Maternal and Child Health Services Title V Block Grant

Arkansas

FY 2024 Application/ FY 2022 Annual Report

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Arkansas Department of Health

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Governor Sarah Huckabee Sanders
Renee Mallory, RN, BSN, Interim Secretary of Health
Jennifer Dillaha, MD, Director

June 15, 2023

HRSA Grants Application Center
ATTN: MCH Block Gant
901 Russell Avenue, Suite 450
Gaithersburg, MD 20879

To Michele Lawler,

Enclosed is a copy of the Arkansas Maternal and Child Health Services Title V Block Grant 2024 Application and the 2022 Annual Report.

Arkansas is not requesting a waiver of the 30 percent allotment of the federal allocation for Children with Special Health Care Needs.

If you have any questions or require additional information regarding this application, please contact Dr. Hattie Scribner at (501) 661-2495 or email her at Hattie.Scribner@arkansas.gov.

Respectfully,

Renee Mallory, RN, BSN
Interim Secretary of Health

I.B. Face Sheet

The Face Sheet (Form SF424) is submitted electronically in the HRSA Electronic Handbooks (EHBs).

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix F of the 2021 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms,"* OMB NO: 0915-0172; Expires: January 31, 2024.

II. Logic Model

Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: January 31, 2024.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

Arkansas Title V Maternal and Child Health Services Block Grant
2022 Report and 2024 Application

III.A. Executive Summary

III.A.1. Program Overview

This annual report represents the second submission under the Maternal and Child Health (MCH) federal guidance for the 2021-2025 cycle and includes National Performance Measures (NPM), State Performance Measures (SPM), and Evidenced-based/Evidence-Informed Strategy Measures (ESM).

The Arkansas Department of Health (ADH) is one of 15 state agencies comprising the executive branch under the direction of Governor Sarah Huckabee Sanders leadership. The Title V Maternal and Child Health Block Grant (MCHBG) supports the ADH's mission and vision by addressing emerging and priority needs, improving gaps in and barriers to access to care, and increasing the capacity of the public health and health care systems and workforce.

The MCH programs are housed in the ADH's Family Health Branch (FHB), which is part of the agency's Center for Health Advancement (CHA). Arkansas's Title V MCHBG Program consists of shared leadership between the ADH Family Health Branch and the Arkansas Department of Human Services' (ADHS) Children with Chronic Health Conditions Program within the Division of Developmental Disabilities Services (DDS). The state Title V MCH leadership team makes program and policy decisions and ensures alignment across programs and agencies. Designated state priority leads oversee program and policy work and provide technical assistance and oversight to local Title V grantees.

ADH conducted a needs assessment for Title V and Maternal, Infant, and Early Childhood Home Visiting (MIECHV) grant programs during 2019 and 2020. Arkansas used a mixed-methods approach, which allowed the state to gather information from local, state, and national sources as well as internal colleagues and external partners. In-person stakeholder meetings, surveys, and virtual domain meetings comprised the methods of assessment strategies. Findings from those assessments informed the selection of priority needs, strategies, objectives, and measures in the state's 2021-2025 Title V action plan.

In 2020, the Arkansas Title V staff established domain specific working groups. Each group is made up of stakeholders with lived experience, professional expertise, and/or community leadership and engagement skills who serve in an advisory capacity to the Arkansas Title V team. Annually, each domain met with stakeholders in the fall of 2022 to discuss program updates. Attendees included the Arkansas's Physician Associations, Family-Based Organizations, Department of Education, Children with Special Health Care Needs (CSHCN), Part C, Head Start Collaboration, Advocates for Children and Families, ADH interagency department (e.g., WIC, Chronic Disease), pediatricians, AR Transition Services, parent information and advocacy groups such as Family 2 Family (F2F) and the Center for Exceptional Families (TCFEF), Early Childhood Special Education (Arkansas Department of Education), First Connections, and Arkansas' Part C Early Intervention Program.

Arkansas identified 15 areas of concern, 11 of which align with national performance measures. The national priorities include well woman care, neonatal care for low birthweight infants, breastfeeding, infant safe sleep,

developmental screening, child injury, physical activity among children and adolescents, bullying, transition to adult care for children with and without special health care needs, and oral health during pregnancy.

The state-specific priorities are newborn hearing screening, adolescent nicotine use, and the health care system for children with special health care needs. An overview of Arkansas's Title V MCH needs, including emerging needs, gaps in services, program capacity, and internal and external partners for each domain is outlined below.

Women/Maternal Health. Mental health was a constant survey theme for this group. Among the 53 participants responding to this question, nearly half (49%) cited mental health services as one of the three most important gaps in women's health. Mental health disorders were listed as the fourth most important for Arkansas women. Other important gaps in services for women included the availability of health care providers (32%), transportation (30%), and illicit or other drug abuse prevention programs (30%).

Perinatal/Infant Health. Almost half (47%) of the 49 participants responding stated the availability of transportation was an important gap in the state for perinatal and infant health. Almost two-thirds (60%) of respondents stated they would like to see new strategies or interventions for making transportation more available. A lack of health care providers and specialty care compounds the problem, particularly in rural areas. Survey participants offered the following suggestions for improving access to breastfeeding support and care: provide more access to lactation experts in communities, provide additional access to lactation experts beyond telephone services, provide special group clinics with a nutritionist to assist new mothers in breastfeeding, provide more support and incentives to breastfeeding mothers, expand the ADH's breastfeeding program, provide better outreach for breastfeeding programs with local providers and hospitals, and educate hospital nurses on how to encourage new mothers to breastfeed.

Child Health. Developmental and behavior disorders (57%) ranked as the most important public health problem by respondents. Almost half (48%) of respondents reported that an existing strategy or intervention was in place for the children they serve, yet one-fifth (21%) of respondents indicated that developmental monitoring and screening was one of the top three areas where gaps existed. Childhood obesity and overweight (52%) and related risk factors such as physical inactivity (34%) and poor nutrition (32%) ranked as the second, third, and fourth most important public health problems among Arkansas children. Partners included the Arkansas School Health Team, with members from the ADH and the Division of Elementary and Secondary Education (DESE) of the Arkansas Department of Education (ADE). This team provides training, programs, and resources to reduce childhood obesity and address behavioral health needs.

Adolescent Health. Overweight and obesity was recognized as one of the most important public health problems facing adolescents (55%). Compared to children, fewer respondents believed that key strategies or interventions existed for physical health education (32.6%) and nutrition education (27.9%). Tobacco use including vaping (48%) ranked second most important. Use of electronic vapor products has been on the rise in Arkansas and across the nation. Partners include the Arkansas School Health Team and the ADH Tobacco Prevention and Cessation Program (TPCP).

Children with Special Health Care Needs (CSHCN). For CSHCN, availability of transportation was cited as the most important public health need (50%). One-fourth (24.4%) of respondents said key strategies or interventions were in place. Families have difficulty understanding, accessing, and navigating the health system for CSHCN, including Medicaid and other financial assistance, technological issues including internet access, accessing available specialists and services, and finding respite care.

The Title V program activities are in alignment with key state priorities outlined in the ADH 2020-2023 Strategic Plan and guides our work to promote health at every stage in life through policies, systems, and environmental changes, with emphasis on health equity, life course theory Arkansas's Title V MCH priorities include:

- Improve preterm, low-birthweight, and pregnancy outcomes.
- Promote breastfeeding to ensure better health for infants and children.
- Promote safe and healthy infant sleep behaviors and environments, including improving support systems and daily living conditions.
- Increase the percent of infants and children receiving a developmental screening.
- Reduce the burden of injury among children.
- Decrease the prevalence of childhood and adolescent obesity.
- Improve access to health care for women, specifically women who face significant barriers to better health, to improve preconception health.
- Increase the number of adolescents with and without special health care needs who successfully transition to adult health care.

Arkansas selected the following 11 NPM that most closely align with the priorities mentioned above.

NPM 1: Percent of women, ages 18 through 44, with a preventive medical visit in the past year.

- Obj. 76/Indic. 73.1 Not Achieved) (2022 Obj. 74/Indic. 75.5 Achieved)

NPM 3: Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU).

- Obj. 83/Indic. 80.5 Not Achieved) (2022 Obj. 81/Indic. 76.5 Not Achieved)

NPM 4A: Percent of infants ever breastfed, **B)** Percent of infants breastfed exclusively through six months.

- **A)** 2021 Obj. 72/Indic. 76.2 Achieved (2022 Obj. 76.5/Indic. 74.9 Not Achieved)
- **B)** 2021 Obj. 21/Indic. 19.9 Not Achieved (2022 Obj. 20/Indic. 24.4 Achieved)

NPM 5A: Percent of infants placed to sleep on their backs, **B)** Percent of infants placed to sleep on a separate approved sleep surface, and **C)** Percent of infants placed to sleep without soft objects or loose bedding.

- **A)** 2021 Obj. 80/Indi. 76.9 Not Achieved (2022 Obj. 77/Indic. 77.8 Achieved)
- **B)** 2021 Obj. 35/Indic. 36.8 Achieved (2022: Obj. 37/Indic. 38 Achieved)
- **C)** 2021 Obj. 41/Indic. 44.3 Achieved (2022 Obj. 45/Indic. 47.8 Achieved)

NPM 6: Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year.

- 2021 Obj. 25/Indic. 25.9 Achieved (2022 Obj. 26/Indic. 28.4 Achieved)

NPM 7.1: Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9.

- 2021 Obj. 105/Indic. 108.9 Achieved (2022 Obj. 103/Indic. 117.8 Achieved)

NPM 8.1: Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day.

- 2021 Obj. 29/Indic. 29.7 Achieved (2022 Obj. 30/Indic. 28.8 Not Achieved)

NPM 8.2: Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day.

- 2021 Obj. 23/Indic. 22.7 Not Achieved (2022 Obj. 19/Indic. 22.7 Achieved)

NPM 9: Percent of adolescents, ages 12 through 17, who were bullied or who bully others.

- 2021 Obj. 31/Indic. 29.6 Not Achieved (2022 Obj. 34/Indic. 29.6 Not Achieved)

NPM 12 (Non CSHCN): Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transitions to adult health care.

- 2021 Obj. 15.5/Indic. 16.7 Achieved (2022 Obj. 17/Indic. 13.7 Not Achieved)

NPM 12 (CSHCN): Percent of adolescents with and without special health care needs, ages 12 through 17 who received services to prepare for the transitions to adult health care.

- 2021 Obj. 14/Indic. 14.6 Achieved (FY22 Obj. 15/Indic. 20.5 Achieved)

NPM 13.1: Percent of women who had a preventive dental visit during pregnancy.

- 2021 Obj. 40/Indic. 33.9 Not Achieved (2022 Obj. 34/Indic. 41.3 Achieved)

Arkansas also selected the following four SPM to monitor progress with state priority needs not specifically addressed by an NPM. The state-specific priorities are newborn hearing screening, adolescent nicotine use, the health care system for children with special health care needs, and implicit bias in public health systems.

SPM 1: Percent of newborns with timely follow-up of a failed hearing screening.

- 2021 Obj. 61/Indic. 49.2 Not Achieved (2022 Obj. 64/Indic. 56.5 Not Achieved)

SPM 2: Percent of youth, grades 9 through 12, who report using nicotine products.

- 2021 Obj. 25/Indic. 29.2 Achieved (2022 Obj. 27.5/Indic. 20 Not Achieved)

SPM 3: 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 needed.

- 2021 Obj. 0/Indic. 0 Not Reported (2022 Obj. 15/Indic. 82.1 Achieved)

SPM 4: Percent of Family Health Branch, Arkansas Home Visiting Program, and Title V CSHCN staff who complete an equity training.

- 2021 Obj. 50/Indic. 89.2 Achieved (2022 Obj. 90/Indic. 57.8 Not Achieved)

The role of the state Title V program is supported by a variety of state and federal funding sources. Total expenditures were $37,122,483 for FY2022. Before adding other federal funds, total Federal- State MCH Partnerships Expenditures $24,656,113, a slight increase from FY2021. The MCHBG funds contribute to a portion of program management positions that are responsible for planning, oversight, and strategic work to improve public health systems. These programs strive to ensure women and children receive the health benefits they are entitled to; including preventive health services and screening, to promote the importance of coordinated care, and to address issues of health equity. Within the quality improvement initiative, the Title V staff analyze efforts, effectiveness, as well as the impact of work to improve public health policies and processes. The Title V Program's nurse care coordinators work with families to develop family-centered plans, to reach priority goals for the CSHCN 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 selected strategies are achieved through the engagement of stakeholders in the planning, implementation, and evaluation processes. Program evaluation efforts are ongoing. The MCH epidemiologist works with the Arkansas State Systems Development Initiative (SSDI) staff to provide data, measure progress, and inform decision making around program objectives and measures. Each domain is required to share the work that has been done by MCH by having an annual stakeholders meeting, a public hearing, and a public comment period.

Arkansas' noted accomplishments are related to their collaborative partnerships. Priorities have been addressed by expanding and continuing long term partnerships. The Arkansas Maternal and Perinatal Outcomes Quality Review Committee (MPOQRC) has developed a new partnership with the University of Arkansas for Medical Sciences (UAMS); who has received funding to work on perinatal regionalization, which has long been a problem for our state. State School Health and Wellness Coordinators are working to increase the partnerships between communities and their schools. The CSHCN focuses on their partnerships with medical professionals to create a well-functioning system that helps families access care.

One of the largest ongoing challenges facing MCH is staffing. The State of Arkansas has implemented a hiring freeze of any employee vacancies paid with state funds. Many of the employees who carry out the work of MCH are paid by multiple funding sources and this hiring freeze does affect the work that these employees are able to do in fulfilling the priorities and outcomes of Title V.

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 (LHU) and in the communities. Program staff participate on various committees and boards to remain abreast of information and trends to develop strategies essential to reducing service gaps statewide. A few examples include 1) Arkansas Maternal/Perinatal Outcomes Quality Review Committee (MPOQRC), which review data on births and to develop strategies to improve outcomes; 2) Arkansas Maternal Mortality Review Committee (MMRC) 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 statewide; 4) Excel by Eight Initiative – a collaborative advocating to improve health and education outcomes for infants and toddlers; and 5) Arkansas Children's Hospital (ACH) Natural Wonders Partnership Council, First 100 Days Workgroup – a network of child health groups, agencies, and funding sources collaborating to address the evolving health issues of children in their first 100 days of life.

In FY22, the state spent 53.41% 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. Thirty one percent supported CSHCN for care coordination, specialty outreach clinics, respite care, support for family involvement, and home modifications. Nine percent were spent on providing maternity services for pregnant women. The Family Planning Program receives funding via Title X, as well as commercial and Medicaid reimbursement. The Federal-State Partnerships expenditures totaled $24,656,114. Listed below are a few examples of contacts/subgrants, which support MCH and CSHCN services.

- ACH – provide Nurse Family Partnership (NFP), MIECHV, and in-home visiting.
- UAMS – provide clinical consultation, technical assistance, and diagnosis regarding newborn screening results.
- University of Arkansas at Little Rock (UALR) – provide technical service to implement the Women's Infant and Children Parenting Program.
- Arkansas Hands & Voices – provide family-to-family support services enabling Deaf/Hard of Hearing children to reach their full potential.
- UALR MidSOUTH – provide technical services to implement the WIC Baby and Me program; a parenting program focused on strengthening the parent/child relationship, promoting healthy child development, and connecting parents to community resources in WIC clinics.
- Department of Health and Human Services: 1) AR Disability Coalition's F2F Health Information Center provides peer support and training for CSHCN families; 2) CoBALT (Community-Based Autism Liaison and Treatment) Project trains teams how to screen for and diagnose developmental delays and disabilities.

