TABLE OF CONTENTS

American Recovery and Reinvestment Act of 2009

Communities Putting Prevention to Work (CPPW): Obesity/Physical Activity/Nutrition

The Arkansas Department of Health (ADH) is submitting this State Coordinated Small City and Rural Community application to assist two targeted communities – the City of North Little Rock (small city) and Independence County (rural area) - to integrate population based approaches to reduce obesity risk factors, prevent and/or delay chronic disease, and promote wellness through policy, systems and environmental change. Selection of these communities was based on proposals submitted in response to a competitive statewide partnership opportunity announcement. An independent panel of state level experts in health policy, community development and programmatic best practices chose these communities because their proposals exhibited the necessary capacity, interest and readiness to partner with the ADH to successfully achieve CPPW outcome goals for Category A.

I. PROGRAM INFRASTRUCTURE AND FISCAL MANAGEMENT

ADH is organized into 5 Centers, three of which will play a major role in this application (see organizational chart in Appendix 1). The Center for Local Public Health (CLPH) will provide the state level management, community support and guidance and financial management and reporting. The Center for Health Advancement will provide policy and best practice expertise and the Center for Public Health practice will provide epidemiologic and evaluation expertise.

The Center for Local Public Health is responsible for the operation, ongoing development and support of a community focused local public health system that is cost effective and provides a quality set of services The Local Public Health Offices or local health units (LHU) in Arkansas protect and improve community well-being by preventing disease, illness, and injury and impacting social, economic and environmental factors fundamental to good

health. There are currently 96 LHUs, in five geographically designated areas of the state, at least one in each of Arkansas's 75 counties. The Administrators of the LHU provide leadership and local coordination for the public health activities in their county. Over the past 10 years each LHU has been asked to establish linkages with key stakeholders to build community partnerships through the Hometown Health Improvement (HHI) initiative, resulting in the formation of 81 community based health coalitions across the state . These HHI Coalitions focus on local policy development, community education and health system improvement. The LHU administrators are an active participant in their local HHI Coalition and will serve on the Local Leadership Team in each pilot community.

The **Hometown Health Support Services Branch**, located in the CLPH is closely linked with all LHUs and community- based HHI Coalitions will provide leadership for the activities proposed in this application. This branch of the Center has two sections: HHI and the Office of Rural Health and Primary Care (ORHPC). HHI is state supported but locally controlled initiative that aids communities in coalition building, community health assessment, prioritization of health issues and the development and implementation of community health strategies that are locally designed and sustained. At present, there is an HHI coalition in every Arkansas County (See map in Appendix 4). Hometown Health Improvement (HHI) is an integral part of the ADH structure and facilitates the linkage of state-level experts on health policy; program best practices and epidemiology to local communities provide guidance for coordinating comprehensive local health goals and initiatives.

Andrea Ridgway, MS, RD, LD, CDE, HHI Section Chief, will serve as the Principal Investigator for this project and interim state health department's Healthy Communities' Program Coordinator until this position can be filled. Mrs. Ridgway is responsible for

developing and maintaining state-level partnerships and program development at the state level, managing fiscal appropriations, and producing state and federal reports. Mrs. Ridgway reports to Stephanie C. Williams, BSN, RN, RNP, the HHI Branch Chief, who serves on the Center's leadership team. The Office of Rural Health and Primary Care (ORPHC), also located in the HHI Branch, supports grants to communities that address issues related to chronic disease care and prevention. William Rodgers, Section Chief of ORPHC, Mrs. Williams, and Mrs. Ridgway will all serve on the State-Community Management Team for CPPW (See Curricula Vitae Appendix 2) and provide technical assistance to HHI sites to help them to achieve their identified local health improvement goals. An ADH HHI Regional Manager is located in each of the five ADH regions. These managers provide general oversight for the coordination of HHI activities within the region and technical assistance. They also assist with development of professional standards for the agency, ensure professional competence of local HHI support staff members, (e.g., public health educators); connect communities with resources, and participate in statewide health planning efforts. The HHI Regional Managers responsible for the pilot communities of North Little Rock and Independence County are Julie Harlan (Central) and Joy Laney (Northeast), respectively. (See Curricula Vitae in Appendix 2)

In addition three new staff positions will be created with ARRA funds to provide community support and technical assistance to the pilot communities (See job descriptions in Appendix 2). The ***CPPW Branch Manager*** will devote 100% FTE and to oversee overall planning, implementation, monitoring and evaluation of the program, including general oversight of staffing, fiscal, reporting, and training. This position will function as the Program Coordinator to ensure participation in the national evaluation activities and the development of a sustainability plan, as well as encourage linkages to other community-based efforts funded by

ARRA. The ***Training Coordinator*** will devote 100% FTE to coordinating training, technical assistance programmatic support and consultation to the funded communities and Leadership Teams in risk factor surveillance; program evaluation; sustainability; evidence and practice-based policies, systems, and environmental changes; community engagement, and intervention selection and development.. The ***Budget Analyst*** will devote 100% FTE to oversight of accounting, procurement, cost allocation, audit, funds management, project activities including transfer of funds to the communities and ARRA reporting and documentation from pilot communities.

The HHI Branch and regional HHI support staff have an established infrastructure which will allow immediate implementation of effort at both the state and community levels. This unique linkage between the state health department, regional offices, local health units and the community is a tremendous asset and appears to align with the duties required to coordinate small city and rural community activities.

The **Center for Health Advancement** is organized in branches housing most federal programs. Two of these branches, Lifestage Health and Chronic Disease, will provide expertise in policy, systems, and environmental change strategies for this project. The Lifestage Health Branch includes 5 sections: Physical Activity, Nutrition, Children in Schools, Adults in Worksites, and Older Adults in Communities. Becky Adams is the Associate Branch Chief for Lifestage Health and also serves as the current State Obesity Coordinator. She will serve on the State Leadership Team (See curricula vitae in Appendix 2).

