

Changing the Culture of Health in Arkansas

A Coordinated Approach to Health Promotion and Prevention of Chronic Diseases and Related Complications

The Chronic Disease Programs of the Arkansas Department of Health have led a process resulting in a coordinated plan to incorporate chronic disease efforts across the full spectrum of agencies, organizations and institutions involved in prevention and health promotion efforts. This plan ensures linkages, consistency, coordination and joint funding in order to maximize resources in the state. It also reflects the numerous efforts planned to address obesity through nutrition and physical activity strategies – making it the definitive plan for addressing obesity in Arkansas.

PLANNING BY INVOLVED PARTNERS

Representatives from public and private sector organizations were included to provide a balanced view of obesity, chronic diseases and appropriate strategies to adopt. Department of Health representatives included the Nutrition and Physical Activity Coordinators, funded through the Obesity Prevention Program, as well as the Program Coordinator. The Directors of Tobacco Prevention, Breast and Cervical Cancer, Diabetes, Arthritis, Cardiovascular Health, Five-A-Day represented those Federally funded programs in the deliberations and plan development.

The following listing reflects key stakeholders and leaders from state and community organizations included in the planning process.

* indicates partners who have taken the lead on one or more of the objectives or strategies

AARP	University of Arkansas Cooperative Extension Service*
Arkansas Center for Health Improvement	Arkansas Minority Health Commission
Arkansas Department of Health*	League of United Latin American Citizens
Arkansas Department of Education	Department of Human Services, Division of Aging and Adult Services
Arkansas Disability Coalition	Department of Human Services, Division of Services for the Blind
Arkansas Chapter, American Heart Association	American Association of Physical Education, Recreation and Dance*
Arkansas Hospital Association	Arkansas Hospitality Association
Arkansas Medical Dental and Pharmaceutical Association	Coalition for a Tobacco-Free Arkansas
Arkansas Office of ADA	Students Working Against Tobacco
Arkansans for Drug Free Youth	State Board of Health
American Lung Association	Arkansas Foundation for Medical Care
Arkansas Medical Society	
Baxter Regional Medical Center	

Arkansas Blue Cross and Blue Shield

Community Health Centers of Arkansas*

White River Rural Health Center

Living with Lupus Foundation

Arkansas Chapter, Arthritis Foundation

University of Arkansas for Medical Sciences,
Rural Hospital Program, College of Public
Health*

Individual Podiatrist

Arkansas General Assembly House Member

Arkansas Cancer Coalition*

Arkansas Healthy Aging Coalition

Consumer Representatives

Arkansas Parks and Tourism

Arkansas State University at Jonesboro

5-A-Day Coalition*

Governors Council on Fitness*

University of Arkansas at Pine Bluff

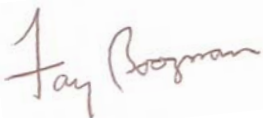
The burden of chronic diseases, including diabetes, stroke, heart and lung diseases, and cancer is higher in Arkansas than in the nation generally. Based on any number of indicators, Arkansas is one of the least healthy states in the country. Heart disease and stroke continue to be the leading cause of death in Arkansas and the nation. The burden of chronic disease in Arkansas and the increased risk of citizens in the state to chronic diseases are directly linked to a lack of physical activity, poor eating habits and poor lifestyle choices, including the use of tobacco products.

Reducing the burden of chronic disease is a task of such magnitude that only a combined effort of many organizations and individuals will result in success. Under the Healthy Arkansas Initiative, policy makers, health professionals and business leaders have partnered to change the culture of health throughout the state. The Chronic Disease State Plan illustrates the result of such a partnership. Through this plan, and other Healthy Arkansas activities, Arkansas is set on a course to reach the Healthy People 2010 goals in obesity, physical inactivity and tobacco use.

Public and private sector organizations, educational institutions and professional organizations, and major medical facilities have combined their efforts under the banner of the Chronic Disease Planning Team to publish Changing the Culture of Health, the Healthy Arkansas Plan a comprehensive plan for chronic disease prevention and health promotion in Arkansas. The plan addresses the full range of chronic disease: primary prevention, medical treatment and control, and prevention of secondary events such as obesity, high blood pressure, high cholesterol and diabetes.

We applaud and support the efforts of health professionals and public and private partners in the development of this plan and look forward to continuing partnerships and collaboration for its implementation.

Sincerely,

A handwritten signature in brown ink that reads "Fay Boozman". The signature is written in a cursive, flowing style.

Fay Boozman, MD, MPH
Director
Arkansas Department of Health

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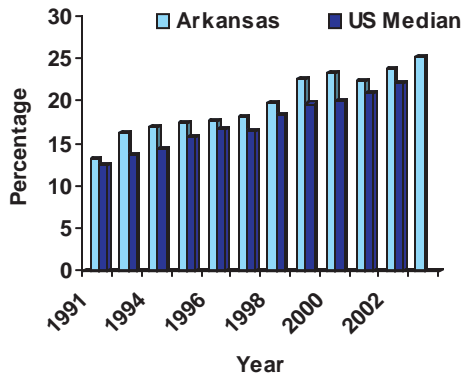
Circumstances that could Influence the Plan

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DISEASE BURDEN IN ARKANSAS

Obesity is a substantial and pressing problem in Arkansas. For the past 12 years, the prevalence of obesity among adults in the state has been above the national median (see Figure 1). In the most recent year for which data are available from the Behavioral Risk Factor Surveillance Survey (2003), some 25 percent of Arkansas adults can be classified as obese, and an additional 36 percent were overweight. In 2002, the last year for which comparison data are available, Arkansas ranked 13 among the 52 states and territories – among the most obese states in the nation.

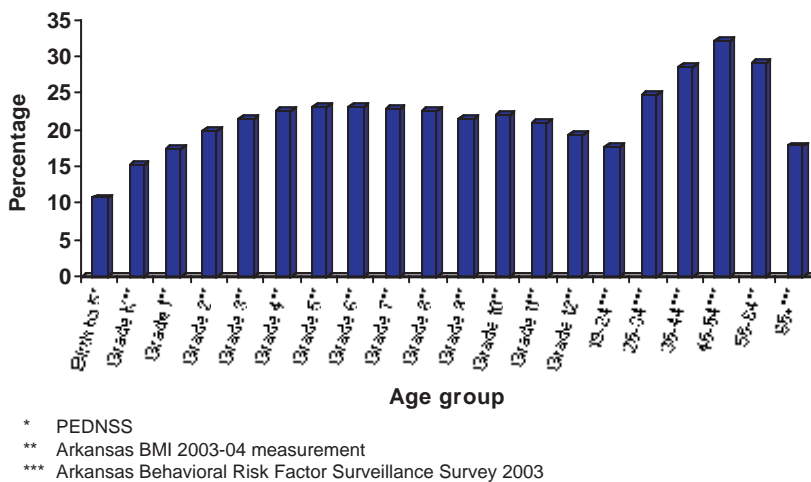
Figure 1: Obesity, Arkansas and US Median, 1990 - 2003



Obesity represents a growing problem in the state. Over the past decade the percentage of adults in the state who are obese has nearly doubled, increasing from 13 percent in 1991 to 25 percent in 2003 (see Figure 1). This alarming trend shows no signs of abating and, if continued, is estimated to result in more than 1 million overweight or obese Arkansans by the year 2020.