III.A.3. MCH CSHCN Success Story

Families new to Arkansas face unique challenges in navigating unfamiliar systems for healthcare and support services.

In 2022, a mother and child moved to Arkansas; the mother was concerned because her child was 3 years old and nonverbal. The mother had been told that her child could not be tested for Autism until age five. By the time the mother reached the Title V CSHCN Nurse Coordinator in February, she had spoken with four other people in an effort to seek services for her child.

During the conversation with the CSHCN Nurse Coordinator, the mother was tearful because she didn't know where to go or what to do to get help for her child. The Nurse Coordinator discovered the family had private health insurance. First, the Nurse Coordinator explained that she did not have to wait until her child turned five to access autism-specific diagnostic testing. Next, a Tax Equity and Fiscal Responsibility Act (TEFRA) application (disability of Arkansas Medicaid for children) was emailed to the mother. The Nurse Coordinator assisted with the completion of the application over the phone, and it was submitted to determine eligibility.

The child's TEFRA was approved, and the Arkansas Health Insurance Premium Payment Program (ARHIPP) and the out-of-state evaluation reports were obtained for speech therapy to begin.

By August, the child was attending an Early Intervention Day Treatment (EIDT) full-time, and the parent was able to receive Medicaid Non-emergency Transportation gas mileage reimbursement. The child also received an Autism diagnosis and received Autism-specific services at home through the State's Autism Waiver and Applied Behavioral Analysis (ABA) program and additional therapies at a developmental enrichment center for preschool-aged children with disabilities.

The mother also chose an ABA provider in her community so that her child and family could participate in ABA therapy three days a week from home while attending the EIDT program the other two days of the week.

The CSHCN Nurse Coordinator helped the mother establish a network of support by providing accurate information and resources specific to the child and family needs.

This Title V CSHCN story is a prime example of the MCH Block grants purpose, which is 1) to provide and to assure mothers and children access to quality MCH services, and 2) to provide and to promote family-centered, community-based, coordinated care for children with special health care needs (CSHCN) and to facilitate the development of community-based systems of services for such children and their families.

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III.B. Overview of the State

Arkansas is in the southern region of the U.S. It covers an area of 53,178 square miles and is organized into 75 counties. Arkansas borders six other states (Missouri, Oklahoma, Texas, Tennessee, Louisiana, Mississippi). The Mississippi River forms the state borders to Tennessee and Mississippi in the east.

Geography: Of the 75 counties in the state, 54 are considered rural (72%), with 41% of residents living in rural areas compared to 14% in the U.S. The capital and largest city is Little Rock. Major population areas are Fort Smith, Hot Springs, Jonesboro, Pine Bluff, and Texarkana, Northwest Arkansas (Fayetteville, Springdale, Rogers, and Bentonville), and Little Rock/North Little Rock. The county with the highest population is Pulaski County, where Little Rock is located. Benton County had the greatest increase (20%) between 2010 and 2019. Phillips County decreased from 22,000 to 18,000, representing the largest decrease (18.3%). (Source: U.S. Census 2022 Quick Facts)

Counties in the Mississippi Delta are especially rural and poor. They have high concentrations of minority populations, especially African American. Counties along the state's western border are mountainous and rural. The population of immigrant Hispanic families from Central and South America is high in these counties. Arkansas and Hawaii are home to the largest groups of Marshall Islanders living outside of the Marshall Islands.

Population: According to the U.S. Census 2022 Quick Facts, Arkansas is home to 3,045,637 residents. Arkansas's population is primarily White (71.3%) with African American (15.7%) secondary. Other groups are Hispanic/Latino (8.3%), two or more races (2.3%), Asian (1.8%), and American Indian/Alaska Native (1.1%). Of the total population, 17.5% are age 65 and over, 23.2% are under age 18, and 6% children under age five.

Economy: The average family income in Arkansas is $52,123 per year. This is lower than the U.S. average of $76,000. Almost 40% of Arkansas households have incomes less than $25,000 per year, and 39% receive supplemental income. (Source: U.S. Census 2022 Quick Facts) Arkansas' Gross Domestic Product (GDP) was $165,220 billion in 2022, representing 0.61% of the national GDP and making Arkansas the 35th largest state economy. Arkansas's per-capita GDP in 2019 was $43,394.00, which was $21,847.00 lower than the national figure. However, the 2019 per-capita GDP was a 2.5% increase over 2016. The state's GDP declined to $129 billion in 2022. Prior to 2020, the GDP had increased each year since 2009. (Federal Reserve Bank of St. Louis. Total gross domestic product for Arkansas. 2020)

The U.S. Census Bureau reports the majority (58%) of Arkansans ages 16 and older are in the civilian labor force. (Source: U.S. Census 2022 Quick Facts) Arkansas ranks 35th in business environment, which includes new business openings and the rate of patents for new inventions. Arkansas ranks 33rd in economic growth, determined by the growth of the young population in the state, growth by migration, and increased GDP. The disparity in earnings per job between rural and urban areas remains significant, with urban residents earning on average 19% more than rural residents. (Source: U.S. Census 2022 Quick Facts)

Unemployment: Arkansas's unemployment rate has dropped to 2.8% as of April 2023, meaning that only 39,000 individuals are unemployed. This rate is less than a third of Arkansas's pandemic unemployment of 10.1% in April 2020. Arkansas's unemployment rate is lower than the national average of 3.4% and the state ranks 16th for lowest level of unemployment. (Source: Bureau of Labor Statistics)

Education: Education levels in Arkansas are lower than the U.S. average for both high school and bachelor's level degrees or higher. Approximately 85% of Arkansans ages 25 or older finished high school or an equivalency exam compared to 88.9% nationwide. The discrepancy is wider between those who have a bachelor's degree: 24.3% of Arkansas possess a bachelor's degree compared to 33.7% in the U.S.

Poverty: Arkansas's prevalence of poverty continues to be high. With 16.3% of people below Federal Poverty Level (FPL), Arkansas is the 4th highest in the U.S. In 2021, 22.4% of Arkansas's children under the age of 18 lived in poverty compared to 16.9% in the U.S. The situation is worse for children under the age of five: 26.5% live in poverty compared to 18.3% nationally. Across the U.S. approximately 16.5% of children ages 5-17 live in poverty, but 20.9% of children in this age group in Arkansas live in poverty In the Coastal Plains and Delta regions of Arkansas, 36% of children live in poverty. (Source: U.S. Census 2022 Quick Facts)

The percentage of children living in poverty has been declining. However, 22% of Arkansas's children live in poverty, compared to 17% nationwide. (Source: Annie E. Casey Foundation. 2021 Kids Count® Profile) Poverty is

statistically linked to negative outcomes for children, from low birthweight and poor nutrition in infancy to increased risk of academic failure, emotional distress, and teen pregnancy. Access to food, adequate shelter, and transportation is limited for many Arkansans. More than 19% of Arkansas children experience food insecurity, tied with Oklahoma for the second worst in the country. (Source: Feeding America. Food Insecurity and Poverty in the US. 2020)

Health Professional Shortage: Of the 75 counties in the state, 54 are considered rural (72%) and 51 (68%) have Health Professional Shortage Areas (HPSAs) (Arkansas State Health Assessment 2020). The primary care physician (PCP) ratio in rural versus urban areas is 1:1.8 (73 PCPs per 100,000 people vs. 133 PCPs per 100,000 people), indicating a great need for the provision of primary healthcare in these HPSAs with limited or no access to preventive services. The HPSAs are mostly distributed in Southeast (SE), Southwest (SW), Northeast (NE) and Northwest (NW) Arkansas (Arkansas State Health Assessment 2020). Arkansas is a rural state in which limited access to healthcare is a primary factor in delays for diagnosis and treatment.

Health Rankings: According to American Health Rankings (2022), Arkansas ranks 48th out of 50 in overall health and 49th in health of women and children. A range of measures rank unfavorably when compared to other states. With 50 being the worst and one being the best, Arkansas ranks:

- 49th – adult obesity in women
- 49th – teen births
- 47th – physical inactivity in adult women
- 47th – adult women who smoke
- 47th – infant mortality
- 46th – child mortality
- 44th – low birthweight live births
- 44th – immunization form children
- 43rd – adverse childhood experiences
- 42nd – maternal mortality
- 41st – diabetes in adult women (Source: Behavioral Risk Factor Surveillance System-BRFSS 2021)

Arkansas ranks 43rd in child well-being, which has four domains: health, education, economic well-being, and community and family. Within these domains, Arkansas ranks 46th in community and family, 46th in health, 39th in economic well-being, and 34th in education. (Source Kids Count Data Book, 2022)

Social and Behavioral Health Determinates: The rural regions have higher rates of infant mortality, obesity, food insecurity, and child poverty than urban areas. Infant mortality rates range from 7.2 deaths per 1,000 live births in urban areas to 8.2 per 1,000 in the Delta. More than 50% of adults in the state are classified as overweight or obese. Arkansas ranks in the top five states for food insecurity. The disparity in earnings per job between rural and urban areas remains great, with urban residents earning on average 19% more than rural residents. Arkansas has 14 rural counties with “persistent poverty” and “persistent child poverty”. Persistent child poverty is defined as having child (<18 years old) poverty rates of at least 20% in all of the following sources: 1980, 1990, and 2000 decennial censuses, and 2007-2011 American Community Survey 5-year average. Each of the risk factors noted here contribute to significant socio-economic inequality.

Mortality: Arkansas and Tennessee ranked 45th in the nation for average life expectancy. In 2020, life expectancy was 74.4 years compared to 77 years nationally. Benton County (northwest) had the longest life expectancy: 78.8 years. Phillips County (eastern) had the shortest life expectancy: 68 years. This difference in life expectancy reflects the impact that the social factors and determinants noted above can have on the health of a population. COVID-19 had a large impact on life expectancy, with an estimated drop in life expectancy of 2.7 years between 2019 and 2021 across the U.S. The drop was especially felt among African American men.
Arkansas ranks 43rd in the nation for premature death, the leading causes of which are chronic diseases, accidents,

influenza, and pneumonia. Heart disease, cancer, chronic lung disease, stroke, diabetes, and kidney disease are the leading causes of death associated with chronic disease. The state's high rates of chronic disease can be linked to lack of physical activity combined with very high rates of obesity, high blood pressure, and tobacco use.

Unintentional injury is the fourth leading cause of death in the state. Accidents are the number one killer of Arkansans between the ages of 1-44 and the ages of 1-14. In 2021, death from influenza and pneumonia is the 13th most common cause of death in Arkansas. COVID-19 was the third leading cause of death in Arkansas for both 2020 and 2021.

In Arkansas, African Americans have higher rates of infant mortality compared to whites or Latinos. The infant mortality rate for African Americans in 2020 was 11.8 compared to 6.0 for whites and 6.0 for Latinos. The infant mortality rate is the annual number of babies per 1,000 live births who die before their first birthday. In 2020, 260 babies died in Arkansas before their first birthday. Both Arkansas and Alabama mortality rate was 47th in the U.S. at 7.3 per 1,000 live births. Prior to 2019, Arkansas had been in the top three states for highest infant mortality rate for three consecutive years (2016-2020). (Source: CDC. Infant Mortality Rates by State. 2021)

The leading causes of neonatal death in Arkansas are birth defects, prematurity, problems with the pregnancy, difficulty breathing, and bleeding. The leading causes of post-neonatal death are unintentional injuries, SIDS, birth defects, problems with blood circulation, lung problems, infection, and homicide. Additional numbers for 2021 show Arkansas were 5th in preterm birth rate (12.04 per 1,000) and 12th in low birthweight rate (9.52 per 1,000).

Challenges and Strengths: Arkansas has unique challenges that impact the health status of its MCH population. Availability of and accessibility to health care and preventive health services varies widely in Arkansas. Central Arkansas is relatively urban and well supplied with health services for women and children. However, even in these counties, low-income families experience barriers in access to care. Other regions are rural, and many are medically underserved as defined by the HRSA.

People in rural Arkansas have greater difficulty getting the health care services they need, in part due to cost. In general, 15.3% of Arkansans report that they were not able to see a doctor in the past 12 months due to the cost, compared to 13% in the U.S. In rural counties, more than 20% of residents were not able to see a doctor due to cost. In Arkansas, 25% of working-age adults have no health insurance. (Source: U.S. Census 2022 Quick Facts) In addition to cost, a shortage of health care services available is also a limiting factor.

Access to basic food, shelter, and transportation is limited for many Arkansans. There are 7,153 homes in the state lacking complete plumbing and 11,744 without kitchens. More than 12,221 homes are without phone service and 67,187 are without a method of transportation. As a result, families are limited in their ability to connect with others or access necessary goods and services.

Despite these challenges, Arkansas's healthcare delivery improved as a result of the Medicaid expansion, which was vital to the health of the state's MCH population. Many previously uninsured Arkansas women and children were able to enroll in a healthcare plan.

As of 2020, 1,512,266 (87%) people between the ages of 18-64 were enrolled in health care coverage. According to Small Area Health Insurance Estimates (SAHIE), 328,510 women (83.1%) ages 18-64 were insured with 66,880 (16.9%) women remaining uninsured. Ninety-six percent (651,502) of the total number of children (678,661) under 18 were insured.

No other state experienced a more rapid decline in its number of uninsured residents. The uninsured level fell from 16% in 2013 to 11% in 2022. (Source: U.S. Census 2022 Quick Facts) Arkansas's Medicaid expansion efforts have been in the form of the Private Option, which allows Medicaid to fund private insurance companies for families at or below 138% of the Federal Poverty Level (FPL). The 1115 Medicaid Waiver that funded family planning services for women up to 250% of the FPL was ended in December 2013.

Defined Roles/Responsibilities and Targeted Interest: The Arkansas's Title V MCH Block Grant Program relies on shared leadership between ADH's Family Health Branch and the Arkansas Department of Human Services' (DHS) Children with Chronic Health Conditions Program (CCHCP) to execute services statewide. The state Title V MCH leadership team makes program and policy decisions and ensures alignment across the programs and agencies. Designated Title V MCH staff manage state-level program and policy work and provide technical

assistance and oversight to the local Title V grantees. (Section VI: ADH and CSCHN Organizational Charts)

The intricate roles of statewide coordinated services target the health interests of at-risk and vulnerable populations regardless of race, ethnicity, or national origin. Therefore, reducing health disparities throughout the state continues to be a major ADH focus. The ADH's Office of Health Disparities and Elimination (OHDE) provides leadership in improving health outcomes by advocating for health equity for at-risk populations as defined by race or ethnicity, age, education, disability, geographical location, income, and sexual orientation for all MCH programming. The OHDE serves as the ADH's coordinating office for consultative services and training in cultural and linguistic competency, coordination, partnership building, program development and implementation, and related efforts to address the needs of underrepresented populations. This office promotes the integration of Culturally and Linguistically Appropriate Services (CLAS) within health programs.

Multiple initiatives impact the state's Title V directives. All highest priority services are provided in all 75 counties. High-priority services not provided through ADH's Local Health Units are organized through ADH's Central Office such as newborn metabolic and hearing screening, school health, and home visiting programs. Secondary services include basic preventive services that local health care systems may not have the capacity to provide, especially maternity care.