The **Center for Health Practice,** which is comprised of two branches (Epidemiology and Health Statistics) focuses on elements essential to an effective, strong community health presence, which include compilation, analysis and publication reports on statistical health

indicators and the study of the distribution of diseases, impairments and injuries. This Center will provide the expertise in surveillance and evaluation including BRFSS implementation. Mary McGehee, PhD, serves as the Survey Unit Section Chief and LaTonya Bynum is the State BRFSS Coordinator. (See curricula vitae in Appendix 2 and letter of support in Appendix 5).

The Arkansas Department of Health (ADH), a centralized health department operating local health units in each of the state's 75 counties, will serve as the lead fiduciary agency. County governments provide facilities and support for the clinical, environmental and home health services offered by the agency. Due to the centralized nature of the public health system in Arkansas, county health units cannot serve as independent local fiduciary agents. Therefore, the ADH Office of Financial Management (OFM) has policies and procedures applicable to all fund control operations, and has general fiscal responsibility for internal control, accounting systems, and periodic reviews. The ADH OFM operates under the major statutory responsibilities, functions, and authorities used by the Arkansas Department of Finance and Administration (DFA) Office of Accounting, which are contained in the Arkansas General Accounting and Budgetary Procedures Law, Arkansas Revenue Stabilization Law, and Arkansas Revenue Classification Law. The DFA Office of Accounting must maintain a fully adequate accounting and reporting system. The State of Arkansas uses the Arkansas Administrative Statewide Information System (AASIS) as the accounting and reporting system for all State Government Agencies.

ADH Financial Management is responsible for oversight of all accounting, procurement, grants management, cost allocation, budget, and funds management for all Department programs. ADH Financial Management maintains a cost center structure with internal orders to track expenses by organizational unit, funding source and funding year. The ADH Grants

Management Section ensures federal grants expenditures are consistent with state laws, regulations and federal grantors funding requirements.

Award Agreements will be used to transfer funds received by ADH to another entity to carry out specific activities of a program, for the purpose of which the funding was provided. Signed award agreements with ADH and sub-grantees are subject to grant compliance requirements applicable to the funding agency prior to transfer of funds. ADH will be responsible for monitor status of all funds and reconcile against the State of Arkansas accounting system (AASIS). Teams determine and recover any unobligated funds prior to federal primary grant closure reporting. ADH OFM ensures compliance with CDC AR-14 Accounting System Requirements.

Award recipients are required to have annual audits in accordance with OMB Circular A-133 as well as site visits, submission of quarterly quantitative performance reports of goals achieved and monthly financial reports of expenditures and award balance. Through the sub-grantee process, the ADH will ensure that at least 75% of the Communities Putting Prevention to Work funds is distributed to the designated fiduciary agent of each selected communitya. Adequate funds will be allocated to enable each community to fully participate in the required data collection and evaluation activities.

In order to implement the transparency and accountability requirements of the ARRA, centralized reporting to www.FederalReporting.gov will go through the Arkansas Recovery Office. The Department of Finance and Administration (DFA) and the Department of Information Systems (DIS) have developed an ARRA state reporting application to interface with the federal site. The state report asks for additional data to be submitted because we are committed to providing more information than is required at the federal level. This will help to

ensure that Arkansas citizens know how and where the money is being spent. The DFA Office of Intergovernmental Services is responsible for assisting state agencies and will be conducting meetings with each agency to discuss the required data elements and to demonstrate the Web application.

Policies, once enacted, have the power to impact populations long after funding for specific initiatives has ended. This is especially true for initiatives to combat obesity, increase physical activity, and decrease tobacco use and exposure to second-hand smoke, as these are strategic priorities in the Arkansas state plan. The activities of this grant proposal will be integrated into the ongoing activities of the ADH. The Governor, the legislature and state agency leadership will be supportive of sustaining positions created with ARRA funds, which will also be leveraged to obtain non-federal funds to sustain the efforts of this initiative.

The **State-Community Management Team** will consist of a mix of representatives from ADH's Centers and the two funded communities. The ADH representatives will assist in providing policy and environmental change expertise and technical assistance.

Table 1: State-Community Management Team

Name	Position	Expertise
Center for Local Public Health		
Andrea Ridgway, MS, RD, LD, CDE	HHI Section Chief (Interim ADH/CPPW coordinator)	Community development, population and individual health interventions
Stephanie C. Williams, RNP	HHI Branch Chief	Community development, administration and pediatric medicine
William Rodgers*****	ORHPC Section Chief	Rural Health Services and primary care system development
To be hired	ADH CPPW Branch Chief	Management, assessment, evaluation
To be hired	ADH CPPW Training Coordinator	Programmatic support, policy and environmental change, community engagement
To be hired	ADH CPPW Budget Analyst	Funds management
Center for Health Practice		
LaTonya Bynum*****	State BRFSS Coordinator	BRFSS surveillance

Obesity Prevention Program		
Becky Adams, MPH, RD/LD, CDE	State Obesity Coordinator	Proven practices and policies in obesity control and prevention
State Community Management Team Representatives from Other State Agencies		
Laura McDowell*****	Arkansas Department of Education (ADE) School Health Coordinator	School interventions
Paula Smith*****	ADE State School Nurse Consultant	School interventions, school surveillance
Kathleen Courtney*	ADE YRBSS Coordinator	YRBSS surveillance
Debby Woods*****	ADE PANT Coordinator	School Physical Activity, Nutrition and Tobacco Initiatives
Community Representatives		
To be hired	Arkansas County CPPW Program Coordinator	Program implementation, management and evaluation
To be hired	Boone County CPPW Program Coordinator	Program implementation, management and evaluation
**See letters of support in Appendix 5 that designate commitment to serve on the State Community Management Team.*		

Arkansas has a successful track record for utilizing multi-partner, multi-level initiatives to advance health improvements through public policy, systems development and collaborative planning. The following examples illustrate significant accomplishments of the past decade which have involved state leaders, grass roots advocacy of local hometown health improvement coalitions and academia from the university to local public school level.

