Arkansas Maternal Child Health Services Block Grant
2026 Application/2024 Annual Report

III.A. Executive Summary

III.A.1. Program Overview

The Arkansas Department of Health (ADH) is one of 15 state agencies under the direction of Governor Sarah Huckabee Sanders' leadership. Maternal Child Health (MCH) supports the ADH's mission by addressing priority needs, improving gaps and barriers to access to care, while increasing the capacity of public health, healthcare systems, and workforce.

The MCH programs are housed in the ADH's Family Health Branch (FHB), which is part of the agency's Division for Health Advancement (DHA). Arkansas's MCH Program consists of shared leadership between the ADH FHB and the Arkansas Department of Human Services (ADHS) Children's Special Services (CSS) (aka Children with Special Healthcare Needs - CSHCN) within the Division of Developmental Disabilities Services (DDS). The state MCH leadership team makes program and policy decisions to ensure alignment across programs and agencies. Designated state priority leads oversee program and policy work and provide technical assistance and oversight to local MCH grantees.

The ADH FHB contracted with the University of Arkansas at Little Rock (UALR) School of Public Affairs Survey Research Center (SRC) to collect data for the MCH Five Year Comprehensive Needs Assessment. A web-based survey was created and approved by the UALR Institutional Review Board – Protocol 24-046-R2. The web-based survey was distributed via email utilizing Qualtrics platform and a preferred email list of ADH stakeholders. The response rate was **39.15%** of eligible participants who completed the web-based survey between August 2024 through November 2024.

Respondents were based across 20 counties that represented a diverse range of organizational affiliations, with the largest group being healthcare professionals (28.57%), followed by state or local public health organizations (25.71%), and community-based or non-profit organizations (24.29%). Parents/guardians accounted for 7.14% of respondents, university or academic institutions made up 4.29%, and 10.00% identified as "other."

The research team also conducted virtual focus groups and key informant interviews covering each of the five domains. Focus group participants volunteered at the completion of the web-based survey.

Based upon the needs assessment findings, the population and emerging needs were captured for each domain.

Table 1: MCH Population and Emerging Needs by Health Domain

	Population Needs	Emerging Needs
Women/ Maternal	Mental health disorders Access prenatal care Access insurance Overweight/obese Maternal mortality Teen pregnancy	Mental health services Navigating health systems Postpartum care Healthcare provider availability
Perinatal/ Infant	Access to WIC program Care coordination: medical home Access lactation experts Breastfeeding education/support Access family-to-family support Health insurance availability	Transportation availability Home visiting services Access family-to-family support Navigating health system Parent education services Healthcare provider availability
Child	Mental health services Developmental delays Overweight/obese Care coordination: medical home Parent education/family-to-family support	Transportation availability Navigating health system Mental health services Health insurance availability Healthcare provider availability
Adolescent	Mental health services Overweight/obese Peer influence Poor nutrition Illicit or other drug abuse	Mental health services Navigating health system Suicide prevention Health insurance availability Nutrition education
CSS	Transportation availability Access family-to-family support Care coordination services Obtaining personal care services Medical equipment/assistive technology	Mental health services Care coordination services Family-to-family support Transportation availability

MCH efforts are a direct result of partnership building to address gaps in the workforce that support local health unit direct services. The MCH program maintains strong partnerships with advocacy groups, community-based organizations, federally qualified health centers (FQHC), committees, coalitions, Medicaid, family partnership organizations, and other state offices. Other innovative partnerships consist of the March of Dimes and Zeta Phi Beta Sorority, which focuses on the improvement of access to prenatal care. The Natural Wonders Partnership Council (NWPC) also seeks to improve child health. CSS services are established by family-professional partnerships such as the Family to Family (F2F) Health Information Center and peer services to families and the Parent Advisory Council (PAC). These partnerships enable MCH to coordinate multiple programs statewide, leverage resources, and address service gaps. Working with diverse stakeholders provides unconventional venues to capture individuals that are most vulnerable.