ADH proposed a statewide Strategic Plan for 2020-2023, which included goals and supporting strategies to address MCH population needs. The plan is designed to address four health conditions as priority areas: 1) Addiction/Mental Health/Suicide, 2) Maternal and Infant Health, 3) Vaccines/Infectious Disease, and 4) Obesity. (Source: Arkansas Department of Health. State Strategic Plan. 2021)

The Title V MCH and CSHCN administrators, along with MCH partners and ADH staff, utilize various methods to determine the importance, value, and priority of competing factors that impact health services delivery. The Title V program receives input and advice from partners, stakeholders, and other organizations. The overall goal of Arkansas's MCH program is to improve health and reduce disparities. Supporting that goal are five priority areas:

1. Strengthen core services: Family Planning, Prenatal Care, WIC Program, Immunizations, and Home Visiting.
2. Develop more effective population-based approaches: prevent injuries, reduce infant mortality, increase physical activity, and improve oral health.
3. Communicate public health value and societal contribution: economic development, public awareness, and benefits of prevention.
4. Secure adequate human and financial resources: workforce needs and training and funding acquisition.
5. Increase departmental effectiveness and accountability: strengthen leadership, management systems, information technology, data use, and accountability.

Cross-cutting these areas is an emphasis on community engagement, partnerships, and policy development. The overall theme is to strengthen and improve traditional public health clinical services while focusing on program development, engaging more in public awareness and policy development, and retooling administrative processes to work more effectively and efficiently. The public is engaged through ADH's Hometown Health Initiative (HHI), a community-driven process that empowers local communities to take ownership of health problems by working to identify and implement solutions.

Service Delivery: The Arkansas DHS houses programs that are important to improving MCH health in the state. DHS's Division of Medical Services (DMS) administers the Medicaid Program, which serves approximately two-thirds of children in the state. Most children are covered based on income eligibility through ARKids First A or B, depending on income level. Medicaid funded almost half the births (44%) in Arkansas in 2020. Out of the 35,251 births in Arkansas in 2020, 15,352 were paid by Medicaid. Nationwide, 42% of births were funded by Medicaid in 2020.

Transitioning from pediatric to adult care is a priority of ADH for all youth and young adults in Arkansas, including those with disabilities, chronic health conditions, or other needs. The Arkansas Department of Human Services (DHS) is also home to the state's Title V CSHCN program in the Division of Developmental Disabilities Services (DDS). ADH's Title V Director is working to improve collaboration with this division, which includes maintaining an important partnership with the Division's Medical Director. Services for CSHCN are closely associated with specialty services of the University of Arkansas for Medical Sciences (UAMS) Department of Pediatrics. The Division also supports the state's early intervention program (Part C), known as First Connections.

As the only medical school in the state, UAMS plays a critical role in Arkansas's health care system. Development of the UAMS College of Public Health in 2001 led to stronger links between state health-engaged agencies and the university system. UAMS's pediatrics and obstetrics/gynecology departments partner with ADH to provide direct

care to women and children and to carry out initiatives to improve systems of care.

Arkansas Children's Hospital (ACH) in Little Rock plays an important role in the health care system. It is one of the largest children's hospitals in the U.S., attracting patients from around the region, other states, and other countries. The hospital provides most of the pediatric critical care in the state. The hospital's administration is also committed to involvement in community and state level public health concerns such as infant mortality, injury prevention, home visiting, and school health initiatives.

Statewide Systems of Care: The state's centralized healthcare system is in the capital city, Little Rock, with 6.54% of the state's population. The city is situated in the middle of the state and is the site for the ADH Central Office, five large hospitals including the UAMS (the state's only medical school), DHS, and other state agencies focused on improving the health of women and children. Cities of moderate size in the corners of the state are home to sizable medical communities and are the locations of UAMS's Regional Programs.

The state's Title V MCH administrative office is housed within the Family Health Branch of the Arkansas Department of Health's (ADH). ADH provides programs and services statewide through 94 local health units, at least one in each of Arkansas' 75 counties.

In addition to the hospitals in Little Rock, there are 112 other hospitals, 29 of which are identified as Critical Access. The state has 12 Federally Qualified Health Centers (FQHCs) that provide services at 168 sites. There are also 119 rural health clinics. There are 54 counties with hospitals. Thirty-eight community hospitals have fewer than 100 beds, and 37 counties are served by a single hospital. Twenty-three counties are served by a single Critical Access Hospital. Twenty-one counties do not have a local hospital. (Source: U.S. Census 2022 Quick Facts)

The current number of physician practices in Arkansas is inadequate to provide needed medical services to the population. Physician and other health care provider shortages are common. The average caseload for a Primary Care Physician (PCP) is 1,522 patients. Arkansas ranks 38th in the nation for number of PCPs (82.3 per 100,000 population). There are only 405 pediatricians and 289 obstetricians/gynecologists in the state. Arkansas ranks 50th in the number of dentists (40.9 per 100,000). (Source: U.S. Census 2022 Quick Facts)

UAMS is a centralized point of referral for all medically complicated patients and provides medical and health education for the entire state. Except for communities on the eastern border that depend on the city of Memphis, Tennessee, all state communities relate to UAMS and Little Rock hospitals as sources of highly specialized medical care. UAMS's Regional Programs provide family medicine residency training in communities around the state. These programs have improved the distribution of PCPs.

Arkansas Children's Hospital (ACH) is that state's only pediatric health system. ACH treats all children from birth to age 18 from across the state and surrounding areas. This private, nonprofit hospital works to meet the health needs of all children, but also supports efforts to improve the overall health and well-being of our youngest children. In 2018, a third satellite clinic of Arkansas Children's Hospital (ACH) opened in Springdale in Northwest Arkansas. The clinic is in the fastest growing area of the state and allows more CSHCN access to pediatric specialty care.

Family physicians provide most of the state's medical care and are by far the most numerous specialty practitioners in Arkansas. Specialists in obstetrics, pediatrics, internal medicine, surgery, and others have practices in the more urban communities. While Arkansas is geographically of modest size compared to some other states, the distances from cities such as Fayetteville and Texarkana to Little Rock require two to four hours of travel time. For families with few resources, these distances represent significant barriers to access specialized care.

Arkansas's Medicaid transitioned three years ago from a fee-for-service system to an organized care delivery model for the highest need behavioral health and developmental disability populations. The model, the Provider-led Arkansas Shared Savings Entity (PASSE) Program, provides care coordination services. The PASSE system went full risk March 2019. PASSEs are responsible for integrating physical health, behavioral health, and developmental

disability services. Members are assigned a care coordinator who is responsible for creating a service plan for each individual. PASSE currently serves 55,000 Arkansas Medicaid clients.

Specific State Efforts: The former Governor, Asa Hutchinson initiated efforts that supported the MCH Block Grant purpose to promote the health of mother 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 as defined in Section 501(a)(1)(b).

In December 2021, Arkansas's Governor Asa Hutchinson announced his plan to fund additional Community and Employment Support (CES) Waiver slots and eliminate the waitlist, as it existed December 2021, by June 2025. The additional funding over the next several years will open slots for approximately 3,000 children and adults on the wait list for the CES Waiver. Arkansas Department of Human Services (ADHS) announced in February 2022 after receiving feedback from Medicaid clients and providers, that American Rescue Plan funding would be utilized in phase one to improve the recruitment and retention efforts to stabilize the workforce for this disabled population in their homes.

III.C. Needs Assessment
FY 2024 Application/FY 2022 Annual Report Update

III.C. Need Assessment Update

Women and Maternal Health

To conduct needs assessment for the Women and Maternal Health domain, Title V invited stakeholders to a virtual meeting on March 24, 2022. Participants included staff from ADH, UAMS, the Arkansas Minority Health Commission, Arkansas Foundation for Medical Care (AFMC), Office of Oral Health, and Arkansas Department of Human Services' (ADHS) Division of Medical Services. Participants were asked to select the priority needs from the Title V Women's Maternal Health Needs Assessment that they believed were still ongoing priority needs. The respondents selected one or more of the following priority needs:

- Access issues
- Medicaid expansion for postpartum coverage for one full year
- Oral health
- Mental health disorders

Current program strategies to achieve Women and Maternal Health MCH objectives were reviewed by stakeholders and agreed upon that Arkansas was achieving results.

Perinatal and Infant Health

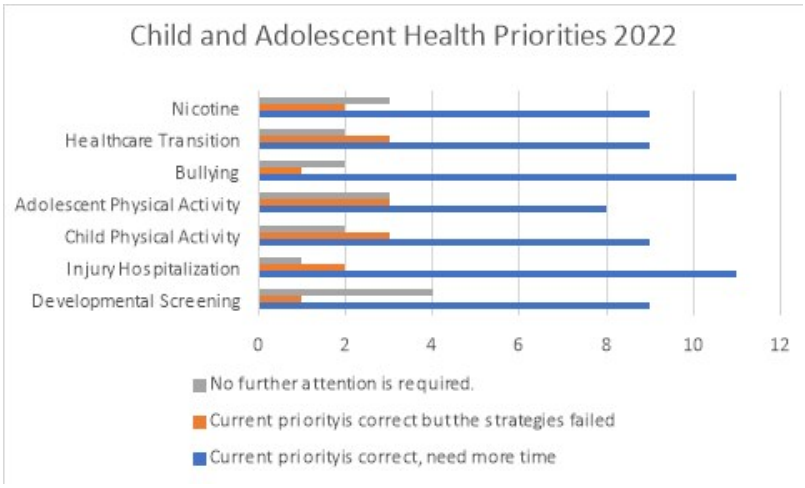
To conduct needs assessment for the Perinatal Domain, the Title V Perinatal Domain invited stakeholders to a virtual meeting June 9, 2022. Participants included ADH Title V Staff, ADH WIC, Arkansas Home Visiting Network, Arkansas Infant and Child Death Review, Arkansas Minority Health, Baptist Hospital, Arkansas Department of Human Services, the Arkansas Chapter of the American Academy of Pediatrics and Arkansas Children's Hospital. Participants were asked how to help the families that are served by our programs. Collected feedback included the following:

- Provide new mothers with more information about infant mortality.
- Create a statewide safe sleep education plan.
- Plan statewide activities to increase breastfeeding rates.
- Use local organizations to circulate information about programs, services, events, etc.

Key program strategies to achieve block grant objectives were reviewed with the stakeholders and 100% agreed the activities were achieving the desired results.

Child and Adolescent Health

The Child and Adolescent Health domains held an annual meeting during the fall of 2022. Thirteen individuals attended the meeting representing the Arkansas's Physician Associations, Family-Based Organizations, Department of Education, Children with Special Health Care Needs, Part C, Head Start Collaboration, Advocates for Children and Families and interagency departments within ADH (e.g., WIC and Chronic Disease). During the meeting, all priorities and evidence-based strategies were reviewed and assessed via an interactive poll. The majority of the attendees reported the current priorities were correct, measures and strategies were doable, but more time was needed to develop and see desired results.



Children with Special Health Care Needs (CSHCN)

The Title V CSHCN Program conducts ongoing needs assessment for the CSHCN Domain in addition to the required 5-year State Needs Assessment. The program convened a virtual stakeholder meeting June 8, 2022, inviting cross agency collaboration from stakeholders from other Title V programs under the Arkansas Department of Health, pediatricians, AR Transition Services, parent information and advocacy groups such as Family 2 Family and the Center for Exceptional Families (TCFEF), Early Childhood Special Education (Arkansas Department of Education), program staff and staff from other DDS programs such as First Connections, Arkansas' Part C early intervention program.

The June stakeholder engagement meeting reviewed key program strategies to achieve block grant objectives with the stakeholder participants. 100% (22 out of 22) of participants agreed the program's activities were achieving the desired results. To promote engagement and to solicit input and feedback from stakeholders in attendance, this interactive domain meeting used online IdeaBoardz. Participants were asked if they felt the priority needs identified in the 2021 Title V CSHCN Needs Assessment were still an ongoing need of families of CSHCN and if any new needs had arisen as a result of the pandemic. Stakeholders in attendance responded (anonymously) on the IdeaBoardz (or not anonymously in the zoom chat) to identify that the following needs identified in 2021 are still a priority need:

1. Transportation.
2. Understanding, financing, accessing, and navigating the health care system including Medicaid.
3. Technological issues with Internet access and computer use to access teletherapy, virtual appointments, and online learning.
4. Accessing specialists and services.
5. Finding respite care.

Participants were asked to identify any new or emerging needs of CSHCN and their families or additional priority areas. Stakeholders at the meeting identified emerging and additional priority needs as:

Additional Priority Needs:

- Availability of respite services
- Trauma-informed care

Emerging Needs:

- TEFRA changes post-COVID may leave many children uninsured.

- Dental (State insurance not covering Arkansas's children).
- Pay for conducting developmental screenings (there is a code now in Medicaid, but providers can't bill).
- TeleMed access.
- ABA (Applied Behavioral Analysis) or other Evidence-Based Practices (EBP) for school-aged children.

An effective State Needs Assessment also looks at the strengths in the State and considers ways to use these strengths to overcome barriers to meet identified needs. To support this work, participants were asked, "how we can work together to support Access to Care?" Stakeholders shared ideas, with the most popular ideas (the ideas shared by stakeholders that earned the most votes on IdeaBoardz) involving:

- Clearly communicate timeline/expectations to families seeking services and provide more support in the application process.
- Building partnerships with other agencies and nonprofits outside of those the Title V CSHCN program usually partners with.
- Request CSHCN program information and a link to make a referral be placed on the new Part C Program (First Connections) website.

To ensure that Arkansas's Title V CSHCN program is effectively partnering across agencies to support Access to Care and aligning key strategies with other initiatives and work in the state, the June 2022 meeting provided an opportunity for participants to share "what's going on" to identify these State strengths which could be used to support CSHCN and their families in accessing care, supports, and services. Stakeholders in attendance who represented other programs and agencies serving the Children and Youth with Special Health Care Needs (CYSHCN) population were asked to identify initiatives or strategies their program is doing (or planning to do) that support access to care for this domain population. Stakeholders suggested extending/enhancing access to services through more effective collaboration between divisions in the lead agency and with other State departments. Stakeholders also identified current initiatives and work in the State that the Title V CSHCN program could align strategies with to improve Access to Care, including:

- The State's work to promote the 'Learn the Signs. Act Early.' tools (LTSAE)
- Pritzker Initiative/Grant goal of increasing percentage of young children (0-5) who receive developmental screenings.
- National Wonders First 2100 Days Initiative
- Family 2 Family launch of Project Accelerate

In the area of Transition from Pediatric to Adult Health Care, participants had opportunities to share "what's going on" to identify State strengths that could be used to support CSHCN and their families in preparing for and experiencing a smooth transition from pediatric care systems. All stakeholders in attendance were asked about their ideas for supporting Transition for not only this domain population but all youth. Ideas shared in the meeting included:

- Sharing resources from the Got Transition website with pediatric providers.
- Share clear state goals and partner with additional stakeholders for broader dissemination.
- Enlist the help of the Arkansas AAP to encourage all practitioners to complete the CHC Core Elements of Transition survey, for the state to have more complete data.
- Identify leaders in pediatric to adult transitions, collect stories, and share them widely.

Stakeholders participating had additional ideas to support the transition of all youth into adult health care through collaboration with education professionals (school-based nurses, regular and special education, school-based mental health, parent centers/groups), a key program strategy. Ideas for collaboration involved going beyond sharing information at school transition fairs to include:

- Hosting parent information meetings at schools on the importance of transition and how to prepare
- Share health care assessments for students/families to complete to discover goals and activities for students to accomplish while in high school
- Getting CHC Transition booklets into more youth's hands through partnership with schools to include as part of all Health classes
- High schools incorporate core elements of transition in student graduation planning from 9th-12th grade.

