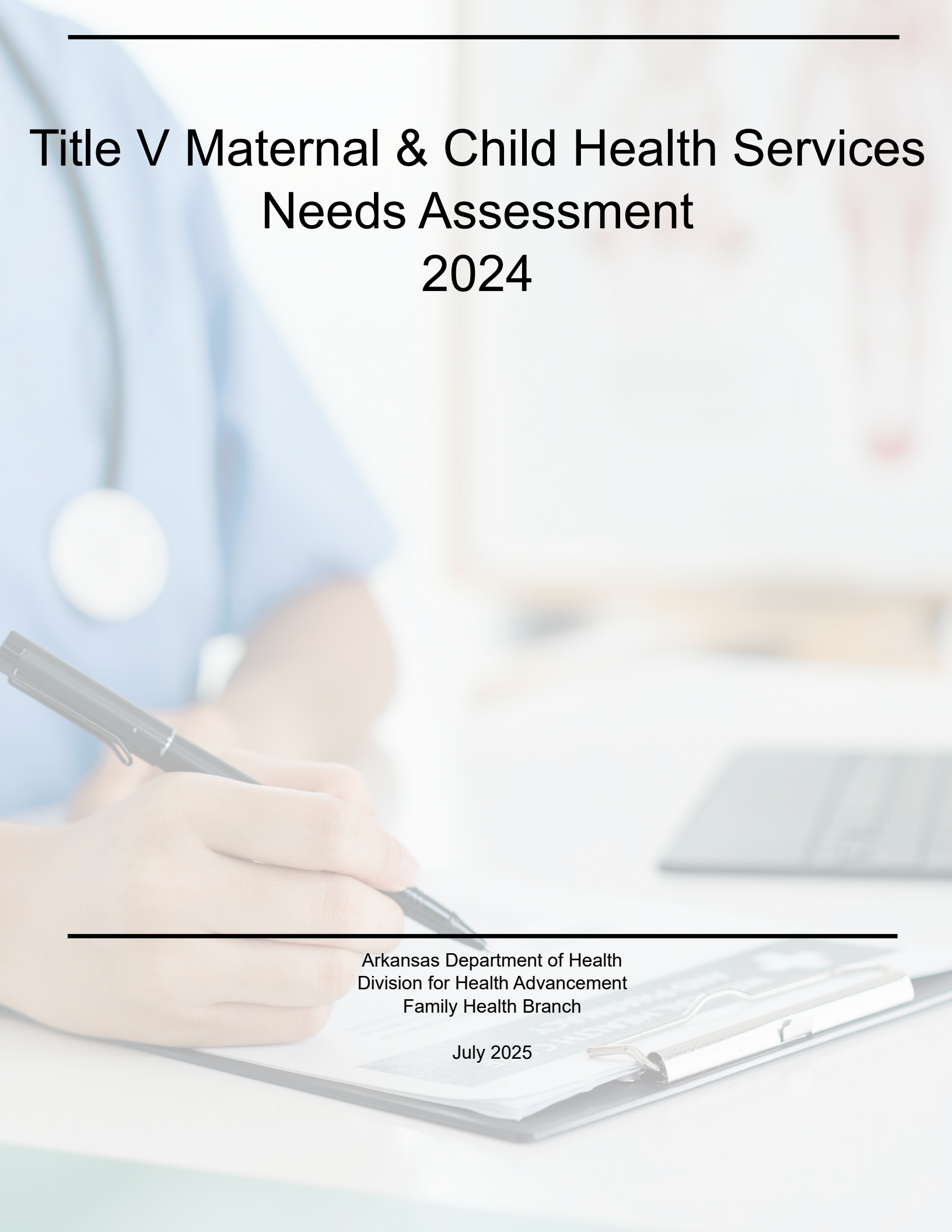
Title V Maternal & Child Health Services Needs Assessment 2024



Arkansas Department of Health
Division for Health Advancement
Family Health Branch

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A. INTRODUCTION

The Title V Maternal and Child Health (MCH) Services Block Grant to States Program (hereafter referred to as the MCH Block Grant) is authorized by Sections 501-509 of Title V of the Social Security Act (42 U.S.C. §§ 701-709). The formula grant funds are awarded to 59 states and jurisdictions that address the health services needs within a state for the target population of mothers, infants and children, which include infants, and children with special health care needs (CSHCN), and their families.

Through the MCH Block Grant, Arkansas promotes the development and coordination of systems of care for the MCH population, which are family-centered, community-based, and culturally appropriate. As defined in section 501(a)(1) of the Title V legislation, the purpose of the MCH Block Grant is to enable Arkansas

- To provide and to assure mothers and children (those with low income or with limited availability of health services) access to quality MCH services.

- To reduce infant mortality and the incidence of preventable diseases and handicapping conditions among children, to reduce the need for inpatient and long-term care services, to increase the number of children (especially preschool children) appropriately immunized against disease and the number of low income children receiving health assessments and follow-up diagnostic and treatment services, and otherwise to promote the health of mothers and infants by providing prenatal, delivery, and postpartum care for low income, at-risk pregnant women, and to promote the health of children by providing preventive and primary care services for low income children.

- To provide rehabilitation services for blind and disabled individuals under the age of 16 receiving benefits under Title XVI, to the extent medical assistance for such services is not provided under Title XIX.

- To provide and to promote family-centered, community-based, coordinated care (including care coordination services, as defined in subsection (b)(3) for children with special health care needs and to facilitate the development of community-based systems of services for such children and their families.

The enclosed report documents the need assessment process, findings, and priority needs of Arkansas. This report provides helpful insights about statewide efforts, barriers, and data affecting mothers, children, infants, and children with special health care needs (CSHCN), and their families.

B. EXECUTIVE SUMMARY

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. keynote

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 (DHS) 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 the 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 systems 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 systems 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 systems 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.

Table 2: Priority Needs from 2021-2025 and 2026-2030 State Action Plan

Women/Maternal **2021-2025 Priority Needs:** 1) Well Woman Care, 2) Oral Health during Pregnancy **2026-2030 Priority Needs:** 1) Postpartum Care - **NEW** **Rational for Change:** This new priority need emphasizes the strong focus on ensuring women have quality visits assessing maternal recovery, addressing chronic health conditions, supporting mental health, and providing guidance on family planning. This change aligns with current MCH strategic plan initiatives and legislation in the state and nation.
Perinatal/Infant **2021-2025 Priority Needs:** 1) Persistently High Infant Mortality Rate, 2) Access to Care **2026-2030 Priority Needs:** 1) Persistently High Infant Mortality Rate - **CONTINUED**, 2) Developmental Screening - **REVISED** **Rational for Change:** The priority need "Access to Care" was retitled to "Developmental Screening" to more accurately reflect the public health issue being addressed.
Child **2021-2025 Priority Needs:** 1) Developmental, Behavioral and Mental Health of Children (developmental screening), 2) Child Safety Due to Intentional Injury (hospitalizations rate), 3) Physical Activity **2026-2030 Priority Needs:** 1) Physical Activity – **CONTINUED**, 2) Access to Care (medical home) - **NEW** **Rational for Change:** Access to a medical home providing components of recommended care was a common theme in the needs assessment across all domains. Adding this priority needs to be aligned with other MCH partner strategic plans.
Adolescent **2021-2025 Priority Needs:** 1) Physical Activity, 2) Child Safety due to Intentional Injury (bullying), 3) Transition to Adulthood, 4) Access to Care (use of nicotine products among youth) **2026-2030 Priority Needs:** 1) Child Safety Due to Intentional Injury/Bullying – **REVISED**, 2) Tobacco Use – **REVISED** **Rational for Change:** The two 2026-2030 priority needs were retitled to better convey the public health issues facing adolescents in the state.
CSHCN **2021-2025 Priority Needs: 1)** Transition to Adulthood, **2)** Access to Care **2026-2030 Priority Needs**: **1)** Transition to Adulthood - **CONTINUED**, **2)** Access to Care - **CONTINUED** **Rational for Change:** No change.

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 work 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 family income beginning the 2025-2026 school year.

The Arkansas Home Visiting Network (AHVN) works with several agencies including Arkansas Center for Health Improvement (ACHI), ADH, Arkansas Advocates for Children and Families, and the Arkansas Chapter of American Academy of Pediatrics to help identify activities and strategies to help reduce health differences of Arkansas families. The Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) AHVN also works closely with Delta Dental and Arkansas Blue Cross Blue Shield through the Natural Wonders Partnership Council (NWPC) to address health differences at a system level, including disseminating medical and dental resources, insurance information, and public assistance options to MIECHV families. The AHVN assists MIECHV-funded models in reducing health differences by providing training and technical assistance designed to improve awareness 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, offer training classes for prospective resource parents, relative caregivers, and individuals interested in adopting children in custody of the Arkansas Division of Children and Family Services (DCFS). The training is designed to help resource/adoptive parents understand the challenges and rewards of rearing abused or neglected children. Also, the Arkansas Women, Infants 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 seek 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, several bills were passed to promote the health and well-being of mothers, infants, and children.

- **Act 123**: Ensures that all public-school students receive free school breakfast regardless of their family income beginning the 2025-2026 school year.
- **Act 140**: Healthy Moms, Healthy Babies changed Medicaid regulations to make prenatal care more accessible through presumptive eligibility and reimbursement for expanded services
- **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.
- **Act 868**: Creates a comprehensive statewide system of care (Maternal Outcomes Management System) to address maternal health research/resources; inclusive of establishing grant program for birthing and delivery hospitals.

Lastly, the ongoing challenge facing MCH is the difficulty hiring qualified candidates due to the competitive pay to secure high-quality employees. The 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.

C. NEED ASSESSMENT

I. Process Description

In 2024, the collaborative MCH leadership departments (ADH Family Health Branch and DHS CSS) contracted with the University of Arkansas at Little Rock (UALR) School of Public Affairs Survey Research Center (SRC) to collect quantitative and qualitative data from internal and external stakeholders (inclusive of family agencies) for the MCH Five Year Comprehensive Needs Assessment.

The MCH leadership team is composed of the MCH Director; CSHN Director Domain Leads for Women's Health, Child and Adolescent Health, Perinatal and Infant Health, CSS; and the MCH Epidemiologist. This team participated in the MCH needs assessment process with UALR SRC. The domain leads identified stakeholders based on their knowledge of key health areas and partnering activities that support each domain.

The stakeholder's engagement 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." Stakeholder engagement tools include surveys, focus groups, and stakeholder meetings.

Arkansas employed a priority-setting process that incorporated stakeholder input, community-identified issues, and data findings. MCH stakeholders, including community groups, individuals, and family organizations, were invited to participate in the needs assessment stakeholder survey and focus groups. Community-based or non-profit organizations and parent/guardians accounted for more than 30% of survey participants. The Title V Leadership Team and MCH partners discussed needs identified from survey, focus group, interview findings and selected priority needs and national/state performance measures.

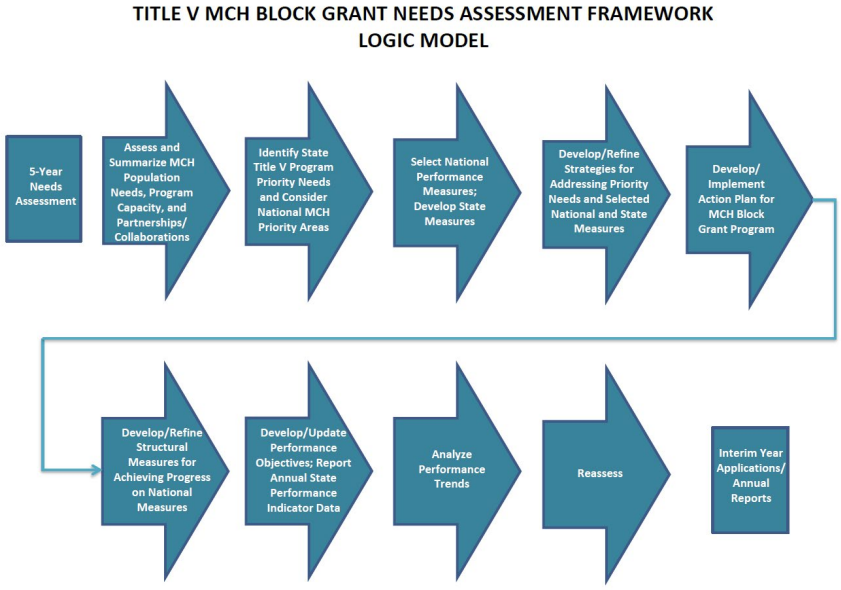
The Arkansas Title V program embraced a collaborative approach to planning, implementation, and evaluation**.** The MCH team worked alongside partners to align identified priorities with ongoing initiatives and service systems. Data findings and stakeholder input were used to inform performance measures and guide the development of strategies within the State Action Plan. The Title V Leadership Team participate on several MCH workgroups, community organizations, and partnerships, thereby keeping a strong pulse on MCH-related programs, activities, and grants throughout the state. Refer to the "Title V Program Partnerships, Collaboration, and Coordination" section (III.C.1.b.iii) and the "Family and Community Partnerships" section (III.C.1.b.iv) for a more detailed description. The Title V Director and domain leads works actively to engage with MCH stakeholders and partners to work collaboratively on current initiatives, and to develop, plan, and implement projects. For example, the

Arkansas Department of Health's 2024-202 Strategic Plan prioritizes women and maternal health as one of its five focus areas. The Women's Health and Maternal Health Workgroup represents several levels and departments of the agency, including the Arkansas Secretary of Health and other agency leadership, women's health program, health disparities elimination program, statistics, and epidemiology. These programs work together with agency support to implement multi-prong strategies outlined in the strategic plan to improve the health of women before, during, and after pregnancy. Title V and its partners assess and evaluate activities periodically to monitor implementation, to identify barriers and resolve challenges, and to determine program effectiveness. Program data and feedback are used in continuous quality improvement efforts to ensure desired program outcomes are achieved.

The goal of the MCH five-year needs assessment was to gather feedback about state, regional, and local programs and services related to improving the health and well-being of Arkansas families. The qualitative and quantitative data was used to learn about current health concerns, emerging needs, strategies, interventions, and gaps in services for all MCH populations: women, including women of childbearing age and pregnant women, infants, children, and adolescents with and without special health care needs. The data also helped identify and map existing programs and services that inform statewide strategic planning and resource allocation essential to improving services.

As depicted by the MCH logic model below, NPMs and SPMs were identified based upon the comprehensive need assessment findings, which were supported by secondary data sources. The MCH team selected seven NPMS and two SPMs, which aligned with the priority needs of the MCH population health domains.

The selection of the NPMs and SPMs led to the development of the State Action Plan to develop strategies and overarching five-year objectives to address the priority needs areas.



The MCH logic model framework (above) guided the methodology of the data collection process. From August 2024 through December 2024, data was captured through the following methods: 1) web-based survey, 2) focus groups, 3) one-on-one interviews, and 4) secondary data resources. These quantitative and qualitative methods were used to assess the strengths and needs of the MCH population in each of the five identified population health domains, MCH program capacity, and supportive partnerships/collaborations. The web-based survey was created in collaboration with the UALR SRC and ADH. The survey was reviewed and approved by the UALR IRB – Protocol 24-046-R2, August 2024.

