventionControl/Pages/Resources.aspx>

**Figure 15. Prevalence of Self-Reported Diabetes among Adults, Arkansas and United States, 2004-2013**



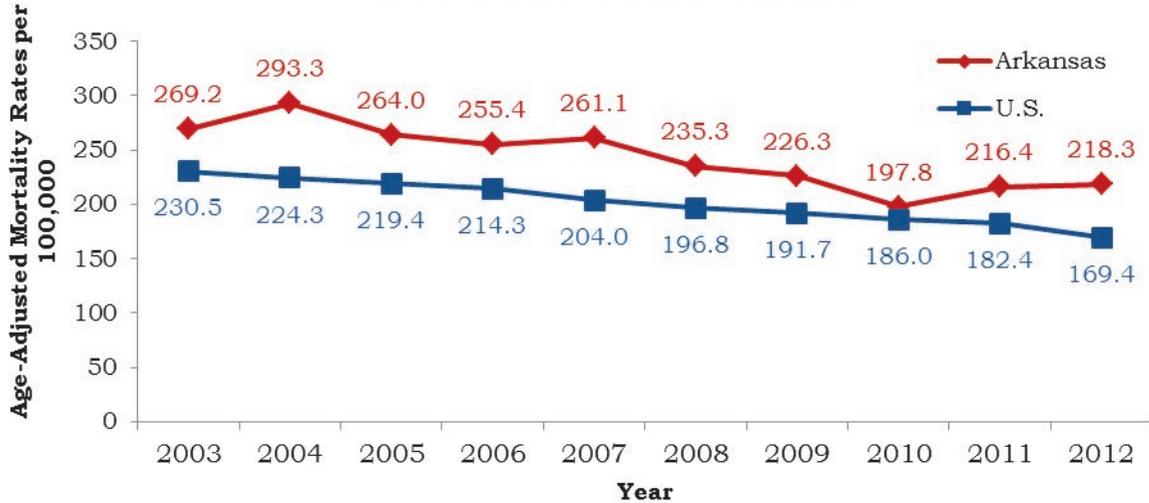
Source: Behavioral Risk Factor Surveillance System, CDC

Notes: 2011 data are not comparable to prior years of data. The U.S. prevalence is the median of the states and Washington, D.C. Awaiting 2014 estimates.

..... Indicates different weighting procedures and the inclusion of cellular telephones for years beginning with 2011. The data for 2011 and after are not comparable to previous years.

- The percent of Arkansas’s adults who self-reported having been told by a doctor that they had diabetes increased from 7.1% in 2004 to 9.6% in 2010. In 2013, the percent of adults with self-reported diabetes was greater in Arkansas at 11.5% than in the U.S. at 9.7% (Figure 15).

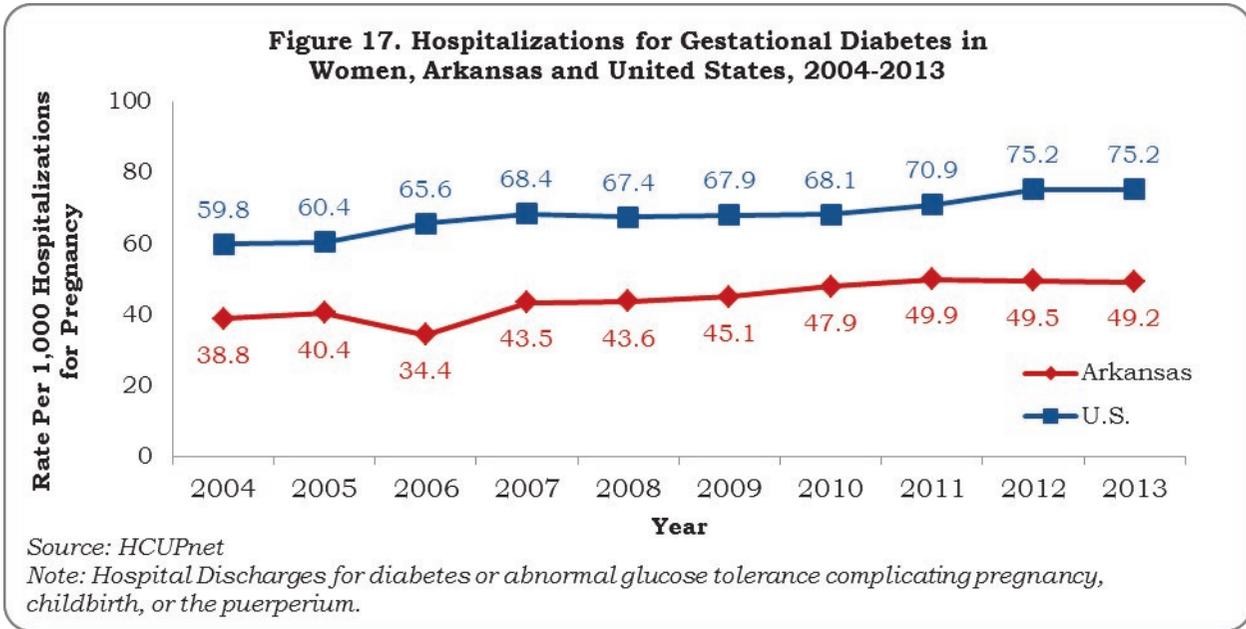
**Figure 16. Mortality Rate for End-Stage Renal Disease, Arkansas and United States, 2003-2012**



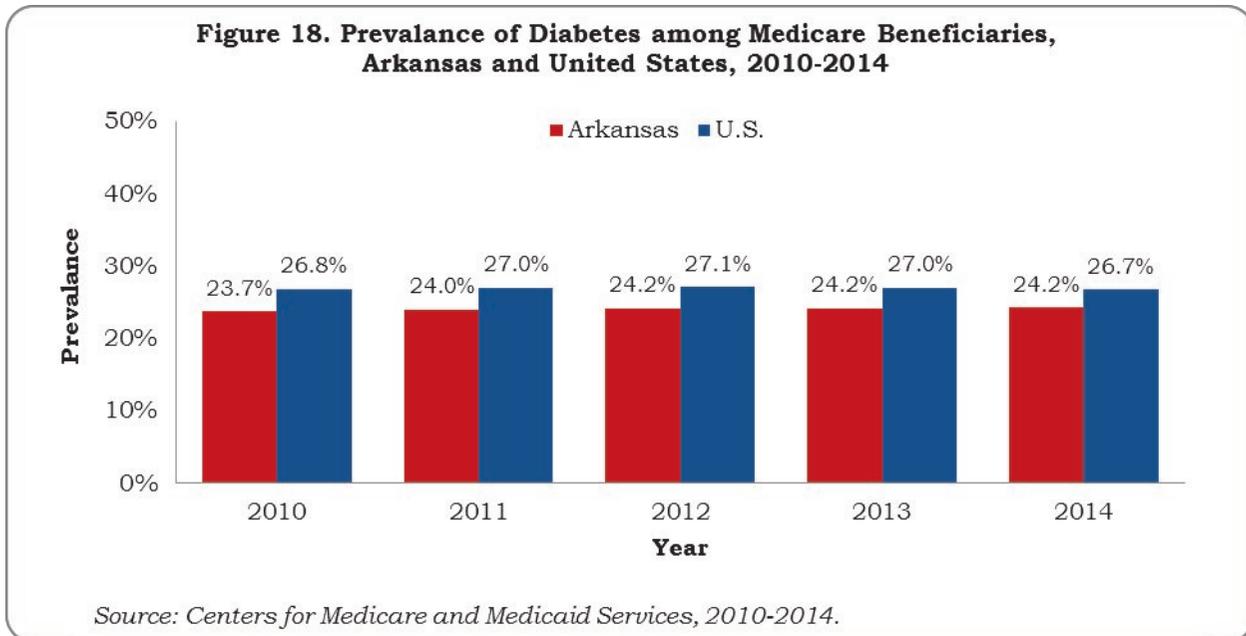
Source: U.S. Renal Data System (2014 Amended estimates)

Note: Rates are per 1,000 patient years. The lag period for reporting data is 2 years.

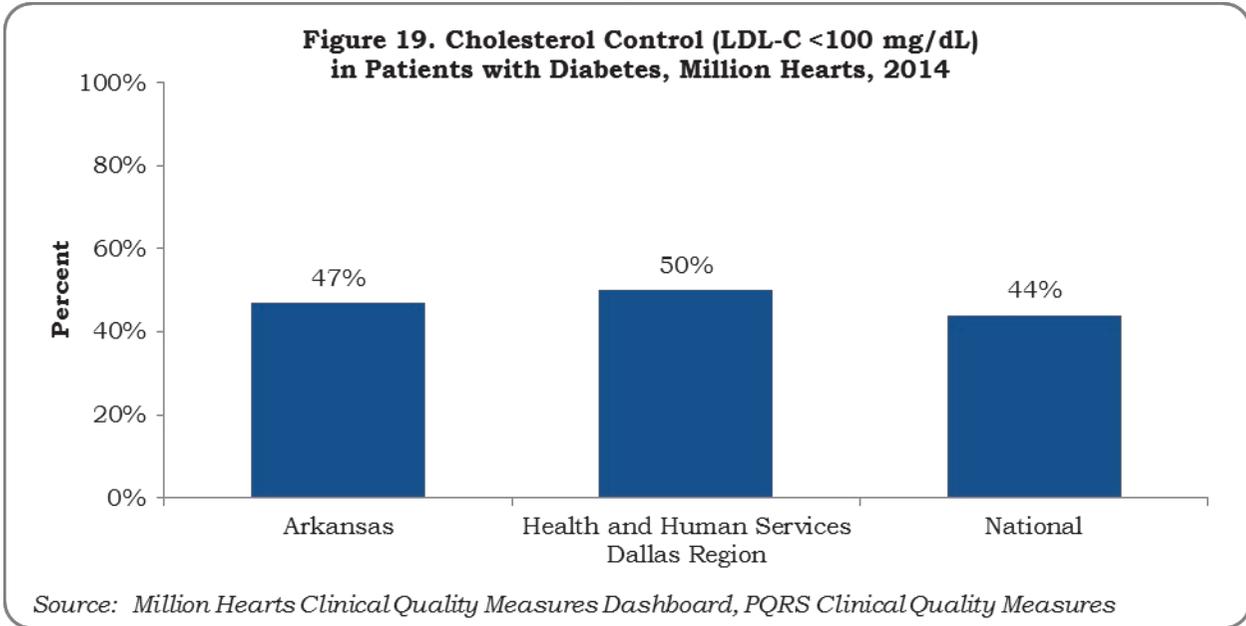
- For Arkansas and the U.S., the age-adjusted end-stage renal (kidney) disease mortality rate decreased by between 2003-2012. The decrease in end-stage renal disease mortality has been greater for the U.S. than Arkansas (Figure 16).



- The rate of hospitalizations for gestational diabetes i.e. diabetes occurring with pregnancy has increased between 2004 and 2013 for both Arkansas and the U.S. During this timeframe Arkansas had lower rates of gestational diabetes hospitalizations than the U.S. (Figure 17).

