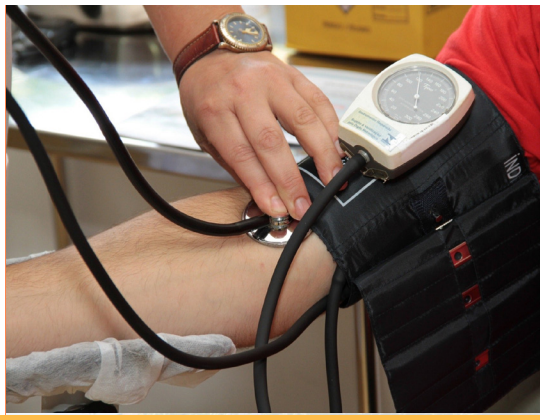
2019

# Arkansas

# Chronic Disease



## Communication Kit


Arkansas Chronic Disease Coordinating Council

ARKANSAS DEPARTMENT OF HEALTH

# Table of Contents



---


**A Communication Kit on Chronic Disease in Arkansas, 2019**



All material in this document is in the public domain and may be reproduced or copied without permission; citation is appreciated.


Inquiries regarding the content of this communication kit may be directed to:


**Becky Adams, DrPH, RD, CDE**
Arkansas Department of Health
Chronic Disease Prevention and Control (CDPC) Branch
501-661-2334 Phone
4815 W. Markham, Slot # 6
Little Rock. Arkansas 72205
becky.adams2@arkansas.gov


This communication kit is provided by...

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

# 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 Communications 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 Section 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. Kit link:
FY2017_AR_Chronic_Disease_Communication_Kit_03_13_2017_crop_removed.pdf

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 at https://www.healthy.arkansas.gov/images/uploads/pdf/HealthyPeople2020.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 a Chronic Disease?

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.[1]

## Chronic Disease Coordinating Council

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.

[1]http://www.nationalhealthcouncil.org/NHC_Files/Pdf_Files/AboutChronicDisease.pdf

Arkansas Chronic Disease Coordinating Council


# Arkansas: Hospitalizations for Leading Chronic and Acute Diseases

Table 1. Hospitalization Rates for Leading Chronic and Acute Diseases
Arkansas, 2005-2014

| Cause | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 |
|---|---|---|---|---|---|---|---|---|---|---|
| Acute Myocardial Infarction | 267.7 | 255.9 | 246.2 | 245.3 | 236.6 | 226.2 | 225.7 | 232.2 | 227.4 | 223.2 |
| Other Ischemic Heart Disease | 532.6 | 525.4 | 486.5 | 458.3 | 373.2 | 378.7 | 355.7 | 325.5 | 244.7 | 215.9 |
| Lung and Bronchus Cancer | 31.4 | 32.1 | 33.4 | 33.0 | 35.9 | 31.1 | 32.5 | 26.5 | 20.4 | 22.4 |
| Hypertensive Diseases | 122.6 | 122.6 | 119.2 | 104.4 | 107.6 | 106.0 | 99.7 | 101.2 | 97.6 | 100.9 |
| Diabetes Mellitus | 211.0 | 206.7 | 206.5 | 211.2 | 201.2 | 204.3 | 211.5 | 203.8 | 206.4 | 216.2 |
| Colorectal Cancer | 59.9 | 53.1 | 55.7 | 52.1 | 51.3 | 50.2 | 49.2 | 46.2 | 46.6 | 47.2 |
| Acute Stroke | 366.7 | 343.8 | 326.1 | 322.5 | 321.1 | 322.0 | 320.8 | 334.2 | 314.5 | 303.1 |
| Pancreatic Cancer | 14.1 | 12.2 | 12.5 | 11.0 | 12.3 | 10.9 | 11.4 | 10.0 | 11.9 | 11.0 |
| Breast Cancer (Female) | 66.6 | 67.2 | 72.2 | 61.6 | 60.4 | 59.6 | 52.5 | 40.9 | 29.5 | 21.2 |
| Prostate Cancer | 64.5 | 65.5 | 68.2 | 67.4 | 73.4 | 63.4 | 66.1 | 54.0 | 41.5 | 45.6 |

Source: Healthcare Cost and Utilization Project online query system (HCUPnet); Notes: Rates are per 100,000 Arkansas population for all diseases. Population estimates were obtained from United States Census Bureau. Stroke hospitalizations include ischemic and hemorrhagic strokes, and transient ischemic attacks (TIA). Hypertensive Diseases include primary hypertension, hypertensive heart disease, hypertensive renal disease, and secondary hypertension.

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 acute myocardial infarction, other ischemic 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 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: https://www.healthy.arkansas.gov/images/uploads/pdf/HealthyPeople2020.pdf

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 statewide chronic disease coalitions, and select organizations.

**Coalition Members:**

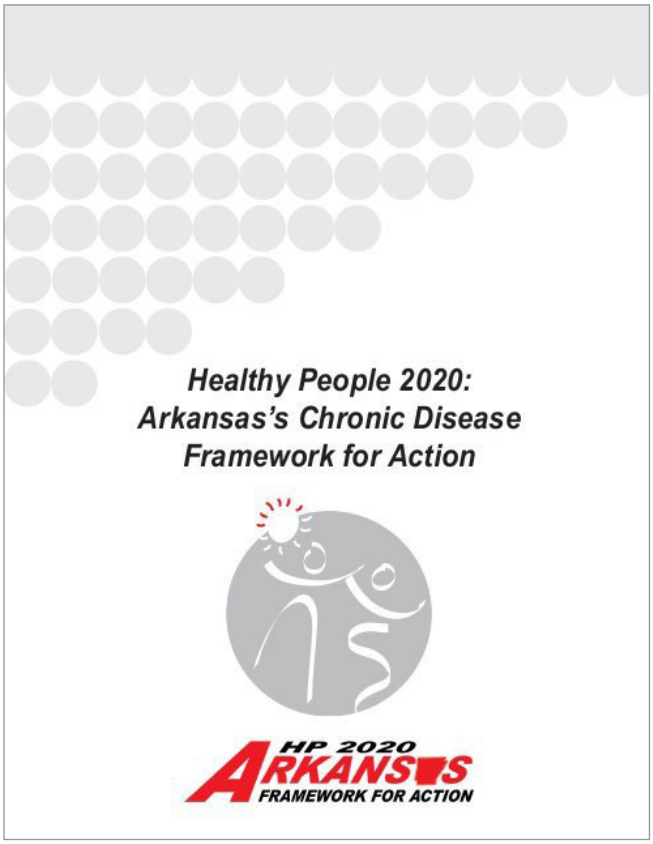
1. Arkansas Arthritis Coalition
2. Arkansas Breastfeeding Coalition
3. Arkansas Cancer Coalition
4. Arkansas Coalition for Obesity Prevention
5. Arkansas Diabetes Advisory Council
6. Arkansas Oral Health Coalition
7. Arkansas Tobacco Control Coalition
8. Heart Disease and Stroke Coalition
9. Project Prevent Youth Coalition

**Supporting Organizations**

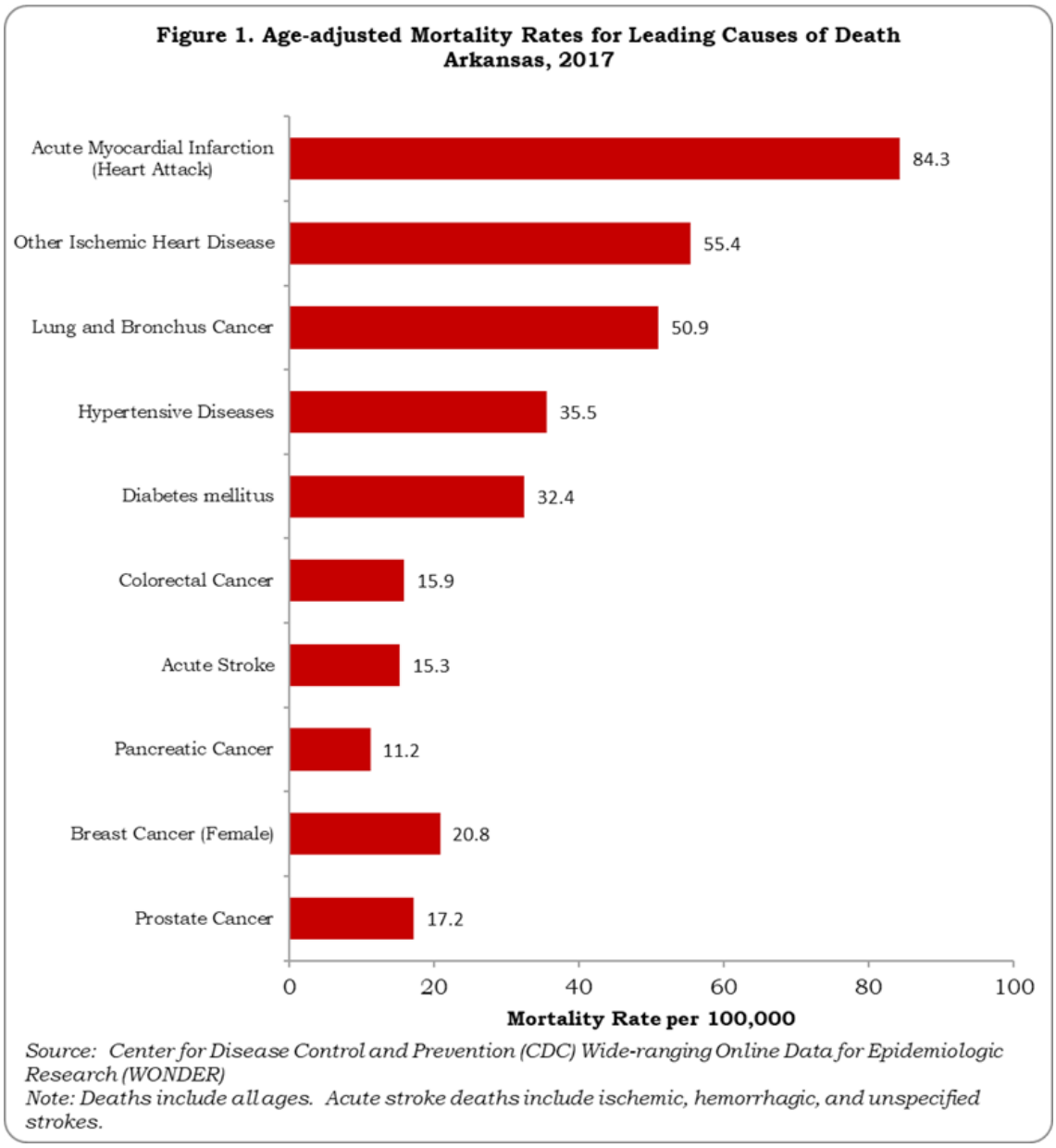
- American Lung Association in Arkansas
- Arkansas Center for Health Improvement
- Arkansas Community Health Workers Association
- Arkansas Department of Health
- Arkansas Department of Human Services, Division of Medical Services
- Arkansas Disability and Health Program
- Arkansas Foundation for Medical Care
  Arkansas Minority Health Commission
- Arthritis Foundation, INC, Arkansas
- Community Health Centers of Arkansas, Inc.
- Hometown Health Improvement
- UAMS Fay W. Boozman College of Public Health

## Contact Information

4815 W. Markham Street Slot 6
Little Rock, AR 72205
Phone: (501) 661-2942



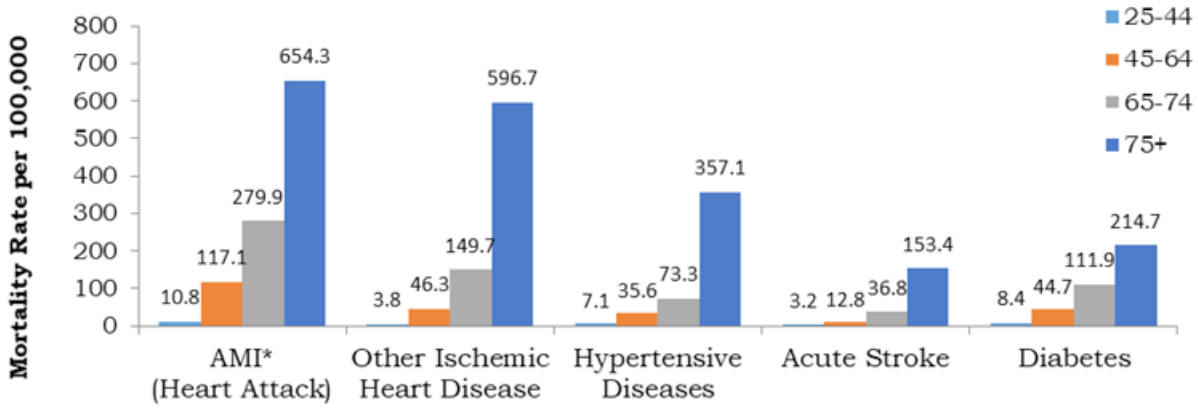
# Arkansas: Hospitalizations for Leading Chronic and Acute Diseases




In 2017, acute myocardial infraction (heart attack) and other ischemic heart disease death rates were higher than rates for hypertension, stroke, and diabetes mellitus. Invasive cancer death rates were highest for lung and bronchus cancer, followed closely by breast cancer among females (Figure 1).

# Chronic Disease Mortality Profile

**Figure 2a. Age-specific Mortality Rates for Leading Causes of Death: Heart Disease, Stroke, and Diabetes, Arkansas, 2017**

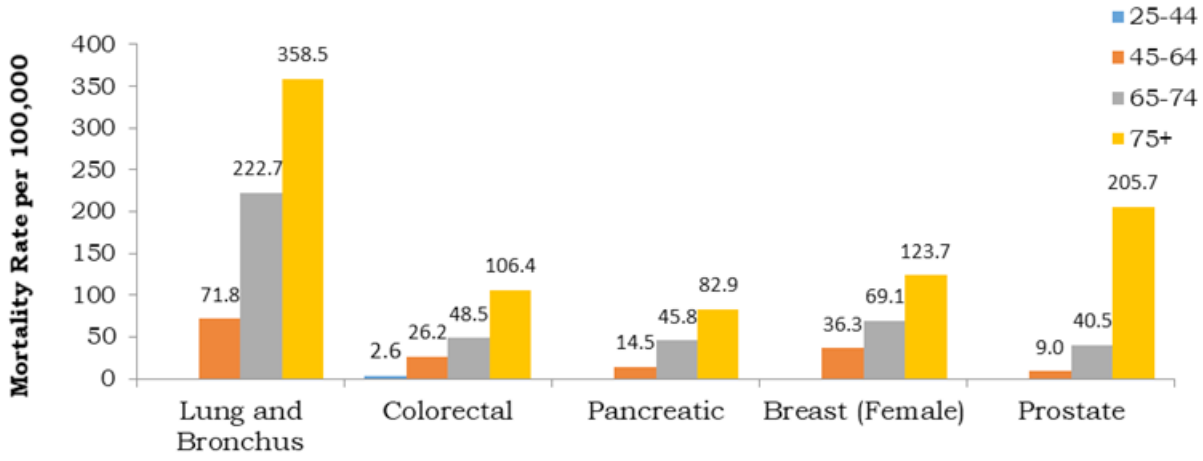



*Source: CDC WONDER*

*Note: Acute Stroke deaths include ischemic, hemorrhagic, and unspecified strokes. *Acute Myocardial Infarction*

When examining cause-specific death rates by age groups, death rates due to chronic diseases were highest for people over 75 years of age in 2017. Younger age groups were also affected indicating that significant healthy lifestyle changes are needed to lower their rates of dying from chronic diseases (Figure 2a).

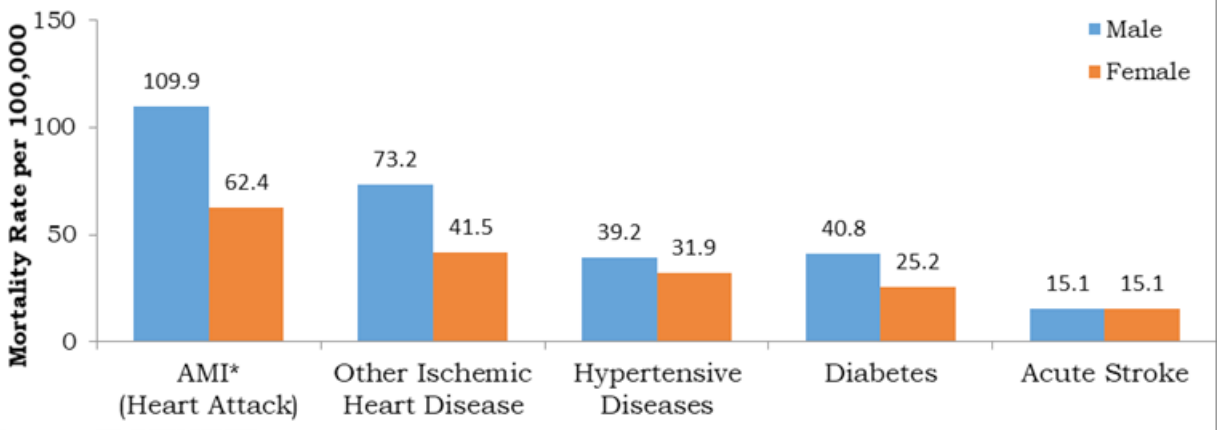
**Figure 2b. Age-specific Mortality Rates for Leading Causes of Death: Cancers, Arkansas, 2017**




*Source: CDC WONDER*

Death rates for each of the five leading cancers increased by age group in 2017, and was highest among those over 75 years of age. The number of deaths among those 25-44 were too small to report for all cancers except colorectal cancer (Figure 2b).

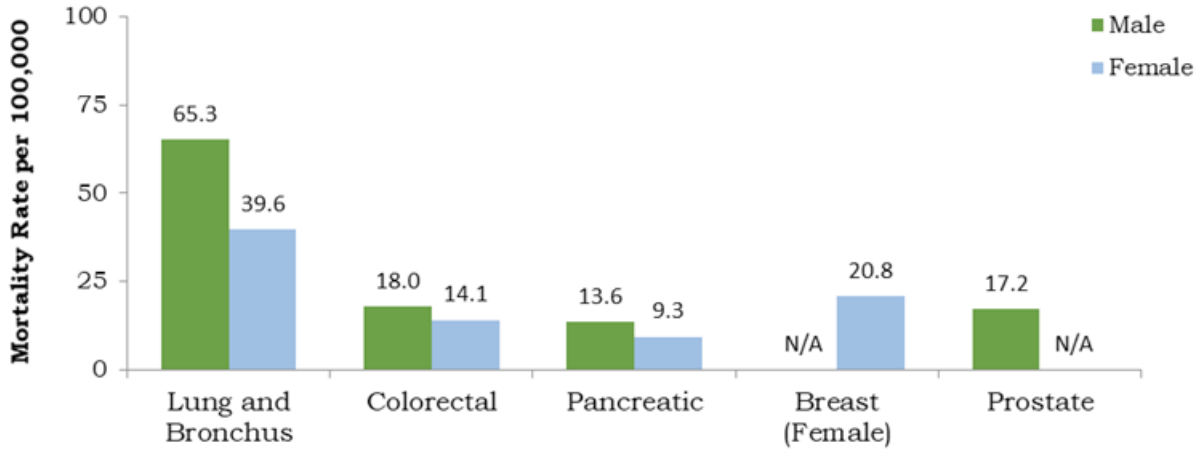
**Figure 3a. Age-adjusted Mortality Rates for Leading Causes of Death: Heart Disease, Stroke, and Diabetes, by Gender, Arkansas, 2017**




*Source: CDC WONDER*
*Note: Acute Stroke deaths include ischemic, hemorrhagic, and unspecified strokes. *Acute Myocardial Infarction*

In 2017, death rates for heart disease and diabetes were higher among males than among females (Figure 3a).

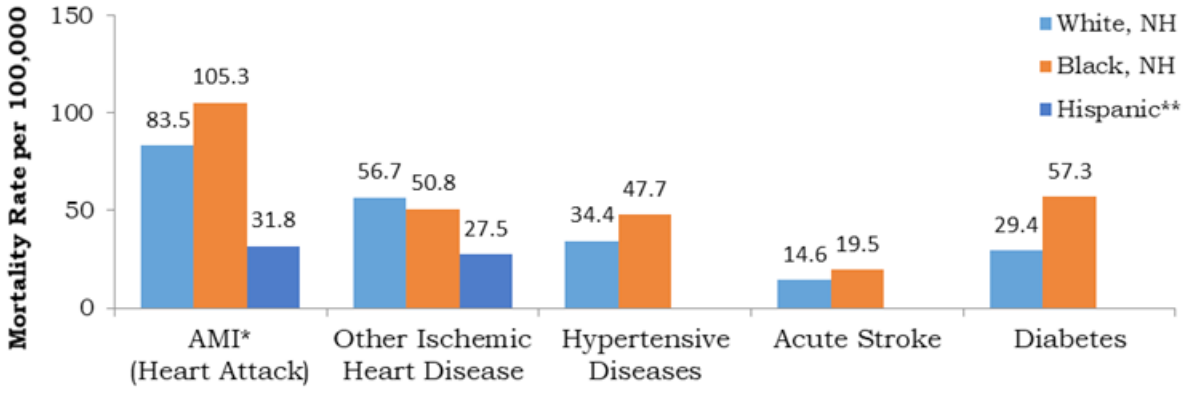
**Figure 3b. Age-adjusted Mortality Rates for Leading Causes of Death: Cancers, by Gender, Arkansas, 2017**




*Source: CDC WONDER*
*Note: N/A indicates that rates are not applicable.*

Death rates for lung and bronchus cancer, colorectal cancer, and pancreatic cancer were higher among males than females in 2017 (Figure 3b).

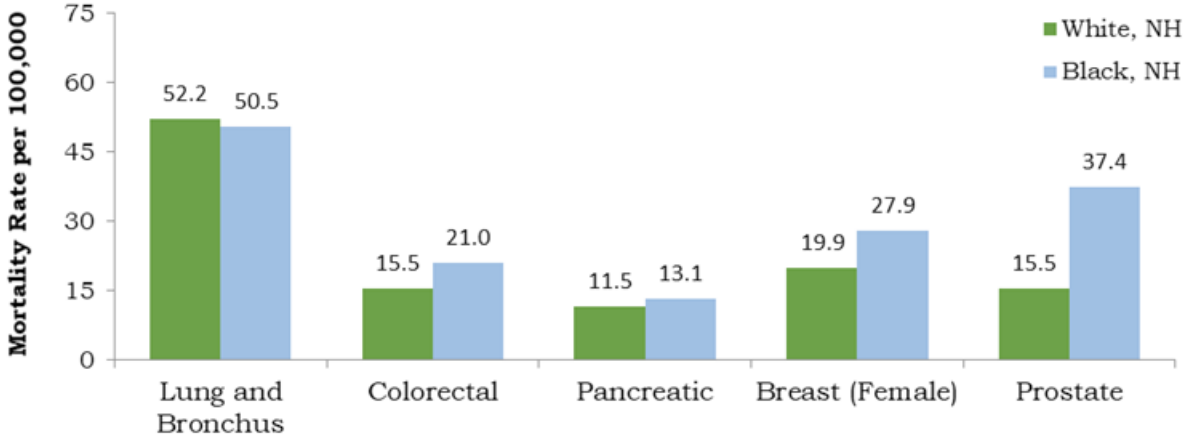
**Figure 4a. Age-adjusted Mortality Rates for Leading Causes of Death: Heart Disease, Stroke, and Diabetes, by Race/Ethnicity, Arkansas, 2017**




*Source: CDC WONDER*
*Note: Stroke deaths include ischemic, hemorrhagic, and unspecified strokes.*
**Acute Myocardial Infarction **Hypertensive dieseases, acute stroke, and diabetes mortality rates are suppressed for Hispanics due to low numbers of deaths.*

In 2017, Non-Hispanic Blacks had higher death rates from heart attacks, hypertensive diseases, stroke, and diabetes mellitus than Non-Hispanic Whites. Hispanics had lower rates of death from heart attacks and other ischemic heart disease than either Non-Hispanic Whites or Non-Hispanic Blacks. Numbers of deaths due to hypertensive diseases, diabetes, and stroke among Hispanics were too low to generate mortality rates (Figure 4a).

**Figure 4b. Age-adjusted Mortality Rates for Leading Causes of Death: Cancers by Race/Ethnicity, Arkansas, 2017**




*Source: CDC WONDER*
*Note: Cancer mortality rates are suppressed for Hispanics due to low numbers of deaths.*

Non-Hispanic Blacks had higher death rates due to leading cancers than Non-Hispanic Whites in 2017. Deaths among Hispanics from these cancers were too small to generate rates (Figure 4b).

# Coalitions

Arkansas Arthritis Coalition

Arkansas Cancer Coalition

Arkansas Coalition for Obesity Prevention (ArCOP)

Arkansas Diabetes Advisory Council

Heart Disease and Stroke Coalition

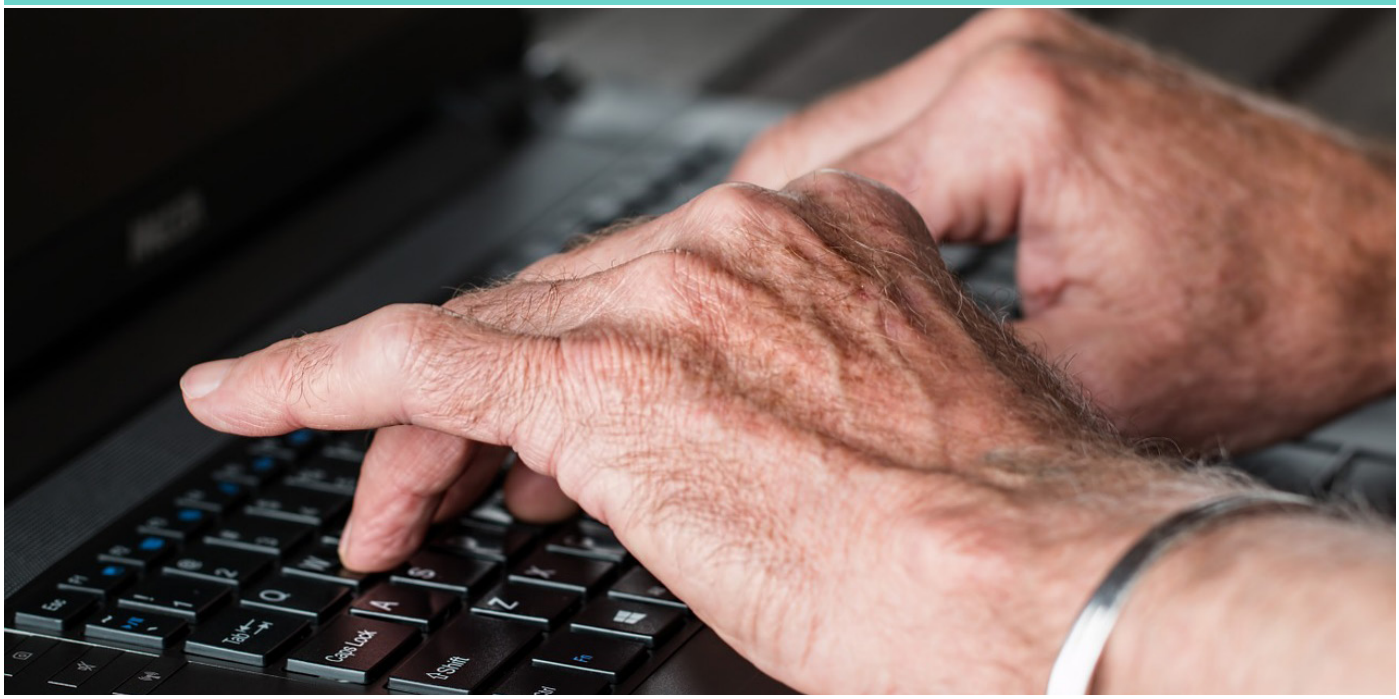
Arkansas Oral Health Coalition

Arkansas Tobacco Control Coalition

Arkansas Breastfeeding Coalition

Project Prevent Youth Coalition

# Arkansas Arthritis Coalition



**The Arkansas Arthritis Coalition is open to anyone interested in reducing the burden of arthritis in Arkansas.**

## Mission

To improve the health and well-being of Arkansans by working collaboratively to promote, protect and support breastfeeding.

## Goals

**Increase** awareness about the prevalence, burden of arthritis and what we can do to management arthritis.

**Increase** physical activity, including walking.

**Increase** healthcare provider counseling about physical activity.

**Increase** acces to, use of, and  referral to evidence-based self-management programs and safe areas for walking.

## About Arthritis

"Over 50 million Americans have arthritis, making it the number one cause of disability in the country." "These numbers are only going to keep growing-unless we take a stand. https://www.arthritis.org/about-arthritis/

## Help your patients take charge

As a healthcare provider, you can:

1. assess the current physical activity levels of your patients through the use of physical activity vital signs (PAVS),
2. Provide your patient with brief counseling and a physical activity prescription, and
3. refer to an evidence base program such as Walk With Ease.