1) **Web-based Survey:** Introductory emails were sent to potential participants prior to the distribution of the web-based survey (qualitative/quantitative). The survey was distributed via email utilizing Qualtrics platform from a preferred stakeholders list from each domain. At the end of the survey, participants had the option to participate in a domain focus group. The survey response rate calculated using the AAPOR RR1 formula was 39.15% (101).
    - Survey's Sent: 260
    - Ineligible Responses: 2 (either not 18 years of age or declined)
    - Eligible Surveys Sent: 258
    - Completed Surveys: 101

2) **Virtual Focus Groups:** Focus group participants volunteered via the web-based survey. No incentives were offered to participants. Five virtual focus groups were conducted via Zoom: one focus group for each MCH domain topic. The focus groups were audio recorded and transcribed verbatim via Zoom and Otter.ai. Transcripts were coded manually, analyzed by a single coder, using an inductive approach to determine major themes, subthemes, and exemplary quotes.

3) **One-on-One Interviews:** Nine key informant interviews were conducted with MCH domain leads and ADH/DHS staff. Interviews were audio recorded and transcribed verbatim via Zoom and Otter.ai. Transcripts were coded manually, analyzed by a single coder, using an inductive approach to determine major themes, subthemes, and exemplary quotes.

4) **Secondary Data Resources:** Secondary data sources were utilized to help identify population needs and strategies to support NPMS and SPMs. Documents noted in the MCH Needs Assessment included the Federally Available Data (FAD) Resource Document, the MIECHV 2020 Needs Assessment, the 2022 ACH Community Needs Assessment, and the 2024-2029 ADH Strategic Plan. Other state data utilized included Vital records, Pregnancy Risk Assessment Monitoring System (PRAMS), Medicaid, WIC, and Behavioral Risk Factor Surveillance System (BRFSS).

Table 3: Data Collection Engagement Type

Group	Engagement Type
Web-Based Survey	State/Local Healthcare Organizations, Community-Based Organizations, Non-profit Organizations, Parents and Guardians, University/Academic Institutions, and Others
Focus Groups	Arkansas Advocates for Children & Families, Arkansas Center for Health Improvement, Arkansas Children's Hospital, Arkansas Department of Health Office of Health Disparities Elimination (OHDE), UAMS Audiology, UAMS Pediatrics, Arkansas Autism Partnership, Department of Human Services (DHS) Children's Special Services, Arkansas Disability Coalition, ADH School Health Services, ADH Immunizations and Child Health Programs, Northwest AR Educational Cooperative, Arkansas Center for Health Improvement, Southwest AR Educational Cooperative, and Arkansas AWARE
One-on-One Interviews	Key Informants: Several ADH and DHS offices along with sub-offices, including Newborn Screening; School Health; Title X Family Planning; Maternity; DHS Children's Special Services; Licensed Lay Midwifery; Maternal Mortality Review Committee and Maternal, Infant, and Early Childhood Home Visiting

Quantitative and qualitative methods were used to assess the strengths and needs of the MCH population in each of the five health domains. A web-based survey was created in collaboration with the UALR Survey Research Center and the Arkansas Department of Health. For each of the MCH population domains, survey questions asked about priority health concerns, existing interventions and opportunities for new strategies, gaps and pressing needs, weaknesses and strengths of the current public health system, and emerging health concerns. The survey employed both close-ended and open-ended questions.

Key MCH stakeholders across the state were identified for each domain, and participants were asked to share the survey link with others who would be able to provide input on the health needs of Arkansas mothers and children. The survey response rate was 39.2% out of 258 eligible participants who completed the survey after the initial email was sent on August 7, 2024, and the final reminder email was sent on October 7, 2024. Respondents were based in 20 of the 75 counties across Arkansas, but they provided services and healthcare for all 75 counties across the state. Respondents represented a diverse range of groups, including healthcare professionals (28.6%), state or local public health organizations (25.7%), community-based or nonprofit organizations (24.3%), parent/guardians (7.1%), university or academic institutions (4.3%), and "other" (10.0%). The survey was distributed via email utilizing the Qualtrics platform in August 2024. Multiple survey reminders were sent, and domain leads also reached out to their stakeholder groups to encourage them to complete the survey.

The research team conducted 5 virtual focus groups via Zoom, with one focus group covering each MCH population domain. Participants were recruited from the initial Qualtrics survey with a question asking if they would be interested in giving additional feedback in a follow-up discussion. Survey respondents who indicated their interest were contacted via email. In total, 17 individuals participated. Focus groups were audio recorded, and recordings were transcribed verbatim via Zoom and Otter.ai. Transcripts were coded manually and analyzed to determine major themes, subthemes, and exemplar quotes. This was done by a single coder, using an inductive approach.

The research team also conducted virtual interviews with internal ADH staff via Zoom. Participants were nominated by ADH based on their level of knowledge on maternal and child health issues in Arkansas and oversight of key health areas within the health domains. Overall, 9 interviews were completed by the research team. Interviews were audio recorded, and recordings were transcribed verbatim via Zoom and Otter.ai. Transcripts were coded manually, and analyzed by a single coder, using an inductive approach to determine major themes, subthemes, and exemplary quotes.

Data sources were utilized to inform the needs assessment process. Aside from the web-based survey, focus groups, and interviews, data from a multitude of sources were used to inform the needs assessment process, some of which are listed below:

- U.S. Census Bureau – population, demographics, and socioeconomic data
- CDC WONDER – natality, mortality, infant deaths, and population files
- Arkansas Health Statistics – birth and death records
- ADH local health unit data – family planning and maternity clinics
- Arkansas Maternal Mortality Review Committee
- Behavioral Risk Factor Surveillance System (BRFSS)
- Pregnancy Risk Assessment Monitoring System (PRAMS)
- Women, Infant, and Children (WIC)
- Maternal, Infant, and Early Childhood Home Visiting (MIECHV)
- National Immunization Survey (NIS)
- Infant Hearing Program / Early Hearing Detection and Intervention (EHDI)
- National Survey of Children's Health (NSCH)
- Youth Risk Behavior Surveillance System (YRBSS)
- Title V Children's Special Services

The need assessment findings and state data helped to determine and address gaps between current conditions and projected outcomes. The Title V needs assessment aims to identify key health issues affecting women and children, as well as the resources available to address these challenges. The interface between the collection of Needs Assessment data, the finalization of the state's Title V priority needs, and the development of the State's Action Plan began with data collection. Data collected from the needs assessment survey, focus groups, interviews, and other data sources were analyzed and eight priority need areas were identified for the next five-year reporting cycle. Title V selected national performance measures (NPM) and developed state performance measures (SPM), evidence-based or -informed strategic measures (ESM), and 5-year objectives to create the State Action Plan. By gathering data from various

stakeholders and employing evidence-based methodologies, Title V established a clear understanding to identify the priority areas for the Five Year (2026-2030) State Action Plan. Refer to “Identifying Priority Needs & Linkage to Performance” section (III.C.1.c) for more details.

II. FINDINGS

II.A. MCH Population Health and Well Being

Women/Maternal Health: Focus groups and interviews participants commended the state's ability to provide essential services for women despite limited funding, with one respondent praising their resilience. A particular success has been the widespread availability of same-day insertions for long-acting reversible contraception (LARC), which ensures timely access to effective contraceptive options. Additionally, public health campaigns, especially those distributed via social media have helped raise awareness about women's health issues. Campaigns like the CDC's "Hear Her" were recognized for enhancing the public's understanding of topics ranging from contraception to broader health concerns.

Survey respondents acknowledged several strengths within Arkansas's current public health system for women of childbearing age. The Arkansas Department of Health (ADH) and local health units offer a wide range of services, with programs such as WIC, SNAP, and Medicaid playing a central role in supporting maternal and child health. Initiatives like mobile healthcare units, expanded women's services, and the integration of midwives and doulas reflect a growing commitment to comprehensive maternal care. County-level access and enhanced outreach efforts have improved service delivery, particularly where community-based organizations and public health nurses are involved. Additionally, collaborative networks such as information sharing between WIC and other ADH programs help to identify and support families that might otherwise fall through the cracks. While women in urban and suburban areas with insurance generally experience better access, the existing infrastructure provides a strong foundation for broader systemic improvements.

However, several pressing needs were consistently emphasized. Survey participants were asked to identify the three most important public health problems affecting Arkansas women of childbearing age and pregnant women. The most frequently mentioned problems were mental health disorders, access to insurance and/or healthcare costs, and lack of access to early and adequate prenatal care. Other notable concerns included being overweight or obese, maternal mortality, and teen pregnancy. Additionally, issues like illicit drug abuse, lack of access to reproductive health services, and unintended pregnancy were highlighted. A dominant concern shared during the focus groups and interviews was the significant shortage of maternal healthcare providers across the state, with entire counties classified as maternal care deserts. The March of Dimes' report *Where You Live Matters: Maternity Care in Arkansas* shows 45.3% of Arkansas counties are defined as maternity care deserts compared to 32.6% in the nation. Fifteen percent of Arkansas births are born in maternity care deserts. Transportation barriers, especially in rural areas, further complicate access to care, with stories of missed appointments due to rigid Medicaid transportation rules or the inability to bring additional children.

Postpartum women were identified as a particularly underserved population with many unable to access necessary mental health services, follow-up care, and support for postpartum health. Respondents highlighted the gaps in Medicaid coverage and a lack of emphasis on maternal mental health in postnatal care. Although Medicaid covers 50-60% of all pregnancies in Arkansas annually, many women lose Medicaid coverage shortly after giving birth, leading to stress and potential health risks. Currently, Arkansas coverage under Medicaid ends at 60 days postpartum. PRAMS data show the percentage of women who attended a postpartum checkup within 12 weeks after giving birth has steadily dropped from 88.3% in 2020 to 84.3% in 2023. Women with lower educational attainment (less than high school education=63.5%, college graduate=96.8%), Medicaid insurance (Medicaid=76.1%, private=91.1%), younger ages (<20 years=81.8%, 20-24 year=79.6%, 30-35 years=90.1%), or Black race (71.1% v. White= 89.3%) were less likely to attend a medical visit within a year of giving birth. Regardless of educational attainment, insurance status, and race, women do not receive all the recommended components of care at postpartum visits, where contraception, maternal warning signs, and depression counseling and screening should occur. Among those who attended postpartum visits, less than 7 out of 10 women (68.6%) received all recommended components in 2023. Women with higher education (college graduate=61.0%), private insurance (65.1%), older ages (30-34 years=61.0%, ≥35 years=64.1%), White race (67.5%), in urban areas (66.0%), and not enrolled in WIC (63.3%) were less likely to receive a comprehensive postpartum visit. Data from the Arkansas Maternal Mortality Review Committee's 2024 annual report shows that the majority (70%) of pregnancy-related deaths occur within 365 days after giving birth. Half of these deaths occur within the first 42 days.

To address these needs, participants proposed several strategies. Chief among them was increasing Medicaid reimbursement for both physicians and doulas, which would help stabilize rural healthcare access and support non-clinical providers. Community-based models, including the use of certified nurse midwives, social workers, and patient navigators were identified as essential in reaching underserved populations. Mobile maternal health units were seen as promising, but only if deployed with community trust and buy-in. When asked to prioritize a single area of reform, respondents highlighted the need for comprehensive sex education, the extension of postpartum Medicaid coverage to one year, and greater support for community-based birth workers.

In March 2024, Arkansas Governor Sarah Huckabee Sanders signed the Executive Order to Support Moms, Protect Babies, and Improve Maternal Health. Stakeholders from across the state collaborated to develop new policies, program, and approaches to improve health outcomes for pregnant women, new moms, and babies. The Committee released a report, *Healthy Moms, Healthy Babies,* and in February 2025, Governor Sanders signed House Bill 1427 ("Healthy Moms, Healthy Babies Act") into law. The act strengthens maternal care in Arkansas by unbundling global payment, increasing provider reimbursements, and expanding access to telemedicine. It establishes Presumptive Medicaid eligibility for pregnant women, increased Medicaid reimbursement rates to help providers fill coverage caps and offers reimbursement for doulas and community health workers services. The Arkansas Department of Health

has made women and maternal health a priority in its 2024-2029 ADH Strategic Plan, specifically targeting maternal mortality, health care before and during pregnancy, overweight and obesity before pregnancy, and access to healthy foods.

Perinatal/Infant Health: When asked about the strengths of Arkansas's current public health system for perinatal and infant care, focus group and interview participants praised programs like the Women, Infants, and Children (WIC) Program, newborn screening, Medicaid, home visiting programs (like MIECHV), and the infant hearing screening program. A commonly cited strength was the state's efficiency in conducting newborn screenings. Participants commended the quick turnaround and consistent performance across the state, with one noting that most blood spot samples are received within 48 hours—a benchmark seen as indicative of a strong, responsive system. Additionally, breastfeeding awareness and support services have increased, including significant rises in the use of breastfeeding helplines, attributed to broader education and outreach efforts. Local health units and dedicated professionals in the field were seen as assets, with respondents noting the compassion, knowledge, and commitment of public health staff. The existence of community taskforces and a shared focus on improving perinatal care were also mentioned as hopeful indicators of progress.

Despite these gains, Arkansas continues to face high infant mortality rates, particularly in rural areas with limited provider access. Participants expressed concern over inadequate provider capacity and a lack of specialized training for infant care in many rural hospitals. In some cases, infants are transported out of town not because of acute medical need, but due to a lack of skilled staff or equipment. Providers noted that many nurses and therapists in community hospitals are not comfortable managing infant cases, especially those requiring respiratory support. A shortage of lab services in rural areas compounds these challenges. Facilities often lack trained staff in pediatric phlebotomy and must send samples out of state for rare disorder testing, delaying results and complicating care coordination. Transportation barriers further inhibit timely access to care, particularly for families in rural communities without reliable vehicles or gas money. Another significant concern was low Medicaid reimbursement rates, which participants said disincentivize pediatric practice and contribute to provider shortages. Pediatricians reported spending critical time with parents to address needs and maternal well-being tasks that are not adequately reimbursed under current Medicaid structures. This issue, combined with the rising costs of newborn screenings, has placed a financial strain on providers and institutions alike. There was also a noted lack of parental education around newborn screenings. Participants observed that many families are unaware of what the screenings entail or how to respond if their child fails one. Similarly, the number of birthing hospitals with up-to-date safe sleep certifications has declined, reducing the effectiveness of safe sleep education and advocacy.

When asked to identify the most pressing public health problems facing Arkansas's perinatal and infant populations, survey respondents revealed several areas of greatest concern, particularly access to the WIC Program, care coordination through a medical home, and access to lactation experts and breastfeeding education and support. Other

notable concerns included access to family-to-family support, health insurance availability, and premature delivery. Additional barriers such as difficulty navigating health/public systems, shortages in healthcare providers, and the need for safe sleep interventions also surfaced. Though some respondents selected more specialized concerns like poor nutrition, sudden unexpected infant deaths, or post-neonatal mortality, these were less frequently chosen, indicating a shared focus on access and structural supports as foundational issues. The interim needs assessment conducted last year showed premature delivery, unsafe sleep practices, and breastfeeding were strong concerns among participants.