Data from multiple sources -- including the Pediatric Nutrition Surveillance System, the Arkansas Act 1220 BMI measurements, and the Behavioral Risk Factor Survey -- indicate that obesity is a problem that affects every age group in the state (see Figure 2). Starting with preschool aged children and continuing with every age group as indicated, Arkansas residents show higher percentages of obesity than the nation overall.

Figure 2: Overweight/obese by age category, Arkansas, various data sources

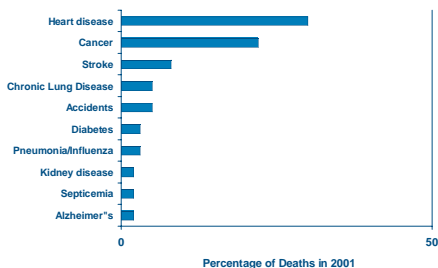


The data suggest that overweight/obese status peaks for youth in the middle school years, with some overall decline in the high school years. However, rates climb dramatically from young adulthood through middle age, with a marked decline among persons age 65 and older. The same data sources indicate substantial weight disparities among racial/ethnic groups among children, young adults, and adults in the state. Overall, African Americans are more likely to be overweight than their white counterparts. For example, among Arkansas school children, 24 percent of African American and 26 percent of Hispanic youth are overweight, compared to 20 percent of whites. These data suggest that the health of Arkansans is substantially threatened by high levels of obesity. Concentrated and comprehensive efforts to address the issue within all age groups of the state and in multiple settings will be important to arresting this disturbing trend.

Heart disease and cancer currently account for many more deaths than influenza, pneumonia, and AIDS combined, and are the leading causes of death for both men and women within all racial and ethnic groups in Arkansas.

Figure 3

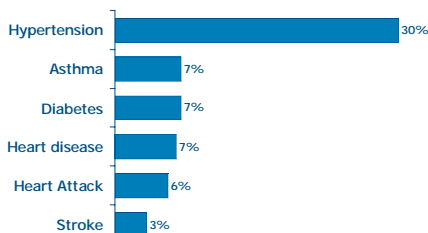
Leading Causes of Death in Arkansas, 2001



In the year 2001, the leading causes of death in Arkansas were heart disease and cancer (see Figure 3). Eight of the ten leading causes of death were chronic, non-infectious conditions. Chronic diseases also account for large portions of the direct and indirect costs of health care, including inpatient and outpatient medical care, home health care, pharmaceuticals, lost productivity, and lost years of productive life. Chronic diseases, thus, are a significant component of the disease burden within the state and an important component of public health activities in Arkansas.

Information about the proportion of Arkansas residents who deal with various chronic disease conditions is limited. The best source of that information is the Behavioral Risk Factor Surveillance Survey (BRFSS), a telephone survey administered annually within the state. The estimates of disease occurrence obtained from the BRFSS are based on self-report and are not confirmed with laboratory or other diagnostic testing.

In 2003, the BRFSS indicated that the most common chronic condition faced by Arkansas adults is hypertension, with 30 percent of respondents indicating that they had been told by a physician that they had high blood pressure (see Figure 4). Seven of every 10 Arkansas adults had been told that they had diabetes and/or heart disease, or reported that they had asthma. Approximately 6 percent of Arkansans had been told they had had a heart attack (myocardial infarction) and 3 percent had been told they had had a stroke.

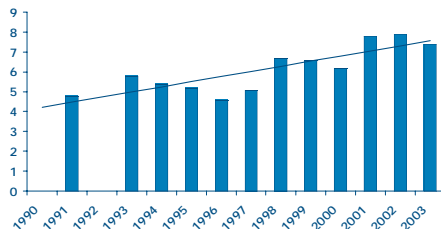
Figure 4
Prevalence of Chronic Disease Conditions,
Arkansas 2003

Source: BRFSS 2003

A review of selected conditions for which data are available, 1990 through 2000 indicates that the proportion of Arkansas adults who are affected by these conditions is increasing in Arkansas.

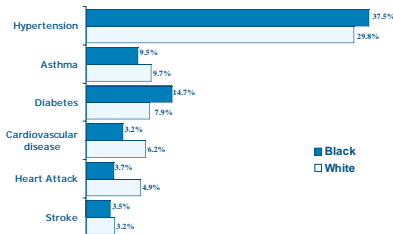
For example, diabetes, as depicted in Figure 5, has increased from 5 percent in 1991 to just over 7 percent in 2003, a growth of some 54 percent. While data from the BRFSS are not available to document trends in other conditions (for example, cardiovascular disease and asthma), data from national surveys such as the National Health Interview Survey and the National Health and Nutrition Examination Survey suggest increasing national trends in these conditions as well. If these trends continue, the health care systems will be likely be burdened beyond capacity.

Figure 5
Trends in Prevalence of Diabetes, Arkansas Adults, 1990-2003



Source: BRFSS

Figure 6
Prevalence of Chronic Disease Conditions, By Racial/Ethnic Group, Arkansas 2003

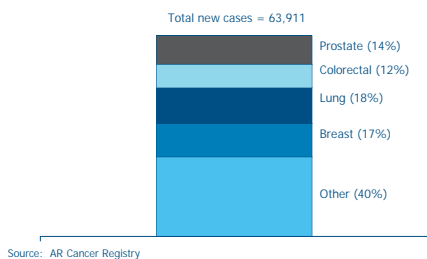


Source: BRFSS 2003

The burden of disease is not equally distributed across racial and ethnic groups. For example, hypertension and diabetes are substantially more common among blacks than whites, while asthma is more commonly reported by whites. It is interesting to note that, although hypertension is more common among blacks, approximately the same proportions of blacks and whites reported having had a stroke, and more whites than blacks reported having cardiovascular disease (i.e., angina, heart disease) and/or a heart attack.

Arkansas' cancer registry tracks the occurrence of new cancer cases among the state's residents. The registry receives

Figure 7
Incidence, Cancer by Type, Arkansas 1997-2001



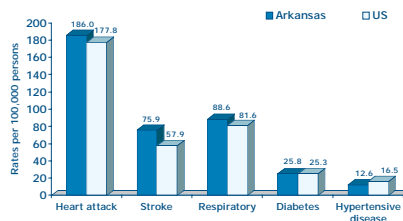
Source: AR Cancer Registry

information from physicians, laboratories, and hospitals across the state. Overall, in the years 1997 through 2001 combined, the registry recorded nearly 64,000 new cases of cancer, or an average of approximately 12,780 cases per year. The most frequent forms of cancer were breast and lung cancer, each accounting for approximately 11,000 new cancer cases in the period (see Figure 7). Also during the 5-year period, approximately 9,000 cases of prostate cancer and another 7,700 cases of cancer of the colon and rectum were documented, accounting for one of every in four new cancer cases. Taken together, these four common forms of cancer accounted for 6 of every 10 new cancer cases occurring in the period.

