



ARKANSAS'S MATERNAL, INFANT, AND EARLY CHILDHOOD HOME VISITING PROGRAM

2020 NEEDS ASSESSMENT

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Acronyms

ACF	Administration for Children and Families
AACF	Arkansas Advocates for Children and Families
ADH	Arkansas Department of Health
AHR	America's Health Rankings
CAPTA	Child Abuse Prevention and Treatment Act
CBCAP	Community-Based Child Abuse Prevention
CHR	County Health Rankings
DHHS	Department of Health and Human Services
DHS	Department of Human Services
FBBH	Following Baby Back Home
HRSA	Health Resources and Services Administration
HFA	Healthy Families America
HIPPY	Home Instruction for Parents of Preschool Youngsters
KCDC	Kids Count Data Center
MIECHV	Maternal, Infant, and Early Childhood Home Visiting
MCH	Maternal and Child Health
MOD	March of Dimes
mPINC	Maternity Practices in Infant and Nutrition Care
NCHS	National Center for Health Statistics
NFP	Nurse-Family Partnership
PAT	Parents as Teachers
SES	Socio-economic Status

Arkansas has implemented the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program since its inception in 2011. The MIECHV Program gives pregnant women and families with children ages 0 to 5 years old, particularly those considered at-risk, the necessary resources and skills to raise children who are physically, socially, and emotionally healthy and ready to learn. States are required to implement voluntary, evidence-based and/or promising approach programs that best meet the needs of these children and their communities while achieving the following goals:

- Improve maternal and child health,
- Prevent child abuse and neglect,
- Encourage positive parenting, and
- Promote child development and school readiness.

Arkansas's original needs assessment for the MIECHV Program, conducted in 2010, guided strategic decision making about where to implement or expand services, how to improve the state's capacity to direct resources high risk communities, and how to strengthen the early childhood system. Over the past ten years, MIECHV data has been reviewed annually to identify progress as well as barriers to implementation. MIECHV data are also reviewed in concert with the development of the state's annual Title V Maternal and Child Health (MCH) Block Grant application.

Changes have occurred in the state over the past ten years, creating the need for a renewed understanding of the needs of women, children, and families in Arkansas. The purpose of this needs assessment update is to:

- Gain an understanding of the current communities with concentrations of risk.
- Identify the quality and capacity of existing early childhood home visiting programs.
- Review the state's capacity for providing substance abuse treatment and counseling.
- Coordinate with and incorporate findings from the state's Title V MCH Block Grant, Head Start Program, and Title II Child Abuse Prevention and Treatment Act assessments.

Before presenting the primary findings, we will provide an overview of Arkansas's standing related to the MIECHV Program's priority needs and benchmark measures.

Arkansas State Overview

There is a real need for maternal and child-focused home visiting services in Arkansas. In 2019, approximately 19% of the state's residents were women of childbearing age (15-44 years) and 6% were children ages 0 to 5 years old (U.S. Census Bureau, 2019-a). Additionally, there were 175,900 pregnant women and families with children not yet in kindergarten in Arkansas (National Home Visiting Resource Center). Those families included 225,400 children between the ages 0 to 5 years old: 16% were less than 1 year old, 33% were 1 to 2 years old, and 51% were ages 3 to 5 years old. Thirty-one percent of the families were low-income, 24% were single mothers, 8% had no high school diploma, and 5% were under the age of 21.

According to the most recent publication of America's Health Rankings (AHR), Arkansas ranks 48 out of 50 states (with 50 being the worst) in overall health (2019-a) and 49th in the health of women and children (2019-b). In 2019, Arkansas ranked 48th for women accessing prenatal care before the third trimester. What's more, children in the state have the highest rates of adversity in the country: 56% have had at least one adverse childhood experience, which is 11% higher than the national average (Sacks & Murphey, 2018).

Many families in the state live in communities with high concentrations of risk, including risk factors identified by the Health Resources and Services Administration (HRSA) as priorities linked to the need for home visiting services. The priority risk factors are outlined below along with a description of how Arkansans are impacted by each. High priority families must also meet eligibility requirements to enroll

in the voluntary programs. Eligibility requirements vary by home visiting model and each local implementing agency is responsible for ensuring families meet all required criteria to enroll.

Low Income Families

Growing up in poverty can hinder cognitive growth and be a factor in the development of behavioral, social, and emotional problems. Research confirms that birth through age 5 are critical years because:

- Brain development from the late prenatal period through age 5 happens sequentially starting with development of sensory pathways, followed by language development, and then the development of higher cognitive function (Harvard Center on the Developing Child, n.d.) and is most rapid during this time. Ongoing stress and lack of nurturing and stimulation can negatively affect development.
- Early interventions for low-income and at-risk children lead to improvements in health, social skills, school success, and development. As adults, these children have improved job opportunities and earnings, are healthier, and are less dependent on social services.
- Investments in early childhood have a good return. Research has shown investments in early childhood home visiting yields a range of returns from \$1.75 to \$5.70.

According to the most recent report by AHR, one in four children ages 0 to 5 years old live in poverty in Arkansas compared to less than one in five across the U.S. (2019-c). Arkansas ranks 48 of 50 in average median household income (AHR, 2019-d) and on average, the median household income for females is 20% lower than males and is lowest for non-Hispanic black households. Arkansas also ranks high in many areas related to child poverty including household food insecurity (49 of 50), infant mortality (48 of 50), adverse childhood experiences (47 of 50), concentrated disadvantage (34 of 50), and students experiencing homelessness (32 of 50) (2019-e through 2019-j).

According to the most recent publication of the Kids Count Data Center (KCDC) report, 39% of children in Arkansas live in a single-parent family compared to 35% in the U.S. (2018-a) and from 2016 through 2018, only 24% of families headed by an unmarried woman received child support (2018-b). In 2018, 25% of families with children under age 18 received Supplemental Security Income, cash public assistance income, or Food Stamps/SNAP in the previous 12 months (2018-c).

Arkansas is one of the states with the highest income inequality in the country: since 1979, income for the top 1% of households has increased 110% compared to an increase of only 9% for all other households (Center on Budget and Policy Priorities and Economic Policy Institute, 2015). In fact, the top 5% of households in Arkansas receive 19% of the income: the average income for the poorest 20% of households is \$17,879 and for the middle 20% is \$52,674, compared to \$259,930 for the top 5%.

As required by HRSA, Arkansas collects and reports additional data related to low income: demographic data on caregiver education and unemployment and benchmark data on premature birth among home visiting program enrollees. These measures are discussed in related sections below.

Families with Pregnant Women Younger Than 21 Years of Age

According to the most recent AHR report, Arkansas has had the highest teen birth rate in the country among females ages 15 to 19 since 2014 (2019-k). Although the rate teen birth rate dropped from 40 live births per 1,000 females ages 15 to 19 to 33 live births per 1,000 females ages 15 to 19 from 2014 to 2019, rates in other states dropped as well, leaving Arkansas with the highest rate across the U.S.. Although teen birth rates are falling in the state and across the country, Arkansas rates remain at least 63% higher than national rates.

In Arkansas, as across the U.S., the majority of teen births are among the 18 to 19 year olds (KCDC, 2018-d). Rates among this age group have been declining for more than 10 years in both Arkansas and the nation; however, as noted above, rates in Arkansas remain significantly higher than those in the U.S.: 58 live births per 1,000 females ages 18 to 19 in Arkansas compared to 32 live births per 1,000 females ages 18 to 19 in the U.S.

In 2019, almost 500 (17%) of the teen births were to teens who were already mothers (KCDC, 2018-e). Across the U.S., this is true for 15% of the teen births. Teen pregnancy and childbearing can have significant and lifelong impacts on the mother and child. Teen mothers are more likely to drop out of high school, have difficulty getting and keeping a job, and live in poverty. Children of teen mothers are more likely to have lower school achievement and drop out of school, increasing the difficulty of finding employment and continuing the cycle of poverty. The state's MIECHV program annually assesses the number of households containing an enrollee who is pregnant and under age 21 as a demographic measure. In 2018, the program served 314 (13% of total households served) such households and in 2019, the number of households increased to 357 (15% of total households served).

Families with a History of Child Abuse/Neglect/Interactions with Child Welfare Services

According to the most recent report of the Child Welfare League of America (2020), there were 8,538 victims of child abuse or neglect in Arkansas in 2018. Across all confirmed cases, 38% experienced neglect, 20% experienced physical abuse, 19% experienced sexual abuse, and 23% experienced multiple types of abuse. There were 44 child fatalities in 2018, an increase of 19% over 2017. More than half (53%) of the child abuse or neglect victims were female and the majority (67%) of the victims were White. The majority (67%) of perpetrators were parents of the child. The largest age group (22%) of victims was children under the age of 1, with a total of 1,855 confirmed cases. Thirty-nine percent of the victims were between the ages of 0 to 3 years old and 21% were ages 4 to 7. Additionally, 495 infants screened positive for prenatal substance exposure. The Arkansas MIECHV Program assesses child injury and child maltreatment as benchmark measures. Since 2017, the rate of injury-related visits to the Emergency Department has declined among children enrolled in home visiting. Since 2018, the ADH has worked with the Arkansas Department of Human Services (DHS) Division of Children and Family Services to obtain administrative data related to child maltreatment among the families served by the MIECHV Program. The percent of children enrolled in home visiting with at least one investigated case of maltreatment following enrollment within the reporting period was 7.9% in 2018 and 6.5% in 2019.

Families with a History of Substance Abuse or Need Substance Abuse Treatment

The Arkansas MIECHV Program assesses the number of households with a history of substance abuse or with someone who needed substance abuse treatment annually as a demographic measure. In 2019, the program served 174 such households, which was down slightly from 182 households in 2018

The most recent report by AHR revealed that the percentage of women with a recent live birth who reported consuming alcohol during the three months before pregnancy was 49% (AHR, 2019-1). The percentage of women ages 18 to 44 who reported binge drinking (four or more drinks on one occasion in the past 30 days) or chronic drinking (eight or more drinks per week) was 17%. The rate of pregnant women in alcohol or drug treatment increased from 3.4 per 1,000 live births in 2010 to 3.6 per 1,000 live births in 2014 (Arkansas Foundation for Medical Care, 2017). The number of babies born in Arkansas with neonatal abstinence syndrome increased five-and-a-half times between 2004 and 2013, with the largest increase occurring after 2010 (Arkansas Foundation for Medical Care, 2017). The rate of neonatal abstinence syndrome diagnosis in Arkansas increased nearly fifteen fold between 2000 and 2017 (Arkansas Department of Health). In 2018, the rate decreased slightly. Arkansas ranks in the top three states for prescription opioid exposure (>20%) during pregnancy among those who were commercially insured (Bateman, Hernandez-Diaz, Rathmall, et al., 2014). In fact, between 20% to 30% of pregnant

women insured by Arkansas Medicaid receive an opioid prescription during pregnancy (Desai, Hernandez-Diaz, Rathmell, et al., 2014).

Families with Users of Tobacco Products in the Home

In 2019, Arkansas ranked 43 of 50 in women who reported using tobacco while pregnant (AHR, 2019-n). The percentage reflects a slight downward trend since 2016. The percentage of mothers who use tobacco during pregnancy is trending downward across the U.S. as well, although Arkansas's percentage (14%) is double the national average (7%). The percentage of women ages 18-44 who reported smoking at least 100 cigarettes in their lifetime and currently smoke daily or some days is 29% in Arkansas (AHR, 2019-o). The percentage has been flat over the past few years in the state as, across the nation, the percentage has decreased from 17% in 2016 to 15% in 2019. The state's MIECHV Program assesses the percent of primary caregivers enrolled in home visiting who reported using tobacco or cigarettes at enrollment and were referred to tobacco cessation counseling or services within three months of enrollment as a benchmark measure. The percentage of referrals has increased since 2017: from 43% to 53% (2018) and 57% (2019).

Families That Are or Have Children with Low Student Achievement

A look at economic, racial, and regional disparities shows low-income and minority students perform below other students on national tests (ForwARd Arkansas, 2015). Children living in poverty are more likely to have poor educational outcomes, including low achievement and reading scores, low vocabularies, and higher drop-out rates. Research shows that students who attend quality pre-kindergarten programs are better prepared when they start school, especially low-income kids and English language learners. Arkansas ranks in the top 20 nationally for pre-kindergarten access. In 2018, state-funded pre-kindergarten programs served 32% of 4 year olds and 19% of 3 year olds (National Institute for Early Education Research, 2018). Though the state spends more than \$113 million to support these programs, that amount is an inflation-adjusted decrease from 2016-2017, which translates into a decrease in spending of \$115 per child.

Major achievement gaps exist by race in Arkansas. From the 2008-2009 through the 2017-2018 school years, there were obvious disparities in literacy and math achievement by race in the state: White students consistently scored higher in literacy and math compared to Hispanic and Black students (University of Arkansas Office for Education Policy, 2019). White students scored above the average percentile of 50% in each category. White students scored 26 percentage points higher than Black students in math achievement and 24 percentage points higher than Black students in literacy achievement. White students scored 11 percentage points higher than Hispanic students in math achievement and 13 percentage points higher than Hispanic students in literacy achievement. These persistent gaps are reflected in the fact that Arkansas is among the lowest in the nation for college graduation and degree attainment rates (ForwARd Arkansas, 2015). Only 20% of students taking the ACT met college-ready benchmarks in all four subjects and almost 50% of all students enrolling in public universities require remedial coursework.

Families with a Child Who Has Developmental Delays or Disabilities

In 2019, the percentage of children ages 9 months to 5 years with a health care visit in the past 12 months whose parent completed a standardized developmental screening tool was 31% in Arkansas compared to 35% in the U.S. (AHR, 2019-p). Arkansas's MIECHV Program assesses the percent of children enrolled in home visiting with a timely screen for developmental delays using a validated parent-completed tool annually as a benchmark measure. The percentage of screenings has increased since 2017, when 74% were screened: 84% in 2018 and 85% in 2019. The state also assesses the percent of children enrolled in home visiting with positive screens for developmental delays who receive services in a timely manner. The percentage declined to 51% in 2019 from 59% in 2018 and 58% in 2017.

Families That Include Members of the Armed Forces Who Have Had Multiple Deployments

The estimated number of active duty military personnel located in Arkansas is 4,388 (Defense Manpower Data Center, 2019). The families of these personnel include 2,081 spouses and 4,095 children. There are more than 13,000 National Guard and reserve members. The families of these personnel include 6,629 spouses and 10,166 children. In 2019, the Arkansas MIECHV program served 34 military families and in 2018, served 42 military families.