In 2023, Arkansas ranked second in the nation for its high infant mortality rate, which increased from 7.67 deaths per 1,000 in 2022 to 8.22 in 2023 (CDC WONDER linked birth/infant death records). Arkansas also ranked second highest in the nation for sudden unexpected infant death (SUID) between 2018 and 2022. Sudden infant death syndrome (SIDS) is the second leading cause of infant deaths in Arkansas, after birth defects. The *2024 Arkansas Infant and Child Death Review Annual Report* reported that the majority of infant deaths were classified as SUID and asphyxiation due to an unsafe sleep environment. This includes co-sleeping in an adult bed and/or the infant being placed to sleep on their side or stomach. Providing a safe sleep environment for babies can help to reduce the risk of sleep-related infant deaths, such as SIDS and accidental suffocation. While 71.1% of Arkansas mothers place their babies on their back to sleep, this practice is lower among mothers with lower education (less than high school=56.2%) and Black and Hispanic mothers (56.0%, 62.5%). Fewer than 30% of Arkansas mothers lay their babies to sleep on a separate approved sleep surface, and the risk is higher among babies born to mothers with lower education (less than high school=10.5%), Medicaid insurance (20.8%), older age ($\geq$35 years=17.6%), and Hispanic ethnicity (19.8%).

Child Health: Stakeholders participating in interviews and focus groups noted several strengths and recent improvements in child health services affecting children ages 1-11 years of age. Primarily, the state has seen progress in increasing the number of well-child visits, a vital preventive measure that supports early identification of developmental and health concerns. Participants also praised efforts in oral health, highlighting successful initiatives like the Arkansas Department of Health's oral health clinic and the mobile dental units operated by Arkansas Children’s Hospital, which have expanded access to care in underserved areas. Urban areas such as Northwest, Central, and Northeast Arkansas were frequently highlighted as having strong services and greater access to care. School-based health clinics and local health units were commended for providing accessible and routine care, especially in the areas of immunization and vaccinations. Specific programs such as Vaccines for Children (VFC), WIC, and early hearing detection and intervention were recognized as effective public health initiatives. Participants also acknowledged efforts to connect children to resources, improvements in school-based healthcare access, and the presence of compassionate, culturally effective care in some areas. Additionally, several responses mentioned outreach efforts and a variety of available resources, as well as the coverage offered under the Affordable Care Act for essential pediatric services.

Despite improvements, several pressing challenges persist. A critical concern voiced by participants was the ongoing shortage of healthcare providers, particularly pediatricians and home visiting staff. This shortage delays diagnoses and care continuity for children, especially in rural and high-need areas. Home visiting programs, which provide vital support to at-risk families, are especially affected by staffing turnover and low wages. While many staff are dedicated and passionate, the lure of higher-paying opportunities often draws them away, undermining program stability and effectiveness. Low Medicaid reimbursement rates were another common issue. Participants emphasized that pediatrics, focused heavily on prevention, is often undervalued in the reimbursement structure, which disincentivizes providers from taking on Medicaid patients. This issue is compounded by complex Medicaid enrollment processes that present barriers for families, particularly those with limited literacy or language proficiency. Participants stressed the need for targeted outreach to underserved areas and in-person translation services, especially in rural areas.

Survey respondents were asked to identify what they believe are the three most pressing public health problems currently impacting children in Arkansas. Respondents cited mental health, developmental delays, and obesity as pressing issues. The needs assessment identified the Early Hearing Detection and Intervention (EHDI) Program and developmental monitoring and screening as key strategies for improving children's health, both of which play critical roles in identifying and addressing developmental issues at an early stage. Findings highlight the need for increasing the number of children who do not pass their hearing screening and need timely follow-up diagnostic evaluation. The Infant Hearing Program (IHP) has made great strides in working towards the EHDI 1-3-6 benchmarks, which guide timely evaluation and intervention opportunities to support optional language development. The Joint Committee on Infant Hearing recommends all infants that do not pass the initial screening receive a confirmatory diagnosis by three months of age and enrollment in Early Intervention (EI) by six months of age if identified as Deaf/Hard of Hearing (DHH). The state's provisional data for 2024 indicates an increase in the percentage of children that received a diagnostic evaluation by three months of age after not passing the hearing screening. The program examines screening, diagnostic, and early intervention data to identify and address at-risk geographic areas, underserved segments of the population, and barrier to timely follow-up after not passing the hearing screening.

In 2020, one in eight (13.1%) Arkansas children aged 2 through 4 years enrolled in the WIC Program were classified as being obese. Data from the 2022-2023 National Survey of Children's Health (NSCH) shows one-fourth of all children ages 6 through 11 years and one-fifth of adolescents aged 12 through 17 were obese. Physical activity plays a vital role in preventing obesity in children and adolescents and reducing the risk of obesity in adulthood. Physical activity levels among Arkansas children have not improved over the past several years (NSCH 2018-2019=29.6% physically active at least 60 minutes per day, 2022-2023=27.2%). Children with special health care needs (CSHCN=23.4%) and children whose parents have a college degree (18.3%), have private insurance (18.1%), higher incomes (200-399% FPL=19.8%), and White race (25.6%) were less likely to meet the physical activity guidelines.

Other concerns mentioned as the most important public health problems facing children include limited access to care coordination via a medical home, as well as insufficient availability of parental education and family-to-family support. In 2022-2023, fewer than half of children in the state had a medical home (45.3%). At-risk populations less likely to report having a medical home providing all components of recommended care include CSHCN with any functional limitations (32.9%) and children whose parents have lower education (less than high school=22.4%, HS graduate=30.4%), no insurance or Medicaid (24.6%, 37.6%), low-income (<100% FPL=31.5%), single-parent household (32.6%), and of Hispanic, Asian, or Black ethnicity or race (29.4%, 31.6%, 34.4%).

In response to these challenges, participants proposed several strategies to improve child health access and outcomes. Increasing pay for home visitors was identified as essential for retaining skilled staff and sustaining high-quality services. Additionally, some recommended developing internship pipelines and engaging semi-retired healthcare professionals to fill critical workforce gaps. These approaches could help alleviate provider shortages while fostering mentorship and practical training for future healthcare workers. Participants also provided several practical suggestions to improve the public health system of care for Arkansas children. Expanding school-based health clinics to serve as medical homes and managing case coordination was a prominent recommendation. Improving access by extending clinic hours to evenings and weekends was mentioned repeatedly, as was reducing wait times for insurance programs. Transportation remains a persistent barrier, and respondents have urged more options to help families reach appointments. Calls for greater outreach, particularly to rural and underserved areas were frequent, with suggestions for increased staffing, better training for public health professionals, and targeted funding to enhance statewide reach. Respondents also emphasized the importance of marketing and awareness campaigns to educate families about available resources, alongside improved federal and state data collection on children's healthcare access and outcomes to drive policy changes and system improvements.

Adolescent Health: Focus group and interview participants highlighted recent strengths and improvements in adolescent health systems. One notable advancement was the reduction of stigma surrounding mental health, with more open conversations occurring among students and families. Additionally, the growth of school-based health centers was recognized as a positive trend, including those developed without state grants. A robust school nurse network was also praised for facilitating fast, coordinated responses to public health concerns. Many survey respondents also pointed to the existence of school-based health services, tobacco prevention programs, and access to family planning services at Local Health Units (LHUs). Some also noted that a compassionate workforce and free or low-cost services help reduce barriers, though awareness of these services remains a hurdle. A few respondents commended policy shifts and efforts made to improve adolescent health, even while acknowledging those efforts may not yet be sufficient.

Participants identified several key factors necessary for helping adolescents aged 12–17 live their fullest lives, particularly those without special health care needs. Foremost

among these was access to mental health support. Participants emphasized the need for comprehensive services to help youth manage stress, trauma, and emotional regulation. Special attention was drawn to preventive interventions for adverse childhood experiences (ACEs) and targeted support for vulnerable populations such as those aging out of foster care. Empowering adolescents with coping strategies and emotional intelligence was considered essential for promoting long-term mental wellness and resilience. Access to mental health services was described as severely lacking due to workforce shortages, high co-pays, and inadequate program funding. Many schools offer mental health services, but participants noted that the quality and accessibility vary widely. Similarly, provider shortages and low Medicaid reimbursement rates were seen as obstacles to accessing healthcare more broadly, especially for adolescents in rural areas.

The most significant public health problems affecting adolescents in Arkansas, as identified by survey respondents, are primarily related to mental health issues. These include depression, anxiety, and other related conditions, which were cited by many participants. Students who are bullied are more likely to experience mental health issues such as depression, anxiety, and feelings of sadness and loneliness. About one in three adolescents (NSCH 2022-2023=36.8%) reported being bullied, an increase during the last several years (2020-2021=30.5%, 2021-2022=33.4%). At particular risk are CSHCN (55.7%), especially those with elevated service need (66.2%).

Being overweight or obese and peer influence also emerged as major concerns, with each accounting for a notable percentage of responses. Other challenges include poor nutrition, illicit drug use, and tobacco use, including vaping. Almost one in four Arkansas adolescents (23.7%) self-reported on the 2023 YRBS to be using tobacco. Tobacco uses dramatically increases among 12th graders (42.3%) compared to other grades (9th-11th=18%).

In response to challenges, participants proposed several strategies. Expanding telehealth services for mental health was seen as a promising solution for increasing access, especially in underserved regions. There was strong support for high-quality pre-K programs that teach emotional regulation, with the hope of creating a foundation for healthier adolescent behavior. The need for comprehensive sexual health education was also emphasized, as students consistently reported inadequate information in this area. Lastly, stakeholders suggested collaborations with pharmacists to extend access to contraceptives and create referral systems that connect adolescents with health department services after their six-month prescriptions lapse.

CSHCN: Focus group and interviews highlighted the effectiveness of care coordination programs. Participants commended long-serving nurses and staff who actively assist families in navigating resources and accessing services, emphasizing their dedication and resourcefulness. Additionally, recent rebranding efforts and community events, such as the annual Family Bistro Conference organized by the Parent Advisory Council, have significantly increased public awareness of available support. This event draws stakeholders from across Arkansas and provides families with access to a wide range of

resources, presentations, and vendor information within the disability services realm. Medical advancements and policy shifts have further contributed to improved service delivery. Newborn hearing screenings now reach approximately 98% of infants, representing a substantial public health achievement. In the area of developmental health, changes to diagnostic policies have facilitated earlier and more efficient identification of autism, while revised rates for autism waiver staffing have enhanced the ability to serve rural communities by increasing provider competitiveness in smaller towns.

Despite these gains, several critical challenges remain. Chief among them is the need for enhanced parental education and peer-to-peer support, particularly for families of children newly diagnosed with conditions such as autism. Participants described families entering the diagnostic process with little understanding of the system, often feeling overwhelmed and without guidance. Peer support was seen as a key intervention to help families navigate complex service systems, including waivers, provider networks, and insurance requirements. Transportation emerged as another persistent barrier, especially for families in rural areas. Participants described situations where families were forced to choose between essential needs, such as food and medical appointments, due to travel costs. There was strong interest in expanding the use of mobile units to bring services closer to where families live. Access to respite care was also cited as a major issue. Even when families are given flexibility to choose and hire their own respite providers, finding individuals willing and available to deliver services remains a significant challenge. Another area of concern involved transition-age services. Participants noted that as children reach adulthood, typically between ages 18 and 21, they often lose access to vital therapies and support previously covered. Families are frequently unprepared for this transition, leading to urgent and disheartening situations where young adults lack services and support systems due to not being enrolled in relevant programs like the CES Waiver or vocational services.

Survey participants identified several critical public health problems impacting children with special health care needs (CSHCN) in Arkansas. The most frequently cited concern was the availability of transportation, followed closely by access to family-to-family support services and care coordination. Four out of ten CSHCN have a medical home that provides all recommended components. Trend data show the percentage of CSHCN in a medical home have consistently declined over the past few years (NSCH 2018-2019=49.4%, 2022-2023=41.9%). Younger CSHCN (0-5 years=35.7%) and those whose parents have a high school graduate degree (34.9%), Medicaid (36.4%), low-income (31.5%), a single-parent home (32.0%), or Hispanic or Black ethnicity or race (25.4%, 37.0%) were less likely to be in a medical home.

Other notable challenges included obtaining personal care services, accessing medical equipment or assistive technology, and securing access to primary and specialty care physicians. Additional issues, though less frequently mentioned, involved the availability of healthcare providers, health insurance, transition support to adult health care services, and access to preventive dental health care services. In Arkansas, fewer than 1 in 5 CSHCN (18.6%) receive services to prepare for the transition to adult health care (NSCH

2022-2023). In particular, CSHCN with any functional limitation (9.7%) experience low rates of transitions services. CSHCN whose parents are in a two-parent married household (12.6%), had some college education (14.2%), Medicaid insurance (15.1%), or low-income (100-199% FPL=16.3%) were also less likely to receive all components of successful transition services.

To address these public health challenges, respondents reported a range of strategies and interventions currently in place. Care coordination services were the most common, followed closely by assistance with navigating health and public health systems and family-to-family support services. Other key interventions included improving health care provider availability, expanding school-based health care services and enhancing health insurance access. Education about health care transition and transportation availability initiatives were also highlighted. Overall, the responses point to a broad but interconnected set of priorities focused on strengthening service delivery, enhancing family support systems, and addressing key health needs for CSHCN in Arkansas.

Participants of the focus groups and interviews offered several strategies to address these challenges. First, they emphasized the importance of expanding family support groups across different diagnoses, pointing to successful models such as the Department of Human Services' Parent Advisory Council. Secondly, they called for broader awareness efforts to inform families about home- and community-based services, transition support, and vocational programs. Disseminating clear information through trusted community partners, including schools, provider offices, and local organizations were identified as a key step in ensuring families understand available options and next steps. Participants also highlighted the underutilization of rehabilitation and workplace readiness programs, particularly for youth exiting the school system. Specific programs, such as those offered at UAMS, were praised, though there was concern that too few families were aware of their existence.

II.B. Title V Program Capacity

II.B.1. Impact of Organizational Structure

The ADH is one of 15 state agencies under the direction of Governor Sarah Huckabee Sander's leadership. ADH serves to protect and improve the health and well-being of all Arkansans with more than 100 services statewide and the support of over 2,100 diverse and dedicated employees and public and private partners. The ADH is a unified health department, with a main office in Little Rock and 92 LHUs in each of the state's 75 counties. ADH is managed by the Secretary of Health, Renee Mallory, which reports directly to Governor Sanders as a Cabinet member.

The Arkansas Department of Health provides program and services statewide through a centralized system with the main office in Little Rock and 92 local health units, at least one in each of Arkansas' 75 counties. Arkansas has five public health regions (Central, Northeast, Northwest, Southeast, and Southwest) that provide public health services and have broad flexibility to implement public health activities that meet the needs of clients in the region. Each region has a leadership team that includes representation from each of the following areas: administration, environmental health, information technology, quality improvement, patient care, medical care, epidemiology, and Hometown Health.

The ADH is comprised of the Public Health Laboratory and five Divisions:

1) Division for Health Advancement (DHA),
2) Division for Health Protection (DHP),
3) Division for Local Public Health (DLPH),
4) Division for Public Health Practice (DPHP), and
5) Division for Preparedness and Emergency Response (DPEP).

The Divisions are collectively responsible for the oversight of various Branches. Each Branch within a Division is comprised of Sections that fall underneath the administration of the ADH. The ADH administration supports all programs and oversights of finances; human resources; information technology; legal; minority health; community support; health communication and marketing; policies and procedures; workforce development; and facilities support services.

