HRSA
Health Resources & Services Administration

Title V MCH Block Grant Program

ARKANSAS

State Snapshot

FY2026 Application / FY2024 Annual Report

December 2025

Title V Federal-State Partnership - Arkansas

The Title V Maternal and Child Health Block Grant Program is a federal-state partnership with 59 states and jurisdictions to improve maternal and child health throughout the nation. This Title V Snapshot presents high-level data and the executive summary contained in the FY2026 Application / FY2024 Annual Report. For more information on MCH data, please visit the Title V Federal-State Partnership website (https://mchb.tvisdata.hrsa.gov)

State Contacts

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SSDI Project Director	State Family Leader
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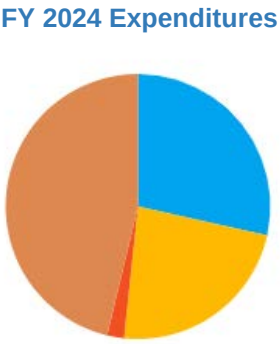
State Youth Leader
No Contact Information Provided

State Hotline: (800) 235-0002

Funding by Source

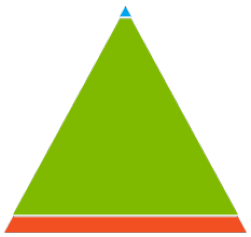
Source	FY 2024 Expenditures
Federal Allocation	$7,394,830
State MCH Funds	$6,016,725
Local MCH Funds	$0
Other Funds	$537,213
Program Income	$11,997,115



Funding by Service Level

Service Level	Federal	Non-Federal
Direct Services	$335,699	$2,264,526
Enabling Services	$6,535,522	$15,315,612
Public Health Services and Systems	$523,609	$537,213

FY 2024 Expenditures Federal



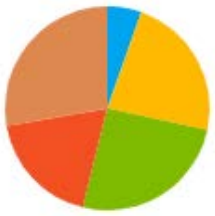
FY 2024 Expenditures Non-Federal

Percentage Served by Title V

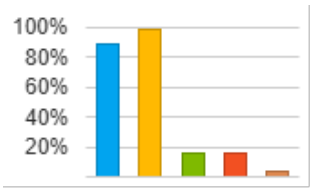
Population Served	Percentage Served	FY 2024 Expenditures
Pregnant Women	88.9%	$1,378,998
Infants < 1 Year	98.0%	$5,916,563
Children 1 through 21 Years	16.2%	$6,520,698
CSHCN (Subset of all infants and children)	16.2%	$4,696,819
Others *	4.2%	$7,127,776

*Others– Women and men, over age 21.

FY 2024 Expenditures
Total: $25,640,854



FY 2024 Percentage Served



The Title V legislation directs States to conduct a comprehensive, statewide maternal and child Health (MCH) needs assessment every five years. Based on the findings of the needs assessment, states select seven to ten priority needs for programmatic focus over the five-year reporting cycle. The State Priorities and Associated Measures Table below lists the national and state measures the state chose in addressing its identified priorities for the 2025 Needs Assessment reporting cycle. All states are also reporting on two Universal National Performance Measures, Postpartum Visit and Medical Home.

State Priorities and Associated Measures

Priority Needs and Associated Measures	Priority Need Type	Reporting Domain(s)
Postpartum Visits NPMs • 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 - PPV o ESM PPV.1: Percent of Arkansas Home Visiting Network providers trained on postpartum care best practices	Continued	Women/Maternal Health
Persistently High Infant Mortality Rate NPMs • 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 - SS o ESM SS.1: Percent of women enrolled in the WIC Plus Baby and Me Program who place their infant to sleep on their back	Continued	Perinatal/Infant Health
Developmental Screening SPMs • SPM 1: Percent of children with timely follow-up evaluation after not passing the hearing screening	Revised	Perinatal/Infant Health

Access to Care
 	
NPMs
• Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH
  o ESM MH.1: (Child Health) Number of educational materials distributed
  o ESM MH.2: (CSHCN) Percent of Title V CSHCN PCP practices who participate in the Arkansas Patient-centered Medical Home network
	Continued	Child Health,
		Children with Special Health Care Needs