BMI Initiative - In 2003, the Arkansas General Assembly passed and Governor Mike Huckabee signed into law Act 1220[1]. This multi-pronged statute has one ultimate goal: to improve the health of Arkansas children. Act 1220 mandated that parents shall be provided with an annual Body Mass Index (BMI) report by age of their child, as well as an explanation of what BMI means and health effects associated with obesity.

[1] Ark. Code Ann. §§ 20-7-133 – 135

The Arkansas Child Health Advisory Committee, a committee mandated by the Act, comprised of state and local representatives from the health community and education communities and charged with making recommendations on the implementation of Act 1220, decided that parents would receive information regarding their child's BMI on a confidential health report. The Arkansas Center for Health Improvement (ACHI), the state's health policy center, was asked to take the responsibility of developing and implementing standardized statewide BMI assessments and reporting information to provide parents with important knowledge regarding any health risks their child may incur as a result of being overweight or underweight. To accomplish this, ACHI put together a BMI Task Force in partnership with local school districts, the Arkansas Departments of Education, the Arkansas Department of Health, the Arkansas Department of Human Services, staff from the Arkansas Children's Hospital, and the University of Arkansas Medical System's College of Public Health.

Subsequent legislation in the fifth year of BMI assessment (Act 201 of 2007[2]) limited BMI measurements to students in K, 2, 4, 6, 8, and 10 only to alleviate the burden on school systems of unfunded mandates. BMI measurement in Arkansas public schools continues to provide a valuable biometric indicator of the obesity burden and associated risk of Arkansas children. Aggregate BMI measurement information is reported yearly and is easily accessible via the Arkansas Center for Health Improvement website.

Partnership Between Health and Education – One of the major strengths in Arkansas in support of school based interventions is the partnership forged between the Departments of Health and Education as a result of the Tobacco Master Settlement Agreement (MSA) in 2000. The Coalition for a Healthier Arkansas Today (CHART) developed a plan for spending the MSA

[2] Ark. Code Ann. § 20-7-135

funds that focused on strategies to improve and optimize the health of Arkansans. ADH used MSA funds to develop a support system for school nurses by hiring 17 Registered Nurses to serve as Community Health Nurse Specialists (CHNS) and the position of State School Nurse Consultant (SSNC) employed by ADH and housed at the Arkansas Department of Education. This position is held by Paula Smith (see Curricula Vitae in Appendix 2). The SSNC works with school nurses, school administrators, and CHNS to improve the health of school children in Arkansas. She provides professional leadership for all Arkansas school nurses and serves as a liaison for school nurses with state agencies.

The Community Health Nurse Specialist (CHNS) Cynthia Wilborn will work with the City of North Little Rock and is housed with the ADH Central Region; since there is no Educational Cooperative for the Central Arkansas counties (see Curricula Vitae in Appendix 2 and letter of support from Central Region in Appendix 5). The remaining 15 nurses are housed at the 15 Educational Cooperatives around the State that serve as resources to all school districts, school nurses, and teachers and corresponding school districts on health issues. Marilyn Cone (see Curricula Vitae in Appendix 2), housed in the North Central Arkansas Educational Cooperative in Melbourne, will work with the Independence County schools on this project (see Educational Cooperative map in Appendix 4 and letter of support in Appendix 5). The CHNS additional duties include: (1) identifying and evaluating training needs of school nurses and targeted communities with respect to nutrition, physical activity and other related public health issues, (2) participating in policy development and enforcement, (3) linking school-based efforts with those HHI coalitions, and (4) acting as a liaison between schools and health care providers.

ADH and Hometown Health Improvement have also broadened efforts to work with schools specifically in support of Act 1220. Through additional funding ADH added six

Community Health Promotion Specialists (CHPS) positions. The CHPS position works with schools, community coalitions, health care providers, and the HHI support staff to address the problem of childhood obesity by supporting the implementation of physical activity and nutrition standards and policies approved by the State Board of Health and the State Board of Education. The CHPS in the Central Region Anna Haver, CHES is located with the ADH's Central Region office and will work with the City of North Little Rock on their local leadership team (see Curricula Vitae in Appendix 2 and letter of support from Central Region in Appendix 5). The CHPS in the Northeast Region Mark Oliver is stationed in the Wilbur D. Mills Cooperative in Beebe, but will provide support and serve on the local leadership team for Independence County (see Curricula Vitae in Appendix 2).

To promote communication and simplify working relationships, two Community Nurse Specialist Supervisors in the Hometown Health Improvement Branch manage the CHNS and the CHPS. Nancy Green supervises the 8 CHNS and 3 CHPS in northern Arkansas. Cheryl Lindly supervises the 8 CHNS and 3 CHPS in central and southern Arkansas. These supervisors work closely in tandem with each other and serve on the Coordinated School Health team with the other main partners from Department of Education and Department of Human Services (see Curricula Vitae in Appendix 2 and letter of support in Appendix 5).

The **Arkansas Coalition for Obesity Prevention (ArCOP)** was formed in 2007 to bring together partners from across the state to work on solutions to the obesity problem in the State of Arkansas. ADH and HHI are active members of ArCOP and its working groups. The mission of **ArCOP** is to improve the health of all Arkansas communities by increasing physical activity and healthy eating to reduce and prevent obesity. It envisions that all Arkansans will value and practice healthy lifestyles through created and supported opportunities for physical activity and

healthy eating. ArCOP has five working groups with goals, objectives, and work plans aimed at reducing and preventing obesity: 1) Access to Healthy Foods; 2) Built Environment; 3) Worksite Wellness; 4) Health Care; and 5) Early Childhood and Schools (See letter of support in Appendix 5).