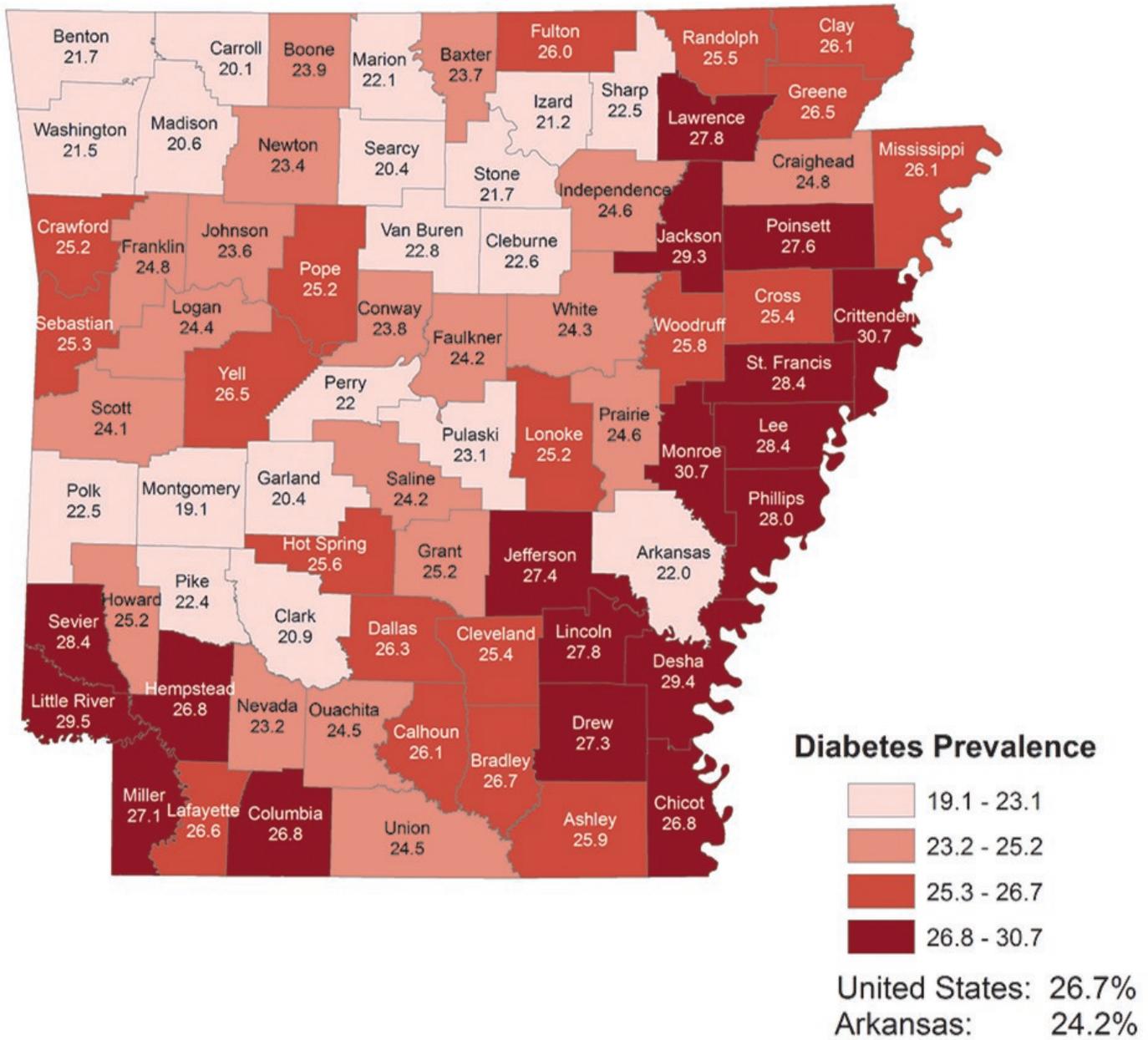


- EMR data show the prevalence of diabetes among the Medicare population has remained relatively steady over time for both Arkansas and the U.S. In 2014, the prevalence of diabetes among Medicare beneficiaries was 24.2% for Arkansas and 26.7% for the U.S. (Figure 18).



- The percentage of diabetes patients 18-75 years old with cholesterol under control (low-density lipoprotein [LDL-C] <100 mg/dl) in Arkansas was lower than that of the Health and Human Services Dallas Region, and higher than the national value in 2014 (Figure 19). The Million Hearts clinical target for LDL-C control among diabetic patients is 70%.
- Figure 20 (page 26) shows Arkansas’s diabetes prevalence among Medicare beneficiaries is higher in eastern and southern counties compared to state and national averages.

**Figure 20. Prevalence of Diabetes Among Medicare Beneficiaries  
Arkansas, 2014**



Date Created: January 16, 2016  
 Source: Centers for Medicare & Medicaid Services  
 Author: Brandy Sutphin, CPH, MPH, Chronic Disease Epidemiology Section



# HEART DISEASE & STROKE

## Heart Disease and Stroke Prevention Coalition

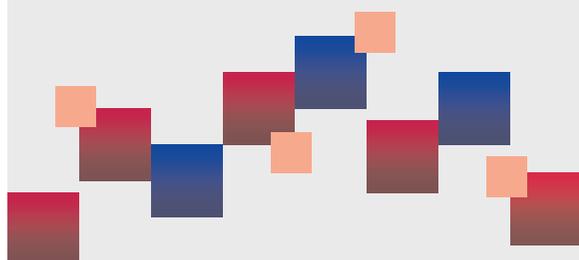
The Heart Disease & Stroke Coalition was established in 2000 to implement prevention interventions to reduce heart disease and stroke morbidity, mortality and related health disparities in Arkansas. The Coalition is composed of 27 internal and external organizations and has developed two state plans with the most recent published in 2012, *Cardiovascular Health: More Than Just preventing Heart Disease and Stroke*. The Coalition consists of four workgroups (Million Hearts™, Hypertension, Risk Factors for Youth and Adults and Policy and Education) that meets regularly and reports to the general membership.

### MISSION

Reduce deaths from heart disease and stroke and improve overall cardiovascular health among Arkansans.

### GOALS

- Increase** healthy behaviors among Arkansas youth
- Identify** and treat risk factors for heart disease and stroke among Arkansas youth
- Increase** healthy behaviors and improve the identification and treatment of adverse risk factors among Arkansas adults
- Improve** recognition and treatment of acute heart attacks and stroke among Arkansas adults
- Reduce** re-hospitalization rates for Arkansans recently discharged after a heart attack, stroke or heart failure
- Implement** policy and systems changes to improve local and state capacity to address heart disease, stroke and related factors among Arkansans.



As part of the new paradigm in healthcare, the Heart Disease and Stroke Prevention Coalition and the Chronic Disease Prevention and Control Branch is acknowledging and supporting the Million Hearts™ campaign. With the help of our partners, the ADH hopes to decrease the number of heart attacks and strokes among Arkansans and improve the overall health outcomes of our citizens.



Learn more about ADH's role in Million Hearts™ by viewing their page at <http://www.healthy.arkansas.gov/programsServices/chronicDisease/HeartDiseaseandStrokePrevention/Pages/MillionHearts.aspx>. This isn't the only activity with which the Heart Disease and Stroke Prevention Section is involved. Many others can be found on the activities page at <http://www.healthy.arkansas.gov/programsServices/chronicDisease/HeartDiseaseandStrokePrevention/Pages/Activities.aspx>.

## STATE PLAN

The Heart Disease and Stroke Prevention Coalition has a detailed short-term plan, "*Cardiovascular Health/More than Just Preventing Heart Disease and Stroke 2011-2015*," that reflects and refers to many of the objectives found in the Chronic Disease Coordinating Council's "*Framework for Action*." The full PDF of the plan can be found at <http://www.healthy.arkansas.gov/programsServices/chronicDisease/HeartDiseaseandStrokePrevention/Documents/CvhStatePlan.pdf>.

## RESOURCES

[American Diabetes Association](#)

[American Heart Association](#)

[American Stroke Association](#)

[CDC Division for Heart Disease and Stroke Prevention](#)

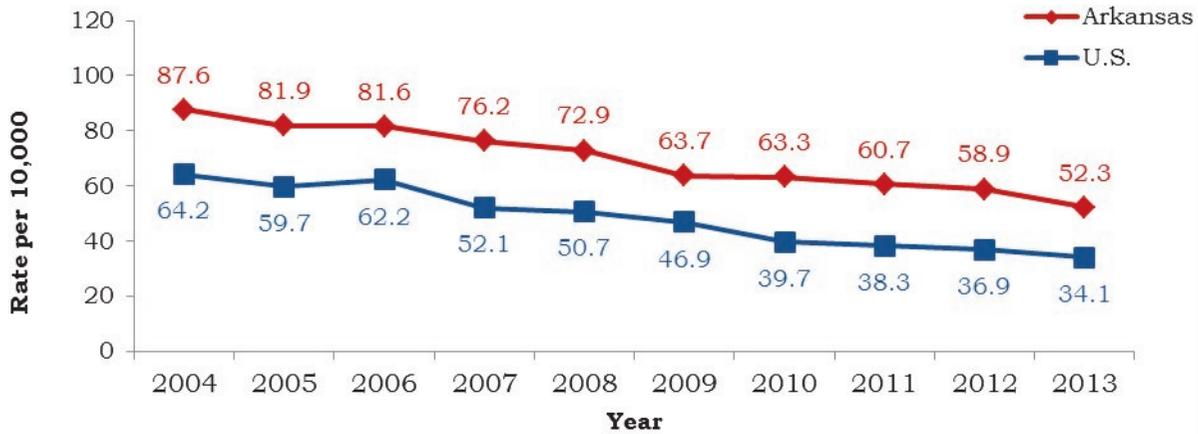
[National Association of Chronic Disease Directors](#)

[National Heart, Lung and Blood Institute \(NHLBI\)](#)

[National Institutes of Health](#)

[National Stroke Association](#)

**Figure 21 Hospitalizations for Coronary Heart Disease, Arkansas and United States, 2004-2013**

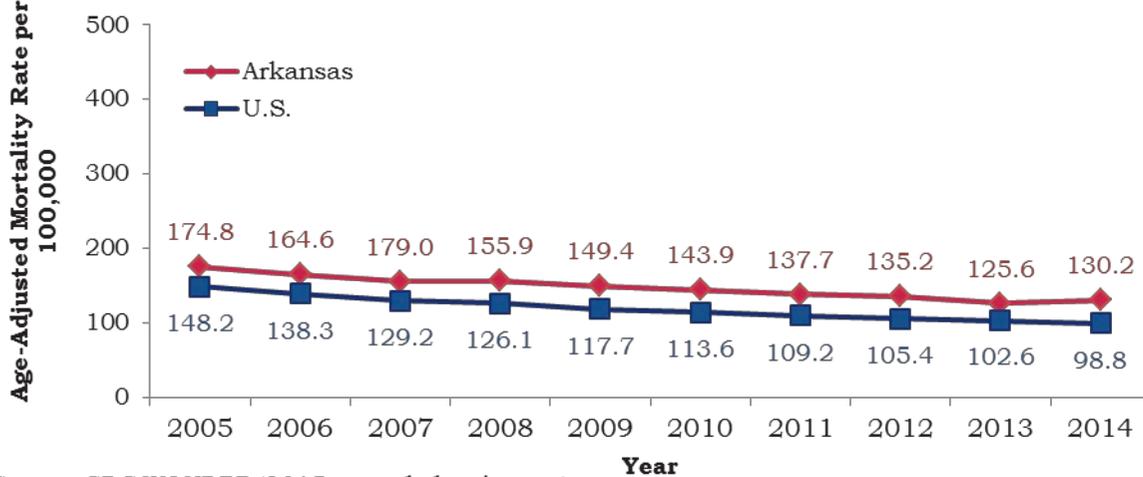


Source: HCUPnet (2015 amended estimates)

Note: Arkansas population obtained from UALR IEA State Level Population Estimates 2004-2013. US population obtained US Census.

- The rate of hospitalizations from coronary heart disease in Arkansas showed a decrease of 40.3 percentage points from 87.6 per 10,000 hospitalizations in 2004 to 52.3 per 10,000 hospitalizations in 2013. The state’s hospitalization rates were consistently higher than for the U.S. during this time period (Figure 21).

**Figure 22. Mortality Rate for Coronary Heart Disease, Arkansas and United States, 2005-2014**

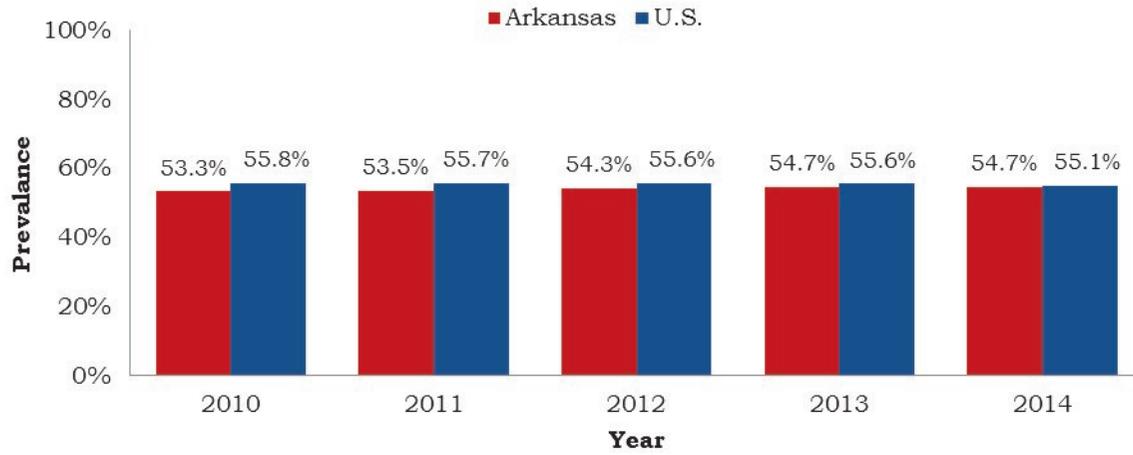


Source: CDC WONDER (2015 amended estimates)

Note: Rates are age-adjusted to the 2000 U.S. standard population.