Deaths from chronic disease conditions accounted for a substantial portion of the mortality burden in Arkansas. The leading cause of mortality, both in Arkansas and in the United States overall, was heart disease, followed by cancer. As noted in Figure 8, mortality rates for cardiovascular disease (heart attacks and stroke), and respiratory diseases were higher in Arkansas than in the United States.

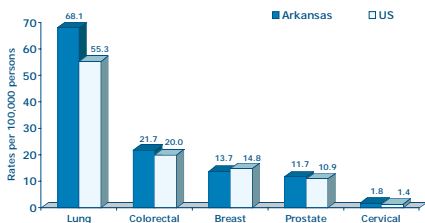
Similarly, the cancer mortality rate (all sites combined) for Arkansas (208 deaths per 100,000 persons) is higher than the national rate of 196 deaths per 100,000 persons. Lung cancer evidenced a mortality rate of 68 deaths per 100,000 persons, and this rate was higher than that observed in the US population overall (see Figure 9). In comparison, cancers of the colon and rectum accounted for some 22 deaths per 100,000 persons in the population, and breast and prostate cancer had rates of 14 and 12 deaths (respectively) per 100,000 persons. All of these rates were essentially comparable to the national rates.

Figure 8
Mortality rates, Arkansas and United States, 2001



Source: CDC: all rates age-adjusted to 2000 standard million; all rates per 100,000 persons.

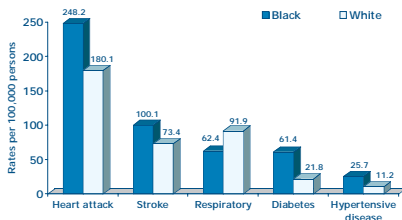
Figure 9
Site-specific cancer mortality rates,
Arkansas and United States, 2001



Source: CDC, all rates age-adjusted to 2000 standard million; all rates per 100,000 persons

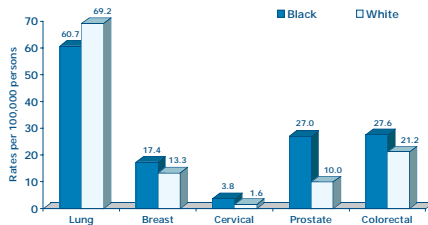
Disparities are noted between racial and ethnic groups in mortality as well as in prevalence of disease. As seen in Figure 10, mortality rates associated with heart attack, stroke, diabetes, and hypertensive disease are substantially higher among blacks than whites, while rates of mortality associated with respiratory diseases are higher among whites. Similarly, mortality rates associated with breast, cervical, prostate, and colorectal cancer are higher among blacks than among whites (see Figure 11). Mortality rates associated with lung cancer are higher among whites.

Figure 10
Mortality rates by Racial/Ethnic Group, Arkansas 2001



Source: CDC, all rates age-adjusted to 2000 standard million; all rates per 100,000 persons

Figure 11
Cancer mortality rates, by Racial/Ethnic Group,
Arkansas, 2001

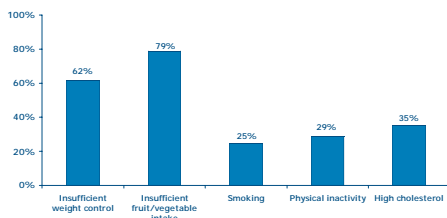


Source: CDC, all rates age-adjusted to 2000 standard million; all rates per 100,000 persons

CURRENT STATUS: RISK BEHAVIORS REPORTED BY ARKANSAS ADULTS

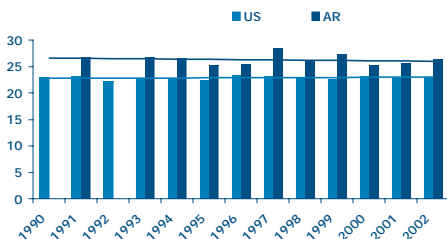
A number of factors contribute to the development of chronic diseases. Some of these factors – such as age, gender, race or ethnic origin, family history, genetic predisposition, and others – cannot be changed. Some factors associated with disease development and severity, however, are modifiable. It is those modifiable risk factors that are the focus of many public health prevention and control efforts.

Figure 12
Risk Factors Among Arkansas Adults



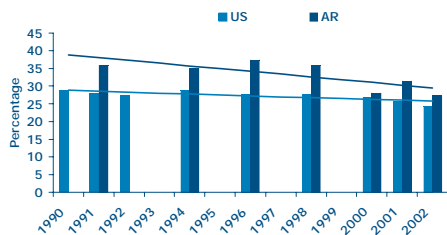
Source: BRFSS 2003

Figure 13
Trends in Adult Smoking, Arkansas versus US, 1990-2002



Source: BRFSS

Figure 12
Trends in Physical Inactivity, Arkansas versus US, 1990-2002



Source: BRFSS

The Behavioral Risk Factor Surveillance Survey (BRFSS) provides information each year about the status of Arkansas adults in terms of those modifiable risk factors. The most recent information available from this survey (see Figure 12) indicates that more than three-quarters of the state’s adults reported that they do not consume the recommended five servings of fruits and/or vegetables daily, and only a third reported that they were physically active in their daily lives. Given these findings, it is not surprising that a majority (62%) of Arkansas’s adults may be at risk for chronic disease conditions because they are overweight or obese (based on their self-reported weight and height).

Further, the survey indicated that in 2003, one out of every four Arkansas adults was a smoker. Given that tobacco use, particularly smoking, is thought to be associated with a large number of chronic conditions — including but not limited to heart disease, chronic respiratory conditions such as asthma and emphysema, and lung cancer – there is reason for concern in these findings. Just over a third of Arkansas adults indicated that they had been told they had high blood cholesterol, a major risk factor for cardiovascular disease.

The observed trends in these risk factors do not encourage optimism for the future. In Figures 13 through 16, the trends in risk factors reported through the Arkansas BRFSS over the decade 1990 through 2002 are compared to the trends seen nationally for smoking, physical inactivity, and insufficient fruit and vegetable intake and

obesity. In each case the trends have been unfavorable over the period.

Throughout the period, the proportion of adult smokers has been higher in Arkansas than in the nation overall. Overall, the proportion of Arkansas smokers has remained essentially stable over the period.

A somewhat different picture is seen in physical activity levels reported by Arkansas adults within the annual BRFSS (see Figure 14). In each year of the past decade, Arkansas adults reported activity levels that were lower than those reported nationally. However, while the proportion of inactive adults in the nation overall has remained essentially stable, the proportion in Arkansas has shown some tendency toward a downward trend.

Data are not available during the early years of the decade to compare fruit and vegetable intake among adults in the United States and Arkansas (see Figure 15). In 1994, however, Arkansas fared slightly better than the nation in the percentage of adults who met recommended fruit and vegetable intake. Unfortunately, in subsequent years, the trend has worsened in Arkansas, and the gap between Arkansas and the nation has narrowed. At the end of the period, approximately three-fourths of adults in Arkansas and the nation overall reported that they ate fewer than the recommended five servings daily.