In addition to the measures above, Arkansas's MIECHV Program assesses several other demographic and benchmark measures. These measures are discussed below.

Demographic Measures

Marital status. In 2018, there were 1,152,175 households in Arkansas (U.S. Census Bureau, 2018-a), 32% of which had children under age 18 in the home. Of those, almost 153,000 were female-headed households with no husband present and 85,122 with children under the age of 18 in the home. There were 45,390 children living below 100% of the federal poverty level in these households (KCDC, 2018-g). In 2019, Arkansas MIECHV served 1,939 female participants. Of those 41% were married, 52% were not and/or had never been married, and 7% were widowed, divorced, or separated. Children growing up in single-parent families typically do not have the same economic or human resources available as those growing up in two-parent families. Compared with children in married-couple families, children raised in single-parent households are more likely to drop out of school, to become a teen parent, and to experience a divorce in adulthood.

Education. Educational attainment is linked to health outcomes. Lower educational attainment among adults is highly correlated with poorer health. Higher educational attainment is associated with better jobs, increased earnings, increased knowledge of healthy lifestyles, better self-reported health, and fewer chronic health conditions. In Arkansas, 88% of the population are high school graduates compared to 85% nationally (AHR, 2019-q). In 2018, one-in-ten had only a 9th to 12th grade education; 23% had some college; 7% had an associate's degree; 14% had a bachelor's degree, and 8% had a graduate or professional degree (Census Bureau, 2018-b). Fourteen percent of births were to women who had completed fewer than 12 years of education at the time of the birth (KCDC, 2018-h).

Employment. Arkansas ranks in the bottom third of the nation for women's employment, earnings, poverty, and opportunity (Status of Women, 2018). Women ages 16 and older who work full-time, year-round have median annual earnings of \$32,000, which is 0.80 cents on the dollar compared with men who work the same. Hispanic women earn just 51 cents for every dollar earned by White men. If the pay between employed women and men in comparable positions were the same the poverty rate would be reduced by almost half and poverty among employed single mothers would drop by more than half.

Housing. In Arkansas, 14% of occupied housing units have at least one of the following problems - lack of complete kitchen facilities, lack of plumbing facilities, overcrowding, or severely cost-burdened occupants –compared to 18% in the U.S. (AHR, 2019-r). Eight of 10 mothers with children who are homeless reported domestic violence (AHR, 2019-s). Additionally, six of 10 people in families experiencing homelessness are 18 years or less and 2% of public school students in Arkansas lack a fixed, regular, and adequate nighttime residence compared to 3% in the U.S.

Access to medical care. The percentage of women ages 18-44 in Arkansas who reported having one or more people they think of as their personal doctor or health care provider has rested between 70 to 75% since 2016. In 2019, 74% women reported having a usual source of care, slightly higher than the U.S. at 73%. (AHR, 2019-t).

Access to dental care. In 2019, 60% of women ages 18-44 reported visiting the dentist or dental clinic within the past year compared to 67% in the U.S. (AHR, 2019-u).

Benchmark Measures

Table 1 shows a comparison of Arkansas’s status on each MIECHV benchmark measure from 2017 through 2019. Indicators in green show movement in a positive direction, red shows movement in a negative direction, and yellow indicates no movement in either direction. From 2018 to 2019, Arkansas’s MIECHV Program has shown positive improvement in ten measures, negative movement in six measures, and has maintained performance in two measures. Continuous quality improvement initiatives were implemented to address the drop in performance values for postpartum care and safe sleep. Challenges in completing developmental referrals were addressed in collaboration with the state’s Part C Program manager. The program manager conducted trainings for MIECHV Program staff and has committed to work with Arkansas MIECHV to improve this measure. All other measures that saw a decline are under review to identify the cause of the drop. These data, along with all other benchmark data, will continue to be reviewed on a quarterly basis and quality improvement initiatives will be developed and implemented to address negative movement as needed.

Table 1
Arkansas MIECHV Benchmark Measures, 2017 to 2019

Construct	Benchmark Descriptor - by Performance Indicator	2017 %/Value	2018 %/Value	2019 %/Value	Comparison Against Previous Year
Depression Screening	% primary caregivers screened for depression within 3 months of enrollment or delivery	75	85	92	
Well Child Visit	% children who received last recommended visit based on American Academy of Pediatrics schedule	82	82	82	
Postpartum Care	% mothers enrolled prenatally/within 30 days of delivery who received a postpartum visit within 8 weeks of delivery	87	86	73	
Tobacco Cessation Referral	% primary caregivers who reported using tobacco at enrollment and referred to cessation counseling within 3 months of enrollment.	43	53	57	
Safe Sleep	% infants enrolled always placed to sleep on their backs, without bed-sharing or soft bedding	53	76	55	
Parent-Child Interaction	% primary caregivers who receive observation of caregiver-child interaction	94	87	93	

Early Language and Literacy	% children with family member who reported during a typical week s/he read, told stories, and/or sang songs with their child daily, every day	57	56	58	
Developmental Screening	% children with timely screen for developmental delays	74	84	85	
Behavioral Concerns	% home visits where primary caregivers were asked if they had concerns about child's development, behavior, or learning	94	99	97	
Intimate Partner Violence Screening	% primary caregivers who are screened for intimate partner violence	85	77	85	
Intimate Partner Violence Referrals	% primary caregivers with positive screen for IPV who receive referral	100	74	82	
Preterm Birth	% infants born preterm following program enrollment	5	6	9	
Breastfeeding	% infants breastfed any amount at 6 months of age	18	15	15	
Child Injury	Rate of injury-related visits to Emergency Department since enrollment among children enrolled	2	2	0.02	
Child Maltreatment*	% children with at least one investigated case of maltreatment following enrollment	No data available	No data available	6.5	
Primary Caregiver Education	% primary caregivers without high school degree/equivalent who subsequently enrolled in, maintained continuous enrollment in, or completed high school or equivalent	63	28	41	
Continuity of Insurance Coverage	% primary caregivers enrolled with continuous health insurance for at least 6 consecutive months	90	92	84	
Completed Depression Referrals	% primary caregivers referred to services for positive screen for depression who receive one or more service contacts	2	22	61	

Completed Developmental Referrals	% children enrolled with positive screens for developmental delays who receive services in a timely manner.	58	59	51	
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**Note: MIECHV Program began reporting administrative data related to child maltreatment as required by HRSA in 2019. ADH has an MOA in place with Arkansas Department of Human Services to access de-identified data.*

Preterm birth. Premature birth is the leading cause of death and disability among newborns and infants: an estimated 36% of all infant deaths across the U.S. are attributed to prematurity (March of Dimes, 2019). In an average week in Arkansas, there are 747 babies born. Of those, 79 babies are born preterm, 57 babies are born late preterm and 13 babies are born very preterm. The March of Dimes report card shows Arkansas’s prematurity grade as an ‘F’ (2019). In addition to the high preterm birth rate, racial and ethnic disparities persist: the preterm birth rate among Black women is 47% higher than the rate among all other women. Preterm births are highest among mothers aged 40 to 44 years old and mothers who did not graduate from high school (AHR, 2019-v).

Breastfeeding. Breastfeeding rates are on the rise in Arkansas and around the U.S.; however, despite the increase in rates, Arkansas ranks 46 of 50 and falls behind the U.S. rates and Healthy People 2020 goals in almost every measure. The state is performing better than the U.S. and Healthy People 2020 goals in “breastfed infants receiving formula before two days of age” and is exceeding Healthy People 2020 goals in “live births occurring at Baby-Friendly facilities” (Centers for Disease Control, 2018; Healthy People 2020). The percentage of live births occurring at Baby-Friendly facilities is also increasing: from 0% in 2016 to 22% in 2019 in Arkansas and from 8% in 2016 to 26% in 2019 in the U.S. (AHR, 2019-w). Breastfeeding success is also measured by the Maternity Practices in Infant and Nutrition Care (mPINC) survey. Each hospital and birth center facility in the U.S. that routinely provides maternity care services is surveyed and receives an mPINC score, which range from 0 to 100, with higher scores representing better maternity care practices. In 2019, Arkansas’s score was 67 compared to 79 for the U.S.

Depression Screening and Referral. In 2017, 21% of Arkansas women reported symptoms compared to 13% nationally. One of the barriers to addressing depression and mental health concerns in Arkansas is the fact that the state only has 232 (per 100,000 population) psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, and providers that treat alcohol and other drug abuse as well as advanced practice nurses specializing in mental health care per 100,000 population (AHR, 2019-z).

Well Child Visit. In Arkansas, there are two Medicaid-funded health insurance options, based on family income: ARKids First A and ARKids First B (DHS, 2020). The programs provide well-child care including vaccines and regular checkups. These programs provide coverage for more than 70,000 children across the state. During 2016-2017, 76% of babies ages 0 to 2 in Arkansas had a well-baby checkup in the past 12 months compared to 82% in the U.S (AHR, 2019-aa). The 2019 percentage also represents a decline from 2016, when 92% of babies ages 0 to 2 in Arkansas had a well-baby checkup in the past 12 months.

Postpartum Care. In 2017, 86% of women with a recent live birth reported receiving a postpartum checkup compared to 90% in the U.S. (AHR, 2019-ab).

Safe Sleep. The percentage of women with a recent live birth who reported their infants are usually placed on their backs to sleep was 92% in 2017, which represents an increase of 21 percentage points over 2018 and is 12 percentage points higher than the U.S. (80%) (AHR, 2019-ad). Arkansas has a Safe Sleep Collaborative Improvement and Innovation Network (CoIIN) team that has been active in the national Infant Mortality CoIIN since 2016. In the course of four years, Arkansas reached their goal of

having at least a 10% reduction in Sudden Unexpected Infant Deaths by adopting and educating partners about the ABCs of safe sleep. In fact, the team reported an 18% reduction from baseline.

Intimate Partner Violence. Among the 35 states with data related to the percentage of women with a recent live birth who experienced violence by husband or partner (current or former) during most recent pregnancy, Arkansas has the worst ranking (AHR, 2019-ae). The percentage of women ages 18 and older who reported experiencing contact sexual violence, physical violence, and/or stalking by an intimate partner in their lifetime was 41%, four percentage points above the national average (AHR, 2019-af). Since Arkansas has the highest teen birth rate in the nation, it is important to understand intimate partner violence among teens. The percentage of Arkansas's high school students who report they were ever forced to have sex when they did not want to (19%) is almost three times the national average (7%) (U.S. Department of Health and Human Services (DHHS), 2016). The percent of high school students in Arkansas who report they experienced physical dating violence including being hit, slammed into something, or injured with an object or weapon on purpose by someone they dated or went out with is 50% higher in Arkansas (12%) than the U.S. (8%) (U.S. DHHS, 2016). Females are victims of intimate partner violence more often than males.

Continuity of insurance. In 2016-2017, the percentage of children ages 0-17 in Arkansas and across the U.S. with health insurance of any type was 94% (AHR, 2019-ag). The percentage of insured children ages 0-17 in Arkansas whose health plan has either no or reasonable out-of-pocket costs; offers benefits or covered services that meet the children's needs; and allows them to see needed health care providers (2-year estimate) (79%) was higher than the national average (74%) (AHR, 2019-ah). Although the percentage of women ages 18-44 who are not covered by private or public health insurance has declined since 2013, more women in Arkansas are still uninsured compared to women across the U.S. (AHR, 2019-ai).

Identifying At-Risk Communities with Concentrations of Risk

At-Risk Counties Overview

Arkansas's MIECHV Program used the simplified method to develop the list of at-risk counties in the state. The simplified method, an approach developed by HRSA, uses nationally available county-level data to generate indices of risk in five distinct domains: low socio-economic status (SES), adverse perinatal outcomes, child maltreatment, crime, and substance use disorder. Indicators within each domain align with the characteristics described in the MIECHV authorizing statute (https://www.ssa.gov/OP_Home/ssact/title05/0511.htm) to identify communities with concentrations of risk. This method identifies a county as at-risk if at least half the indicators within at least two of the domains had z-scores greater than or equal to one standard deviation higher than the mean of all counties in the state. For Arkansas, this means a county is considered at-risk in a domain if the county has a rate that is among the highest 16% of counties in the state for that domain. This needs assessment reviews the at-risk counties for all five domains combined and for a subset of the substance use disorder separately (See *Capacity for Providing Substance Use Disorder Treatment and Counseling Services* section).

Data analysis identified 16 at-risk counties that would benefit from early childhood home visiting: Arkansas, Ashley, Chicot, Conway, Crittenden, Desha, Garland, Greene, Jackson, Jefferson, Lafayette, Lee, Miller, Mississippi, Phillips, and St. Francis. Details about the risk domains by at-risk county are shown in Table 2. Of the 16 counties, 11 were at-risk for high levels of adverse perinatal outcomes (preterm birth and low birth weight), eight are at-risk for high levels of crime, seven were at-risk for high levels of alcohol and illicit drug use, six were at-risk for low SES, and three were at-risk for high levels of child maltreatment.

Table 2
County Risk Level and Identified Domains of Risk

County	Risk Level	Risk Domains
Arkansas County	2	Crime, Substance Use
Ashley County	2	Perinatal Outcomes, Substance Use
Chicot County	3	Perinatal Outcomes, SES, Substance Use
Conway County	2	Child Maltreatment, Substance Use
Crittenden County	2	Crime, Perinatal Outcomes
Desha County	2	Perinatal Outcomes, Substance Use
Garland County	2	Crime, Substance Use
Greene County	2	Child Maltreatment, Crime
Jackson County	3	Child Maltreatment, Crime, SES
Jefferson County	3	Crime, Perinatal Outcomes, Substance Use
Lafayette County	2	Perinatal Outcomes, SES
Lee County	2	Perinatal Outcomes, SES
Miller County	2	Crime, Perinatal Outcomes
Mississippi County	2	Crime, Perinatal Outcomes
Phillips County	3	Crime, Perinatal Outcomes, SES
St. Francis County	3	Crime, Perinatal Outcomes, SES

Eleven of the counties were at-risk in two domains and five were at risk in three domains. Pregnant women and families with children ages 0 to 5 in these counties are in the greatest need of home visiting services. As can be seen in Map 1, the highest concentration of at-risk counties is along the eastern and southern borders of the state. In Arkansas, this area is referred to as the Delta, much of it running along the Mississippi River. The highest rates of minority population, low SES, low education level, low access to health care, and high rates of chronic illnesses are located in this area.