The PAVS consists of two: 1. how many days per week do you engage in moderate to strenuous exercise like a brisk walk? 2.how many minutes do you engage in exercise at this level? https://www.exerciseismedicine.org/assets/page_documents/EIM%20Health%20Care%20Providers'%20Action%20Guide.pdf

## Walk With Ease

The Arthritis Foundation Walk with Ease Program is a community-based physical activity and self-management education program. It can be done by individuals using the Walk with Ease workbook on their own, or by groups led by trained leaders. Both the individual and group formats are set up as a structured six-week program. While walking is the central activity, Walk with Ease also includes health education, stretching and strengthening exercises, and motivational strategies. "Walk with Ease was specifically developed for adults with arthritis who want to be more physically active. The program is also appropriate for people without arthritis, particularly those with diabetes, heart disease and other chronic conditions, who want to get more active. The only pre-requisite is the ability to be on your feet for at least 10 minutes without increased pain." https://www.arthritis.org/Florida/-Files/Documents/offering-programs/walk-with-ease-faqs.pdf

## Promoting Physical Activity

The Arkansas Arthritis Program is promoting the CDC's public awareness campaign "Physical Activity. The Arthritis Pain Reliever. Visit the web-site for more information. https://www.cdc.gov/arthritis/interventions/campaigns/index.htm

## Benefits of Physical Activity

- Reduce pain and improve function by 40 percent among adults with arthritis
- Reduce heart disease risk by 40 percent
- Reduce diabetes risk by almost 50 percent
- Reduce morality and recurrent breast cancer risk by nearly 50 percent
- Reduce high blood pressure incidences by about 50 percent
- Lower stroke risk by 27 percent
- Lower colon cancer risk by more than 60 percent
- Decrease depression as effectively as certain medications and behavioral therapies

## Arthritis Resources and References

http://www.cdc.gov/vitalsigns/arthritis/index.html

http://www.exerciseismedicine.org

https://www.arthritis.org/living-with-arthritis/tools-resources/walk-with-ease/

https://www.cdc.gov/arthritis/interventions/campaigns/index.htm

https://oaaction.unc.edu/resource-library/for-community-partners/

## Contact Us

If you're ready to:

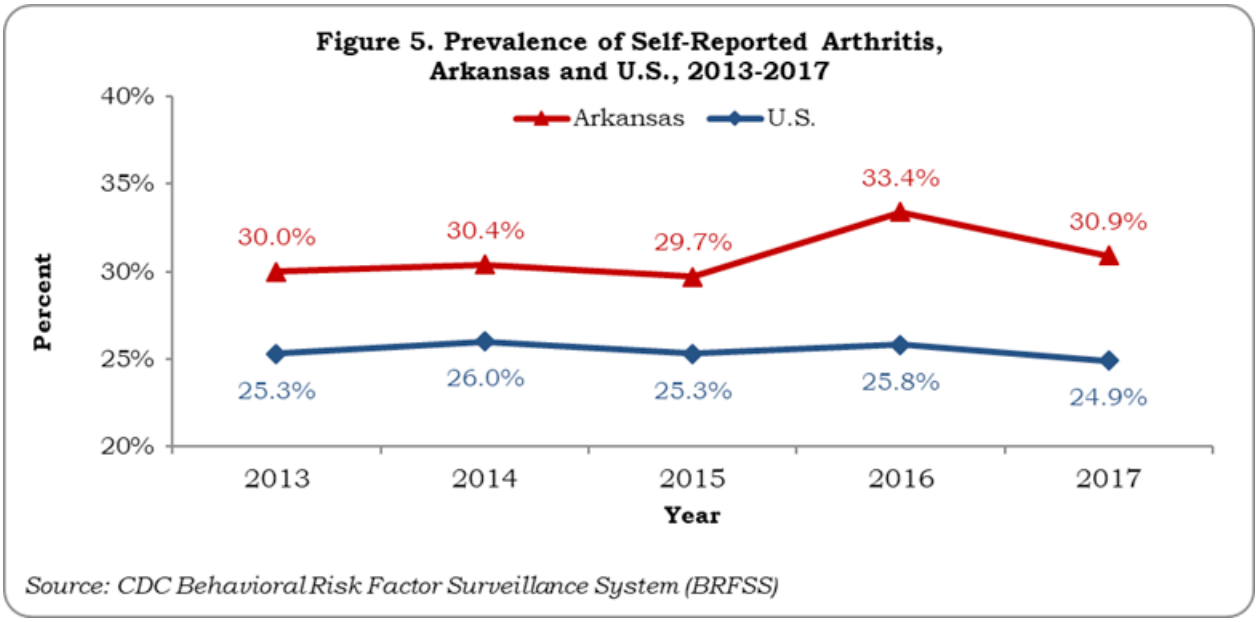
- counsel and refer your patients to be physically active,
- to bring Walk With Ease to your Worksite or other community programs, or
- join a Walk With Ease Group.

## Contact Information

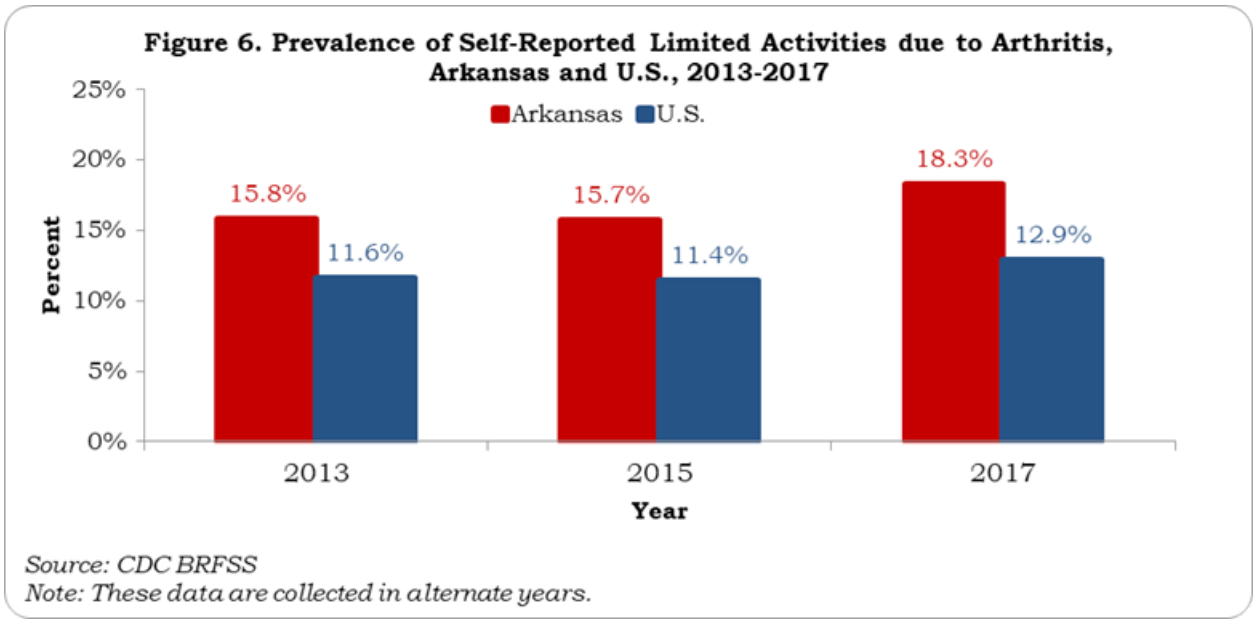
**Donna Miller, Arthritis Program Manager**
Email: donna.miller@arkansas.gov
Telephone: 501-661-2279

**Becky Adams DrPH, RD, CDE**
Director, Partnership and Policy Support
Section Chief, Nutrition, Physical Activity and Obesity
Email: becky.adams2@arkansas.gov
Telephone: 501-661-2334

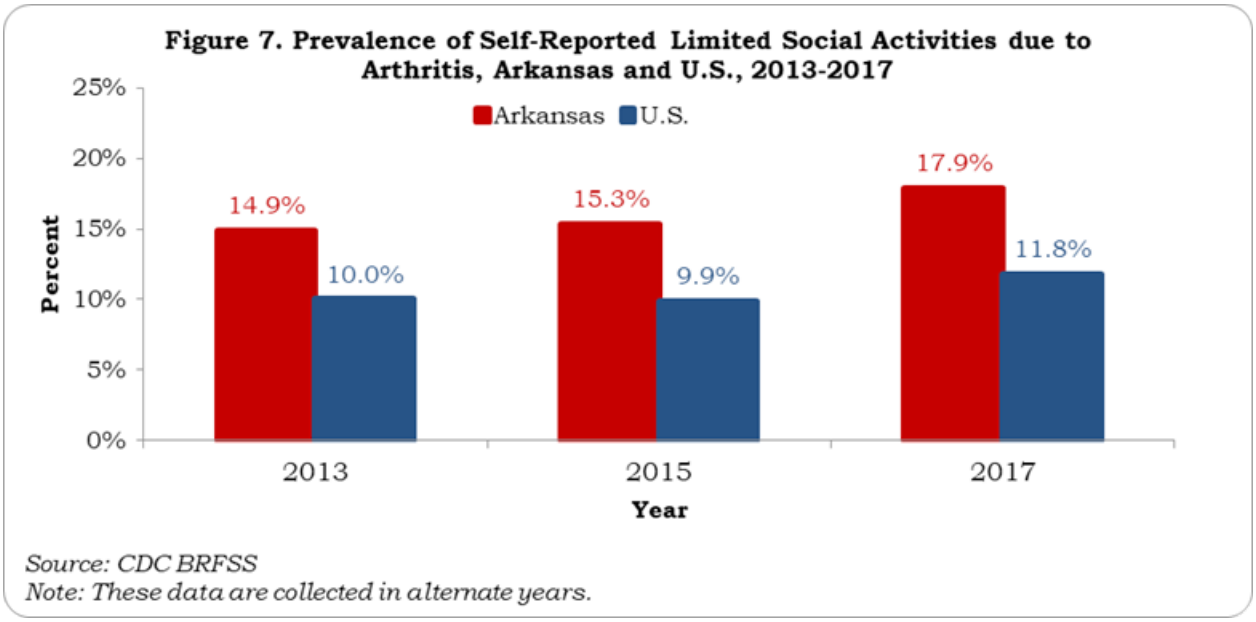
# Arthritis Prevelance



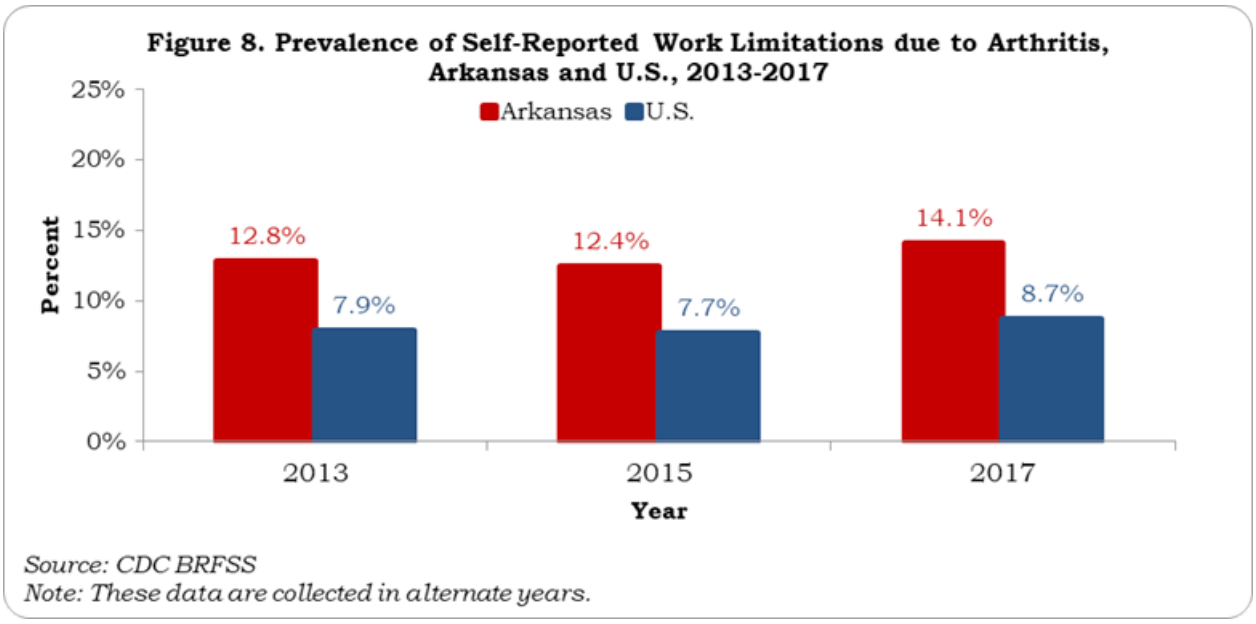

From 2013 to 2017, adults in Arkansas reported a higher prevalence of arthritis than adults in the United States (U.S.). Arkansas's prevalence of self-reported arthritis increased from 30.0% in 2013 to 33.4% in 2016, and a subsequent drop to 30.9% in 2017 (Figure 5).




In each year represented above, the percent of adults who reported limited activities due to arthritis was higher in Arkansas than the U.S. Between 2013 and 2017, the percent of adults that reported limited activities increased in Arkansas, from 15.8% to 18.3%, and in the U.S., from 11.6% to 12.9% (Figure 6).




From 2013 to 2017, the percent of adults who reported limitation of social activities due to arthritis was higher in Arkansas than nationally. The percent of adults with limited social activities increased in Arkansas (from 14.9% to 17.9%) and the nation (from 10.0% to 11.8%) during this time period (Figure 7).




From 2013 to 2017, the percent of adults who reported work limitations due to arthritis was higher in Arkansas than the U.S. During this time period, the prevalence of those reporting work limitations increased for Arkansas, from 12.8% to 14.1%, and the U.S., from 7.9% to 8.7% (Figure 8).

# Arkansas Breastfeeding Coalition

**The Arkansas Breastfeeding Coalition is a statewide multidisciplinary partnership of health care organizations and others invested in improving breastfeeding in Arkansas. It was formed in 2007 and is a 501c3.**

## Mission

To improve the health and well-being of Arkansans by working collaboratively to promote, protect and support breastfeeding.

## Goals

**Increase** public acceptance of breastfeeding, increase public awareness of the health risks associated with formula, and promote behavioral change that results in increased rates of breastfeeding initiation and duration.

**Promote** public policies that support breastfeeding and encourage active support for breastfeeding among key community leaders.

**Educate** health care providers and community members about health care risks associated with not breastfeeding and how they can support those mothers who choose to breastfeed their babies.

**Advocate, promote and educate** Healthy People 2020 breastfeeding goals.

According to the AAP and a Tufts University Meta-analyses: For the mother, NOT breastfeeding is associated with increased risk of blood loss postpartum, slower involution of the uterus postpartum, increased risk of Type 2 diabetes for women who did not have a history of GDM, hypertension, postpartum depression, rheumatoid arthritis, breast cancer, ovarian cancer, and endometriosis.

For the infant, NOT being breastfed is associated with increased risk of acute otitis media, atopic dermatitis, gastrointestinal infections and diseases, lower respiratory tract diseases, asthma, obesity later in life, cardiovascular disease later in life, type 1 diabetes, type 2 diabetes, childhood leukemia and lymphoma, and SIDS. For preterms, it increases risk of necrotizing enterocolitis, sepsis, growth failure, developmental disabilities, enteral feeding, neurodevelopmental issues, lower intelligence, poorer motor skills, retinopathy, and metabolic syndrome.

arkansas breastfeeding coalition

## Evidenced-Based Interventions

The Arkansas Breastfeeding Coalition has successfully implemented and managed the following grants and projects:
An annual statewide Lactation Symposium, co-sponsored by UAMS ANGELS. This will be our seventh year to sponsor this in 2019.
A grant from the Office of Women's Health to help non-traditional worksites implement areas and support for their employees who are pumping.
Two grants from AMCHP to provide support to employers to help them accommodate and support moms who are pumping.
A grant from the Arkansas Black Hall of Fame to provide a Big Sister style support group for pregnant moms in Faulkner county who are African American and first time moms. These included breastfeeding classes.
A grant from NACCHO to hire a breastfeeding peer counselor in Desha county to reach more African American and low income moms in that area and to provide training to hospital staff.

## How to Get Involved

The Arkansas Breastfeeding Coalition has the following committees and welcomes participation from anyone interested in promoting breastfeeding in Arkansas:
Education- The Coalition is focused on improving breastfeeding rates through advocacy and raising awareness of economic and health impacts of breastfeeding. The Education Committee will focus on training and sharing information regarding these activities and will develop materials.

Grants- Responsible for seeking grant funding proposals for projects that contribute to the promotion, protection, and support of breastfeeding. Grant Committee is knowledgeable about grant funding guidelines and policies. This Committee is responsible for reviewing grants submitted to the Coalition with a request for the Coalition to act as the fiduciary agent. Any organization requesting that the Coalition act as a fiduciary agent must act in accordance with the WHO Code of Marketing of Breastmilk Substitutes and must not have activities in conflict with the Mission Statement and Goals of the Coalition.

**Health Disparities** - The Coalition is focused on support for breastfeeding. Access to support and accurate information is often limited among ethnic and racial minorities and those of lower socioeconomic status. The Health Disparities Committee will monitor factors that cause disparities in breastfeeding rates in the state and will encourage activities and policies to increase breastfeeding among those populations that currently have lower rates.

**Membership** - The Membership Committee develops and implements an action plan for recruiting, retaining, and educating members, develops guidelines for membership and is responsible for nominations and ballots for Executive Committee positions. The membership committee is also responsible for keeping the web site and Facebook pages current.

**Regional Representation** - This committee will have representatives from each region of the state and will bring information about the needs and interests specific to that region to the Coalition. They will also bring the information from the Executive Committee back to their area.

## Contact Information

**www.arbfc.org,**
Chair Lucy Towbin
Lucy.Towbin@arkansas.gov
www.facebook.com/ArkansasBreastfeeding

## Resources

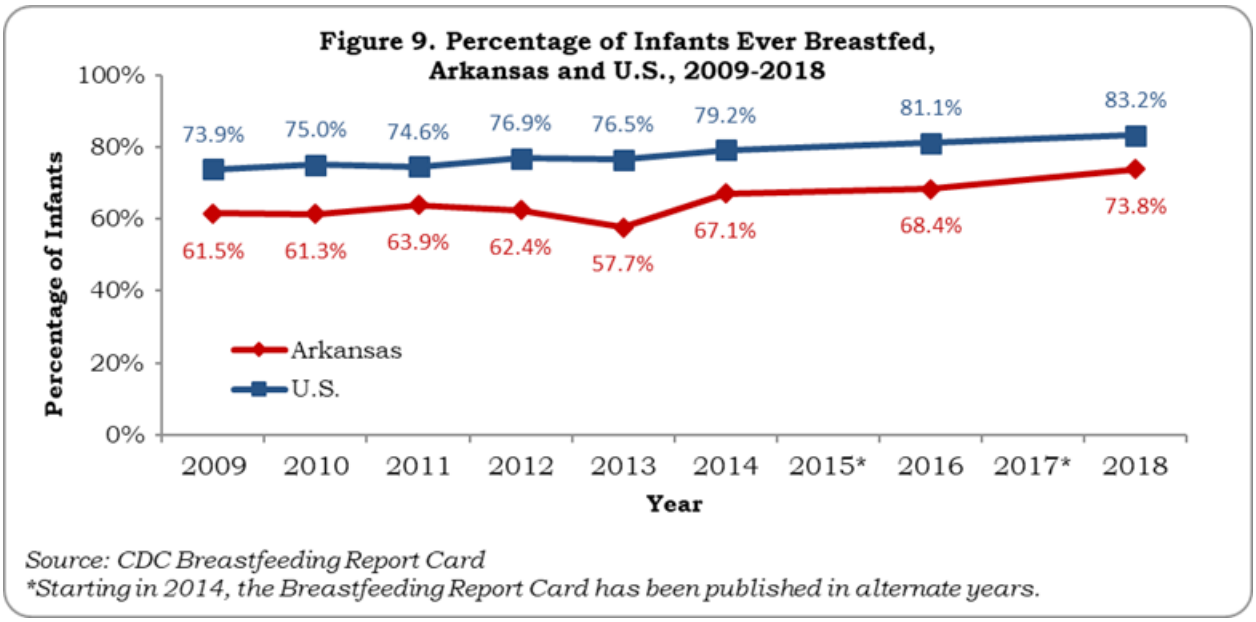
**24 Hour Breastfeeding Helpline:**
**1-800-445-6175**

**La Leche League of Arkansas for mother to mother suppor**t -
https://lllofarkansas.weebly.com/
and https://www.facebook.com/lllcentralarkansas

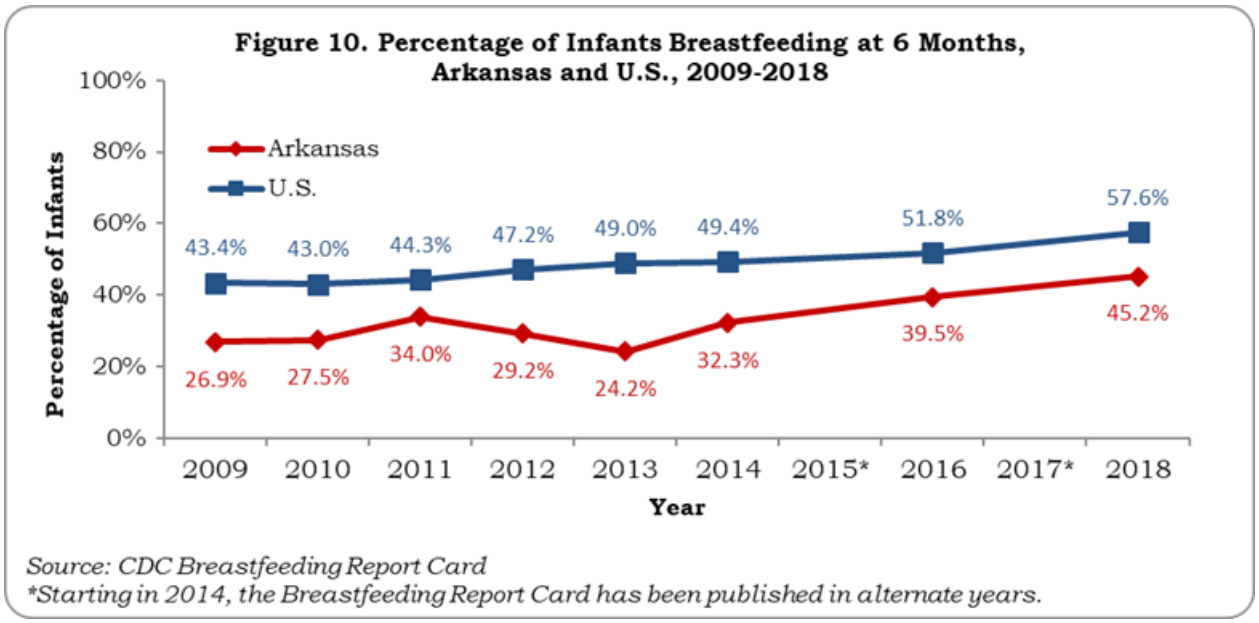
**WIC Breastfeeding Peer Counselors** -
http://www.healthy.arkansas.gov/programs-services/topics/breastfeeding-peer-counselor-program

**Other Arkansas Department of Health Breastfeeding Information:**
http://www.healthy.arkansas.gov/programs-services/topics/breastfeeding-information-and-support

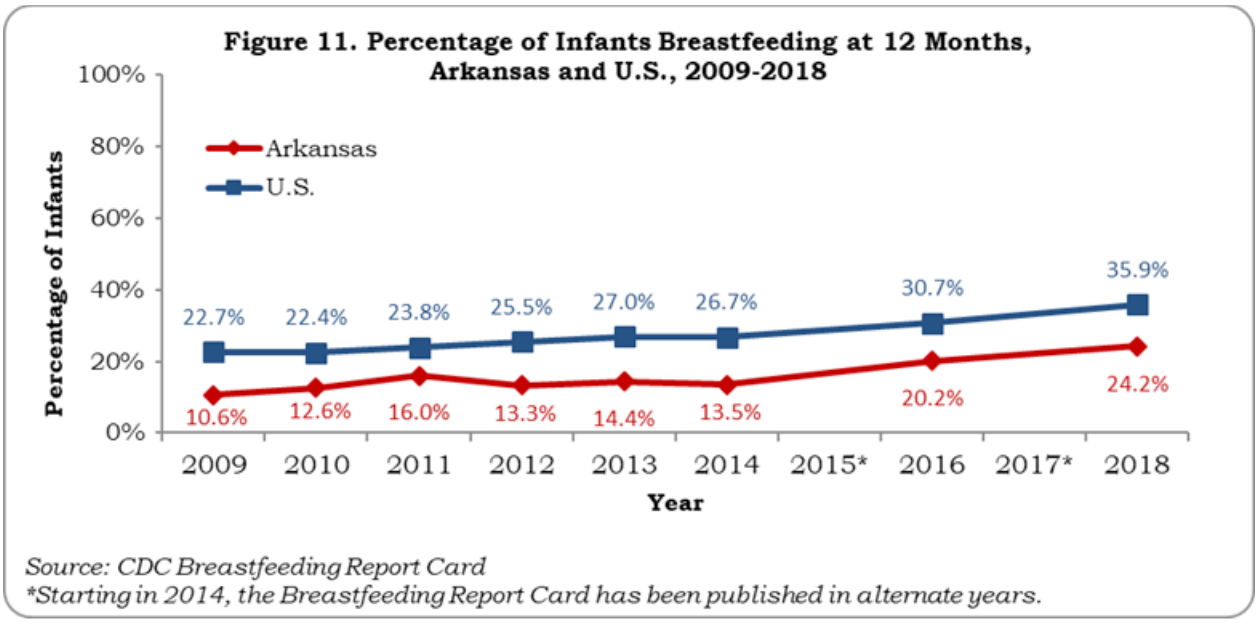
# Breastfeeding Prevelance



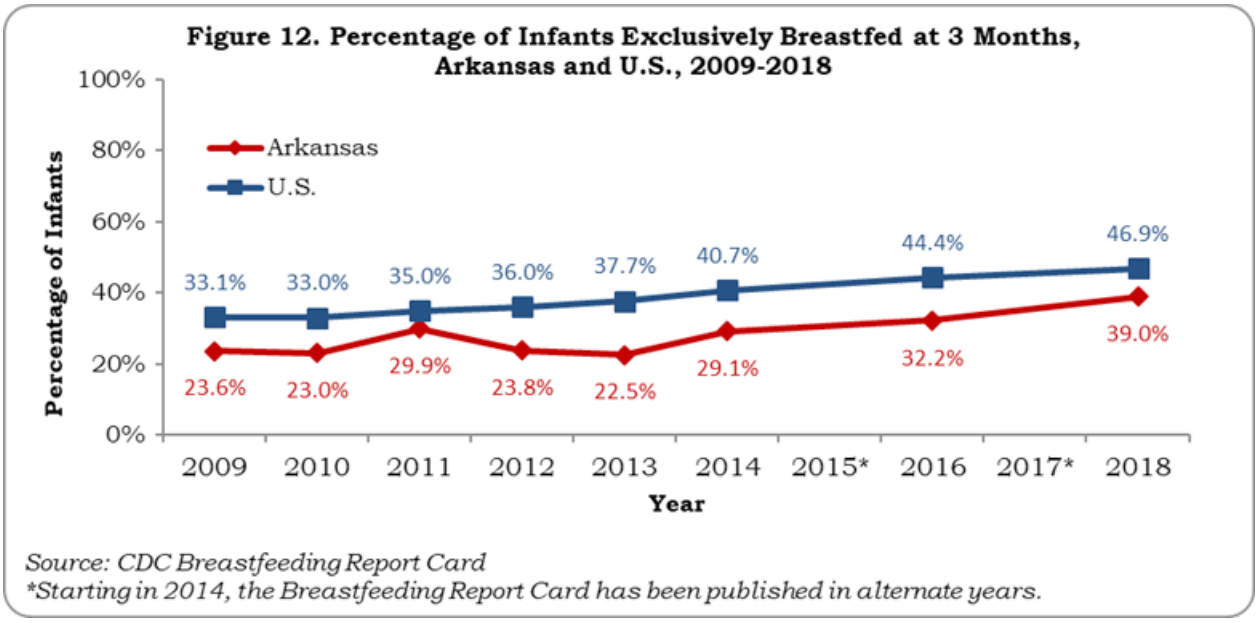

Between 2009 and 2018, the percentage of infants ever breastfed increased for Arkansas, from 61.5% to 73.8%, and for the U.S., from 73.9% to 83.2%. Arkansas's breastfeeding prevalence remains lower than the national prevalence (Figure 9).