- Heart disease is the single largest chronic disease causing death in Arkansas. Of this group of diseases, the largest contributor to deaths is coronary heart disease (CHD). The state’s age-adjusted CHD mortality rate showed a decrease of 25.5 percentage points from 174.8 deaths per 100,000 population in 2005 to 130.2 deaths per 100,000 population in 2014 (Figure 22).
- Arkansas’s rate of decline for CHD mortality is lower than the U.S. rate (Figure 22).

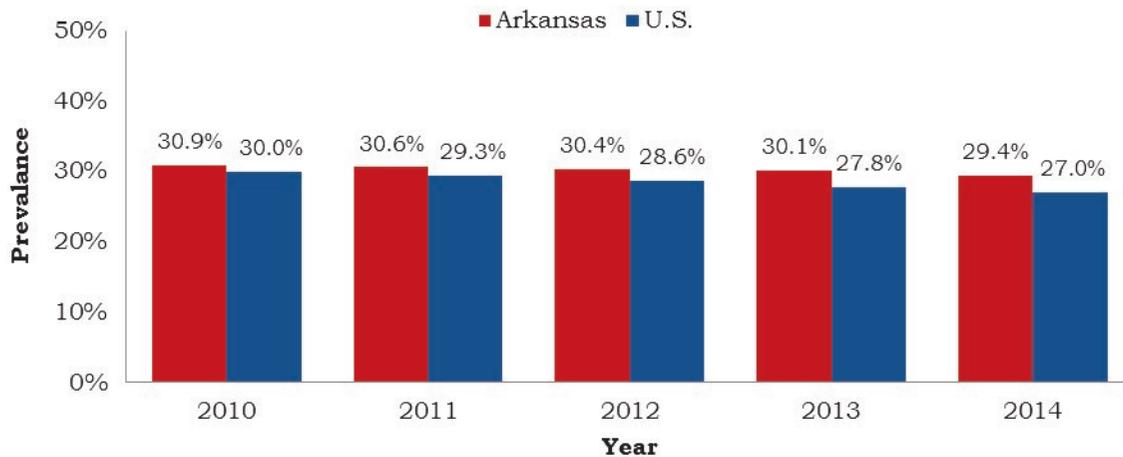
**Figure 23. Prevalence of Hypertension among Medicare Beneficiaries, Arkansas and United States, 2010-2014**



Source: Centers for Medicare and Medicaid Services, 2010-2014.

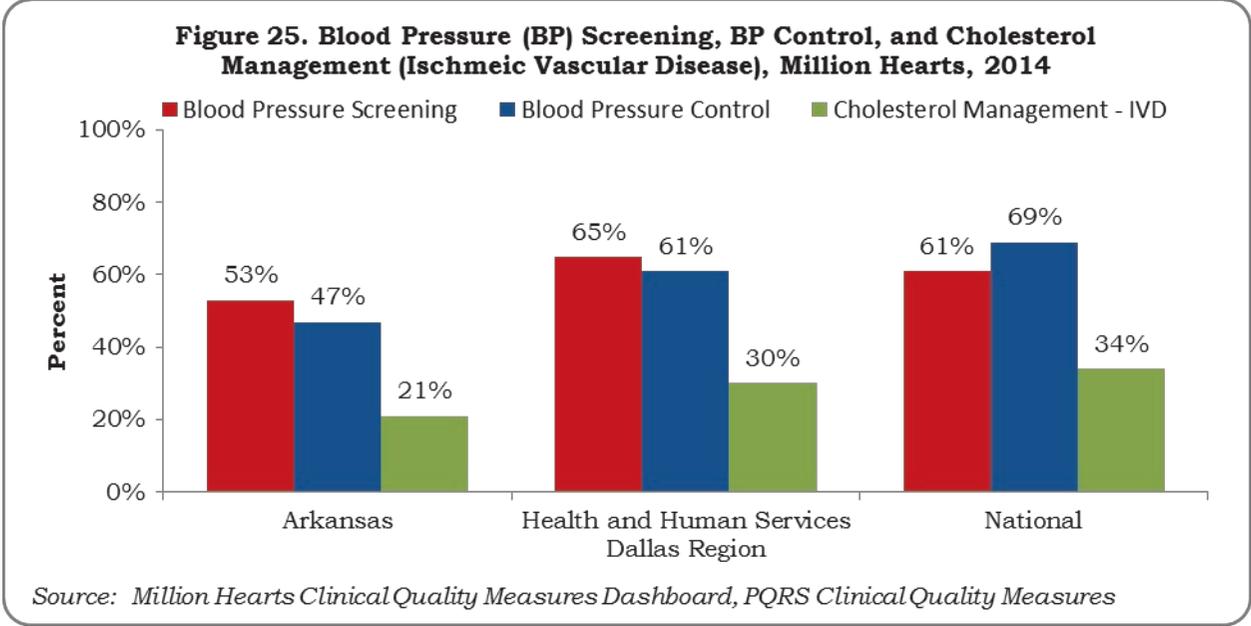
- The prevalence of hypertension as shown by EMR data among the Medicare population has increased over time for both Arkansas and the U.S. In 2014, the prevalence of hypertension among the Medicare population was 54.7% for Arkansas and 55.1% for the U.S (Figure 23).

**Figure 24. Prevalence of Coronary Heart Disease among Medicare Beneficiaries, Arkansas and United States, 2010-2014**



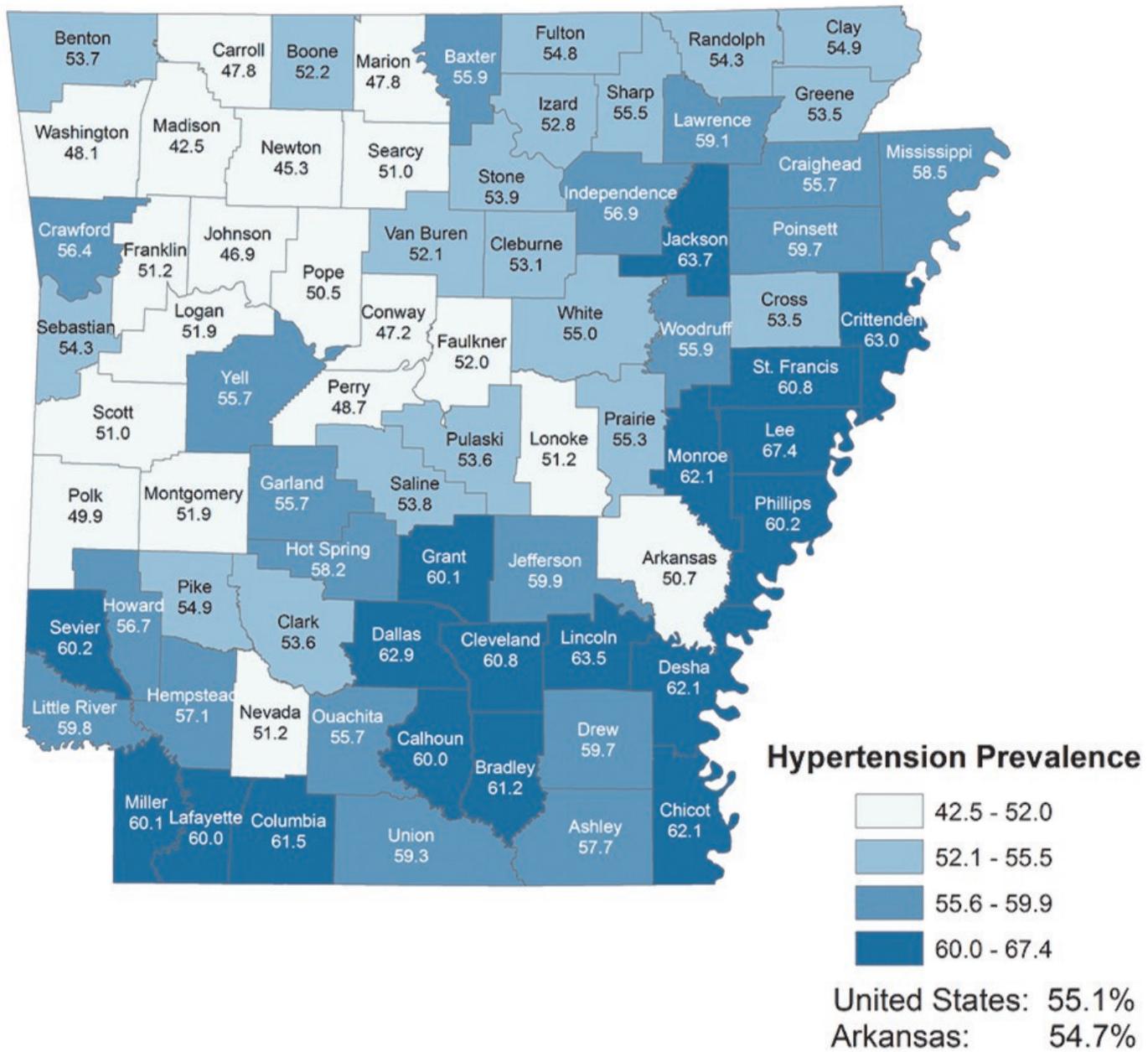
Source: Centers for Medicare and Medicaid Services, 2010-2014.

- EMR data show the prevalence of coronary heart disease among the Medicare population has decreased over time for both Arkansas and the U.S. (Figure 24). In 2012, the prevalence of coronary heart disease among the Medicare population was 29.4% for Arkansas and 27.0% for the U.S. (Figure 24).



- In 2014, the percentage of patients 18+ years old screened for blood pressure (BP) was lower for Arkansas (53%) than either the Health and Human Services (HHS) Dallas Region (65%) or National levels (61%) (Figure 25).
- The percentage of patients 18-85 years old diagnosed with hypertension and adequately controlled for blood pressure (BP <140/90 mmHg) was lower for Arkansas at 47% than either the HHS Dallas region at 61% or the Nation at 69%, in 2014 (Figure 25).
- Cholesterol Management for patients 18+ with Ischemic Vascular Disease (IVD) who had their low-density lipoprotein under control (LDL-C <100 mg/dl) in 2014, was lower for Arkansas at 21% than for the HHS Dallas Region at 30%, or the Nation at 34% (Figure 25).
- Arkansas, the HHS Dallas Region and the U.S. are yet to meet the Million Hearts clinical target of 70% for these three measures.
- Figure 26 (page 32) shows a higher than state and national prevalence of hypertension in southern and eastern counties of Arkansas.
- Figure 27 (page 33) shows the highest prevalence of coronary heart disease in the northeastern, central and southeastern counties of the state.