Thirty-four stakeholders attended the stakeholder engagement meeting in June. The program is identifying strategies to engage more of the 111 individuals invited so that stakeholders participating include more families of CSHCN and stakeholders involved are representative of the demographics of the clients served and of the State as a whole.

Click on the links below to view the previous years' needs assessment narrative content:

2023 Application/2021 Annual Report – Needs Assessment Update

2022 Application/2020 Annual Report – Needs Assessment Update

2021 Application/2019 Annual Report – Needs Assessment Summary

III.D. Financial Narrative

	2020		2021	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$6,972,695	$7,147,145	$6,966,533	$6,966,533
State Funds	$7,246,131	$3,406,239	$5,338,793	$3,556,732
Local Funds	$0	$0	$0	$0
Other Funds	$600,150	$385,716	$526,852	$429,730
Program Funds	$14,127,834	$12,635,545	$13,336,283	$13,297,312
SubTotal	$28,946,810	$23,574,645	$26,168,461	$24,250,307
Other Federal Funds	$11,863,984	$11,289,247	$13,744,134	$11,916,336
Total	$40,810,794	$34,863,892	$39,912,595	$36,166,643

	2022		2023	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$6,961,610	$7,136,666	$7,002,733	
State Funds	$4,785,791	$4,042,597	$4,465,398	
Local Funds	$0	$0	$0	
Other Funds	$603,629	$482,506	$603,629	
Program Funds	$15,681,851	$12,994,345	$13,505,838	
SubTotal	$28,032,881	$24,656,114	$25,577,598	
Other Federal Funds	$13,826,992	$12,466,369	$13,178,472	
Total	$41,859,873	$37,122,483	$38,756,070	

	2024	
	Budgeted	Expended
Federal Allocation	$7,136,666	
State Funds	$4,722,429	
Local Funds	$0	
Other Funds	$603,629	
Program Funds	$12,424,008	
SubTotal	$24,886,732	
Other Federal Funds	$16,363,473	
Total	$41,250,205	

III.D. Financial Narrative

III.D.1. Expenditures

In Arkansas, total expenditures were $37,122,483 for FY2022. Before adding other federal funds, total Federal-State MCH Partnerships Expenditures $24,656,114, a slight increase from FY2021. The state spent 53.41% 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, adolescent sexual health, and reducing child maltreatment.

The Children and Youth with Special Health Care Needs program at the Arkansas Department of Human Services (DHS) spent 31.34% of the Title V grant. The program provides services to this population throughout the state. They provide care coordination, specialty outreach clinics, respite care, support for family involvement, and home modifications.

Just over nine percent (9.26%) of the funds were spent on providing maternity services for pregnant women. Less than six percent (5.77%) of the grant expenditures went to administrative costs, which include a portion of the salaries for the Title V Director, Medical Director for the Family Health Branch, and administrative positions that oversee and assist all MCH programs.

The total state match contribution of $17,519,448, far exceeded the Maintenance of Effort requirement of $5,797,136. Expenditures of state funds ($4,042,597) has increased from FY2021 ($3,556,732). Overall, expenditures were managed conservatively because of the uncertainty regarding reimbursements.

Sources of reimbursement include Medicaid and private insurance for maternity, family planning, case management, and immunizations. Fees support ADH's Newborn Screening program. The Arkansas Department of Health has been working to capture reimbursement from commercial insurance and to increase services (Well Woman Visits) that are needed and are reimbursable. The Family Planning Program, which resides within the Family Health Branch, continues to receive funding via Title X, as well as commercial and Medicaid reimbursement.

Note: The FY2022 expenditure reports are calculated by using the actual expenditure amount from October 1, 2021 through April 30,2023 and the anticipated expenses from May 1, 2023 through September 30,2023. The FY2022 Expenditures are expenses only related to the B04MC45200 grant.

*See Expenditure Table

Expenditure Table for 2021 and 2022

	2021		2022	
	Budgeted	**Expended**	**Budgeted**	**Expended**
Federal Allocation	$6,966,533	$6,966,533	$6,961,610	$7,136,666*
State Funds	$5,338,793	$3,556,732	$4,785,791	$4,042,597
Local Funds	$0	$0	$0	$0
Other Funds	$526,852	$429,730	$603,629	$482,506
Program Funds	$13,336,283	$13,297,312	$15,681,851	$12,994,345
SubTotal	$26,168,461	$24,250,307	$28,032,881	$24,656,114
Other Federal Funds	$13,744,134	$11,916,336	$13,826,992	$12,466,369
Total	$39,912,595	$36,166,643	$41,859,873	$37,122,666
				*Award amount is $7,136,666
	2023		**2024**	
	Budgeted	**Expended**	**Budgeted**	**Expended**
Federal Allocation	$7,002,733	It will not be report during this time.	$7,136,666	
State Funds	$4,465,398		$4,722,429	
Local Funds	$0		$0	
Other Funds	$603,629		$603,629	
Program Funds	$13,505,838		$12,424,008	
SubTotal	$25,577,598		$24,886,732	
Other Federal Funds	$13,178,472		$16,363,473	
Total	$38,756,070		$41,250,205	

III.D.2. Budget

Preventive and Primary Care for Children is budgeted at $3,872,285 or 54.26% percent of the MCH Federal Allocation. The amount projected for Children with Special Health Care Needs is $2,236,632, which is 31.34% of the total. The Title V administrative costs are estimated at $414,160, or 5.80% of the total allocation. The amount budgeted for maternity services for pregnant women is $613,589, which reflects the decrease in the number of pregnant women seeking services at ADH. The amount of total state funds budgeted is $7,136,666, which is about the same as the amount budgeted in previous years. This reflects state dollars directly budgeted in ADH and DHS MCH programs. It also includes salaries paid from state general revenue that support MCH programs captured in time allocation reports. The total state match is $17,750,066. Each of these budgeted items satisfies Title V legislative requirements.

Besides the administration of the allotted Title V funds, Title V administrative costs help support policy development as well as program development and management. The Title V Block Grant funds provide an essential link between the programs in our state serving children and mothers. The funds provide a bridge between ADH and DHS, a partnership that is committed to coordinating efforts to ensure efficiency in serving the citizens of the state. It also serves as a platform from which new initiatives (Maternal Mortality Review Committee and the Perinatal and Maternal Quality Review Committee) and partnerships outside of state government, such as the Natural Wonders Partnership and the Arkansas Home Visiting Network, can tackle the health issues of the State's women and children. Additionally, these funds may help support a Statewide Perinatal Forum that will provide a platform for all the individual perinatal health groups to share information and data.

ADH’s accounting system maintains financial accounting records and has a fiscal management system, both of which ensure a clear audit trail. Programs are allocated shares of the Title V block grant along with the required state match. Budgeted Title V amounts for FY2024 are similar to FY2022.

III.E. Five-Year State Action Plan

III.E.1. Five-Year State Action Plan Table

State: Arkansas

Please click the links below to download a PDF of the Entry View or Legal Size Paper View of the State Action Plan Table.

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

Arkansas Title V Maternal and Child Health Services Block Grant
2022 Report and 2024 Application

III.E.2. State Action Plan Narrative Overview

III.E.2.a. State Title V Program Purpose and Design

The Title V Maternal and Child Health (MCH) program resides in two separate state agencies, the Arkansas Department of Health (ADH) and the Department of Human Services (DHS). ADH serves as the Title V grantee and transfers funds to DHS to support the Children with Chronic Health Conditions Program (CCHCP) serving as the state's Children with Special Health Care Needs (CSHCN) program. The ADH, led by Renee Mallory as the Interim Secretary of Health, houses the Title V program in the Family Health Branch (FHB) within in the Center of Health Advancement, and Dr. Hattie Scribner began serving as the state's Title V Director March 2023. The DHS, led by Secretary Kristi Putnam, houses the Title V program within the Division of Developmental Disabilities Services; the CCHCP program is led by Traci Turner. Placement of the Title V programs within these state agencies promotes effective programming and enables collaborations supporting the delivery of health care services and connection to early childhood and behavioral health programs that are housed within these agencies as well. Organization charts identifying the Title V positions and organizational relationships are included in this application. Arkansas' Title V personnel are funded by a blend of federal formula, competitive grants, state funds, and other program funding as available. Staffing assignments are based on mandates, statewide and internal priorities, contractual obligations, and federal and state funding availability for specified projects and programs.

The Title V program at ADH fits well with other programming to conduct activities supporting the agency's mission, to protect and improve the health and well-being of all Arkansans. The ADH serves as a gap filler for many health care services in the state. Arkansas is a rural state with many areas of poverty and limited access to health care providers. The ADH works to fill these gaps in many ways through local health units (LHU). The ADH staffs at least one LHU in each county to provide quality services for mothers, infants and children. Title V funds support staffing and supplies in the agency's maternity clinics and contribute to the other programs that provide health services for women and children. Over the past several years, support has shifted from direct services to population-based services and the establishment of infrastructure. Efforts have included support of Perinatal Regionalization, Safe Sleep activities, Maternal Mortality Review Committee (MMRC), Infant and Child Death Review, Safety Baby Showers, a 24/7 Breastfeeding HelpLine and a statewide conference on Adverse Childhood Experiences (ACEs).

The CCHCP program delivers services for children birth to 21 years of age who have intellectual or developmental disabilities or delays by providing case management and care coordination. Services provided by the CCHCP program include medical supplies, adaptive equipment, respite services and vehicle modifications. The program addresses the needs of CSHCN and their families through Community Based Offices (CBO) within the local DHS offices. Title V funded staff are housed in the CBOs located in 14 counties throughout the state.

Arkansas's Title V Program also supports staff participation in councils, workgroups and boards organized by MCH partners and other stakeholders. The staff's participation is essential in bringing expertise and experience to these groups, which contributes to the coordination of activities through the identification of synergies and assists in avoiding the duplication of efforts. Participation in workgroups enables collaboration with partners statewide and assures the mission and priorities of Arkansas's Title V program are considered as organizations shape their own policies and develop activities. Although there was a change in leadership in the Title V program, staff and agency leadership continued to participate in workgroups relevant to the program's success. As an example, Title V staff participate in the following:

Advisory Council Memberships

- Arkansas Children's Hospital Natural Wonders Partnership Council
- Arkansas Department of Health's Quality Council
- Injury Prevention Advisory Board
- Birth to Eight Initiative
- Community Health Centers of Arkansas, Project Catalyst Stakeholder
- Division of Child and Family Services Advocacy
- Council Injury Prevention Advisory Board

- March of Dimes' Healthy Babies Are Worth the Wait Advisory Board
- Arkansas Interagency Coordinating Council for First Connections
- Universal Newborn Hearing Screening, Intervention and Tracking Advisory Board
- Arkansas State Genetics Health Advisory Board
- University of Arkansas Partner's for Inclusive Communities Advisory Council
- Arkansas Lifespan Respite Coalition
- Arkansas Governor's Commission on People with Disabilities
- Arkansas Advocates for Children and Families' Kids Count Coalition
- Disability Rights of Arkansas Legislative Committee
- Arkansas Behavioral Health Planning and Advisory Council

Workgroups

- Arkansas Foundation for Medical Care's Adverse Childhood Experiences/Resilience Workgroup
- Arkansas Home Visiting Network Conference Planning Workgroup
- Arkansas State PRISM Team supported by the Association of State Health Officers and Association for Maternal and Child Health Programs
- Breastfeeding Promotion Taskforce
- Colposcopy Planning Workgroup
- Mental and Community Mental Health Workgroup for ADH's Strategic Plan
- Natural Wonders First 2100 Days Workgroup
- Maternal Mortality Review Development Workgroup
- Perinatal Regionalization Workgroup
- Project Launch
- Safe Sleep Workgroup
- Workgroup to Revise Rules for the Licensed Lay Midwives
- Workgroup to revise ADH Needs Assessment and Health Improvement Plan
- State Adolescent Health Coordinators

The framework that Arkansas' Title V Program functions under has many influences, but rests on a foundation that is data driven. From the establishment of baseline measurements to the continual evaluation of our efforts, the program relies on data and analysis to improve the health and welfare of the citizens of Arkansas. Arkansas' Title V Program follows the Maternal and Child Health Block Grant's Logic Model in developing the program plan. Considerable weight is given to evidenced-based and promising practices. Arkansas also establishes relationships with other states to learn about new and innovative approaches to improving MCH outcomes.

The state's Title V needs assessment helped the leadership team identify the areas where programs can have the most impact. The assessment is monitored annually, informing the program about progress and barriers. Arkansas' Title V staff continues to use the concepts of continuous quality improvement, including the Model for Improvement and Plan-Do-Study-Act processes, to shape planning and programming. Planning and programming are also influenced by theoretical and practical considerations, as well as state and agency priorities. For example, the Title V Director participates as part of the team that reviews the ADH strategic plan to ensure issues regarding infant mortality and behavioral and community health align with the MCH program plan. The Title V Director's involvement also assures that agency policy reflects the purpose and priorities of the MCH program, and that those priorities are kept in the forefront of agency 's efforts and planning.

III.E.2.b. State MCH Capacity to Advance Effective Public Health Systems

III.E.2.b.i. MCH Workforce Development

The Title V program staff at the ADH are housed within the Center for Health Advancement's Family Health Branch and the Center for Local Public Health's LHUs. During the reporting period, Title V funds supported the equivalent of 62 full-time positions as shown in the attached organization charts. Staff in these positions provide maternity, family planning, and well woman services in each of the state's five public health regions. These services are coordinated through the ADH's patient care manager, MCH specialists, Hometown Health Improvement program administrator, and LHU administrator at the specific clinic site. At the state level, the Women's Health Physician Specialist and the Women's Health Section Chief assure us that needed services are provided according to state and federal rules and regulations. The ADH Women's Health Section develops, coordinates, and establishes the policies and procedures for the perinatal and family planning programs; responds to LHU staff for the interpretation of policy and management of problems and responds to other needs of the field or patients as needed. The ADH's Adolescent Health, Child Health and Newborn Screening Sections provide similar support to the field, with the Child Health Medical Director providing clinical leadership.

During the past year, 10 vacant Title V positions were filled and there are currently two positions vacant due to retirements and/or resignations. The State of Arkansas has implemented a hiring freeze of any employee vacancies paid with state funds.

In April 2022, Renee Mallory assumed the position as the Interim Secretary of Health. Dr. Jennifer Dillaha is the Director and State Health Officer. Dr. Hattie Scribner was hired late March 2023 as the Family Health Branch Chief/MCH Project Director. Derica Mack resigned as the Women's Health Section Chief mid-May. Also, Dr. Schexnayder will be leaving in July. It's anticipated to fill the positions by the end of 2023.

ADH Title V MCH Leadership:

Position Title	Name	Qualifications
Title V MCH Director, FHB Chief	Hattie Scribner	PhD, MHS, MCHES®
Family Health Medical Director	William Greenfield	MD, OB/GYN, MBA
Child Health Medical Director	Steven Schexnayder	MD
Women's Health Medical Director	Mike Riddell	MD, OB/GYN
Women's Health Section Chief	Vacant	
Child Health Section Chief	Kimberly Scott	MSHS, CHES
MCH Epidemiologist	Lucy lm	MPH
Home Visiting Coordinator	Phillip Borden	MPH
Home Visiting Section Chief	Janice Black	BA
Newborn Screening Coordinator	Pat Purifoy	RN
School Health Section Chief	Shannon Borchert	MS, CHES

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. The ADH requires specific mandatory training courses for all employees, but a majority of the course offerings are elective and available to complete at will. 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 OnDemand 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.