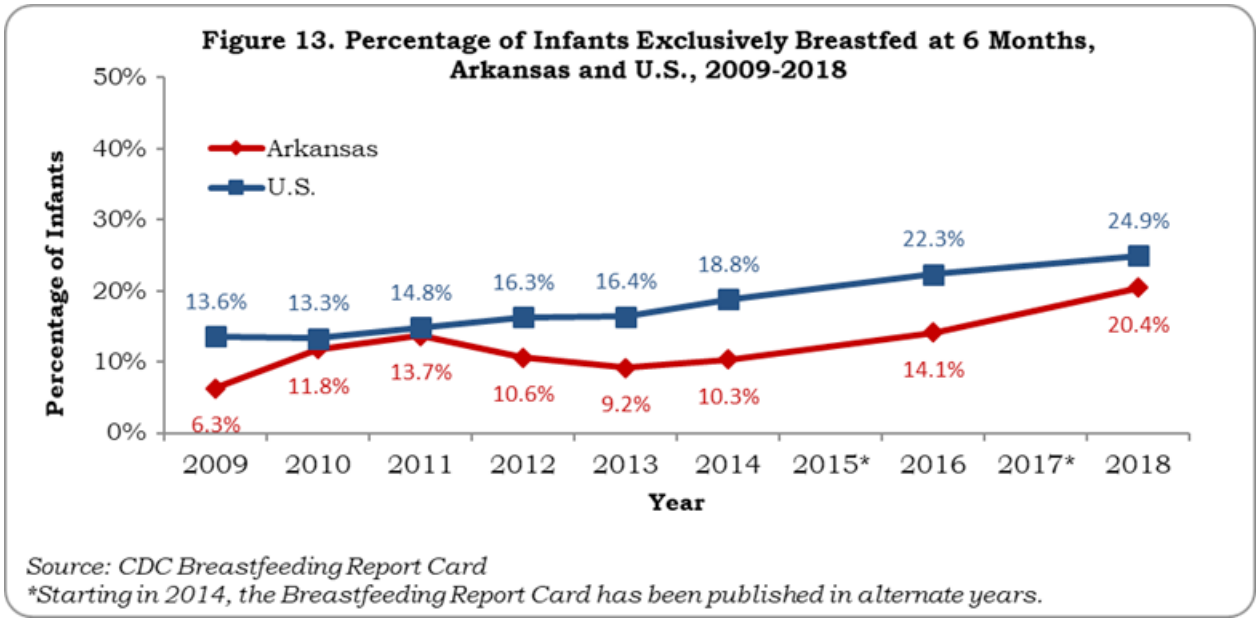

The percentage of infants breastfeeding at 6 months of age increased in Arkansas, from 26.9% to 45.2%, between 2009 and 2018. The percentage of infants breastfeeding at 6 months of age in Arkansas remained below the national rate throughout the last 10 years (Figure 10).



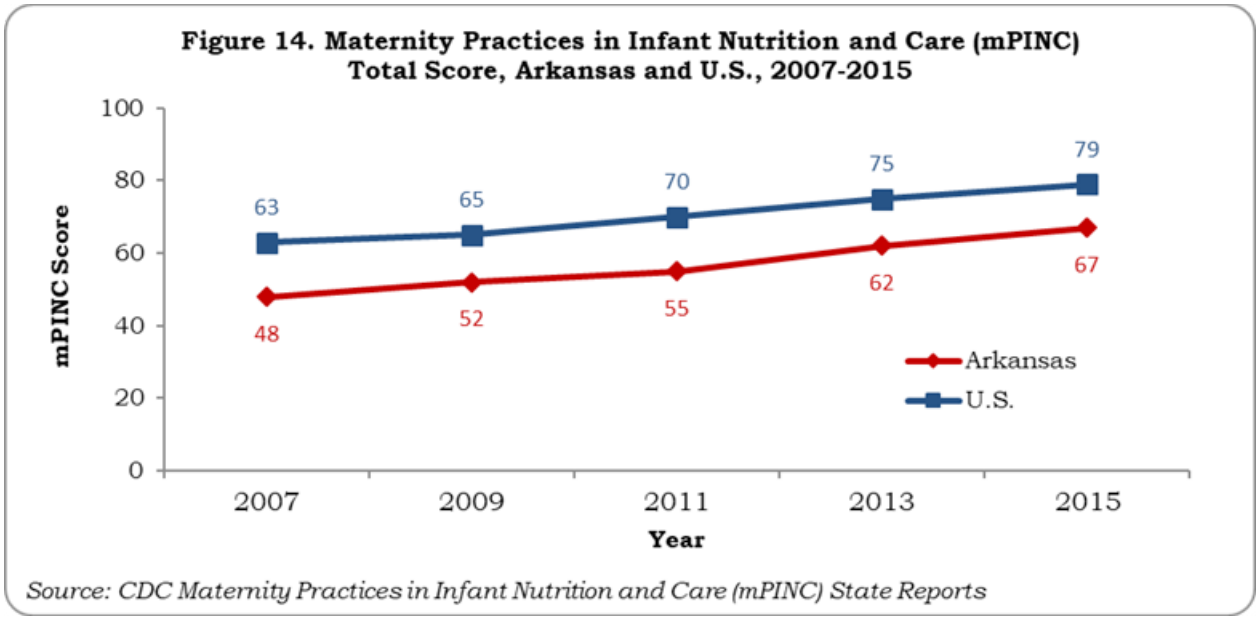

Between 2009 and 2018, the percentage of infants breastfeeding at 12 months of age more than doubled in Arkansas, from 10.6% to 24.2%, and increased by more than half for the U.S., from 22.7% to 35.9% (Figure 11).




Between 2009 and 2018, the percentage of infants exclusively breastfed at three months of age nearly doubled in Arkansas, from 23.6% to 39.0%, and increased by nearly half nationally, from 33.1% to 46.9% (Figure 12).




Between 2009 and 2018, the percentage of infants exclusively breastfed at 6 months tripled in Arkansas, from 6.3% to 20.4%, and nearly doubled nationally, from 13.6% to 24.9% (Figure 13).




The Maternity Practices in Infant Nutrition and Care (mPINC) survey measures infant feeding care practices, policies, and staffing expectations at hospitals that provide maternity services. Each hospital is given a score from 1 to 100 based on: policies for staff training and infant feeding care, practices in supplementing breastfed infants, and protocols for support after discharge to home. These scores are then averaged to calculate the state total score. Between 2007 and 2015, the mPINC score increased for both Arkansas and the U.S., from 48 to 67 and 63 to 79, respectively (Figure 14).

# Arkansas Cancer Coalition

**The Arkansas Cancer Coalition (ACC) is a network of cancer control partner organizations formed in 1993.**

## 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 is key in helping to find breast, cervical, colorectal, lung, skin, oral and other 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.

## Evidence-Based Interventions

The ACC provides funding for projects that implement evidence-based cancer control strategies in these areas:

- Policy, Systems and Environmental Change
- Cancer Prevention
- Lung Cancer
- Colorectal Cancer
- Breast Cancer
- Prostate Cancer
- Oral Cancer
- Skin Cancer
- Cervical Cancer
- Palliative Care
- Survivorship
- Surveillance & Evaluation
- Bone Metastasis
- Genomics

In collaboration with the ACC and in support of the Arkansas Cancer Plan, the Arkansas Department of Health's Comprehensive Cancer Control Program 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: Cancer is Personal" 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 roundtables 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 roundtable, please contact info@arcancercoalition.org or visit www.arcancercoalition.org for more information.

Roundtables include the following:

- Breast Cancer Roundtable
- Lung Cancer Roundtable
- Colorectal Cancer Roundtable
- HPV Roundtable

New roundtables may also form to address special issues.

## Resources

**Arkansas Cancer Coalition**
www.arcancercoalition.org

**American Cancer Society - Arkansas**
www.cancer.org

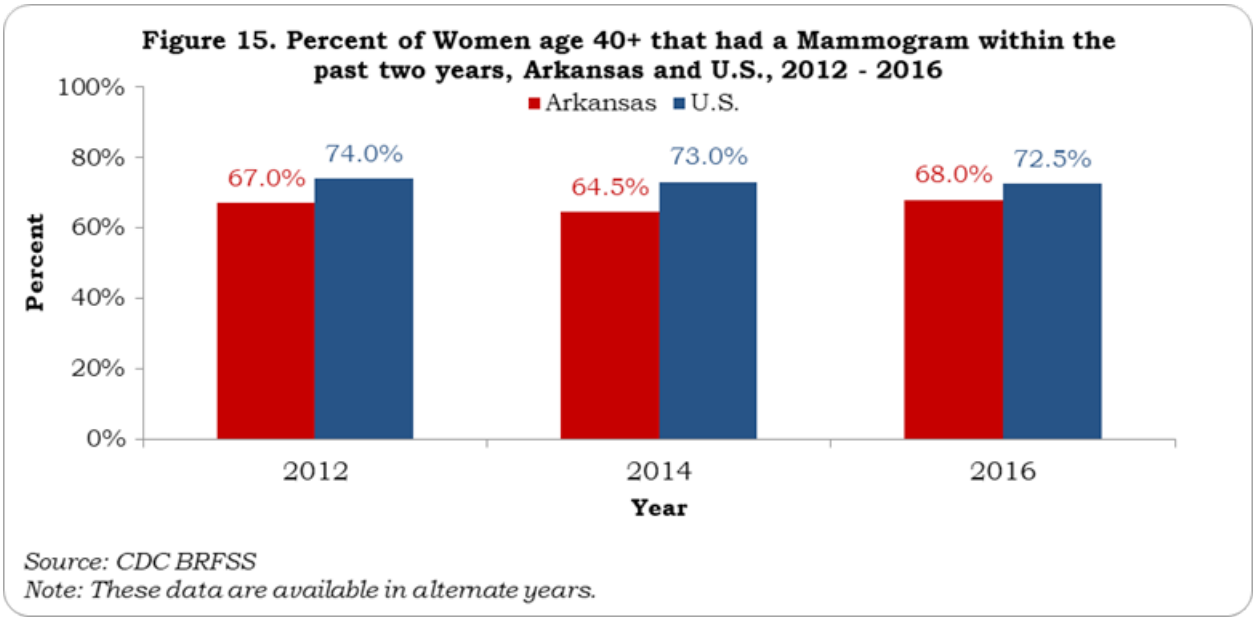
**American Lung Association in Arkansas**
www.lung.org

**Arkansas Department of Health, BreastCare**
www.ARBreastCare.com

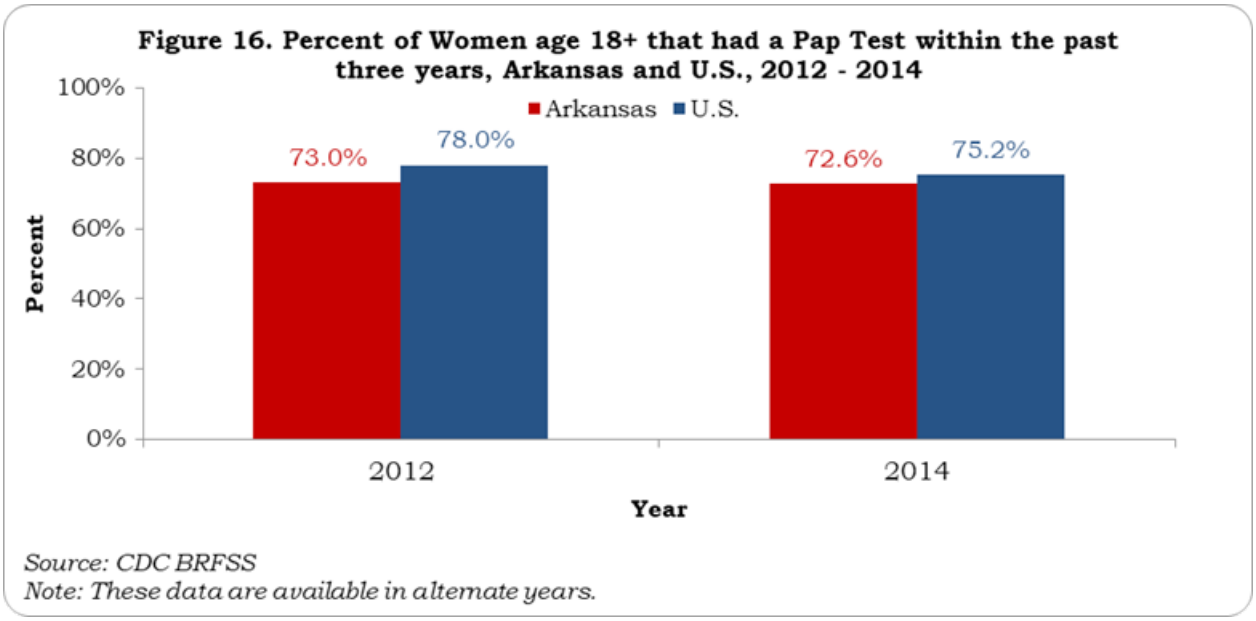
**Centers for Disease Control and Prevention**
www.cdc.gov/cancer

**Susan G. Komen**
www.komen.org

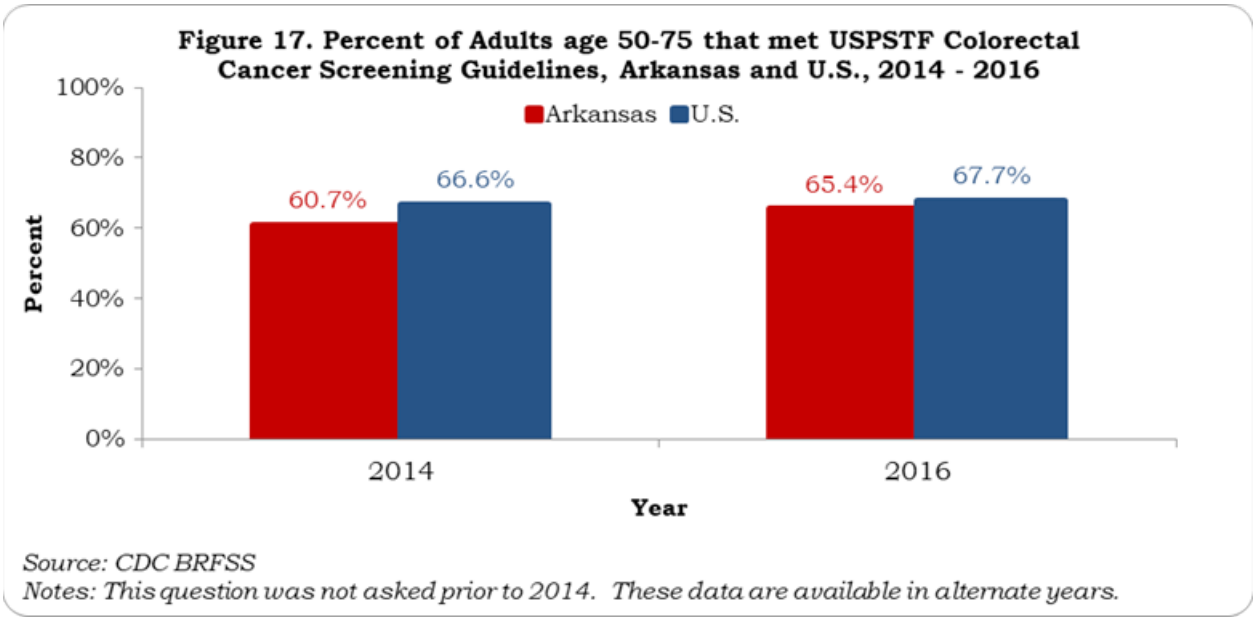
# Cancer Screening Prevelance



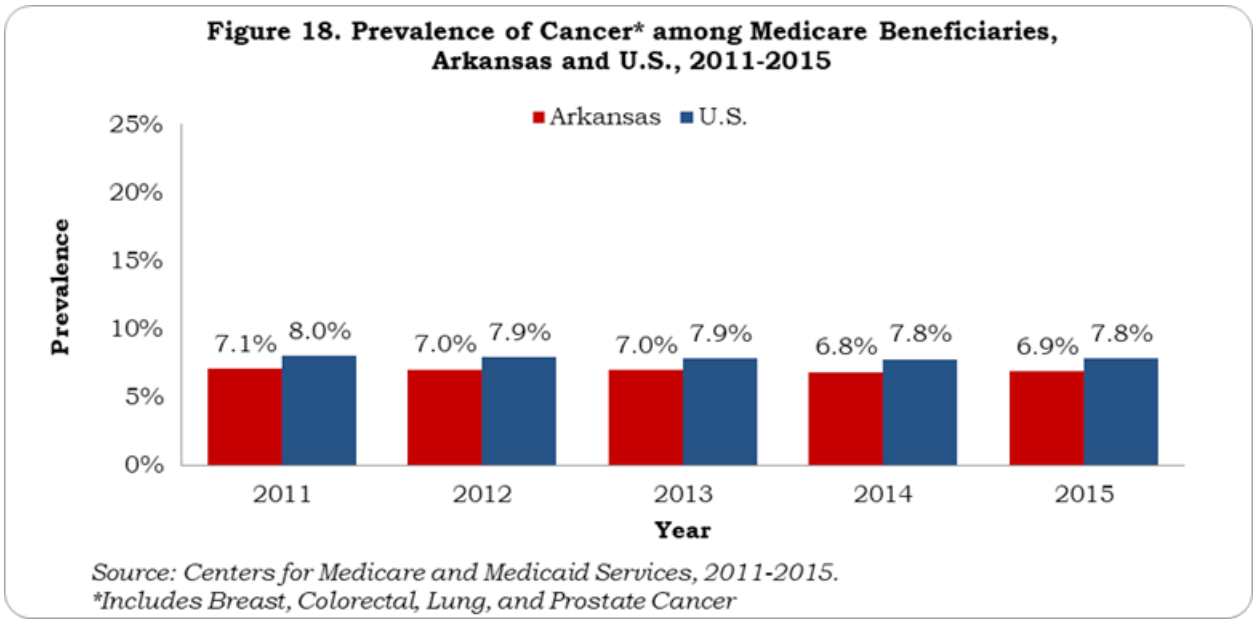

The percent of women who reported they had a mammogram within two years prior to participating in the BRFSS survey increased slightly in Arkansas (from 67.0% to 68.0%), but decreased nationally (from 74.0% to 72.5%) between 2012 and 2016. In each year, the percent of women who reported having a mammogram was lower in Arkansas than the U.S. (Figure 15).




Between 2012 and 2014, the percent of women that reported they had a pap test within three years prior to the BRFSS survey decreased in both Arkansas, from 73.0% to 72.6%, and the nation, from 78.0% to 75.2%. Throughout this time period, the percent of women reporting a pap test was lower in Arkansas than the U.S. (Figure 16).




The percent of adults age 50-75 who reported meeting the United States Preventive Services Task Force (USPSTF) colorectal cancer screening guidelines was higher for the U.S. than in Arkansas between 2014 and 2016. The prevalence of colorectal screening increased during this time in both Arkansas, from 60.7% to 65.4%, and nationally, from 66.6% to 67.7% (Figure 17).

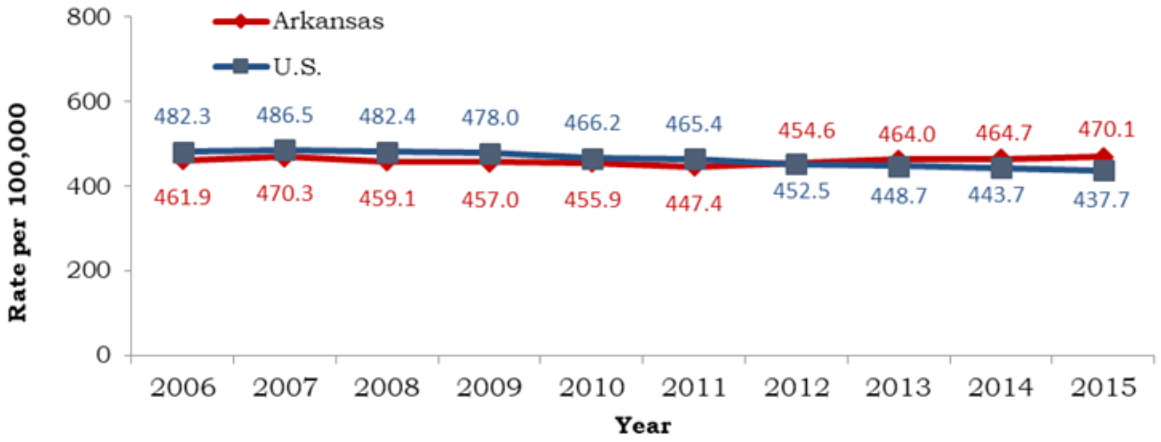



Electronic health record (EHR) data show the prevalence of cancer among Medicare beneficiaries has remained stable over time for both Arkansas and the U.S. In 2015, the prevalence of cancer among the Medicare population was 6.9% for Arkansas and 7.8% for the U.S. (Figure 18).

Figure 27 (page 27) shows that although Arkansas's cancer prevalence among Medicare beneficiaries is lower than that of the U.S., 40% of the state's counties have higher than the state's average prevalence for leading cancers (breast, cervical, lung, and prostate cancers).

# Cancer Incidence and Mortality

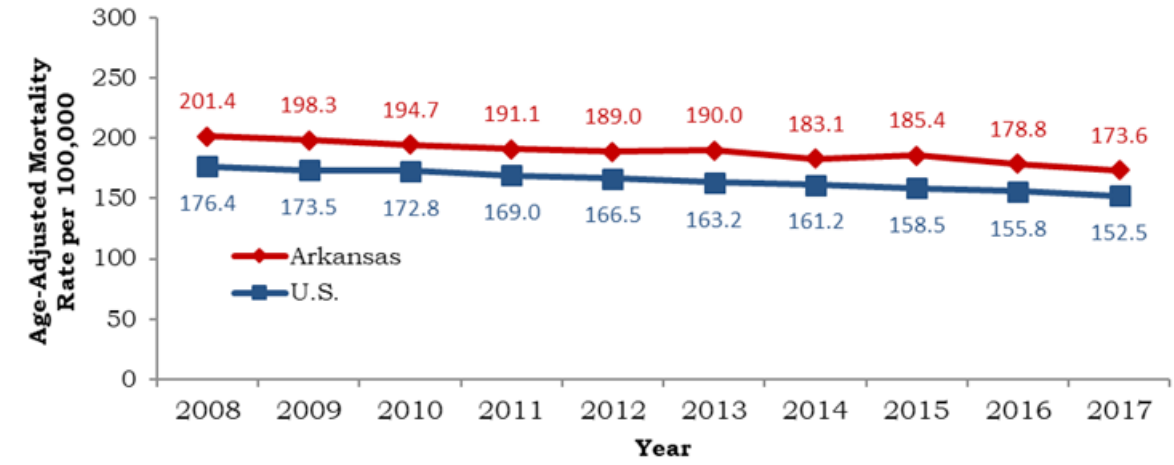
**Figure 19. Age-adjusted Incidence Rates of Malignant Neoplasms (All Sites, All Invasive Cancers), Arkansas and U.S., 2006-2015**




*Source: CDC WONDER*

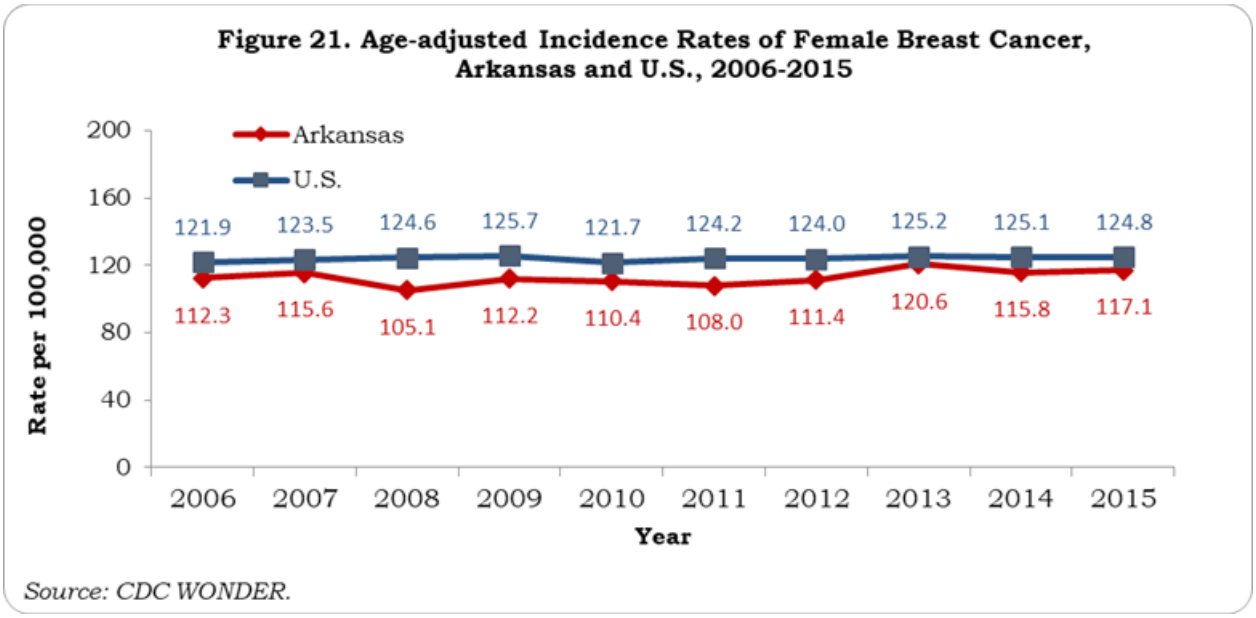
The incidence (occurrence of new cases) rates of malignant neoplasms (invasive cancers), in Arkansas, increased from 461.9 per 100,000 in 2006 to 470.1 per 100,000 in 2015. U.S. incidence rates decreased during this time period from 482.3 to 437.7 per 100,000 population (Figure 19).

**Figure 20. Age-adjusted Mortality Rates of Malignant Neoplasms (All Sites, All Invasive Cancers), Arkansas and U.S., 2008-2017**

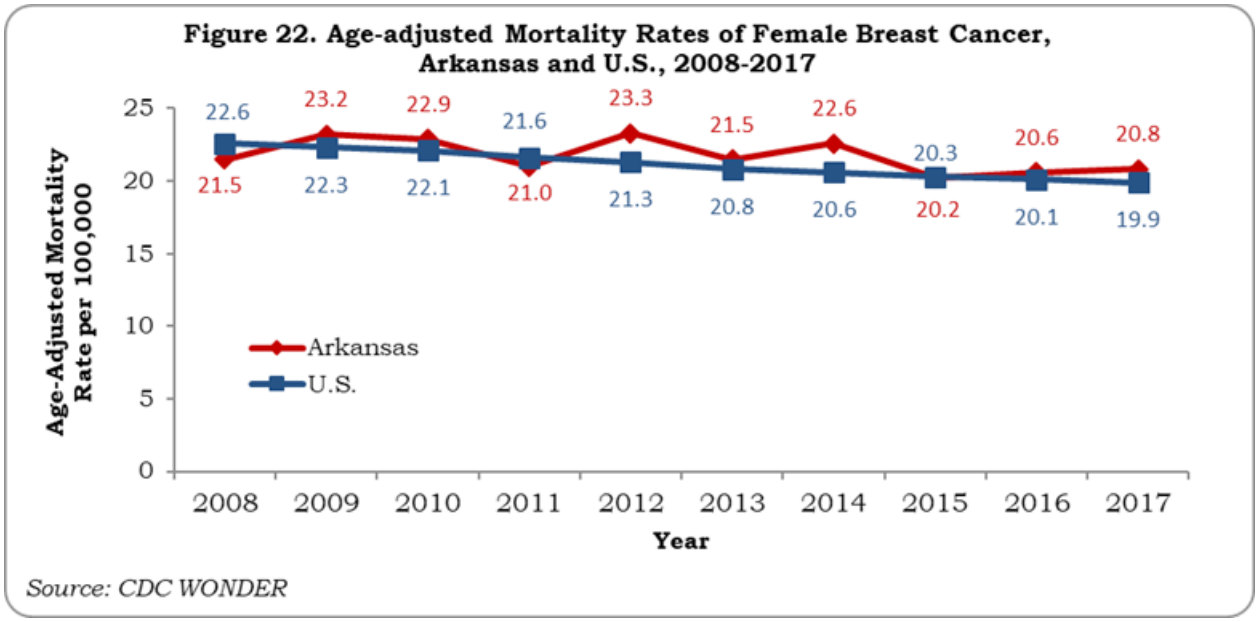



*Source: CDC WONDER*

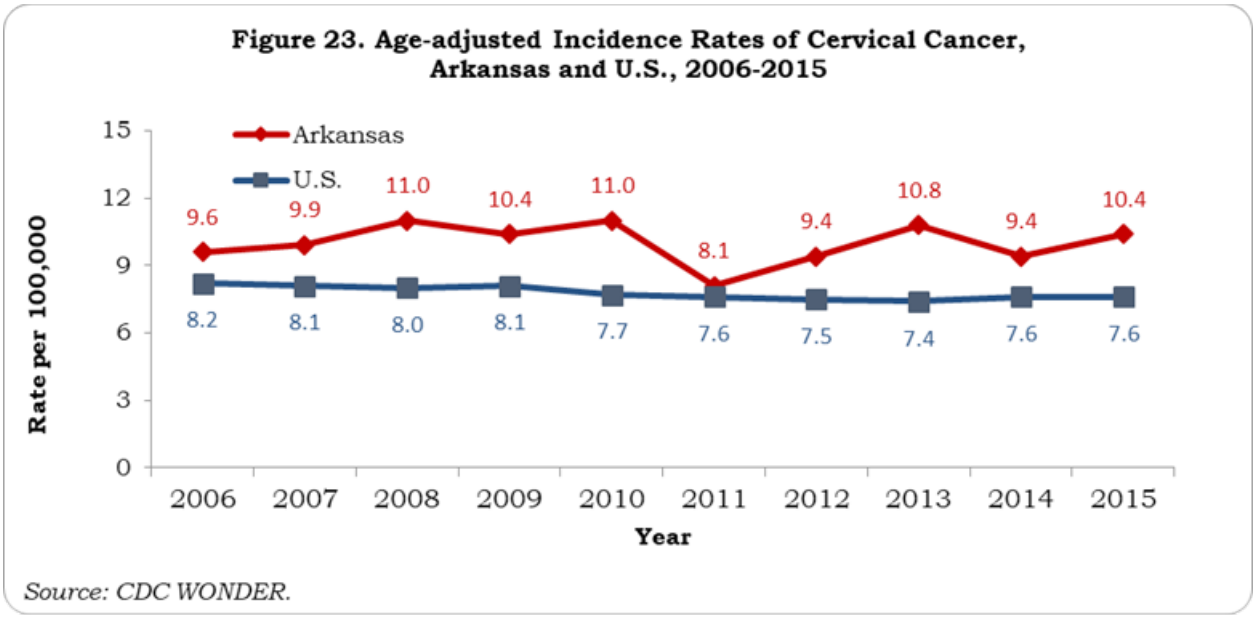
Invasive all-cancer mortality (death) rates for both the state and the nation have declined during the past decade; however, Arkansas's overall rates have consistently been higher than national rates (Figure 20).