Final staffing of the Pilot Project, the ***North Little Rock Fit-2-Live Challenge*** (F2LC), a collaboration of the City of North Little Rock (CNLR), the North Little Rock School District (NLRSD) and the Arkansas Department of Health (ADH), Arkansas Center of Health Improvement (ACHI) and the Arkansas Municipal League (AML) will occur not later than (90) days of notice of selection as a grantee by the CDC (see organizational staffing in Appendix 1). The Fit-2-Live Challenge will be managed directly from the Mayor's Office of Sustainability (see CAP in Appendix 3) by the NLR Sustainability Coordinator who serves as policy a key advisor to the Mayor and City Council members and who will exercise administrative responsibilities for implementation and oversight of the F2LC. Administrative oversight for the North Little Rock School District (NLRSD) will be managed directly from the Office of the Superintendent by the Coordinated School Health Program Coordinator (CSHPC). The CNLR and NLRSD have partnered on a set of guiding principles described in the CAP that set forth the foundation for a "progressive collaboration" toward creating a healthier community. In partnership with Coalition members the CNLR, as principal sub-grantee, has the demonstrated experience, management and fiscal oversight and local political commitment required to ensure fulfillment of all grant requirements and commitments. Experience in federal grants includes ARRA reporting; CDBG Entitlement Grant Management, EPA-Brownfield's Grant Management, HUD-NSP1 Grant implementation and reporting and many others. The F2LC staff is skilled in program management and accountability management expertise. Recipients of

entitlement, formula and competitive Recovery Act ("ARRA") grants (see CAP), the Principal Collaborators (PC) have a demonstrated record of conservative, professional financial management and experience meeting the reporting requirements of ARRA (see CAP) including Project Management and Oversight. Moreover, recognizing that the ADH will fulfill the role of lead/fiduciary agency, the CNLR will work closely with the ADH fiscal agent responsible for CPPW oversight to ensure timely and comprehensive reporting in concert with ARRA and OMB Recovery Act requirements as set for in the CNLR Fiscal Responsibility and Management Policy. Additionally, in its role as the lead/fiduciary agent for the F2LC, the CNLR will hold all sub-grantees accountable to CPPW expenditures commitments, prompt and accurate reporting and achievement of programmatic milestones pursuant. The PC are preparing a Sustainability Plan that will document steps to ensure that the initiatives launched by means of the CPPW grant will be fully implemented in a sustainable fashion. A statement regarding sustainability Plan is found in the CAP. The PC will comply with all requirements specified in Division A of the Recovery Act (Public Law 111-5), including reporting requirements outlined in Section 1512 of the Act and designated Recovery Act outcome and output measures as detailed in the CPPW FOA. For purposes of reporting, the PC acknowledge and will vigorously comply with the requirement that Recovery Act recipients (ADH) must report on Recovery Act sub-recipient (PC) including sub-grantee and sub-contractor activities as specified in the FOA. The PC have provided Letters of Support from key local, state and national political and collaborative leadership and have carefully defined roles, responsibilities and skill sets of proposed staff (see Appendix 5).

The Independence County Wellness Coalition was organized in 2001 and became a federally recognized non-profit entity shortly thereafter. The coalition maintains strong ties with

all municipal and county government as well as all public school districts that will be participating in the project. The coalition will adhere to all ARRA reporting and financial requirements and will work closely with ADH fiscal managers to assure that all requirements are fulfilled.

Sustainability- Policies, once enacted, have the power to impact populations long after funding for specific initiatives has ended. As illustrated by Arkansas's continued Body-Mass Index assessment project and progress school wellness initiative development, our state has a successful history of leveraging financial and human resource capital from multiple sources to enable projects to continue beyond initial funding periods In addition, combating obesity, increasing physical activity, and tobacco cessation are strategic priorities in the Arkansas State Plan, indicating buy-in by the Governor, the legislature and state agencies that will be supportive of sustaining positions created with ARRA funds.

Performance Measures: ADH will ensure the following: adequate staffing to administer, manage, and evaluate the program; expertise and collaboration for the State Community Management Team; development of a sustainability plan with collaboration with the pilot communities and other state agencies; transfer at least 75% of funds to the pilot communities; procedures to track and monitor expenditures and implementation of the ARRA reporting system.

II. LEADERSHIP TEAM AND COALITIONS

City of North Little Rock: The Leadership Team assembled by the CNLR has demonstrated knowledge and experience in enacting policy, environmental and systems change at the highest levels of local, regional, and national affairs in the organizations/communities that they lead and serve. As a result, the Leadership Team has broad influence in the community that

has resulted in the successful implementation of broad-based policy, systems, and environmental changes initiatives (see CAP in Appendix 3). The Leadership Team has expressed a high-level commitment to the CPPW Initiative including a commitment of time and resources (see letters of support in Appendix 5). Finally, the Leadership Team has demonstrated a history of successful collaboration with community leaders in the advocacy, formulation and implementation of broad-based policy, systems and environmental change initiatives set forth in the CAP.

The Leadership Team has expressed a commitment to actively participate in overseeing the strategic direction of the F2LC including development and implementation of policy changes selected from the prescribed interventions and will participate in project-related local and national meetings as set forth in the FOA. The Leadership Team has expressed its commitment to establish and maintain an organizational structure and governance, including a Memorandum of Understanding amongst the Coalition members for the NLR Comprehensive Community Wellness Coalition. The coalition members have vast experience working together with community leaders to implement broad-based policy, systems and environmental change initiatives in the community. The Coalition is composed of leader-representatives from a variety of sectors and spheres of influence representing virtually every aspect of community life including: national, regional, statewide and local organizations dedicated to improving the overall responsiveness of cities to its populations, foundation and community-action agencies, state education agency, state human services agency, Arkansas Municipal League, ICLEI (Local Governments for Sustainability), US Conference of Mayors, Clinton Climate Initiative, Green Building Council, Bicycle Advocacy groups, local Parks Council, US Department of Defense, EPA, Arkansas Department of Environmental Quality, Wal-Mart Corporation and Foundation, county-wide Transit Authority, Metropolitan Planning Organization (MPO), Winrock

International, Clean Cities Coalition and local healthcare systems such as Baptist Health, the ACHI at UAMS and many others. The PC will encourage linkages with other-community-based efforts and the Office of Regional Health Administrator, with special attention to leveraging federally funded and foundation activities, including Recovery Act funds.