Taking into account the low levels of physical activity and insufficient fruit and vegetable intake reported by adults, it is not surprising that the proportion of obese adults has been increasing substantially nationally and in Arkansas over the past decade (see Figure 16). In 1990 the proportion of adults who were obese were essentially equal in Arkansas and the nation overall (12%).

Figure 15
Trends in Insufficient Fruit and Vegetable Intake,
Arkansas versus US, 1990-2002

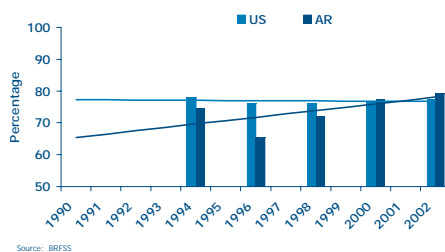
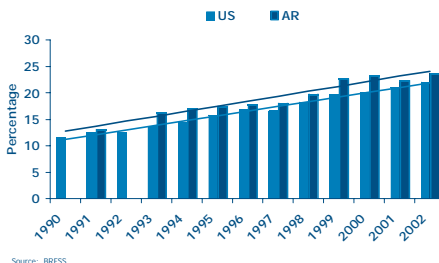


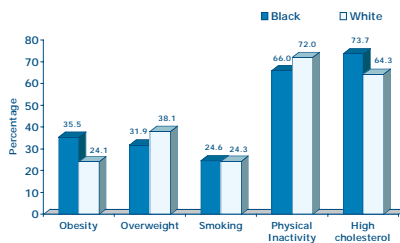
Figure 16
Trends in Obesity, Arkansas versus US, 1990-2002



However, over the ensuing decade, the proportion of obese adults has increased substantially in both Arkansas and the nation as a whole, and the proportion of obese adults in Arkansas has remained higher than the national level in each year since 1991.

As depicted in Figure 17, higher proportions of blacks are obese, and have high cholesterol and diabetes, compared to their white counterparts. However, more whites than blacks were physically inactive, and were overweight (but not yet obese). These disparities between groups likely explains some portion of the disparities seen between groups in the prevalence of diabetes, which is substantially higher among Arkansas's black citizens.

Figure 17
Risk Factors by Racial/Ethnic Group, Arkansas 2003



Source: BRFSS 2003

FACILITATING FACTORS CONTRIBUTING TO NUTRITION AND PHYSICAL ACTIVITY

HEALTHY ARKANSAS

In May 2004, Governor Mike Huckabee launched Healthy Arkansas to facilitate change in Arkansas from one of the most unhealthy states in the country to one of the healthiest. Chronic diseases, including diabetes, stroke, lung and heart diseases and cancer, are more prevalent in Arkansas than in the nation generally. A Healthy Arkansas Blueprint for Changing the Culture of Health focuses on strategies to reduce and tobacco use, obesity and physical inactivity – the three modifiable risk factors of these diseases.

The Healthy Arkansas Initiative specifically targets three major population groups: children in schools, adults at worksites and aging Arkansans, with a specific focus on state employees and Medicaid recipients.

Healthy Arkansas is a comprehensive effort to clearly define specific areas where behavior changes can lead to healthier citizens. In addition, the strategies focus on activities at the state and community levels.

To implement the key strategies and achieve success, Healthy Arkansas is building on and expanding current programs and partnerships like those in cardiovascular health, diabetes, tobacco prevention and control, arthritis and comprehensive cancer control. Hometown Health Coalitions and other local partnerships also provide support for activities at the community level.

Healthy Arkansas is a “work in progress.” It provides the foundation for building a better state of health with the flexibility to grow and adjust to changing populations and identified needs.

Worksite wellness programs and activities are one area of focus. The Department will serve as a clearinghouse and advisor on best practices for worksite wellness programs and activities. Additionally, a statewide pilot program for 10,000 employees in the Departments of Health and Human Services is being conducted, and includes incentives for healthy behaviors. Healthy Arkansas has also implemented an insurance incentive for all state employees who completed a health risk assessment. The insurance coverage has also expanded benefits to include coverage of smoking cessation and preventive health screens.

Older Arkansans’ nutritional and physical activity needs are being addressed through collaboration with senior centers, Area Agencies on Aging, and the state office of Aging and Adult Services in the Department of Human Services. Specifically, training is being conducted on a best practice for increasing seniors’ physical activity; promotion of walking trails and programs to include older Arkansans are also components.

Medicaid has expanded program components to increase benefits of preventive health services and include tobacco cessation coverage. And the Department of Human Services is exploring ways to increase healthy food choices to other low-income populations.

The Health Department coordinates Media/Marketing efforts across all nutrition and chronic disease funding areas. A special coordinating group within the Department is ensuring the most efficient use of such outreach resources. Likewise, when requests for proposals and contracts from the chronic disease programs are let, this coordination helps ensure that resources are used effectively and efficiently. Where possible, other funding sources, such as the Women's Infants' and Children's Special Nutrition Program (WIC), are providing support to Healthy Arkansas.

HEALTHY ARKANSAS LOCAL PLANS

Department of Health Hometown Health Improvement coalitions led by community-level Department of Health colleagues, developed local plans in each county in support of nutrition, physical activity, tobacco use cessation goals. In counties with no active coalitions, Leadership Planning Groups were convened to develop these local plans. These plans include best practices for implementation at the local level to address nutrition, physical activity and tobacco use.

In Arkansas, the 10 most populous counties are home to more than 50 percent of the state's population. It is through concentrated efforts in these counties that the greatest gains can be made. Funding and programmatic activities are being focused on these counties. For instance, recently awarded funding from the Cardiovascular Health Program was targeted to community-based groups in these 10 counties.

This involvement and support from communities is essential in providing opportunities to promote healthy behaviors and funding healthy initiatives such as walking trails. The implementation of best practice programs at the local level will help raise awareness of the general public of the link between obesity and the development of chronic diseases. This will help remove a barrier to behavior and policy changes. It will serve to inform people about the importance of daily decisions about physical activity and good nutrition. Community-based programs will also provide positive social, family and environmental supports that are necessary for achieving and maintaining individual lifestyle changes.

ACT 1220 OF 2003

The 84th Arkansas General Assembly, recognizing the health risks associated with the trends of inactivity and poor diet among young Arkansans, passed Act 1220 of 2003 to create the Child Health Advisory Committee. The Act directed the Committee to develop nutrition and physical activity standards and to make policy recommendations.

Beginning in August 2003, the Committee met monthly to carry out the mandates of the new law. Among the factors they considered were foods sold individually in school cafeterias; competitive foods offered at school through vending machines, student stores, fund raisers, etc.; physical education and activity; continuing professional development of food service staff; systems to ensure the implementation of nutrition and physical activity standards; monitoring and evaluating results; and reporting outcomes.

The Committee drafted and submitted nutrition and physical activity standards and policy recommendations to the Department of Education in June 2004. With support of the Governor, the Department of Education and the Board of Education are currently in the process of promulgating rules and regulations for many of the recommendations.