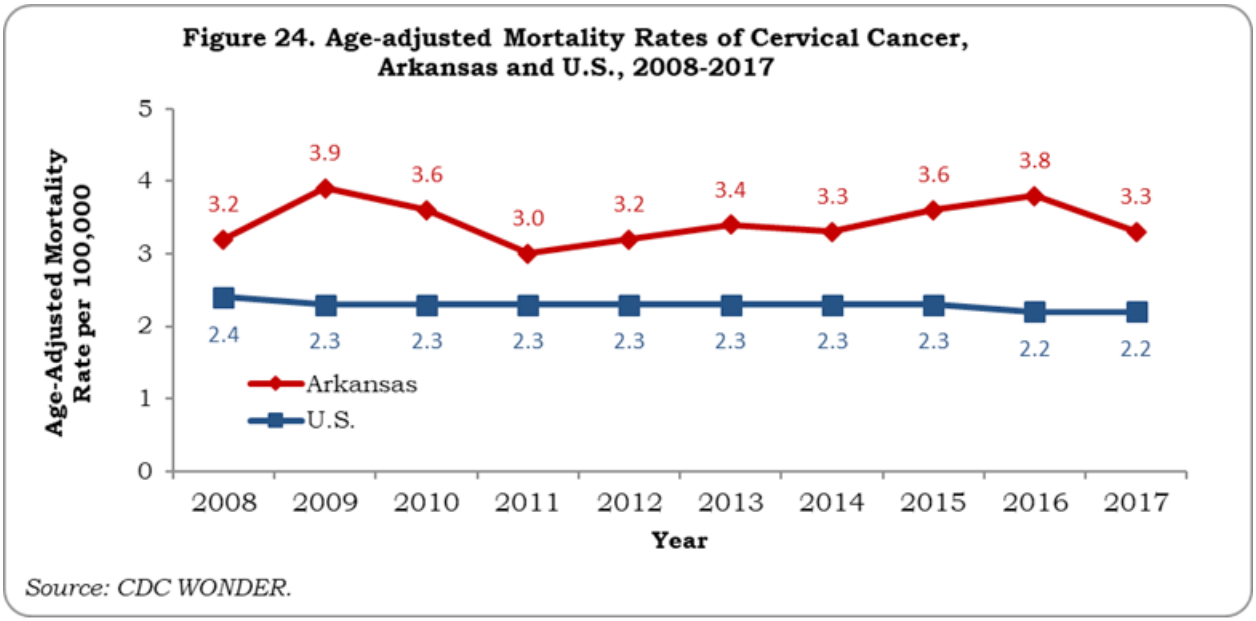

Between 2006 and 2015, the incidence rates of female breast cancer increased slightly in both Arkansas (from 112.3 to 117.1 per 100,000) and the US (from 121.9 to 124.8 per 100,000). During this time, the incidence rate of female breast cancer was lower in Arkansas than the U.S. (Figure 21).



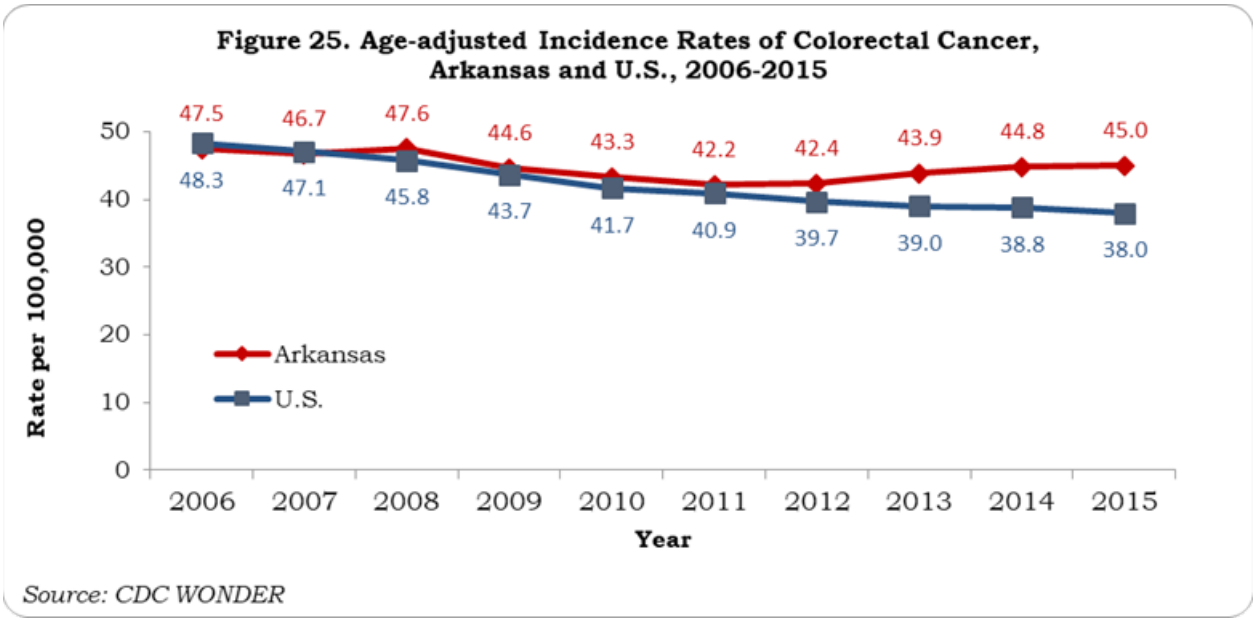

Death rates due to female breast cancers showed similar trends for Arkansas and the U.S. between 2008 and 2017. The death rates decreased in both Arkansas, from 21.5 to 20.8 per 100,000, and nationally, from 22.6 to 19.9 per 100,000 during this time period (Figure 22).



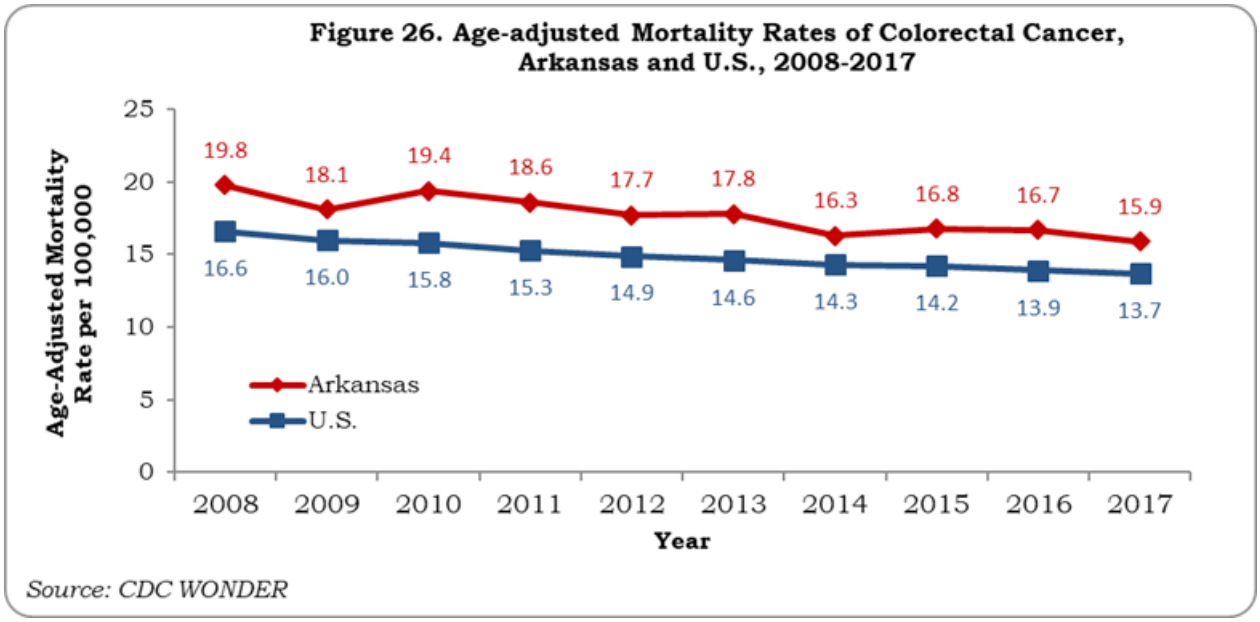

The incidence rates of cervical cancer increased in Arkansas (from 9.6 to 10.4 per 100,000), but decreased nationally (from 8.2 to 7.6 per 100,000) between 2006 and 2015. The incidence rate was lower for the U.S. than in Arkansas, during this time period (Figure 23).




Between 2008 and 2017, the death rates of cervical cancer remained relatively stable between 3.2 and 3.9 per 100,000 in Arkansas, and between 2.4 and 2.2 per 100,000 for the U.S. The death rates of cervical cancer were higher for Arkansas compared to the U.S. for each year displayed (Figure 24).

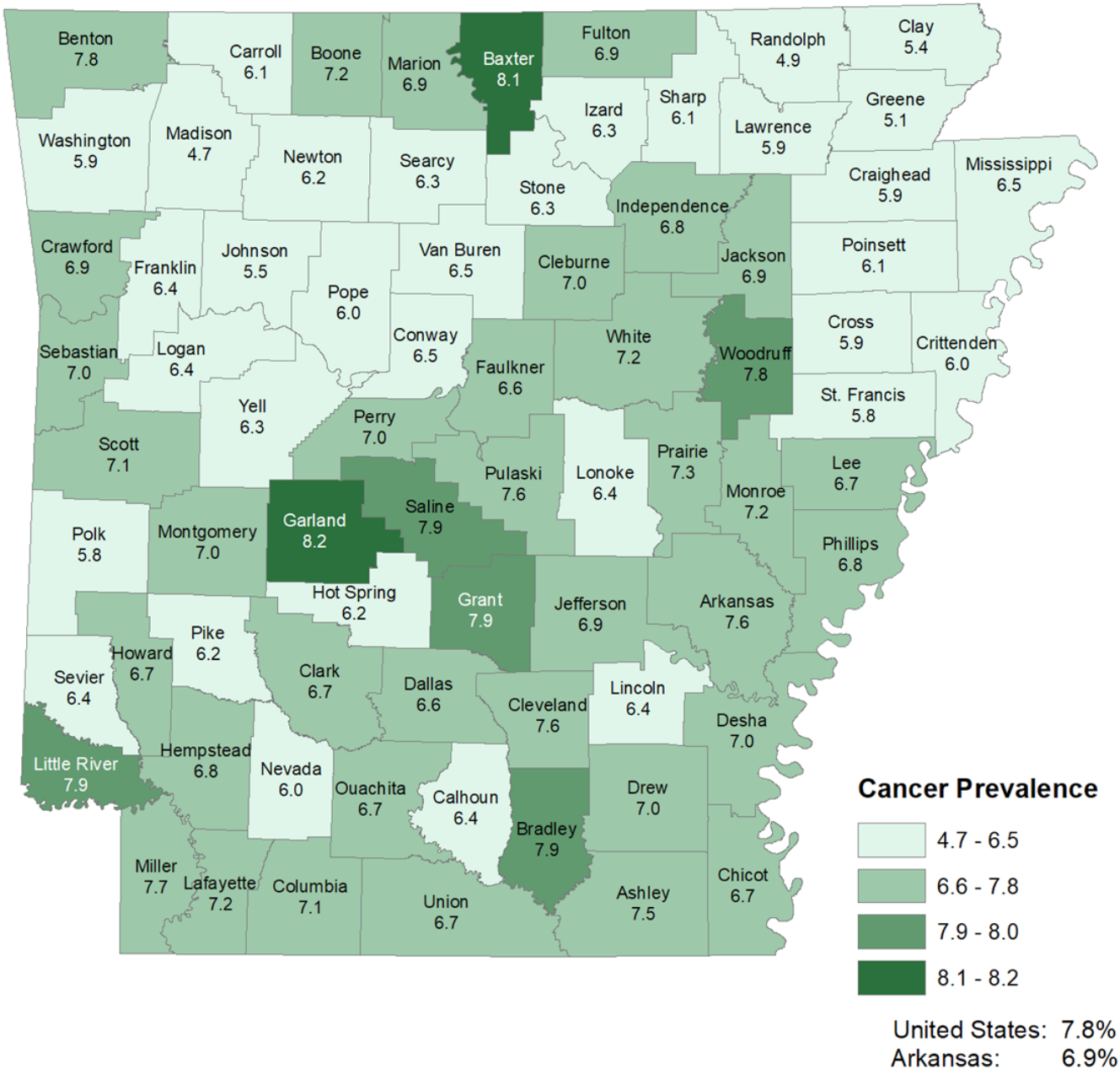



The incidence rates of colorectal cancer decreased in both Arkansas (from 47.5 to 45.0 per 100,000) and the U.S. (48.3 to 38.0 per 100,000), between 2006 and 2015. From 2008 to 2016, the incidence rates of colorectal cancer was lower for the U.S. than Arkansas (Figure 25).




Between 2008 and 2017, the death rates of colorectal cancer decreased in both Arkansas (from 19.8 to 15.9 per 100,000) and the U.S. (from 16.6 to 13.7 per 100,000). Over the last decade, death rates of colorectal cancer were higher for Arkansas than the U.S. (Figure 26).

# Cancer Prevelance By State Counties




*Includes Breast, Colorectal, Lung, and Prostate Cancer

Date Created: April 8, 2019
Source: Centers for Medicare & Medicaid Services, 2015
Author: Brandy Sutphin, MPH, Chronic Disease Epidemiology Section

ARKANSAS DEPARTMENT OF HEALTH

# 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

The Arkansas Coalition for Obesity Prevention is a 501c3 organization and is governed by a Board of Directors elected by the members. The Directors include the Chair, 1st Vice Chair, 2nd Vice Chair, Past Chair, Secretary and Fiscal Chair. There is an advisory committee to guide the Board, Organization and Membership. The President/ Executive Director leads the organization and the efforts to Grow Healthy Communities through policy, system and environmental enhancements.

## 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 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

Arkansas Coalition for Obesity Prevention

## Growing Healthy Communities (GHC)

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 who receive the "Emerging" designation, are laying a strong foundation with a team of at least five individuals. GHC teams are made up of diverse stakeholders who are interested in creating healthier communities: elected officials, fundraisers, community volunteers and professionals in education, health-care, civic government and more.

### Blossoming Communities

Communities that receive the "Blossoming" designation build upon the requirements of Emerging Communities and also provide community highlights, strategize plans for change, document successes and lessons learned. Strategic plans guide the direction community members take towards a clear, unified vision.

### Thriving Communities

Communities that receive the "Thriving" designation build upon the requirements of Blossoming Communities and also demonstrate environment, system and policy level enhancements. A community's ability to make lasting change to both the environment and public policies is a sign of success and sustainability.

## 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:

- Working with communities to establish community gardens, Farmer's Markets with Double Up Food Bucks, and providing the Growing Healthy Produce mobile unit.
- Providing education about healthy affordable food preparation through the cooking demonstrations and nutritional education classes.
- Promoting breastfeeding as the first nutritional meal for babies.

## 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

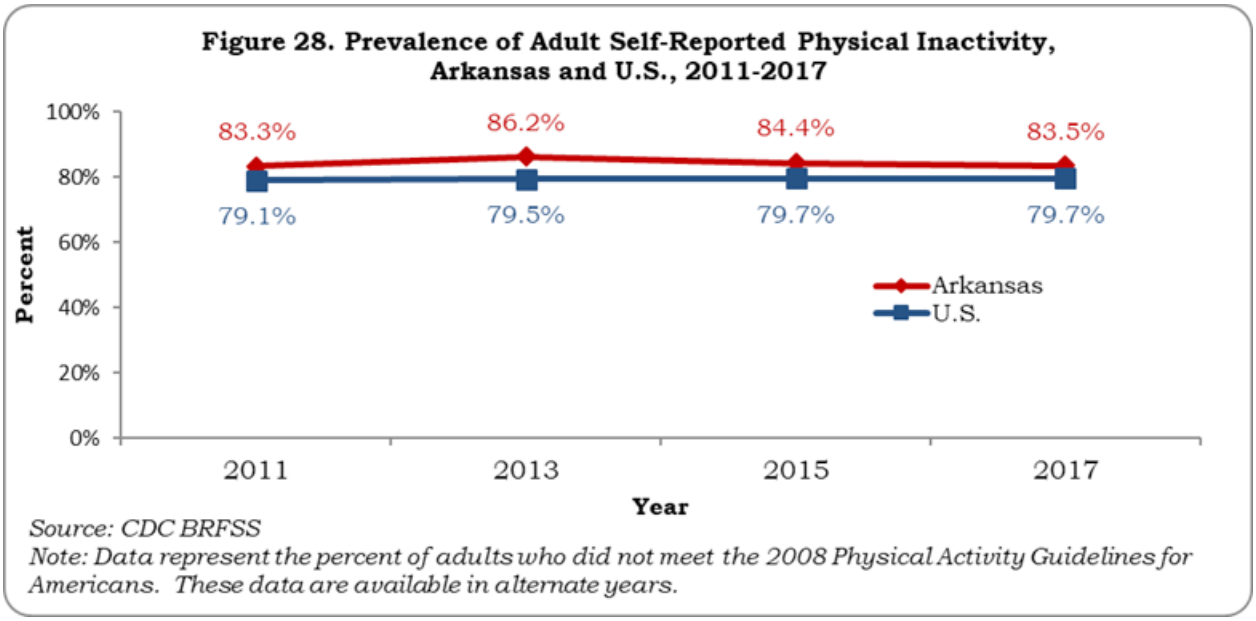
A lack of physical activity is one of the leading contributors to obesity and poor health. In many neighborhoods, there are not sufficient, safe places for walking, bike riding or physical play. Our community environments must change so that all families have access to safe places to be physically active. 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.

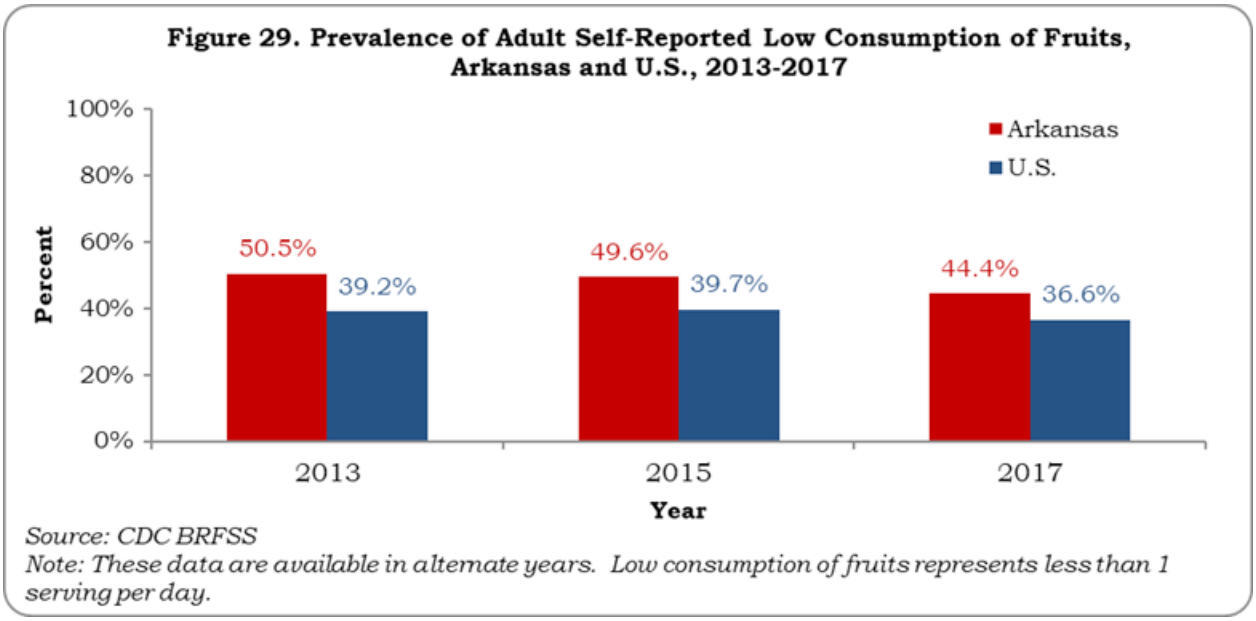
### Contact Information

**PO Box 1212 Greenbrier, AR 72058**
**Email:** Katrina.Betancourt@arkansasonbesity.org
**On Twitter:** #AROBESITY
**On Facebook:** https://www.facebook.com/arkansasobesity
**Online:** http://www.arkansasobesity.org/

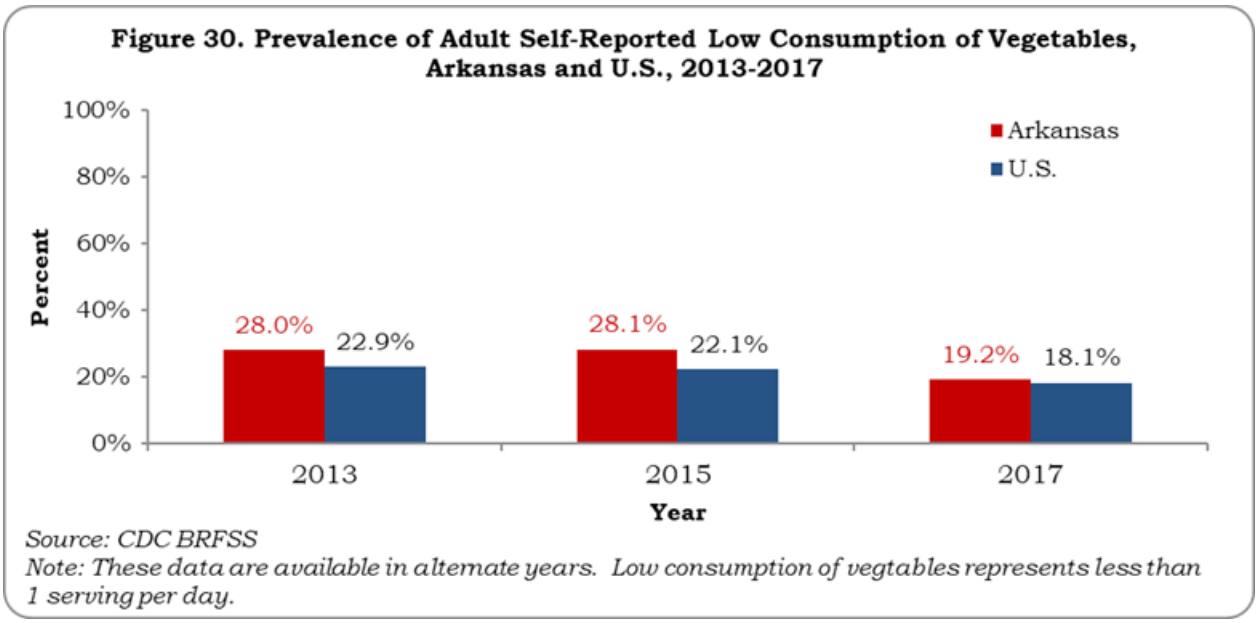
# Prevalence of Physical Activity, Fruit and Vegetable Consumption, and BMI Categories



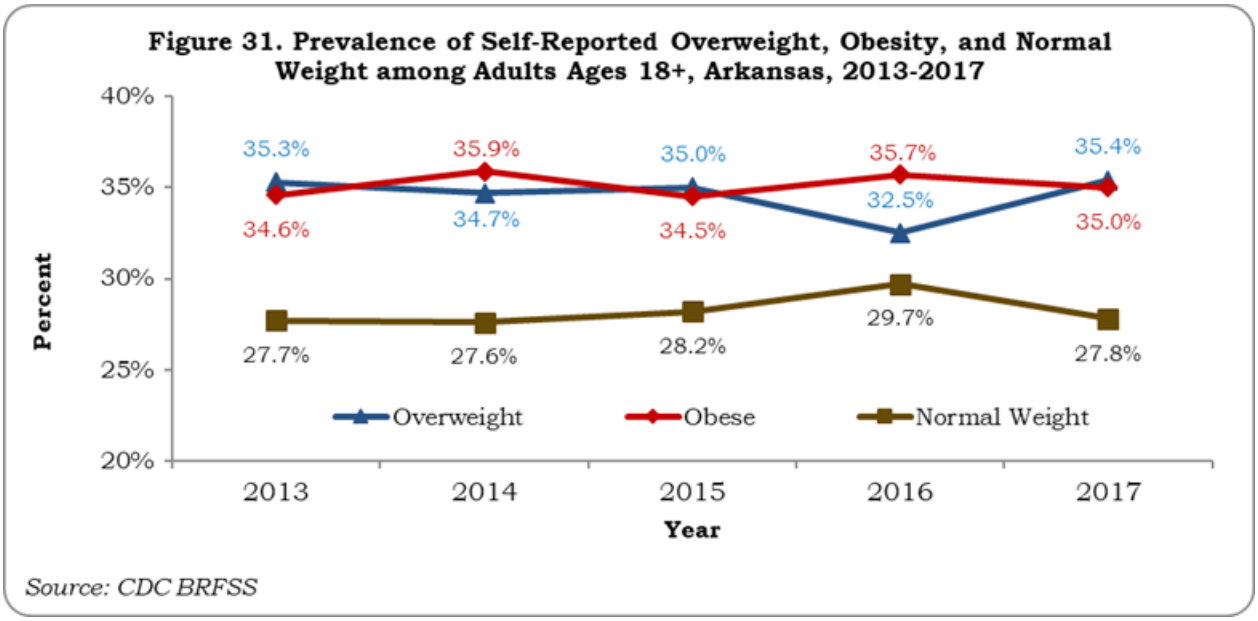

The percentage of Arkansan adults who reported that they did not meet minimum recommendations of the 2008 U.S. Department of Health & Human Services physical activity guidelines for 150 minutes of cardiovascular exercise and at least two days of strengthening exercises per week did not change much between 2011 and 2017. The percent of adults that reported not meeting the guidelines was higher in Arkansas than in the U.S. throughout this time period (Figure 28).




In 2013, 50.5% of Arkansas adults reported consuming less than one serving of fruit per day, compared to 39.2% of U.S. adults. This decreased to 44.4% in Arkansas and 36.6% in the U.S. in 2017 (Figure 29).




In 2017, 19.5% of adults in Arkansas reported consuming less than one serving of vegetables per day, compared with 18.1% of U.S. adults. The prevalence of vegetable consumption has been decreasing over time (Figure 30).




The self-reported prevalence of overweight (body mass index or BMI = 25.0-29.9) and obesity (BMI ≥30.0) remained relatively unchanged in Arkansas between 2013 and 2017. Normal weight prevalence increased from 2013 to 2016, before deceasing in 2017. Adult obesity has decreased by 0.7 percentage points between 2016 and 2017, while the percentage of overweight adults has increased by 2.9 percentage points (Figure 31).

# 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 Arkansas Diabetes Council (DAC) is to reduce the economic, social, physical and psycho-logical 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 strat-egies.

## Goals

Increase prediabetes/diabetes knowledge among patients and caregivers.