○ ESM MH.3: (CSHCN) Percent of Title V CSHCN receiving care in the AR PCMH network who report the care they received meets medical home principles ○ ESM MH.4: (CSHCN) Percent of Title V CSHCN staff who participate in a medical home training SPMs • SPM 2: 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		
Physical Activity NPMs • Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day - PA-Child ○ ESM PA-Child.1: Percent of school personnel who participated in Coordinated School Health training with increased knowledge of evidenced-based physical activity practices and curriculum and physical activity ○ ESM PA-Child.2: Percent of children attending public schools, grades K through 5, who are in the normal or healthy weight zone for Body Mass Index.	Continued	Child Health
Tobacco Use NPMs • Percent of adolescents, grades 9 through 12, who currently use tobacco products - TU ○ ESM TU.1: Number of students, grades 9 through 12, who participate in tobacco education training	Continued	Adolescent Health
Child Safety Due to Intentional Injury / Bullying NPMs • Percent of adolescents, with and without special health care needs, ages 12 through 17, who are bullied or who bully others - BLY ○ ESM BLY.1: Number of school personnel, partners, and community members participating in mental health related trainings	Continued	Adolescent Health
Transition to Adulthood	Continued	Children with Special Health Care Needs

NPMs

- 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 - TAHC
  - ESM TAHC.1: Percent of PCP practices of transition age children (12 through 17) receiving Title V CSHCN services that participate in the Six Core Elements of Health Care Transition self-assessment
  - ESM TAHC.2: Percent of Title V CSHCN (ages 12 through 17) with an annual update to the transition plan developed with the youth and family
  - ESM TAHC.3: Number of School-based Health Center Coordinators that complete a Title V Health Care Transition Readiness Assessment Survey with questions regarding the school district's health center
  - ESM TAHC.4: Number of CSHCN (ages 12-17) with an annual update to the transition plan developed with the youth and family.

Executive Summary

Program Overview

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

III.A. Executive Summary
III.A.1. Program Overview

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

The MCH programs are housed in the ADH's Family Health Branch (FHB), which is part of the agency's Division for Health Advancement (DHA). Arkansas's MCH Program consists of shared leadership between the ADH FHB and the Arkansas Department of Human Services (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.

How Federal Title V Funds Complement State-Supported MCH Efforts

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

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

As of April 2025, the Federal-State Partnerships expenditure totaled $25,945,883. In FY25, the state spent 54.31% of the Title V funds on preventive and primary care for children, including school health programming, adolescent health, and programs focusing on safe sleep, breastfeeding, and reducing child maltreatment. CSHCN supported 31.34% of care coordination, specialty outreach

clinics, respite care, support for family involvement, and home modifications. Maternity services for pregnant women spent 10 percent (10.09%). The Family Planning Program receives funding via Title X, as well as commercial and Medicaid reimbursement.

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

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

MCH Success Story

III.A.3. MCH Success Stories
This year's success stories represent how the Arkansas MCH programs assisted mothers and CSHCN through coordinated care, family-centered, and community-based services.

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

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

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

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

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

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

Maternal and Child Health Bureau (MCHB) Discretionary Investments - Arkansas

The largest funding component (approximately 85%) of the MCH Block Grant is awarded to state health agencies based on a legislative formula. The remaining two funding components support discretionary and competitive project grants, which complement state efforts to improve the health of mothers, infants, children, including children with special needs, and their families. In addition, MCHB supports a range of other discretionary grants to help ensure that quality health care is available to the MCH population nationwide.

Provided below is a link to a web page that lists the MCHB discretionary grant programs that are located in this state/jurisdiction for Fiscal Year 2024.

List of MCHB Discretionary Grants

Please note: If you would like to view a list of more recently awarded MCHB discretionary investments, please refer to the Find Grants page that displays all HRSA awarded grants where you may filter by Maternal and Child Health.