BMI SCREENINGS

Act 1220 also mandated the measurement and reporting of body mass index information on students. The program has served as a means to raise awareness of the problems with youth. In fact, many school districts have taken action to change nutrition and physical activity policies.

Many of the traditional reward systems that revolved around food, such as pizza parties for good behaviors, are being examined and questioned by school district personnel. For example, one elementary school has eliminated giving sodas as a reward. Also the use of school foodservice as an additional funding source that often forces the sale of popular, non-nutritive foods and beverages is being discussed.

One school has put healthy choices in their vending machines, and another has eliminated the morning snacks brought from home. As one other district removed vending machines from the 5th and 6th grades, they also decided to change their milk provider to one who offers low-fat products — a low-fat vanilla, strawberry, chocolate and white milk in a plastic bottle. It is reported that the students love the new milk varieties and milk consumption has increased.

Many of the schools are focusing on healthier meals. One school is serving more baked foods instead of frying everything. Yet another district is trying new items on the menus and adding more fresh fruits.

The fact that schools are coming together in their Nutrition and Physical Activity Advisory Committee meetings, and either contemplating the School Health Index or actually completing modules, is an example of the success recently achieved in Arkansas. The formation of the local Nutrition and Physical Activity Advisory Committees was also required by Act 1220.

Another school has had a daily 20 minute physical activity focus, in addition to the required physical education, for their elementary campus for several years. They have an indoor gym, but now are looking for funding to pave the existing outside dirt walking trail to make it more user friendly in wet weather.

One of the 16 educational cooperatives in the state was selected by the Blue and You Foundation to receive more than \$100,000 to support “Wellness Academics and You,” a biannual Student Health newsletter to be sent to parents. Also the funds will support Fitness Festivals at the end of the school year for participating schools.

SUPPORT FOR TRAILS

In 2004, 18 trail projects were funded through the Arkansas Trails for Life Grant Program. The program was established by Act 1750 of 2001 to assist communities in establishing health and fitness trails across Arkansas. Funds for the Program are provided by the Arkansas Department of Health through the Master Tobacco Settlement Agreement, and are operated through an agreement between the department and the Arkansas Department of Parks and Tourism. Each year, \$250,000 is available to grant to communities through a competitive process. Applicants for fiscal year 2005 increased by 100%, with thirty-eight projects recommended for funding.

The Arkansas River Trail is one of the Trails for Life Grant projects funded in 2004. The Trail is a project of the Headwaters Partnership whose goal is the completion of a 24-mile walking trail in an urban area that will link several parks in Central Arkansas. The Headwaters Partnership is a unique coalition of representatives from more than 20 federal, state, county, and municipal public

and private organizations, providing public education and outreach activities about the benefits of trail use. Each member has provided professional leadership, technical expertise, financial and fund-raising assistance, in-kind labor, materials, and other resources from disciplines ranging from environmental conservation and recreation, economic development, to community health and wellness in the public and private sector. By linking messages about healthy eating with physical activity in a natural environment, the Arkansas River Trail has become a model for other cities and states.

On May 19, 2004, hundreds of people living and working in Little Rock participated in the seventh annual Out for Lunch event. The event included a ground-breaking ceremony to kick off construction of the downtown Little Rock section of the Arkansas River Trail, called the Medical Mile, as well as, educational activities designed to encourage people to reduce their risk for obesity and chronic diseases by being physically active and making healthy food choices. The Medical Mile will serve as an outdoor health museum, including various informational displays and interactive kiosks to educate visitors about the health benefits of good nutrition, regular physical activity, and tobacco use prevention and cessation.

POTENTIAL BARRIERS TO PROGRESS AGAINST OBESITY

LEGISLATIVE ACTION

As previously mentioned, legislation passed in the 2003 session of the Arkansas General Assembly mandated public school districts collect and report body mass index information on students, established the State level Child Health Advisory Committee, and established Nutrition and Physical Activity Advisory Committees in every school district in the state. The response to Act 1220 has been varied, with some superintendents calling it a terrible thing to others having fully embraced the requirements. Arkansas remains the only state to date that has this requirement.

The Departments of Education and Health and the Child Health Advisory Committee will continue to inform and education school administrators, parents, and legislators on the BMI process, benefits and results.

COLLABORATIVE EFFORTS

The prevention and control of obesity in Arkansas will require a dedicated and cooperative effort from health care providers, communities, public health, academic institutions, government and the citizens. Many examples of successful partnerships exist, and the Healthy Arkansas Initiative has brought visibility to the issues. However, Arkansas remains challenged to overcome its barriers to the successful implementation of any program that requires such far-reaching policy, environmental and behavioral changes in the population.

Support from health care providers will be essential in encouraging healthy behaviors, identifying those at risk for obesity and its complications, and providing referrals for lifestyle counseling. Strategies have been identified by the planning committee to address these items. However, 77 percent of the state's 75 counties are identified as medically underserved areas. Arkansas ranks 15th in the nation in the percent of uninsured citizens (16.3 percent), well over the national average of 13.1 percent.

Support from policy makers such as legislators, city planners and school superintendents and school board members will be essential in guiding policy changes to encourage healthy eating and physical activity behaviors. For example, current school policies regarding physical activity and increasing academic requirements discourages adequate physical education.

While Healthy Arkansas has achieved success in educating and promoting collaborative efforts, this effort and more must continue in bring about the necessary lifestyle changes.

RURAL STATE

Arkansas is a small and primarily rural state. While 26 percent of the US population lives in rural areas, 49 percent of Arkansans reside in areas of fewer than 2500 people. The rural nature of the state requires unique interventions. Physical barriers such as distance between school and home limit the effectiveness of popular interventions, such as a “walk to school” program.

Likewise, because of a lack of population density in many geographic areas, the infrastructure that supports variety in available, community level activities has not developed. Outside of school-supported athletic programs and business-sponsored softball teams, many communities do not have physical activity opportunities for residents. Also, the availability of safe walking options may be limited by lack of physical infrastructure, such as sidewalks.

PREVIOUS INTERVENTIONS

The Governor's Council on Fitness has long promoted physical activity and reported on statistics for both children and adults. Most recently, the Council has sponsored three annual events that promote physical activity in different population groups. The Governor's Leadership in Fitness Awards recognizes individuals and organizations whose efforts have positively affected the health and fitness of Arkansans.

During the first week in May, 600 fourth graders from across the state representing outstanding physical education programs will converge on the State Capitol lawn at the invitation of the Council. The Great Arkansas Workout consists of ten different sports and workout stations led by the top coaches and fitness instructors in Arkansas.

In recognition of National Employee Health and Fitness Day, the Council and various sponsors host Out For Lunch. This event encourages employees to walk from their office to designated sites where other walkers gather together and celebrate the day. In 2004, the Governor's Council partnered with Five-A-Day, the Arkansas River Trails Project, and the University of Arkansas Cooperative Extension Service for the Out For Lunch event.

The Arkansas Governor's Council on Fitness partnered with the Arkansas Department of Education in sponsoring nine workshops in different educational cooperatives in the state. The workshops, "Movement Activities for Young Children," provided activities for teachers to use during physical education classes and to integrate into the regular classroom.