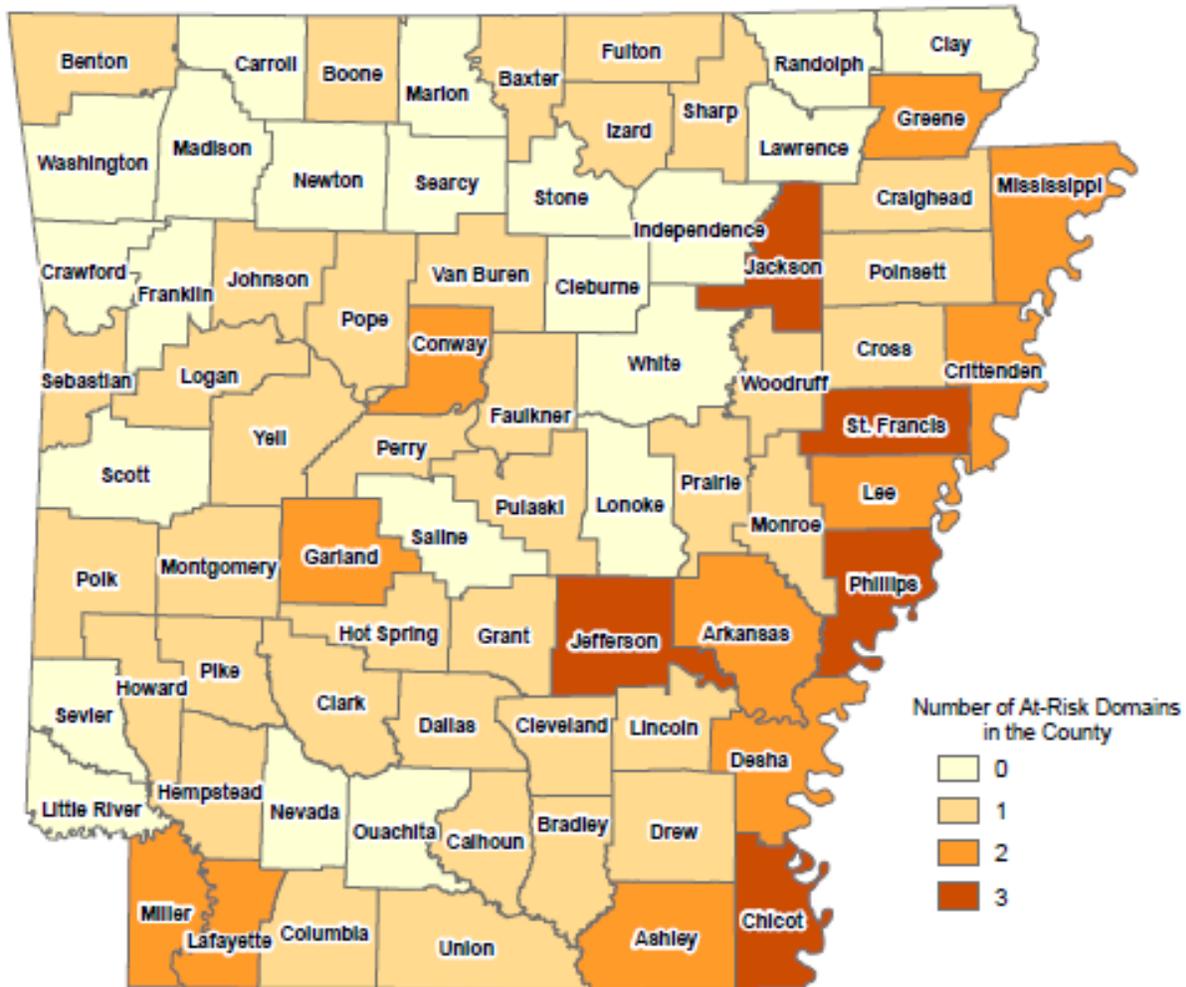
The counties found to be at-risk in three of the five domains include Chicot, Jackson, Jefferson, Phillips, and St. Francis. A brief review of county-specific risk factors for each of these five counties follows.

Chicot County. Chicot County is the state's southeastern-most county. The population of Chicot County has declined 14% since the 2010 Census (U.S. Census Bureau, 2019-b). Children under 18 years of age (n=2,451) make up 22% of the population and children under age five (n=822) account for 6%. More than one-third of the county lives in poverty (Arkansas Children's Hospital, 2019). The county ranks 71 of 75 counties, with 75 being the worst, in health outcomes (how long people live and how healthy people feel while alive) and health factors (health behaviors, clinical care, social and economic, and physical environment factors) (County Health Rankings (CHR), 2020-a). In measures related to MIECHV, the percentage of live births with low birthweight (11%) is higher than the state rate (9%) and there are racial disparities: the percentage of Hispanic and Black women who experience this is 14% and 13% compared to White women at 5%. According to the most recent CHR report, the teen birth rate in the state is 38 live births per 1,000 females ages 15 to 19, which means the rate in Chicot County is 11 percentage points higher than the state (49 live births per 1,000 females ages 15 to 19). Racial disparities also exist: the birth rate for Black teens is 57 live births per 1,000 females ages 15 to 19 compared to 39 live births per 1,000 females ages 15 to 19 for White teens. Child mortality rates, the percentage of the population who lack adequate access to food, the percentage of children in single parent households, and the percentage of children eligible for free or reduced lunch are all higher than the state average. The percentage of children under the age of 18 living in poverty (44%) is nearly double the state average (24%). Again, disparities exist: 73% of Hispanic children and 50% of Black children live in poverty compared to 17% of White children. Median household income is \$15,300 less than the state median and

disparities exist: Black households earn \$23,700 compared to \$30,200 for Hispanic and \$44,800 for White households.

Map 1

At-Risk Domains by County



Jackson County. The county ranks 62 of 75 counties in health outcomes and 69 in health factors (CHR, 2020-b). The percentage of low birthweight births (9%) is the same as the state rate and there are racial disparities: 14% of Black women experience this compared to White women at 8%. The teen birth rate is 28 percentage points higher than the state: 66 live births per 1,000 females ages 15 to 19. The percentage of the population who lack adequate access to food, the percentage of children in single parent households, and the percentage of children eligible for free or reduced lunch are all higher than the state average for each measure. The percentage of children under the age of 18 living in poverty (30%) is higher than the state average and disparities exist: 60% of Black children and 56% of Hispanic children live in poverty compared to 27% of White children. Median household income is \$10,500 less than the state median. Disparities exist in median household income: total income for Black households is \$15,400 less than White families.

Jefferson County. The county ranks 69 of 75 counties in health outcomes and 67 in health factors (CHR, 2020-c). The percentage of live births with low birthweight (13%) is four percentage points higher than the state rate (9%) and disparities exist: 16% of Hispanic and 14% of Black women

experience this compared to 9% of White women. The teen birth rate is eight percentage points higher than the state rate: 46 live births per 1,000 females ages 15 to 19. The percentage of children in single parent households and the percentage of children eligible for free or reduced lunch are both higher than the state average. The percentage of children under the age of 18 living in poverty (34%) is higher the state average (24%) and disparities exist: 45% of Black children and 29% of Hispanic children live in poverty compared to 22% of White children. Median household income is \$8,500 less than the state median and disparities exist: Hispanic households earn the least (\$29,100) followed by Black households (\$32,200). White households earn \$51,400 and the median income for Asian families (\$60,000) is more than double that of Hispanic and almost double that of Black households.

Phillips County. The county ranks 74 of 75 counties in health outcomes and health factors (CHR, 2020-d). Phillips County consistently has one of the lowest life expectancies in the state. The percentage of low birthweight births (13%) is four percentage points higher than the state rate and disparities exist: 14% of Black women experience this compared to 8% of White women. Phillips and St. Francis Counties tie for the highest teen birth rate in the state with each reporting 76 live births per 1,000 females ages 15 to 19, which is double the state rate (38 live births per 1,000 females ages 15 to 19). The percentage who lack adequate access to food, percentage of children in single parent households, and the percentage of children eligible for free or reduced lunch are all higher than the state average for each measure. The percentage of children under the age of 18 living in poverty (48%) is double the state average and disparities exist: 67% of Black children live in poverty, which is almost three times the state average (24%), almost five times greater than White children (15%), and more than six times greater than Hispanic children (11%). Median household income is \$17,200 less than the state median and disparities exist: Black households earn \$21,200, less than half of White households (\$48,600).

St. Francis County. The county ranks 68 of 75 counties in health outcomes and 73 in health factors (CHR, 2020-e). The percentage of live births with low birthweight (13%) is four percentage points higher than the state rate and disparities exist: 15% of Black women experience this compared to 8% of White women. As mentioned previously, St. Francis is tied with Phillips County for the highest teen birth rate in the state with each reporting 76 live births per 1,000 females ages 15 to 19, double the state rate. The percentage who lack adequate access to food, percentage of children in single parent households, and the percentage of children eligible for free or reduced lunch are all higher than the state average. The percentage of children under the age of 18 living in poverty (46%) is almost double the state average (24%) and disparities exist: the percentage of Black children in poverty (50%) is more than double the state average, more than double that for White children (23%), and more than eight times greater than Hispanic children (6%). Median household income is \$13,800 less than the state median and disparities exist: Black households earn \$10,000 less than White households.

The counties found to be at-risk in two of the five domains include Arkansas, Ashley, Conway, Crittenden, Desha, Garland, Greene, Lafayette, Lee, Miller, and Mississippi. County-specific risk factors for each of these counties are described below.

Arkansas County. The county ranks 52 of 75 counties in health outcomes and 44 in health factors (CHR, 2020-f). The percentage of live births with low birthweight (10%) is slightly higher than the state rate (9%) and disparities exist: 18% of Black women experience this compared to 7% of White women. The teen birth rate is 18 percentage points higher than the state: 56 live births per 1,000 females ages 15 to 19. The percentage who lack adequate access to food, percentage of children in single parent households, and the percentage of children eligible for free or reduced lunch are all higher than the state average. The percentage of children under the age of 18 living in poverty (24%) matches the state average and disparities exist: 39% of Black children live in poverty compared to 31% of Hispanic children. Additionally, the percentage of Black children living in poverty is more than double that of White children (18%). Median household income is \$3,200 less than the state median and disparities exist:

Hispanic households earn less than half of the state median and Black households earn \$20,300 less than White households.

Ashley County. The county ranks 49 of 75 counties in health outcomes and 60 in health factors (CHR, 2020-g). The percentage of low birthweight births is higher than the state rate and disparities exist: 16% of Black women experience this compared to 10% of White women. The teen birth rate is seven percentage points higher than the state: 45 live births per 1,000 females ages 15 to 19. Disparities exist: the teen birth rate for Black teens is 50 per 1,000 live births compared to 44 for White teens and 33 for Hispanic teens. One in five people lack adequate access to food. The percentage of children under the age of 18 living in poverty (29%) is slightly higher than the overall (24%) and disparities exist: 60% of Black children and 32% of Hispanic children live in poverty compared to 14% of White children. Median household income is \$6,000 less than the state median and disparities exist: Black households earn less than half of the state median and Hispanic households earn \$26,600 compared to White households, which earn \$48,900.

Crittenden County. The county ranks 70 of 75 counties in health outcomes and 62 in health factors (CHR, 2020-g). The percentage of low birthweight births (14%) is higher than the state rate (9%) and disparities exist: 17% of Black women experience this compared to 8% of White women. The teen birth rate is twenty percentage points higher than the state: 55 live births per 1,000 females ages 15 to 19. Disparities exist: the teen birth rate for Black teens is 69 per 1,000 live births compared to 31 for White teens and 33 for Hispanic teens. One in four people lack adequate access to food. The percentage of children under the age of 18 living in poverty (29%) is slightly higher than the state overall (24%) and disparities exist: 48% of Black children and 47% of Hispanic children live in poverty compared to 14% of White children. Median household income is \$4,500 less than the state median (\$42,600) and disparities exist: Black households earn \$12,200 less than the state median and while White households earn \$57,600 and Asian households earn \$76,800, more than double that of Black households .

Conway County. The county ranks 30 of 75 counties in health outcomes and 36 in health factors (CHR, 2020-h). The percentage of live births with low birthweight equals the state rate (9%) and racial disparities exist: 15% of Black women experience this compared to 8% of White women. The teen birth rate (45 live births per 1,000 females ages 15 to 19) and the percentage of children eligible for free or reduced lunch (56%) are both higher than the state measures. The percentage of children under the age of 18 living in poverty (27%) is higher than the state average and disparities exist in the county: the percentages of Hispanic children in poverty (48%) is double the state average and the percentage of Black children in poverty (39%) is 15 percentage points higher than both the state average and White children in poverty. Median household income is less than the state median and disparities exist: Black households and Hispanic households earn less than the county's median.

Desha County. The population of Desha County has declined 13% since 2010 (U.S. Census Bureau, 2019-c). Currently, children under 18 years of age make up one-fourth of the population and children under age 5 account for 6%. One-fourth of the county lives in poverty. The county ranks 73 of 75 counties in health outcomes and 70 in health factors (CHR, 2020-c). In measures related to MIECHV, the percentage of live births with low birthweight (14%) is higher than the state rate (9%) and racial disparities exist: 18% of Black women experience this, which is more than double that of White women (8%). The teen birth rate is 11 percentage points higher than the state: 49 live births per 1,000 females ages 15 to 19. The percentage of the population who lack adequate access to food, the percentage of children in single parent households, and the percentage of children eligible for free or reduced lunch are all higher than the state average for each measure. The percentage of children under the age of 18 living in poverty (36%) is 50% higher the state average and again, disparities exist: 68% of Hispanic children and 61% of Black children live in poverty compared to 11% of White children. Median household income is \$11,000 less than the state median and disparities exist: Black households (\$22,800) earn less than half of White households (\$45,600).

Garland County. The county ranks 39 of 75 counties in health outcomes and 23 in health factors (CHR, 2020-j). The percentage of live births with low birthweight equals the state rate and racial disparities exist: 14% of Black women experience this compared to 9% of Hispanic women and 8% of White women. The teen birth rate is four percentage points higher than the state: 42 live births per 1,000 females ages 15 to 19. The percentage of children in single parent households and the percentage of children eligible for free or reduced lunch are higher than the state average for each measure. The percentage of children under the age of 18 living in poverty (35%) is higher the state average and again, disparities exist: 59% of American Indian/Alaska Native children live in poverty compared to 46% of Black and Hispanic children, 24% of White children, and 16% of Asian children. Median household income is \$3,500 less than the state median and disparities exist: total income for Black households (\$25,400) is less than that of Hispanic families (\$30,200) and White families (\$45,900).