**Figure 26. Prevalence of Hypertension\* Among Medicare Beneficiaries  
Arkansas, 2014**



\*Blood Pressure >140/90 mmHg

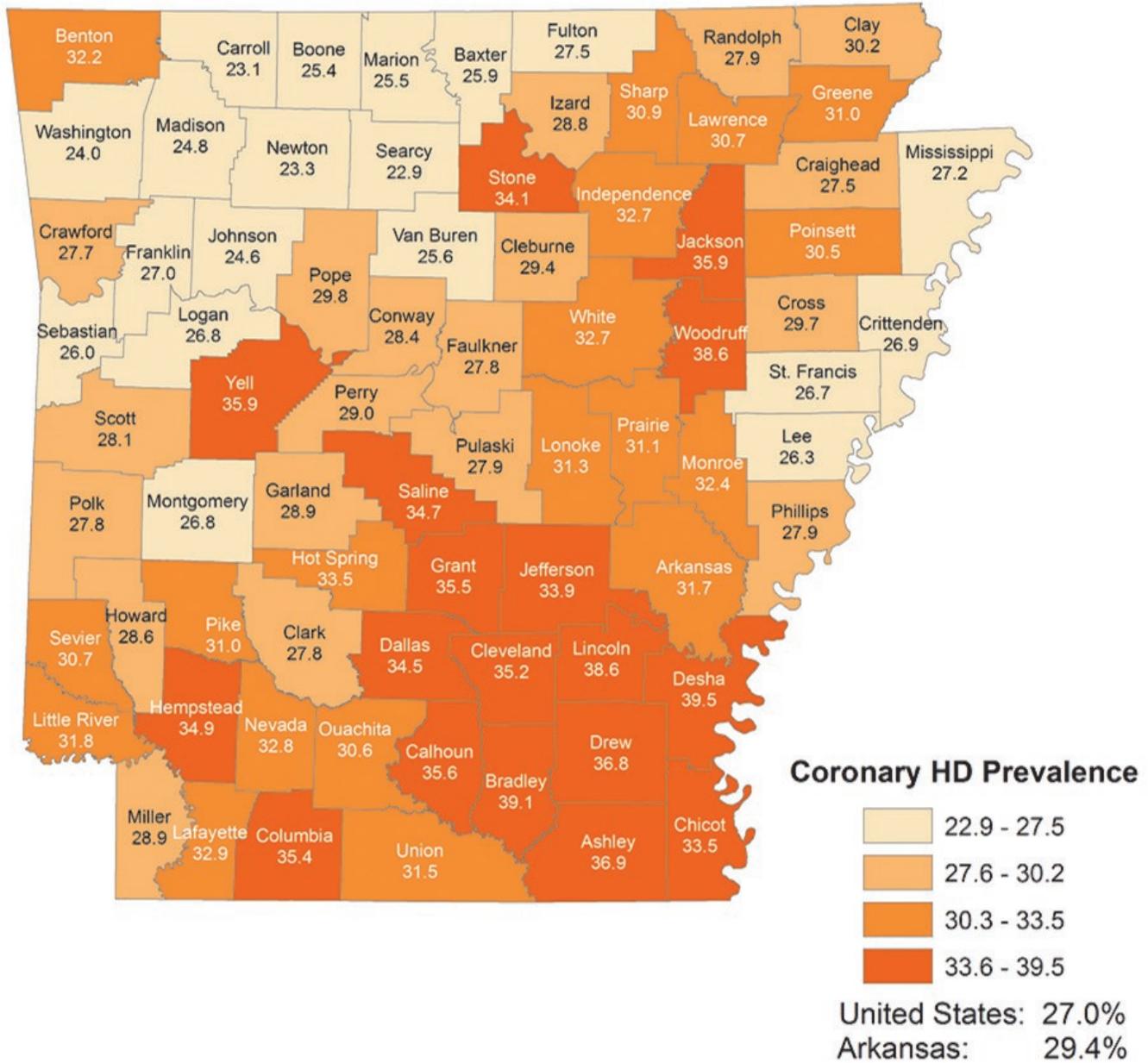
Date Created: January 16, 2016

Source: Centers for Medicare & Medicaid Services

Author: Brandy Sutphin, CPH, MPH, Chronic Disease Epidemiology Section

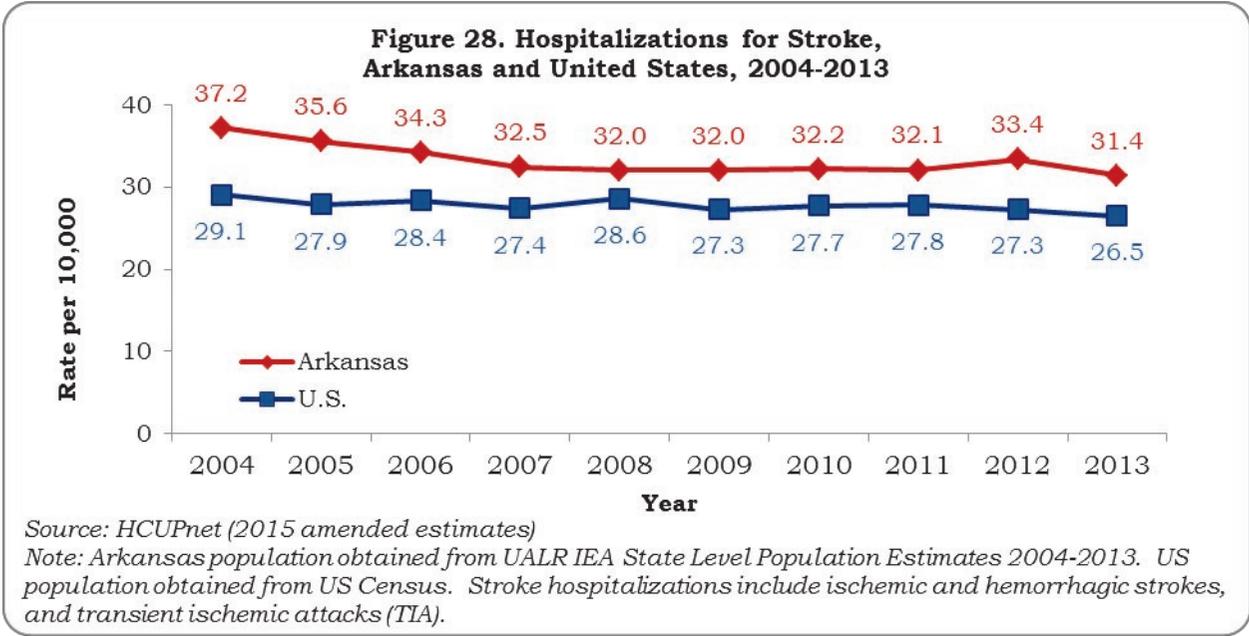


**Figure 27. Prevalence of Coronary Heart Disease Among Medicare Beneficiaries  
Arkansas, 2014**

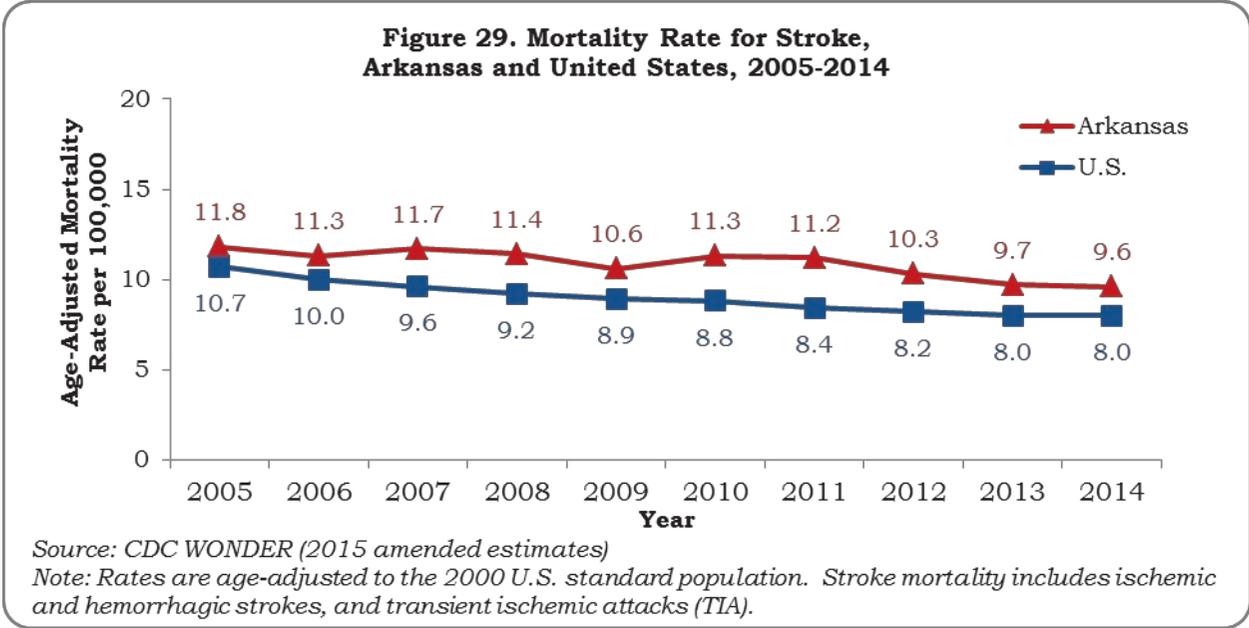


Date Created: January 16, 2016  
 Source: Centers for Medicare & Medicaid Services  
 Author: Brandy Sutphin, CPH, MPH, Chronic Disease Epidemiology Section



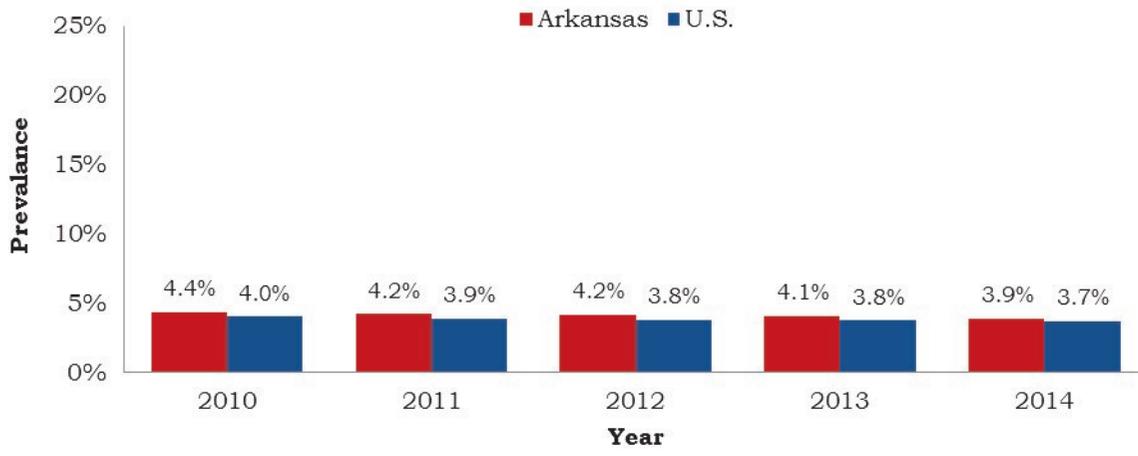


- Stroke hospitalization rates in Arkansas decreased from 37.2 per 10,000 hospitalizations in 2003 to 31.4 per 10,000 hospitalizations in 2013 (a decrease of 15.6 percentage points), but remained higher than the stroke hospitalization rate for the U.S (Figure 28).



- Since 2005, the age-adjusted stroke mortality rate has been on the decline for both Arkansas and the country, but Arkansas's stroke mortality rates have been consistently higher than national rates. Arkansas showed a decrease of 18.6 percentage points in stroke mortality from 11.8 deaths per 100,000 population in 2005 to 9.6 deaths per 100,000 population (Figure 29).

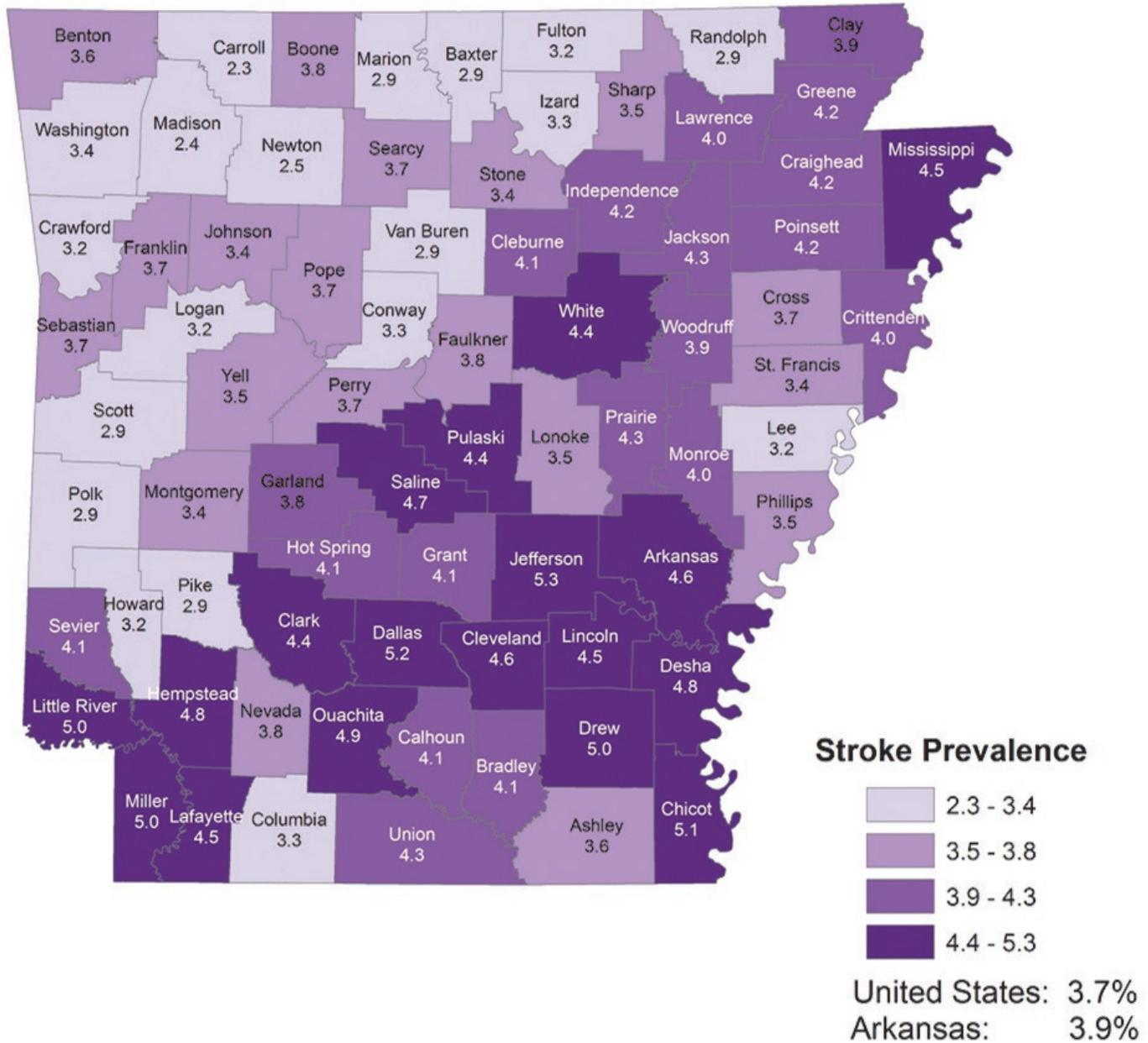
**Figure 30. Prevalence of Stroke among Medicare Beneficiaries, Arkansas and United States, 2010-2014**



