# Assessment of Childhood and Adolescent Obesity in Arkansas

## Arkansas Center for Health Improvement

### Purpose

To halt the progression of childhood obesity in Arkansas

### Target Population

School-age children in Arkansas

### Goals

- Improve access to healthier foods and beverages in schools
- Create local committees to promote physical activity and nutrition
- Report each student's body mass index (BMI) to his or her parents

### Years in Operation

2003 – present

### Results

Since the first year of this program, the percentage of overweight children and adolescents in Arkansas has decreased (from 20.9 percent to 20.6 percent), and the percentage of children and adolescents at risk for becoming overweight held steady at 17.2 percent. In addition, the total number of students assessed increased from 347,753 to 366,801.

### Funding

The Arkansas Center for Health Improvement (ACHI) had an operating budget of more than $4.5 billion in FY 2007. This funding came largely from grants and contracts, and to a lesser extent from corporate sponsors and philanthropic support. Grants specific to the Assessment of Childhood and Adolescent Obesity program include:[2]

- Defining and Classifying Diseases and Risks Linked to Childhood Obesity: Robert Wood Johnson Foundation – $2.3M
- Healthy Achievement Through Awareness and Action: U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion – $249,999
- Strategic and Logistic Planning for Arkansas BMI Database: Robert Wood Johnson Foundation – $135,824

### Key Partners

Local school districts; Arkansas Department of Education; U.S. Department of Health and Human Services; staff from the Arkansas Children's Hospital; University of Arkansas for Medical Sciences' College of Public Health; Community Health Nurses

## What Works and Why

In 2003, leaders in Arkansas developed a unique and comprehensive approach to address childhood obesity in public schools and local communities. Among other provisions, the new law called for improved access to healthier foods and beverages in schools, the creation of local committees to promote physical activity and nutrition, and confidential reporting of each student's BMI to his or her parents. Over the past four years, public schools across the state have embraced the importance of working with families and communities to provide a healthy learning environment by improving nutrition and finding ways to increase physical activity. In addition, ACHI continued to improve methods for reporting BMI of students.

## Structure and Operations

In 2003, the Arkansas General Assembly passed and Gov. Mike Huckabee signed *Act 1220* into law. Among its provisions, *Act 1220* mandates that parents shall be provided with an annual BMI by age for their child, as well as an explanation of what BMI means and the health effects associated with obesity.

The Arkansas Child Health Advisory Committee, a committee mandated by *Act 1220* and charged with making recommendations on its implementation, decided that parents will receive information regarding their child's BMI on a confidential health report.

ACHI was asked to take the responsibility of developing and implementing standardized statewide BMI assessments and reporting. To accomplish this, ACHI put together a BMI Task Force in partnership with local school districts, the Arkansas Departments of Education, the U.S. Department of Health and Human Services, staff from the Arkansas Children's Hospital, and the UAMS College of Public Health. The BMI Task Force developed a timeline and a strategy for implementation. Comparison testing on assessment equipment was done at nearly every school with multiple measures being taken.

Following a successful pilot program in 2005–2006, all schools were able to report student BMI data via a paperless, Web-based system for the 2006–2007 school year. Use of the system included the capacity to immediately generate confidential Child Health Reports for parents.

## Barriers to Success

The number of BMI assessment forms valid for analysis increased each year over the first three years of reporting, reaching 85.5 percent in 2005–2006. In 2006–2007, the number decreased to 77.6 percent. The majority of invalid forms contained no measurement information for students. A contributing factor to the decrease in valid forms may have been the uncertainty surrounding the BMI assessment process that was created by proposed state legislation during the 2007 General Assembly. The uncertainty caused some schools to delay conducting their BMI measurements, and these delays prevented some schools from completing their measurements before the end of the school year.[3]

## For More Information

Additional information is available online: http://www.achi.net/index.asp