The needs assessment findings informed the selection of priority needs, National Performance Measures (NPMs), and State Performance Measures (SPMs) for the 2025 – 2029 State Action Plan. Arkansas selected seven NPMs (including medical homes) that closely aligns with the seven priority areas and two SPMs to monitor the progress of state's priority needs not specifically addressed by an NPM.

Priority Need	Health Domain
Postpartum Visit	Women's Health
Persistently High Infant Mortality Rate	Perinatal/Infant
Access to Care	Child, CSS
Physical Activity	Child
Tobacco Use	Adolescent
Bullying	Adolescent
Transition to Adulthood	CSS
Developmental Screening	Perinatal/Infant

Table 2: Priority Needs, NPMs and SPMs by MCH Population Health Domains

Women/Maternal: Postpartum Visit – PPV[1] A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth B) Percent of women who attended a postpartum checkup and received recommended care components
Perinatal/Infant: Safe Sleep – SS (Safe Sleep, Formerly NPM 5A, 5B, 5C) A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding D) Percent of infants room-sharing with an adult during sleep
Child Health: Physical Activity – PA-Child: Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day
CSS and Child Health: Medical Home – MH: Percent of children with and without special health care needs, ages 0 – 17, who have a medical home[1] A) Percent of children with and without special health care needs, ages 0 through 17, who have a personal doctor or nurse B) Percent of children with and without special health care needs, ages 0 through 17, who have a usual source of sick care C) Percent of children with and without special health care needs, ages 0 through 17, who have family centered care
Adolescent Health: Tobacco Use – TU: Percent of adolescents, grades 9 through 12, who currently use tobacco products
Adolescent Health: Bullying – BLY: Percent of adolescents, with and without special health care needs, ages 12 through 17, who are bullied or who bully others
CSS: Transition – TR: Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care
Perinatal/Infant: SPM 1 – Developmental Screening. Percent of newborns with timely follow-up of a failed hearing screening
CSS: SPM 2: Percent of families with children with special health care needs served by MCH CSHCN who report that their child received the health care services they needed

MCH supports coordinated, family-centered services, including services for CSS. Within the quality improvement initiative, the MCH staff analyze efforts, effectiveness, as well as the impact of work to improve public health policies and processes. The MCH Program's nurse care coordinators worked with families to develop family-centered plans, to reach priority goals for CSS and their families. Nurse care coordinators also coordinate support and services for eligible families through collaborative partnerships with other programs and related agencies. Partnerships with related agencies around common goals ensure coordinated, comprehensive services to assist families in reaching their goals for their children.

The states' approach to eliminating health inequalities provides optimal healthcare and resources for all Arkansans by addressing emerging and priority needs, improving gaps in and barriers to accessing care, and increasing the capacity of the public healthcare systems and workforce. Strategies to advance health equality includes 1) providing technical assistance, referrals and resources pertaining to the needs of populations; 2) collaborating with the ADH, the Arkansas Minority Health Commission (AMHC), the Arkansas Center for Health Improvement (ACHI), and the University of Arkansas for Medical Sciences (UAMS) to improve state health data collection, use, and dissemination strategies; and 3) supporting the development and dissemination of information, strategies, and policies which contribute to the improved health outcomes of Arkansans. As an example, the Governor recently approved ACT 123 of the 95th General Assembly of the State of Arkansas, which provides free school breakfast regardless of their family income beginning 2025-2026 school year.

The Arkansas Home Visiting Network (AHVN) works with several agencies including ACHI, ADH, Arkansas Advocates for Children, and the Arkansas Chapter of American Academy of Pediatrics to help identify activities and strategies to help reduce health differences of Arkansas families. Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) AHVN also works closely with Delta Dental and Arkansas Blue Cross Blue Shield through the NWPC to address health differences at a system level, including disseminating medical and dental resources, insurance information, and public assistance options to MIECHV served families. The AHVN assists MIECHV-funded models in reducing health differences by providing training and technical assistance designed to improve cultural competency in the delivery of screenings, assessments, case management, family support, and referrals.