Independence County Leadership Team: The Independence County Wellness Coalition is dedicated to the promotion of health for all citizens in Independence County but engaging representative and partners in outlying areas of the county has been an ongoing challenge. Independence County is made up of several small towns surrounding Batesville. They are Cushman, Magness, Moorefield, Newark, Oil Trough, Pleasant Plains and Sulphur Rock. Batesville School District and Southside School District are both in Batesville and serve students from Batesville and Cushman. Cedar Ridge School District is in Newark and serves Newark, Oil Trough, Magness, and Sulphur Rock. Midland School District serves some of Oil Trough and all of Pleasant Plains. By utilizing strong linkages to the school districts and developing local leadership teams with a recognized linage to the county coalition they feel a shared sense of purpose and commitment have been achieved.

There are four school/community Leadership Teams which represent 8 communities. These groups have joined with the existing Independence County Hometown Wellness Coalition to extend the Coalition to better serve each community and the county as a whole. See CAP plan in Appendix 3 for list of leadership team and sector represented.

Name	Position
Mayor Elumbaugh	City of Batesville
Mayor Tim Brown	City of Cushman
Mayor John Hall	City of Magness
Mayor Randy Nash	City of Moorefield
Mayor Randy Hendrix	City of Newark
Mayor Bobby Davis	City of Oil Trough
Mayor Rick Siler	City of Pleasant Plains
Mayor Kendall Batson	City of Sulphur Rock

Independence County Coalition: The Independence County Wellness Coalition is a network of community members and organizations working together to prevent obesity and promote healthy lifestyle choices in the communities of the county. These partnerships assure a comprehensive approach to improving the health in the community and are vital to the success of the public health system.

The Coalitions' major goals are to provide educational programs on obesity prevention and healthy living, create a sustainable, united coalition through community wide collaboration, promote positive public awareness, and collaborate on programs to decrease obesity in youth and tobacco use.

The Coalition offers quarterly education programs on obesity prevention and healthy living. These forums are always free and open to the public, and some provide continuing education for health and wellness professionals. The Coalition meets monthly to evaluate, adjust and expand existing programs and to add new programs. In the past, the Independence County Wellness Coalition has been recognized for their annual "Walk the Walk to Wellness" program with the Northeast Arkansas Health Hero Award. The program included an adult "Out to Lunch" walking program and "Kids March into May," a school-based physical activity and nutrition program.

The Independence County Wellness Coalition has worked collaboratively to support community wide initiatives through broad partnerships including representatives of the local medical community, such as White County Medical Center, the area's largest hospital and representatives from academia and business sectors such as the University of Arkansas Community College at Batesville, the Independence County Chamber of Commerce and the Independence County CEO Roundtable. It is this strong multi-agency collaborative that has

historically provided a strong basis for program sustainability in Independence County (See CAP in Appendix 3).

Both Dr. Paul Halverson, the Director of ADH, and Dr. Joe Thompson, Arkansas' Surgeon General, recognize the need for implementing statewide policies to improve the health of all Arkansans. Every effort will be made to coordinate our proposed grant activities with other state and community initiatives under the American Recovery and Reinvestment Act (ARRA) to ensure the greatest impact of our efforts. Dr. Thompson, as the governor's health policy advisor and chair of the Governor's Health Roundtable, and Dr. Halverson, as a member of the Governor's cabinet, are able to routinely advise and brief the executive and legislative leadership in Arkansas. This routine access and familiarity with key state health policy makers will serve as an important aid in maximizing state ARRA resources.

In addition to their influences on state policy, both Dr. Halverson and Dr. Thompson are involved in national policy, as well. Dr. Halverson is currently President of the Association of State and Territorial Health Officials (ASTHO), which is the national nonprofit association representing and supporting heads of public health agencies in the United States, the U.S. Territories, and the District of Columbia, as well as the 120,000 public health professionals these agencies employ. ASTHO members, the chief health officials of these jurisdictions, are dedicated to formulating and influencing sound public health policy and to assuring excellence in state-based public health practice. Dr. Thompson currently serves as a member of the Board of Directors of Academy Health, which is a national professional society for health services researchers and health policy analysts that work to improve the knowledge base of health care decision-making by helping to translate health research findings into policy and practice. Dr. Halverson and Dr. Thompson are frequently asked to provide data-based consultation to

members of Arkansas's Congressional Delegation, federal agencies, and White House officials as well as to public health policy groups across the country. Dr. Halverson and Dr. Thompson will provide key leadership and support for the overall sustainability of ARRA funded initiatives that improve the health of Arkansans. Dr. Thompson, in his role as director of the Robert Wood Johnson Foundation's Center to Prevent Childhood Obesity, has a similar national impact, providing oversight and guidance to the RWJF half a billion dollar effort in the area of child and adolescent obesity.

Performance Measures: Local pilot communities will track partnerships and collaborations with meeting minutes, membership lists, attendance and participation.