**Expand** providers' cultural competency, prediabetes/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 prediabetes/ diabetes (or their family members), nurse educators, dietitians, health educators, primary care providers, podiatrists, endocrinologists, epidemiologists, psychologists, pharmacists, community health centers, diabetes education programs, Diabetes Prevention Program organizations, 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 prediabetes knowledge among patients to improve prevention lifestyle changes and diabetes knowledge among patients and caregivers to improve diabetes self-management behaviors and related health outcomes.

### Provider Education

Expand providers' cultural competency, diabetes/prediabetes 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

### Consumers:

Prediabetes Risk Test at https://doihaveprediabetes.org/

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) at http://www.childrenwithdiabetes.com/

Juvenile Diabetes Research Foundation International

HealthierUS.gov

ChooseMyPlate.gov

Choose to Move at https://www.heart.org/HEARTORG/

Learning About Diabetes.org

National Kidney Disease Education Program

National Kidney Foundation - Chronic Kidney Disease

Centers for Disease Control and Prevention - Kidney Disease Initiative

### Prescription Assistance Programs:

RXAssist.org (directory of patient assistance programs)

Partnership for Prescription Assistance at pparx.org

### Spanish Speaking:

National Alliance for Hispanic Health

Diabetes Report from the National Alliance for Hispanic Health

### Professionals:

National Standards of Medical Care in Diabetes - 2018

National Diabetes Prevention Program Recognized Program

Diabetes Self-Management Education and Support (DSME/S) program

American Diabetes Association

American Dietetic Association

National Diabetes Education Program

STOP Diabetes

Road to Health Toolkit

Prediabetes Risk Test

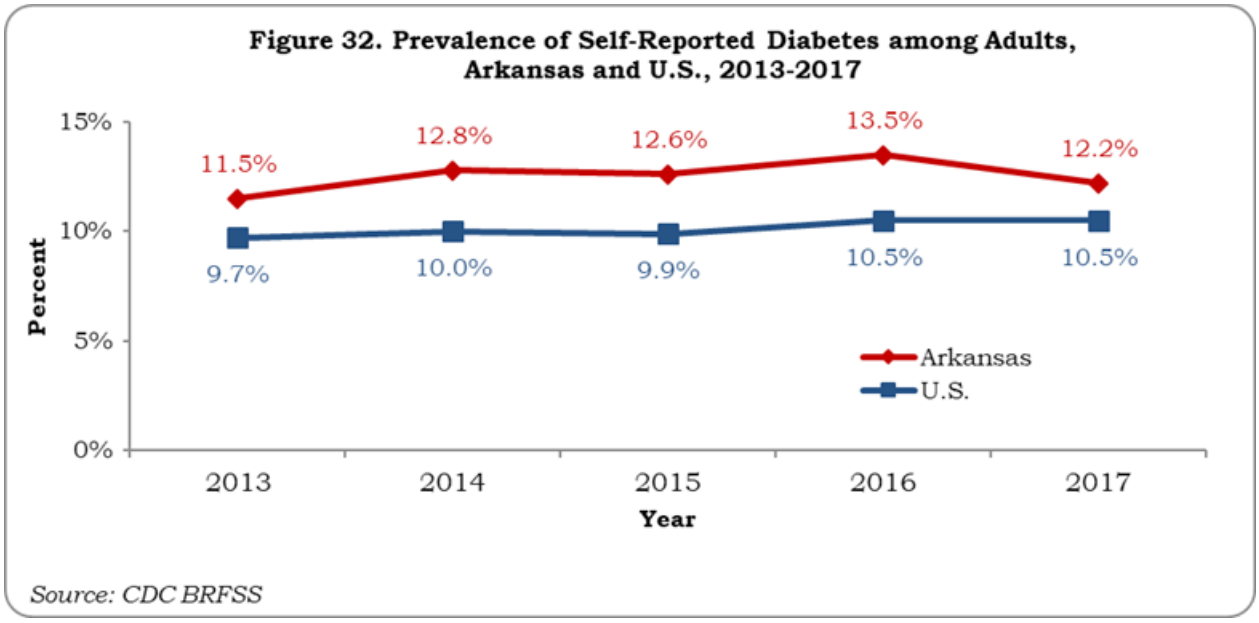
Prevent Diabetes STAT

## Contact Information

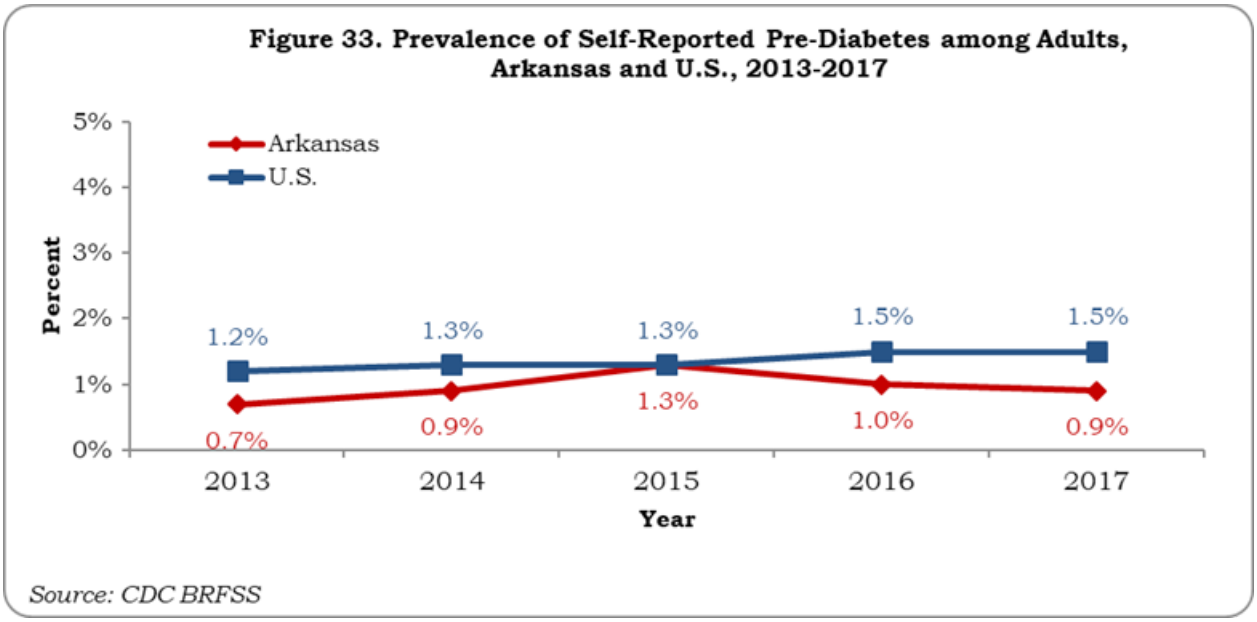
Rachel Johnson, ADH Diabetes Section Chief

Email: Rachel.Johnson@arkansas.gov

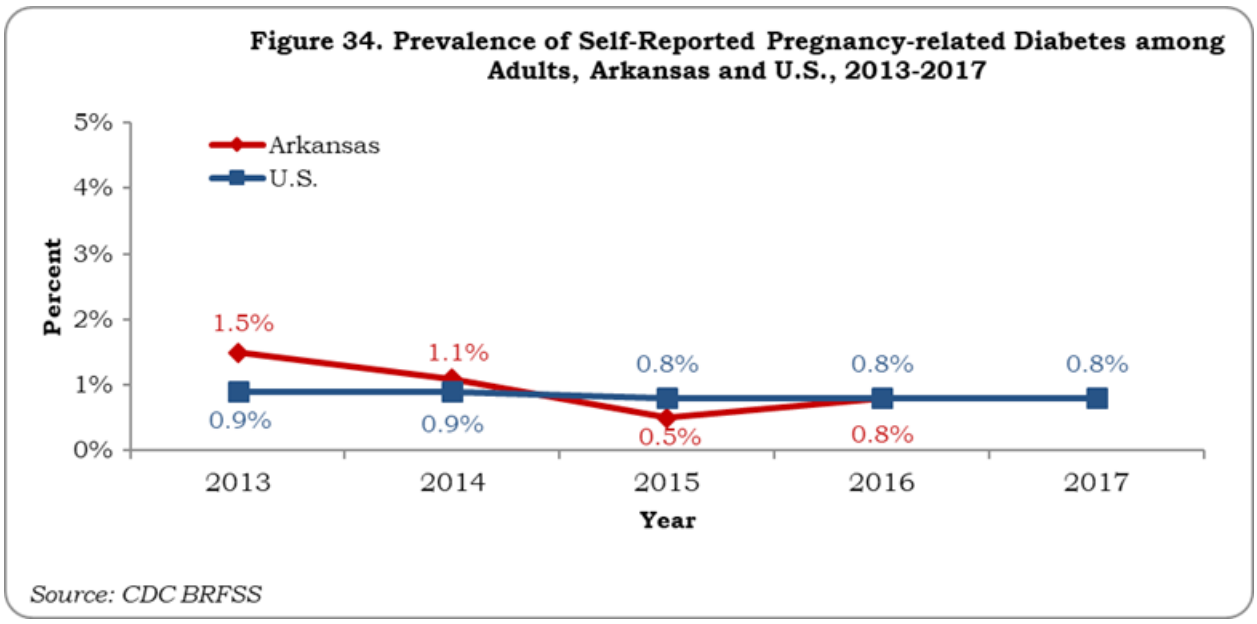
# Prevalence of Diabetes and Pre-Diabetes



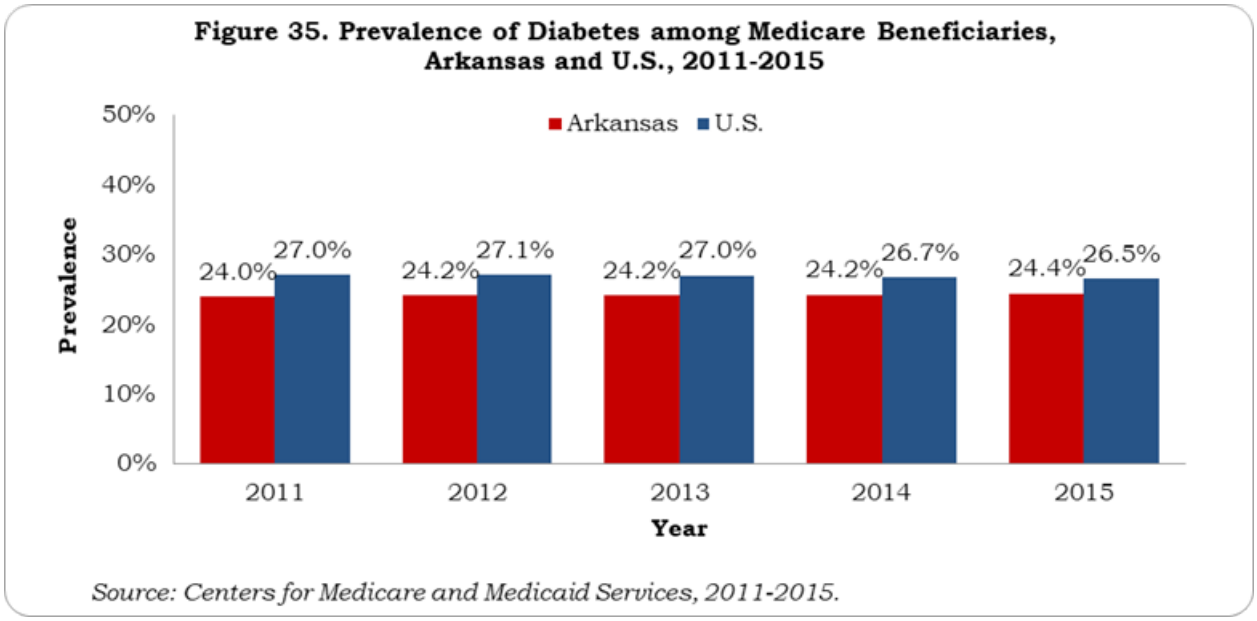

The percentage of Arkansan adults who self-reported having been told by a doctor that they had diabetes increased between 2013 and 2016, before dropping in 2017. In 2017, the percentage of adults with self-reported diabetes was greater in Arkansas at 12.2% than for the U.S. at 10.5% (Figure 32).




The percentage of Arkansan adults who self-reported having been told by a doctor that they had pre-diabetes increased between 2013 and 2015 (from 0.7% to 1.3%), before dropping in 2016 and 2017. In 2017, the percentage of adults with self-reported pre-diabetes was lower in Arkansas at 0.9% than for the U.S. at 1.5% (Figure 33).



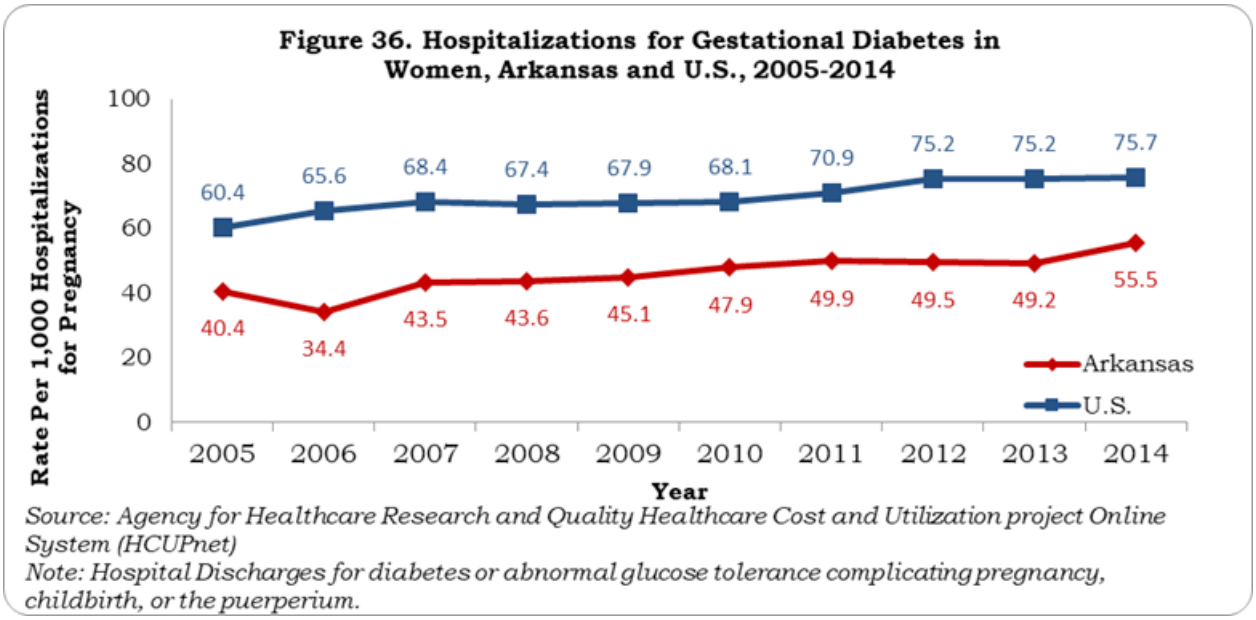

The percentage of adult women in Arkansas who self-reported having been told by a doctor that they had pregnancy-related diabetes decreased between 2013 and 2016. In 2016, the percentage of adults with self-reported diabetes was the same in Arkansas and the U.S. at 0.8%. Data for Arkansas were not available in 2017, but the percent remained the same for nationally (Figure 34).




EHR data show the prevalence of diabetes among the Medicare population has remained relatively steady over time for both Arkansas and the U.S. In 2015, the prevalence of diabetes among Medicare beneficiaries was 24.4% for Arkansas and 26.5% for the U.S. (Figure 35).

Figure 37 (page 39) shows Arkansas's diabetes prevalence among Medicare beneficiaries is higher in eastern and southern counties compared to state and national averages.

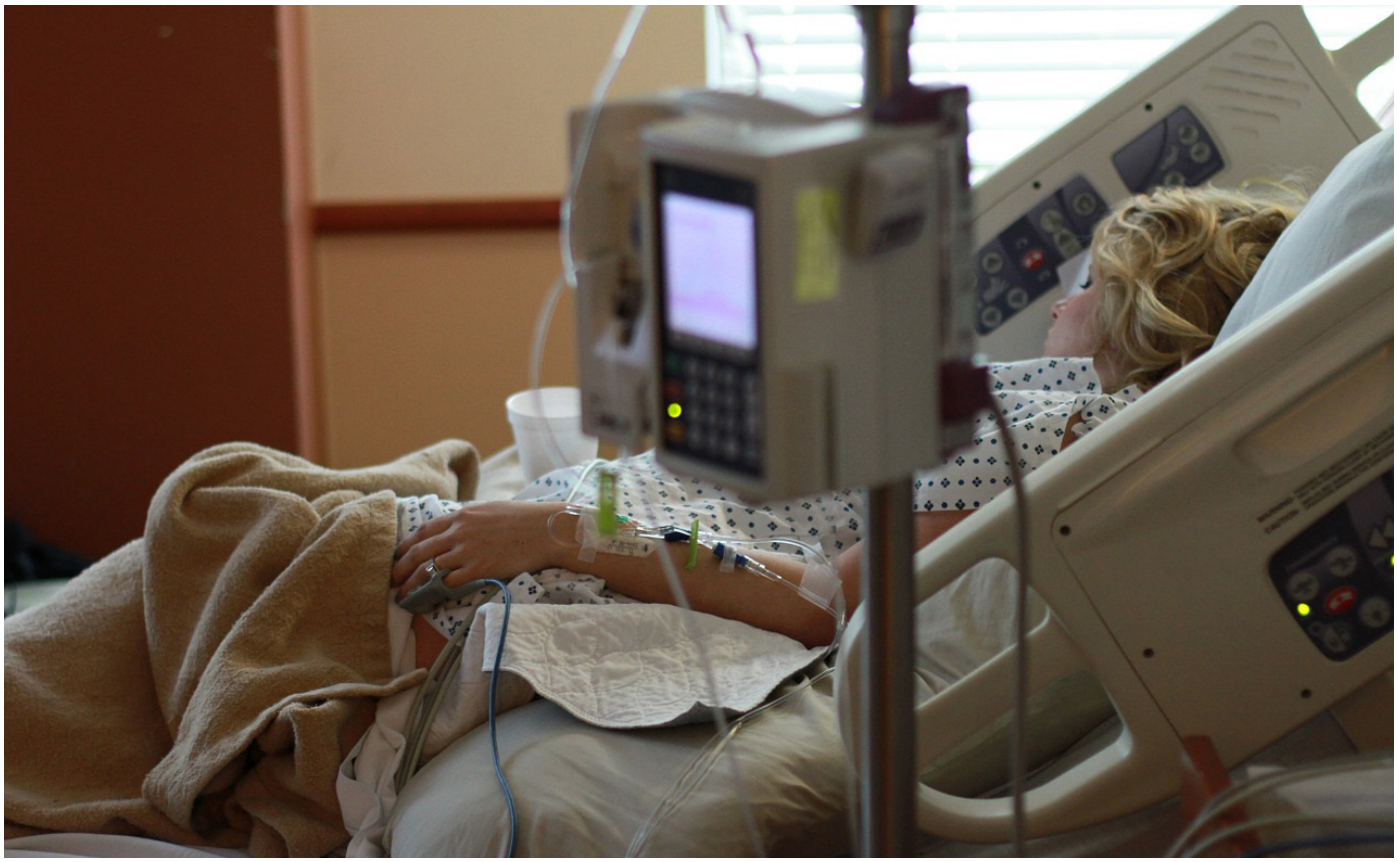
# Hospitalization For Gestational Diabetes



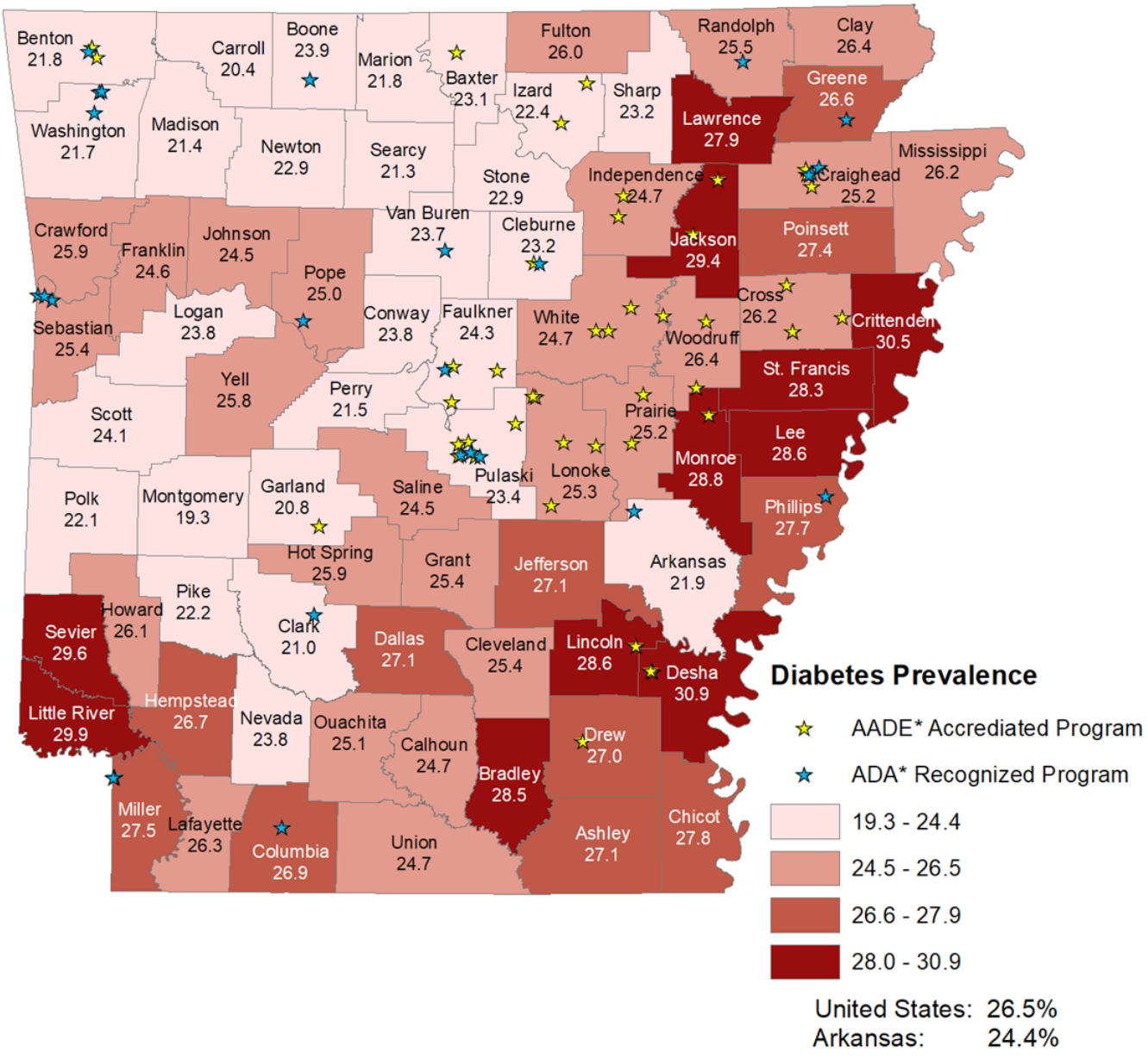

*Source: Agency for Healthcare Research and Quality Healthcare Cost and Utilization project Online System (HCUPnet)*

*Note: Hospital Discharges for diabetes or abnormal glucose tolerance complicating pregnancy, childbirth, or the puerperium.*

The rate of hospitalizations for gestational diabetes, i.e. diabetes occurring during pregnancy, increased between 2005 and 2014 for both Arkansas and the U.S. During this timeframe Arkansas had lower rates of gestational diabetes hospitalizations than the U.S. (Figure 36).



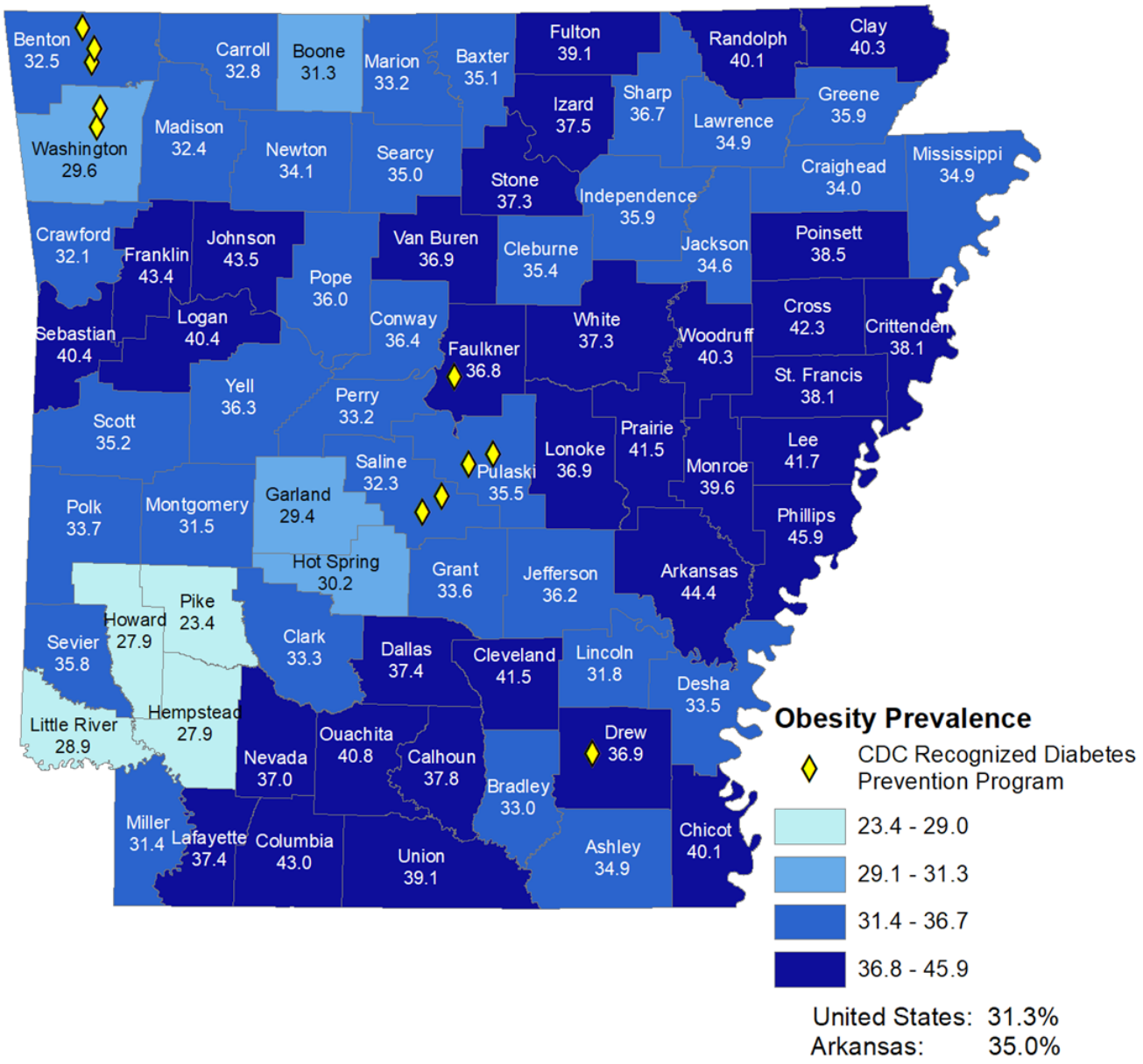
# Figure 37. Prevalence of Diabetes and Diabetes Self-Management Education and Support (DSMES) Programs in Arkansas, 2019




Date Created: April 8, 2019
Source: Centers for Medicare & Medicaid Services, 2015; Diabetes Advisory Council, 2019
Author: Brandy Sutphin, MPH, Chronic Disease Epidemiology Section
*American Association of Diabetes Educators (AADE), American Diabetes Association (ADA)

ARKANSAS DEPARTMENT OF HEALTH

# Figure 38. Prevalence of Adult Obesity and Diabetes Prevention Programs (DPP) in Arkansas, 2019




Date Created: April 8, 2019
Source: Arkansas Department of Health, Health Statistics Branch, 2017; Diabetes Advisory Council, 2019
Author: Brandy Sutphin, MPH, Chronic Disease Epidemiology Section

ARKANSAS DEPARTMENT OF HEALTH

# 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. The Coalition meets regularly and reports to the general membership.**

## Mission

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

## Goals

**Reduce** coronary heart disease deaths. 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.

## Healthy Lifestyle

The Arkansas Department of Health (ADH) and other healthcare providers are adopting new hypertension (high blood pressure) guidelines developed by the American Heart Association, American College of Cardiology, and nine other health professional organizations. These guidelines mean that some patients who were not thought to have high blood pressure may now be considered hypertensive. Hypertension leads to illness and death, but can be prevented. Important lifestyle changes can help people who have high blood pressure reduce risk of a heart attack or stroke. These include quitting smoking, moving more, and eating healthy foods.