The Children with Chronic Health Conditions Program (CCHCP) team is organized in a Statewide network of staff located in 14 Community Based Offices (CBO) located in Arkadelphia, Berryville, Fort Smith, Harrisburg, Huntsville, Hope, Jonesboro, Little Rock, Mena, Monticello, Mountain View, North Little Rock, Pocahontas, and Prescott. Community-Based Offices are within county DHS offices for easy location and access to consumers. The 2022 year closed with 24 full-time employees including one extra help position, a Parent Consultant, three Area Managers, and a Nurse Manager. During the year, the Medical Records Supervisor retired in September and an Administrative Specialist III in December. Three new Community-based Nurses were hired in the spring, bringing the total number of nurses back up to 12. Program staff consists of registered pediatric nurse care coordinators providing case management to families of program eligible CSHCN across the state. The team of Nurse Care Coordinators are supervised by registered nurse regional managers. The Parent Consultant supports program management and oversees the Parent Advisory Council and Community Outreach. Administrative specialists provide support to families, manage program referrals, and carry out Medicaid billing for Targeted Case Management Services.

The Program partners with a variety of other state agencies, programs, and resources to ensure staff have relevant, ongoing professional development. In this reporting period, capacity building training for the CSHCN workforce included training through the Leadership Education in Neurodevelopmental Disabilities (LEND) Program, UAMS Peds Place, Connecting Across Professions Learning on Demand (LOD), Association of Maternal and Child Health Programs, Family Voices, University of Arkansas for Medical Sciences Partners for Inclusive Communities, the State's OSEP-funded Parent Training and Information Center (PTIC), the Center for Exceptional Families, and the Arkansas Behavioral Health Planning and Advisory Council. A Division of Developmental Disabilities' personnel development specialist trained CSHCN staff on equitable access, family engagement and leadership. The DHS Office of Personnel Development provided soft skills training on time management and clear communication to avoid conflicts.

DHS Title V Leadership Team:

Position Title	Name	Qualifications
CSHCN Program Director	Tracy Turner	BS, Human Services
Nursing Coordinator	Iris Goacher	BS, Health Ed., Minor in Nursing
Program Administrator		ADN, RN
Area Manager Northwest	John Taylor	BSN, RN
Area Manager Northeast	Stacey Schratz	RNP
Area Manager South	Tina Smith	ADN, RN
Parent Consultant	Rodney Farley	Parent of an adult with SHCN

The state Title V leadership team met monthly, except during the period the Title V Director's position was vacant. During these meetings, the team discussed training needs for program staff. Anticipated training needs for the professional development of Title V program staff include:

- Updated Title V Block Grant Guidance, release expected 2024.
- Blueprint for Change: A National Framework for a System of Services for Children and Youth with Special Health Care Needs

    - Health Equity
    - Family and Child Well-being and Quality of Life
    - Access to Services
    - Financing of Services
- National Performance Measure (NPM) and National Outcome Measure's Framework
    - Measure Domain Types
        - Clinical Health Systems
        - Health Behaviors
        - Social Determinants of Health
- Universal NPM's with Focus on Access and Quality of Primary/Preventative Care
- Continuous Quality Improvement

III.E.2.b.ii. Family Partnership

The ADH values family/consumer partnerships which they continue to build and strengthen for the state's MCH population, including CSHCN. The Child Health Section houses the Infant Hearing Program (IHP), which serves as the state Early Hearing Detection and Intervention (EHDI) program. The IHP partners with a family-based organization, the Arkansas Hands & Voices (H&V) Chapter, to increase enrollment in family-to-family support services (FSS) amongst families with Deaf/Hard of Hearing (DHH) children.

Arkansas H&V is the local chapter of the national parent organization providing unbiased support to families with DHH children. Through this partnership, the IHP endeavors to enroll families with DHH children in FSS before their child is 6 months of age, to connect the family to a DHH adult before the child is 9 months of age and provide access to advocacy support. The IHP provides fiscal support enabling the Arkansas H&V Chapter to facilitate the Guide by Your Side educational program, Advocacy, Support, and Training (ASTra) program, host events to allow families with DHH children to gather and connect with one another in various areas of the state, and support parents' attendance at national conferences such as the annual EHDI meeting and H&V Leadership Conference. Additionally, the IHP partners with H&V members to obtain nominees for parent representative on the Universal Newborn Hearing Screening, Tracking, and Surveillance Advisory Board, assist the IHP in programming efforts and ensure the family voice is included when developing educational materials and/or delivering presentations to health care providers to increase awareness of EHDI recommendations.

The CCHCP strives to engage families in a variety of ways, including offering parents of CSHCN opportunities to take on leadership roles as members of the Parent Advisory Council (PAC). The PAC to the Title V CCHCP has been a vital stakeholder group since 1990. This diverse group of parents and guardians of CSHCN from around the state coordinate the annual Famous Family Bistro, a parent information and education conference for families of CSHCN. The PAC members also support the program in outreach efforts by holding at least one parent support group meeting or workshop in their region of the state each year. The PAC representatives' peer to peer outreach ensures that family voices are heard and considered in program planning. The PAC is committed to advocacy and educating other families, government agencies, and health care professionals on topics that affect CHSCN. The PAC goals include:

- Educating families/partners about current health care issues.
- Educating partners concerning the changing needs of families.
- Providing a vital link between families of CSHCN and available resources.
- Providing feedback to appropriate agencies on how services are delivered to children and their families.
- Promoting family access and utilization of various support groups.

CCHCP also supports family partnership and leadership by employing the parent of an adult with special health care needs in the role of Parent Consultant to the Title V Program for Arkansas. The Parent Consultant collaborates with related agencies advocating for CSHCN as well as adults. His service on various boards not only represents the needs of parents of CYSHCN but also promotes partnerships with these agencies and the CCHCP. Boards the Parent Consultant serves on includes the University of Arkansas Partner's for Inclusive Communities Advisory Council, Arkansas Lifespan Respite Coalition, Arkansas Governor's Commission on People with Disabilities (chair), Arkansas Advocates for Children and Families' Kids Count Coalition, Arkansas Interagency Coordinating Council for First Connections, Disability Rights of Arkansas Legislative Committee, Arkansas State Genetics Health Advisory Board, and Arkansas Behavioral Health Planning and Advisory Council. The Parent Consultant strives to nurture new local support groups, attend community events and conferences to provide information about the CCHCP Program and network to form collaborative partnerships with these programs and agencies. In 2023, the Parent Consultant attended the following conferences to represent the needs of parents of CYSHCN and the CCHCP Program: the Arkansas Behavioral Health Planning and Advisory Council Conference, the Arkansas Lifespan Respite Conference, Arkansas Down Syndrome Association's ACCESS School Transition Conference,

and the DDS Beyond the Borders Conference.

The Parent Consultant is responsible for coordinating the PAC. In 2023, the PAC convened the first two quarterly meetings via zoom and included service providers and agencies for collaboration and to receive joint training. July 2023 marked the return to in person quarterly meetings with the option remaining for PAC representatives to attend virtually, if needed to facilitate parent participation.

III.E.2.b.iii. MCH Data Capacity

III.E.2.b.iii.a. MCH Epidemiology Workforce

The Arkansas Title V Program funds a 0.5 FTE maternal and child health epidemiologist, who is organizationally housed in the ADH Epidemiology Branch's Chronic Disease Epidemiology Section. She has a Master of Public Health degree with a concentration in epidemiology. Though the Epidemiology Branch and the Family Health Branch (FHB) are located in different buildings, the MCH epidemiologist meets regularly with FHB staff in person and by Zoom, telephone, and email. She has worked with the FHB since 2013 in multiple programs. In the past, the epidemiologist has provided data and technical support for the agency's strategic plan for MCH activities and Title V MCH focus areas such as infant mortality; developmental, behavioral, and mental health of children including the newborn screening program and the infant hearing program; well woman; and CSHCN transition to adulthood. She served as data coordinator for the Arkansas Collaborative Improvement and Innovation Network (ColIN) to Reduce Infant Mortality, in which she submitted quarterly data to grantors and developed program resources such as provider and partner maps. The MCH epidemiologist also assists with other agency and Epidemiology Branch projects, particularly relating to women, infants, or children, including the Tobacco Data Deck, county health profiles, data checks on other chronic disease products, and technical assistance with software such SAS (statistical analysis software), REDCap, and ArcMap.

The Epidemiology Branch and the Health Statistics Branch (HSB) are both located organizationally in the ADH Center for Public Health Practice. As such, the two branches have the same center director and science officer, both of whom can produce a synergistic effect for allowing access to HSB data, including birth, death, hospital discharge, and survey data. The MCH epidemiologist works closely with the HSB State System Development Initiative (SSDI) staff and oversees four Memoranda of Agreements (MOAs) between the Epidemiology Branch, FHB, and HSB. These MOAs provide the FHB and the MCH epidemiologist access to individual-level data to support the Title V MCH application/annual report and infant mortality initiatives, the Arkansas Maternal Mortality Review Committee, and the Arkansas COVID-19 Pregnant Women and Infants Registry (see SSDI data narrative for more details on data sharing). In addition to the strong relationship between the FHB, the Epidemiology Branch, and the SSDI program, the MCH epidemiologist has had long working ties with the HSB Survey Section Chief where the Behavioral Risk Factor Surveillance System (BRFSS) and the Pregnancy Risk Assessment Monitoring System (PRAMS) are located. The MCH epidemiologist is a member of the ADH PRAMS Steering Committee, which serves to examine and update PRAMS survey questions and monitor and utilize survey data to improve the maternal and perinatal experiences of Arkansas mothers and babies.

The MCH epidemiologist and the FHB staff regularly engage with the ADH Information Technology Services (IT) staff. Local Health Unit data for family planning clinics and maternity clinics are stored in the Greenway electronic health records system accessible by IT. Data for the FHB's Infant Hearing Program (IHP) are also stored in the IT system. The MCH epidemiologist, FHB Women's Health Section, and FHB Infant Hearing Program work with IT to create reports to monitor and improve the quality and timeliness of services.

Due to the COVID-19 pandemic, the MCH epidemiologist, along with all other epidemiologists and many other agency personnel, were called to serve in temporary capacities that pulled them away from their regular duties. During this time, the MCH epidemiologist and the FHB's medical director managed the COVID-19 Pregnant Women and Infants Registry, funded through the CDC Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Infectious Diseases (ELC), Project W REDCap: Surveillance for Emerging Threats to Mothers and Babies Network (SET-NET). This registry seeks to identify and collect data on women infected with SARS-CoV-2 during pregnancy and their infants. In 2021, a permanent Project W coordinator-epidemiologist was hired; however,

the MCH epidemiologist continues to assist with uploading new data to the Project W REDCap database and providing support and guidance for a supplemental CDC COVID-19 stillbirth project. Findings from these two programs will be used to inform others about the effects of SARS-CoV-2 infection on pregnancy and the infant's development up to six months of age.

Although not directly tied to the Title V MCH Block Grant, the full-time Women, Infants, and Children (WIC) Program epidemiologist and the part-time Nurse-Family Partnership (NFP) epidemiologist, also located in the Chronic Disease Epidemiology Section, work closely with the MCH epidemiologist to fulfill maternal and child health data needs for the agency and the FHB. The NFP epidemiologist position is currently vacant but is expected to be filled soon. Several Title V ESMs are WIC-focused, and the two epidemiologists have worked closely throughout the years on projects such the COVID-19 pregnancy registry, newborn screening hospital reports, and other data products.

III.E.2.b.iii.b. State Systems Development Initiative (SSDI)

Arkansas States Systems Development Initiative (SSDI) focuses on providing MCH programs with access to relevant timely data and information to monitor health indicators and to develop innovative programs and policies directed toward improving the health of mother and child population. Arkansas SSDI efforts complement the Title V MCH data capacity and analysis. Activities support, enhance, and expand State Title V MCH data capacity to allow for informed decision-making and resource allocation that support effective, efficient, and quality programming for women, infants, adolescents, and those Children with Special Health Care Needs (CSHCN). As the FY 2023 MCH Block Grant application along with FY 2021 Annual Report was completed, the SSDI linkage datasets were utilized for several measures. The FY 2023 MCH Block Grant application required an updated needs assessment which was conducted and completed in July 2022. The SSDI has assisted the MCH epidemiologist at the Family Health Branch (FHB) with responses to these requests in a very timely manner with up-to-date information. SSDI's contribution to MCH projects are numerous. During the FY 2022 (12/01/2021 – 11/30/2022) reporting period, the Arkansas SSDI team collaboration with internal and external partners has accomplished the following activities.

- The Health Statistics Branch (HSB) 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 HSB 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 needed linkage data from the respective databases. These databases include hospital discharge data, PRAMS, fetal, birth, and death certificates. 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 overall success of the Mother's project could only be achieved through excellent teamwork and partnership.

- 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 called 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 of the UAMS - with financial support from the Medicaid Program - began the HRPP Program partnership. The HRPP Program partnership brings maternal fetal medicine specialty care via telemedicine to high-risk women living in remote areas to ensure that every woman in Arkansas at risk of having a complicated pregnancy receives the best perinatal care possible. The linked datasets are used to evaluate the pregnancy outcomes of the HRPP Project. This evaluation is one part of the evidence-based medical approach the Arkansas Department of Health (ADH), the Arkansas Department of Human Services (ADHS), and UAMS are doing to improve maternal and child health in the state. Articles related to data linkages have been published in various scientific journals.

- One example of achieving SSDI goals was to make MCH stakeholders aware of available linked data sets. A data sharing agreement was signed between the Arkansas Department of Health (ADH) and the Arkansas Department of Human Services (ADHS), Division of Medical Services in December 2021. The purpose of the agreement is to assess the effectiveness of a variety of interventions intended to improve the birth outcomes of infants born to Medicaid or the Children's Health Insurance Program (CHIP) beneficiaries, and to assess the health care utilization and outcomes of children enrolled in Medicaid or CHIP as infants. SSDI staff receive three datasets annually (Category 1: Infants enrolled in Medicaid/CHIP; mother not enrolled, Category 2: Infants enrolled in Medicaid/CHIP; mother also enrolled, and Category 3: Mothers enrolled in

Medicaid/CHIP; infant(s) not enrolled), through “MoveIT” Departments’ secured file servers. SSDI staff has already matched infants in Categories 1 and 2 to birth certificate data per the HRSA SSDI Award Performance Goals. SSDI staff match Category 3 mothers enrolled in Medicaid/CHIP to infant’s birth certificates and provide ADHS with certain fields from the birth certificates for all three categories of infants. CY2019 - CY2020 Medicaid/CHIP versus birth certificate records linkage were completed in time and uploaded to ADHS secured servers. The birth linkage outcomes on Medicaid/CHIP had been reported at a December 2021 advisory panel meeting and stakeholder meeting at the end of March 2022. The ADHS Secretary leads the meeting, which includes several other secretaries, ADH representatives, and legislative representatives.