UAMS Head Start Program, a federally funded program available to low income families. As the program has screened participating children, they have referred children who are overweight or at risk for being overweight to registered dietitians for counseling with the parents. They also use a nutrition curriculum in the classroom.

The University of Arkansas at Little Rock and members of Share America have linked together to form an after-school program that promote better citizenship while engaging students and families in activities that promote healthy living. Families have participated in community garden projects, family fun night at a local gymnasium, and nutrition classes. Health risk assessments have also been completed on parents and their children.

The Employee Benefits Division of the State of Arkansas conducted an abbreviated health risk assessment of state government employees enrolled in health insurance plans offered by the state.

The employees received a discount on their next year's insurance premium, and received an even greater financial incentive if their spouse participated. Information was provided to plan enrollees as risk factors were identified.

The Family and Consumer Sciences Agents of the University of Arkansas Cooperative Extension Service offer a weight management program called Reshape Yourself in communities across the state. The program focuses on setting reasonable weight loss goals, healthy eating practices and regular physical activity. The agents collaborate with local health care providers to conduct blood pressure, cholesterol and glucose screenings before and after the 15-week program.

The Five-A-Day Program in the Arkansas Department of Health encourages Arkansas citizens to adopt a healthy lifestyle through good nutrition. One important aspect of the program is the Five-A-Day Coalition that focuses on strategies to educate in the areas of media, schools, worksites and communities.

The purpose of the Diabetes Control Program in the Department of Health is to reduce diabetes in Arkansas. The program has successfully developed, implemented and evaluated strategies aimed at reducing the diabetes health disparity in high-risk populations. Additionally, Eli Lilly entered into a partnership with the Medicaid Program in the Arkansas Department of Human Services to provide case management for those with diabetes in order to help control secondary conditions.

The Arthritis program has worked to improve physical activity levels in target populations in Garland and Independence counties. These counties were selected because of the large population within the age demographic of 45 to 64 years of age, and associated with BRFSS data, along with the judged willingness of persons to participate in the programs. The People with Arthritis Can Exercise (PACE) program, along with water based programs, supported by the Arthritis Foundation have been used as model programs.

Training has been conducted to allow for the implementation of the Peer Exercise Program Promotes Independence (PEPPI) program in senior centers and other facilities located in the central region of the state. The collaboration between the Arkansas Department of Health and CareLink, the central Arkansas Area Agency on Aging, was a success. This effort has led to collaboration for several presentations around the state to promote PEPPI, as well as informational sessions and trainings. Both agencies are actively committed to improving the well being of older Arkansans, and support each other when necessary. CareLink won an award for PEPPI at the Arkansas Aging Conference for best innovative program in a senior center.

PLAN DEVELOPMENT PROCESS

In Fall 2003, the Chronic Disease Work Unit of the Arkansas Department of Health started working on a coordinated Chronic Disease State Plan. They began with nutrition and physical activity because at least 5 state plans had overlapping nutrition and physical activity objectives and strategies.

Many of the partners are working on multiple state plans with overlapping objectives for nutrition and physical activity and tobacco, and also with overlapping target audiences such as worksites, health professionals, schools etc. A leadership group with members representing each of the chronic disease coalitions developed a draft plan to serve as the one plan to address chronic diseases in the state. The purpose of the coordinated state plan is to maximize resources and results, while minimizing strain and inconvenience of partners and targeted populations. The various partner entities will lead implementation of the nutrition, physical activity and tobacco objectives.

The state plan index was used to evaluate the draft chronic disease state plan and the process used to formulate it. The index was also used to identify weaknesses (i.e., the need for additional industry/state level partners).

At the same time the Governor made obesity and chronic disease prevention his priority. He convened an executive committee that included the Arkansas Department of Health (ADH), Department of Human Services (DHS) and the Department of Education.

The Healthy Arkansas Blueprint was developed. Four workgroups at ADH were charged with developing sections of the plan. These workgroups were given specific criteria including the use of the draft Nutrition and Physical Activity state plan that is included in the Chronic Disease state plan. The Nutrition and Physical Activity/Obesity Leadership group met in November 2004 to prioritize strategies and review the CD state plan for obesity prevention and treatment objectives.

The Chronic Disease Unit is planning one combined meeting per year to review progress on objectives and prioritize strategies for the upcoming year. The first meeting is planned for April 2005.

GOALS

As the planning committee deliberated on this statewide plan, the members identified overarching goals and goals related to specific areas. The overarching goals are applicable to nutrition, physical activity, obesity, and chronic diseases. These broad goals cross all disease types and populations.

Overarching Goals

- Promote health and reduce chronic disease
- Eliminate racial and ethnic disparities among Arkansans in heart disease and strokes, arthritis, diabetes, cancer, and obesity.
- Ensure a comprehensive surveillance system by expanding and coordinating data collection to achieve an accurate assessment of burden, identify gaps and evaluate progress.

The more specific goals – those related to nutrition, physical activity, obesity, tobacco use and health systems— were categorized by the planning committee members.

The work of the planning group resulted in a statewide effort that reflected the needs and efforts of a broad sector of organizations, not just the chronic disease programs within the Arkansas Department of Health. The goals cover an 8 to 10 year time frame and focus on changing health status indicators in Arkansas. However, there are also short term objectives which address processes for impacting these indicators.

The following is a comprehensive listing of the goals, objectives and related strategies.

GOALS, OBJECTIVES AND STRATEGIES

NUTRITION GOALS, OBJECTIVES AND STRATEGIES

Develop environments that are supportive of healthy eating.

- **Objective 1:** By June 30, 2010, implement Healthy Arkansas Restaurant Award to promote healthy menu choices and smoke-free restaurants
 - **Strategy 1:** Publicize through advisory groups such as Child Health Advisory Committee, Wellness Coalition etc.
 - **Strategy 2:** Select Committee representatives of various organizations to review and score applications.
 - **Strategy 3:** Announce winners through statewide media
 - **Strategy 4:** Provide site recognition, to include door stickers and table tents.
- **Objective 2:** By June 30, 2010, increase proportion of worksites that establish policies for healthy food and beverage options served on site and at company sponsored functions such as: cafeteria vending machines, company picnics, potlucks, etc. etc. from 10% to 12%. (2003 : 10% , CVH survey)
 - **Strategy 1:** Educate employers about the benefits of worksite wellness programs, emphasizing fiscal savings (increased productivity, fewer absences, reduced use of health care resources).
 - **Strategy 2:** Provide information on model programs relative to the size of the workforce, identifying local and national wellness champions.
 - **Strategy 3:** Provide guidelines for vending, catered meetings and events.
- **Objective 3:** By, June 30, 2010, increase the proportion of mothers who breastfeed their babies from 14.25 % (2004) to 15%.
 - **Strategy 1:** Encourage and promote breastfeeding in disparate populations.
 - **Strategy 2:** Collaborate to incorporate the CD rom or web curriculum for breastfeeding as a required element of the University of Arkansas for Medical Sciences and Maternal and Child Health Pediatric, Family Practice and Obstetrics residency programs.