DHA oversees the Family Health Branch (FHB), in which the Title V MCH Block Grant resides. The FHB contains multiple sections: Women's Health (Maternity, Family Planning, Licensed Lay Midwife programs), Child and Adolescent Health; Newborn Screening (NBS), Perinatal and Infant Health, and Maternal, Infant, and Early Childhood Home Visiting (MIECHV). The Title V program is strategically positioned to support a comprehensive and coordinated approach to the implementation of the Title V Five-Year Action Plan through collaboration and coordination across a range of family-

serving programs. This unique placement directly influences the capacity to effectively address priorities and services identified in the statewide MCH needs assessment.

Title V CSHCN program activities have historically been housed within the Arkansas Department of Human Services (DHS). DHS is also one of 15 state agencies under the direction of Governor Sarah Huckabee Sander's leadership. DHS is a large separate agency led by Kristi Putnam, Secretary of Human Services, who also reports directly to the Governor. DHS consists of eight major divisions and the Title V CSHCN Program is housed within the Division of Disabilities Services (DDS). DDS also contains administrative units for Early Intervention Services (Part C) as well as direct and coordinating services for children and adults with developmentally challenging conditions.

II.B.2. Impact of Agency Capacity

The ADH emphasizes infrastructure-building and population-based activities through preventive health information and educational messages to public health care providers, referrals, and linkage to services, and coordination of services.

Within the DLPH, ADH has 92 LHUs across the state and contracts with several community-based organizations, hospitals, direct service providers, family support organizations and others to address MCH priorities and state and national performance measures.

A) Preventive and primary care services for pregnant women, mothers and infants up to age one.

Women's Health Services are coordinated at the ADH state level through the DHA and the DLPH. ADH LHUs provide reproductive health services to adult and adolescent women. These services include health history assessment, laboratory tests including PAP tests, physical assessment, contraceptive methods, health education, and treatment and referral. Ninety-two of the LHUs and three school-based satellite clinics provide family planning services, with at least one site in each county. The ADH LHUs expanded well women capabilities and services in recognition of the importance of taking a preconception, inter-conception, and life span approach to women's health.

The Women's Health Program offers education materials and links to other resources on a wide range of topics that affect women, including healthy eating, physical activity, vitamins and nutrients, oral health, genetic illness, mental health and depression, safe relationships, family planning, pregnancy, sexually transmitted illnesses, and substance abuse. Per culturally and linguistically appropriate service (CLAS) recommendations, publications are available in English and Spanish.

The clinical care component of the ADH Women's Health Programs is directed by the ADH Family Health Medical Director (.5 FTE). The Medical Director spends an average of 50% of his time dedicated to the maternity program. The Medical Director is a Fellow of the American College of Obstetrics and Gynecology and a Diplomat of the American Board of Obstetrics and Gynecology. The Medical Director is instrumental in directing research and the review of statistics for program planning and evaluation as well as establishing protocol and maintaining the quality control of the Cervical Cytology program, which includes the supervision of tracking abnormal Pap tests. The Advance Practice Nurse (APN) and the Registered Nurse Practitioners (RNP) who deliver health care services through ADH maintain a collaborative practice agreement to fulfill the requirements for prescriptive authority as set forth in the Arkansas Nurse Practice Act. The APNs and RNPs work under protocols that are developed, reviewed, and authorized by the Medical Director on an annual basis. The parameters of the APN/RNP's practice scopes are defined by licensure and advanced education. The ADH FHB's Women's Health Section oversees the Licensed Lay Midwife Program, which provides a choice for home delivery. There are currently 31 Licensed Lay Midwives and 14 Lay Midwife Apprentices in the state.

With the focus on strengths for pregnant women and infants, all LHUs have public health nurses who have specialized training and a supportive nursing policy to provide care to pregnant women. They provide essential nursing care and referral to local physicians and neighboring clinics. ADH provides maternity services in 60 LHU sites in 55 counties. These clinics are attended by “circuit-riding” Women’s Health Nurse Practitioners (WHNPs) who serve as the prenatal clinician. The WHNPs develop close referral relationships with local physicians and provide Family Planning, STI, and Breast and Cervical clinic services. These WHNPs are administratively supervised by ADH Patient Care Leaders at the regional level and clinically supervised by a board-certified OB-GYN, the Medical Director in the Women’s Health Section. The Women’s Health Medical Director is also a board-certified obstetrician. The Medical Director travels statewide to attend specialized clinics in LHUs and provide direct supervision to the 5 WHNP Coordinators in all regions. In turn, these Coordinators provide clinical supervision for the other 30 WHNPs (6 vacant positions).

The Maternal and Child Health Specialists (MCHS) in the LHUs work with multiple programs related to women and children including Maternity, Family Planning, Well Woman, Cervical Cytology, BreastCare, Laboratory and CLIA, and maltreatment/human trafficking. The MCH Specialists are RNs who have the responsibility of providing education and training for the medical staff in the 92 LHUs. There are currently 12 MCH specialists (1 vacant position) for the state divided among the five Regions. The MCHS are the policy experts for the policies listed for the nurses in the field. Also, they perform and summarize the annual audits for the Family Planning and Maternity programs for each Region.

For infants, all LHU nurses are trained in fundamental child health nursing care and make referrals to local family physicians and pediatricians. At the present time, LHU services for infants are provided in WIC and Immunization clinics, and all children who are covered by Medicaid’s ARKids A and B are referred to privately practicing primary care physicians (PCPs) and Community Health Centers (CHCs). ADH also offers resources and technical assistance to parents, childcare, foster care, community action groups and others on how to prepare and keep children safe, healthy and in developmentally appropriate learning environments. Topics include developmental screening and milestones, infant safe sleep practices, and feeding babies under one year old.

B) Preventive and primary care services for children.

The FHB promotes health and well-being, health equality, early and ongoing learning and development, and safe environments and relationships for all children and their families. It targets efforts toward African American infants and women, in addition to MCHBG support, the section oversees grants from HRSA and CDC to improve the health, development, learning, and well-being of children and their families. The Medical Director provides physician direction for child health programs, especially the population-based services for children.

Specifically, the Adolescent Program works to ensure equal opportunities for improved social, emotional, and physical health and wellbeing for adolescents and young adults.

Program goals include providing access to appropriate quality health services, ensuring safe and supportive environments at home, school, and in the community and increasing sexual health services and information. The program has also worked across ADH on a collaborative strategy to focus on adolescent and young adult health within multiple programs.

The ADH School Health program is the most promising program to address the health care needs of Arkansas's adolescents. ADH has 16 Community Health Nursing Specialists (CHNS) who are responsible for guidance and training for school nurses across the state. In addition, CHNS are required to participate in policy development and delivering/promoting tobacco prevention efforts within schools and communities statewide. School Based Health Clinics (SBHCs) are currently operated by local health providers in Arkansas and are funded through the Arkansas Department of Education (ADE). The ADE's School Health Services Office works in collaboration with the ADH and Arkansas Medicaid in the Schools to coordinate resources for the SBHCs. Funding comes from the Arkansas Tobacco Excise Tax created by Arkansas Act 180 of 2009. All SBHCs offer physical health services, mental and behavioral health services, and school health outreach programs based on student and community needs. Many offers other services, such as oral health and optometry and utilize the Coordinated School Health model. Adolescents are also seen in the LHUs for well women care or family planning.

Several divisions, branches and sections within the ADH, the DHS, and the ADE work every day to improve the health and welfare of children in the state. While the role of ADH indirect service provision has decreased in recent years, the department is still the sole provider of WIC services and continues to administer a significant percentage of all immunizations to children and youth. ADH also operates screening programs at the state level. The DHS has organizational units dedicated to Medicaid services, childcare and early education, foster children, and abused and neglected children. ADE is extremely involved in health through the Coordinated School Health Initiative and SBHC, as well as in ongoing wellness activities. Five Community Health Promotion Specialists (CHPS) (1 vacant position) provide resources to Arkansas School Wellness Committees to work toward reducing obesity in schools, as mandated by Arkansas Act 1220.

Among other things, the DHA oversees the Personal Responsibility Education Program (PREP), which works to lower teen pregnancy and sexually transmitted infections. It focuses on activities for reducing the pregnancy rates and birth rates for youth populations, especially youth populations that are vulnerable or at the highest risk for pregnancies, or otherwise have special circumstances, including youth in foster care, homeless youth, youth with HIV/AIDS, pregnant youth under the age of 21, mothers under 21 years of age, minorities, and youth residing in areas with high birth rates for youth.

C) Children with Special Healthcare Needs (CSHCN).

Title V Program for CSHCN is housed in the DHS Division of DDS. The program's name was changed to Children's Special Services in January 2024. The program promotes an integrated system of services for infants, children and youth up to age 18 years who

have or are at risk for chronic physical, developmental, behavioral, or emotional conditions and require health and related services beyond what is generally needed. CCHC works together with families, policy makers, health care providers agencies, and other public-private leaders to assist in addressing their concerns related to CSHCN by promoting assessment, intervention, education, and coordination of services including family support, care coordination, and health information. Medicaid-covered Title V Targeted Case Management coordinates services that assist members in accessing all social, medical, educational, and other services appropriate to the individual's needs. Currently, DDS has 13 community-based offices in: Arkadelphia, Berryville, Fort Smith, Harrisburg, Huntsville, Hope, Jonesboro, Little Rock, Monticello, Mountain View, Pocahontas, Prescott, and Pulaski County (Donaghey Plaza). Pediatric registered nurses serve as facilitators, educators, advocates, and collaborators. They provide local, state and national resources, clinical support staff with experience in assisting families to access the services needed. All staff is certified by DDS as having completed a DDS Case Management Training Program. The professional staff includes registered nurses and social workers who have many years of experience working with the medical and social needs of the children and youth being served. Each office also has clerical staff to assist in the processing of applications and communicating with families.

In addition, the UAMS/ACH CoBALT Project has been working with community-based physicians and other pediatric health professionals to complete assessments, offer probable diagnoses, and make referrals for appropriate intervention services. The CoBALT Project trains and provides ongoing consultation to physicians and other pediatric health professionals in the triage of children with suspected autism spectrum disorders. As a result, referrals to appropriate services have increased.

The specialty medical care provided by the staff at ACH and UAMS is excellent. A new campus of pediatric specialty services opened in northwest Arkansas and is filling a tremendous need in that area. Outreach clinics in other parts of the state for specialty care remain in place with support from the Title V CSHCN program staff. As a small state, the network of professionals who serve CSHCN and their staff is smaller as well. This leads to the ability to develop relationships, work together on projects and initiatives, and provide general support for programs to meet needs.

D) Lifecourse Capacity

Within the life course domain, ADH supports five home visiting models that are funded through the HRSA's Affordable Care Act - MIECHV Program. Four of the models in Arkansas are funded with competitive MIECHV funds: Healthy Families America (HFA), Home Instruction for Parents of Preschool Youngsters (HIPPY), Parents as Teachers (PAT), and a promising approach, Following Baby Back Home (FBBH). The Nurse Family Partnership (NFP) model is administered by the ADH using MIECHV formula funding. These programs are voluntary and provide education and information as well as resources and support to expectant parents and families with young children. The home visiting programs focus on different family needs: some programs focus on health and wellness, some on school readiness, while others focus on healthy development, child welfare, and care coordination. All address parenting skills to some degree. The

different models may work with an expectant mother or a young family from birth into the child's 4th – 5th year of life.

II.B.3. Title V Workforce Capacity and Workforce Development

During the reporting period, Title V funds support a total of 70 positions (full/partial): nine at the FH Administrative office as shown in the attached organization charts; and 62 (27 clinical and 35 non-clinical) staff in the field that provide maternity, family planning, and well woman services in each of the five public health regions.

ADH Key MCH Leadership

Position Title
Title V MCH State Director, FHB Chief
Family Health Medical Director
Child Health Medical Director
Women's Health Medical Director
Women's Health Section Chief
Child Health Section Chief
MCH Epidemiologist
SSDI Project Director
Home Visiting Coordinator
Home Visiting Section Chief
Newborn Screening Manager
School Health Section Chief

ADH Workforce Development: ADH continues to use a multi-faceted approach to encourage and support Title V program staff's professional development. The Title V Director promotes the use of workforce development resources available through the MCH Workforce Development Center and MCH Navigator. Additionally, the ADH requires the use of learning modules as part of each employee's performance development plan. The Training Finder Real-Time Affiliate Integrated Network (TRAIN) Learning Management System offers online and in-person training opportunities on a broad range of topics, including leadership training, facilitation skills, and communication. ADH requires specific mandatory training courses for all employees. Each employee develops an individual training plan with their supervisor as part of the individual annual performance development plan. In addition to these learning resources, training opportunities can include participation in ADH Grand Rounds, or the University of Arkansas for Medical Science's Learn-On-Demand series and opportunities to receive financial assistance to enroll in post-baccalaureate studies or attend local and national topical sessions and conferences are available as resources allow.

DHS Workforce Capacity: The Community-Based Office structure of the Title V CSS Program is organized in a statewide network with staff located in 12 Community-Based Offices in Arkadelphia, Berryville, Fort Smith, Harrisburg, Huntsville, Hope, Jonesboro, Little Rock, Monticello, Mountain View, Pocahontas, and Prescott. All staff are in the Arkansas Department of Human Services (DHS) County Offices which provide convenient locations and easy access for consumers.

The 2024 year closes with 19 full-time staff including one extra help, three Registered Nurse Supervisors, and a Medical Assistance Manager who provides oversight of the grant activities. During the year, the program had two staff retire (Nurse Manager and Registered Nurse), and one resign (Administrative Specialist III). A new Parent Consultant started in 2024. Workforce challenges continue to exist. The program remains committed to hiring vacant positions as outlined in CSHCN/DDS/ Children's Special Services.

DHS Key CSS Leadership

Position Title
Title V CSS DDS Assistant Director
Medical Assistance Manager
RN Supervisor Northwest
RN Supervisor Northeast
RN Supervisor South
Family Leader

CSS Clinical and Non-Clinical Staff

CBO	Clinical	Non-Clinical
Arkadelphia	1	1
Berryville	1	0
Central Office	0	3
Ft. Smith	2	1
Hamburg	1	0
Harrisburg	1	1
Hope	1	0
Huntsville	Vacant	1
Jonesboro	2	0
Monticello	0	0
Mtn. View	1	1
Pocahontas	0	1
Prescott	Vacant	0

*Temporary Extra Help: 1 Clerical

DHS Development: Ongoing professional development is available and relevant through program partners including other state agencies and programs. In this reporting period, capacity building training for the CSHCN workforce included training through the Leadership Education in Neurodevelopmental and Related Disabilities (LEND), University of Arkansas for Medical Sciences (UAMS) Peds Place, Connecting Across Professions Learn on Demand, Association of Maternal and Child Health Programs, Family Voices, UAMS Partners for Inclusive Communities, the State's Office of Special Education Program funded Parent Training and Information Center (PTIC), the Center for Exceptional Families, and Arkansas Behavioral Health Planning and Advisory Council. The DHS Office of Personnel Development provided training on the Power of Positivity.