III. INTERVENTION AREA AND POPULATIONS OF NEED

The first targeted intervention area is the entire City of North Little Rock (NLR), Arkansas, a City of 57,928 (2009 MetroPlan estimate-see Appendix A, Exhibit 15), with an approximate area of 53.5 square miles. The 2000 census estimated a population mix of: 59.57% White, 37.50% Black, and 3.50% Hispanic, Asian and other. The following racial groups were enrolled in the NLRSD in 2009: 33.59% White, 58.78% Black, 6.48% Hispanic, and 1.15% Asian, Native American, and Hawaiian (see maps in Appendix 4). As indicated in the Community Action Plan (CAP), populations to be served include, to the extent possible, all citizens of the City of North Little Rock − with particular emphasis on populations that suffer a disproportionately high rate of chronic disease due to lack of access to healthy food choices and guided, routine physical activity opportunities. Moreover, the NLRSD Meal Status Data for the 2009-2010 School Year report that 65% of pre-K to 12th Grade students are eligible for free/reduced lunches. The Leadership Team and Principal Collaborators (PC) have recognized that interventions to reduce obesity and increase physical activity should focus upon

neighborhood schools and neighborhoods exhibiting a high percentage of African American, Hispanic and Caucasian low-income populations.

Health-risk behaviors contributing to the leading causes of mortality and morbidity are established during childhood, extend into adulthood, and are interrelated. Participation in these activities compromises well-being, health and life-course development and may contribute to disparities in health care. Health-risk behaviors identified by the CDC[3] include: (A) activities that contribute to unintentional and intentional injuries and violence; (b) tobacco use; (c) alcohol and other drug use; (d) sexual behavior; (e) dietary practice; and (f) physical inactivity. Risk behavior indicators for North Little Rock school-aged children are determined from four sources: the North Little Rock School District "2008-2009 Assessment of Childhood and Adolescent Obesity"; the percentage of students participating in free/reduced cost lunch program per school; Pulaski County Empowerment Zone HUD data maps (see Appendix A, Exhibit 22); and 2000 Census information on racial groups per census tract [given the age (2000) of Census Tract and Empowerment Zone data, the Leadership Team and Coalition lessened its reliance upon this data in favor of more recent School District-derived information]. However, these data paint a picture of concentrated areas of poverty within an overall healthy community. The NLRSD has not administered Youth Risk Behavior Surveillance Surveys (YRBSS) and has not participated in the voluntary Arkansas Prevention Needs Assessment (APNA) since 2006, although NLRSD staff indicates that the APNA will be employed in 2009. Data from other sources in summarized in table below:

Grunbaum JA *et al*. Youth risk behavior surveillance_United States, 2003. MMWR 2004;53(SS-2):1_100; cdc.gov/mmwr/preview/mmwrhtml/ss5302a1.htm.

School Type	Number Of Schools	% Enrolled Free Or Reduced Lunch	After-School Program*	BMI Results for 2008-09
Pre-K	1	90%	1-YES/1-NO	
Pre-K/5th	9	82%-96%	5-YES/4-NO	
K-5th	4	3<35%-1>93%	4-NO	
6th only	1	70%	YES	
7th-8th	2	1<44%-1>88%	YES	
6th-8th	1	90%	YES	
9th-10th	1	55%	YES	
11th-12th	1	49%	YES	
9th-12th	1	89%	YES	
DISTRICT WIDE	21	65%		36.40%
*All but 1 school limit after school programs to academic tutoring in math and reading.				

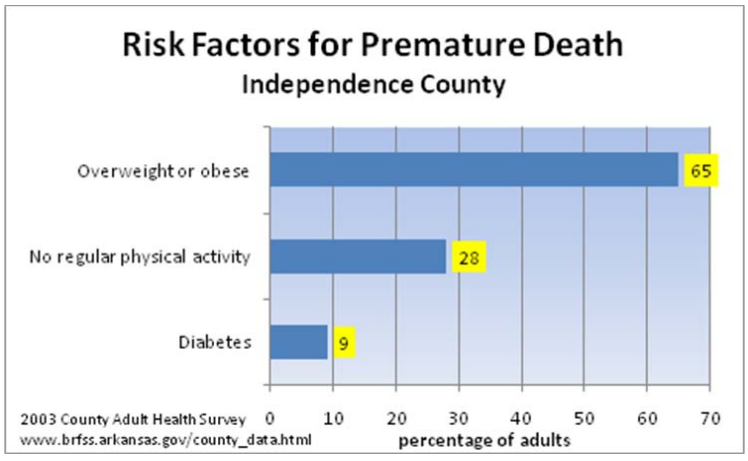
The percentage of students participating in the School Lunch Program is an indicator of the prevalence of student poverty in public schools. Research has documented that children from low-income families are more likely than others to go without necessary food; less likely to be enrolled in good preschool programs; more likely to be left back a grade; and more likely to drop out of school. The School Lunch Program provides low-income children with access to nutritious food and promotes learning readiness and healthy eating habits. National data indicate that health-risk behaviors are prevalent by the end of middle-school. By ninth grade, many adolescents are frequently engaged in behaviors that could compromise their lifetime health and well-being. Thus, the ideal time for prevention activities is the transition from elementary school to middle school, if not sooner. Local data also indicate that NLR is, from Pre-K through Middle School (8th grade), educating youth that may be undernourished and live in poverty or near poverty conditions. Identified barriers to successful implementation of programs included in the F2LC were identified as cultural in terms of comprehension and commitment of target populations, and organizational in terms of leadership, importance and resource sharing and are discussed at length in the CAP. Assets to be deployed are also discussed in the CAP.