Greene County. The county ranks 28 of 75 counties in health outcomes and 13 in health factors (CHR, 2020-k). The percentage of live births with low birthweight is slightly lower than the state rate. The teen birth rate is 11 percentage points higher than the state: 49 live births per 1,000 females ages 15 to 19. Unlike the other at-risk counties covered so far, the percentages of Greene County's population experiencing food insecurity, children in single parent households, and children eligible for free or reduced lunch are lower or the same as the state. The percentage of children under the age of 18 living in poverty (24%) equals the state average, although disparities exist: one-fourth of White children live in poverty compared to 8% of Hispanic children. Disparities exist in median household income for the county: American Indian/Alaska Native, Asian, and Black families earn less than the county median while White families earn \$1,800 more.

Lafayette County. The county ranks 47 of 75 counties in health outcomes and 66 in health factors (CHR, 2020-l). The percentage of live births with low birthweight is slightly higher than the state rate. The teen birth rate is 22 percentage points higher than the state: 60 live births per 1,000 females ages 15 to 19. As with most other at-risk counties, the percentage of the population experiencing food insecurity, the percentage of children in single parent households, and the percentage of children eligible for free or reduced lunch are higher than the state averages. The percentage of children under the age of 18 living in poverty (35%) is higher than the state average and disparities exist: 61% of Black children live in poverty compared to 8% of White children. The median household income is \$11,600 less than the state median and disparities exist: White households earn \$12,000 more than the county median while Black households earn \$13,000 less than the county median and less than half of the state median.

Lee County. The county ranks 66 of 75 counties in health outcomes and 74 in health factors (CHR, 2020-m). The percentage of live births with low birthweight (14%) is higher than the state rate (9%) and the teen birth rate is 12 percentage points higher than the state: 50 live births per 1,000 females ages 15 to 19. As with most other at-risk counties, the percentage of the population experiencing food insecurity, the percentage of children in single parent households, and the percentage of children eligible for free or reduced lunch are higher than the state averages. The percentage of children under the age of 18 living in poverty (51%) is higher than the state average and disparities exist: 48% of Black children live in poverty compared to 5% of White children. The median household income is \$19,000 less than the state median and disparities exist: White households earn \$2,300 more than the state median, 76% more than the county median, and \$30,300 more than Black households.

Miller County. The county ranks 55 of 75 counties in health outcomes and 58 in health factors (CHR, 2020-n). The percentage of low birthweight births (10%) is higher than the state rate (9%) and the teen birth rate is 14 percentage points higher: 52 live births per 1,000 females ages 15 to 19. As with most other at-risk counties, the percentage of the population experiencing food insecurity and the percentage of children in single parent households are higher than the state averages. The percentage of children under the age of 18 living in poverty (33%) is higher than the state average and disparities exist: 70% of Hispanic children and 55% of Black children live in poverty compared to 18% of White children. The

median household income is \$4,900 less than the state median and disparities exist: White households earn \$7,700 more than the state median, \$19,000 more than Black households, and more than double Hispanic households.

Mississippi County. The county ranks 72 of 75 counties in health outcomes and in health factors (CHR, 2020-o). The percentage of live births with low birthweight (11%) is higher than the state rate (9%) and the teen birth rate is 26 percentage points higher than the state: 64 live births per 1,000 females ages 15 to 19. Disparities exist: the rate for Black teens (80) is more than double the state rate and the rate for Hispanic teens (65) and White teens (49) are also higher than the state rate. The percentage experiencing food insecurity, the percentages of children in single parent households, and the percentages of children eligible for free or reduced lunch are higher than the state averages. The percentage of children under the age of 18 living in poverty (36%) is higher than the state average and disparities exist: the percentages of Black children (56%) and Hispanic children (55%) living in poverty are more than double the state average (24%). The median household income is \$10,400 less than the state median and disparities exist: White households earn \$6,200 more than the county median while Black and Hispanic households earn less than \$30,000.

In addition to the 16 counties identified as at-risk using HRSA's simplified method, the Arkansas MIECHV Program currently serves families in 44 additional (Phase II) counties with poor outcomes for children. Each county offers at least one MIECHV-funded model and 31 of the 44 are at risk in one statutorily-defined risk area (Table 3). In reality, all counties in the state are at-risk for poor maternal and/or child health outcomes of one kind or another. Arkansas's overall food insecurity rate is 17.2%, which is 2nd worst in country. The state's child food insecurity rate in Arkansas is 23.2% (164,000 children), which is 3rd worst in country (Arkansas Foodbank Network, 2018). The most recent data from the Agency for Healthcare Research and Quality revealed quality measures for child health have improved over baseline, from weak to average; however quality measures for maternal health have declined from average to weak. Other outcomes for women and children have not improved and racial disparities persist in all indicators related to maternal and child health.

County-specific data demonstrates the need to continue MIECHV-funded services in each of the 44 Phase II counties (Table 3). Information in red type on Table 3 indicates data that is equal to or worse than Arkansas's average. Information in yellow type indicates data that is equal to or worse than the national average but not as high as the Arkansas average. Data points for each Phase II county include:

- ∂ **Preterm birth rate (< 37 weeks gestation):** The 2020 March of Dimes (MOD) Report Card gives Arkansas a grade of F related to preterm births in the state (National Center for Health Statistics (NCHS), 2018). The MOD goal is six or fewer preterm births per 1,000 live births. Arkansas's rate is 11.2 preterm births per 1,000 live births compared to the US at 10.0 preterm births per 1,000 live births. Fourteen of the 44 Phase II counties have rates of 11.2 or higher, with the highest being 15.3 preterm births per 1,000 live births in Cross County. Seventeen counties have preterm birth rates that are higher than the national rate but lower than Arkansas rate. Only two counties received an A grade (Polk and Searcy Counties).
- ∂ **Low birthweight rate (< 2500 grams):** Arkansas's low birthweight rate is 9.4 per 1,000 live births, which is 1.1 percentage points higher than the national average and 1.6 percentage points higher than the Healthy People 2030 goal of 7.8 per 1,000 live births (NCHS, 2018). Twelve of the 44 Phase II counties have low birthweight rates of 9.4 or higher and 11 counties have rates that are higher than the national rate (8.3 per 1,000 live births) but lower than the state rate. The highest rate is 13.6 per 1,000 live births (Columbia County) and the lowest rate is 6.0 per 1,000 live births (Searcy County).
- ∂ **Infant mortality rate (death in the first year of life):** Data was only available for 17 of the 44 Phase II counties due to missing data or insufficient numbers. Of the 17 counties, eight had infant mortality rates of 8.1 (state rate) per 1,000 live births or higher (NCHS, 2017). Eight counties had

infant mortality rates that were higher than the national rate (5.9 per 1,000 live births) but lower than the state rate. The highest rate was 23.0 per 1,000 live births (Stone County) and the lowest was 6.2 per 1,000 live births (Craighead County).

- ∂ **Teen birth rate (ages 15 through 19):** Arkansas's teen birth rate is the worst in the country. Each of the 44 Phase II counties had a teen birth rate that was equal to or higher than the rate for Arkansas and/or the United States (NCHS, 2018). Twenty-five counties had rates equal to or higher than the state rate of 38.0 per 1,000 live births. Nineteen counties had teen birth rates that were higher than the national rate (17.4 per 1,000 live births) but lower than the state rate. The highest rate was 65.0 per 1,000 live births (Hempstead County) and the lowest was 18.0 per 1,000 live births (Clark County).
- ∂ **Pregnant women with no 1st trimester prenatal care:** In Arkansas, 32.2% of women do not receive prenatal care in the first trimester (Arkansas Advocates for Children and Families (AACF), 2016). This is 9.3 percentage points higher than the national average (22.9%). Sixteen counties had higher percentages than Arkansas's average, ranging from 32.6% to 49.7%. Twenty-one counties had percentages between the national rate and Arkansas rate, ranging from 24.6% to 31.9%. The highest rate was in Sharp County (47.9%) and the lowest was in Monroe County (16.2%).
- ∂ **Children ages 0 through 18 living in single parent households below 100% poverty:** More than one-third (35.0%) of Arkansas children between the ages of 0 through 18 years live in a single parent household with income below 100% poverty compared to 29.0% across the U.S (AACF, 2018). In three of the 44 Phase II counties, percentages are equal to or higher than Arkansas's average and in 13 counties, percentages are higher than the national average but lower than Arkansas's average. Monroe County has the highest percentage of children ages 0 through 18 living in single parent households below 100% poverty (39.0%) and Benton County has the lowest (12.0%).
- ∂ **Children under age five living in poverty:** Almost one-third (31.9%) of children under the age of five in Arkansas live in poverty compared to 18.0% across the U.S. (U.S. Census Bureau, 2010 – 2014). Twenty-six of the 44 Phase II counties have between 32.4% and 55.0% of children under age five living in poverty. Fourteen counties have rates higher than the national average but lower than Arkansas's average, ranging from 19.4% to 31.7%. The county with the highest percentage of children under age five living in poverty is Monroe (55.0%) and Cleveland County has the lowest percentage (13.0%).
- ∂ **Child abuse and neglect rate (true reports):** In 2019, there were 12.1 reports of child abuse or neglect per 1,000 children under the age of 18 compared to 9.2 reports of the same across the nation (Arkansas Department of Human Services, U.S. DHHS Administration for Children and Families (ACF), 2019). Four counties reported rates higher than Arkansas's rate, ranging from 12.4 per 1,000 to 16.1 per 1,000. Ten counties reported rates higher than the national rate but lower than Arkansas's rate, ranging from 9.4 per 1,000 children under the age of 18 to 11.4 per 1,000. The highest rate was 16.1 per 1,000 children under the age of 18 (Boone County) and the lowest was 3.3 per 1,000 children under the age of 18 (Howard County).
- ∂ **Median household income:** The median household income in Arkansas is \$47,100.00, which is \$16,079.00 lower than the average median income in the U.S. (\$63,179.00). In 34 of the 44 Phase II counties, median household income was below Arkansas's average, ranging from \$31,700.00 to \$46,800.00. Only two counties had median household incomes higher than the U.S.: Benton and Saline Counties.

As Table 3 indicates, all Phase II counties performed poorly in at least four of the nine measures and two counties (Poinsett and Sharp) performed poorly across all measures. Home visiting remains a powerful tool to continue to improve maternal and child health outcomes across the 44 Phase II counties.

Table 3

Phase II: Additional MIECHV Counties to be Served

County	Statutorily-defined Risk Domain	# Families Served	Home Visiting Model	Rate of Preterm (< 37 weeks) Birth and Grade (Goal ≤ 8.1% of Live Births)	Rate of Low Birth-weight (< 2500 grams) Infants (HP 2020 goal 7.8 per 1,000 live births)	% Infant Mortality Rate per 1,000 Live Births* (HP 2020 goal 6 per 1,000 live births)	Rate of Teen Births (ages 15-19) per 1,000 Live Births	% Pregnant Women – No 1 st Trimester Prenatal Care	% Children Ages 0-18 Living in Single Parent Households Below 100% of Poverty	% Children Under Age 5 Living in Poverty	Rate of Child Abuse and Neglect (True Reports) Per 1,000 children under age 18	Median Household Income
Data Source & Year(s)	HRSA	Arkansas Home Visiting Data	---	National Center for Health Statistics (NCHS) 2018	NCHS 2018	NCHS 2017	NCHS 2018	Arkansas Advocates for Children and Families (AACF) 2016	AACF 2018	US Census Bureau Small Area Income and poverty Estimate (SAIPE) 2010 -2014	AR Department of Human Services/ US DHHS, ACF 2019	SAIPE 2018
Arkansas/ US	---	---	---	11.2 (F)/ 10.0 (C-)	9.4/ 8.3	8.1/ 5.9	38.0/ 17.4	32.2/ 22.9	35/ 29	31.9/ 18.0	12.1/ 9.2	\$47,100/ \$63,179
Baxter	Crime	10	HIPPY	9.0 (B-)	6.5	*	36	27.3	23	26.7	10.9	\$39,700
Benton	Crime	93	HFA, PAT	10.1 (C-)	7.5	7.1	28	24.3	12	19.4	4.6	\$69,000
Boone	Child Maltreatment (CM)	59	HFA, PAT	9.2 (B-)	7.1	*	42	24.7	22	31.7	16.1	\$44,500
Bradley	Substance Use Disorder (SUD)	2	FBBH	11.4 (F)	10.8	*	43	27.8	30	50.3	5.5	\$37,700

Calhoun	Adverse Perinatal Outcome (APO)	3	FBBH, HIPPY	12.0 (F)	8.4	*	29	31.0	21	32.4	5.7	\$45,000
Carroll	N/A	8	HFA, PAT	8.5 (B+)	6.9	7.8	45	36.3	25	26.7	9.6	\$45,000
Clark	SUD	62	FBBH, HIPPY, PAT	11.1 (D)	9.0	*	18	29.1	26	38.7	5.9	\$45,400
Cleburne	N/A	13	HFA, HIPPY	9.0 (B-)	8.9	*	38	25.0	24	28.6	10.2	\$44,900
Cleveland	SUD	34	HIPPY, NFP	12.2 (F)	8.4	*	26	26.8	21	13.0	8.6	\$47,600
Columbia	APO, Socio-economic Status (SES)	11	FBBH	14.6 (F)	13.6	9.6	27	29.2	28	38.5	5.1	\$40,900
Craighead	Crime, SUD	2	HIPPY	12.0 (F)	9.7	8.0	34	31.9	25	37.7	11.2	\$45,600
Crawford	N/A	25	PAT	10.7 (D+)	7.9	6.2	40	42.2	23	27.1	8.3	\$47,400
Cross	APO, SUD		NFP	15.3 (F)	10.3	16.3	48	22.6	28	35.0	9.7	\$41,200
Dallas	APO	26	HIPPY	9.9 (C)	12.0	*	25	30.6	34	15.8	12.4	\$37,300
Drew	SES, SUD	1	HIPPY	10.7 (D+)	8.4	11.5	33	33.2	27	46.0	6.1	\$42,500
Faulkner	SUD	47	HFA, PAT	9.7 (C)	7.2	6.9	25	29.3	17	22.8	5.3	\$53,900
Fulton	CM, SES	37	HFA, HIPPY, PAT	8.4 (B+)	6.6	*	42	31.6	33	45.4	7.9	\$43,700
Grant	SUD		FBBH, NFP	12.9 (F)	8.9	*	30	23.7	18	16.3	4.6	\$52,100
Hempstead	Crime	7	FBBH	10.6 (D+)	9.1	*	65	35.4	31	53.9	4.9	\$38,700
Hot Spring	SUD	55	HIPPY, PAT	10.8 (D)	9.3	*	43	34.0	30	17.3	5.6	\$47,200
Howard	SES	4	HIPPY	8.8 (B)	7.6	*	42	33.3	27	29.9	3.3	\$40,200
Independence	N/A	126	HIPPY, PAT	11.6 (F)	8.7	7.9	38	37.0	20	41.0	8.6	\$45,600
Izard	CM, SES	58	HFA, HIPPY, PAT	10.1 (C-)	6.9	*	37	35.8	28	36.0	9.7	\$37,800
Lincoln	SES, SUD	34	HIPPY, NFP	10.5 (D+)	8.9	*	34	22.2	27	44.5	7.5	\$45,000