Promote life-long healthy eating habits among Arkansans.

- **Objective 1:** By June 30, 2010, increase the number of community based initiatives to address one or more dietary guidelines by 2%.. (Baseline to be determined by June 2005)
 - **Strategy 1:** Collect baseline data.
 - **Strategy 2:** Develop or acquire and distribute appropriate messages and materials related to nutritional balance, portion control and healthy eating.
 - **Strategy 3:** Promote policies and regulations that ensure the offering of fat-free and low-fat dairy options to participants in state-guided programs. (i.e., schools, day cares, WIC) (Coop ext lead for CVH)
 - **Strategy 4:** Establish pilot vending machine and physical activity programs in schools to determine if interventions affect BMI.
 - **Strategy 5:** Improve meals provided by the AAA, including senior center meals and meals on wheels.

- **Objective 2:** By June 30, 2010, increase the proportion of Arkansans who consume at least two daily servings of fruit and at least three daily servings of vegetables. (Adult from 21% (BRFSS 2003) to 25%; Students from 20% (YRBS 2001) to 23%)
 - **Strategy 1:** Increase awareness of recommendations to eat at least 5 daily servings of fruits and vegetables among school personnel, students and families, employers and employees, health care professional and policy makers through media and on-site promotional campaigns.
 - **Strategy 2:** Promote development of farmers' markets as a means of increasing consumption of fruits and vegetables
 - **Strategy 1:** Promote marketing healthy options, including fresh fruit in gas stations and convenience stores

OBESITY GOAL, OBJECTIVES AND STRATEGIES

Promote maintenance and / or achievement of a healthy body weight

- **Objective 1:** By June 30, 2010, increase of the proportion of school-aged children and adults who have a healthy BMI (body mass index) (Adults 38% in 2003 to 42.1%, School BMI 03-04 60% to 65%)
- **Strategy 1:** Implement an awareness campaign emphasizing the association between being overweight and the development of acute, chronic or disabling illnesses such as type II diabetes, cancer, heart disease and joint disease.
- **Strategy 2:** Provide education on BMI to the general public, health professionals and policy makers through a variety of communication venues.
- **Strategy 3:** Increase number of medical care providers who document BMI and appropriate counseling on patients' records.
- **Strategy 4:** Ensure continuation of BMI assessments in all public schools as required by Act 1220.

PHYSICAL ACTIVITY GOAL, OBJECTIVES AND STRATEGIES

Improve health, fitness, and quality of life through daily physical activity

- **Objective 1:** By June 30, 2010, increase proportion of school-aged children and adults who engage in regular physical activity 30 minutes a day, at least five times a week. (BRFSS 35% in 2003 to 37% , YRBS 66% in 2001 to 85%)
- **Strategy 1:** Promote the mandatory implementation of daily quality physical activity programs statewide in all grades, K-12.
- **Strategy 2:** Promote fitness testing twice a year for all students with incentives for improvement and / or achievement of target levels
- **Strategy 3:** Promote the integration of physical activity and core curriculum instruction by both physical education and regular classroom teachers.
- **Strategy 4:** Support legislative efforts to make a state mandated requirement for daily physical education.
- **Strategy 5:** Increase the proportion of health care professionals who provide individualized counseling related to physical activity.

- **Objective 2:** By June 30, 2010, Increase the proportion of adolescents who view TV 2 or fewer hours on a school day from 57.1% (YRBS 2001) to 60%.
 - **Strategy 1:** Implement an awareness campaign that publicizes resources for increasing physical activity and decreasing TV viewing time.
 - **Strategy 2:** Promote classroom-based health education focused on reducing television viewing and video game playing

- **Objective 3:** By June 30, 2010, increase community-based inventions and environmental supports that encourage appropriate physical activity by 2%. (Baseline collected by June 2005)
 - **Strategy 1:** Collect baseline data.
 - **Strategy 2:** Promote opportunities for safe physical activity (e.g. green spaces, community recreation facilities, walking trails and safe sidewalks)
 - **Strategy 3:** Promote development and utilization of walking trails and educate communities about funding opportunities.
 - **Strategy 4:** Promote community gardens as a means to increase physical activity.
 - **Strategy 5:** Develop programs to establish or expand existing physical activity programs oriented towards families.
 - **Strategy 6:** Enlist the support of citizens, civic groups, amateur and professional sports associations and voluntary organizations to promote and improve fitness.
 - **Strategy 7:** Promote the development of school policies allowing community access to school facilities for physical activity.
 - **Strategy 8:** Implement evidence-based physical activity programs in senior centers.
 - **Strategy 9:** Enlist the aid of older adults in promoting health and fitness programs for older adults in their communities.
 - **Strategy 10:** Emphasize the chronic care model for exercise through the Arkansas Collaborative
 - **Strategy 11:** Develop partnerships between medical professionals and communities to facilitate patient referrals to local physical activity resources.

- **Strategy 12:** Implement evidence-based physical activity programs in senior centers.
 - **Strategy 13:** Enlist the aid of older adults in promoting health and fitness programs for older adults in their communities.
- **Objective 4:** By June 2010, increase to 30% the proportion of worksites that offer employer-sponsored physical activity (Survey of Employer Cardiovascular Health Policies and Programs, 2002; 28% of organizations have a designated exercise/walking area. Among these almost half have outdoor only facilities.)
- **Strategy 1:** Promote model worksite programs statewide to promote physical activity
 - **Strategy 2:** Produce worksite wellness materials and make them available on the web.
 - **Strategy 3:** Identify best practices in worksite wellness and make available to coalitions at the local level.
 - **Strategy 4:** Develop a worksite wellness program clearinghouse.

TOBACCO GOALS, OBJECTIVES AND STRATEGIES

Influence attitudes and knowledge around tobacco use in order to change behaviors

- **Objective 1:** By June 30, 2010, decrease the percentage of Arkansas youth that initiate tobacco use from 29.3% to 23%.
 - **Strategy 1:** Conduct outreach to teens through media
 - **Strategy 2:** Enforce laws that restrict minors' access to tobacco products
 - **Strategy 3:** Develop grassroots information or media awareness campaigns focusing on preventing youth initiation through local coalitions such as Students Working Against Tobacco (SWAT)
 - **Strategy 4:** Encourage public and private schools, grades K – 12, and other youth organizations to enforce tobacco-free policies and tobacco prevention activities at all school events, whether on or off campus.
 - **Strategy 5:** Develop and enforce policies that prohibit tobacco advertising.
 - **Strategy 6:** Promote and encourage school policies that implement tobacco prevention programming / curriculum and provide teacher in-service on tobacco prevention.