II.C. State Systems Development Initiative (SSDI)

At the Arkansas Department of Health (ADH), the State Systems Development Initiative (SSDI) staff, housed within the Vital Records and Statistics Branch (formerly the Health Statistics Branch, or HSB), collaborates with the ADH Family Health Branch (FHB), the State Title V Maternal and Child Health (MCH) program, to achieve four key goals: (1) Strengthen capacity to collect, analyze, and utilize reliable data for the Title V MCH Block Grant to assure data-driven programming; (2) Strengthen access to and linkage of key MCH datasets to inform MCH Block Grant programming and policy development, while enhancing data interoperability and information exchange; (3) Enhance the development, integration, and tracking of health equality and social risk factor of health metrics to inform Title V programming; and (4) Develop and enhance capacity for timely MCH data collection, analysis, reporting, and visualization to inform rapid state program and policy action related to emergencies and emerging issues/threats.

The Arkansas SSDI program plays a critical role in supporting Title V MCH Block Grant efforts by maintaining robust data systems and providing timely data, analytical expertise, and technical assistance. It draws on diverse MCH-relevant data sources, including vital statistics, hospital discharge data, Medicaid, the Children's Health Insurance Program (CHIP), and survey data. The Family Health Branch relies on this epidemiological data to evaluate trends, address discrepancies, guide program planning, and track progress toward goals. SSDI's provision of birth and death datasets, combined with its analytical and technical assistance, has significantly strengthened Title V data capacity and resolved prior data-sharing challenges. To ensure ongoing success, a formal data-sharing agreement has been established. These integrated datasets now serve as a foundation for program planning, reports, presentations, fact sheets, grant applications, media releases, and various other initiatives.

As a capacity-building initiative, the Arkansas SSDI strengthens the data and information infrastructure of the state's MCH programs. Its primary focus is to provide Title V MCH programs with timely access to data, supporting the monitoring of health indicators and the development of innovative programs and policies aimed at improving the health and well-being of Arkansas's mothers, children, and families. The Arkansas SSDI complements and enhances the analytical capabilities of Title V MCH programs. Its activities bolster the state's MCH data infrastructure, empowering informed decision-making and strategic resource allocation to support high-quality, effective, and efficient programming for women, infants, adolescents, and Children with Special Health Care Needs (CSHCN). During the FY 2024 reporting period (December 1, 2023 – November 30, 2024), the Arkansas SSDI team collaborated with internal and external partners to implement a work plan aligned with the program's four core goals.

The following activities were successfully carried out and completed:

- The SSDI staff collaborated with the Newborn Screening (NBS) Program, housed within the Family Health Branch (FHB) of the Arkansas Department of Health (ADH), to monitor and enhance the quality of newborn screenings across the state. Mandatory screening for inborn conditions in Arkansas began with Act 192 of 1967, which required testing all newborns for phenylketonuria. Since then, the

number of conditions screened has expanded significantly. The program now oversees follow-up for more than 30 disorders using blood spot cards, alongside two point-of-care tests (newborn hearing screening and critical congenital heart disease), covering a total of 33 disorders. In March 2023, Mucopolysaccharidosis Type I (MPS I) and Pompe disease were added to the test panel. In 2024, 94.7% of approximately 34,343 babies born in Arkansas were screened for these genetic disorders. SSDI supports the NBS Program by providing bi-annual NBS-birth records linkage reports by county and health clinic. These reports include two data sets, one including infants with rejected samples and another excluding them, delivered to FHB staff to assess needs in counties with lower screening rates. Additionally, SSDI provided a race/ethnicity breakdown of infants screened in CY 2024 to the MCH Epidemiologist for the FY 2026 Title V MCH Block Grant Application and 2024 Annual Report: Newborn Screening (Form 4), as required.

The Public Health NBS Lab Manager, SSDI staff, and Newborn Screening Manager continuously monitor data timeliness at three key stages: from birth to specimen collection, collection to receipt at the ADH Public Health Laboratory (PHL), and receipt to reporting of test results. Their goal is to complete this process within 168 hours (7 days). However, the CY 2024 report showed an average of 172.0 hours, slightly exceeding the target. Several factors contributed to delays in the receipt-to-reporting phase. In July 2024, an unexpected disruption occurred when both PHL mass spectrometers malfunctioned, requiring samples to be outsourced to an accredited external facility. Shipping and processing times at the external lab extended the turnaround time, as PHL could not process samples in-house until repairs were completed in August. In December, the process again surpassed 168 hours due to staffing shortages during the holiday season, equipment issues (two instruments in the PCR area were down), and the validation of a new reporting database. During this period, PHL operated across two systems (StarLIMS and Specimen Gate), further complicating workflows. Collaborative efforts with vendors and new protocols have since improved critical result reporting and coordination with birthing hospitals. Despite challenges like staffing shortages, the NBS Program remains committed to its objectives. Quarterly Hospital Timeliness Reports are shared with birthing facilities to track specimen submission timeliness, with facilities falling below an 80% compliance benchmark contacted for follow-up discussions. By the end of CY 2024, a yearly comparison report of all birthing facilities indicated an average compliance rate of 86.4%. The program also supports partner hospitals through virtual education and technical assistance to ensure efficient specimen collection and timely delivery to the lab for processing.

- The Vital Records and Statistics Branch (VRSB) partners with the University of Arkansas for Medical Sciences (UAMS) to provide technical support and assistance with the mother's project. The Hospital Discharge Data Section (HDDS) of the VRSB provides Statistical Analysis System (SAS) datasets each year to aid in evaluating care and outcomes of maternity patients and their newborns. Accomplishments pertaining to this project include the collaboration between the SSDI staff and HDDS staff to ensure an accurate amount of time is

allotted to collect the linkage data needed from the respective databases. These databases include Pregnancy Risk Assessment and Monitoring Survey (PRAMS), fetal, birth and death certificates. Once the linkage data is provided to HDDS team, HDDS proceeds with linking that data with the hospital discharge databases. There are five datasets requested within this project that require intense and detailed SAS programming. Once completed, all analysts meet to discuss and compare the quality and accuracy of the results. The only barrier encountered was the significant amount of time consumed depending on the analysis found. The strategy to overcome this barrier included communication and cooperation from all analysts. Although this was a barrier, the project deadline was met which resulted in the overall success of Mother's Project. This could only be achieved through excellent teamwork and partnership. The CY 2022 Mother's project master dataset along with the other four datasets were submitted to UAMS in June 2025.

- SSDI staff have conducted linkages between Medicaid data to birth, infant death, death, and hospital discharge data files for the High-Risk Pregnancy Program (HRPP) Project (formerly known as the Antenatal and Neonatal Guidelines for Education and Learning Systems, or ANGELS). To reduce infant mortality and improve patient care for clients covered by the Arkansas Medicaid program, the directors of the Maternal Fetal Medicine and Neonatology Divisions at UAMS, with financial support from the Medicaid Program, launched the HRPP partnership. This program delivers maternal-fetal medicine specialty care via telemedicine to high-risk women living in remote areas, ensuring that every woman in Arkansas at risk of a complicated pregnancy receives the best possible perinatal care. The linked datasets are used to evaluate the pregnancy outcomes of the HRPP Project. This evaluation is part of an evidence-based medical approach by the Arkansas Department of Health (ADH), the Arkansas Department of Human Services (DHS), and UAMS to improve maternal and child health in the state. Articles related to these data linkages have been published in various scientific journals.

- One example of achieving SSDI goals is making linked datasets available to Maternal and Child Health (MCH) stakeholders. A data-sharing agreement was signed between the Arkansas Department of Health (ADH) and the Arkansas Department of Human Services (DHS), Division of Medical Services in December 2021. The agreement aims to: (1) assess the effectiveness of various interventions designed to improve birth outcomes for infants born to Medicaid or Children's Health Insurance Program (CHIP) beneficiaries, and (2) evaluate the healthcare utilization and outcomes of children enrolled in Medicaid or CHIP as infants.

  SSDI staff at the Vital Records and Statistics Branch receive three datasets annually, described below, via the departments' secure "MoveIT" file servers:

  1. Category 1: Infants enrolled in Medicaid/CHIP; mother not enrolled.
  2. Category 2: Infants enrolled in Medicaid/CHIP; mother also enrolled.

3. Category 3: Mothers enrolled in Medicaid/CHIP; infant(s) not enrolled.

SSDI staff have successfully matched infants in Categories 1 and 2 to birth certificate data, aligning with the HRSA SSDI Award Performance Goals. For Category 3, SSDI staff link mothers enrolled in Medicaid/CHIP to their infants' birth certificates and provide DHS with specific fields from the birth certificates for all three categories. The CY 2023 Medicaid/CHIP versus birth certificate linkage was completed on time and uploaded to DHS's secure servers. The outcomes of this birth linkage for Medicaid/CHIP beneficiaries were presented at an ARHOME advisory panel meeting in December 2024, chaired by the DHS Secretary and attended by other secretaries (including ADH) and legislative representatives.

- The Vital Records and Statistics Branch (VRSB) maintains a Memorandum of Agreement with the Family Health Branch's Arkansas Maternal Mortality Review Committee (AMMRC) to identify, collect, and analyze maternal deaths in Arkansas. The AMMRC holds quarterly meetings with a multidisciplinary panel to review cases and recommend strategies for preventing maternal deaths. In late 2024, it released its fifth annual report to the Arkansas Legislature, covering maternal deaths from 2018 to 2021, and is now preparing its sixth report and a fact sheet for 2018–2022. Related articles and resources are available at Arkansas Maternal Mortality Review Committee. By engaging clinical and non-clinical partners, the AMMRC leverages data to enhance care quality for guiding targeted interventions at patient, provider, facility, system, and community levels.

  The ADH's SSDI team supports these efforts by linking death records to live birth and fetal death records to identify pregnancy-associated deaths within one year of a woman's death, adhering to the CDC's Pregnancy Mortality Surveillance System (PMSS) guidelines. This process involves extracting records with ICD-10 Chapter O codes, linking death records to birth or fetal death records, and reviewing death certificates with a pregnancy checkbox, with cases verified through medical record reviews from relevant facilities. Additional data sources include Women, Infants, and Children (WIC) records, Emergency Medical Services (EMS) reports, prenatal and delivery records, State Health Alliance for Records Exchange (SHARE) records, Emergency Room (ER) records, hospitalization records from the prior two years, obituaries, autopsy reports, social media, news reports, and police investigations. Through these comprehensive efforts, the ADH ensures high data quality in maternal mortality surveillance, collaborating with partners to compile evidence-based findings for the AMMRC's reports, which are presented to the Arkansas Legislature to inform policies and drive improvements in maternal and child health outcomes for communities most in need.

- To support Arkansas' hepatitis C elimination plan, the Arkansas Department of Health (ADH) is enhancing both its surveillance efforts and linkage to care strategies. As part of this initiative, the SSDI team at the Vital Records and Statistics Branch (VRSB) collaborated with the Infectious Disease Branch (IDB) and the Epidemiology Branch (EB) to link mortality data with the hepatitis C case

registry. This collaboration helps identify deceased patients, improving the accuracy of epidemiological statistics and understanding of the state's disease burden. These enhancements not only strengthen the registry's data quality but also support better care coordination for living patients - advancing SSDI's mission to build capacity for data-driven public health programs. In addition, SSDI provides ongoing technical support to IDB to sustain and strengthen hepatitis C surveillance annually, aligning closely with Arkansas' broader elimination goals. Expanding beyond infectious disease, SSDI also plays a vital role in maternal and child health initiatives. Through the Surveillance for Emerging Threats to Mothers and Babies Network (SET-NET) project, staff have linked syphilis and hepatitis C datasets to birth, death, and fetal death records from 2017 to 2022. This integrated approach supports monitoring of prenatal exposures, follow-up data collection for affected infants, and improved outcomes for pregnant women and their babies - complementing programs like the Title V Maternal and Child Health and reinforcing SSDI's commitment to data-informed decision-making.

Community engagement is another cornerstone of ADH's work. The Office of Faith-Based Outreach exemplifies this commitment by partnering with diverse faith communities to promote health through tailored education and wellness initiatives. With an inclusive, adaptable approach that respects each faith tradition, the office collaborates with ADH divisions to advance public health goals, engages directly with faith leaders to meet specific community needs, and works alongside local organizations to share valuable resources. Statewide communication platforms ensure outreach efforts are timely, relevant, and equality focused. Complementing these efforts, the ADH Office of Health Disparities Elimination has partnered with the ADH Worksite Wellness program to create a more supportive environment for staff. Notably, they introduced reserved parking spaces for expecting employees and providing maternity care packages to those employees, further demonstrating ADH's dedication to wellness. These combined efforts came to life in late 2024, with Faith-Based Outreach activities kicking off in November at the Chicot County Community Health Fair in Eudora. The momentum continued with SNAP and Narcan training sessions in Little Rock, a "Women in Ministry" brunch, and a series of December events - including World AIDS Day observances, an HIV Awareness Summit in Pine Bluff, a healthy eating booth at *Breakfast with Santa* in Little Rock, and a mid-month lecture and summit presentation. The year concluded on a high note with holiday food distributions in Little Rock and Pine Bluff, marking a vibrant season of outreach, support, and service across the state.

- The Arkansas Department of Health (ADH) employed strategic initiatives to support its mission to strengthen family and consumer partnerships for the Maternal and Child Health (MCH) population, particularly Children with Special Health Care Needs (CSHCN), through the Title V Children's Special Services program. From December 1, 2023, to November 30, 2024, the program significantly expanded its outreach by conducting 37 in-person events, a 61 percent increase from the prior year, and four virtual events. Title V delivered 27

presentations and served as a vendor exhibitor at 16 events, with two events featuring the program in both roles. These initiatives engaged a diverse audience, including health care professionals, school personnel, parents and guardians, referral organizations, community partners, and children and youth with and without special health care needs. Presentations covered essential topics, such as a comprehensive Title V overview, health care transition guidance, and resources tailored for families of CSHCN, fostering greater awareness and support. Community outreach efforts extended to school transition fairs, health fairs, festivals, disability conferences, and farmers' markets, where students received Health Care Transition Tips booklets and educational materials, ensuring widespread engagement and education.

Key in-person events included the Health Care Conference in Northwest Arkansas, the School Health Conference in Central Arkansas, and the 2024 School-Based Health Center Training. A highlight was the 11th annual Famous Family Bistro Conference, organized by the Parent Advisory Council (PAC) for families of CSHCN, which offered training on critical topics such as Individualized Education Programs (IEPs), 504 Plans, Individualized Family Service Plans (IFSPs), Guardianship and Special Needs Trusts, Bullying and School Safety, Advocacy Fundamentals, and adolescent development. Virtual engagements were equally significant, with two presentations delivered in collaboration with the Arkansas Disability Coalition, a nonprofit dedicated to supporting families and professionals. These included a Title V program overview for Coalition staff and a session on pediatric-to-adult health care transitions for participants in the Coalition's nine-week Leadership Gym, a program focused on leadership development. Additionally, a virtual presentation to the Child Health Advisory Committee, comprising pediatric professionals, school personnel, and dietitians, highlighted Title V's role in supporting school nurses with resources such as medical equipment and information on state waivers. A final virtual community meeting, facilitated by a PAC member, provided families with information about Title V and programs like the Tax Equity and Fiscal Responsibility Act (TEFRA), further enhancing access to vital resources.