Lonoke	N/A	7	FBBH, PAT	10.1 (C-)	7.9	8.9	31	21.5	16	21.2	4.7	\$56,700
Madison	N/A	39	HFA	10.1 (C-)	6.1	*	48	38.9	27	29.1	13.4	\$42,700
Marion	N/A	3	HFA	9.7 (C)	8.1	*	48	28.9	32	39.7	11.4	\$36,600
Monroe	APO, SES, SUD	7	FBBH, HFA, NFP	13.3 (F)	11.3	*	56	16.2	39	55.0	7.8	\$32,900
Mont- gomery	SUD	7	HIPPY	9.9 (C)	6.1	*	43	40.8	31	35.4	8.0	\$38,300
Nevada	N/A	4	FBBH	10.1 (C-)	11.5	*	49	N/A	30	50.8	8.0	\$37,600
Newton	N/A	1	PAT	9.0 (B-)	6.1	*	43	28.6	33	20.3	9.4	\$36,100
Ouachita	N/A	3	FBBH, HIPPY	12.2 (F)	11.0	*	45	31.9	33	40.2	8.1	\$37,600
Pike	SUD	37	HIPPY	10.1 (C-)	7.2	*	36	21.6	28	54.9	4.9	\$41,500
Poinsett	CM, SUD	5	HIPPY	12.8 (F)	9.7	8.4	55	35.8	35	39.4	15.3	\$37,400
Polk	Crime	19	HFA	8.0 (A-)	6.1	*	45	37.1	30	46.4	9.5	\$39,000
Prairie	APO, SUD	4	FBBH, HFA, NFP	11.8 (F)	8.3	*	42	19.1	24	33.0	6.5	\$43,200
Pulaski	Crime, SES, SUD	108	FBBH, HFA, PAT	12.0 (F)	11.0	8.5	36	27.1	26	28.2	4.8	\$50,000
Saline	N/A	10	FBBH, HFA, HIPPY, NFP	10.8 (D)	8.0	6.6	24	24.6	13	45.6	4.4	\$63,700
Searcy	N/A	17	HFA	5.3 (A)	6.0	*	37	32.6	35	25.2	8.1	\$31,700
Sebastian	Crime	58	PAT	10.4 (D+)	8.0	6.6	40	47.9	23	33.5	8.4	\$46,800
Sharp	CM, SES	58	HFA, HIPPY, PAT	13.0 (F)	10.5	*	51	49.7	34	38.2	9.9	\$36,000
Stone	N/A	52	HIPPY, PAT	10.1 (C-)	7.1	23.0	50	28.7	33	51.1	9.9	\$34,000
Union	Crime, SES	12	FBBH	11.1 (D)	10.6	8.5	46	31.1	25	38.7	5.9	\$45,300
Washington	N/A	35	HFA, PAT	10.7 (D+)	7.9	6.8	28	41.0	17	31.3	5.7	\$50,900

women prior to the end of the 28th week of pregnancy, FBBH enrolls only families with children coming out of the neonatal intensive care unit, and HIPPY enrolls families with children ages 2 to 5 years old.

Table 4

Counties Currently Served by MIECHV, Program Capacity, and Families Served, FY 19

Program	Counties Served	Program Capacity, FY19	# of Families served, FY19	# of active Families, 9/30/2019
NFP	Entire: Crittenden, Jefferson, Lee, Mississippi, Monroe, Phillips, St. Francis Partial: Arkansas, Cleveland, Cross, Grant, Lincoln, Prairie	283	391	253
FBBH	Arkansas, Ashley, Bradley, Calhoun, Clark, Columbia, Garland, Grant, Hempstead, Lafayette, Lonoke, Miller, Monroe, Nevada, Ouachita, Prairie, Pulaski, Saline, Union, White, Woodruff	90	150	77
HFA	Arkansas, Benton, Boone, Carroll, Cleburne, Conway, Faulkner, Fulton, Garland, Green, IZard, Jefferson, Polk, Pulaski, Marion, Madison, Monroe, Prairie, Saline, Searcy, Sharp, Van Buren, Washington	368	465	314
HIPPY	Baxter, Calhoun, Clark, Cleburne, Cleveland, Conway, Craighead, Dallas, Drew, Fulton, Garland, Hot Spring, Howard, Independence, IZard, Jefferson, Lincoln, Mississippi, Montgomery, Ouachita, Pike, Poinsett, Saline, Sharp, Stone, Van Buren	462	617	376
PAT	Benton, Boone, Carroll, Clark, Conway, Crawford, Crittenden, Faulkner, Fulton, Garland, Green, Hot Spring, Independence, IZard, Jefferson, Lonoke, Newton, Pulaski, Saline, Sebastian, Sharp, Stone, Washington	495	698	455
TOTALS		1,698	2,321	1,475

Individuals and Families Receiving MIECHV Services in Arkansas

Table 5 provides detailed information about the individuals and families served by Arkansas’s MIECHV program in 2019 (Annual Demographic Report). Those served represent all major race, ethnicity, and age groups. As would be expected given the target populations for MIECHV, most recipients are children (42%) and female adults (37%). Minorities represent a larger portion of MIECHV recipients when compared to Arkansas’s overall child and adult population. More than one-third (35%) of children served were non-Hispanic minorities compared to 26% of Arkansas’s children and nearly one-fifth (18%) of child recipients were Hispanic/Latino, as compared to 8% of children under age 5 in Arkansas (U.S. Census Bureau, 2019-d). Among adult recipients, non-Hispanic minorities were also more

represented than their portion of the overall population (32% vs 19%), and the Hispanic/Latino group represented slightly more than twice their portion of the overall Arkansas population (16% vs 6%) (U.S. Census Bureau, 2019-e).

As Table 5 illustrates, the majority of program enrollees are faced with one or more significant risks: 93% were low income, 32% had a child with developmental delays or disabilities, 29% has someone in the home with low student achievement, 15% were teen mothers, and 14% interacted with child and family services.

Table 5
Arkansas MIECHV Recipient Demographics, 2019

Children		Adults	
Child Gender	Number Served	Adult Status	Number Served
Male	1105	Pregnant Women	518
Female	1103	Female Caregivers	1421
		Male Caregivers	45
Child Age Range	Number Served	Adult Age Range	Number Served
<1 year	671	≤17 years	88
1 to 2 years	854	18 to 19 years	138
3 to 4 years	575	20 to 21 years	188
5 to 6 years	101	22 to 24 years	280
Unknown age	7	25 to 29 years	522
		30 to 34 years	402
		35 to 44 years	262
		45 to 54 years	42
		55 to 64 years	32
		65+ years	15
		Unknown age	15
Child Ethnicity	Number Served	Adult Ethnicity	Number Served
Hispanic/Latino	394	Hispanic/Latino	316
Not Hispanic/Latino	1787	Not Hispanic/Latino	1649
Unknown	27	Unknown	19
Child Race	Number Served	Adult Race	Number Served
AI/AN	15	AI/AN	15
Asian	57	Asian	58
Black or African American	554	Black or African American	514
Pacific Islander	1	Pacific Islander	6
White	1328	White	1264
More than one race	144	More than one race	40
Unknown/Did not Report	109	Unknown/Did not Report	87
Primary Home Language (Child)	Number Served		
English	1701		
Spanish	358		
Other	71		
Unknown/NA	78		

Adult Education Status		Household Priority Group	
Status	Number Served	Status	Number Served
< HS diploma	431	Low income HH	2199
HS diploma/GED	793	Pregnant under age 21	357
Some college/training	310	History of child abuse/neglect/child welfare services	322
Technical training	77	History of substance abuse/need treatment	174
Associate degree	123	Tobacco use	340
Bachelor's degree	233	Low student achievement	694
Other	0	Child with developmental delays or disabilities	751
Unknown/NA	17	Serving/Former U.S. armed forces	72

In addition to the information shown in Table 5, Arkansas's Annual Demographic Report (2019) revealed the following about the families served: 66% of pregnant women were not married, more than half of female caregivers were unemployed, almost one-fourth were non-English speaking, more than 10% of pregnant women were homeless, and 10% of all adults were uninsured.

Gaps in Early Childhood Home Visiting

This needs assessment identified 16 at-risk counties and Table 6 shows which MIECHV Programs, if any, are available in the at-risk counties. Three of at-risk counties - Chicot, Desha, and Jackson - do not have any MIECHV services available to populations in need. As noted above, Chicot, Desha, and Jackson Counties are rural and poor counties where there are significant disparities in health care status for pregnant women and young children. Racial and ethnic health disparities persist in these counties, as do disparities related to income, food security, and family stability. However, none of the three counties were identified as at-risk in Arkansas's 2010 needs assessment and, as a result, no MIECHV funds were directed to those areas of the state.

Table 6
MIECHV Programs Available in At-Risk Counties

County	MIECHV Programs Available
Arkansas County	FBBH, HFA, NFP
Ashley County	FBBH
Chicot County	None
Conway County	HFA, HIPPY, PAT
Crittenden County	NFP, PAT
Desha County	None
Garland County	FBBH, HFA, HIPPY, PAT
Greene County	HFA, PAT
Jackson County	None
Jefferson County	HFA, HIPPY, NFP, PAT
Lafayette County	FBBH
Lee County	NFP
Miller County	FBBH

Mississippi County	HIPPY, NFP
Phillips County	NFP
St. Francis County	NFP

Arkansas’s MIECHV Programs operate through six different types of local implementing agencies including the Arkansas Department of Health’s local health units, University of Arkansas for Medical Science’s Kid’s First clinics, school districts, educational cooperatives, community foundations, and family support agencies. Family support agencies for each county include local health unit, DHS, University of Arkansas Cooperative Extension Service, and hospitals. Southeastern Arkansas Educational Cooperative serves Chicot and Desha and the Northeastern Arkansas Educational Cooperative serves Jackson County. Desha County has one family support agency; however, neither Chicot nor Jackson County do. With additional MIECHV funding, it may be possible to extend existing or establish new programs in one or more of these counties through a family support or other agency or fiduciary. In determining how best to allocate new resources, it will be important for the State to incorporate its understanding of the cost per family to operate each home visiting model with comprehensive information on the characteristics of local at-risk populations and the capacity of local service systems before committing to expanding or establishing programs in any given community.

Extent to Which Home Visiting Programs are Meeting the Needs of Eligible Families

As noted in the *Identifying At-Risk Communities with Concentrations of Risk* section above, there are close to 200,000 pregnant women and families in the state who could benefit from home visiting services (National Home Visiting Resource Center). In the most recent reporting year (2019), Arkansas’s MIECHV Programs conducted 30,871 home visits to 2,375 households. Current funding for Arkansas MIECHV Program allows the state to serve almost 5,000 women, children, and caregivers each year. This, however, represents only 2.5% of families who could use the support, education, and resources provided by home visiting programs.

As a part of this needs assessment, the Arkansas MIECHV Program conducted a survey of home visiting service recipients to gauge community needs. All recipients were assured anonymity to elicit accurate responses to the survey questions. The survey was built in Survey Monkey and shared with families by state model leads for every home visiting program in the state, including state-funded programs. Between December 2019 and February 2020, 37 service recipients (34 female, 2 male, and 1 other) completed the survey.

Respondents represented a variety of experience in receiving services, with 19 newly enrolled in the previous year, five starting services between one to two years ago, and 13 receiving services for at least two years. Respondents were young and middle age adults, with ten being 18 to 24 years old, fourteen being 25 to 34 years old, eight being 35 to 44 years old, and five being 45 to 54 years old. Children from all age categories were also represented in the homes of the respondents. These 37 homes contained a total of 16 infants (<1 year), 22 toddlers (age 1 to 2), 18 preschool children (age 3 to 5), 16 young school age children (age 6 to 8), and 16 older children (age 9+).

Two groups that were not represented were first time pregnant women, as all respondents had already had their first child, and homes where English is not the primary language, as 36 respondents stated the primary language spoken at home was English and one did not answer. First time mothers and non-primary English-speaking recipients may encounter different barriers than represented in this survey. Future surveys should explicitly target first time pregnant women and non-primary English speakers to ensure that responses accurately reflect the entire pool of program recipients. Hispanic families are also under-represented in this survey, as only one respondent identified as that ethnicity. This may be a reflection of the lack of non-primary English speakers and targeting this group in future surveys will likely increase the representation of Hispanic families.

Table 8 shows the demographic breakdown of survey respondents. The majority of respondents received services from HIPPY (38%) or SafeCare (27%), an affiliate program with which MIECHV Programs coordinate services. Most respondents were also single (35%) or married (51%) and were nearly equally split between African American (42%) and White (47%). Most survey respondents were the working poor, with 70% working at least part time. Perhaps due to the method of distribution, only one in four respondents (24%) had no post-high school education compared to approximately three in five service recipients. Given these limitations, the survey of service providers may be more representative of the overall population. However, the recipient survey still provides interesting, and valuable, information on the needs of the served population.

Table 8
Family and Caregiver Demographics of Survey Respondents

Category	Recipients	Category	Recipients
Home Visiting Model		Employment Status	
NFP	1	Employed full time	19
FBBH	0	Employed part time	6
HFA	5	Self-employed	1
HIPPY	14	Unemployed/Student	6
PAT	4	Homemaker	5
SafeCare	10		
Not Sure	3		
Relationship status		Education	
Single	13	No HS Degree	2
Married	19	HS Degree/GED	7
Divorced	3	Some College	10
Other	2	College	13
		Higher Education	5
Race		Ethnicity	
(multiple responses allowed)		Hispanic/Latino	1
Black	16	Not Hispanic/Latino	35
White	18	Did not answer	1
Other/N/A	4		

The survey contained five questions focused on assessing community capacity and the need of the service recipients:

1. What type of supports or services the recipient sought in the past year.
2. What barriers they experienced when seeking these services.
3. Other challenges they experienced getting support for their family.
4. The degree they agreed with a set of statements concerning home visiting services.
5. Anything else they would like to say about their experiences with home visiting services.