- SSDI staff have worked with the FHB’s Newborn Screening (NBS) Program to monitor and improve the quality of newborn screenings throughout the state. Newborn screening for inborn conditions has been mandatory in Arkansas since Act 192 of 1967 stipulated screening of all newborns for phenylketonuria. Since that time, the number of conditions screened for has grown substantially. The program oversees follow-ups on disorders screened using the blood spot card in addition to two point of care tests, hearing screen and critical congenital heart disease, for 31 disorders counting the two POC tests. Ninety-eight percent (98%) of the approximately 35,070 babies born in Arkansas in 2021 were screened for these genetic disorders. SSDI provided two NBS-Birth records linkage by county/health clinic bi-annually; one creates a dataset that includes information on infants with rejected samples and the other creates a data set that excludes infants with rejected samples used by the Family Health Branch staff to evaluate needs for those counties have lower percentage of newborn screen. In addition, the race/ethnicity breakdown of the infants screened in CY2021 was provided to the MCH Epidemiologist for the 2023 Title V MCH Block Grant Application/2021 Annual Report: Newborn Screening (Form 4). The Newborn Screening Program is in the Child and Adolescent Health Section at Family Health Branch of the Arkansas Department of Health.
- The Public Health NBS Lab Manager, SSDI staff, and Newborn Screening Manager work diligently and continue to monitor monthly timeliness of data at three points during the process: date of birth to specimen collection, collection to receipt in the ADH Public Health Lab, and receipt to reporting of test results. Time is measured in hours and a goal of less than 168 hours (7 days) from birth to reporting of test results was set. The 2021 report indicated the average was 205.6 hours. There were several factors that contributed to the increase in the number of hours from receipt to reporting. Arkansas experienced a week of inclement winter weather that closed the agency and shutdown the statewide courier service. The agency has since put together a continuity of services plan for future weather and other emergency events. During the months of May, October, November, and December the laboratory experienced various equipment issues that prevented the timely reporting of some test results. A big factor in the later months was the implementation of new mass spectrometry instruments that coincided with the addition of a new disorder to the screening panel. The instruments were installed in the lab in November and, due to numerous problems, resulted in a longer than usual verification for use. As a result, the vendor worked with ADH NBS lab and follow-up staff to coordinate the shipping of specimens to their lab in Pennsylvania to complete the testing for fatty, organic, and amino acid disorders as well as the new disorder, X-linked adrenoleukodystrophy (X-ALD). A protocol was also implemented to report critical results in a timely manner to the nursing staff for continuity of care. This factor plays an important part by assisting the NBS Nurse educator in scheduling ZOOM/Virtual conference calls with the birthing hospitals that have the strongest need to meet the < 168 hours goal. Each birthing facility receives a quarterly Hospital Timeliness Report to identify the number of specimens collected and received by the NBS lab within 48 hours of collection. Any facility that does not meet the goal of 80% of specimens reaching the lab within 48 hours is contacted to discuss potential issues related to timely specimen submission. At the end of 2021, a yearly comparison report of all birthing facilities had an average of 85.3%.

The program provides support to partner hospitals with virtual education opportunities and technical assistance to ensure effective collection to receipt in the lab for processing.

- The HSB has a data sharing agreement in place with the ADH COVID-19 Pregnant Women and Infants Registry, which conducts surveillance of pregnant women infected with SARS-CoV-2 during pregnancy and their infants. SSDI staff perform linkages between registry data and birth, death, and fetal death data to assess pregnancy outcome and to obtain needed information for medical chart abstraction such as the providers of prenatal and pediatric care and hospital where birth or death occurred. The 2020 COVID-19 data of pregnant women was linked to 2020 and 2021 birth certificate data, death data and fetal death data. Approximately 96% of the covid data of pregnant women was linked to the birth, 0.8 % were linked to the fetal death, 0.8% of the babies whose mothers have a COVID were linked to the death, and 0.08% of mothers were linked to death. As multiple years of linked data sets become available, the analyst can conduct mother-baby linked longitudinal surveillance to better understand the impact of such exposures on pregnant women and their babies.

- Arkansas PRAMS successfully implemented the eleven question COVID-19 supplement from January 2021 to March 2021. The project was implemented with three PRAMS batches as required. Arkansas PRAMS convened its steering committee meeting on June 7, 2022, and provided them with a quick fact sheet with information on the program and some of the findings from the COVID-19 supplement that was implemented in 2021. In addition, the office of Oral Health provides workshops throughout the state and used PRAMS information on Mom's dental health before and during pregnancy. Vital Statistics-PRAMS-BRFSS-Hospital Discharge Data System data were used for presentations, grants, reports, and other documents by partners (such as University of Arkansas for Medical Sciences, Arkansas Department of Human Service, Arkansas Children's Hospital, Arkansas Center for Health Improvement, legislators, Safe Sleep, Office of Health Equity, March of Dimes, Infant Mortality Action Group, etc.) and Family Health Branch staff.

- The HSB continues its agreement to provide annual, and more frequently as requested, access to individual-level birth and death data sets to support the Title V MCH Block Grant application, progress report, and some program activities such as efforts to decrease infant mortality. Upon request, aggregate data for hospital discharge, fetal death, PRAMS, and BRFSS data can also be provided. The HSB established a Memorandum of Agreement (MOA) with the Family Health Branch's Arkansas Maternal Mortality Review Committee (AMMRC) to identify and collect demographic, medical, and social history on maternal deaths in the state. AMMRC holds quarterly Committee meetings with a multidisciplinary panel of experts to discuss cases and make decisions and recommendations for preventing maternal deaths. AMMRC released its second annual report to the Arkansas Legislature in late 2021, which presented findings and recommendations based on 2018 maternal deaths. AMMRC is currently working on its third annual report and an accompanying fact sheet which will showcase reviews of 2019 maternal deaths.

- The SSDI staff has extensive experience in linking many independent databases that will be very useful to the Arkansas Maternal and Child Health projects. To date, the SSDI effort in Arkansas has been able to complete file linkage of birth certificates to the following databases to support MCH Block Grant programs:
    - Infant Deaths
    - Infant/Maternal Deaths Hospital Discharge Data System
    - Deaths – Hospital Discharge Data System
    - Medicaid Eligibility/Paid Claims
    - Children with Special Health Care Needs

- Newborn Screening
- PRAMS
- WIC Eligibility Files
- COVID-19 Pregnant Women and Infants Registry

With the assistance of SSDI staff, the various linked data sets are analyzed to identify trends in maternal and child health, assess low birth weight, preterm births, infant mortality, prenatal care, unintended pregnancy, and other MCH issues. The findings are applied to program planning, performance monitoring and program evaluations. As multiple years of linked datasets become available, the ability to address maternal and child health programmatic and policy issues will be significantly enhanced.

III.E.2.b.iii.c. Other MCH Data Capacity Efforts

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 a data sharing use agreement 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 Agreement allows the raw data to be used to support these efforts.

HSB also houses the Survey Section, where BRFSS and PRAMS staff are located. Within the Epidemiology Branch, the MCH epidemiologist belongs to the Chronic Disease Epidemiology Section, along with epidemiologists working with programs addressing chronic diseases (e.g., cancer screening and prevention, diabetes, arthritis, stroke, and hypertension), health disparities elimination, oral health, and other MCH-related programs such as the Arkansas Maternal Mortality Review Committee (AMMRC), WIC, and Arkansas's Nurse-Family Partnership home visiting program. The Chronic Disease Epidemiology Section has had 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. 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 (see the MCH Epidemiology Workforce Section for additional details).

In response to the COVID-19 pandemic, the 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. In 2021, a permanent epidemiologist position for this registry was funded for 4 years through the Surveillance for Emerging Threats to Mothers and Babies grant.

The Registry seeks 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. A contracted team of abstractors obtains 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. During the last year, the registry has been expanded for use with the stillbirths' project to investigate whether COVID-19 infection increases the risk of a stillbirth.

Childhood obesity is one of Title V's priority areas. Arkansas has the ninth highest obesity rate among adults (America's Health Rankings Annual Report, 2021) and the third highest obesity rate among high school students (CDC Youth Online, 2019). 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 attempt 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. Products and responses are checked for accuracy, reliability, content, formatting, and other features by another epidemiologist. Afterwards, the product will be reviewed by the Chronic Disease Epidemiology Section Chief, the Epidemiology Branch Chief, the Center for Public Health Practice (CPHP) Science Officer, and the CPHP Director. If some instances, review and approval may be required by the ADH Science Officer and the ADH Science Advisory Committee.

One of the key challenges to obtaining and using MCH-relevant data has been access to Medicaid and prescription drug data. Recently, the ADH and the Arkansas Department of Human Services Division of Medical Services entered into a data-sharing agreement for access to Medicaid data. Medicaid claims data will be used to assess and monitor Medicaid female beneficiaries' annual preventive visits, dental services accessed during pregnancy, and births paid for by Medicaid. Arkansas's Maternal Mortality Review Committee (AMMRC) is now working with Medicaid to access and link individual-level claims data to identify points of care and circumstances surrounding maternal deaths. Similarly, AMMRC is collaborating with the state's Prescription Drug Monitoring Program (PDMP) to seek legislative updates that would allow linkage of maternal death cases to PDMP data. AMMRC data indicate that substance use contributed to one in four pregnancy-related deaths in Arkansas. The AMMRC seeks to use the data to better understand the utilization of health care services and to make recommendations to reduce maternal deaths in the state.

Another challenge to utilizing data for MCH program planning and sharing with MCH partners has been how to handle small numbers. The agency seeks to protect confidentiality and to ensure the release of accurate and reliable counts and statistics (e.g., rates and percentages) while providing programs and partners with the data necessary to adequately inform state and local activity planning and evaluation. ADH has recently created standards for working with small numbers, which will be implemented throughout the department.

III.E.2.b.iv. MCH Data Emergency Planning and Preparedness

The Arkansas Department of Health has a Continuity of Operations Plan that has been updated in March of 2022 and is reviewed annually. The following is the Executive Summary of the plan:

Executive Summary: The Arkansas Department of Health (ADH) Continuity of Operations Plan (COOP) is designed to ensure continuity of operations during catastrophic events or disruption of normal departmental functions. The COOP is meant to be detailed and clear in its presentation and uncomplicated in its execution. The primary goal of the COOP is to prevent any major disruption of normal activities from occurring. The second goal is to mitigate potential damages that may occur. The third goal is to rapidly restore critical services following a disruption of operations. This may involve on-site contingency operations or relocation of part or all the affected operations. The fourth goal is to guide recovery from the disruption and resume normal operations rapidly and efficiently.

The primary mission of the ADH is "to protect and improve the health and well-being of all Arkansans." The immediate response efforts will focus on the identified essential functions of the primary mission of the ADH. Each ADH central office and field operation have identified the process, material and staff resources, logistical considerations, as well as the time required to resume each essential function at the local level within 12 hours of COOP activation. Furthermore, these essential functions, considered vital to public health and safety, will be sustained for up to 30 days as normal operations are being restored. Support functions such as Information Technology, Human Resources and Finance that enhance the ADH's essential functions and overall viability are given priority consideration. These support functions are crucial in the planning and execution of the ADH COOP. The critical support functions and roles are detailed in the Responsibilities and Procedures section.

Each essential function and resource requirements are identified and will include:

• Staffing requirements

• Material resource (equipment and supplies) requirements

• Critical data and data systems

• Support activities”

The End.

The state emergency plan outlines the actions to take to provide essential services to the public, including using an alternate facility or using temporary workers, if needed. Essential functions will be restored within 12 hours of a disruptive event. The Center Director was involved in emergency response planning and development. The Title V director is included in the Arkansas preparedness planning, however, is not part of the Incident Management Structure.

ADH can adequately assess and respond to an emergency as evidence by the rapid mobilization of staff and make sure women and children received essential services. Title V leadership and program staff were consulted to determine impact to services and program continuity. Their consultation included input regarding delivery of program services including safety precautions, identification of staff, and communication plans.

III.E.2.b.v. Health Care Delivery System

III.E.2.b.v.a. Public and Private Partnerships

The health care delivery system in Arkansas is multi-faceted and includes a variety of private and public providers and individual, private, and public payers. Consumers of health care services have many choices, and work continues statewide to ensure better health status and outcomes for women and children. Sources of health insurance for women and children in Arkansas include the following:

Coverage Type	Employer	Non-Group	Medicaid	Other Public	Uninsured	Total
Women 19-64	54%	8%	23%	5%	11%	100%
Children 0-18	38%	4%	51%	2%	6%	100% *

Henry J. Kaiser Family Foundation estimates based on Census Bureau's American Community Survey, 2019.

**Data may not sum to totals due to rounding.*

Medicaid in Arkansas

Arkansas's Medicaid transitioned three years ago from a fee-for-service system to an organized care delivery model for the highest need behavioral health and developmental disability populations. The model, the Provider-led Arkansas Shared Savings Entity (PASSE) Program, provides care coordination services. The PASSE system went full risk March 2019. PASSEs are responsible for integrating physical health, behavioral health, and developmental disability services. Members are assigned a care coordinator who is responsible for creating a service plan for each individual. As of March 1, 2022, which is the three-year anniversary of the PASSE program, serves over 55,000 Arkansas Medicaid clients.

In December 2021, Arkansas's Governor Asa Hutchinson announced his plan to fund additional Community and Employment Support (CES) Waiver slots and eliminate the waitlist, as it existed December 2021, by June 2025. The additional funding over the next several years will open slots for approximately 3,000 children and adults on the wait list for the CES Waiver. Arkansas Department of Human Services (ADHS) announced in February 2022 after receiving feedback from Medicaid clients and providers, that American Rescue Plan funding would be utilized in phase one to improve the recruitment and retention efforts to stabilize the workforce for this disabled population in their homes.

In Arkansas, Medicaid provides publicly funded health insurance to approximately 1,000,000 people, including the disabled, the elderly, and children through ARKids First. The total covered by Medicaid is almost one-third of the state's population. Arkansas has led the initiative in health care financing reform mainly through the Affordable Care Act (ACA) and Arkansas Health and Opportunity for Me (ARHOME). ARHOME allows Medicaid to fund private insurance companies to provide insurance to Arkansans whose income does not exceed 138% of the federal poverty level (FPL). In March 2022, ARHOME enrollment was 339,393. The overall uninsured rate fell from 17% in 2013 to 9.1% in 2021. Almost 100% of children have health insurance, 77.7% of which is considered adequate for their needs.

Additionally, Medicaid provides care coordination services for the highest need behavioral health and developmental disability populations in Arkansas. PASSEs are responsible for integrating physical and behavioral health as well as developmental disability services for assigned members. Members are assigned a care coordinator who is

responsible for creating a person-centered service plan for them. For members who do not meet eligibility criteria, the MCH Children with Chronic Health Conditions Program (CCHCP) serves as the safety-net provider for a subset of this population.

The MCH program and Medicaid work together on many projects: management of high-risk pregnancies, teen pregnancy, promoting the use of long-acting reversible contraceptives, providing colposcopies, and data sharing. The formal agreement between Medicaid and MCH in the state is a memorandum of understanding (MOU) between the ADH and the ADHS. A new MOU to emphasize the role of MCH has been attached. Both agencies approved the document last year. While there are few formal advisory committees at Medicaid that MCH sits on, the FHB has established an internal MCH Domain Workgroup and invited Medicaid to participate.

Health Care Delivery System Network and Partnerships

While the ACA has increased the number of insured in the state, it has not increased the number of providers, of which there is a shortage. The number of physician practices in the state is inadequate to provide necessary medical services to the population. The average caseload for a primary care physician is 1,522 patients. Arkansas ranks 38th in the nation for number of PCPs (82.3 per 100,000 population). There are only 405 pediatricians and 289 obstetricians/ gynecologists in the state. Arkansas ranks 50th in the number of dentists (40.9 per 100,000).