*Source: Centers for Medicare and Medicaid Services, 2010-2014.*

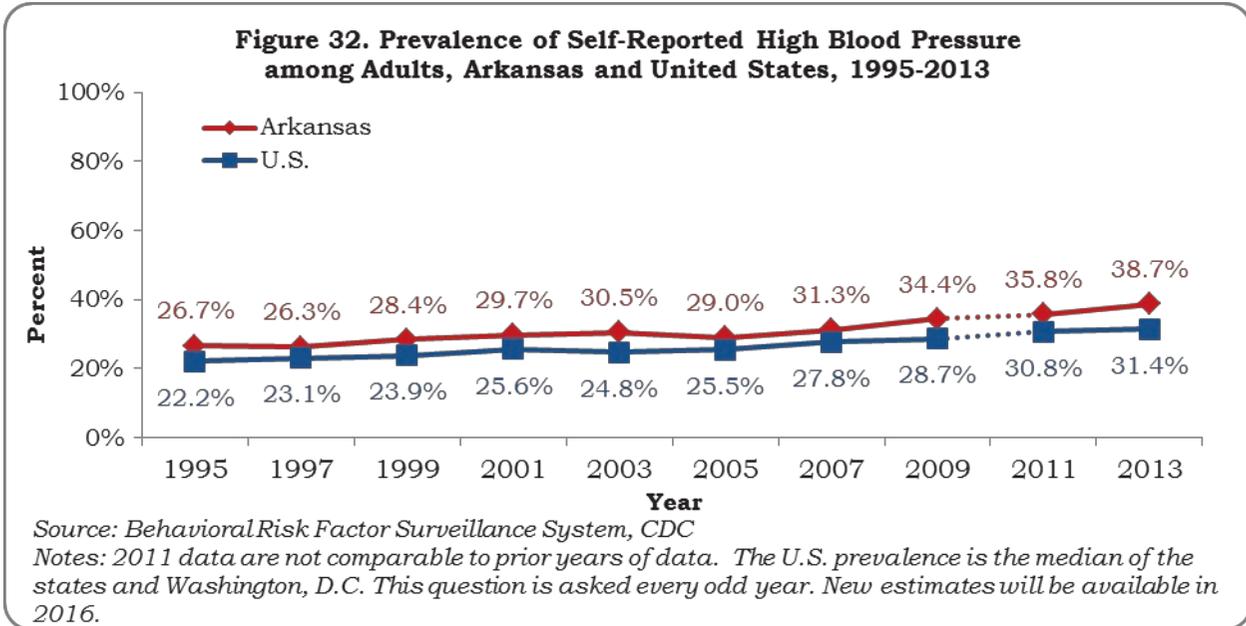
- EMR data show the prevalence of stroke among the Medicare population has decreased over time for both Arkansas and the U.S. In 2014, the prevalence of stroke among the Medicare population was 3.9% for Arkansas and 3.7% for the U.S. Arkansas's stroke prevalence has been consistently higher than the U.S. (Figure 30).
- Figure 31 (page 36) shows that stroke prevalence is highest in the central, northeastern and southern parts of Arkansas.

**Figure 31. Prevalence of Stroke Among Medicare Beneficiaries  
Arkansas, 2014**



Date Created: January 16, 2016  
 Source: Centers for Medicare & Medicaid Services  
 Author: Brandy Sutphin, CPH, MPH, Chronic Disease Epidemiology Section

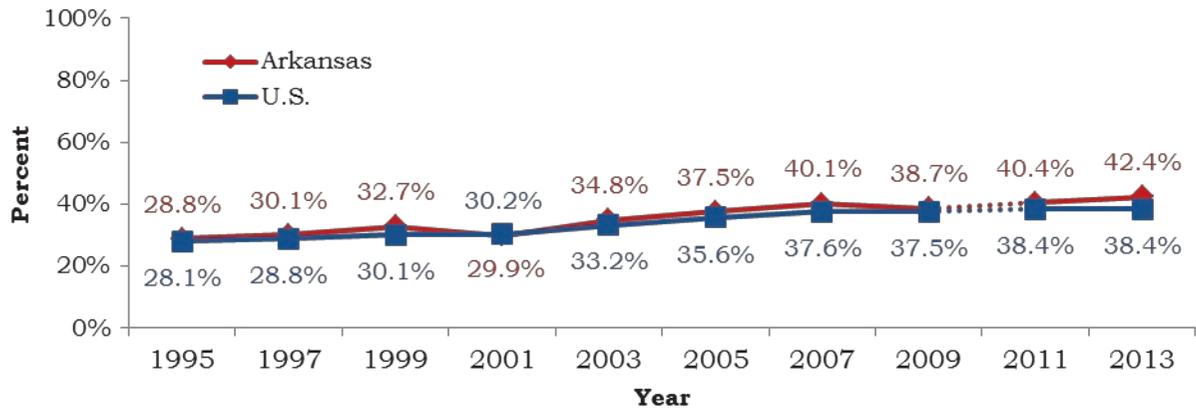




..... Indicates different weighting procedures and the inclusion of cellular telephones for years beginning with 2011. The data for 2011 and after are not comparable to previous years.

- The percent of Arkansan adults who self-reported that they had been told by a health professional that they had high blood pressure increased from 26.7% in 1995 to 34.4% in 2009. This upward trend is also seen for the U.S. In 2013, 38.7% of Arkansas adults self-reported having high blood pressure (Figure 37).
- Neither the state nor the nation met the Healthy People 2010 goal of 14% or less prevalence of high blood pressure.

**Figure 33. Prevalence of Self-Reported High Blood Cholesterol among Adults, Arkansas and United States, 1995-2013**



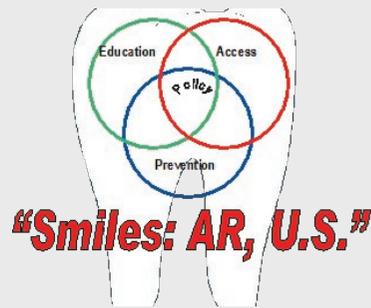
Source: Behavioral Risk Factor Surveillance System, CDC

Notes: 2011 data are not comparable to prior years of data. The U.S. prevalence is the median of the states and Washington, D.C. This question is asked every odd year. New estimates will be available in 2016.

..... Indicates different weighting procedures and the inclusion of cellular telephones for years beginning with 2011. The data for 2011 and after are not comparable to previous years.

- In 2013, 42.4% of Arkansas's adults self-reported they were told by a health professional that they had high cholesterol. Arkansas's prevalence for self-reported high cholesterol was greater than the national prevalence (42.4%) and the Healthy People 2010 target of 17% or less. The prevalence of self-reported high blood cholesterol in the state and in the U.S. has increased over time (Figure 33).

# ORAL HEALTH COALITION



The Arkansas Oral Health Coalition is a voluntary not-for-profit organization representing oral health stakeholders throughout Arkansas.

## MISSION

To promote life-long optimum oral health through primary prevention at the community, healthcare professional and family levels through accessible, comprehensive and culturally competent community-based oral health care provided through a variety of financing mechanisms; through educational opportunities throughout life that will allow individuals to make better decisions for their health; and through informed and compassionate policy decisions at all levels of government.

## GOALS

**Formulate** and promote sound oral health policy

**Increase** awareness of oral health issues

**Assist** in promotion of initiatives for the prevention and control of oral diseases

## Policies

The Arkansas Oral Health Coalition has adopted the following policies:

1. **Support for dental hygienists conducting dental screenings**
2. **Support for community water fluoridation**
3. **Support for healthy snacks in schools**

## State Plan

The burden of dental disease is far worse for those who have restricted access to prevention and treatment services. To address dental effectively, the Office of Oral Health (OOH), Arkansas Department of Health (ADH) and the Arkansas Oral Health Coalition developed a state oral health plan. The Oral Health Plan for Arkansas came from recommendations at the Governor's Oral Health Summit, in 2002. Funded by the Centers for Disease Control and Prevention (CDC).

Updated in 2013, the plan outlines a series of recommendations and strategies to promote oral health in Arkansas. The steps involve federal, state, and local initiatives. The plan focuses on education, access, prevention, and policy. A complete copy of the plan can be found at

[www.healthy.arkansas.gov/programsServices/oralhealth/Documents/AROHPlan.pdf](http://www.healthy.arkansas.gov/programsServices/oralhealth/Documents/AROHPlan.pdf)

## MAJOR PROJECTS

### **Monthly Meetings:**

The Arkansas Oral Health Coalition meets monthly except in December. For more information on meeting dates and times, please contact the Office of Oral Health, (501) 661-2051.

### **Annual Meeting:**

The Governor's Oral Health Summit serves as the venue for the semi-annual meeting of the Arkansas Oral Health Coalition. The all-day conference provides continuing education on dental issues of importance to everyone with an interest in public health Dentistry. For information on conference dates and times, please contact the Office of Oral Health, (501) 661-2051.

### **School-Based Dental Sealants:**

The Centers for Disease Control and Prevention (CDC) reports that tooth decay affects more than one fourth of U.S. children aged one to five years and one-half of those aged 12 to 15, and is almost entirely preventable. High risk children who are often from low-income families face access to care issues. Bringing sealant services to schools is a practical approach for increasing sealant prevalence. School-based sealant programs have the potential to link students with treatment services in their community and facilitate enrollment in Medicaid and CHIP. Arkansas Children's Hospital, Mena Healthy Connections, and Wakefield Dental Clinic/UALR Children's International, all Coalition members, conduct active and effective school-based sealant programs.

### **Community Water Fluoridation:**

Community water fluoridation, the adjustment of the existing fluoride levels in public drinking water systems to a level that reduces dental caries, has been demonstrated to be safe, economical, and effective in reducing decay for all people, regardless of age, race, ethnicity or socioeconomic status. In 2011, the Arkansas legislature passed ACT 197 which guarantees fluoridated water to all Arkansas Citizens who receive water from a water system with 5000 or more customers. The Delta Dental Foundation, a coalition member, is enabling this legislation by funding the equipment purchases needed by individual water systems to affect this law.

### **Arkansas Mission of Mercy (ArMOM):**

ArMOM is an annual two-day free dental clinic sponsored by the Arkansas State Dental Association, a coalition member, for underserved Arkansans. All services to relieve pain are provided free of charge by members of the Arkansas State Dental Association, assisted by a host of volunteers.