MCH partners strive to integrate communities, families and caregivers in its work to ensure women and children receive the needed health benefits by promoting the importance of coordinated care. Partnering agencies such as the MidSOUTH Training Academy provide training classes to prospective resource parents, relative caregivers, and people interested in adopting children who are in the Arkansas Division of Children and Family Services (DCFS) custody. The training is designed to help resource/adoptive parents understand the challenges and rewards of rearing abused or neglected children. Also, the Women, Infant and Children (WIC) Baby and Me Parenting Program is implemented in selected WIC clinics across the state. The parenting program focuses on strengthening parent/child relationships, promoting healthy child development, and connecting parents to community resources and primary care physician education.

Program evaluation efforts are ongoing to determine the effectiveness of program strategies to improve outcomes according to goals essential to the MCH program. The MCH epidemiologist works closely with the Arkansas State Systems Development Initiative (SSDI) staff to provide data, measure progress, and inform decision making around NPMs, National Outcome Measures (NOMs), SPMs, State Outcome Measures (SOMs), and Evidence-Based/Evidence-Informed Strategy Measures (ESMs). SSDI data linkage warehouse provides a wide variety of MCH databases from birth to death

certificates, and other program registries such as immunization and tuberculosis to address MCH programmatic and policy issues.

The evaluation goals seeks to 1) strengthen capacity to collect, analyze, and use reliable data for MCH to assure data-driven programming; 2) strengthen access to and linkage of key MCH datasets to inform MCH programming and policy development, and strengthen information exchange and data interoperability; 3) enhance the development, integration, and tracking of social risk factors of health metrics to inform MCH programming; 4) enhance capacity for timely data collection, analysis, reporting, and visualization to inform rapid state program and policy action related to emergencies and emerging issues/threats. These goals are crucial to monitoring health indicators and influencing policies to improve the well-being of Arkansas mothers, children, families, and CSS services.

Arkansas has several notable accomplishments worth mentioning. First, Arkansas was selected to receive a $17 million grant over 10 years for participants in Medicaid and the Children's Health Insurance Program. This Transforming Maternal Health (TMaH) model utilizes a whole-person approach to pregnancy, childbirth and postpartum care that addresses mothers' physical, mental, and social needs. The TMaH model seeks to reduce differences in access and treatment and improve outcomes and experiences for mothers and their newborns. DHS will lead the coordination of this project.

During the 2025 legislative session, bills were passed to promote the health and well-being of mothers, infants, and children.

- ACT 123: Ensure that all public-school students receive free school breakfast regardless of their family income beginning 2025-2026 school year.
- ACT 140: Healthy Moms, Healthy Babies changed Medicaid regulations to make prenatal care much more accessible in maternal care deserts.
    - Establishes presumptive eligibility for pregnant women who apply for Medicaid, which allows immediate prenatal care, while they're waiting for a full application to be processed.
    - Authorizes Medicaid to reimburse doula's and community health workers for visits to pregnant women's homes if related to prenatal or postpartum care.
    - Authorizes Medicaid coverage for office visits, laboratory fees, tests ordered by a physician, blood work, remote monitoring, fetal nonstress tests, glucose monitoring and self-measurement blood pressure devices.
- Act 138: Empowers certified nurse midwives to make hospital admissions and sign birth or death certificates.
- ACT 965: Establishes the certified community-based doula certification act; to certify birth/postpartum doulas in this state to improve maternal and infant outcomes.

Lastly, the ongoing challenge facing MCH is the difficulty of hiring qualified candidates due to the competitive pay to secure high-quality employees. Arkansas Legislature amended ACT 499 to establish a new pay plan aimed at raising salaries to align closer to private sector salaries effective July 2025.

III.A.2. How Federal Title V Funds Complement State-Supported MCH Efforts

ADH supports MCH efforts by funding nursing salaries and supplies for MCH services in the agency's local health units. MCH staff participate in various committees and boards to remain abreast of information and trends to develop strategies essential to reducing service gaps statewide. A few examples include 1) Arkansas Maternal/Perinatal Outcomes Quality Review Committee (MPOQRC), which reviews data on births and develop strategies to improve outcomes; 2) AMMRC works to understand pregnancy-associated deaths and create actionable steps to prevent future deaths; 3) Universal Newborn Hearing Screening, Intervention and Tracking Advisory Board serves in an advisory capacity to ensure early detection of hearing conditions for all infants; 4) Excel by Eight Initiative – a collaborative advocating to improve health and education outcomes for infants and toddlers; and 5) Arkansas Children's Hospital (ACH) Natural Wonders Partnership Council, First 100 Days Workgroup – a network of child health groups, agencies, and funding sources collaborating to address the evolving health issues of children in their first 100 days of life.