MCH is still a gap filler in areas lacking providers and in areas where providers are not taking Medicaid patients or uninsured patients. The irony is that with Arkansas Works, some providers can fill the offices with privately insured patients and do not have an incentive to take Medicaid or no-pay patients. Despite the availability of coverage, some of the population has not yet enrolled. One-third of the family planning patients served by the ADH in the local health units are without insurance of any kind.

There are 113 hospitals in the state that provide the bulk of in-patient care. The ADH works closely with these local providers to ensure that standards of care are met. Apart from this regulatory relationship, ADH also partners with the Arkansas Hospital Association (AHA) on issues of common interest at the systems level, including the development of the breastfeeding toolkit for hospital use, the state's Infant Mortality Collaborative Improvement and Innovation Network initiatives, and the Arkansas Maternal and Perinatal Outcomes Quality Review Committee.

The University of Arkansas for Medical Sciences (UAMS) is a centralized point of referral for medically complicated patients and provides medical and health education for the entire state. Except for the cities of West Memphis and Helena on the eastern border that depend on the city of Memphis, Tennessee, all state communities relate to UAMS and Little Rock hospitals as major sources of highly specialized medical care. UAMS's regional programs provide family medicine residency training in communities around the state, which has improved the distribution of primary care physicians. Family physicians provide most of the state's medical care and are by far the most numerous specialty practitioners in Arkansas. Specialists in obstetrics, pediatrics, internal medicine, surgery, and others have practices in the more urban communities. While Arkansas is geographically small compared to some states, the distances from cities such as Fayetteville and Texarkana to Little Rock require two to four hours of travel time. For families with few resources, these distances represent significant barriers to access specialized care.

The MCH program continually works with partners to meet the health needs of the state. Changes are often driven by the planning of the larger institutions such as Arkansas Children's Hospital (ACH). ADH partners with ACH to provide home visiting services statewide and on a number of other issues including teen suicide, injury prevention, Infant and Child Death Review (ICDR), infant hearing, and newborn screening. As part of our partnership, MCH plays a significant role in ACH's community health needs assessment and the Natural Wonders Partnership Council.

Professional boards of medicine, nursing, and other disciplines are other entities that provide support to the health care system. These disciplines, along with dentistry, pharmacy, chiropractic care, and hospital administration are represented on the Arkansas Board of Health.

III.E.2.b.v.b. Title V MCH – Title XIX Medicaid Inter-Agency Agreement (IAA)

The Arkansas Department of Health entered into an Inter-Agency Agreement with the Arkansas Department of Human Services (DHS), Division of Medical Services (DMS) as the State Medicaid Agency, the DHS Division of Developmental Disabilities Services (DDS), and the Arkansas Department of Health (ADH) for the purpose of carrying out provisions of Titles V and XIX of the Social Security Act, as amended.

This agreement is set forth to define each agency's responsibilities in order 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, and to facilitate data sharing that will enable ADH and DMS to improve Title V and Title XIX program administration and outcomes. The agreement outlines principles, regulatory authority, services, reimbursement terms, data sharing details, and responsibilities for each entity. This agreement serves as a concise guide for coverage and provision of certain services.

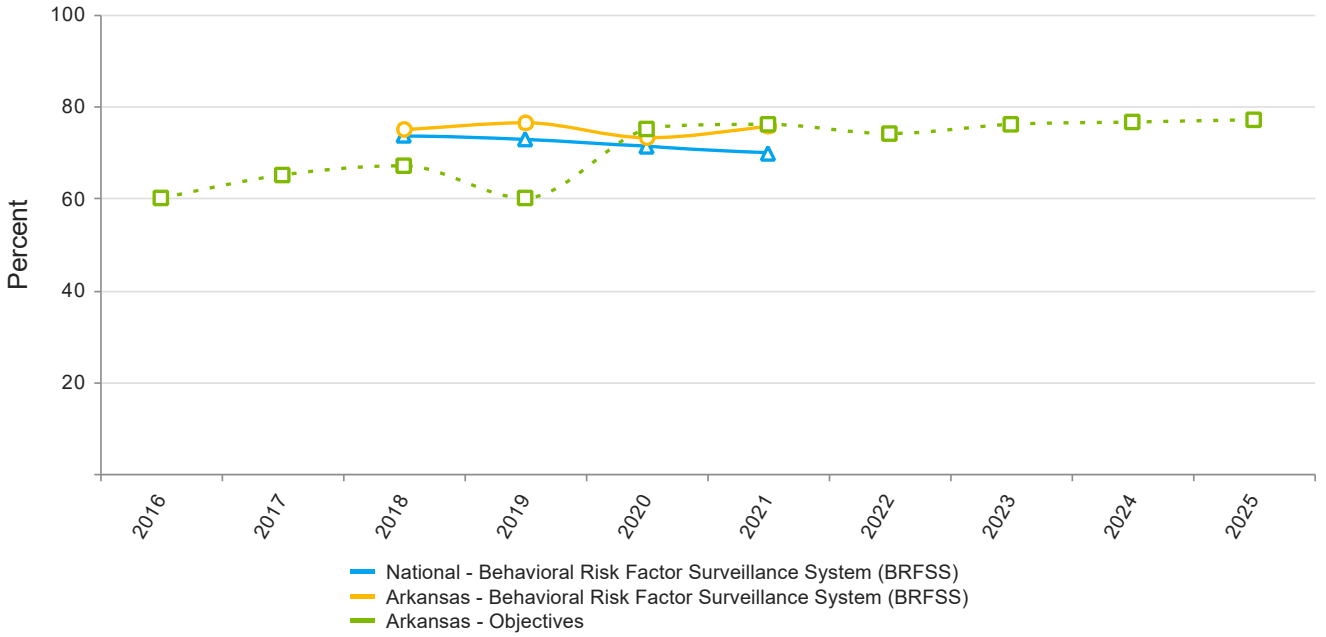
A pdf copy is uploaded under Section IV. Title V – Medicaid IAA/MOU of the application.

III.E.2.c State Action Plan Narrative by Domain

Women/Maternal Health

National Performance Measures

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year
Indicators and Annual Objectives



Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective			75	76	74
Annual Indicator		74.8	76.2	73.1	75.5
Numerator		383,916	391,445	369,110	386,008
Denominator		513,590	513,789	504,995	511,351
Data Source		BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year		2018	2019	2020	2021

Previous NPM-1 BRFSS data for survey year 2017 that was pre-populated under the 2018 Annual Report Year is no longer displayed since it is not comparable with 2018 survey data.

Annual Objectives			
	2023	2024	2025
Annual Objective	76.0	76.5	77.0

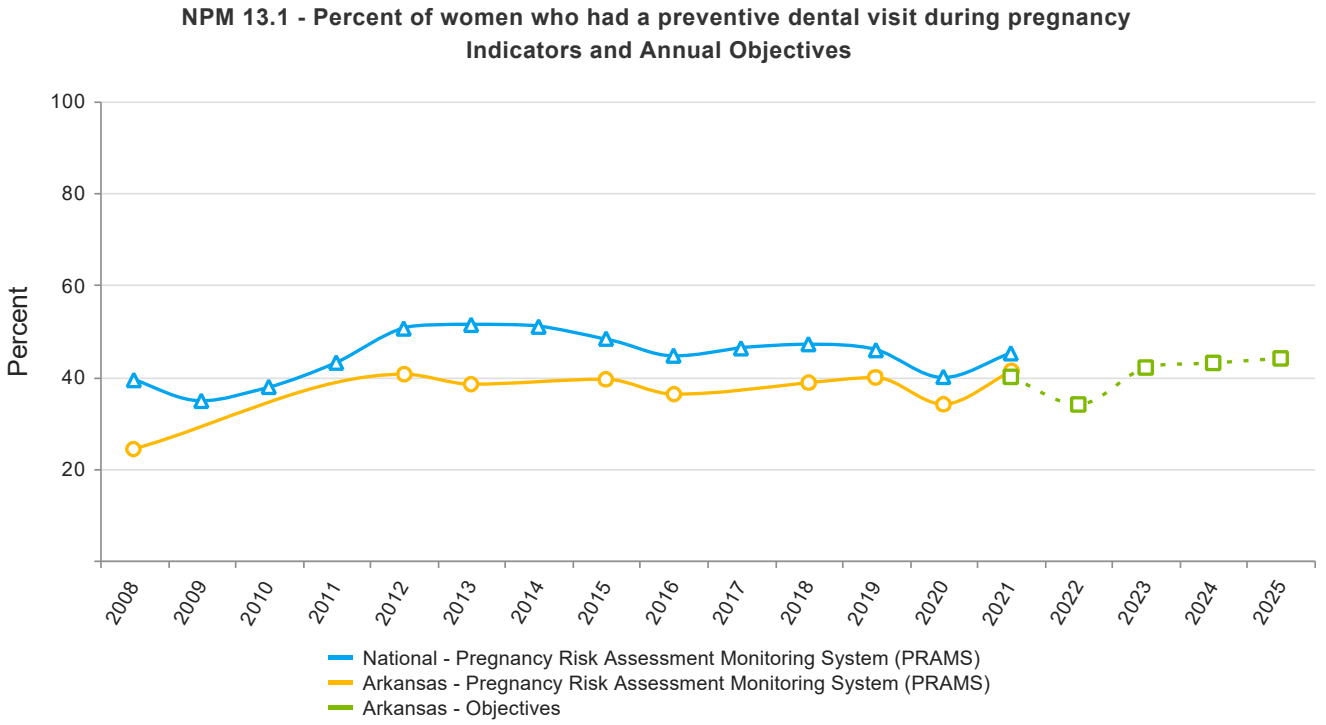
Evidence-Based or –Informed Strategy Measures

ESM 1.1 - Number of women, ages 18 through 44, with a past year preventive medical visit in an Arkansas Department of Health local health unit

Measure Status:	Active

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	53,000	41,000	33,105	28,000	29,000
Annual Indicator	39,593	33,105	27,082	27,055	27,349
Numerator					
Denominator					
Data Source	ADH Electronic Health Records	ADH Electronic Health Records	ADH Electronic Health Records	ADH Electronic Health Records	ADH Electronic Health Records
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	30,000.0	30,000.0	30,000.0



Federally Available Data				
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)				
	2019	**2020**	**2021**	**2022**
Annual Objective			40	34
Annual Indicator	36.2	40.0	33.9	41.3
Numerator	12,462	13,291	10,887	13,559
Denominator	34,405	33,232	32,120	32,811
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2016	2019	2020	2021

State Provided Data				
	2019	2020	2021	2022
Annual Objective			40	34
Annual Indicator				41.3
Numerator				13,559
Denominator				32,811
Data Source				PRAMS
Data Source Year				2021
Provisional or Final ?				Final

Annual Objectives			
	2023	2024	2025
Annual Objective	42.0	43.0	44.0

Evidence-Based or –Informed Strategy Measures

ESM 13.1.1 - Number of presentation or education events on the importance of oral health during pregnancy

Measure Status:			Active	
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			5	7
Annual Indicator			7	11
Numerator				
Denominator				
Data Source			Office of Oral Health and Womens Health Section	Office of Oral Health and Womens Health Section
Data Source Year			2021-2022	2022-2023
Provisional or Final ?			Provisional	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	8.0	9.0	10.0

State Action Plan Table

State Action Plan Table (Arkansas) - Women/Maternal Health - Entry 1	
Priority Need	
Well Woman Care	
NPM	
NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year	
Objectives	
1. By December 31, 2025, increase the percent of women, ages 18 through 44, with a preventive medical visit in the past year to 77%.	
Strategies	
1 .Continue to work with the ADH's Hometown Health Coalition in each public health region to partner with local churches, schools, and civic organizations to provide community-based educational program and activities.	
2. Continue community-level grassroots outreach activities led by ADH maternity clinic nurses in the local health units, such as health fairs, engagement with local organizations and business partners, and women's shelters.	
3. Partner with the Arkansas Home Visiting Network to educate expectant and new mothers about the importance of annual preventive checkups.	
ESMs	**Status**
ESM 1.1 - Number of women, ages 18 through 44, with a past year preventive medical visit in an Arkansas Department of Health local health unit	Active

NOMs

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

NOM 3 - Maternal mortality rate per 100,000 live births

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

NOM 5 - Percent of preterm births (<37 weeks)

NOM 6 - Percent of early term births (37, 38 weeks)

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.2 - Neonatal mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy

NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

State Action Plan Table (Arkansas) - Women/Maternal Health - Entry 2

Priority Need

Oral Health

NPM

NPM 13.1 - Percent of women who had a preventive dental visit during pregnancy

Objectives

1. By December 31, 2025, increase the percentage of women who had preventive dental visit during pregnancy to 44%.

Strategies

1 . Work with the ADH Office of Oral Health to develop collaborations with obstetricians and gynecologists in the state to encourage women to continue their regular dental visits during their pregnancy through the Paint a Smile (PAS) program.

2. Distribute educational materials for pregnant women to maternal and dental healthcare providers through partnership with ADH Office of Oral Health, Delta Dental of Arkansas, and the Count the Kicks Campaign.

3. Provide dental health education and counseling at initial or subsequent maternity visits to women attending ADH maternity clinics.

ESMs	Status
ESM 13.1.1 - Number of presentation or education events on the importance of oral health during pregnancy	Active

NOMs

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

Arkansas Title V Maternal and Child Health Services Block Grant
2022 Report and 2024 Application

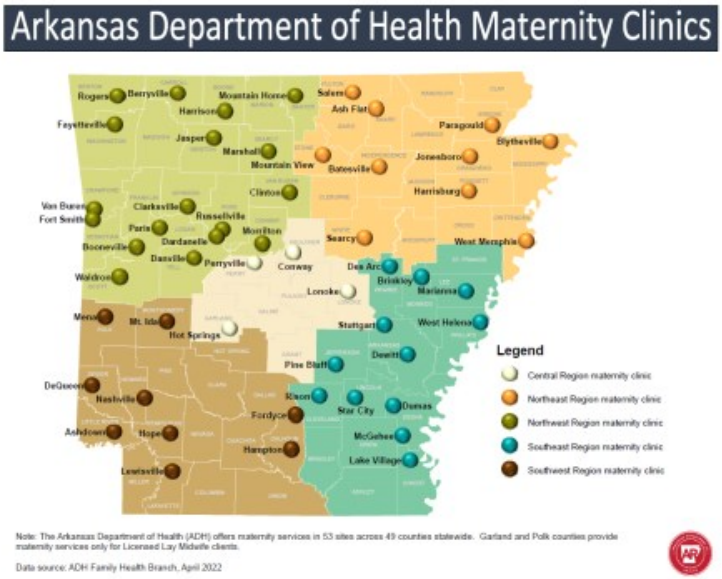
III.E.2.c. State Action Plan Narrative by Domain

Women and Maternal Health 2022 Annual Report

Local Health Units

The Arkansas Department of Health (ADH)- Women's Health program provides direct healthcare, referral services, preconception, inter-conception counseling, and preventive screenings for women of reproductive age in all 75 counti in Arkansas. ADH also provides education, screening, and referral for smoking cessation to women of childbearing age to reduce smoking among pregnant women. LHUs serve the state's vulnerable and hard-to-reach populations, especially those in rural areas where access to medical care is limited. The ADH's Women's Health programs suppo the provision of direct health care and referral services to address the perinatal, reproductive health, well woman, and other preventive service needs for women across the state. The ADH currently offers maternity services in 53 LHUs covering 49 counties (Map1) including:

- Case management.
- Prenatal assessments, including risk assessments, history, physical, laboratory tests, gestational age, and feta assessments.
- Management of abnormal prenatal findings.
- Prenatal counseling and education.
- Women, Infants and Children (WIC) program.
- Vitamins and mineral supplements.
- Post-partum services.