The following table (Table 9) shows the number of recipients that sought specific services or support. The most common services sought were general help in finding services (29.7%), health care services (27.0%), parenting advice or information (37.8%), childcare or day care (32.4%), and nutritional support (27.0%). This shows that basic life services, knowledge, food, and care, were among the most sought-after services for program recipients. Given that program services are aimed at low income and at-risk recipients, these results are not surprising. The fact that 18.9% of respondents sought assistance in gaining employment and 10.8% sought assistance in gaining job training, appears to reflect a desire for an improvement in life circumstance. As more than one in five (21.6%) respondents sought behavioral health

care, increased services in this area are an obvious need for MIECHV target population (See *Capacity for Providing Substance Use Disorder Treatment and Counseling* section below).

Table 9

Types of Services or Support Sought in the Past Year (choose all that apply)

Service or support	# of Recipients Who Sought the Service
Parenting advice or information	14
Childcare or day care	12
Finding help to find services, in general	11
Food (for example, WIC or SNAP)	10
Health care	10
Behavioral health care	8
Employment	7
Information on a healthy pregnancy	6
Dental care	4
Job training or education	4
Legal services	3
Housing	2
Transportation	2
Cash assistance (for example, TANF or Social Security)	1
Domestic violence	1
Other	1
Translation or interpretation	0

When the follow-up question concerning barriers to gaining support was asked, most of the respondents reported that there was no barrier to gaining the needed support regardless of support category. The most common barrier noted for services or supports listed in Table 9 was that the services were too expensive, which was the case in 14 situations: two seeking health care, two seeking dental care, three seeking behavioral health care, four seeking childcare, one seeking transportation support, one seeking employment support, and two seeking job training. However, in eight cases (one finding general help, one health care, two parenting advice, one childcare or day care, one employment, and two job training) respondents indicated that the staff did not understand their needs. Improving staff communication and awareness may reduce the barriers in these situations and improve the ability of recipients to receive needed support.

Respondents were also asked seven questions to gauge how satisfied they were with the services they received (Table 10). For all the questions, more than 90% of the respondents agreed or strongly agreed while none strongly disagreed. This shows that, while respondents did have barriers to gaining the support they needed, in general, they were happy with the services the programs provided.

Table 10*How Strongly Respondents Agreed with the Following Statements*

Statement	Strongly Agree	Agree	Disagree	Strongly Disagree
Home visiting materials are provided on our family's spoken language, either by the home visitor or a translator.	27	8	1	0
I am satisfied with the home visiting services.	27	8	1	0
The home visiting services are helpful.	27	8	1	0
My family feels our home visitor works with us to set mutual goals that are obtainable for our family.	27	7	2	0
My family is comfortable talking to our home visitor about things my family needs.	27	7	2	0
The frequency of the home visits is sufficient.	27	7	2	0
Home visiting services are provided on our family's spoken language, either by the home visitor or a translator.	26	9	1	0

The quality of Arkansas's MIECHV Programs was supported by responses to the follow-up question encouraging respondents to tell ADH about their experiences with the home visiting services they received. While most respondents did not comment, the comments that were received were very heartening and showed how well received the MIECHV Programs are. The following is a list of comments left by the recipients (comments were not edited except to protect the identity of the staff):

- My educator does an awesome job at making sure we have everything we need and go over everything we have questions over.
- This program is great !! Especially for first time moms, that dont do internet so much!.. :)
- Love our home visitor
- She is kind and respectful
- Excellent program
- We love being involved with HIPPIY. The amount of education they provide is amazing! We also love all the extras the program provides such as all the supplies,the books,the monthly meetings(my girls favorites), and the HIPPIY store. [Staff's name] is such a blessing to our family. Our kids look forward to her coming over every week and can't wait to show her all the new things they learned and tell her all about their week. Being a stay at home mom I look forward to the little bit of adult talk I get to have with her each week! We love her!
- We love the program and have had a wonderful experience. Our HBE , [Staff's name], is caring and helps me with my needs when she can
- [Staff's name] has just started working for the program and she is amazing . It seems like I have known her my whole life .
- i love this program
- My home visitor is the most amazing person !
- It is very helpful
- The home visits are very supportive. They have helped me a lot mentally

In addition to having a sufficient number of service opportunities for high risk families, it is equally important that services reflect high quality. Although the identification of service quality is a complex and ongoing process, Arkansas's evidence-based home visitation programs have been credentialed or certified as required by the relevant national models. Additionally, all programs employ reflective supervisory

strategies, require model- and topic-specific training for home visiting staff; and are involved in local partnerships and collaborations. These issues are discussed below.

During the same period as the needs survey for home visiting recipients, ADH conducted a survey of home visiting program staff. Additional detail on this survey is in the “Gaps in Staffing, Community Resources, and Other Requirements to Operate a Home Visiting Program in the At-Risk Counties” section below. The survey contained three to assist in gauging the need of the communities involved:

1. What are the top 10 issues you see facing the families you serve
2. How often do you believe the families you serve had their needs met in these areas
3. Are there any groups in your county that have more difficulty than others getting needed services (if so, please describe)

Table 11 shows the issues that home visiting staff see facing the families they serve, and the number of staff that consider the topic to be one of the top three issues. Employment was considered the top issue overall, with nearly one-third (32%) of respondents listing it in the top three. This was closely followed by transportation (30%), then finding help to find services in general, and behavioral health needs (both 27%). This is in comparison to the top services that respondents in the recipient survey sought: finding help to find services in general, parenting advice, health care, childcare, and food. It is possible that the disconnect is due to the small number of responding recipients, or a difference between viewpoints. It may also be due to the possibility that the respondents for the recipient survey do not reflect the overall recipient population. A second recipient survey focused on previously underrepresented groups may provide a more accurate point of view.

Table 11

Service or Support Issue Facing Families and Number of Staff Considering That Issue Top Three

Service or support issue	# of Staff Considering Issue in Top Three
Employment	31
Transportation	29
Behavioral health care	26
Finding help to find services, in general	26
Childcare or day care	23
Housing	22
Job training or education	17
Health care	16
Parenting advice or information	16
Dental care	15
Cash assistance	6
Food	6
Information on a healthy pregnancy	3
Legal services	2
Translation or interpretation	2
Domestic violence	1
Other	1

When asked about how often the home visiting staff believes that families are having their needs met, the responses for most categories are between sometimes and usually. This shows that there may be a general

need to improve services across the board in the eyes of the staff. Table 12 shows the average score for each category, where 1 = rarely/never, 2 = sometimes/ inconsistently, 3 = usually, and 4 = always. The highest score was given to parenting advice or information, with an average score of 3.19. The only other issue to receive a score at or above usually was information on healthy pregnancies. The lowest scoring issues were cash assistance with an average score of 2.14 and a tie between transportation and legal services, both receiving an average score of 2.20. No issue received a score below sometimes/inconsistently. This shows that staff consider the best areas of support being providing information, while the worst areas of support being in resource intensive areas.

Table 12

Average Score Given by Staff When Asked Whether Families Are Having Their Needs Met

Service or Support Issue	Average score
Parenting advice or information	3.19
Information on a healthy pregnancy	3.01
Food	2.93
Finding help to find services, in general	2.90
Health care	2.84
Childcare or day care	2.60
Dental care	2.56
Housing	2.48
Behavioral health care	2.45
Domestic violence	2.45
Employment	2.34
Translation or interpretation	2.33
Job training or education	2.29
Legal services	2.20
Transportation	2.20
Cash assistance	2.14

When asked if there were population groups in the counties they serve that have more difficulty getting needed services than other groups, 24 respondents said yes and 44 said no. Six of the 19 respondents that gave specific populations stated that the Marshallese population had greater difficulty getting needed services. Other minority populations that were included were: Spanish speakers, African Americans, and Guatemalans. Those in rural areas or with transportation difficulties were mentioned by five respondents.

Professional Development. In order to ensure the at-risk families receive services that reflect an understanding of their needs, Arkansas’s MIECHV Training Institute develops and offers online, instructor-led, and virtual-blended professional development courses for all home visitors in the state. These trainings are developed based on findings from needs assessments conducted by the Training Institute. They address the concerns noted above such as cross-cultural competence, intimate partner violence, family planning, supporting families in crisis, working with diverse families, medical homes, and early dental health.

The Training Institute has developed a total of 44 instructor-led trainings, 21 online trainings, and three virtual-blended courses. There are two courses that address providing home visiting services during the current COVID-19 pandemic including *Getting the Most Out of Your Virtual Home Visits* (virtual-blended) and *Support for Virtual Home Visits During the COVID-19 Crisis*. The *Support* module is

available online and includes resources for home visitors, parents, and children as well as discussion posts where home visitors can share ideas and resources with each other.

Gaps in Staffing, Community Resources, and Other Requirements to Operate a Home Visiting Program in the At-Risk Counties

As noted above, the ADH conducted a survey of home visiting program staff via Survey Monkey. All recipients were assured anonymity so they could freely answer the survey questions. The survey was sent to all MIECHV program leads and to the state funded SafeCare program, with which MIECHV Program coordinates to provide services. Between December 2019 and February 2020, 97 home visiting staff (61 home visitors, 33 home visiting supervisors/coordinators, 1 program staff, 2 unknown) completed the survey.

The respondents to this staff survey was comparable to the recipient survey in a number of ways. The vast majority were female (93). Their experience in the program was varied, with 26 being with the program for less than a year, 12 with the program for one to two years, and 58 with the program for more than two years. Most of the staff were also young to middle age adults, with 20 being 18 to 24 years old, 38 being 35 to 44 years old, 24 being 45 to 54 years old, and 12 being 65+ (two did not provide an age). As with the recipient survey, the respondents represented all programs except Following Baby Back Home. The staff had a higher level of education than recipients. While most respondents spoke English at home, two spoke Spanish at home, and three spoke both English and Spanish. Table 13 provides important demographic information concerning the staff respondents.

Table 13
Survey Respondent (Staff) Demographics

Category	Recipients	Category	Recipients
Home Visiting Model		Education Level	
NFP	6	No HS Degree	0
FBBH	0	HS Degree/GED	6
HFA	18	Some College	16
HIPPY	33	College	53
PAT	20	Higher Education	20
SafeCare	21	Other/Prefer not to say	2
Not Sure	0		
Race (multiple responses allowed)		License, Certificate, or Degree	
White	63	Nursing	8
African American	19	Education/Training	20
Other/N/A	17	Social Work	9
Ethnicity		Behavioral Health	8
Hispanic/Latino	11	Developmental	4
Not Hispanic/Latino	82	Other	19
Prefer not to say	4	None of the above	26
Languages Program Service Provided In			
English	76		
Spanish	23		
Other	3		

The final questions asked in the staff needs assessment survey concerned their own position. Respondents were asked to rank which supports or services they found most beneficial to their job, and then to rank which issues they found to be the greatest barriers. Tables 14 and 15 show the number of staff who ranked

each subject in their top three items respectively. The ranking issue for both tables was salary. Nearly the same percent found salary to be one of the top three benefits (51.5%) and one of the top three barriers (50.5%). While it is not possible to follow-up on the reason some responses overlapped, given that the surveys were anonymous, it is possible that this reflects the complicated differences in public and private positions. Most other issues were considered more of a benefit than a barrier by staff, except:

- Access to counseling/support to prevent compassion fatigue, where only 11.3% indicated that this benefit was in their top three, but 35.1% considered the lack of such support to be in one of the top three barriers.
- Availability of services to refer families, where 20.6% stated this was one of the top three resources available to the staff, but 37.1% stated that the lack of such services was one of the top three barriers.
- Broad, coordinated efforts to support families was considered by 15.5% to be a top-level resource, but 19.6% considered the lack to be a top-level barrier.

Table 14

Support and Resources Available to Staff and the Number Who Consider It Among the Top Three

Support or resource	# Who Consider It Top Three
Salary	50
Direct supervision	20
Support structure within the organization	38
Broad, coordinated efforts to support families	15
Availability of services to refer families	20
Reimbursement for mileage/out-of-pocket expenses	21
Sufficient training and development opportunities	26
Manageable caseload	29
Personal safety	26
Self-care	11

Table 15

Service Staff's Most Pressing Challenges and the Number Who Consider It Among the Top Three

Issue or Barrier	# Who Consider It Top Three
Insufficient salary/benefits	49
Lack of direct supervision	12
Lack of organizational support	26
Broad, coordinated efforts to support families at county/town/state level	19
Unavailability of services to families	36
No reimbursement for mileage/out-of-pocket expenses	2
Lack of available training and development opportunities	5
Staff capacity to serve families - caseloads are too big	19
Personal safety	20
Not enough opportunity/support of self-care	34

Capacity for Providing Substance Use Disorder Treatment and Counseling Services

Arkansas's 2019 annual MIECHV data report revealed 7% of families served had a history of or needed treatment for substance abuse. Given the emphasis on substance abuse-related issues by the

MIECHV authorizing statute, this needs assessment includes information about the general availability of services for pregnant women and new parents presenting with this challenge.

Range of Substance Use Disorder Treatment and Counseling Services

There are 144 substance abuse treatment facilities in Arkansas (National Survey of Substance Abuse Treatment Services, 2018) and only 22 (or 15%) report having programs that target pregnant or postpartum women. Only four of these facilities (or 3% of all facilities) provide resident beds for the children of these women and/or child care for the client’s children.

The majority of facilities offer outpatient care (90%); however, only 19% offer residential treatment and seven hospitals (5% of all facilities) offer inpatient treatment (2%) or detoxification (5%). The majority of facilities accept cash or self-payment (88%), private health insurance (73%), and state financed health insurance (56%). Forty-nine percent of facilities accept Medicaid and 29% accept Medicare. A majority also offer services on a sliding fee scale (60%) or at no charge or minimal payment for clients who cannot pay (66%), and 4% offer free treatment for all clients.

Ninety-seven percent of the facilities around the state offer screening for substance abuse, 90% offer comprehensive substance abuse assessment or diagnosis, and 87% offer screening for mental health disorders. Individual, group, and family counseling are available at more than 90% of facilities and the majority also offer substance abuse education and counseling as well as mental health services, case management services, social skills development, mentoring/peer support, and assistance obtaining social services.

Needs assessment research revealed 14 counties at-risk for substance abuse in Arkansas, five of which were identified earlier as communities with concentrations of risk. Table 16 lists the program available in these counties, with only Desha County having no available MIECHV program. All 14 counties were considered at-risk for cocaine and marijuana use, but not at risk for alcohol or heroin use.