To improve accessibility and visibility, Title V implemented strategic communication initiatives. The Title V brochure was updated with a QR code linking to the Children's Special Services website and translated into Marshallese, as was the application for services. A media campaign, featuring two videos and a 30-second commercial, was shared across social media, television, and streaming platforms. One video, narrated by a parent, shared a family's experience with Title V services, while the second, presented by a Nurse Care Coordinator, outlined available services, eligibility criteria, and access procedures. These efforts amplified the program's impact and reach. Through a combination of robust in-person and virtual engagements, comprehensive community outreach, and innovative communication strategies, Title V Children's Special Services demonstrated a steadfast commitment to empowering families and supporting CSHCN, aligning with ADH's mission to enhance family and consumer partnerships within the MCH population.

- The Vital Records and Statistics Branch (VRSB) maintains its agreement to provide annual, and more frequent upon request, access to individual-level birth and death datasets to support the Title V MCH Block Grant application, progress reports, and related program activities such as initiatives aimed at reducing infant mortality. Upon request, aggregate data for hospital discharges, fetal deaths, and surveys like PRAMS and BRFSS, all housed within VRSB, can also be made available. The Arkansas SSDI project draws upon resources from within VRSB, across the Arkansas Department of Health (ADH), and from other state agencies. SSDI staff actively coordinate and collaborate with epidemiologists and Title V MCH staff to meet data needs for performance tracking, strategic planning, and support of program registries such as cancer and immunization. The success of SSDI relies on strong partnerships among public and private entities. All data elements from birth, death, and fetal death certificates, along with HDDS and PRAMS survey data, reside within VRSB. Other key data sources, including Medicaid/CHIP, CSHCN, WIC, and Newborn Screening, are maintained by ADH or the Arkansas Department of Human Services and are accessible under departmental data use policies. Publications from the Vital Records and Statistics Branch are available on the ADH website: https://www.healthy.arkansas.gov/programs-services/program/data-and-statistics.

- SSDI staff possess extensive experience in linking numerous independent databases, providing valuable support to Arkansas Maternal and Child Health (MCH) projects. To date, the SSDI team in Arkansas has successfully completed file linkages between birth certificates and the following databases to bolster MCH Block Grant programs:
    - Infant Deaths
    - Infant/Maternal Deaths Hospital Discharge Data System
    - Deaths – Hospital Discharge Data System
    - Medicaid Eligibility/Paid Claims/Children's Health Insurance Program
    - Children with Special Health Care Needs
    - Newborn Screening
    - Pregnancy Risk Assessment Monitoring System (PRAMS)
    - WIC Eligibility Files
    - Hepatitis C/Syphilis
    - COVID-19 Pregnant Women and Infants Registry

  With SSDI staff assistance, these linked datasets are analyzed to identify trends in maternal and child health, including low birth weight, preterm births, infant mortality, prenatal care, unintended pregnancies, and other key MCH issues. The resulting insights inform program planning, performance monitoring, and program evaluations. As multiple years of linked datasets become available, the capacity to address maternal and child health programmatic and policy challenges will be significantly strengthened. For instance, during the preparation of the FY 2026 MCH Block Grant application, SSDI linkage datasets were utilized to support several performance measures. The FY 2026 application required an updated needs assessment, which was completed in July 2025.

Thanks to SSDI support, the MCH epidemiologist has been able to assist the Family Health Branch in responding to these requests promptly, delivering up-to-date and reliable information.

In FY 2024, the State Systems Development Initiative (SSDI) supported the Title V Maternal and Child Health (MCH) Block Grant by enhancing data capacity and integration. These efforts are aligned with four core objectives: promoting data-driven programming, improving dataset access and interoperability, integrating health equality and social risk factors of health metrics, and enabling rapid responses to public health challenges, such as pandemics. Key achievements included improved newborn screening efficiency and strengthened maternal mortality surveillance through vital records linkages for the 2018–2021 Arkansas Maternal Mortality Review Committee report. SSDI also completed Medicaid/CHIP birth certificate linkages to evaluate health outcomes. Partnerships with the University of Arkansas for Medical Sciences on the Mother's Project, the High-Risk Pregnancy Program's telemedicine services, and community efforts, including faith-based outreach, supported equitable interventions for women, infants, adolescents, and children with special health care needs. These initiatives addressed differences and social risk factors of health.

Through these efforts, SSDI collaborated with maternal and child health staff and partners to identify underserved populations and develop measures to guide outreach, interventions, and quality improvements. SSDI's adaptability ensured data continuity during emergencies, such as pandemics or natural disasters. Expanded data linkages, including hepatitis C surveillance and participation in the Surveillance for Emerging Threats to Mothers and Babies Network, provided actionable insights for maternal and infant health. SSDI's contributions to the FY 2026 MCH Block Grant application's needs assessment, finalized in July 2025, delivered reliable data for performance measures. By continuously assessing, planning, and evaluating, SSDI supports Arkansas's maternal and child health programs. This fosters efficient and impactful public health outcomes in annual Title V Block Grant applications and reports, ensuring sustained progress toward data-driven, health solutions.

II.C.1. Other Data Capacity

Title V program activities are supported through a wide range of MCH data and information systems, including surveys, surveillance systems, and partner data resources. Many activities were described in the MCH Epidemiology Workforce Section and SSDI Section of this application. This narrative describes data enhancing partnerships and activities in greater depth.

The ADH's Health Statistics Branch (HSB) houses the Vital Statistics Section, where vital records such as birth, death, fetal death, marriages, and divorce data are maintained and analyzed, shared with partners, and submitted to CDC for national reporting. Vital statistics are a crucial component to monitoring trends in births, maternal deaths, fetal and infant deaths, and hospitalizations. Vital records data contribute greatly to understanding changing priority needs for the five domains and are used to report progress in achieving Title V NPM, SPM, and ESM annual objectives. Preterm birth rates, very low birthweight births at hospitals with a Level III or greater NICU, infant mortality, and other measures utilize vital records data. As stated, the Family Health Branch and HSB have established data sharing use agreements in which individual-level data are made available to the MCH epidemiologist for the Title V grant application and annual report. Limited provisional data sets are available upon request. Arkansas continues its efforts to mobilize partners to reduce infant mortality in the state, and the Memorandum of Agreements allows the raw data to be used to support these efforts.

HSB also houses the Survey Section, where the Behavioral Risk Factor Surveillance System (BRFSS) and the Pregnancy Risk Assessment Monitoring System (PRAMS) staff are located. The MCH epidemiologist and the Chronic Disease Epidemiology Section have a long-lasting relationship with the HSB's BRFSS and PRAMS programs. For Title V grant activities, both surveys provide data on general women's health and ante-, intra-, and post-partum maternal behaviors, beliefs, health care services, and education. Data on general preventive medical visits, breastfeeding, safe sleep practices and related education efforts have been essential. BRFSS and PRAMS analyze the data upon request and seek opportunities to support Title V on products and projects. As mentioned before, the MCH epidemiologist participates in the ADH PRAMS Steering Committee, which collaborates on new PRAMS phase questionnaires and projects. In the past, the Family Health Branch has sponsored CDC optional modules and state-sponsored questions on the BRFSS survey. In 2019 and 2021, the Family Health Branch sponsored the BRFSS Family Planning module to better understand contraceptive use and reasons for not using contraceptives among women of reproductive ages. The Family Health Branch also partnered with PRAMS staff to receive CDC supplemental funding to add COVID-19-related questions to the PRAMS questionnaire. For the 2024 BRFSS questionnaire, the agency opted to remove the Family Planning Module and Reaction to Race Module.

ADH developed a surveillance system linking reported cases from hospitals, clinics, schools, and other sources with laboratory data. The MCH epidemiologist used this real-time data to identify cases for the Arkansas COVID-19 Pregnant Women and Infants Registry, a program funded through the CDC Epidemiology and Laboratory Capacity (ELC) grant's Surveillance for Emerging Threats to Mothers and Babies

Network (SET-NET). In 2021, a permanent epidemiologist position for this registry was funded. The Registry sought to identify women infected with the SARS-CoV-2 virus during pregnancy, collect information on their disease progression (i.e., exposure, symptoms, hospitalization, and treatment), prenatal care, birth outcome, and the infant's development up to six months of age. Abstractors obtain information from hospital and clinic medical charts, and data are submitted to CDC monthly. Another component of this grant is to share information and data findings with MCH health care professionals in the state. Since then, the Registry has expanded with syphilis infection as well as the stillbirths project to investigate if COVID-19 infection increases the risk of stillbirth.

Childhood obesity is one of Title V's priority areas. Arkansas tied for the 12th highest obesity rate among adults (CDC Behavioral Risk Factor Surveillance System, 2022), and the state has the 6th highest obesity rate among high school students (CDC Youth Online, 2021). The Arkansas General Assembly passed Act 1220 of 2003, requiring every public-school student to have a biannual body mass index (BMI) assessment performed and reported confidentially to their parents. Currently, this includes students in grades K, 2, 4, 6, 8, and 10. The Family Health Branch contracts with the Arkansas Center for Health Improvement (ACHI) to produce an annual statewide BMI statistical report, which is used to inform state, local, and school district program planning and evaluation and to monitor and evaluate activities related to Title V obesity related NPMs and ESMs. The report is posted online and distributed to partners.

The Family Health Branch, Health Statistics Branch, and Epidemiology Branch receive requests for MCH data from legislators, media, partners, students, and other internal and external parties. The program and MCH epidemiologist strive to respond to data requests in a timely manner. In cases where reports or products are generated for the public or sensitive data are requested such as for small sub-populations (i.e., geographic, race/ethnic, etc.) or requests involving low counts or rates based on small numbers, data must go through a rigorous Epidemiology Branch review process, which is also described in the MCH Epidemiology Workforce Section of this grant application/annual report. Products and responses are checked for accuracy, reliability, content, formatting, and other features by another epidemiologist. The work is then reviewed by the Section Chief, the Epidemiology Branch Chief, and in some instances, review and approval may be required by the ADH Science Officer and the ADH Science Advisory Committee. A few years ago, the agency convened a workgroup of ADH epidemiologists and statisticians to assess current and best practices for working with and reporting small numbers. In May 2023, the second version of the ADH Standards for Working with Small Numbers report was released. The standards and recommendations for reporting data with small numbers seek to promote good professional practice among staff involved in data analysis and reporting within the agency, and to protect confidentiality when protected health information is reported outside the agency. Programs, partners, and other interested parties request health data for smaller geographic areas such as county- or city-level data and for sub-population groups such as minorities or teens. In many cases, these data may be partially masked to protect potentially identifiable health information. This can affect the extent to which public health programs and partners can identify populations or geographic areas at risk and develop appropriate interventions.

II.D. Title V Program Partnerships, Collaboration, and Coordination

According to the 2024 Annie E. Casey Foundation, Kids Count Kids Data Book Interactive, Arkansas ranks 45th overall in the nation for economic well-being, education, health, family, and community. The ADH Family Health Branch utilizes family-community partnerships to improve overall physical and mental health of families, reduce injuries, and increase access to care. The Child Health IHP, the MIECHV, and CSS programs values family/community partnerships to build and strengthen the state's MCH population, including CSHCN.

Through the MCH Block Grant, partnerships support and promote the development and coordination of systems of care for the MCH population. Integrated systems of public health, health care and related community services help ensure equal access and coordination to achieve maximum impact.

Stakeholders Meeting
The Title V Program hosted a stakeholder's meeting on June 30, 2025, via zoom. The purpose of this meeting was to review current data on maternal and child health in Arkansas and to discuss the Title V Executive Summary, Five-Year Needs Assessment findings, priority needs, and strategies for the 2026 Block Grant Application. This meeting also provided an opportunity to form partnerships across programs, organizations, sectors, populations, and communities.

The notice of public comment was sent to stakeholders for each domain, which consisted of government and non-governmental agencies, clinical and non-clinical staff, community-based and family centered organizations. Stakeholder representation consisted of:

- Arkansas Advocates for Children and Families
- Arkansas Children's Hospital
- Arkansas Department of Health
- Arkansas Department of Human Services
- Arkansas Disability Coalition
- Arkansas Hands and Voices
- Arkansas Head Start Program
- Arkansas Hospital Association
- Division of Developmental Disability Services
- Head Start Collaboration Offices and State Systems
- University of Arkansas Medical Sciences

The agenda for the Public Hearing's (MCH) Services Block Grant Application included:

- Program updates of 2024 activities/outcomes of each domain
- Overview of the Title V Five-Year Needs Assessment Findings
- Statewide strengths, weaknesses, and potential solutions
- Update on 2025 Arkansas Legislative bills affecting the Title V Program
- Strategies to expand partnerships and services to at risk populations

The meeting focused on the Maternal and Child Health Block Grant programs, covering various aspects of healthcare services for mothers, infants, and children in Arkansas. Participants discussed program achievements, needs assessment findings, and priority areas for improvement, including postpartum care, access to healthcare, and infant mortality reduction. The meeting also highlighted recent legislative changes, grant opportunities, and ongoing initiatives to address healthcare differences and improve outcomes for vulnerable populations in rural areas.

Meeting Overview

Introduction: The meeting began by welcoming stakeholders and introducing domain leads for the various health services programs. The team discussed the application process and content for the Title V MCH program, focusing on priority needs areas. Participants were reminded to keep their phones muted and to include their names and organizations in the chat for record-keeping purposes. The meeting was recorded, and attendees were instructed to email if they had concerns about being recorded. The session was set to start with a presentation on MCH health services, including achievements, needs assessment findings, and priority needs choices.

MCH Block Grant Program Overview: The meeting provided an overview of the Maternal and Child Health (MCH) Block Grant program, which supports healthcare services for mothers, infants, and children, including those with special healthcare needs.

Women/Maternal Health: The Women's Health section highlighted key programs such as family planning, maternity care, licensed midwifery, and the Maternal Mortality Review Committee, noting differences in pregnancy-related deaths among racial and age groups.

Perinatal/Infant Health and MIECHV: Updates were presented on Perinatal and Infant Health, emphasizing Arkansas's high infant mortality rate and efforts to improve outcomes through education, prenatal care, and initiatives like breastfeeding promotion and safe sleep practices. The MIECHV Section Chief highlighted partnerships with organizations like UAMS, Arkansas Children's Hospital, and DHS. He discussed the success of their breastfeeding helpline, which received 5,301 calls in 2024 due to added texting features.

Child Health: The Child Health Section Chief focused on services for children 0-11 years, emphasizing partnerships with MIECHV program and WIC to increase developmental screening and reduce injuries. Other improvements highlighted included early hearing detection and intervention through partnerships with hospitals, primary care providers, and family-based organizations.

Newborn Screening: The NBS Manager explained that 33 disorders are currently screened, including two point-of-care tests for hearing and critical congenital heart disease. The NBS Manager also announced plans to add MPS II in August, GAMP (guanidinoacetate methyltransferase deficiency) in January 2026, and Krabbe (aka

globoid cell leukodystrophy) by July 2027, bringing the total to 36 conditions. Jennifer also shared statistics from 2024, noting that 94.7% of babies were screened, with the program working on 39,518 cases and confirming 115 diagnosed cases. When asked about the meanings of new tests, Jennifer explained that MPS II (Mucopolysaccharidosis TYPE II) is a lysosomal storage disorder and clarified that CMV (Cytomegalovirus) is currently not being considered for screening in Arkansas.