**Heart Disease and Stroke Coalition**

## Stroke and STEMI

The purpose of the AR Department of Health (ADH) Stroke and STEMI program is to reduce the impact of these time critical diagnoses among Arkansans. To accomplish this goal, the ADH Stroke/STEMI Section is taking a regional approach with extensive collaboration among EMS, hospitals, and the community to optimize the state's system of care. This includes working toward a common standard of care for pre-hospital and in-hospital providers to give patients the best chance of receiving a good outcome.

## Arkansas Clinical Transformation (ACT) Collaborative

The Arkansas Clinic Transformation (ACT) Collaborative is an ADH Health Care System Interventions program. ACT's vision is to maximize the length and quality of life for patients with diabetes, hypertension, and heart disease, satisfy patient and caregiver needs, and maintain or decrease the cost of care. ACT's aim is to transform medical practices to achieve systems change and improve the management of patient populations in practices for preventive screening for these conditions.

## Resources

## Heart Attack

### Heart Attack Overview

http://www.healthy.arkansas.gov/programs-services/topics/heart-attack

### STEMI Advisory Council

http://www.healthy.arkansas.gov/programs-services/topics/stemi-advisory-council-stac

### Heart Disease Resources

http://www.healthy.arkansas.gov/programs-services/topics/heart-disease-resources

CDC Division for Heart Disease and Stroke Prevention

American College of Cardiology

## Stroke

### Symptoms of Stroke/Stroke Initiatives (ASR/ AR Stroke Ready Hospitals)

http://www.healthy.arkansas.gov/programs-services/topics/stroke

### Arkansas Stroke Registry Overview

http://www.healthy.arkansas.gov/programs-services/topics/arkansas-stroke-registry

### ASR Participating Sites

http://www.healthy.arkansas.gov/programs-services/topics/arkansas-stroke-registry-participating-hospitals

### Acute Stroke Care Task Force

http://www.healthy.arkansas.gov/programs-services/topics/arkansas-acute-stroke-care-task-force-asctf

### Arkansas Stroke Ready Hospitals

http://www.healthy.arkansas.gov/programs-services/topics/stroke-ready-hospitals-in-arkansas

### Stroke Resources

http://www.healthy.arkansas.gov/programs-services/topics/stroke-resources

American Diabetes Association

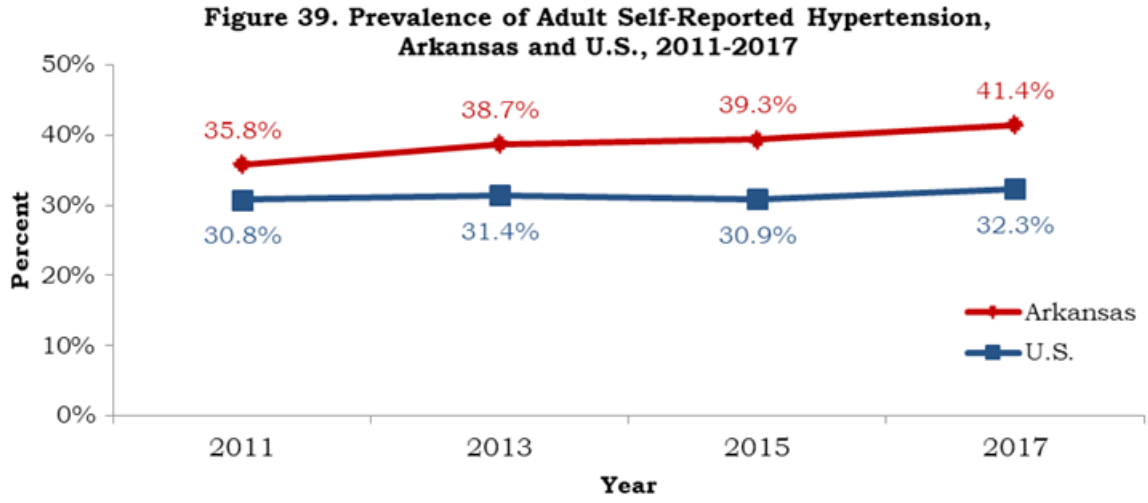
National Stroke Association

## Contact Information

David Vrudny, CPHQ, MPM, MPH(c)
Stroke/ STEMI Section Chief
Arkansas Department of Health
Email: david.vrudny@arkansas.gov
Telephone: 501-661-2096

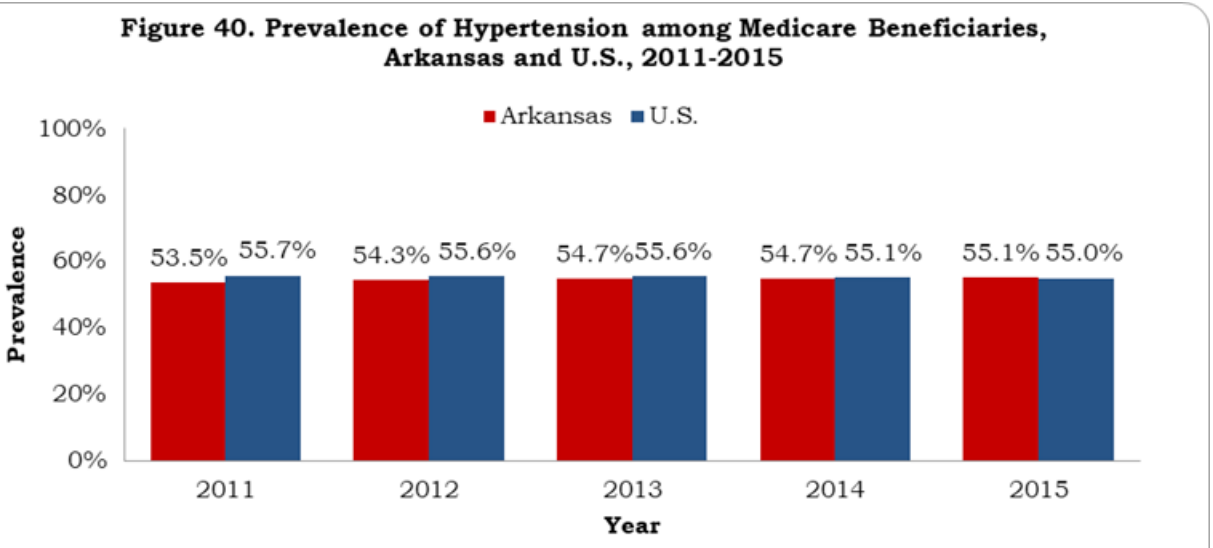
Vanessa Krause, LMSW
Program Director
Arkansas Disability and Health Program
Partners for Inclusive Communities, U of A
322 Main Street, Suite 501
Little Rock AR 72201
Email: vanessas@uark.edu
Telephone: 501-912-4760

# Prevalence of Hypertension and Hyperlipidemia



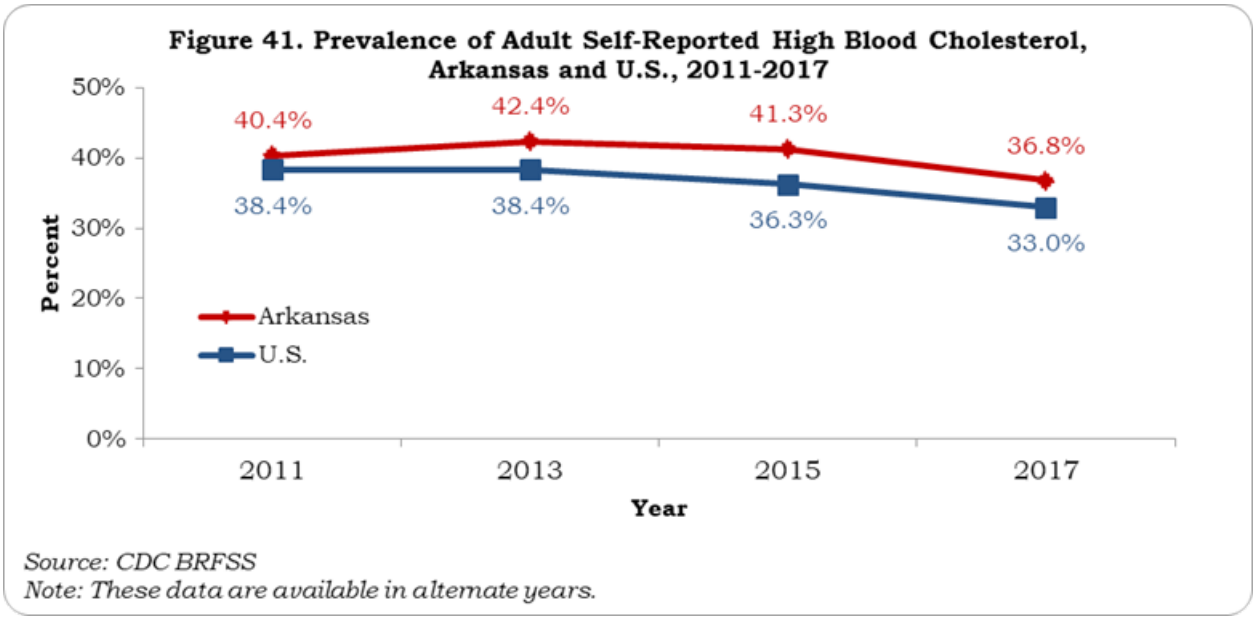

*Source: CDC BRFSS*
*Note: These data are available in alternate years.*

Between 2011 and 2017, a higher percent of adults in Arkansas reported they had been told they had hypertension than the U.S. The percent increased in both Arkansas, from 35.8% to 41.4%, and the U.S., from 30.8% to 32.3%, during this time (Figure 39).

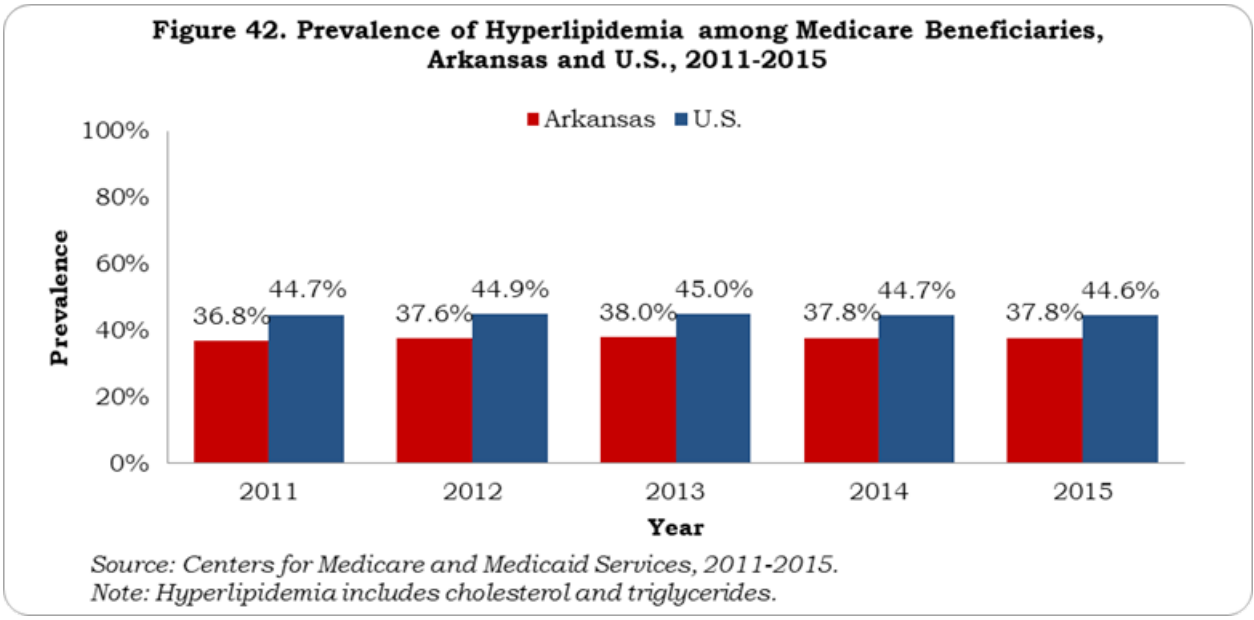



*Source: Centers for Medicare and Medicaid Services, 2011-2015.*

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 2015, the prevalence of hypertension among the Medicare population was 55.1% for Arkansas and 55.0% for the U.S (Figure 40).




From 2011 to 2017, the percent of adults who reported they had been told they had blood pressure was higher in Arkansas than the U.S. The percent decreased in both Arkansas, from 40.4% to 36.8%, and the U.S, from 38.4% to 33.0%, during this time (Figure 41).

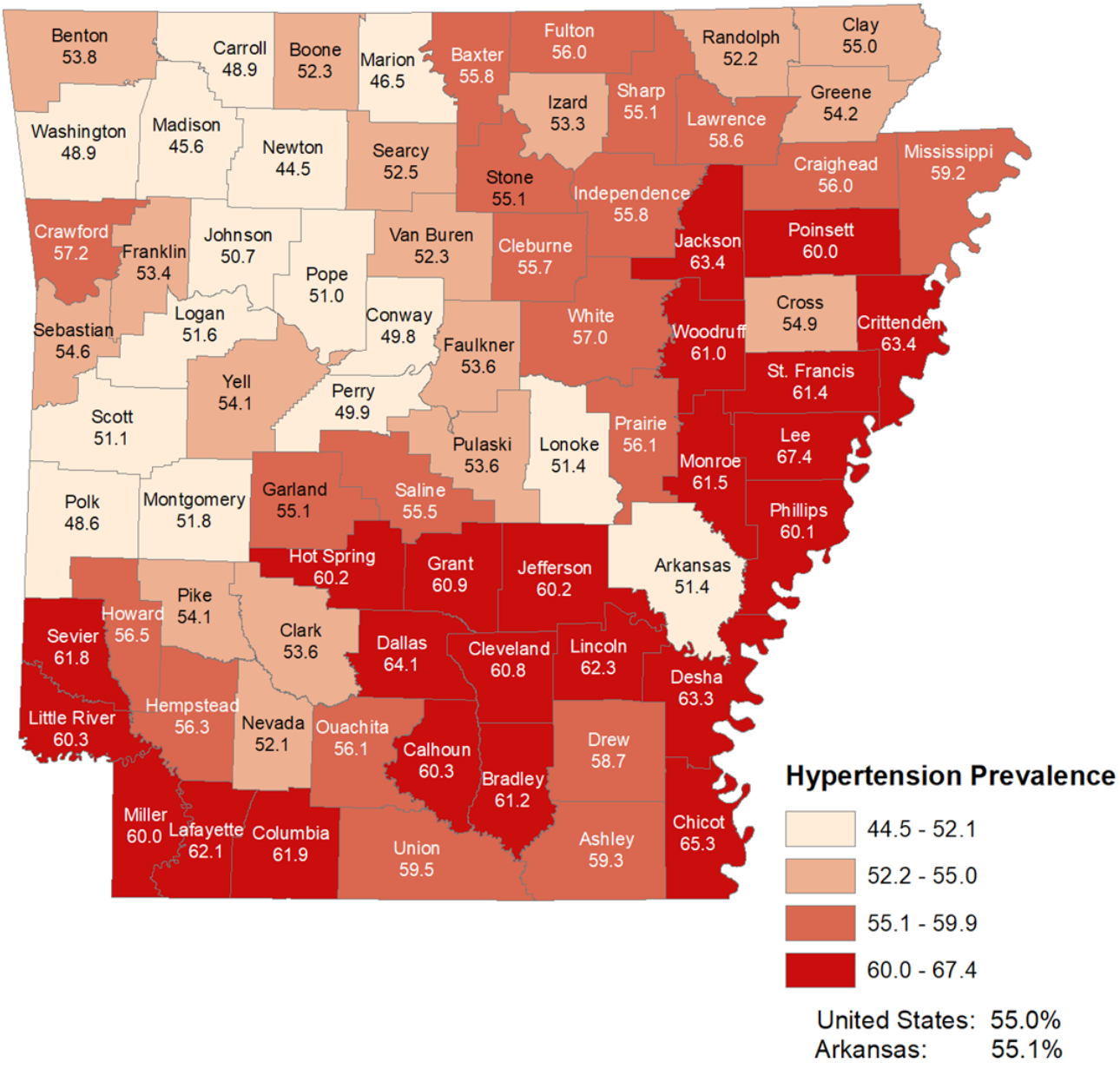



EMR data show the prevalence of hyperlipidemia, a high level of cholesterol and triglycerides, has remained about the same among the Medicare population for both Arkansas and the U.S. In 2015, the prevalence of hyperlipidemia among the Medicare population was 37.8% for Arkansas and 44.6% for the U.S. (Figure 42).

Figure 43 (page 45) shows a higher than state and national prevalence of hypertension in southern and eastern counties of Arkansas.

Figure 44 (page 46) shows the highest prevalence of hyperlipidemia in the northeastern, central and southeastern counties of the state.

# Figure 43. Prevalence of Hypertension*, Arkansas, 2015

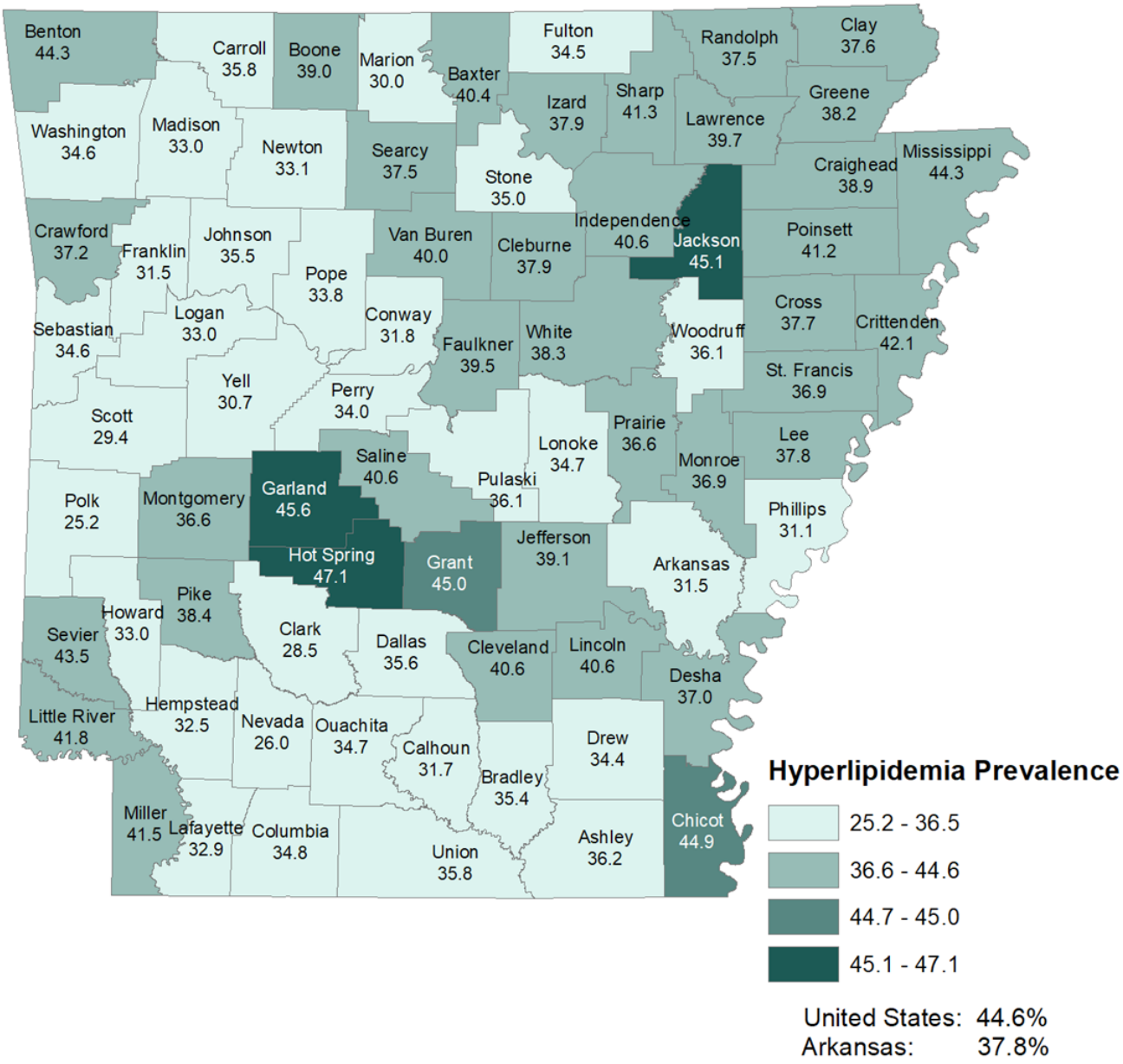



*Blood Pressure >140/90 mmHg

Date Created: April 8, 2019
Source: Centers for Medicare & Medicaid Services, 2015
Author: Brandy Sutphin, MPH, Chronic Disease Epidemiology Section

ARKANSAS DEPARTMENT OF HEALTH

# Figure 44. Prevalence of Hyperlipidemia*, Arkansas, 2015



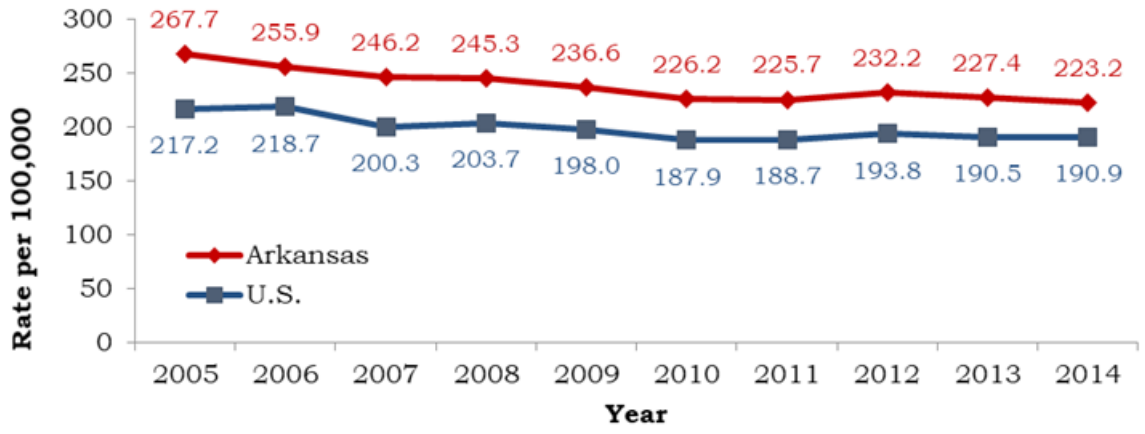

*Includes cholesterol and triglycerides

Date Created: April 8, 2019
Source: Centers for Medicare & Medicaid Services, 2015
Author: Brandy Sutphin, MPH, Chronic Disease Epidemiology Section

ARKANSAS DEPARTMENT OF HEALTH

# Hospitalization For AMI and Stroke

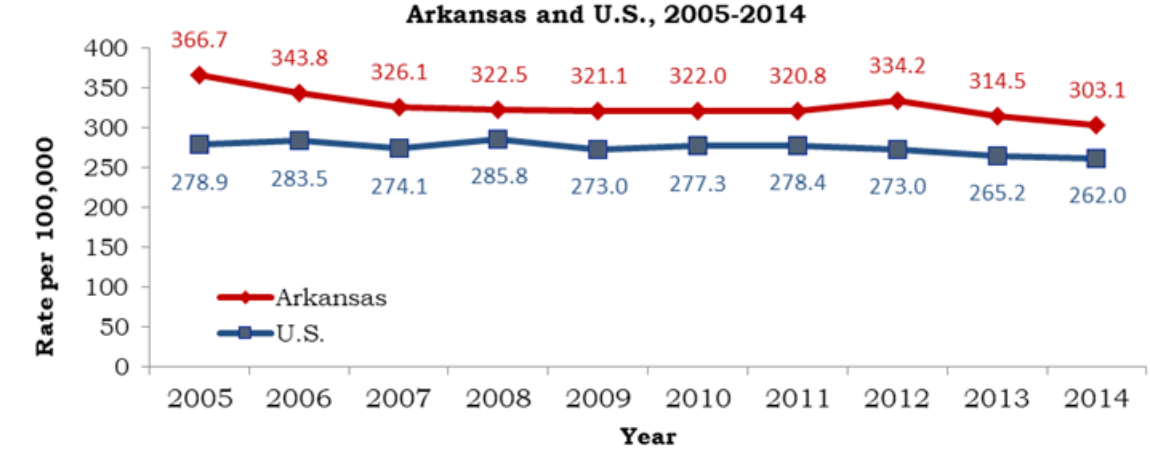
**Figure 45. Hospitalization Rates of Acute Myocardial Infraction, Arkansas and U.S., 2005-2014**




*Source: HCUPnet*
*Note: U.S. Census Population Estimates was used to adjust Arkansas and U.S. rates.*

Acute myocardial infraction (AMI) or heart attack hospitalization rates in Arkansas decreased from 267.7 per 100,000 population in 2005 to 223.2 per 100,000 population in 2014, but remained higher than the heart attack hospitalization rates for the U.S. (Figure 45).

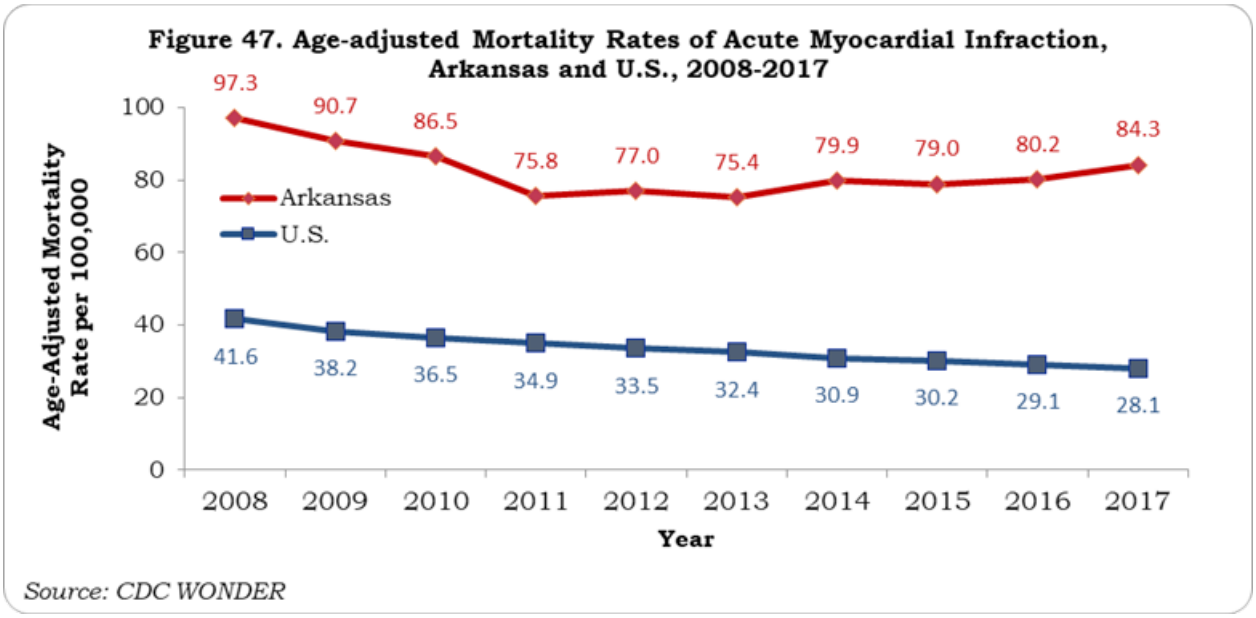
**Figure 46. Hospitalization Rates of Acute Stroke, Arkansas and U.S., 2005-2014**



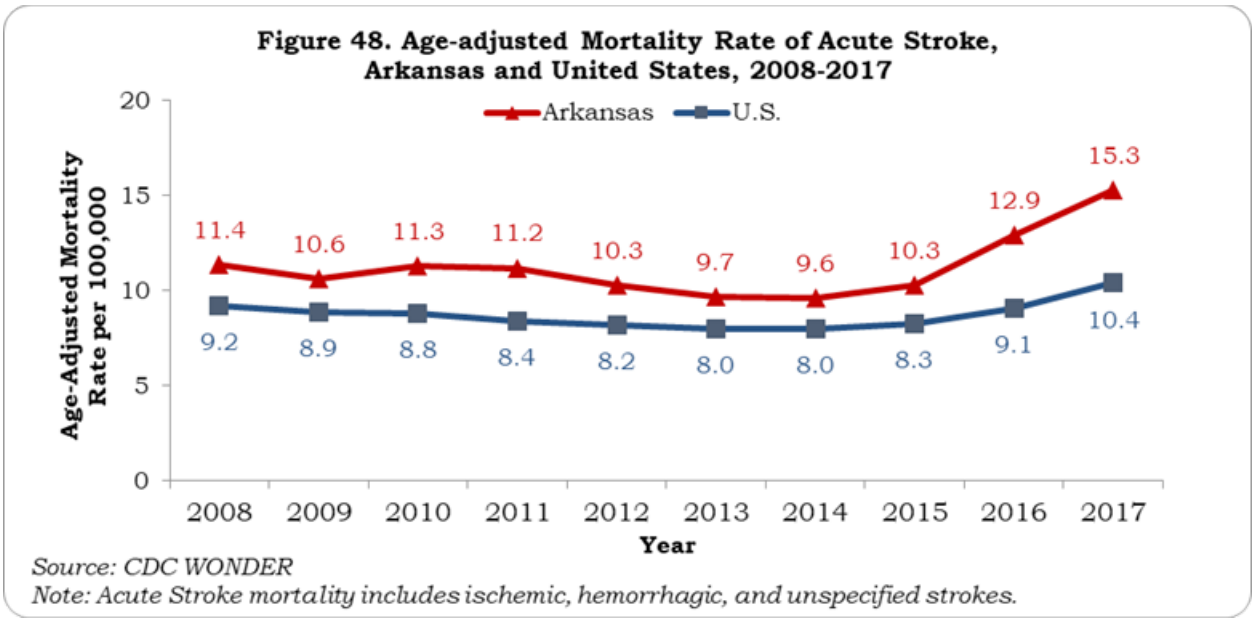

*Source: HCUPnet*
*Note: U.S. Census Population Estimates was used to adjust U.S. rates. Acute Stroke hospitalizations include ischemic, hemorrhagic, and unspecified strokes.*

Stroke hospitalization rates in Arkansas decreased from 366.7 per 100,000 population in 2005 to 303.1 per 100,000 population in 2014 (a decrease of 17.4 percent), but remained higher than the stroke hospitalization rate for the U.S. (Figure 46).