Table 16

At-Risk Communities by Concentration of Risk, Risk for Substance Use, and Home Visiting Model

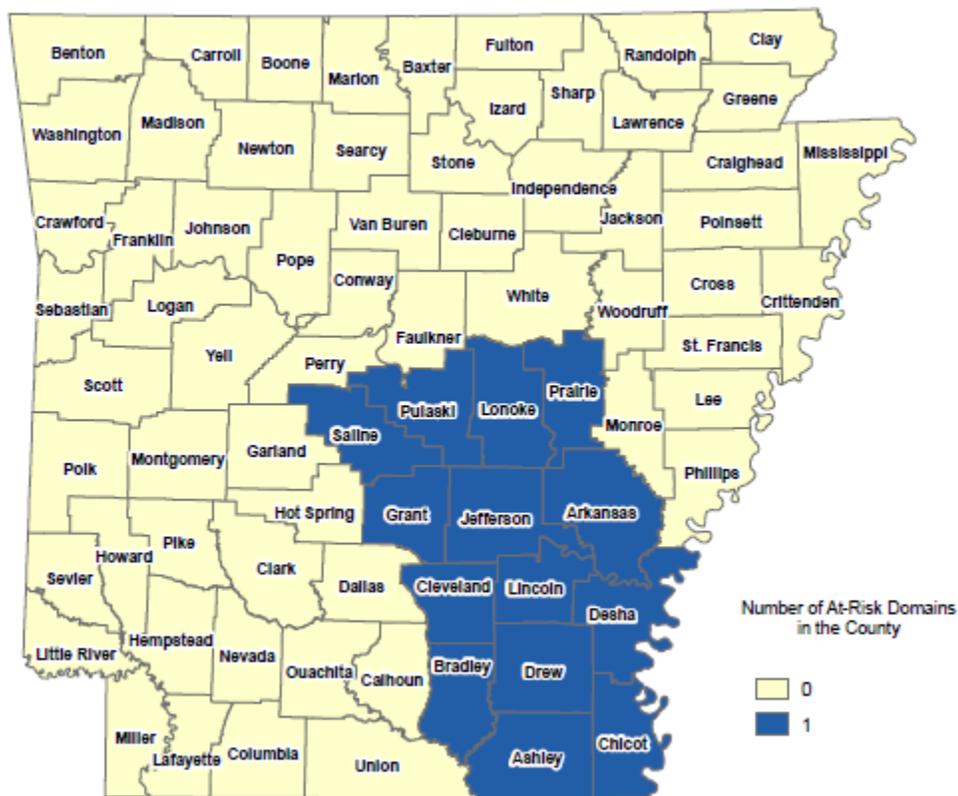
County	Community with Concentration of Risk	At-Risk for Substance Use	MIECHV Program(s) Available in the County
Arkansas County	X	X	NFP, FBBH, HFA
Ashley County	X	X	FBBH
Bradley County		X	FBBH
Chicot County	X	X	None
Cleveland County		X	NFP, HIPPY
Desha County	X	X	None
Drew County		X	HIPPY
Grant County		X	NFP, FBBH
Jefferson County	X	X	NFP, HFA, HIPPY, PAT
Lincoln County		X	NFP, HIPPY
Lonoke County		X	FBBH, PAT
Prairie County		X	NFP, FBBH, HFA
Pulaski County		X	FBBH, HFA, PAT
Saline County		X	FBBH, HFA, HPPY, PAT

When the counties at-risk for substance use are shown on a map, it is startlingly obvious that they are all located to a single contiguous section of the state covering part of the southeast and reaching up into the center of the state (Map 3). Four of the five counties identified as having concentration of risk and being

at-risk for substance use have at least one service provider. Chicot County is the exception: there are no substance use treatment services available there. Patients seeking substance abuse treatment in Chicot County must go to other counties to find treatment service providers. Additionally, people from Arkansas, Chicot, Desha, and Jefferson Counties in need of substance use treatment must travel to other areas of the state to receive it. There are eight providers that serve these counties, two of which are state and/or federally funded and four serve multiple counties (DHS, 2018). Only one county, Ashley, has a facility that provides specialized residential services for women and allows children to accompany the parent (Appendix B). There are outpatient services available for adults and adolescents in four of the five counties and mental health services available in three.

In the nine counties identified as at-risk for substance use only, services are available in eight: Prairie County is the exception as there are no services available there. Across the other eight counties, there are 22 providers who address substance use, the majority of which (64%) are located in Pulaski County, the most populous county in the state and also where the state capital is located. Of the 22 service providers only one offers specialized residential services for women, only two offer co-ed treatment, and five offer residential treatment. Outpatient services for adult patients and mental health services are available in eight counties, outpatient adolescent services are available in seven, and opioid treatment in three.

Map 3
Counties At-Risk for Substance Use



Gaps in the Current Level of Treatment and Counseling Services

As with other public health, health care, and human services, the counties identified as at-risk are significantly underserved in the area of substance abuse prevention and treatment. There are very few people in Arkansas who receive treatment for drug or alcohol problems each year (Addiction Treatment

Services, 2019). Among people ages 18-24, approximately 1 in 7 who need treatment for substance abuse actually receive care (Substance Abuse and Mental Health Services Administration (SAMHSA, 2016)). Among adults ages 25 and older, 6% did not receive the treatment they needed for substance abuse. These figures represent services in the public and private sectors, which reveals a severe shortage of health care providers needed to address the substance abuse challenges faced by citizens of the state. The problem of providing adequate treatment is compounded in the Delta region of the state, where five of the 14 at-risk counties are located, due to the poverty and rural nature of that portion of the state.

Capacity for substance abuse treatment in the at-risk communities is far below what is needed. Few programs exist in the at-risk communities to provide comprehensive local care for substance abuse, particularly in terms of residential facilities and the mental health services that are so often required to achieve true recovery from addiction. The lack of readily available care facilities that provide substantial resident treatment options in all at-risk communities creates transitional problems for those who must travel to another area in order to receive treatment, but must then return to their home community to transition back into community life, without a strong social support network to facilitate the transition. The problems created by the lack of local residential living facilities are compounded when—and this happens with many of those dealing with substance abuse issues statewide—family members reject the person struggling to overcome substance abuse and he/she becomes homeless. There are few facilities in the at-risk counties to deal with these challenges, or with the challenges of reintegrating into society faced by those leaving the penal system, many of whom also cope with substance abuse issues. The lack of widely available options for treatment of the mental health issues from which substance abuse issues often arise, or which often compound substance abuse problems

Barriers to Receipt of Substance Use Disorder Treatment and Counseling Services

One of the biggest difficulties for many people in need of treatment in Arkansas is finding an appropriate facility and bed availability (Addiction Treatment Services, 2019). Another barrier to treatment for many people in the state is they avoid using a professional interventionist for one reason or another. According to SAMHSA (2013), those who felt they needed treatment but did not seek care (2.7% of the population with a substance use disorder) identified the following reasons for not seeking it (respondents could note more than one reason):

- 40% reported they were not ready to stop using alcohol or drugs.
- 31% reported having no health coverage and could not afford cost of treatment.
- 11% reported possible negative effect on their job.
- 10% reported concern that receiving treatment might cause neighbors/community to have a negative opinion of them.
- 9% reported not knowing where to go for treatment.
- 8% reported no program available having the type of treatment needed.

Those who felt they needed treatment and sought but did not receive it (1.5% of the population with a substance use disorder) reported the following reasons for not receiving treatment (respondents could identify more than one reason):

- 37% reported having no health coverage and could not afford cost of treatment.
- 25% reported not being ready to stop using drugs or alcohol.
- 9% did not know where to go for treatment.
- 8% had health coverage but it did not cover treatment or did not cover cost.
- 8% percent reported it was inconvenient or they lacked transportation.
- 7% reported it might have negative effect on job.
- 7% could handle problem without treatment.
- 5% percent did not feel they needed treatment at the time.

Additional burdens identified through research include not having a place to stay to begin treatment, application burdens, fear of treatment, potential loss of child custody, waiting periods, need for referrals, and requiring photo identification (U.S. Department of Health and Human Services, 2015). Based on the findings noted above, areas in which capacity building might be needed include: the expansion of in-patient services for women identified with this problem within the current network of substance abuse treatment programs and the expansion of follow-up services for women who graduate from these programs in order to facilitate the provision of appropriate aftercare services for their young children. Additional recovery support services needed include assistance in areas of employment, housing, and detoxification treatment.

Availability of Wrap-Around Services

Wrap-around services are non-clinical services that facilitate patient engagement and retention in treatment as well as their ongoing recovery. This can include services to address patient needs related to transportation, employment, childcare, housing, legal and financial problems, among others. In 2019, the Clinton Foundation, in partnership with the ADH and multiple faith-based organizations, created a substance use resource guide for prevention, treatment, recovery, and harm reduction in Pulaski County. The guide provides information on substance use disorder treatment programs (adult and adolescent residential, outpatient), medication assisted treatment for opioid use disorder, mutual aid groups (local and national), no cost and low-cost health care, mental health counseling and therapy, local and national hotlines, substance use prevention resources, educational resources, training resources, and supportive local organizations. The guide also provides information on wrap-around services such as sober living homes, transitional living, shelter programs, day shelters and resource centers, food and clothing services, legal resources, and employment resources.

Coordinating with the Title V MCH Block Grant, Head Start, and CAPTA Needs Assessments

Once at-risk communities were identified, needs assessments for the Title V MCH Block Grant, Head Start Program, and the Community-Based Child Abuse Prevention (CBCAP) Grant (funding supports Arkansas's Child Abuse Prevention and Treatment Act (CAPTA)) were reviewed. This review allowed the MIECHV Program to 1) identify existing home visiting services statewide and at the community level; 2) gain input at all levels on the quality of existing home visiting programs and the coordination of services among community partner agencies; and 3) identify underserved populations.

Coordination with Title V MCH Block Grant

Arkansas's MIECHV and Title V Program staff collaborated to host a stakeholder meeting on November 13, 2019. The purpose of this meeting was to review current data on maternal and child health in Arkansas and to discuss areas of concern, partnerships and collaborations, priority needs, and strategies. We also wanted to provide an opportunity to engage stakeholders and form partnerships across programs, organizations, sectors, populations, and communities.

The daylong meeting was held in Little Rock in the central region of the state on the Arkansas Children's Hospital campus. The goals of the meeting were to:

- Identify priority needs for each maternal and child health domain.
- Expand partnerships and networks for referral across counties.
- Commit to work together to collectively improve outcomes.

The objectives of the meeting were to ensure stakeholders left with an understanding of the:

- Purpose, statutes and federal guidance, requirements, and timeline for the MIECHV and Title V Programs.
- Process and activities required to complete the needs assessment.

- State maternal and child health needs, desired outcomes, and partner strengths and capacity.
- Potential partners to support each other's work.

Fifty stakeholders attended including representatives from Arkansas Advocates for Children and Families; Arkansas Chapter of the American Academy of Pediatrics; Arkansas Children's Hospital Center for Effective Parenting; Arkansas Children's Hospital Injury Prevention Center; Arkansas Children's Hospital Quality and Safety Program; Arkansas Division of Developmental Disabilities Services; Arkansas Foundation for Medical Care; Arkansas Home Visiting Network; Baptist Health; Family-to-Family; Partners for Inclusive Communities; the University of Arkansas for Medical Sciences College of Public Health (Community Health Worker Advisory Board; Institute for Digital Health and Innovation; Office of Diversity, Equity, and Inclusion; Translational Research Institute); and the University of Central Arkansas. In addition, multiple programs housed at the Arkansas Department of Health were represented, including Child and Adolescent Health; Chronic Disease; Coordinated School Health; Epidemiology; Health Statistics; Healthy Active Arkansas; Home Visiting Programs; Hometown Health Support Services; Immunization and Outbreak Control; Family Planning; Office of Health Equity; Office of Health Policy; Perinatal Health; Tobacco Prevention and Cessation; WIC; and Women's/Maternal Health.

The meeting began with a presentation about maternal mortality efforts in the state, an overview of the MIECHV and Title V Maternal and Child Health Block Grants, and a review of the current status of each program. Participants were then asked to self-assign into one of the five domain groups based on which group they thought most relevant to their work: Adolescent Health; Child Health; Children with Special Health Care Needs; Perinatal Health; or Women's/Maternal Health. State MIECHV leaders participated in the Perinatal Domain group. Each domain group was assigned a break-out room where they could discuss the most important needs, what the gaps in service were, and who could be engaged to address them. Within the small groups there was active discussion and written ideas as participants identified the gaps and needs of the specific population group. Each small group had a facilitator from either the Arkansas Department of Health or the Arkansas Children with Special Health Care Needs Program. The facilitators were able to ensure that every participant's voice was heard, along with making sure that key notes were being taken.

Over the course of the day, domain groups met to discuss four broad topics: 1) areas of concern (gaps; populations not being reached; emerging needs; and current strengths, weaknesses, and opportunities for improvement of the public health system); 2) partnerships and collaborations (who is missing from the discussion, how to improve partnerships, role of each partner, increasing collaboration); 3) strategies and review of the Health Impact Pyramid (highest priority strategies, distribution of efforts within the pyramid, additional funding sources); and 4) community action (what does each partner have to offer, how work may change as a result of new partnerships, moving forward collectively, and identifying project champions).

Priority needs for the maternal and child health population included healthy relationships, family planning, navigating the health care system, developmental and behavioral health disorders, access to services in rural areas, transportation, access to services, home visiting, tobacco prevention/cessation, breastfeeding support, and nutrition education. Several cross-cutting gaps were identified including access to mental health services, health care services/providers in rural areas, and transportation. Partners also identified several populations not being reached, including undocumented workers, racial/ethnic minorities, and the LGBTQ community. Emerging needs varied by population group and included maternal mortality, adverse childhood experiences, preventive dental care, telemedicine, health literacy, and social determinants of health. Strengths of the public health system included tobacco prevention/cessation efforts, working together instead of in silos, breastfeeding education and support, and family planning clinics. Weaknesses included lack of mental health services, provider education, need for comprehensive sex education, need for health care navigators, and lack of youth engagement in decision making.

Stakeholders recommended many other partners who should be included in discussions about maternal and child health in the state, including: faith-based organizations; youth organizations; Healthy Active Arkansas; University of Arkansas Cooperative Extension Service; Arkansas Center for Health Improvement; Parent-Teacher Association representatives; Arkansas Department of Education, including the Division of Child Care and Early Childhood Education; behavioral health hospitals/clinics; neighborhood associations; student councils; Fatherhood Initiative (Watch Dogs); Arkansas Foundation for Medical Care's Medicaid Benefit Education Group and Connect Care Programs; primary care physicians; pediatricians; family planning doctors; 4-H; day care representatives; and mental health professionals.