### **School-Based Dental Sealants:**

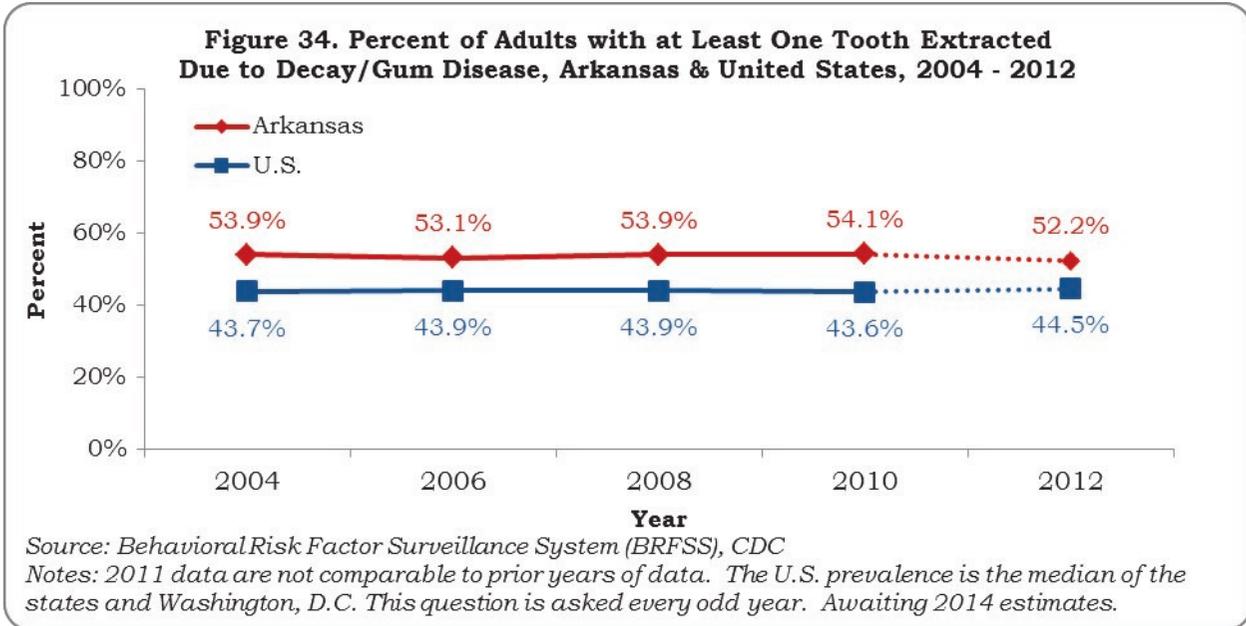
The Centers for Disease Control and Prevention (CDC) reports that tooth decay affects more than one fourth of U.S. children aged one to five years and one-half of those aged 12 to 15, and is almost entirely preventable. High risk children who are often from low-income families face access to care issues. Therefore, bringing sealant services to schools to reach these children is a practical approach for increasing sealant prevalence. Additionally, school-based sealant programs have the potential to link students with treatment services in their community and facilitate enrollment in Medicaid and CHIP. Arkansas Children's Hospital, Mena Healthy Connections, and Wakefield Dental Clinic/UALR Children's International, all Coalition members, conduct active and effective school-based sealant programs

**Fluoride Varnish- Paint a Smile:** During the 2011 Arkansas Legislative Session, the legislature passed a major oral health bill allowing physicians, nurses and other licensed health care providers to apply fluoride varnish to children's teeth. Fluoride varnish is a flavored substance that when painted onto a child's teeth at least twice a year has the potential to reduce decay by 30 percent. The Arkansas Oral Health Coalition in conjunction with the Office of Oral Health has joined forces to promote the use of fluoride varnish among pediatricians and family practice MDs and nurses. The use of fluoride varnish provides an excellent opportunity for physicians and nurses to observe the child's teeth, engage in oral health educational opportunities, and refer to a dental home when children are at high risk for oral disease.

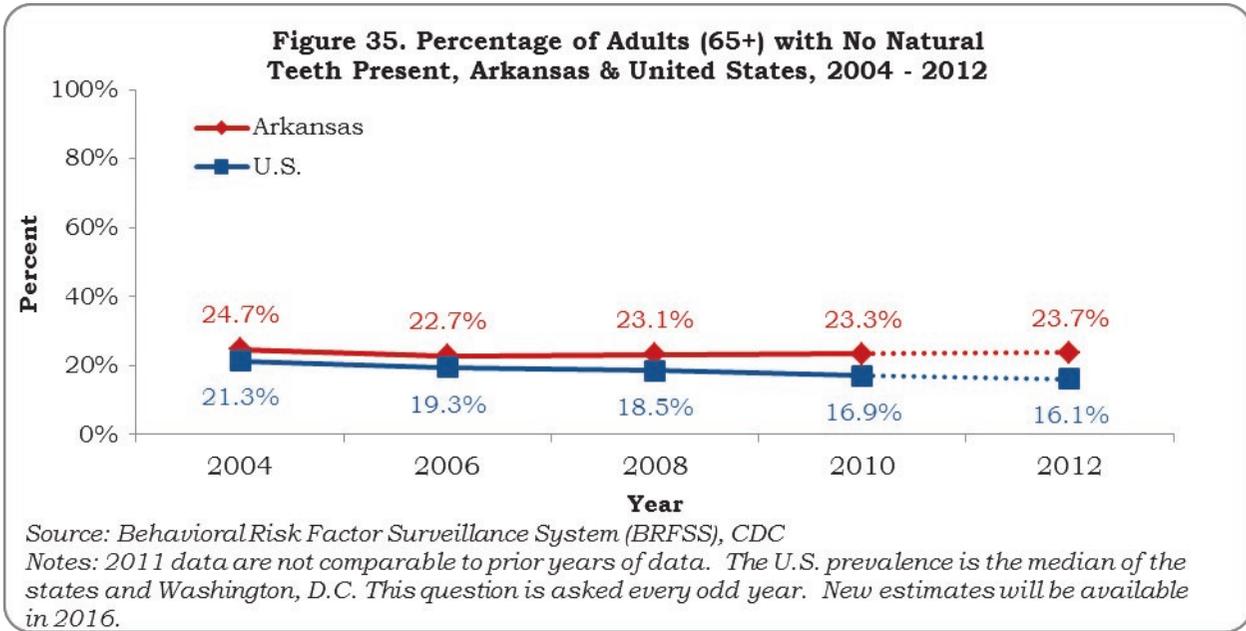
## OFFICE OF ORAL HEALTH

The Arkansas Oral Health Coalition is supported by the Office of Oral Health, Arkansas Department of Health, through CDC funding. The Office of Oral Health (OOH) was established within the Arkansas Department of Health in 1999. The vision for the Office is "optimum oral health for every citizen of Arkansas." To that end, the OOH provides resources and support for counties, communities, neighborhoods, schools, and professional groups to address oral health needs and disparities. More about the Office of Oral Health can be found at:

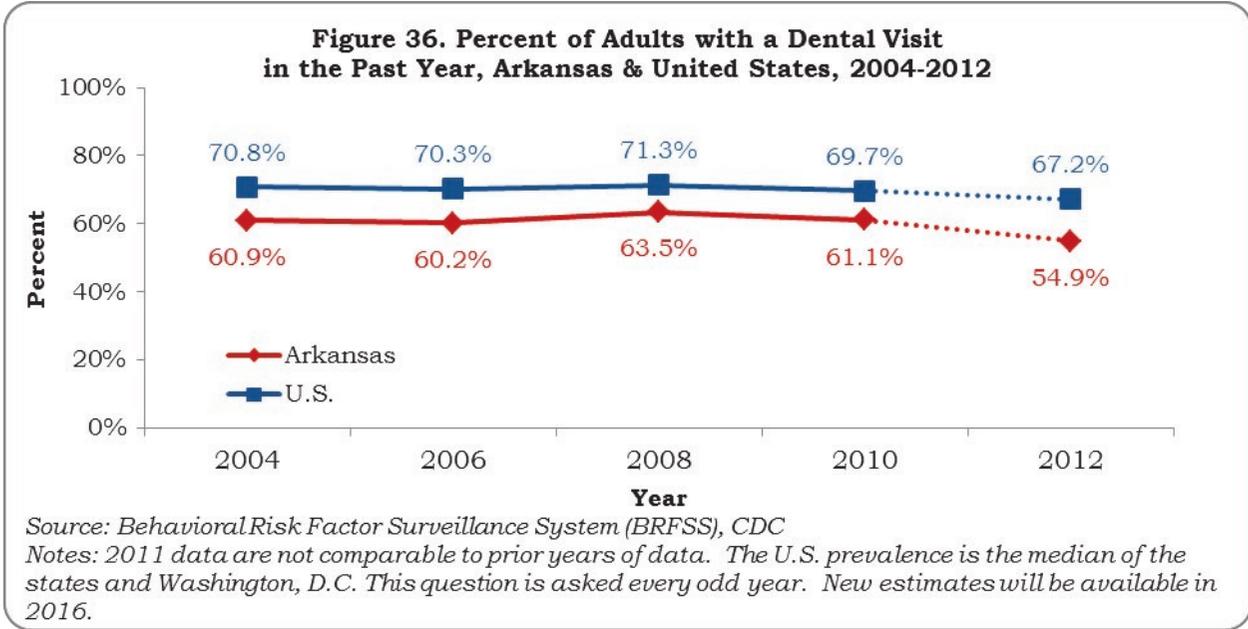
<http://healthy.arkansas.gov/programsServices/oralhealth/Pages/default.aspx>



- Indicates different weighting procedures and the inclusion of cellular telephones for years beginning with 2011. The data for 2011 and after are not comparable to previous years.
- In 2012, self-reported data showed over half (52.2%) of adults had at least one tooth extracted due to decay or gum disease. Arkansas has consistently had a higher self-reported rate of tooth extraction due to decay or gum disease than the U.S (Figure 34).



- Indicates different weighting procedures and the inclusion of cellular telephones for years beginning with 2011. The data for 2011 and after are not comparable to previous years.
- In 2012, self-reported data showed almost one-fourth (23.7%) of older Arkansas adults (ages 65 and older) reported not having any natural teeth. Arkansas remains higher than the U.S. for self-reported loss of natural teeth (Figure 35).



..... Indicates different weighting procedures and the inclusion of cellular telephones for years beginning with 2011. The data for 2011 and after are not comparable to previous years.

- Since 2004, there has been little change in the percentage of Arkansas and U.S. adults self-reporting a dental visit in the past year. The prevalence of adult dental visits in Arkansas was consistently lower than the U.S (Figure 36).

# ARKANSAS TOBACCO CONTROL COALITION



The Arkansas Tobacco Control Coalition (ArTCC) partners with the Arkansas Tobacco Prevention and Cessation Program to strengthen Arkansas's overall tobacco control program by engaging local stakeholders, local community leaders and the public in tobacco control activities.

Although ranked as 48th out of 51 in the nation for adult tobacco use, Arkansas is making definite headway in the fight against tobacco use. Smoking rates have decreased among adults from 2002 - 2014. Reductions in adult smoking have lowered hospital admissions for diseases related to tobacco use, such as heart disease, stroke, emphysema, and bronchitis. Despite this progress, there are still many areas in desperate need of improvement.

ArTCC engages in community mobilization and advocacy with decision makers in order to create local environments that demand policy change, both organizational and grassroots level.

## MISSION

The Arkansas Tobacco Control Coalition (ARTCC) is established to improve health status of all Arkansans and decrease healthcare costs and disparities using evidence-based strategies through policy initiatives to reduce tobacco use and the usage of electronic smoking devices.

## GOALS

- **Build** a strong statewide coalition
- **Smoke free** work places for all employees
- **Protect** residents and employees of nursing and rehab centers from secondhand smoke

# PROJECT PREVENT YOUTH COALITION



YOUTH TOBACCO &  
NICOTINE PREVENTION

The Project Prevent Youth Coalition (PPYC) partners with the Arkansas Tobacco Prevention Program to strengthen Arkansas's overall youth and young adult tobacco prevention program.

Our youth possess a powerful voice when it comes to standing up to Big Tobacco. PPYC provides youth around the state with some exciting, unique ways to engage with fellow youth advocates, inspire others, and spread knowledge.

## MISSION

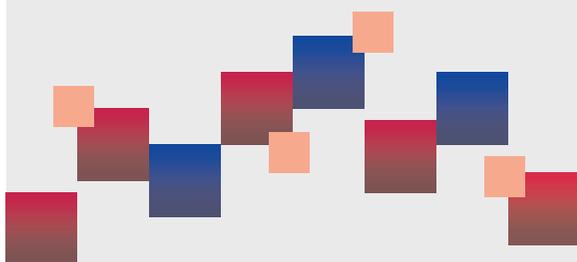
Project Prevent Youth Coalition is aiming for a happy, healthy, and tobacco-free Arkansas.

## GOALS

- **Engage** youth in peer to peer education
- **Engage** youth in advocacy to create local environmental and social norm change
- **Prevent** the initiation of tobacco use among youth and young adults
- **Protect** our youth from smoking or using tobacco products from Big Tobacco advertising

## MAJOR PROJECTS

Project Prevent is just getting started, but we have big plans! PPYC is looking for like-minded youth committed to advocating for tobacco-free communities in Arkansas where we live, work, and play. Just to name a few things, PPYC members will conduct surveys about the advertising from Big Tobacco or clean up their community to be free of tobacco litter.



## FAST FACTS

- Most recently the Surgeon General reported one out of every five deaths is attributable to tobacco use in the United States.
- Tobacco use rates in Arkansas for adults is 24.7% and 19.1% for high school aged children compared to 15.7% and 19% respectively in the nation (2014 YRBSS, BRFSS).
- Each year, 5,800 Arkansans die from tobacco use.
- An estimated \$1.2 billion are spent annually in Arkansas on smoking-related health care costs.
- Nonsmokers exposed to secondhand smoke increase their risk of developing lung cancer by 20-30%.
- Smoking kills more people than alcohol, AIDs, car crashes, illegal drugs, murders, and suicides combined.
- Big Tobacco Companies spend an estimated \$119 million on marketing in Arkansas annually to lure in our youth.
- Mothers who smoke during pregnancy are three times more likely to have a baby die of Sudden Infant Death Syndrome.