- **Strategy 7:** Implement effective community-based programs that engage youth in developing and implementing tobacco control interventions that include teacher training and parental involvement.
- **Strategy 8:** Promote inclusion of evidenced-based curricula and comprehensive school health education

Develop tobacco free environments

- **Objective 1:** By June 30, 2010, increase the number of tobacco free environments from 68% to 100%.
 - **Strategy 1:** Promote governmental and voluntary policies to promote clean indoor air, restrict access to tobacco products, including smoke-free indoor and outdoor venues open to the general public.
 - **Strategy 2:** Encourage Arkansans to prohibit smoking in their own homes.
 - **Strategy 3:** Fund tobacco prevention and education communities to launch a campaign to educate key decision makers on the dangers of second-hand smoke and the importance of smoke-free work and public places
 - **Strategy 4:** Promote clean indoor air environments through media.
 - **Strategy 5:** Encourage businesses to prohibit use of tobacco products on their premises
 - **Strategy 6:** Promote the development of worksite policies that prohibit smoking in buildings, along with outdoor venues open to the general public

Assure statewide access to cessation services and referrals

- **Objective 1:** By June 30, 2010, reduce adult smoking prevalence from 26.3% to 12%.
 - **Strategy 1:** Improve knowledge of cost effectiveness of tobacco cessation services among legislators.
 - **Strategy 2:** Maintain a statewide telephone cessation help line, increase availability of effective cessation programs, and promote policies that cover treatment of tobacco use under public and private insurance.
 - **Strategy 3:** Conduct media campaigns for the general population / target populations promoting tobacco cessation.

- **Strategy 4:** Fund evidence-based cessation programs.
- **Strategy 5:** Promote youth cessation programs by reaching youth through the statewide quitline and marketing campaigns encouraging youth to quit.
- **Strategy 6:** Implement health care provider-based education and patient counseling programs for identified target populations by providing training to health care professionals on effective, personalized tobacco cessation and control methods and materials
- **Strategy 7:** Establish continuing education hours for healthcare providers who complete brief cessation intervention training.
- **Strategy 8:** Encourage employers to offer no-cost tobacco-cessation programs to their employees.

HEALTH SYSTEM SPECIFIC GOALS, OBJECTIVES AND STRATEGIES

Increase Knowledge and awareness of screening and detection services.

- **Objective 1:** By June 30, 2010, increase the availability of prevention and risk reduction campaigns and materials for the public by 5%. (Baseline Healthy Arkansas media campaign needs assessment 2005.)
 - **Strategy 1:** Develop coordinated social marketing messages for the mass media for BreastCare, Tobacco, Cancer, Arthritis, Obesity, CVH and lifestyle habits to increase awareness of risk and risk reduction for the general public.
 - **Strategy 2:** Maintain a central resource center and directory of organizations to provide the public and the media with the latest most accurate chronic disease information. Include a website and lending library and coordinate effort with charitable organizations, insurers, faith-based coalitions, and the Arkansas Wellness Coalition to advocate increased access to chronic disease education and care resources.
 - **Strategy 3:** Collaborate with faith-based organizations to provide healthy lifestyle education to with culturally diverse populations
 - **Strategy 4:** Ensure the availability and quality of educational materials for minorities and medically underserved populations by identifying and inventorying existing culturally-, age- and literacy- appropriate information materials and programs for special populations.
 - **Strategy 5:** Involve health and education professionals and community members with expertise in specific population groups in the assessment of chronic disease prevention and treatment materials.

- **Objective 2:** By June 30, 2010, develop at least three health promotion interventions for healthy aging.
 - **Strategy 1:** Partner with the DHS Division of Aging to provide health education.
 - **Strategy 2:** Establish community level interventions that promote health behaviors among older Arkansans.
 - **Strategy 3:** Promote the transformation of Arkansas senior centers into Wellness Centers.
 - **Strategy 4:** Support Collaborative efforts to provide Wellness Center trainings for AAA, providers and staff.
 - **Strategy 5:** Improve the perception of the importance of older Arkansans and decrease ageism.
 - **Strategy 6:** Develop a variety of clear, consistent health promotion messages for healthy aging targeted to AR older adults of varying educational and income levels, with particular emphasis on inactive, low income and rural older adults.
 - **Strategy 7:** Support efforts to incorporate healthy lifestyle habits into all senior center activities
 - **Strategy 8:** Support grant proposals for pilot projects using the model Wellness Center sites (and expansion to other sites as available)

Increase awareness and compliance with national prevention and treatment guidelines among health care practitioners.

- **Objective 1:** By June 30, 2010, increase the proportion of clinics in Arkansas using components of the planned care model of chronic disease by 10%. (Baseline 34 sites 2004)
 - **Strategy 1:** Increase the number of professional health care students and health care providers in AR who receive education on the planned care model
 - **Strategy 2:** Increase the number of health care providers who document on medical records the patients BMI, Blood Pressure, lipid profiles, smoking status, and lifestyle counseling (smoking cessation, physical activity, nutrition)
 - **Strategy 3:** Enhance the ability of health care providers to provide screening test and exams of the highest quality

- **Strategy 4:** Promote, monitor, and evaluate screening and early detection tests for chronic disease by evaluating screening guidelines and provider performance consistency.
 - **Strategy 5:** Work with organizations such as the health departments and Community Health Centers to increase access to health care and health education in rural areas.
 - **Strategy 6:** Expand the availability of culturally specific support groups, information, and counseling services to assist patients and their families with chronic illnesses.
 - **Strategy 7:** Stimulate the development and use of innovative approaches to the education of the general public as well as continuing education for health professionals about chronic disease, such as the Internet, teleconferencing, and interactive educational software
 - **Strategy 8:** Promote the use of chart flow sheets and member monitoring tools by practicing providers for the prevention and treatment of chronic disease.
 - **Strategy 9:** Educate about and encourage development and continuation of self-management education programs.
 - **Strategy 10:** Provide training and materials to health professionals and students related to prevention and treatment of chronic disease.
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- **Objective 2:** Establish and implement at least three methods to increase the number of state, community or private sector policies, and/or legislative actions for the prevention and treatment of chronic disease.
 - **Strategy 1:** Increase the proportion of the health insurance companies (those that have 25,000 or more members) that participate in the promotion and distribution of nationally accredited chronic disease guidelines or principles and member tracking tools to their network providers and members.
 - **Strategy 2:** Pursue premium differentials for public employees' health and life insurance regarding healthy behaviors.
 - **Strategy 3:** Identify and advocate legislative changes needed to improve chronic disease prevention and treatment in Arkansas.
 - **Strategy 4:** Increase the availability and appropriate reimbursement of Registered Dietitians to provide nutrition education in rural communities.

CIRCUMSTANCES THAT COULD INFLUENCE THE PLAN

Most circumstances that are discussed are not expected to have a major influence on the plan due to the very nature of the document. Because it is broad-based, inclusive of so many partners, and has its roots in local collaboration, circumstances currently foreseen at the state level would have little effect on its completion.

State funding continues to be dedicated to schools, Medicaid and prisons. Those three segments of the state budget consume 98 percent of fiscal resources. Also, in this legislative session, there will be an additional challenge of funding renovation and rehabilitation of school facilities that a recent audit deemed to have safety concerns. School budget priorities must be funded first in Arkansas.

The newly formed College of Public Health at the University of Arkansas for Medical Sciences can provide resources to support this plan, particularly in the area of education and behavior change. Additional opportunities for collaboration will be developed over the short term to facilitate accomplishment of the long-term plan elements.



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Arkansas

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