At the end of the day, all domain groups reconvened to report their findings and receive feedback. A larger discussion not only aided in further sharing of needs, but also allow participants to expand their awareness of service gaps. Prior to closing for the day, stakeholders were told that the state's MIECHV and Title V Programs would like to continue discussions started that day. All participants agreed with the idea and committed to working on domain-specific workgroups throughout the needs assessment process and over the next five years.

In addition to the stakeholder meetings, a maternal and child health needs assessment questionnaire was developed using REDCap and the online survey link was emailed to the stakeholder meeting participants and others. The survey was conducted between November 2019 and February 2020. Results from 133 stakeholders and partners came from across the maternal and child health care spectrum, including MIECHV program staff and partners. Participants identified the top three areas where gaps existed in the public health system. The results of the needs assessment survey were broadly supportive of the results found in the two MIECHV surveys described previously. The major outcomes from this survey were as follows:

Women/Maternal Health

- Top two emerging needs: 1) need for more local mental health and 2) need for more drug and alcohol abuse programs and resources, especially among those without insurance and transportation.
- Forty-nine percent of participants cited mental health services as one of the three most important gaps in women's health and mental health disorders was listed as the fourth most important public health problem affecting women in Arkansas.
- Only 17% of the respondents listed referrals to mental health services as a strong point in the public health system.
- The respondents determined that there were several other important gaps in public health services for women and maternal health: the availability of healthcare providers (32%), transportation (30%), and illicit or other drug abuse prevention programs (30%).

Perinatal/Infant Health

- Forty-seven percent of participants said availability of transportation was an important gap in perinatal and infant health, and transportation was mentioned as not being equally available throughout the state. Lack of public transportation was especially important in rural areas and was a key factor in missed clinic appointments. This was also a concern identified across the Title V MCH, MIECHV, and Head Start needs assessments.
- Sixty percent of respondents said they would like to see new strategies or interventions for making transportation more available.
- Some suggested strategies for improving access to transportation were providing more public transportation in local areas, making transportation free or easily affordable, and educating families about the transportation options available to them.
- Fifty-nine percent said rural areas are not being reached in current statewide efforts for perinatal/infant health.

- Lack of health care providers and specialty care in rural areas compounds the difficulty getting appropriate perinatal/infant healthcare.
- Additionally, there was strong public health infrastructure in place to support breastfeeding, especially through the Women, Infants, and Children (WIC) program. Access to lactation experts (24% of respondents) and breastfeeding education and support (20% of respondents) were ranked as the fifth and sixth top public health gaps for this population, respectively.

Child Health

- Developmental and behavior disorders (57%) was ranked as the most important public health problem by survey respondents. Almost half (48%) of respondents reported an existing strategy or interventions was in place for the children they serve and yet one-fifth (21%) of respondents felt developmental monitoring and screening was one of the top three areas where gaps still existed.
- Suggested strategies for improvement included: facilitating collaboration between ADH, Arkansas Department of Human Services (DHS), and schools to identify and refer students in need; increase networking by area managers and care coordinators to Community-Based Autism Liaison and Treatment (CoBALT) Project clinics and developmental clinics; increase communication with communities on how to increase referrals to clinics in order to screen more children and youth appropriately; and increase presence at lower functioning CoBALT clinics.
- Childhood obesity and overweight (52%) and related risk factors such as physical inactivity (34%) and poor nutrition (32%) were ranked by respondents as the second, third, and fourth most important public health problems among children in Arkansas.
- Recommended strategies included: more school/community based physical and exercise education; regular communication with parents about their child's physical health, changing physical health education laws and increasing recess time; increased funding for physical health education and nutrition education; nutritious meals at school; and expanding online nutrition education availability.

Children with Special Health Care Needs

- Transportation was again a major theme of the needs assessment, with 50% of respondents citing it as the most important need and only 24% indicating that there were already strategies in place to address transportation issues for this group.
- Suggested ways to improve transportation included: reimbursement by Medicaid Transport for families to transport the child to non-emergency medical appointments; educating the parents and the general public about available transport options; and making public transportation wheelchair accessible in all areas.
- Related to transportation availability were the issues of care coordination and assistance navigating through the health system. Families experience great difficulty in understanding, navigating through, and accessing the complex health system for CSHCN, including the Medicaid program, services and financing options available to them, technological issues including internet access and computer use, accessing available specialists and services, and finding respite care.

Coordination with Head Start

The ADH has worked with Arkansas Head Start since the inception of the MIECHV program. The Executive Director of Arkansas Head Start is an engaged member of the Arkansas MIECHV Advisory Committee and the Arkansas Home Visiting Training Institute Advisory Committee. She was involved with the state's MIECHV and Title V needs assessment meetings: helping identify programmatic priorities, barriers, opportunities, and innovations. She also contributed to the development of cross-sector and cross-agency strategies to improve the health of women and children in Arkansas. The Executive Director is also active in a number of committees and work groups where Arkansas MIECHV

is represented. It is through these regular meetings with Head Start and other stakeholders that the Arkansas MIECHV program identifies opportunities for and barriers to program success, determines the strength and reach of program impact, and shares best practices around community engagement and program development. As was done in the past, Arkansas Head Start and Arkansas MIECHV shared data from each program's 2020 needs assessment to identify needs across all populations served.

Coordination with Child Abuse Title II CAPTA

The Arkansas Department of Health has also worked with the state's Title II Child Abuse Prevention and Treatment Act (CAPTA) agency since the inception of the MIECHV program. Staff from the CAPTA program have served on the state's MIECHV advisory board. The Arkansas MIECHV Program is looking for more ways to coordinate and integrate the state's MIECHV work with this partner.

Methods Used to Incorporate Data from Other Needs Assessment

Arkansas's MIECHV Program triangulated the data from the Title V and CVCAP needs assessments to increase the validity of the findings and to better understand the generalizability of the results. A central component of this effort is identifying specific communities or areas which have a high concentration of needs across multiple domains and the extent to which sufficient resources exist to address these needs.

Service Gaps in At-Risk Counties Represented Across Needs Assessments

Counties selected as at-risk tend to have fewer services available relative to need. Several of the gaps identified across the needs assessments were not surprising: lack of community resources, lack of adequate transportation, lack of affordable child care, and maintaining consistent contact for referral sources. The Arkansas MIECHV Program has been aware of these issues since the program's inception. Home visitors address client concerns through referral to existing services; however, as noted above, many of the at-risk communities are poor and poorly resourced, lacking the sources needed by families served by MIECHV.

Other gaps noted across needs assessments was a lack of awareness about partnerships with early childhood advisory boards or efforts to unify early childhood systems and difficulty enrolling military families. The state's MIECHV, Title V, and Head Start Program plan to continue conversations related to these gaps in order to identify ways to address them collaboratively and effectively.

Convening Stakeholders and Ongoing Communication

The Arkansas MIECHV and Title V Programs collaborated to hold follow-up meetings with stakeholders who attended the November 2019 meeting. In early 2020, five meetings were held with groups based on the Title V Maternal and Child Health Block Grant domains: Womens/Maternal Health, Child Health, Adolescent Health, Children with Special Health Care Needs, and Perinatal Health. Each meeting was attended by multiple stakeholders representing various organizations and sectors. At the end of each meeting, the MIECHV and Title V Programs talked with stakeholders about creating opportunities to continue these conversations. The follow-up meetings with maternal and child health stakeholders including MIECHV, Title V, and external stakeholders, are scheduled to begin in October 2020 and continue on a quarterly basis.

Summary

The Arkansas Department of Health (ADH) is responsible for the administration of the federal MIECHV grant award, which supported the establishment of state's MIECHV Program in 2011. The state's program works with pregnant women and families with children ages 0 to 5 years old, particularly those considered at-risk, to provide the necessary resources and skills to raise children who are physically, socially, and emotionally healthy and ready to learn. The goals of Arkansas's MIECHV Program are to 1)

improve maternal and child health, 2) prevent child abuse and neglect, 3) encourage positive parenting, and 4) promote child development and school readiness.

In order to continue to reach these goals, Arkansas's MIECHV Program must remain aware of the needs of the population being served. The purpose of this needs assessment update is to 1) gain an understanding of the current communities with concentrations of risk, 2) identify the quality and capacity of existing early childhood home visiting programs, 3) review the state's capacity for providing substance abuse treatment and counseling, and 4) coordinate with and incorporate findings from the state's Title V Maternal and Child Health (MCH) Block Grant, Head Start Program, and Title II Child Abuse Prevention and Treatment Act assessments. The program used a mixed methods approach including using quantitative data provided by HRSA, qualitative and quantitative data gathered from the stakeholder meetings and from partners such as Head Start, and data from both the MIECHV and Title V stakeholder surveys. Staff from the ADH Health Statistics Branch conducted data analysis and assisted with the writing of this report.

The need for maternal and child home visiting programs in Arkansas is high. Arkansas ranks poorly in many indicators related to health outcomes and health factors such as behavioral health. Further, many of the families in the state, and especially in the counties identified through this needs assessment as at-risk, live in areas with high concentrations of risk that are related to negative lifelong health outcomes. Struggles include living in poverty, teen pregnancy, the need for substance abuse treatment, and poor educational and employment opportunities as well as high percentages of pre-term births and maternal depression. Each of these trials can affect families in real time and also have a multi-generational impact.

Sixteen counties were identified as at-risk in this needs assessment: Arkansas, Ashley, Chicot, Conway, Crittenden, Desha, Garland, Greene, Jackson, Jefferson, Lafayette, Lee, Miller, Mississippi, Phillips, and St. Francis. Five counties were at-risk in three of five domains and eleven counties were at-risk in two of five domains. Poor perinatal outcomes was the most common risk factor in these counties, followed by crime, alcohol and illicit drug abuse, socioeconomic status, and high levels of child maltreatment. The majority of the at-risk counties are in the Delta Region of the state. There is at least one MIECHV Program in 13 of the 16 counties. The exceptions are Jackson, Desha, and Chicot Counties, where no MIECHV-funded home visiting programs exist.

Surveys completed by MIECHV families indicated they are happy with the quality, content, and frequency of the home visits they receive. Staff described the top three service or support issues of the families they serve. Employment was the highest, followed by transportation, which was also noted in the Title V and Head Start needs assessments. Finding behavioral health care services and services in general tied for third. The need for behavioral health care services was also a finding in the Title V and Head Start Needs Assessments.

A survey of home visiting staff revealed the top three benefits for them were salary, support structure within the organization, and having a manageable caseload. Barriers were insufficient salary, unavailability of services to families, and not enough opportunity for self-care. Although low salary has been noted for years as an issue across the states, additional follow-up is needed to tease out why half of Arkansas's respondents felt the salary was sufficient and the other half did not. This may be related to home visiting model (some use nurses and others use paraprofessionals), local implementing agency, or geographic location. The Title V and Head Start needs assessments also found that lack of services and/or lack of access to services is a barrier.

The needs assessment identified 14 counties at-risk for substance abuse: Arkansas, Ashley, Bradley, Chicot, Cleveland, Desha, Drew, Grant, Jefferson, Lincoln, Lonoke, Prairie, Pulaski, and Saline. Five of these counties were also identified as communities of concentrated risk: Arkansas, Ashley, Chicot, Desha, and Jefferson. Gaps in the substance use treatment system in these counties include a lack of treatment options for pregnant women and families with young children and of residential treatment. Many counties

offer some services but not all, which means individuals seeking care must travel out of their community to find treatment. Two counties – Chicot and Prairie – do not have any substance use treatment providers located there.

Arkansas's MIECHV Program is administered in the same Branch as the state's Title V Program and the two programs have worked together seamlessly for years. The MIECHV Program has also worked closely with the state's Head Start Program since the inception of MIECHV in 2011 and the state's CAPTA Program also participates on the MIECHV Advisory Board. Arkansas is working to strengthen relationships with both programs and to continue conversations about how to collaborate and communicate on a more frequent basis.

Arkansas's MIECHV Program plans to share with and use the findings from this needs assessment to guide conversations with the MIECHV state leadership and advisory team, Title V MCH Perinatal Health Program, and internal and external stakeholders who are working to improve the health and health outcomes for the state's at-risk mothers, children, and families.

**Arkansas Department of Health
Maternal, Infant, and Early Childhood Home Visiting Program
2020 Needs Assessment**

Appendix B

Substance Use Treatment Providers and Services by Counties with Both Concentration of Risk and At-Risk for Substance Use

			Arkansas	Ashley	Chicot	Desha	Jefferson
Treatment Program	State Funded (Y/N)	Services Offered					
Jefferson Comprehensive Counseling Associates	N	Adult Outpatient (OP)	X				X
		Adolescent OP	X	X		X	X
		Mental Health	X				X
SE AR Behavioral Health Care System	N	Adult OP	X				X
		Adolescent OP	X				X
		Mental Health	X				X
United Family Services	N	Adolescent OP	X				X
10th District Substance Abuse Program (New Beginnings CASA)	Y	Specialized Women's Svc (children can accompany parents)		X			
		Adult Residential		X			
		Adult OP		X		X	
		Mental Health				X	
Harbor House	Y	Adult OP					X
		Mental Health					X
Cares Behavioral Services	N	Adult OP					X
The PAT Center	N	Adult OP					X
		Adolescent OP					X
		Mental Health					X

		CO-ED Treatment (partners receive treatment together)	X
Preferred Family Healthcare	Y	Adolescent Residential	X
Quapaw House	Y	Adult Residential Adult Observa- tional Detox	X X
Recovery Centers of Arkansas	Y	Adult Residential Adult OP Adult Day Treatment Mental Health	X X X X
Bradford Health Services	N	Adult OP Adult Partial Day CO-ED Treatment Mental Health	X X X X
Baptist Health Medical Center	N	Adult OP Adult Medical Detox Mental Health	X X X
Better Community Develop- ment	N	Adult Residential Adult OP	X X
CATAR Clinic	N	Adult OP Opioid Program	X X
Family Service Agency	N	Adult OP Adolescent OP Mental Health	X X X
Gyst House Quality Living Center	N	Adult OP Adult OP Adult Residential	X X X

The PAT Center	N	Adult OP	X
		Adolescent OP	X
UAMS Center for Addiction Services and Treatment	N	Adult OP Opioid Program	X
		Mental Health	X
United Family Services	N	Adolescent OP	X
		Mental Health	X
Central Arkansas Treatment Services	N	Adult Outpatient Opioid Program	X
Counseling Clinic	N	Adult OP	X
		Adolescent OP	X
		Mental Health	X

Arkansas Department of Health
Maternal, Infant, and Early Childhood Home Visiting Program
2020 Needs Assessment

Appendix C

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