The CAP employs evidence-based measures and system-wide policy initiatives, and addresses environmental barriers to accessing healthy foods and physical activity for all population groups in the CNLR, with particular emphasis on those population groups that suffer disproportionate risk of chronic disease as a result of poor or limited access to healthy foods and guided, routine exercise opportunities (see intervention area maps in Appendix 4). The CAP also addresses a series of intervention strategies that are interlinked, supportive of the goals of the initiative, and sustainable if successful. The Fit-2-Live Challenge addresses all five (5) MAPPS evidence-based strategies in the areas of nutrition and physical activity, combined with a mix of interventions that is appropriate for the unique local circumstances and populations. The CAP was developed during Leadership Team-Coalition discussions with regard: to the selection of interventions; a limited asset-mapping exercise; and limited needs assessment exercise employing four (4) measures to determine community health needs. The Fit-2-Live Leadership Team has not finalized its SMART Objectives for planned interventions, but has developed a framework for development of these objectives that is discussed in the CAP. The PC has long-standing interagency relationships with state and local agencies and programs that address chronic disease prevention and public health. The PC have taken aggressive measures to assure that all local and community-level program providers are "at the table" as members of the local Coalition to prevent duplication of efforts and coordination of deliverables. The F2LC CAP describes the "linkages" established by the F2LC with existing programs as an overall effort to: augment the impact of program activities and avoid duplication; remain focused to avoid generalities; constantly elevate the effort; and avoid dissipation of affects to reverse adult and youth obesity prevalence in the community. As mentioned earlier, the CAP contains information on a Sustainability Plan. However, the Plan is in its formative stages, as is the plan to leverage

other funding sources in the community, (e.g,. foundations, state funding, private sector funds, etc.). The F2LC incorporates cultural and linguistic diversity and the needs of specific populations disproportionately impacted by chronic diseases in the implementation strategy discussed in the CAP. Developing our cultural competencies by equipping our staff with cross cultural knowledge and skills will enable the design and delivery of culturally and linguistically sensitive policy, programs and services to specific populations that are disproportionately impacted by chronic diseases in our community.

The second targeted area, Independence County, has a population of 34,641 and is made up of several small communities surrounding Batesville − Cushman, Magness, Moorefield, Newark, Oil Trough, Pleasant Plains and Sulphur Rock. The age distribution for Independence County is: 24.3% under age 19; 60.9% age 19-64; and 14.8% over age 65. The racial breakdown is 95.5% White, 2.1% Black; and 1.4% other.

In Independence County, 40.7% of the students enrolled in the public school system are overweight or obese which is higher than the state average. According to the Arkansas Center for Health Statistics, the percentages of Independence County adults who are overweight, physically inactive or smokers are higher than percentages found in the state overall as well. According the Census Poverty data for the county, 23% of students enrolled in schools live in poverty. Fifty-seven percent of students enrolled in schools receive free or reduced lunches. Low income students have less opportunity to participate in extracurricular activities.



2008 ARKANSAS COUNTY ESTIMATES (BRFSS)			
Arkansas Adults (Age 18+) Reporting	US	State	Independence
No Exercise in Past 30 Days	24.6	29.7	28.6
Doctor Diagnosed Diabetes	8.3	9.5	11.1
Current Smokers	18.4	22.3	26.3
Overweight (BMI >=25.0 - 30.0)	36.5	36.2	44.1
Obese (BMI >= 30.0)	26.7	29.5	27.9
Overweight & Obese (BMI >=25.0)	63.2	65.7	72.0

Performance Measures: ADH and the local communities will ensure the following: the intervention areas will encompass the entire jurisdiction of the local health department; the interventions selected address all five evidence-based MAPPS strategies; and the interventions have broad reach and impact in the community.

IV. SELECTION OF RISK FACTORS AND INTERVENTIONS

Arkansas is near the top of the list of having unhealthy citizenry due to diet, exercise and obesity. The cause of this condition may be socio-economic due to relatively low incomes and education, but the land use patterns of the State communities contribute to automobile dependency to accomplish most trips rather than allowing trips to be accomplished by walking or using mass transit. Indeed, mass transit opportunities are very limited in the State and it is believed that where a functional transit service is available, communities experience improved health due to increased walking. It is indeed surprising that in an agricultural state with a mild climate, the general population is almost totally dependent on processed foods provided by few and ever larger grocery chains. Modern communications and the internet have replaced much of physical activity time and parents are working longer hours and children are being supervised by television, the internet and texting rather than household chores, active sports, and outside activity.

The focus of a City of North Little Rock study will be addressing physical activity and nutrition through a policy review of urban form and function. Elements to be addressed include:

(1) Review of the city-wide land use pattern to determine ways of establishing neighborhood parks within ½ mile of every resident,

(2) To provide an overview of how land use patterns contribute to poor nutrition and health habits, especially in the target neighborhoods, that may include opportunities or obstacles for establishing smaller grocery chains, community gardens, home gardens, or neighborhood farmers market gardens to provide local, nutritional food,

(3) Improving public transportation to increase pedestrian activity and to address how food distribution might be located near transit stops,

(4) Coordinate with ongoing efforts to address issues related to increasing walking and bicycling (active transportation) in the urban setting, which may involve a community education strategy to encourage courtesy in sharing available roadways with bicycles,

(5) Identifying political and financial obstacles to implementing a bicycle plan that incorporates the bicycle mode of travel throughout the community,

(6) Evaluate and recommend traffic calming strategies to enhance pedestrian safety and to develop a recommend funding strategy to implement a traffic calming program,

(7) Evaluate "Form-Based Zoning" in relation with the existing land use patterns to identify opportunities to transform the urban landscape and selected special nodes to mixed-use, pedestrian friendly settings,

(8) Review the existing built environment and identify zoning and other land use policies that may present a barrier to a more healthy community; focusing specifically on target

areas with a focus on easy access to a variety of healthy foods and develop a strategy to overcome identified barriers.

(9) Identify possible measurements for evaluating improvements in community health.

The Planning Study is to be launched by summer of 2010 with all recommendations and strategies adopted by early 2012. The selected consultant is to work with the Community Wellness Coalition and hold citywide and target area meetings to receive input regarding ways of encouraging a more active lifestyles, reviewing nutrition habits, and exploring strategy options prior to recommending community-wide strategies. The consultant is to produce a draft policy document to be reviewed and endorsed by the Community Wellness Coalition.