# Mortality Rates For AMI and Stroke

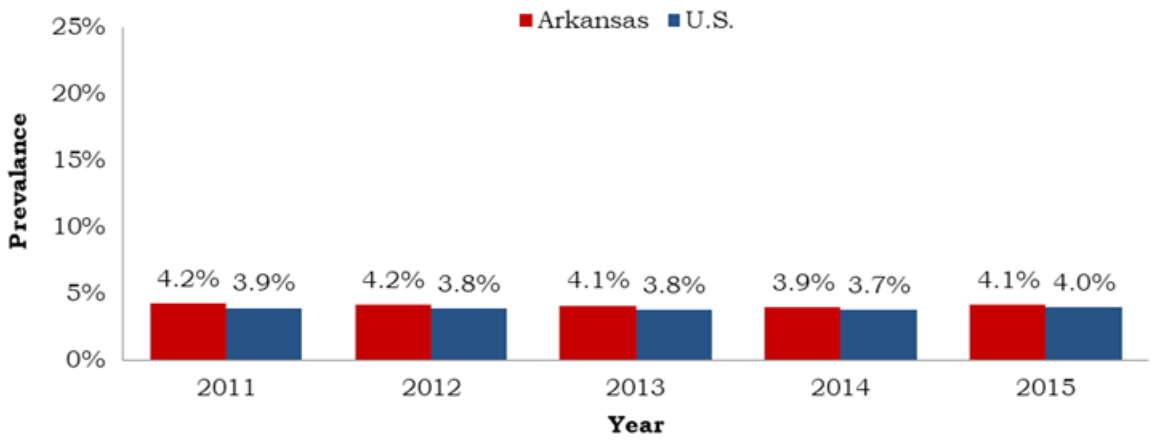



Between 2008 and 2011, the age-adjusted heart attack mortality rate declined for both Arkansas and the United States, although Arkansas's mortality rates have been consistently higher than national rates. Beginning in 2011, heart attack mortality rates increased in Arkansas, from 75.8 per 100,000 to 84.3 per 100,000, while mortality rates in the U.S. continued to decrease (Figure 47).




Between 2007 and 2015, the age-adjusted stroke mortality rate declined for both Arkansas and the country, although Arkansas's stroke mortality rates have been consistently higher than national rates. Between 2014 and 2017, stroke mortality increased for both Arkansas, from 9.6 to 15.3 per 100,000, and the U.S., from 8.0 to 10.4 per 100,000 (Figure 48).

**Figure 49. Prevalance of Stroke among Medicare Beneficiaries, Arkansas and United States, 2011-2015**



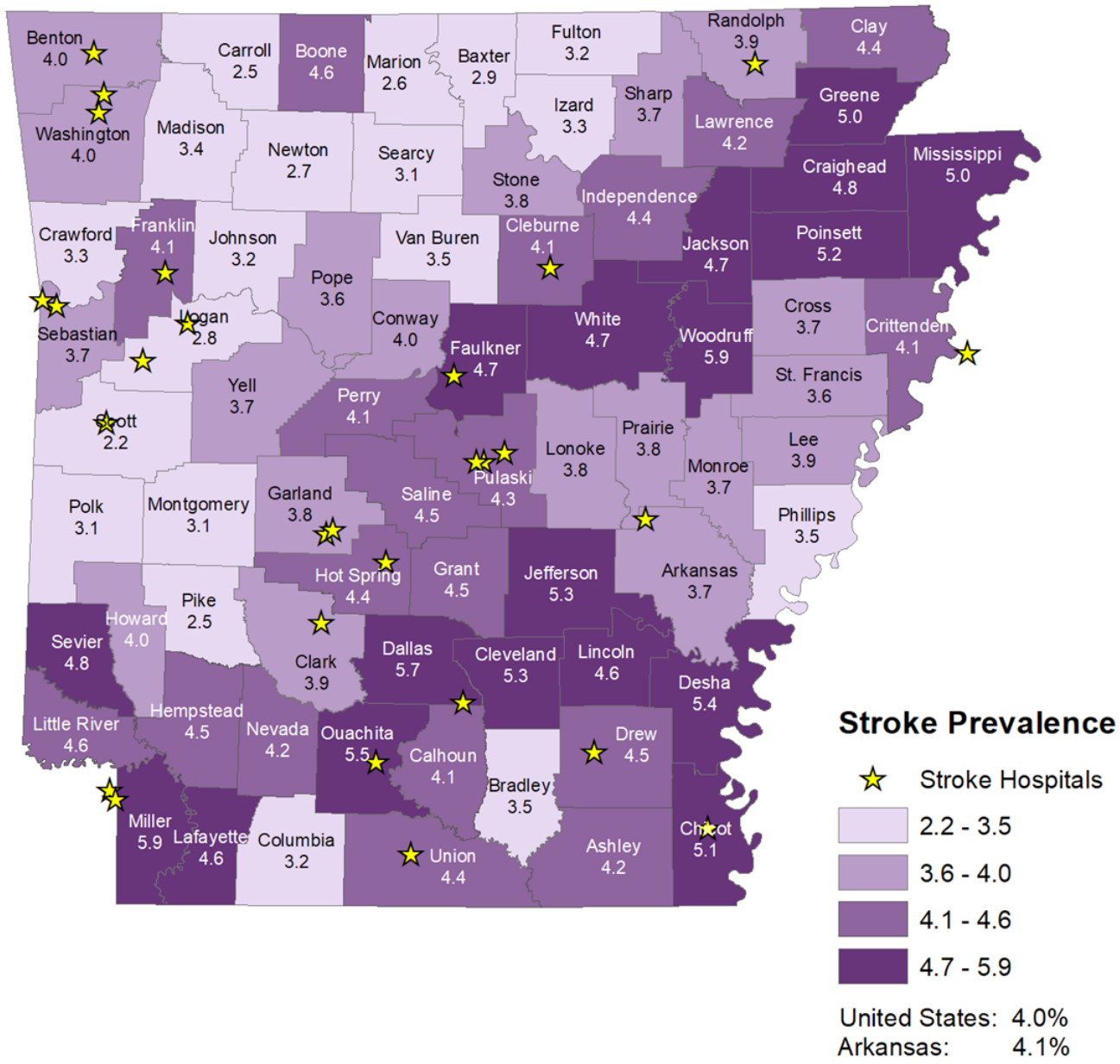

*Source: Centers for Medicare and Medicaid Services, 2011-2015.*

EHR data show the prevalence of stroke among the Medicare population has remained steady over time for both Arkansas and the U.S. In 2015, the prevalence of stroke among the Medicare population was 4.1% for Arkansas and 4.0% for the U.S. Arkansas's stroke prevalence has been consistently higher than the U.S. (Figure 49).

Figure 50 (page 50) shows that stroke prevalence is highest in the central, northeastern and southern parts of Arkansas. Arkansas Stroke Registry hospitals are located in all regions of the state and provide evidence-based standards of care for patients with acute strokes to improve stroke outcomes.

Figure 51 (page 51) shows very high prevalence of acute myocardial infarction (AMI) in the Delta counties of the state. Percutaneous Coronary Intervention (PCI) hospitals in the state provide acute management for AMI to improve patient outcomes.

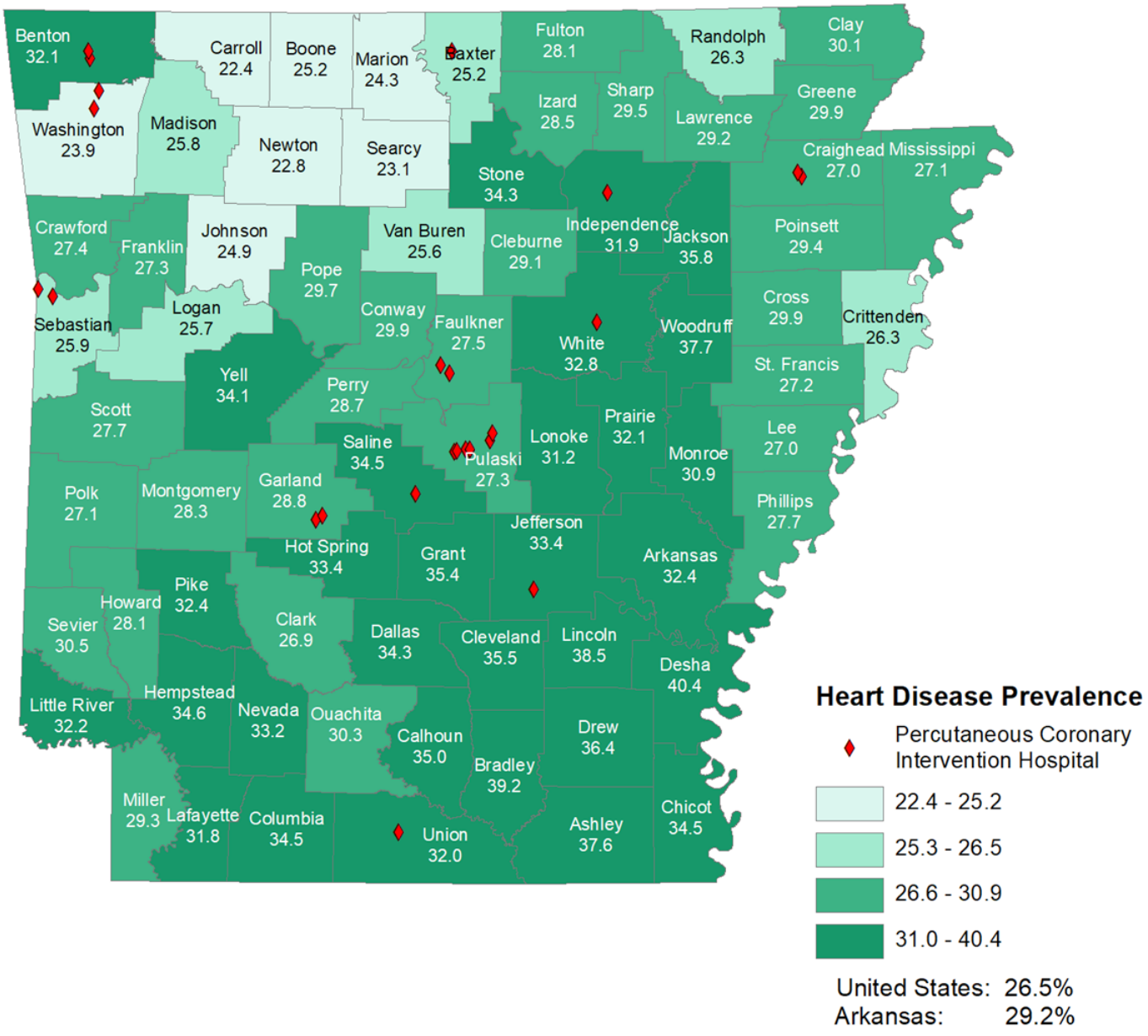
# Figure 50. Prevalence of Stroke and Arkansas Stroke Registry Hospitals, Arkansas, 2019




Date Created: April 8, 2019
Source: Centers for Medicare & Medicaid Services, 2015; Arkansas Stroke Registry, 2019
Author: Brandy Sutphin, MPH, Chronic Disease Epidemiology Section

ARKANSAS DEPARTMENT OF HEALTH

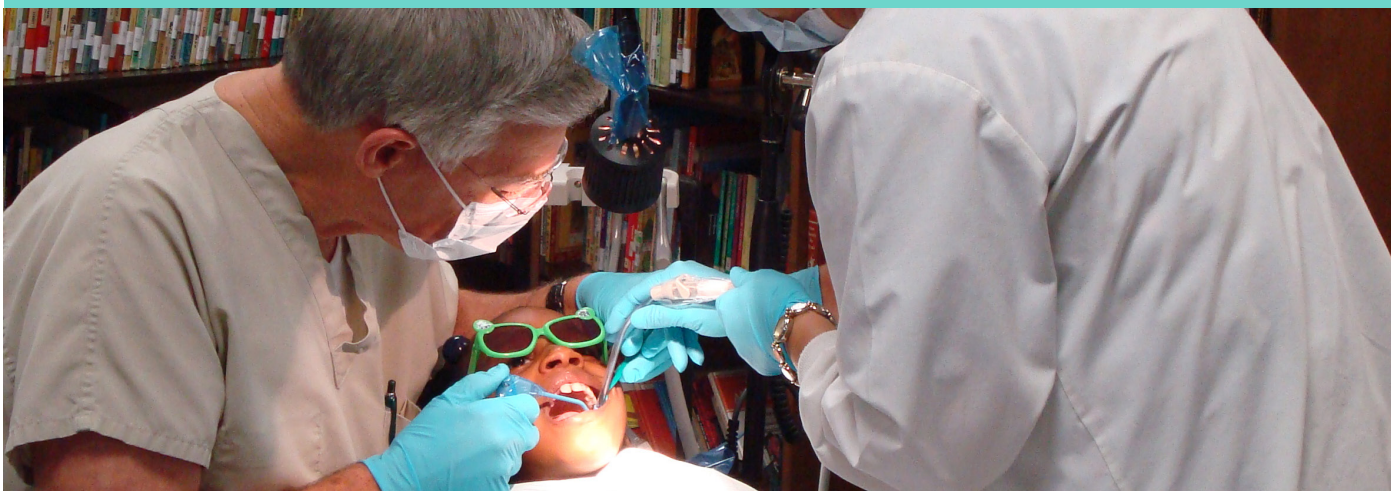
# Figure 51. Prevalence of Ischemic Heart Disease and Percutaneous Coronary Intervention (PCI) Hospitals, Arkansas, 2019




Date Created: April 8, 2019
Source: Centers for Medicare & Medicaid Services, 2015; Arkansas Heart Attack Registry, 2019
Author: Brandy Sutphin, MPH, Chronic Disease Epidemiology Section

ARKANSAS DEPARTMENT OF HEALTH

# 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.

## Policy

The Arkansas Oral Health Coalition has adopted the following policies:

**Support for dental hygienists conducting dental screenings**

**Support for community water fluoridation**

**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 oral health issues 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 came from recommendations at the Governor's Oral Health Summit in 2002. Funded by Centers for Disease Control and Prevention (CDC), the Office of Oral Health is working to develop a new State Plan with the addition of a part-time Epidemiologist.

Updated in 2013, the plan outlines recommendations and strategies to promote oral health. The plan focuses on education, access, prevention, and policy. A complete copy of the plan can be found at https://www.healthy.arkansas.gov/images/uploads/pdf/AR_Oral_Health_Plans_2012-2015.pdf

ARKANSAS ORAL HEALTH COALITION
EDUCATION • PREVENTION • ACCESS

## 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.

**Public Health Surveillance:**

Public health surveillance is the ongoing, systematic collection, analysis, interpretation, and dissemination of data regarding a health-related event for use in public health action to reduce morbidity and mortality and to improve health. Data disseminated by a public health surveillance system can be used for immediate public health action, program planning and evaluation, and formulating research hypotheses. The Basic Screening Survey tool, developed by the Association of State and Territorial Dental Directors, assists state and local public health agencies in monitoring the burden of oral disease at a level consistent with the Healthy People objectives. During the fall of 2016, the Arkansas Oral Health Coalition led by the Office of Oral Health and Arkansas Children's Hospital combined forces to conduct the second Brief Screening Survey of Children's teeth in Arkansas. Updates on oral health in Arkansas are available from the coalition.

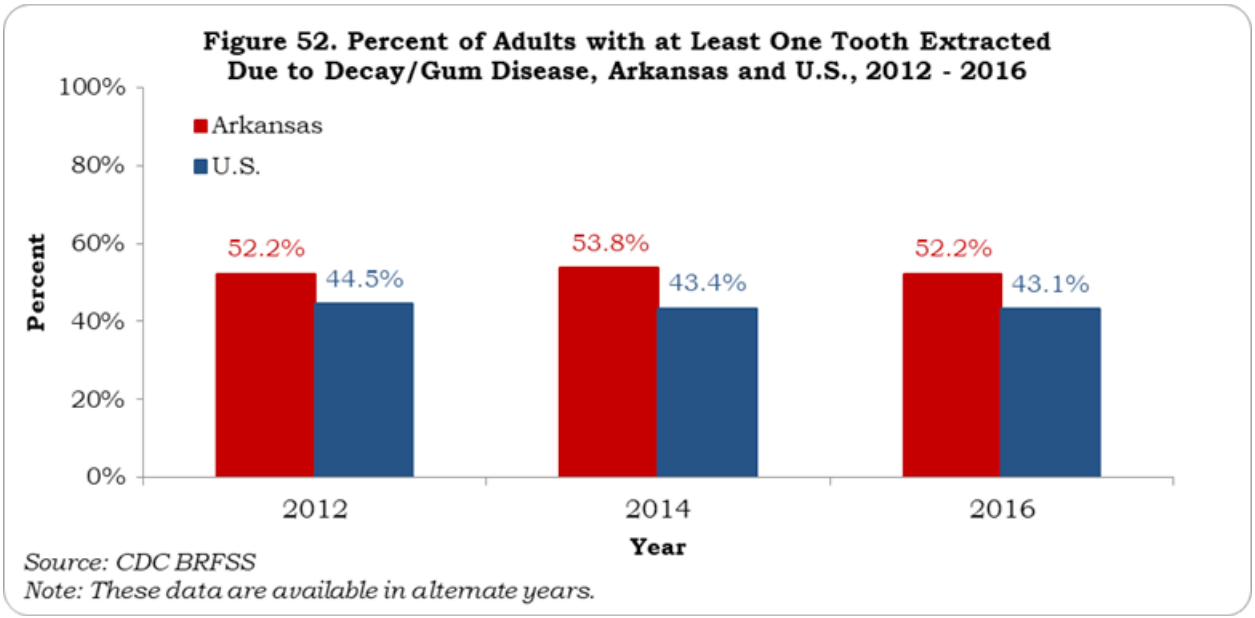
## Office of Oral Health

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: https://www.healthy.arkansas.gov/programs-services/topics/take-care-of-your-teeth

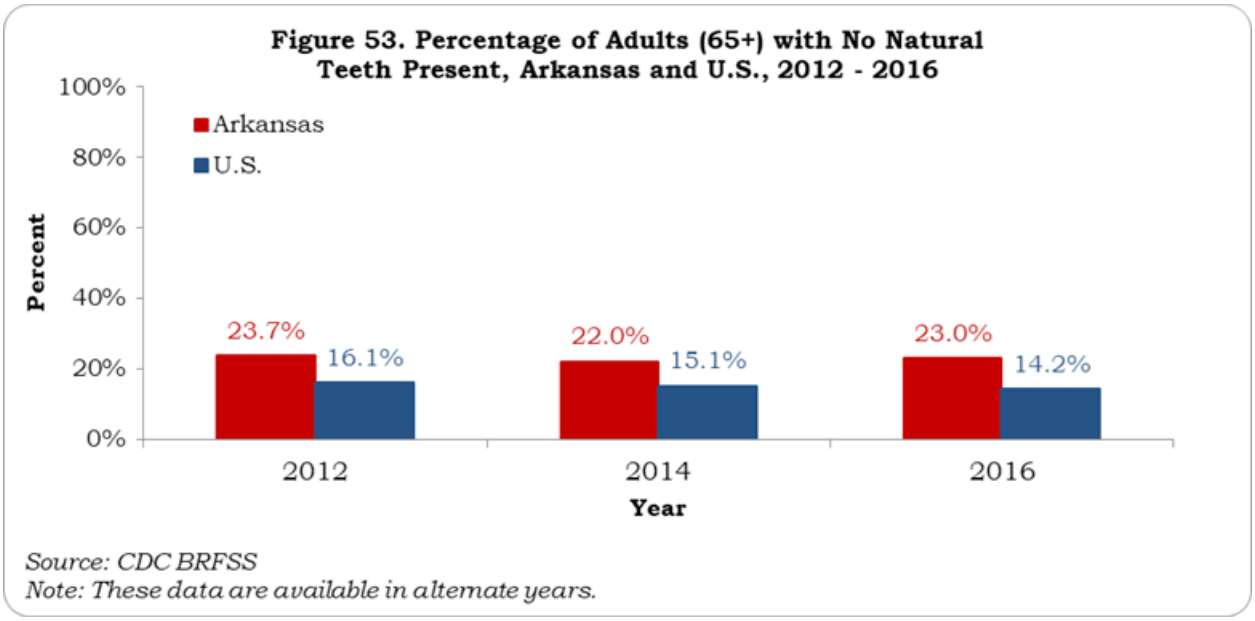
## Contact Information

Phone: 501-661-2051
Email: molly.phares@arkansas.gov

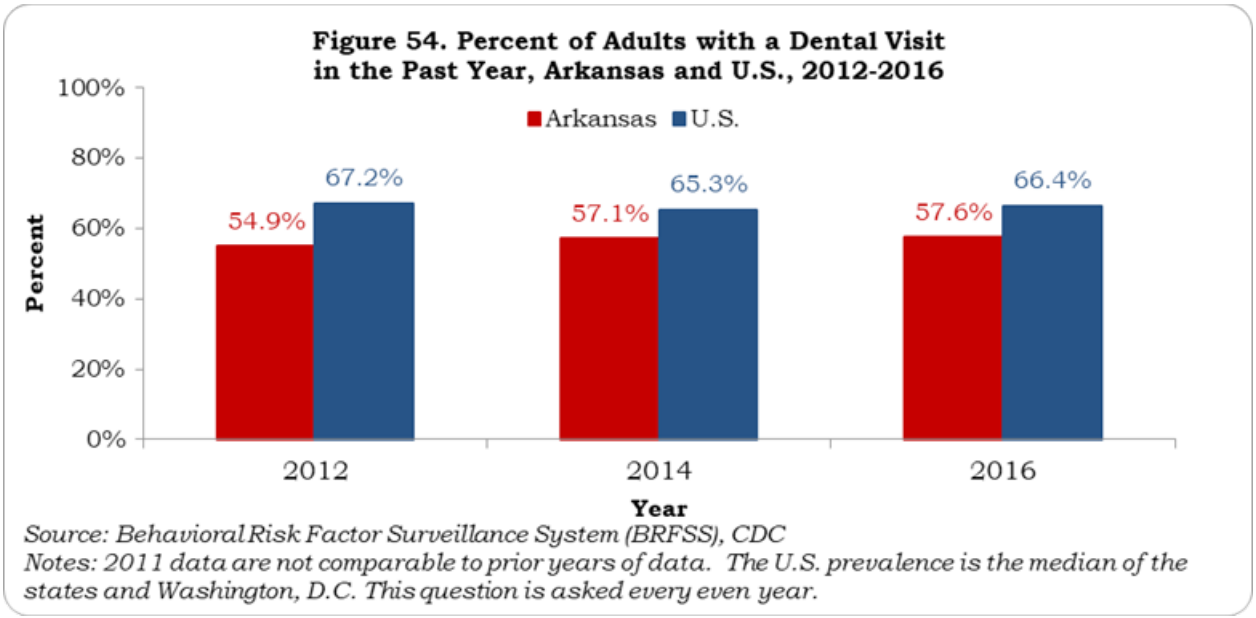
# Prevalence of Oral Health




In 2016, self-reported data showed over half (52.2%) of adults in Arkansas 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 52).

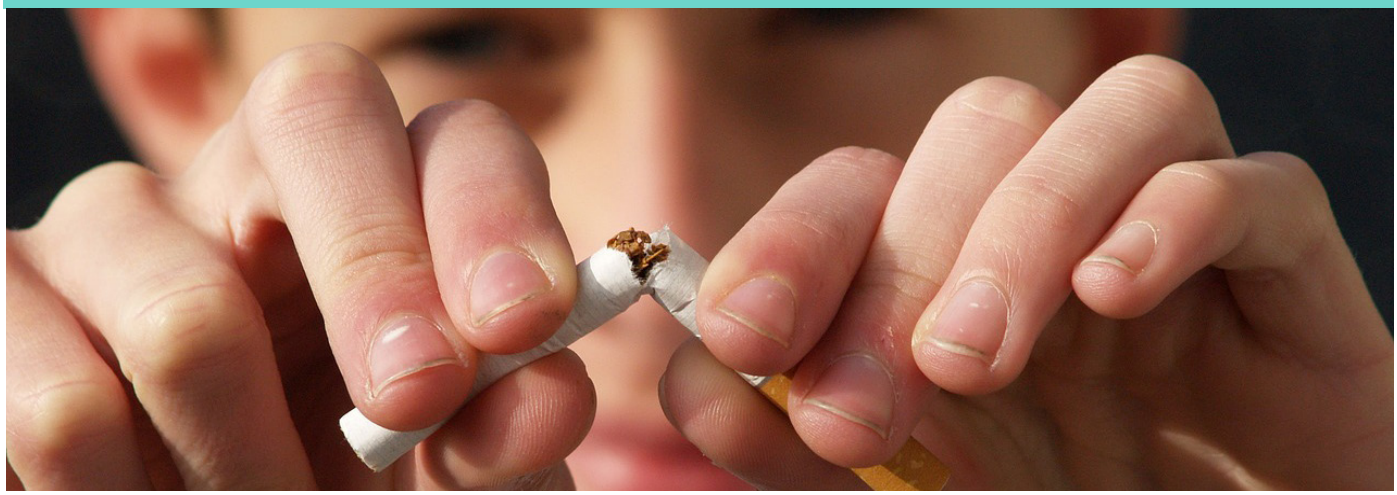



In 2016, self-reported data showed more than one-fifth (23.0%) of older Arkansan adults (ages 65 and older) reported not having any natural teeth. Arkansas percentage for self-reported loss of natural teeth remains higher than for the U.S. (Figure 53).




Between 2012 and 2016, the percentage of Arkansan and U.S. adults self-reporting a dental visit in the past year increased. The prevalence of adult dental visits in Arkansas has consistently been lower than for the U.S. (Figure 54).