## SUCCESS STORIES

### *Legislative Success*

- 1st to have smoke-free car law protecting children under age 14
- 1st to have a smoke-free medical grounds law
- 1st to include e-cigarettes as part of smoke-free state-funded college campuses
- Among the first states to restrict sales of e-cigarettes and other electronic nicotine products to minors
- Among the first states to regulate e-cigarettes packaging and licensing
- 3rd to include statewide smoke-free psychiatric grounds

## RESOURCES

Arkansas Department of Health  
[www.healthy.arkansas.gov](http://www.healthy.arkansas.gov)  
 Centers for Disease Control and Prevention  
[www.cdc.gov/tobacco/](http://www.cdc.gov/tobacco/)  
 Surgeon General Report  
[www.surgeongeneral.gov/library/reports/50-years-of-progress/](http://www.surgeongeneral.gov/library/reports/50-years-of-progress/)  
 The Community Guide  
[www.thecommunityguide.org/tobacco/index.html](http://www.thecommunityguide.org/tobacco/index.html)  
 Tobacco Prevention and Cessation Program  
[Arkansas Tobacco Data Deck](http://ArkansasTobaccoDataDeck)  
 Campaign for Tobacco-free Kids  
[www.tobaccofreekids.org](http://www.tobaccofreekids.org)

## BEST PRACTICES

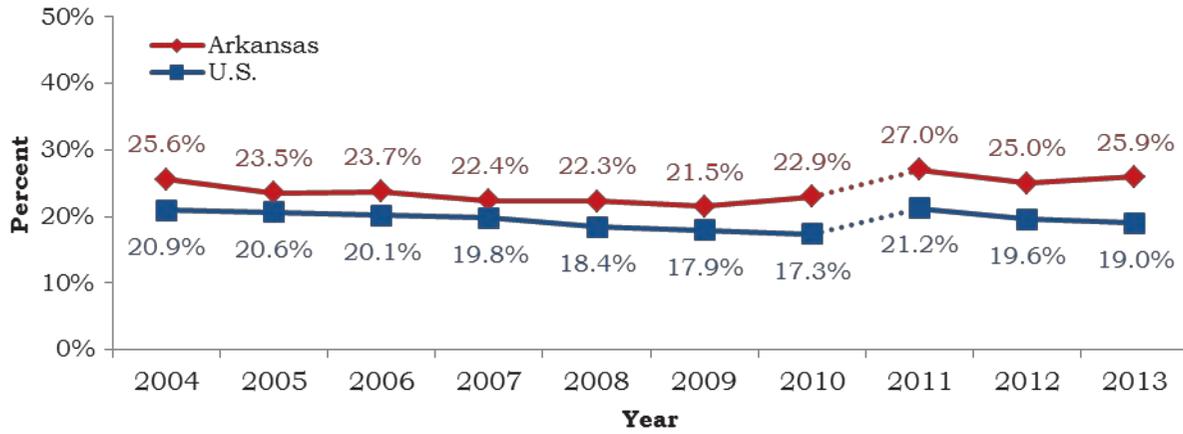
By following best practice, ArTCC and PPYC provide culturally and age-appropriate community action programs; create social and environmental change by encouraging and supporting individuals to make behavior choices consistent with tobacco-free norms; implement mass-reach media and digital media educational campaigns; and promote free quitline services through the Arkansas Tobacco Quitline. These efforts are in place to address the state goals:

- **Prevent** the initiation of tobacco use among youth and young adults
- **Promote** quitting among adults and youth
- **Eliminate** exposure to secondhand and thirdhand smoke/aerosol
- **Identify and eliminate** tobacco-related disparities among population groups

## HOW TO GET INVOLVED

- Become an active member of ArTCC to help change social norms and decrease the burden of tobacco use in Arkansas. Call 501-353-4249 or [www.cleartheairarkansas.com](http://www.cleartheairarkansas.com) for more information.
- Connect with ArTCC and members on social media by following AR Tobacco Control on Facebook, and ARTobaccoCC on Instagram and Twitter.
- Encourage youth to join the PPYC movement at [www.sosprojectprevent.com](http://www.sosprojectprevent.com). As a PPYC member, youth participates in a number of meetings, programs and projects that help raise awareness about the harmful effects of tobacco and nicotine use as well as bring social change.
- Encourage youth to “like” SOS Project Prevent’s [Facebook](#) page and share posts.
- Encourage youth to follow SOS Project Prevent on [Instagram](#) to receive information on how to become an advocate.
- Encourage healthcare providers to Ask, Advise, and Refer patients to the Arkansas Tobacco Quitline (1-800-QUIT-NOW).
- Share our images and infographics available at [www.stampoutsmoking.com](http://www.stampoutsmoking.com) and Stamp Out Smoking [Facebook](#) page to help educate Arkansans and promote free resources.
- Subscribe to the Stamp Out Smoking [YouTube](#) Channel and share our videos with your coalition members.
- Shop tobacco free. Visit [www.shoptobaccofree.org](http://www.shoptobaccofree.org) to find stores in your area that do not sell tobacco products.

**Figure 37. Prevalence of Self-Reported Current Smokers among Adults, Arkansas and United States, 2004-2013**



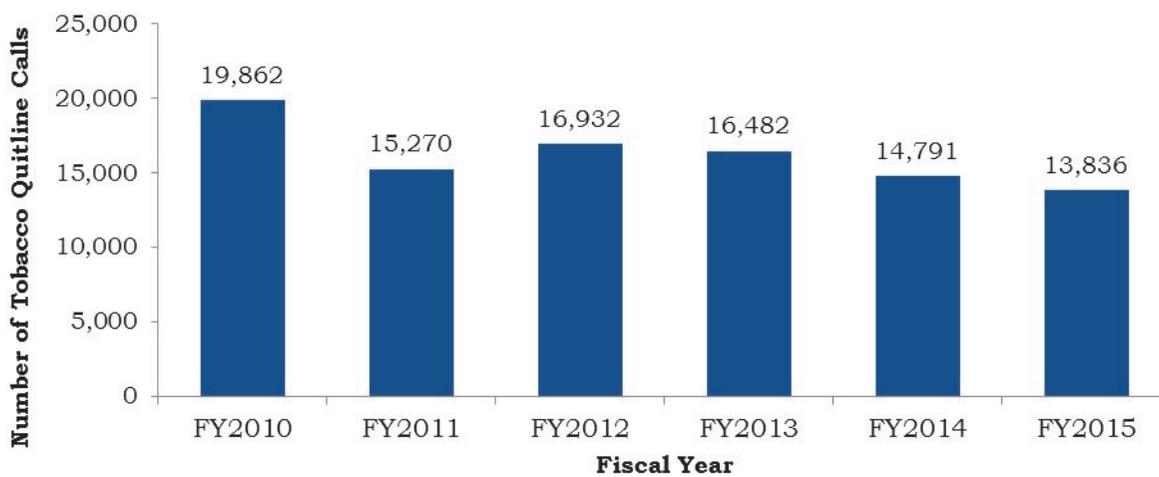
Source: Behavioral Risk Factor Surveillance System, CDC

Notes: 2011 data are not comparable to prior years of data. The U.S. prevalence is the median of the states and Washington, D.C. Awaiting 2014 estimates.

..... Indicates different weighting procedures and the inclusion of cellular telephones for years beginning with 2011. The data for 2011 and after are not comparable to previous years.

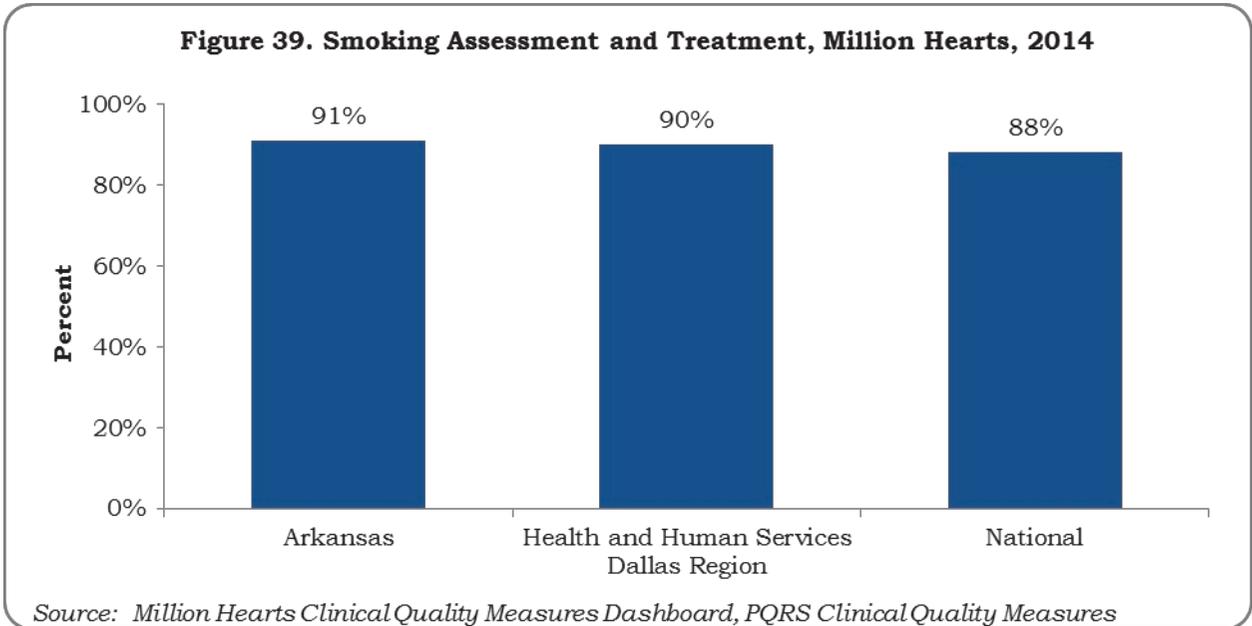
- The percentage of current self-reported adult smokers who smoked at least 100 cigarettes in their lifetime and currently smoke every day or some days declined slightly in Arkansas from 2004 to 2010. In 2013, 25.9% of Arkansas adults self-reported that they were current smokers, which was higher than the prevalence of self-reported current smokers in the nation (Figure 37).

**Figure 38. Arkansas Tobacco Quitline Calls, Fiscal Year 2010 to 2015**



Source: Arkansas Tobacco Prevention and Cessation Program

- The Arkansas Department of Health Tobacco Quitline for tobacco cessation counseling is available seven days a week, 24 hours a day. The program provides free and confidential support to help tobacco users quit (Figure 38).



- In 2014, the percentage of patients 18+ years old who were screened for tobacco use in the last 24 months and received cessation counseling if they were tobacco users was 91% in Arkansas. This prevalence rate was higher than both the Health and Human Services Dallas Region rate of 90% and the National rate of 88% (Figure 39).
- The Million Hearts clinical target is 70% of all patients assessed for smoking and provided cessation counseling if a tobacco user.

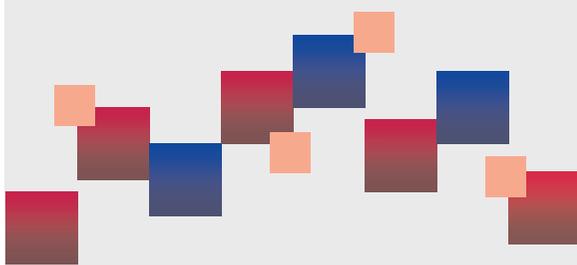
# SUPPORTING ORGANIZATIONS

## ARKANSAS DEPARTMENT OF HEALTH, Chronic Disease Prevention and Control

The goal of the Chronic Disease Prevention and Control (CDPC) Branch is to reduce the impact of chronic diseases and their risk factors in Arkansas. The CDPC Branch employs an integrated approach that encourages complete collaboration with each other and partners, with shared goals and resources, each implementing pieces in concert with each other to accomplish the goals of *Healthy People 2020: Arkansas's Chronic Disease Framework for Action*.

The Chronic Disease Prevention and Control (CDPC) Branch of the Arkansas Department of Health is organized around the following domains:

1. Healthy Communities Support: Developing healthy communities through environmental and policy changes that promote healthy living and maintain healthy individuals;
2. Health Care Systems Support: Working with clinical partners to develop systems of care that respond to patients' needs and provide evidence-based and guidelines-driven preventive, screening and treatment services;
3. Patient Empowerment Support: Creating clinical-community linkages that support and empower individuals in the community to take better care of themselves and their chronic conditions, therefore reducing the chances of relapse and preventable additional encounters with health care providers;
4. Data and Evaluation Support: Improving the quality of data on which better decisions and policies can be based; and
5. Partnership and Policy Support: Building better partnerships to improve collaboration and coordination, and support for policy development and dissemination.