As of April 2025, the Federal-State Partnerships expenditure totaled $25,945,883. In FY25, the state spent 54.31% of the Title V funds on preventive and primary care for children, including school health programming, adolescent health, and programs focusing on safe sleep, breastfeeding, and reducing child maltreatment. CSHCN supported 31.34% of care coordination, specialty outreach clinics, respite care, support for family involvement, and home modifications. Maternity services for pregnant women spent 10 percent (10.09%). The Family Planning Program receives funding via Title X, as well as commercial and Medicaid reimbursement.

Title V funding also builds public health infrastructure for the CSHCN population. Program funding is used by Arkansas's Children's Special Services - CSS to build health care infrastructure and build community capacity to support CSS parents. Listed below are a few examples of contracts and subgrants, which support CSHCN services.

- The Community-Based Autism Liaison and Treatment Program trains in screening and diagnosing developmental delays and disabilities.
- Arkansas Disability Coalition's F2F Health Information Center provides peer-to-peer mentoring and training for CSHCN families.
- Project Delivery of Chronic Care (DOCC) trains CSHCN parents as teachers and provides medical residents with insight to working with CSHCN and their families.
- The Arkansas Parent Advisory Council (PAC) provides leadership opportunities to CSHCN parents and supports parent engagement.
- The Leadership Education in Neurodevelopmental Disabilities (LEND) explores, develops, and evaluates ways to address medically, socially, and economically interrelated health/developmental needs of CSHCN and their families. LEND lectures are attended by Title V staff to increase their knowledge and skills in supporting CSHCN and their families.

III.A.3. MCH Success Story

This year's success stories represent how the Arkansas MCH programs assisted mothers and CSHCN through coordinated care, family-centered, and community-based services.

CSS Story #1: A child diagnosed with Osteogenesis Imperfecta was too heavy to be lifted safely from his wheelchair into the family van's regular factory seat. The mother contacted a Title V Case Manager to inquire about an adaptive seat for her vehicle. The Case Manager coordinated access to funds through the Title V Assistance Program and through the Children's Charity. Title V paid 75% and the Children's Charity paid 25%. The Children's Charity is funded to address the needs of children locally and internationally. With the help of both agencies, the parents received a vehicle conversion for the adaptive seat at no cost. The child was able to safely transfer himself from his wheelchair to the adaptive seat with minimal assistance. The child stated, *"I feel like X-man in this thing".*

The child's quality of life, well-being, and independence improved greatly by having the proper equipment. Furthermore, the risk of injury to the child and his parents was reduced significantly.

CSS Story #2: A child with multiple diagnoses (autism spectrum disorder, oppositional defiant disorder, speech apraxia, epilepsy) was referred to F2F by Juvenile Court. The child also had multiple placements after his maternal grandmother (primary caretaker) died. Finally, the child went to live with his father who was a recovering addict and the paternal grandmother. The child enrolled in a local school, but the child's disruptive behaviors caused additional problems.

Upon the F2F Specialist initial visit, the father was assisted with completing the Community and Employment Services (CES) waiver application. Multiple life changing events contributed to an increase of troubling behavior such as hurting a family member and destroying the grandmother's home. Ultimately, the family and F2F Specialist collaborated with DHS and Family in Need of Services (FINS) to obtain acute placement at ACH. The child was later placed in Conway Human Development Center (CHDC).

The family-centered community care team (DHS, FINS, F2F, CHDC) collaborated and developed a plan for the child to be reunited with his father. The father and grandmother now have regular unsupervised visits with the child. The father has remained sober for two years and is employed full-time. He is also working to secure housing.

The F2F Specialist attributes the family's progress during this difficult season to the reunification team and other organization's coordinating care for the child and his family.