# Arkansas Tobacco Coalition



**The American Lung Association in Arkansas/ Arkansas Tobacco Control Coalition (ARTCC) partners with the Arkansas Tobacco Prevention and Cessation Program to strengthen Arkansas's overall tobacco control efforts program by engaging local stakeholders, local community leaders and the public to reduce the burden of tobacco on our state.**

**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 tobacco control coalition

**Support** tobacco free, smoke free and electronic smoking device free work places for all employees

**Assist** and support local and state organizations in their efforts to promote comprehensive tobacco free and secondhand smoke exposure free communities including electronic smoking device for all public places

## Contact Us

ARTCC@lung.org

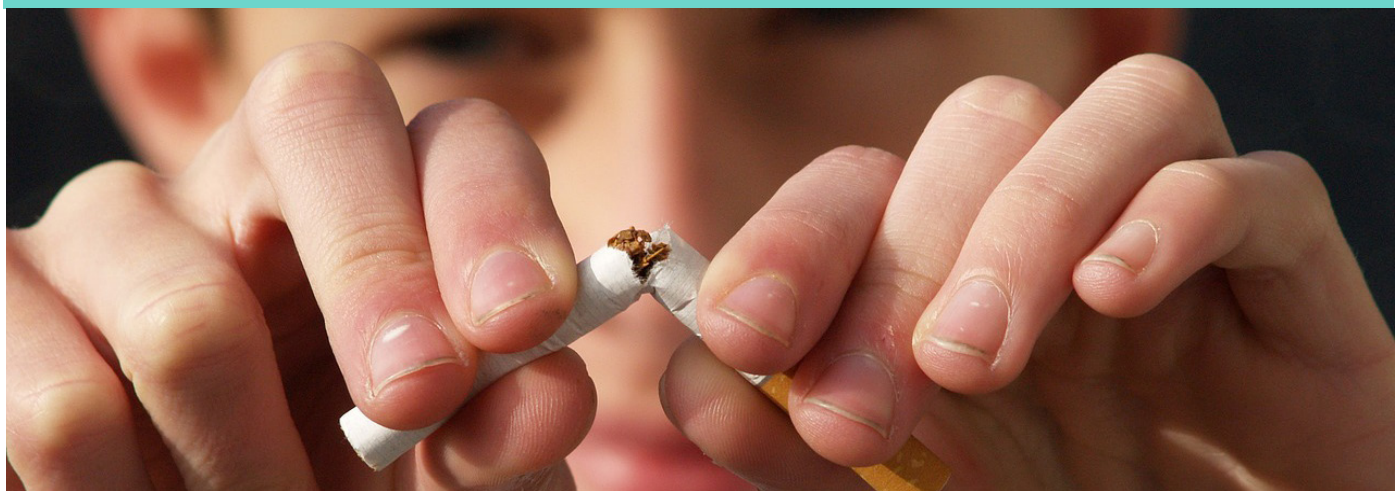
Facebook: AR tobacco Control Coalition

Instagram and Twitter: ARTobaccoCC

Website: Cleartheairarkansas.com

Arkansas ar tobacco control coalition

# Project Prevent Youth Coalition



**The Project Prevent Youth Coalition (PPYC or Project Prevent) began as part of the Arkansas Department of Health's Stamp Out Smoking campaign. In 2015, the Arkansas Department of Health partnered with Arkansas Children's Hospital to coordinate a group of youth whose sole purpose was to change social norms regarding tobacco and nicotine. This collaboration resulted in a network of local youth tobacco groups who organize themselves under the statewide coalition. These youth groups are referred to as Project Prevent Chapters and exist in more than 50 locations across the state. Each chapter host a number of tobacco control activities in their schools and communities throughout the year.**

**Project Prevent operates under the guidance of the Arkansas Department of Health's Tobacco Prevention & Cessation Program, Arkansas Children's Hospital and the PPYC Advisory Committee.**

## Mission

The Project Prevent Youth Coalition will provide youth with action-oriented activities that address social norms about tobacco and nicotine.

## Vision

Statewide tobacco policies and initiatives will be enacted as a result of youth being involved with the Project Prevent Youth Coalition.

## Pillar Projects

Monthly Statewide Meetings

Annual Youth Conference

Ready. Set. Record.

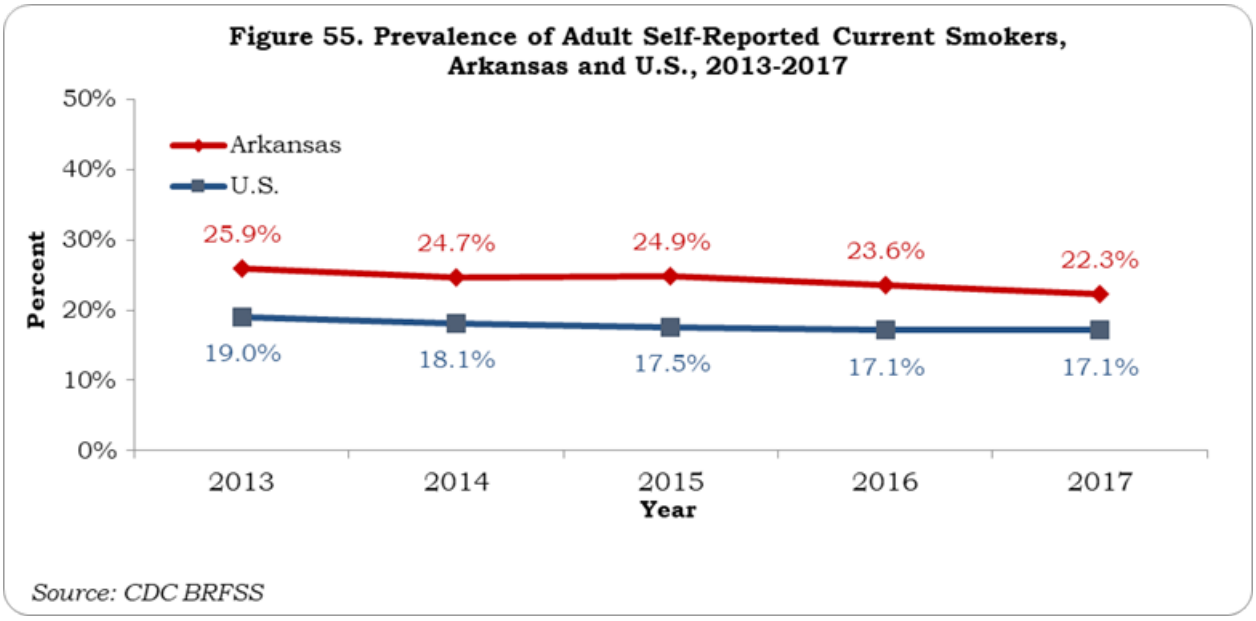
My Reason to Write

Red Ribbon Week

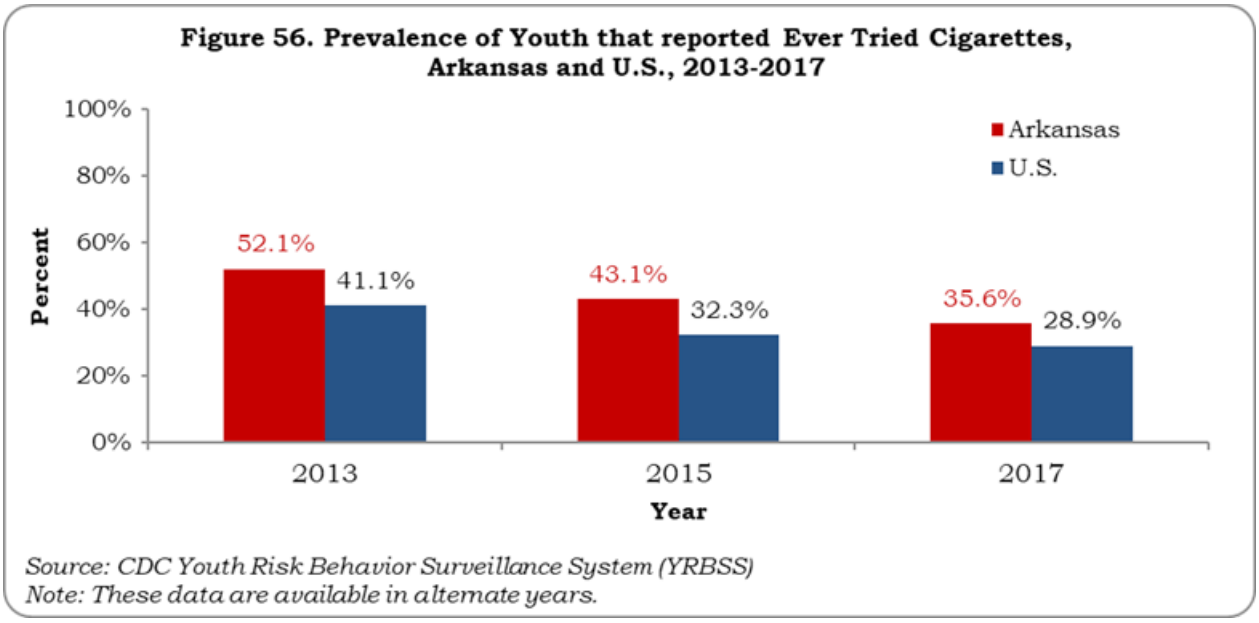
## Connect With Us

Laura Taylor, Program Coordinator
TaylorLB@archildrens.org
Website: sosprojectprevent.com
Facebook: SOS Project Prevent
Instagram: @sosprojectprevent
YouTube: Project Prevent Youth Coalition

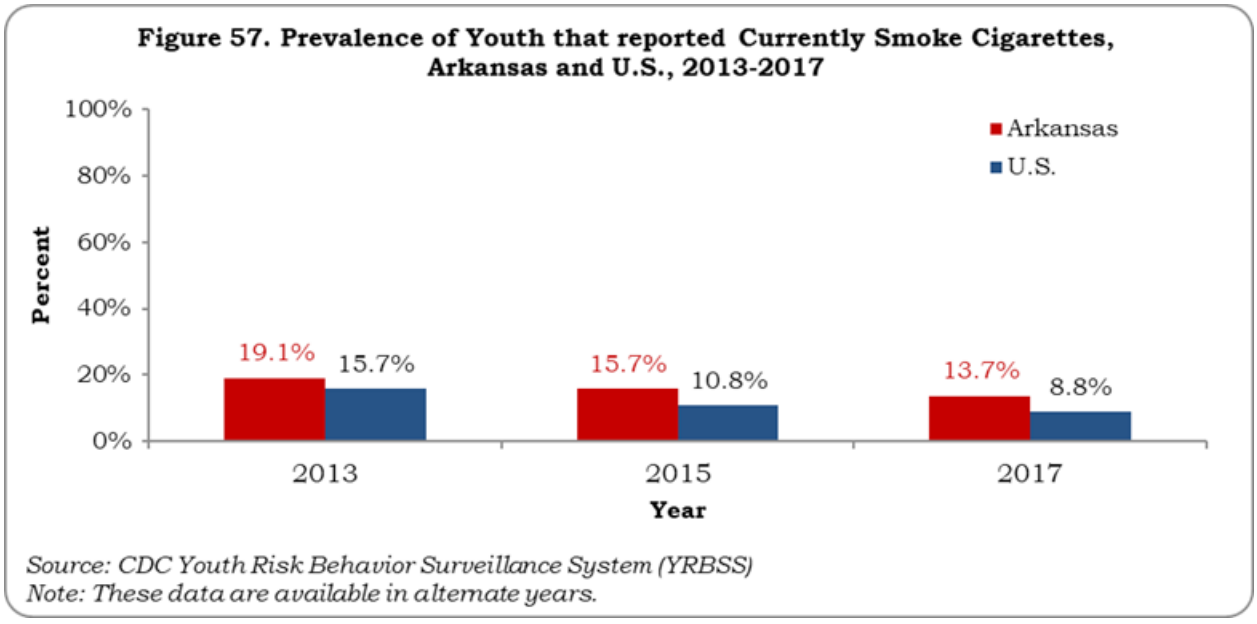
# Prevalence of Tobacco Use



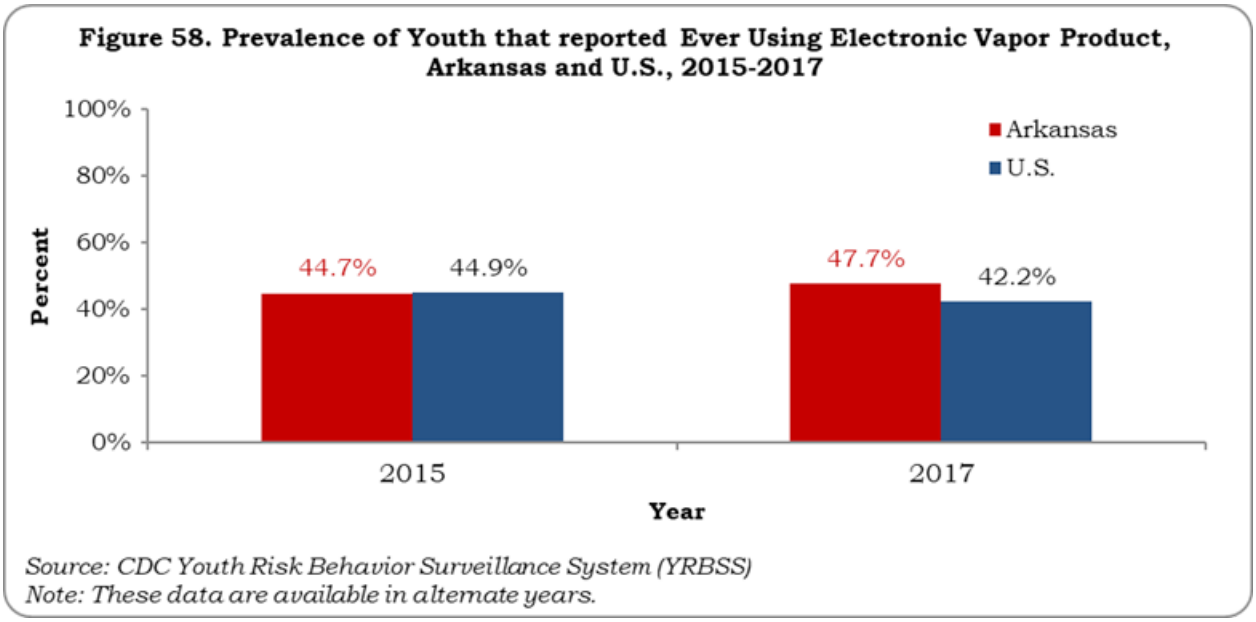

The percentage of current self-reported adult smokers who smoked at least 100 cigarettes in their lifetime and currently smoke every day or some days decreased in Arkansas decreased from 25.9% to 22.3% between 2013 and 2017. The percent of self-reported current smokers has consistently been higher in Arkansas than for the nation (Figure 55).



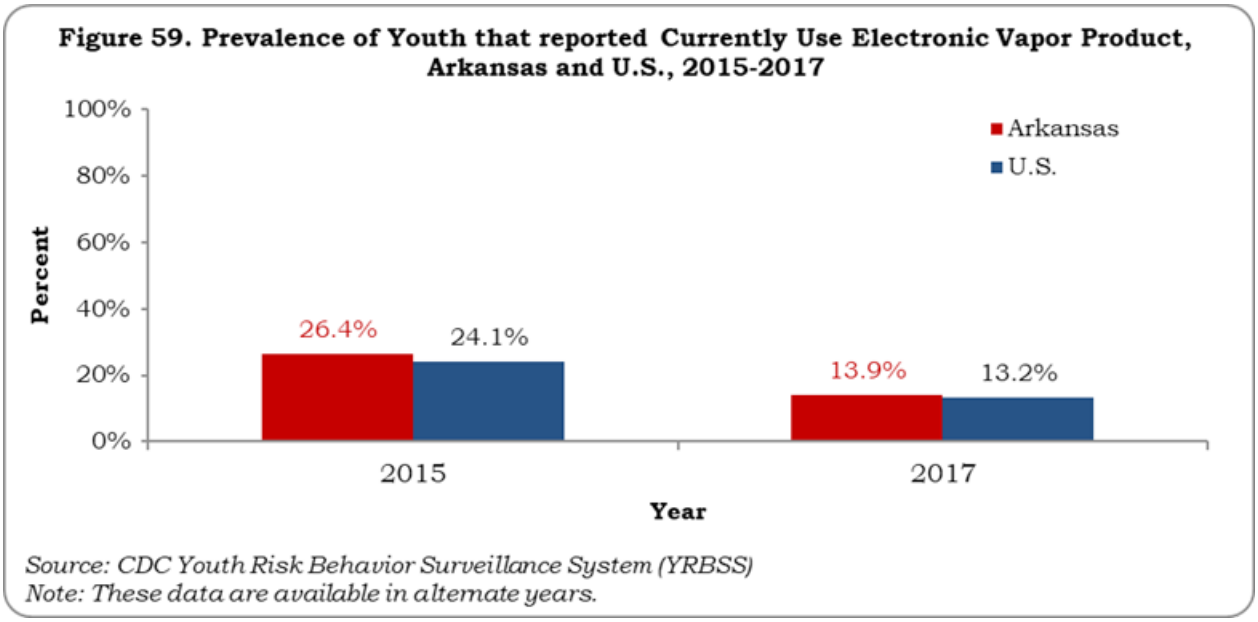

The percentage of youths grade 9 through 12 who self-reported they have ever tired cigarettes deceased in both Arkansas, from 52.1% to 35.6%, and the U.S., from 41.1% to 28.9%, between 2013 and 2017 (Figure 56).




Between 2013 and 2017, the percent of youth that self-reported they currently smoke cigarettes decreased in Arkansas (from 19.1% to 13.7%) and the U.S. (from 15.7% to 8.8%). Throughout this time period, the percent that currently smoke cigarettes was higher in Arkansas than the U.S. (Figure 57).




In 2015, the percent of youths that reported ever trying an electronic vapor product was about the same in Arkansas and the U.S., at 44.7% and 44.9%, respectively. This percent increased in Arkansas in 2017, to 47.7%, but deceased in the U.S., to 42.2% (Figure 58).




Between 2015 and 2017, the percent of youths that currently use an electronic vapor product nearly halved in Arkansas, from 26.4% to 13.9%, and the U.S., from 24.1% to 13.2% (Figure 59).

# Supporting Organizations

**Arkansas Department of Health**
**Chronic Disease Prevention and Control Branch**

**Arkansas Center For Health Improvement (ACHI)**

**Arkansas Community Health Worker Association (ARCHWA)**

**Arkansas Department of Human Services,**
**Division of Medical Services**

**Arkansas Disability and Health Program**

**Arkansas Foundation for Medical Care**

**Arkansas Minority Health Commission**

**Arthritis Foundation Inc. Arkansas**

**Community Health Centers of Arkansas**

**Fay W. Boozman College of Public Health at UAMS**

**Hometown Health Improvement (HHI)**

**American Lung Association in Arkansas**

## Arkansas Department of Health
### Chronic Disease Prevention and Control Branch

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 Sections:

1. Nutrition and Physical Activity: Developing healthy communities through environmental and policy changes that promote access to healthy eating and active living, increasing provider physical activity counseling and for people with arthritis, referral to Walk With Ease;

2. Diabetes: Reducing the burden of diabetes and prediabetes among Arkansans by increasing access, screening, and participation in diabetes self-management and diabetes prevention programs through statewide healthcare systems, community partnerships, and ADH's Be Well Arkansas Initiative.

3. Heart Disease and Stroke: Establishing 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 heart disease and stroke-related encounters with health care providers;

4. Comprehensive Cancer: Increasing the rate of early detection of breast and cervical cancer and reduce the morbidity and mortality rates among women and increasing colorectal cancer screening rates across the state, and

5. Surveillance, Evaluation and Epidemiology: Improving the quality of data on which better decisions and policies can be based.

### Contact Information
4815 W. Markham Street Slot 6
Little Rock, AR 72205
Phone: (501) 661-2942

## 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 of residents 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 Arkansas's poor health status will not improve until the causes are addressed and effective health policies and initiatives are established, altering behaviors and measurably improving health 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. ACHI houses the Health Data Initiative and is the administrator of the Arkansas All-Payer Claims Database. 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
www.achi.net

## Arkansas Community Health Worker Association (ARCHWA)

ARCHWA is a 501©3 non-profit membership based organization founded in 2015, led and directed by community health workers (CHWs). ARCHWA supports CHWs in obtaining additional training and continuing education and provides networking opportunities. Its members also promote CHWs by increasing awareness of their role in improving health and quality of life while reducing the cost of healthcare.

### Mission

To support Arkansas community health workers in promoting improvements in health and health care.

### Vision

Community health workers are seen as members of a vital profession. ARCHWA will be recognized as a leader for improving the public health, well-being and quality of life for all Arkansans.

### Values

- Compassion
- Professionalism
- Accountability
- Trust
- Integrity
- Equity

### Objectives

- Provide training, continuing education and career advancement opportunities.
- Advocate for steady and reliable funding for community health worker programs.
- Increase public and professional recognition of community health worker knowledge, skills and contributions.

### Contact Information

Arkansas Community Health Worker Association
P. O. Box 166713; Little Rock, AR 72206
(870-338-8900)
www.archwa.org

## Arkansas Department of Human Services, Division of Medical Services

The Department of Human Services (DHS) oversees the Medicaid program in Arkansas. Medicaid is a program that helps pay for medically necessary services for eligible Arkansans. Medicaid is operated in partnership between DHS and the Centers for Medicare and Medicaid Services (CMS).

Arkansas Medicaid, the Arkansas Department of Human Services, Arkansas Blue Cross and Blue Shield, and QualChoice of Arkansas partnered to transform our state's health care and payment system. The collaboration is called the Arkansas Health Care Payment Improvement Initiative. Together, Medicaid and private insurance companies represent a large enough portion of the market that initiative leaders felt there would be a big enough incentive for providers to shift to a higher-quality and more cost-efficient system of care.

Working closely with hundreds of physicians, hospital executives, patients, families and advocates, the payers worked for nearly a year to design and build the new payment system. The result is a bold initiative tailored to the needs of Arkansas patients and providers. Though some aspects of this initiative have been or are being tried elsewhere in the country, Arkansas is the first to use this approach statewide and with both public and private payers.

The initiative is part of a larger effort to improve the state's overall health care system by improving access to care, increasing the number of people who are insured and improving the quality of care patients receive. For more information about the larger effort, please visit www.paymentinitiative.org

### Contact Information

Contact Information for DHS Divisions and Offices:
By Phone: 501-682-1001
By TDD: 501-682-8820
Address: Donaghey Plaza, P.O. Box 1437
Little Rock, AR 72203
Source: http://humanservices.arkansas.gov/

## 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

Vanessa Krause, Program Director
322 Main Street, Suite 501
Little Rock AR 72201
Phone: (501) 301-1100
Fax: (501) 682-5423
vanessas@uark.edu
http://uofapartners.uark.edu/adh

## Arkansas Foundation for Medical Care

The Centers for Medicare & Medicaid Services (CMS) transformed the Quality Improvement Organization (QIO) program in the summer of 2014 to better facilitate and guide health care quality improvement efforts throughout the country. Arkansas Foundation for Medical Care (AFMC) joined the TMF QIN-QIO (Quality Innovation Network– Quality Improvement Organization) led by Texas and including Missouri, Oklahoma and Puerto Rico. The contract period began in August 2014 and will run through July 2019. The 12SOW RFP has been released and is in a competitive process at the current time. There are a total of 14 QIN-QIOs nationally that include all of the states and territories in the US.

AFMC's focus over the first two years of 2014 included diabetes self-management education, value-based modifiers, PQRS, care transitions and cardiovascular health. We have now transitioned from PQRS/value based modifier to assisting providers with the new Quality Payment Program in 2017. In addition to this, AFMC was funded to begin work on immunizations and behavioral health specific to the Medicare population in 2015. In August of 2016, the QIN-QIO was funded by CMS to work with outpatient facilities on the implementation of an Antibiotic Stewardship program using the CDC four outpatient core elements to ensure appropriate antibiotic usage.

In 2017, AFMC was awarded Special Innovation Projects (SIPs) in COPD and CKD. AFMC works 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 continue to 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
Phone: (501) 212-8740; jkettlewell@afmc.org

## Arkansas Minority Health Commission

### Mission

To assure all minority Arkansans equitable access to preventive health care and to seek ways to promote health and prevent diseases and conditions that are prevalent among minority populations.

### FY 2019-2023 GOALS

**Goal No. 1**: Increase the number of minority Arkansans that obtain recommended screening for diseases that disproportionately impact minorities.

**Goal No. 2**: Increase the number of minority Arkansans who receive education regarding diseases that disproportionately impact minorities.

**Goal No. 3**: Maintain and promote the use of a resource database to help minority citizens identify and gain access to appropriate health and health care resources in their communities.

**Goal No. 4**: Establish a collaborative network of stakeholders to address workforce diversity and education of health care professionals regarding diseases that disproportionately affect minorities.

**Goal No. 5**: Establish a network of coordination and collaboration with other agencies and organizations addressing the health of minority populations.

**Goal No. 6**: Establish a constituency of individuals, community-based organizations, and communities committed to the mission and goals of AMHC.

**Goal No. 7**: Advocate for policy that will promote the health of minority Arkansans.

### Contact Imformation

1501 S. Main Street, Suite A
Little Rock  AR 72202
(501) 686-2720

## Arthritis Foundation Inc. Arkansas

### Mission

The Arthritis Foundation is boldly pursuing a cure for America's #1 cause of disability while championing the fight against arthritis with life-changing resources, science, advocacy and community connections.

### Goal

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

### Contact Imformation

P.O. Box 56481
Little Rock  AR 72215
Phone: (501) 232-7298
Mobile: (501) 908-9282
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 twelve FQHCs and their 100+ 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 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
http://www.chc-ar.org/

## Fay W. Boozman College of Public Health at UAMS

The vision of the Fay W. Boozman College of Public Health (COPH) 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 COPH is not on treating the individual patient, but on protecting and promoting the health of people and the communities where they live, learn work and play through disease prevention, promoting positive health behaviors, providing health education, and effective public policy. Community-based public health is the guiding principle of the education, research, and service activities of the COPH.

The COPH offers 26 educational programs in the five core public health disciplines – biostatistics, environmental and occupational health, epidemiology, health behavior and health education, and health policy and management – as well as rural and global public health, public health leadership, health administration and healthcare data analytics. The educational programs include post-baccalaureate, graduate, and executive certificates; masters and doctoral level degrees.

Research at the COPH focuses on important public health problems for Arkansans through the Arkansas Prevention Research Center (ARPRC), Arkansas Center for Health Disparities (ARCHD), and the Center for the Study of Tobacco (CST).

The ARPRC conducts community-based, participatory research in the 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, cancer, tobacco smoke exposure and HIV prevention and risk.

The CST serves as focal point for research, training and translational activities that address tobacco use, exposure to tobacco, and the tobacco-related disease burden in Arkansas communities, the nation, and beyond. The CST engages multiple disciplines in conducting collaborative and innovative research designed to inform public health policies and enhance interventions to reduce tobacco use of any kind.

## Hometown Health Improvement (HHI)

Hometown Health Improvement (HHI) was born out of the strategic planning process undertaken by the Arkansas Department of Health (ADH) beginning in 1996. One of the strategies identified was to shift the Department's focus to assisting communities in assessing and responding to their unique health needs.

HHI Regional Managers, assisted by HHI Coordinators, Health Educators, and Rural Health Specialists, provided direct support and technical assistance to local communities. ADH provides assistance with data collection, interpretation and use, resources for coalition building, training and evaluation. The Community Health Nurse Specialists (CHNS) and the Community Health Promotion Specialists (CHPS) work with schools on standards and policies for tobacco, nutrition, and physical activity, as well as provide professional leadership and training to school staff.

Hometown Health Improvement celebrated twenty years of success in 2018. To keep with the changing social and health care environments and truly create conditions where all Arkansans can be healthy, HHI must focus on broader definitions of health that extend beyond medical care to all aspects of community life. To support this transition HHI/ADH must engage all sectors of the community to build healthy public policy, create supportive environments, and strengthen community action. HHI/ADH must provide state and local leadership that will address both social and physical environments where people are born, work, live, age, play and pray.

"With equity and social determinants of health as guiding principles, every person and every organization can take shared accountability to ensure the conditions in which everyone can be healthy regardless of race, ethnicity, gender identity, sexual orientation, geography, or income level."
Karen DeSalvo

### Contact Information

Center for Local Public Health
4815 W. Markham, Slot 21
Little Rock, AR 72205

Office: (501) 280-4561
Fax: (501) 661-2545
Cell: (501) 425-3376

https://www.healthy.arkansas.gov/programs-services/topics/arkansas-hometown-health-improvement

## 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.

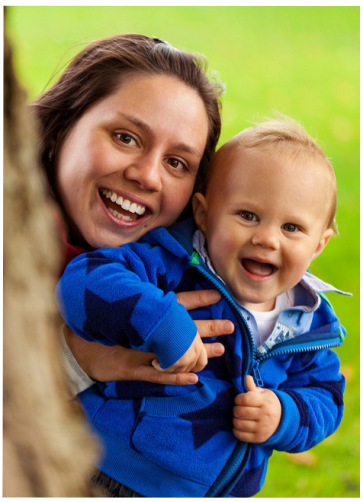
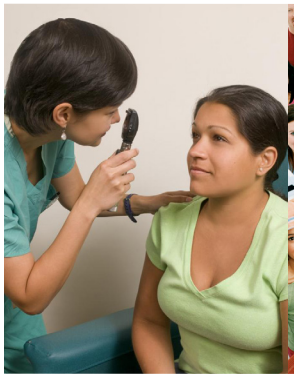
### Contact Information

American Lung Association in Arkansas
2020 W. 3rd St., Suite 301
Little Rock, AR 72205
1-800-586-4872
501-260-1291
www.lung.org





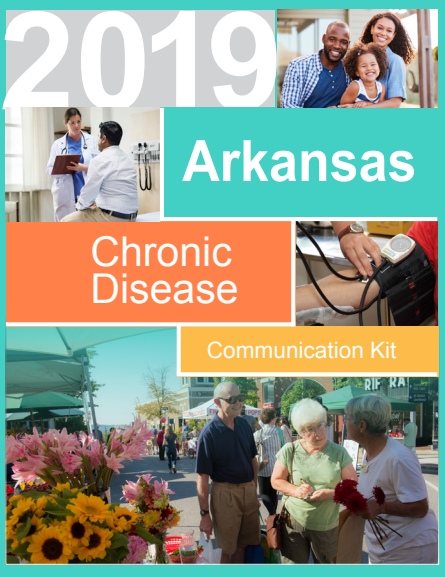





# Notes

# 2019 Arkansas Chronic Disease Communication Kit



Arkansas Chronic Disease Coordinating Council

ARKANSAS DEPARTMENT OF HEALTH