The consultant is to produce a final strategy document address the elements mentioned above and recommendations for incorporation into the Community Land Use Plan and specific recommended amendments to enforcement regulations, i.e. the Zoning Ordinance and Control of Development Regulations.

Independence County has chosen to fully implement the CATCH Program (Coordinated Approach To Child Health) for the target intervention strategy (See CAP in Appendix 3). CATCH brings schools, families, and communities together to teach children how to be healthy for a lifetime. CATCH is effective because healthy behaviors are reinforced through a coordinated approach-in the Classroom, in the Cafeteria, in Physical Education, at Home, and After School. CATCH is research-based and proven to work.

The CATCH Program considers school cafeterias an extension of the classroom. Through the Eat Smart component, breakfast and lunch become opportunities for children to learn, practice, and adopt healthy eating habits. Food Service personnel learn to prepare healthier

meals. The CATCH Family component is designed to get students, parents, and extended family members involved in practicing and adopting healthy eating and physical activity behaviors at home. By doing so, the home environment becomes an extension of the CATCH Program at school. Implemented in community-based programs across North America, CATCH Kids Club, has been designed for after-school and summer enrichment settings. Developed from the nationally-recognized CATCH Program, healthy messages are reinforced beyond the school day via physical activity and nutrition education sessions. See CAP in Appendix 3 for MAPPS nutrition and physical activity interventions.

Performance Measures: ADH and the local communities will ensure the following: the CAPs contain program objectives are SMART; local communities will ensure that sustainability plans are developed; and performance is measured quarterly and are successfully meeting milestones and benchmarks, including evidence of progress in building community capacity to institute policy, systems, and environmental changes.

V. EVALUATION TO MONITOR/MEASURE PROGRESS

ADH in concert with the City of North Little Rock and Independence County will establish a monitoring plan within 60 days of notice of award by the CDC. At 120 days post award, the PCs will finalize a comprehensive evaluation plan and the Youth Risk Behavior Surveillance System (YRBSS) lead will attend a CDC led 3-day training in August 2010. The PCs will monitor and evaluate efforts, including pre and post measurement of all F2LC/CATCH activities and expenditures and will participate in national evaluation activities, including tracking relevant behavioral outcomes utilizing the Behavioral Risk Factor Surveillance System (BRFSS) and the Youth Risk Behavior Surveillance System (YRBSS), participating in modeling studies, and examining cost and context in which community change occurs and other measures as established and enumerated in the FOA. The PCs will submit quarterly reports to the ADH and

strictly comply with all Recovery Act requirements set forth for reporting and monitoring results. To this end the PCs will employ a logic model that will accomplish the following steps: (1) summarize the key elements of the Fit-2-Live Challenge/CATCH, (2) establishes a rationale behind each element, (3) articulates desired short-term and long-term outcomes and how they can be measured, and (4) illustrates the cause-and-effect relationships between the program or program-subset and its desired outcome. The Leadership Teams and the Coalitions understand that short-term outcomes are usually those that are attainable within one year (such as numbers of person entering the Fit-2-Live Challenge as a result of an incentive) and long-term outcomes which are to be assessed after one year and include outcomes observable in: the individual; in interpersonal relationships with peers, friends and family; organizations in which recasting, amending or redefining organizational norms and values, regulations, and policies in such formal organizations such as the public school districts, municipalities, employers, faith-based organizations and others demonstrate observable outcomes; communities in which change initiatives result in changed social norms and community policies thru local coalitions and advocacy groups; and policies that are enacted that result in advancing the desired outcomes of the initiative. Two types of local performance measures are under consideration by the Coalitions and Leadership Teams at this time: (1) measures of efforts that will help Coalitions and Leadership Team members understand what activities and other services are being offered which may include, among others: types and numbers of activities offered, the level and intensity of the activities (daily, weekly, numbers of persons participating) and participant demographics; and (2) measures of effect that reflect changes in the knowledge, skills, attitudes, or behavior of participants and systems engaged in the initiative (including eating habits, times and frequency of food ingestion, weight loss, attitudinal changes, reduced risk behaviors, etc.).

All participating school districts has asserted that they will implement the requirement to collect Youth Risk Behavior Surveillance Survey (YRBSS) according to standard YRBSS protocol to be collected during the fall semester of the 2010-2011 school year and at the end of the project period (see Letters of Support in Appendix 5).

Performance Measures: ADH and the local communities will ensure the following: the evaluation plans addresses the lifespan of the program; participation in national evaluation activities; adequate progress is made on targets for specific outcomes and output measures; and attendance and participation in all training programs required by this FOA.

VI. COMMUNITY PROGRAMMATIC SUPPORT NEEDS

The CNLR has partnered with the Arkansas Municipal League, the Arkansas Department of Health Center for Local Public Health, and the Arkansas Center for Health Improvement (ACHI). It is jointly supported by the University of Arkansas for Medical Sciences, Arkansas Blue Cross and Blue Shield, and Arkansas Children's Hospital and the University of Arkansas Cooperative Extension Service for the purpose of accessing technical and professional guidance into the development and implementation of its Fit-2-Live Challenge initiative. Moreover the CNLR has requested technical assistance from the National league of Cities, Institute for Youth, Education and Families and the Foundation for the Mid-South (a *regional* community foundation serving Arkansas, Louisiana, and Mississippi) and the Annie E. Casey Foundation for technical assistance and best practices guidance and expertise. We seek to strengthen the capacities and resources of individuals, institutions and communities to improve the quality of life for all. The Leadership Team recognizes the enormous technical and evaluative resources of the Center of Disease Control and Prevention and will seek an active partnership with the CDCP in providing

frequent review, analysis and “coaching” with a goal of building a case for sustaining all aspects of the initiative that have demonstrated effectiveness at the community level.