## CHRONIC DISEASE PREVENTION AND CONTROL INITIATIVES

### **Diabetes, Heart Disease, Obesity and Associated Risk Factors**

In 2013, Arkansas received funding from CDC to coordinate public health actions to prevent and control diabetes, heart disease, obesity and associated risk factors and promote school health. This initiative aims to prevent and reduce the risk factors associated with childhood and adult obesity, diabetes, heart disease, and stroke; and to improve management of chronic diseases.

### **Arkansas BreastCare Program**

The Arkansas Department of Health has received grants from the Centers for Disease Control and Prevention in since 1993 to implement the BreastCare program and other cancer initiatives. In 2015, a Colorectal Screening Grant was also received from CDC. Grant activities have included studying how many Arkansas women had breast and cervical cancer; identification of Arkansans across the state to screen, diagnose and treat if needed; and development of public and professional educational materials.

### **Arkansas Stroke Registry**

In 2010 state funding was received, through the Arkansas Acute Stroke Care Task Force, to implement a statewide hospital-based stroke registry. The Arkansas Stroke Registry collects stroke data concerning emergency transport, clinical evaluations, diagnosis and treatment of adult patients presenting to hospitals with an admitting diagnosis of stroke.

## CONTACT INFORMATION

<http://www.healthy.arkansas.gov/programsServices/chronicDisease/Pages/default.aspx>

## ARKANSAS CENTER FOR HEALTH IMPROVEMENT (ACHI)

The Arkansas Center for Health Improvement (ACHI) was formed in 1998 as an innovative solution to the health crisis faced by Arkansas. Data show that Arkansans consistently fall well below national health standards – high numbers are uninsured, lack access to quality health care or face racial health disparities. Many adults and children have unhealthy lifestyles and behaviors that significantly contribute to the crisis.

ACHI believes that Arkansans' poor health status will not improve until root causes are addressed and effective health policies and initiatives that allow our citizens to alter behaviors and that measurably improve health are established statewide. Working with public and private-sector partners, ACHI is a catalyst for improving the health of Arkansans through evidence-based research, public issue advocacy, and collaborative program development.

Since its inception, ACHI has become a trusted health policy leader, receiving both state and national recognition for its efforts to continue debate, dialogue, and development of strategies that advance the health and productivity of Arkansas residents.

The Arkansas Center for Health Improvement (ACHI) is a nonpartisan, independent health policy center dedicated to improving the health of Arkansans. It is jointly supported by the University of Arkansas for Medical Sciences, the Arkansas Department of Health, Arkansas Blue Cross and Blue Shield, and Arkansas Children's Hospital.

## CONTACT INFORMATION

Phone: (501) 526-2244

<http://www.achi.net/index.asp>

## ARKANSAS DISABILITY AND HEALTH PROGRAM

The Arkansas Disability and Health Program was established in 2001 through a grant from the Centers for Disease Control and Prevention. The program is located at Partners for Inclusive Communities (a program of the University of Arkansas). Partners for Inclusive Communities is Arkansas's University Center on Excellence in Disability.

### MISSION

To improve the health and wellness of Arkansans with disabilities.

### GOALS

**Increase** health promotion opportunities for people with disabilities to maximize their health

**Improve** access to health care for people with disabilities

**Build** capacity within state public health to reach people with disabilities through their programs and services

**Increase** awareness of health-related disability policy initiatives

### CONTACT INFORMATION

Phone: (501) 301-1100

<https://uofapartners.uark.edu/arkansas-disability-and-health-program/>

## ARKANSAS FOUNDATION FOR MEDICAL CARE

Centers for Medicare & Medicaid Services (CMS) recently transformed the Quality Improvement Organization (QIO) program to better facilitate and guide health care quality improvement efforts throughout the country. Arkansas Foundation for Medical Care (AFMC) is now part of a team that was recently awarded a CMS five-year contract to be the Quality Innovation Network-QIO for Texas, Arkansas, Missouri, Oklahoma, and Puerto Rico effective Aug. 1, 2014.

What was once a state-based QIO leading the quality improvement and utilization review efforts has now been reconfigured into a new delivery model or Quality Improvement Network (QIN) that will include state consortiums comprised of four other states.

This evolution reflects the shifting priorities and changing approaches to quality care among health care managers and policy makers. Over the last three decades, the overall philosophy of the QIO program has moved from quality assurance (which focuses on individual cases) to quality improvement (which aims to improve overall patterns of care). As the health care needs of Americans continue to evolve, so too, does the work of AFMC.

AFMC will focus on diabetes self-management education, value-based modifiers, PQRS, care transition and cardiovascular health. AFMC will work with providers, patients, families, Medicare and Medicaid beneficiaries, and others to support Arkansas Department of Human Services (DHS) and CMS goals.

Through our QIN-QIO networks, Stakeholder/Partners, Medicare Beneficiaries and Participating Providers will have access to virtual Learning and Action Networks (LAN) and coalitions, educational tools, technical support, and one-on-one consultation.

AFMC works with other organizations and entities to create a health care system that rewards quality and ensures safety.

### CONTACT INFORMATION

Julie Kettlewell, State Program Director, TMF QIN-QIO

Phone: (501) 212-8740

[jkettlewell@afmc.org](mailto:jkettlewell@afmc.org) [www.TMFQIN.org](http://www.TMFQIN.org)

## AMERICAN LUNG ASSOCIATION IN ARKANSAS

The American Lung Association is the leading organization working to save lives by improving lung health and preventing lung disease through education, advocacy and research. For more than 100 years, we have led the fight for healthy lungs and healthy air, whether it's searching for cures to lung diseases, keeping kids off tobacco, or fighting for laws that protect the air we all breathe.

### MISSION

To save lives by improving lung health and preventing lung disease.

### VISION

A world free of lung disease.

### GOALS

The American Lung Association is the leading organization working to save lives by improving lung health and preventing lung disease, through research, education and advocacy. Our work is focused on five strategic imperatives: to defeat lung cancer; to improve the air we breathe; to reduce the burden of lung disease on individuals and their families; to eliminate tobacco use and tobacco-related diseases; and to monitor and enhance organizational effectiveness.

### CONTACT INFORMATION

American Lung Association in Arkansas  
14524 Cantrell Rd, Suite 140 | Little Rock, AR  
72223  
501.975.0758  
[lungAR.org](http://lungAR.org)

## ARKANSAS MINORITY HEALTH COMMISSION

### MISSION

To ensure all minority Arkansans have access to health and health care that is equal to the care provided to other citizens of the state and to seek ways to provide education, address issues and prevent diseases and conditions that are prevalent among minority populations.

### FY 2014-2018 GOALS

**Goal #1:** Increase the number of minority Arkansans that obtain recommended screening for diseases that disproportionately impact minorities

**Goal #2:** Increase the number of minority Arkansans who receive education regarding diseases that disproportionately impact minorities

**Goal #3:** Establish a system of Supported Navigation to help minority citizens identify and gain access to appropriate health and health care resources in their communities

**Goal #4:** Establish a collaborative network of stakeholders to address workforce diversity and education of health care professionals regarding diseases that disproportionately affect minorities

**Goal #5:** Establish a network of coordination and collaboration with other agencies and organizations addressing the health of minority populations

**Goal #6:** Establish a constituency of individuals, community-based organizations, and communities committed to the mission and goals of AMHC

**Goal #7:** Advocate for policy that will promote the health of minority Arkansans

### CONTACT INFORMATION

523 Louisiana, Suite 425  
Little Rock, AR 72201  
(501) 686-2720  
[www.arminorityhealth.com](http://www.arminorityhealth.com)

## ARTHRITIS FOUNDATION SOUTHEAST DIVISIONAL REGION, ARKANSAS

### MISSION

The Arthritis Foundation is the Champion of Yes. Leading the fight for the arthritis community, the Arthritis Foundation helps conquer everyday battles through life-changing information and resources, access to optimal care, advancement in science and community connections.

### GOAL

Our goal is to chart a winning course, guiding families in developing personalized plans for living a full life - and making each day another stride towards a cure.

### CONTACT INFORMATION

10 Corporate Hill Drive  
Suite 220  
Little Rock, AR 72205  
Phone: (501) 708-2917  
Fax: (501) 664-6588  
[www.arthritis.org/arkansas](http://www.arthritis.org/arkansas)

## COMMUNITY HEALTH CENTERS OF ARKANSAS

Community Health Centers of AR (CHCA), Primary Care Association for Arkansas, is a non-profit organization formed in 1985 to create a statewide unified voice within Arkansas for Federally Qualified Health Centers (FQHCs).

CHCA is dedicated to providing technical assistance, training and resources for its eleven member FQHCs and their 70+ sites. CHCA collaborates with state and federal partners, organizations and policy makers to positively influence changes to policies, regulations, and legislation which impede or strengthen the health centers' ability to provide affordable, accessible, comprehensive, quality health care services to the uninsured, underserved, Medicare and Medicaid Arkansans.

CHCA is governed by a board of directors composed of one director from each organizational member of CHCA. The member FQHCs, also known as Community Health Centers (CHCs), provide local, patient-centered, accessible, coordinated care through a team-based approach stressing quality and safety. They provide, on a sliding fee scale based on federal poverty guidelines, primary and preventive care services that are culturally competent, literacy-appropriate and linguistically appropriate. The CHCs are also "Economic Engines," generating job opportunities and resources for their local communities.

### CONTACT INFORMATION

119 S. Izard St.  
Little Rock, AR 72201  
Phone: (501) 374-8225; Fax: (501) 374-9734  
<http://www.chc-ar.org/>

## FAY W. BOOZMAN COLLEGE OF PUBLIC HEALTH at UAMS

The College's vision is *Optimal Health for All*, and its mission is *to improve the health and promote the well-being of individuals, families, and communities in Arkansas through education, research, and service*. The focus of the College is on population health – not on treating the individual patient, but on managing the health of an entire population through disease prevention, promoting positive health behaviors, and effective public policy. Community engagement is a guiding principle of the research activities of the College, as well as student learning, and is supported by its Office of Community-based Public Health.

The College's educational programs are based in five core public health disciplines – biostatistics, environmental and occupational health, epidemiology, health behavior and health education, and health policy and management – and offer 24 degree and certificate options at the post-baccalaureate, master and doctoral levels.

Research at the College has a strong focus on chronic disease and the elimination of health disparities, especially those impacting racial and ethnic minorities. The College is home to the Arkansas Prevention Research Center (ARPRC) and the Arkansas Center for Health Disparities.

The ARPRC conducts community-based, participatory research, currently focused on the southeastern Arkansas Delta region. As a member of the national network of Prevention Research Centers (PRCs), the ARPRC functions as a local, regional, and national resource for developing and applying effective prevention programs and strategies at the community level.

The mission of the ARCHD is the development of research to improve access to quality prevention and health care programs for racial and ethnic minorities with a goal of reducing health disparities. The Center focuses on chronic disease disparities with an emphasis on cardiovascular disease, diabetes, obesity, and cancer.

### CONTACT INFORMATION

The web site of the College of Public Health provides reports and publications that are useful to public health program planners and researchers.

<http://www.publichealth.uams.edu/>

## HOMETOWN HEALTH IMPROVEMENT (HHI)

Through a strategic planning initiative, the Arkansas Department of Health determined that to solve today's health problems would require cooperative action and creative solutions at the local level. The health of the community is a shared responsibility of many entities. Hometown Health Improvement (HHI) brings together a wide range of people and organizations including consumers, business leaders, health care providers, elected officials, religious leaders, and educators to identify community health problems and develop and implement ways to solve them. HHI initiatives currently exist in every county in the state. HHI coalitions do powerful and unique work to improve the health of those in their communities.

### GOALS

Hometown Health Improvement is a locally owned and locally controlled initiative that stresses:

- **Collaboration**
- **Coalition** building
- **Community** health assessment
- **Prioritization** of health issues
- **Development** and implementation of community health strategies that are locally designed and sustained

### CONTACT INFORMATION

Center for Local Public Health  
4815 W. Markham, Slot 22  
Little Rock, AR 72203-1437

Office: (501) 280-4561

Fax: (501) 661-2545

Cell: (501) 425-3376

<http://www.healthy.arkansas.gov/programsServices/hometownHealth/HHI/Pages/default.aspx>



ARKANSAS DEPARTMENT OF  
**Health**