Adolescent Health: The Adolescent Health Section Chief described ADH and ADE's work in providing health services to school-age children across Arkansas, focusing on physical activity, nutrition, and mental health through partnerships with various agencies.

CSHCN: Children with Special Healthcare Services provide medical case management for children 0-18, emphasized access to care and transition to adult systems.

Title V Need Assessment: The MCH Epidemiologist presented findings from a comprehensive needs assessment conducted for Title V grant populations, highlighting key public health issues across five domains: women and maternal health, perinatal and infant health, child health, adolescent health, and children with special healthcare needs. She highlighted challenges in Arkansas's maternal and child health, including barriers to healthcare access, provider shortages, and poor health outcomes, noting that Arkansas ranks poorly in national health metrics for women and children.

The need assessment revealed significant concerns about mental health services, access to care, transportation barriers, and provider shortages, particularly in rural areas. Notable findings included the need for expanded postpartum care coverage, improved WIC program awareness, and increased focus on safe sleep practices to address Arkansas' high infant mortality rates. The discussion emphasized the importance of addressing mental health needs across all age groups, with particular attention to children exposed to prenatal substance use and adolescents facing behavioral health challenges.

Population and Emerging Needs: The Epidemiologist presented the 2026-2030 priority needs for the Title V program, highlighting eight key areas including postpartum care, access to care, transition to adulthood, infant mortality, physical activity, tobacco use, developmental screening, and child safety. She explained that these priorities were selected based on national focus areas and alignment with state and federal initiatives. She also discussed the continuation of various programs, such as the infant hearing program and tobacco use prevention, while introducing new areas like access to care and medical homes, which were required by HRSA for all grantees.

Arkansas Health Improvements: The MCH Director highlighted Arkansas's healthcare improvement efforts, including Medicaid expansion and the MMRC program's impact on maternal health, which led to policy changes and a pilot campaign. The state's newborn screening program successfully screened over 34,000 babies, with 86% receiving results within 48 hours. Arkansas received a $17 million grant for the Transforming

Maternal Health program, and several legislative acts were passed to improve maternal and infant health, including food security for public school students and empowering certified midwives and community-based doulas.

Meeting Recap/Conclusion: The meeting covered updates on the MCH programs, Title V needs assessment, and 2026 Executive Summary, along with discussions on potential solutions for improving newborn screening and rural healthcare access.

The NBS Manager highlighted the progress made through an NBS grant, including education programs and modules, but expressed concern about potential funding loss. The team discussed expanding partnerships and announced an upcoming grant review meeting in November.

Information about the Arkansas Disability Coalition's monthly leadership gym and upcoming disability awareness events was shared with stakeholders.

At the conclusion of the meeting, the MCH State Director announced that the MCH application is due July 28, and stakeholders were encouraged to provide feedback within the next week via the Arkansas Department of Health website (https://healthy.arkansas.gov/programs-services/community-family-child-health/family-health/maternal-child-health/needs-assessment-applications/public-comments-on-mch-application-summary/). Stakeholders were informed about the November 2025 Grant Review Update meeting. **END**

Title V collaborates and coordinates with multiple partners to leverage resources and to extend services to women, children, and families most vulnerable across the state.

- University of Arkansas for Medical Sciences partnerships include: Perinatal Regionalization; ANGELS telemedicine and after-hours call center; Project LAUNCH; Neonatal Abstinence Syndrome; Newborn Screening; and Health Literacy.
- Arkansas Children’s Hospital partnerships include: MIECHV home visiting; Perinatal Regionalization; NWPC; ICDR; Genetic Health Advisory Committee; Medical Home Committee; Leadership Education on Neurodevelopmental and Related Disorders; Child and Adolescent Service System Program; and Injury Prevention Center.
- Arkansas Board of Health is the lead agency for the Arkansas Board of Health, which meets quarterly and has representatives from Arkansas’s professional boards of medicine, nursing, dentistry, pharmacy, chiropractic, and hospital administration.
- Arkansas Perinatal Forum includes stakeholders working on different aspects of perinatal health. Stakeholders share data and discuss activities in the state related to perinatal health to broaden the knowledge of what is happening in Arkansas, identify opportunities for synergies, and avoid duplication of activities.
- Breastfeeding Workgroup hosts a Breastfeeding Workgroup that functions as a forum for sharing information and facilitating activities between

representatives from the Family Health Branch, Child and Adolescent Health Section, Office of Health Disparities Elimination, and WIC program as well as UAMS, ACH, and the Arkansas Breastfeeding Coalition.

- Department of Human Services (DHS, CSHCN efforts) participates in the Developmental Disability Council, Arkansas Interagency Transition Partnership, and Arkansas Lifespan Respite Coalition.
- Arkansas School for the Deaf (ASD) Statewide Services for the purpose of providing diagnostic audiologic evaluations for infants requiring follow-up from newborn hearing screening.
- Healthy Birth-Day (HBD), Inc., for the purpose of providing statewide Count the Kicks, a stillbirth prevention public health campaign.
- ADH Division for Local Public Health, Southeast Public Health Region and Child and Adolescent Health for the purpose of supporting the implementation of the WIC Baby and Me parenting program to promote best practices for strengthening the parent/child relationship, promoting healthy child development, and connecting parents to community resources.
- University of Arkansas at Little Rock/MidSOUTH for the purpose of obtaining technical services to implement the Women, Infant and Children (WIC) Baby and Me Parenting Program in selected WIC clinics across the state. The parenting program focuses on strengthening parent/child relationships, promoting healthy child development, connecting parents to community resources, and reinforcing hospital and primary care physician education.
- ADH Tobacco Prevention and Cessation Program (TPCP), ADH School Health Services Program (SHS), and Arkansas Center for Health Improvement (ACHI) provides the maintenance of a web-based Body Mass Index (BMI) data entry system for both obesity surveillance and health information for parents. The sub-grant also covers the maintenance of data storage and an annual assessment report of BMI student data.
- UAMS Women & Infant Health Service Line for the purpose of providing comprehensive and risk appropriate maternity care to low-income women throughout Arkansas.

For the purpose of carrying out provisions of Titles V and XIX of the Social Security Act, a memorandum of agreement (MOA) was updated to effectively administer the coverage of medical services through ADH's Title XIX Program and to ensure Medicaid coverage for Title V (Maternal and Child Health Block Grant) services provided to eligible individuals receiving Title V services.

The updated MOA between the Title V program and the Medicaid program, builds on the areas of coordination and collaboration. A copy of the most recently signed IAA/MOU located in Section IV of this Application/Annual Report.

Title V program and Title XIX Medicaid program share a common goal of working to improve the overall health of the MCH population, including CSHCN, through affordable health care delivery systems and expanded coverage. Partnership and collaboration between these two programs allow for the effective leveraging of federal and state resources, which yields administrative efficiencies to help ensure that women and

children are provided needed preventive services, health examinations, treatments and follow-up care (family planning, immunization, maternity and infant care, sexually transmitted disease services, and other clinical services).

Examples of delineate coordination and collaboration responsibilities for Title V programs and DDS Children's Special Services program are as follows below:

- DDS direct care coordination for children who are at risk of and/or diagnosed with a hearing condition through varied agencies.
- Providing targeted case management services to assist families of Children's Special Services eligible children in accessing all medical, social, education, and other services appropriate to the Children's Special Services Program.
- Providing specific, individualized information in the EHDI Information System based on EHDI federal reporting criteria to the IHP
- Percent of State Children's Health Insurance Program (SCHIP) enrolled children under 1 year of age receiving at least 1 initial EPSDT screening. in the previous calendar year.

Data sharing between ADH and DMS is vital to ensure mandatory data reporting as required by the Title V MCH Block Grant federal funder. The agreed upon exchange of data enables ADH and DMS to improve Title V and Title XIX program administration and outcomes, develop performance measures that rely on shared data, and facilitate joint planning efforts to identify service delivery gaps to improve delivery of service.

II.D.1. Family and Community Partnerships

MIECHV Family and Community Partnerships: The Arkansas Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program values and attributes many successes to its family and community partnerships. These partnerships include Baptist Health, Arkansas Children's Hospital (ACH) - Arkansas Home Visiting Network (AHVN), and the ACH Infant Child Death Review (ICDR) program in addition to participation in advisory committees and coalitions. Such partnerships strengthen collaborative efforts between the MIECHV program and Title V initiatives. Each of the home visiting models, Nurse Family Partnership (NFP), Health Families of America (HFA), Home Instruction for Parents of Preschool Youngsters (HIPPY), Parents as Teachers (PAT), and Following Baby Back Home (FBBH), have advisory boards comprised of the program state leader and a member from Arkansas Children's Hospital (ACH), Arkansas Home Visiting Network (AHVN), University of Arkansas for Medical Sciences (UAMS), and the Arkansas Department of Health (ADH). Additionally, national accreditation requirements mandate that each program's advisory board contains at least one parent who is either currently enrolled or has successfully completed the home visiting program.

In addition to the advisory boards, each home visiting model incorporates parent surveys. The surveys allow all participants to provide input on topics of interest, home visit planning, and methods of improving the home visiting program. While some of the surveys are optional, models like PAT, HFA, and HIPPY require program supervisors to directly contact parents to solicit feedback regarding the quality of work completed during home visits. The information not only helps to inform and gauge program performance; it also is incorporated into the home visitor's performance evaluation. Another method of fostering family and community engagement is through group meetings. Each home visiting model hosts frequent group meetings in which parents are to collaborate with other parents. Participants are also given the opportunity to offer insights to program staff and community partners regarding program successes and challenges.

The ADH Baptist Health partnership supports the Arkansas Breastfeeding Helpline which provides 24/7 support by a registered nurse who is an International Board-Certified Lactation Consultant. This service provides free access to specialized support for breast-feeding mothers. Mothers can even call from their hospital room before leaving. Texting was added to address the barrier of limited call minutes for many at-risk mothers. ZipMilk.org was added to assist with support resources and locating the nearest in-person lactation specialist. An updated Helpline flyer was developed to include these services. There were 5,301 total Helpline calls during the 2023-2024 grant cycle. Groups like Arkansas Coordinated School Health, Arkansas Minority Health Commission, Community Health Centers of Arkansas, and Delta Community Connections have assisted with providing breastfeeding education and support to communities.

Other quality improvement initiatives have been realized through work driven by the American Rescue Plan Act (ARPA) Grant and the Health Resources and Services Administration (HRSA) Innovation Grant. ARPA funding allowed for increased

collaboration with community and family partners alike to identify and implement strategies for improving home visitor recruitment and retention. For example, during FY2024, the AHVN Community Alignment Manager, Process Improvement Engineer, and the AHVN Director led sixteen focus groups across the state to solicit input from home visitors, community advocates, and parents. The focus groups concentrated on topics like successes and challenges home visitors face, data-related training activities, mental health, and even how local implementing agencies (LIAs), community members, families, and funders perceive the home visiting program. From these focus groups, recommendations were collected. Many of the recommendations have already been implemented. For example, more enhanced mental health services are being provided to home visitors. Also, more in-depth training and home visitor onboarding are provided, which has already demonstrated success in home visitor recruitment and retention.

The HRSA Innovation Initiative has provided quality improvement opportunities regarding home visits. Integrating enhanced technology into the home visiting program, the Innovation Initiative provides for numerous quality improvement opportunities. Like the work performed under the ARPA grant, utilized a community of practice (COP) approach to bring together home visiting professionals, families, and community partners to promote knowledge-sharing, peer discussions, problem-solving, and program planning. Additionally, sustainable evaluation methods and continuous quality improvement (CQI) measures were identified. As such, women and perinatal/infant health and wellbeing efforts are improved, benefitting both the MIECHV program and Title V initiative.

MIECHV also has strong partnerships with organizations like the ADH Women, Infants, and Children (WIC) program and the ACH Infant Child Death Review (ICDR) committee. MIECHV works in conjunction with the ADH WIC program to capture data that drives current and future policies/procedures to provide better health and wellbeing to mothers and infants. For example, FY2024 data obtained through the MIECHV program home visits indicates that 58.9% of infants who were ever breastfed were enrolled in the WIC program. Also, regarding the safe sleep initiative, MIECHV data notes that 90.3% of women enrolled in the WIC Plus Baby & Me program placed their infants on their back to sleep. Such data drives process and quality improvement by indicating what programs are working well as well as where greater focus is needed. The same is true for data collected through the ICDR program. Not only does ICDR data aid in quality improvement, other initiatives regarding education and information sharing contribute as well. For example, in 2024, the ICDR program hosted 36 local team and panel meetings, one annual conference, and two Sudden Unexplained Infant Death (SUID) trainings. These events were held for the purpose of raising infant death awareness and for providing education to parents with infants in the home.

Infant Hearing: The Child Health (CH) Section houses the Infant Hearing Program (IHP), which serves as the state Early Hearing Detection and Intervention (EHDI) program. The IHP partners with the only unbiased family-based organization in the state that has specialized experience in delivering family-to-family services (FSS) for Deaf/Hard of Hearing (DHH) children and their families, the Arkansas Hands & Voices (H&V) Chapter, to increase access to care. The IHP provides fiscal support to the H&V

Chapter to facilitate the Guide by Your Side (GBYS) educational program; Advocacy, Support, and Training (ASTra) program; host family events to allow families with DHH children to gather and connect with one another in various areas of the state; support parents' attendance at national conferences such as the annual EHDI meeting and the H&V Leadership Conference and to support GBYS staff's attendance at IHP stakeholder meetings. Through this partnership, the IHP endeavors to enable parent leaders to provide peer support for families with DHH children in addition to involving parent leaders in conducting effective outreach activities and strategic planning. CH staff supported by MCH funds, including the CH Section Chief and IHP Follow-up Coordinator, are vital in facilitating the family partnership with H&V.

This family partnership provides peer support for families with DHH children through the GBYS and ASTra programs and family events. These programs ensure each identified family has access to a Parent Guide (parent of a DHH child) and a DHH Guide (DHH adult) to assist the family in connecting to resources as they navigate the early intervention system in addition to providing access to advocacy support for families with school age children navigating the education system. Guides and Advocacy Advocates provide virtual one-on-one support and attend family events to serve families. During the reporting period, CH staff met with H&V staff monthly to conduct strategic planning to support opportunities for improvement in increasing in the number of families with DHH children enrolled in FSS before the child is six months of age in addition to connecting the family to a DHH adult before the child is nine months of age. These discussions led to modifications to the GBYS Family Cycle to increase enrollment in FSS by ensuring all families received an initial call from the GBYS Coordinator to promote consistent education to families and to add strategic referrals to primary care physicians and/or audiologists when children were not enrolled in FSS by six months of age to reduce the number of infants lost to follow-up.

Additionally, the IHP partners with H&V members to assist the IHP in increasing the effectiveness of outreach and training activities by ensuring the family voice is included when developing educational materials and/or delivering presentations to health care providers to increase awareness of EHDI recommendations. H&V staff provided content for educational materials and engaged providers (i.e. primary care physicians and audiologists) statewide to increase awareness of the importance of FSS for DHH children and their families. Lastly, this partnership facilitates parent participation in advisory board and stakeholder meetings. H&V staff obtained a nominee for the parent representative on the Universal Newborn Hearing Screening, Tracking, and Surveillance Advisory Board and ensured a parent representative attended meetings for the language acquisition workgroup that was established in 2024. Parent participation was vital for each of these stakeholder groups as they worked to develop state recommendations for follow-up care to effectively support families with DHH children. The following chart identifies the key outcomes of this partnership to increase access to care for DHH children and their families in recent years:

H&V Partnership Outcomes

	2022	2023	2024
Total DHH Child Referrals	28	43	67
Total Enrolled in FSS	17	26	51
Total Connected to a DHH Guide	6	13	30
Total served at H&V Events	236	373	482

Source: H&V ZOHO Report, Run 4/21/2025

CSS Family and Community Partnerships: Family partnerships and leadership were supported by the Title V Children with Special Health Care Needs (CSHCN) domain by employing a Parent Consultant to work directly with families and the Parent Advisory Council (PAC). The Parent Consultant from the previous year retired but a new one was hired in February 2024 to provide direct support to families and family organizations connected to Children's Special Services (CSS). The Parent Consultant joined CSS and continued relationships from previous years as well as adding new partnerships and relationships.

Engaging families include giving parents of CSHCN the opportunity to gain leadership skills as a member of the Parent Advisory Council (PAC) which has been a sustained stakeholder group for Title V CSHCN since 1990. The PAC is entrusted to advocate and educate other families of children with special health care needs, health care professionals, and government agencies. Goals of the PAC include:

- Providing the link between families of CSHCN and available services
- Providing input and feedback to agencies on service delivery to CSHCN and their families
- Promoting access and utilization of family support groups
- Educating service providers concerning the changing needs of CSHCN and their families
- Educating families and partners about current health care issues

PAC members meet quarterly in-person to discuss current needs. Information is shared at the quarterly meetings in which PAC members can share in their local communities. Guest speakers at the 2024 quarterly meetings were from Arkansas Disability Coalition – Family 2 Family, Dennis Development Center's Family Navigator, and the DDS Director. During one of the quarterly months, the PAC also received an introductory presentation to Medical Homes. In 2024, the PAC began meeting monthly by zoom to continue supporting one another and to ensure activities are ongoing throughout the year. PAC members coordinate local community meetings and attend other local events. In 2024, the PAC coordinated three community meetings, attended events as a vendor at two events and coordinated the 11th Family Bistro Conference & Disability Resource Expo in Conway, AR. Families received education on current and emerging needs related to children with special health care needs and their families. There were 56 attendees and 22 vendors at this event. Topics presented include Title V; IEPs, 504's and IFSP's; Guardianship and Special Needs Trusts; Bullying, Cyberbullying & School Safety; Advocacy 101; To Puberty & Beyond; You're the Reason Your Kids Are So Ugly.

All the vendors provide services for CSHCN including care coordination, therapies, childcare, family support, durable medical equipment, CES Waiver, health insurance and life insurance.

The PAC has membership with the Kids Count Coalition an affiliate of Arkansas Advocates for Children, where information is shared regarding children with and without special health care needs including economic well-being, education, health, and family and community. The Parent Consultant attended Lunch and Learn to discuss the 2024 Kids Count Data Book. Arkansas' rankings were as follows:

- Economic Well-Being (46th)
- Education (36th)
- Health (47th)
- Family and Community (46th)

The Kids Count Coalition conducted Children's Policy Roundtables in different parts of the state, and the Parent Consultant attended the roundtable in Fort Smith to listen to the needs of the community. Children's Policy Symposiums were also conducted this year.

The Arkansas Disability Coalition is the Family 2 Family Health Information Center (F2F) and the Family Voices Affiliate Organization in Arkansas. The purpose of the F2F program in Arkansas is to provide family-led and peer-designed education, training, and resources to meet the information and advocacy needs of families of CSHCN and the professionals who serve them. Goals of Family 2 Family include:

- Improving access to health care
- Improving utilization of available resources
- Creating partnerships across the health care system between families of CYSHCN and service providers.

F2F receives a subgrant from Title V to provide health-related information, resources, support and training. F2F Specialists assist parents with completing initial Medicaid applications, Medicaid renewals, and assist with appeals when needed. Additionally, F2F Specialists participate in outreach events at local community events. During these events, F2F assists families by providing information related to CSHCN and can assist families in completing applications for Title V, diagnostic screenings and testing, therapies, respite, CES Waiver, and Autism Waiver. In 2024, F2F provided direct services to 1,991 families; 2,581 professionals; and 107 training courses. F2F created a Family Health Care Plan Book/Binder that is shared with families. In 2024, over 160 families received a Health Care Plan Book that was created to equip families to participate more effectively in the process of their child's overall health care. Families who use them consistently report a sense of empowerment and are more fully engaged when collaborating with professionals during the decision processes regarding their child's health. Health Care Plan Binders/Books are available in English and Spanish languages.

The Arkansas Disability Coalition implemented the Leadership Gym in 2024, which is a program that aims to improve family advocacy skills, mentorship, and grow a leadership

legacy to improve communities in Arkansas. The Leadership Gym is a nine-week program that started in January 2024 and concluded in October 2024.

Project DOCC (Delivery of Chronic Care) is a medical education program that strives to improve the quality of life for children who are chronically ill and/or developmentally disabled and their families. Project DOCC uses parents as educators to train medical residents about their children's special needs in the community. Project DOCC's mission is to promote an understanding of the issues involved in caring for a family living with special health care needs regardless of age, diagnosis or prognosis. Parents can participate in Project DOCC two ways (1) serving as a Host Teacher by inviting the resident into his/her home for a meetings (2) Parent Interviews based on Project DOCC's Illness History Questionnaire.

During SFY 2023-2024, 27 residents were trained, with 87 total family encounters. At the end of 2024, Children’s Special Services began collaboration with Arkansas’ Infant Hearing Program to develop educational material to ensure that families receive programmatic information for all available services for children with special health care needs in one resource document.

Other partners include University of Arkansas Partners for Inclusive Communities, Arkansas Lifespan Respite Coalition, Arkansas Governor’s Commission on People with Disabilities, Arkansas Rehabilitation, ICAN, Disability Rights of Arkansas, Arkansas Advocates for Children and Families – Kids Count Coalition, Arkansas Children’s Hospital, Infant Hearing Program, and Local Union 155 for Pipefitters. One of the members of the Local Union 155 for Pipefitters is the father of a PAC member. During the promotion of the 11th Family Bistro Conference, the Union member mentioned the Family Bistro during one of their monthly meetings. The President was so deeply moved and voiced that he did not know there were so many families in need. This led him to wanting to help in any way he could, leading to a sponsorship for the 2024 Family Bistro Conference.

In 2024, the Parent Consultant attended the following training: Beyond the Borders Conference, Trauma-Informed Culturally Informed Care in the Hospital Setting, 25th Annual Chronic Illness and Disability Conference: Transition from Pediatric to Adult-Based Care, 2024 Federal-State MCH Partnership Meeting. The Parent Consultant attended the following events: Inspire Saline County; Benton Farmers Market; Pulaski County Special School District College, Career & Transition Fair; and AVID College & Career Readiness Relational Capacity Day at Maumelle High School. The Parent Consultant presented Title V from the family engagement aspect at the DeQueen Primary Public Schools Teacher In-Service, including points from the Blueprint for Change and ways educators and school personnel can ensure children access to needed resources related to their child.

III.E. Identifying Priority Needs and Linking to Performance Measures

Findings from the five-year needs assessment web-based MCH stakeholder survey, focus groups, and stakeholder interview were used to identify common themes in the most pressing MCH population health needs and strengths, weaknesses, and gaps in public health systems. The survey included both open-ended and close-ended questions. Open-ended questions, as well as results from the focus group and interviews, allowed for a deeper exploration of public health issues, challenges, and opportunities for new strategies and collaboration. MCH stakeholders from across the state were invited to participate, including state and local agencies, partner organizations, community groups, and families and family-led organizations.

Data from the interim needs assessment conducted last spring, secondary data sources (e.g., vital records, PRAMS, AMMRC, WIC, Infant Hearing Program, NSCH, YRBS, Infant and Child Death Review), and statewide needs assessments and strategic plans highlighting focus areas and initiatives from MCH partners and organizations also guided discussion and selection of needs.

Title V leadership and key MCH partners reviewed needs for each domain, and eight priority needs were selected or developed for the five-year reporting cycle.

Table 4: Title V Priority Needs & MCH Population Domains

Priority Need	Women/ Maternal	Perinatal/ Infant	Child	Adolescent	CSHCN
Postpartum visit	X				
Persistently high infant mortality rate		X			
Developmental Screening		X			
Access to care			X		X
Physical activity			X		
Tobacco use				X	
Child Safety Due to Intentional Injury / Bullying				X	
Transition to adulthood					X

The table below displays priority areas from the 2021-2025 and the 2026-2030 grant cycles. While some priority needs were continued or revised, others were removed and replaced with new priority needs.

Table 5: Priority Needs from Years 2021-2025 and 2026-2030 State Action Plans

MCH Population Domain	2021-2025 Priority Needs	2026-2030 Priority Needs	Rationale for Change (if any)
Women / Maternal	• Well Woman Care • Oral Health during Pregnancy	• Postpartum Care - NEW	This new priority need emphasizes the strong focus on ensuring women have quality visits assessing maternal recovery, addressing chronic health conditions, supporting mental health, and providing guidance on family planning. This change aligns with current MCH strategic plan initiatives and legislation in the state and nation.
Perinatal / Infant	• Persistently High Infant Mortality Rate *(risk-appropriate care, breastfeeding, safe sleep)* • Access to Care *(timely follow-up after newborn does not pass hearing screening)*	• Persistently High Infant Mortality Rate *(safe sleep)* - CONTINUED • Developmental Screening *(timely follow-up after newborn does not pass hearing screening)* - REVISED	The priority need “Access to Care” was retitled to “Developmental Screening” to more accurately reflect the public health issue being addressed.
Child	• Developmental, Behavioral and Mental Health of Children *(developmental screening)* • Child Safety Due to Intentional Injury *(hospitalizations rate)*	• Physical Activity – CONTINUE • Access to Care *(medical home)* - NEW	Access to a medical home providing components of recommended care was a common theme in the needs assessment across all domains. Adding this priority need aligns with other MCH partner strategic plans.

	• Physical Activity		
Adolescent	• Physical Activity • Child Safety Due to Intentional Injury *(bullying)* • Transition to Adulthood • Access to Care *(use of nicotine products among youth)*	• Child Safety Due to Intentional Injury / Bullying – REVISED • Tobacco Use – REVISED	The two 2026-2030 priority needs were retitled to better convey the public health issues facing adolescents in the state.
CSHCN	• Transition to Adulthood • Access to Care *(receipt of services needed)*	• Transition to Adulthood – CONTINUED • Access to Care *(receipt of services needed, medical home)* - CONTINUED	
Cross-Cutting/Systems Building	• Access to Care		The agency does not support this activity.

The Arkansas Title V grant will continue working on many of the previously identified needs that have been removed from the list of priority needs as well as some of the other needs identified in the current needs assessment. (See State Action Plan domain narratives for additional explanation about changes to the domain-specific priority needs, measures, and State Action Plan.)

The needs assessment highlighted several other emerging issues or needs that were not selected as a priority need for the Arkansas Title V MCH Block Grant (see the Needs Assessment Findings: MCH Population Well-Being section for a more detailed description of other needs and challenges identified for each domain group). Several priority needs that were selected align with other MCH state and national initiatives and are supported by legislation and by evidence-based or – supported strategies that are feasible and can affect change.

The priority needs guided selection of national performance measures (NPM) and state performance measures (SPM).

Table 6: Priority Needs, MCH Population Domains, and Selected NPMs and SPMs

Priority Need: Postpartum Visit
Domain: Women / Maternal Health NPM: Postpartum Visit – PPV 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 Postpartum visits are critical for assessing maternal recovery, providing mental health support, addressing chronic conditions, and ensuring proper family planning. Recommended care components improve health outcomes by addressing medical, emotional, and lifestyle factors that impact maternal well-being.
Priority Need: Persistently High Infant Mortality Rate
Domain: Perinatal / Infant Health NPM: Safe Sleep – SS 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 Sleep related deaths continue to be a major contributor of infant mortality nationwide. Arkansas is one of the leading states for infant mortality. Safe sleep practices help lower incidences of infant mortality.
Priority Need: Developmental Screening
Domain: Perinatal / Infant Health SPM: Percent of newborns with timely follow-up of a failed hearing screening Early identification of developmental disorders is critical to the well-being of children and their families. Early hearing detection and intervention improves quality of life and reduces risk for communication delays in children.
Priority Need: Physical Activity
Domain: Child Health NPM: Physical Activity – PA-Child Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Regular physical activity can improve the health and quality of life of Americans of all ages, regardless of the presence of a chronic disease or disability.

Priority Need: Access to Care

Domains: Child Health, CSHCN

NPM: Medical Home – MH. Percent of children with and without special health care needs, ages 0 – 17, who have a medical home

The American Academy of Pediatrics recommends every child should have a medical home to ensure family-centered, comprehensive care coordination. Studies have shown that children with a medical home are more likely to receive preventive care to support early identification and intervention enrollment in addition to avoiding hospitalization for preventable conditions.

Domain: CSHCN

SPM: Percent of families with children with special health care needs served by Title V CSHCN who report that their child received the health care services they needed

The Title V CSS Program seeks to provide and promote family-centered, community-based, coordinated care and facilitates the development of community-based systems of services for children with special health care needs and their families.

Priority Need: Child Safety Due to Intentional Injury / Bullying

Domain: Adolescent Health

NPM: Bullying – BLY. Percent of adolescents, with and without special health care needs, ages 12 through 17, who are bullied or who bully others

Bullying, particularly among school-age children, is a major public health problem that is associated with a number of behavioral, emotional, and physical adjustment problems. Adolescents who bully others tend to exhibit other defiant and delinquent behaviors, have poor school performance, be more likely to drop-out of school, and are more likely to bring weapons to school. Victims of bullying tend to report feelings of depression, anxiety, low self-esteem, and isolation; poor school performance; suicidal ideation; and suicide attempts. Bullying victims who also perpetrate bullying (i.e., bully victims).

Priority Need: Tobacco Use

Domain: Adolescent Health

NPM: Tobacco Use – TU. Percent of adolescents, grades 9 through 12, who currently use tobacco products

Tobacco use has been linked to several diseases including cancer, heart disease and stroke, lung diseases, harmful reproductive effects, and other health conditions. Adolescence is a critical state of development when children grow physical, cognitively, emotionally, and socially to become adults. The lifestyle choices, behaviors, and relationships established during this time can affect an adolescent's current and future health.

Priority Need: Transition to Adult Health Care

Domain: CSHCN

NPM: Transition to Adult Health Care – TAHC. 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

The transition of youth to adulthood has become a priority issue nationwide as evidenced by the clinical report and algorithm developed jointly by the American Academy of Pediatrics, the American Academy of Family Physicians, and the American College of Physicians to improve healthcare transitions for all youth and families. Over 90 percent of children with special health care needs now live to adulthood, but they are less likely than their non-disabled peers to complete high school, attend college or to be employed. Health and health care are cited as two of the major barriers to making successful transitions.