Maternal Health Activities 2022

Objective 1: By December 31, 2025, increase the percent of women, ages 18 through 44 with a preventive medical visit in the past year to 77%.

The state action plan that was submitted does not support NPM1. However, the following strategies aim to accomplish this objective by increasing the number of women who receive their preventive health visit:

1. The ADH Women's Health partnered with the ADH health equity to push out family planning and maternal

health information to increase preventive health visits. Flyers and educational materials about maternal health were sent to local health units.

2. Central Arkansas Alumnae Chapter (CAAC) organized its second annual Health and Wellness Fair in December 2022. CAAC partnered with the ADH, Arkansas Health and Wellness, Breast Care Program, Arkansas Minority Health Commission, Infant Hearing Program, UAMS, and Be Well Arkansas. The fair covered a wide span of topics such as, tobacco cessation, women's health, breast cancer, heart disease, healthy eating lifestyles, and other activities for 200 attendees. The ADH Women's Health Section distributed 30 flyers and talked to women in the community to educate them about getting their initial preventive visits and other maternal services offered at the local health units.
3. School Based Health Centers: the central region provides services at a monthly family planning clinics at Central High School. Information is provided to local colleges on family planning services and preventive annual checkups offered at LHUs. While the southeast region provides two monthly off-site family planning clinics at the university of Arkansas at Pine Bluff campus. The Jefferson County LHU also hosts a monthly clinic at the Dollarway School District's Wellness Center.
4. The development of partnerships with local community-based health and social service providers through local Hometown Health Coalition efforts to establish a community network of services.
5. The ADH Women's Health section continues to work with the ADH's Hometown Health Coalition in each region to partner with local churches, schools, and civic organizations to provide community-based educational program and activities.
6. Distribution of reproductive health and maternity information flyers through the Breastfeeding Coalition to incarcerated women to raise awareness of available services once they were released.
7. Outreach activities by the nurses in the LHUs at the grassroots level to reach out women to educate them about getting their first preventive visit:
    - Visiting doctor's offices, hospitals and sharing with them the maternity and/or family planning services provided in the health units to help patients that do not have a pay source to schedule appointment for prenatal and maternal services.
    - Sharing the maternity and family planning materials with the Department of Human Services so they can refer people who do not qualify for Medicaid to LHUs services.
    - Outreach visits to school nurses, youth groups, women's shelters, health fairs.
    - Asking daycares to post some of LHU flyers which list the maternal and family planning services.
    - The Southwest Region distributed the flyers at influenza vaccination clinics at Tyson's Poultry on October 2, 2022.
    - The Northwest Region LHU staff attended community events hosted by the Veteran Affairs and Marshallese organizations and distributed flyers.
    - The Northwest Region LHU staff participated in a local community parade, created a float (which won first place) and handed out flyers and WIC information.
    - The nurses at the local health units are constantly engaging with the local community and educating them about women's health by attending community events including:
        - Washington Regional Cancer Support Home-Fayetteville.
        - Panther Wellness Clinic-Siloam Springs.
        - Parkhill Women's Clinic-Fayetteville.
        - Willow Creek Women's Clinic-Springdale.
        - Creekside Women's Clinic-Springdale.
        - Her Health Clinic-Fayetteville.
        - Division of Community Correction Reentry Service-Fayetteville.
        - The Church of Jesus Christ-Prairie Grove.
        - Sweet Home Missionary Baptist Church Nurses group- Morrilton.

- Conway County Care Center- Morrilton.
- UACCM continuing education center- Morrilton.
- Conway County Library- Morrilton.
- Community Baby Shower-Berryville.
- Local pregnancy Center the Cradle- Berryville.
- Community wellness committee meeting- Clinton.
- World's Largest Baby Fair-Harrison.

Pregnancy and Oral Health Activities 2022

NPM 13.1: By December 31, 2025, increase the percentage of women who had preventive dental visit during pregnancy to 44%.

The following strategies are implemented to increase the number of women receiving preventive dental visit during pregnancy:

1. Develop collaborations with obstetricians and gynecologists in the state to offer Paint a Smile (PAS) program. PAS trains medical professionals to perform oral health risk assessment, oral health screenings, education, and apply fluoride varnish in clinical settings to close the gap that might exist for people who do not have regular access to comprehensive dental care. The
   dental care during pregnancy is safe and recommended. All women should be encouraged to continue their regular dental visits or to see a dentist during any trimester of their pregnancy. Physical changes during pregnancy increase the mother's risk for oral problems such as gingivitis, tooth mobility, tooth erosion, tooth decay, and gum disease. Additionally, the bacteria responsible for dental cavities can easily be transmitted from the mother to the infant or toddler.
2. The ADH OOH works with LHU nurses to provide oral health education to caregivers and assist them in locating a dental home if needed. Although the focus is on children aged 6 and younger, anyone under 19 years of age is eligible including young expectant mothers.
3. The Arkansas Department of Health used social media platforms to inform and motivate pregnant women to maintain good oral health and see their dentist regularly. In 2022, they reached 4715 people on Facebook, 185 on Instagram, and 795 on Twitter.

Future activities might include partnering with Healthy Birth Day Inc. (HBD), ADH Women's health, ADH OOH, and Delta Dental to launch a campaign to educate women about the importance of practicing good oral hygiene while pregnant. HBD/ Count the Kicks could be integrated not just with traditional healthcare settings like OBGYNs or Midwives, but also with Dentist, Hygienist, and Dental Assistants. The connection between poor oral health and poor birth outcomes is undeniable. That is, by creating a systems protocol for Dental Clinics and educating Dentists on the importance of talking about not just oral health but also touching on the importance of tracking fetal movement is just one more touch point expectant women will have in their lives that will ultimately make a difference.

Challenges in Implementing Title V Activities

- The implementation of Affordable Care Act affected the number of women receiving family planning services at the health units, as it allowed woman to choose private health care provider and permitted teenagers to remain insured under their parents' policies until age 26.
- The overturn in staff represents a challenge with fulfilling state priority needs and activities for pregnancy and Oral Health. In January 2022, the ADH Oral Health director retired. The director was instrumental in writing the ESMs for NPM 13.1 and helping to understand the priority. In March 2022, the ADH OOH section chief resigned from the position. The section chief worked directly under the director and was second in command for the OOH. Furthermore, the MCH director retired as of January 2023 and the Women's Health

section chief has resigned in May 2023. Currently, the new staff operates to revise the old programs and establish new strategies and partnerships (i.e., Delta Dental and ADH OOH) associated with maternal health to better serve women across Arkansas.

Local Health Unit Activities

The following strategies aim at serving women at the health units rather than increasing the number of visits:

1. Review medical record data reports for rates of preventive health services for women ages 18-44 provided in LHUs. In 2022, a total of 14,162 women ages 18-44 received a preventive health visit at the LHU.

2. Family Planning and Well Woman patients at LHUs receive education and counseling on recommended preventive screenings to optimize health. Educational topics include sexually transmitted infection screening, Pap tests, mammogram referral, hemoglobin testing, sickle cell screening, total cholesterol or cholesterol screening referral, wet mount, pregnancy testing, and fecal occult blood testing. The client is also screened for immunization status, smoking, alcohol use, illicit drug use or abuse, human trafficking, and intimate partner violence.

3. Provide referrals to community resources for identified risk factors or medical procedures unavailable at the local health unit. In 2022, Family Planning and Well Woman programs referred patients for a total of 3,191 health-related services not provided by ADH. The services include laboratory tests, radiology, mammography, colposcopy, social services, dental services, tobacco cessation, and referrals to other medical providers. The Family Planning program also made 2,856 referrals to the Special Supplemental Nutrition Program (SNAP) for the WIC program in 2022.

4. Provide preconception counseling prior to pregnancy to women attending an ADH Family Planning clinic. LHUs also provide preventive health screening services and referrals at all Family Planning and Well Woman visits to identify health problems. Family planning patients without a pay source are charged based on a sliding fee scale, with no fee for families with incomes at or below 100% of the federal poverty level. The ADH does not deny services due to inability to pay, and the agency bills third party payers for family planning services.

5. Track medical record data reports for prenatal care entry at local health units. In 2022, ADH maternity clinics served 1,265 women with expected delivery dates. Maternity patients can apply for Medicaid through the Arkansas Department of Human Services (ADHS), while non-citizens or undocumented women can apply for Medicaid's Unborn Child Option for pregnancy coverage. The ADH can provide care until the patient gets Medicaid approval, which varies across the state in terms of duration. After approval, LHU staff help the clients find a local prenatal care provider. The women's health services are crucial given Arkansas's high rural population, high poverty levels, and limited availability of obstetric providers.

Other Programmatic Activities

Appointment Show Rate: The ADH implemented an appointment reminder program for patients using the Vital Interaction software with Greenway PrimeSUITE patient data. The patient receives three reminders: a text reminder is sent five days prior to the appointment with a requested Y/N confirmation response, a voice call reminder is sent 72 hours prior to the appointment If the patient does not respond to the text, and a text reminder is sent with no requested confirmation 24 hours prior to the appointment. The appointment show rate had notably increased from 65.6% during program implementation in March 2016. The show rate for March 2017 to February 2018 was 68.8%, an increase of 3.2 percentage points. From March 2018 to February 2019, the show rate was 69.7%, an increase of 4.1. From March 2019 to February 2020, the show rate was 69.8%, an increase of 4.2. From March 2020 to February 2021, the show rate was 74.2%. From January 2022 to April 2023, the show rate was 79.6%, an increase of almost 9% since implementation.

Promote Maternal Health: Arkansas Maternal Mortality Review committee (AMMRC) works to quantify and understand pregnancy-associated deaths to create actionable and comprehensive recommendations to prevent future deaths. This is accomplished through epidemiological surveillance and multidisciplinary case review led by the committee members. The committee is working toward a partnership with the Center of Disease Control and Prevention to launch Hear Her Campaign in Arkansas. The campaign will be promoted though major social media platforms to reach the target population who are pregnant women, women who have given birth within the last year (postpartum), and their support network (including partners, family, and friends). The main objectives are to raise awareness of urgent maternal warning signs during and after pregnancy, improve communication between patients and their healthcare providers, empower pregnant and postpartum woman to speak up and raise concerns, and provide tools for pregnant and postpartum women and healthcare professionals to better engage in life-saving conversations.

Count The Kicks Campaign: ADH partnered with Healthy Birth Day, Inc. (HBD) in 2022 to release a statewide launch of count the kicks, a stillbirth prevention public health campaign. The nonprofit provides the ADH with social media content and free digital tools for use on all social media platforms. HBD prints Count the Kicks educational materials with ADH logo, including brochures, posters, and app reminder cards in English and Spanish for all maternal health professionals and birthing hospitals in Arkansas. Count the Kicks is a one-of-a-kind stillbirth prevention campaign directed at pregnant women. The success of the public health campaign comes from partnering with maternal health providers to ensure that all women in the third trimester are aware of the importance of counting their baby's kicks, learning what are normal movement patterns for their baby, and telling their provider right away if they detect any changes. During the first quarter of 2023, the number of CTK app downloads among expectant parents was 118 users, the number of Arkansas hits to the CTK website, and social media was 635 people, and the number of CTK materials sent to healthcare professional was 20,965 pieces for 65 orders placed.

Nurse-Family Partnership: The Family Health Branch partners with Arkansas's Nurse-Family Partnership (NFP) home visiting program to improve pregnancy outcomes by helping women be involved in good preventive health practices. The Nurse-Family Partnership (NFP) Program gives first-time moms first-rate help, right from the start. This free, evidence-based program partners first-time moms who meet low-income requirements with specially trained Registered Nurses. Through home-based visits, these nurses educate moms on prenatal and newborn care and teach them how to help their children develop emotionally, physically, and mentally. NFP helps moms prepare for birth and gives both mother and child the support to reach their goals. During home visits, NFP nurses answer questions about pregnancy, childbirth and how to care for a newborn. Nurses help moms set personal and family goals, then link them with resources in the community so they can achieve them. Nurse-Family Partnership/Arkansas Home Visiting Network (arhomevisiting.org).

High Risk Pregnancy Program: the ADH Women's Health Section has a professional services contract with the UAMS Women and Infant Health Service Line (WISL) to facilitate the delivery of comprehensive and risk-appropriate maternity care to low-income women throughout Arkansas. It also supports the ADH in providing outpatient services to ADH high-risk maternity patients. In addition to telemedicine, the contract supports the provision of nursing services, laboratory services, physician services and the liaison/consultation services of a certified nurse midwife for ADH's Lay Midwife Program.

COVID-19 Vaccination in Pregnancy: Women's Health partnered with ADH Surveillance for Emerging Threats to Mother and Babies Program to create a survey for providers to fill out covering possible concerns they might hear from pregnant and breastfeeding women or those trying to get pregnant about the COVID-19 vaccine or COVID-19 in general. In July 2022, the ADH developed a Pregnancy and COVID-19 webpage involve information for the community and health care providers https://www.healthy.arkansas.gov/programs-services/topics/covid-19-and-

pregnancy. The webpage also includes resources from CDC for patient education to promote awareness and encourage women to make inquiries to protect their health against COVID-19.

HPV Prevention: The "HPV Vaccine is Cancer Prevention" Summit was held May 16, 2022, as a hybrid event. The HPV Summit creates a platform for collaboration among medical and dental professionals to increase awareness about the benefits of the HPV (human papillomavirus) vaccine and cancer prevention as well as to increase acceptance of the vaccine. ADH partnered with the Arkansas Immunization Action Coalition to provide education on efforts to improving Arkansans' health through immunizations at the 2022 HPV Summit.

Long-Acting Reversible Contraceptives (LARC): LARC is an important service provided by ADH Family Planning Title X Program. The Women/Maternal Health Domain work closely with Title X staff to expand knowledge of, and access to, all forms of contraception, especially LARC services. In calendar year 2022, 3,571 LARC insertions including Nexplanon and Intrauterine Device (IUD) were performed.

Congenital Syphilis testing, prevention, and treatment: Every region in Arkansas is seeing an increase in the number of syphilis cases, especially among women. From 2017 to 2021 there was a 164% increase (from 562 to 1,482) overall in early syphilis cases and a 285% increase (from 155 to 597) among women of reproductive ages (15-44 years). Syphilis among pregnant women is especially a concern due to the potential of congenital syphilis, which happens when a mother with syphilis passes the infection to her baby during pregnancy. Untreated syphilis during pregnancy can lead to stillbirth, preterm delivery, and other congenital abnormalities. Congenital syphilis is preventable by early detection of maternal infection and appropriate treatment prior to delivery. The State of Arkansas requires testing of all pregnant women at the first prenatal care visit and 3rd trimester (between 28-32 weeks gestation). Furthermore, testing at delivery is required if not done during the pregnancy. Local health units across the state provide Syphilis testing and treatment for free or at low-cost according to income verification. The number of Syphilis test by visit at the maternity clinics was 1070 visits in 2021 and 1051 visits in 2022. On the other hand, the visit counts with patient count at the maternity clinics across Arkansas' five regions was 1243 patients for 2021-2022 and 1266 patients for 2022-2023.

Unintended Pregnancy: The ADH partnered with Arkansas Medicaid, AFMC, and the Arkansas Department of Higher Education to implement strategies and distribute educational materials designed to address unintended pregnancies. Together, these partners developed a toolkit for hospitals and health care providers to use as they discuss health, sexual history, and birth control options with patients. The toolkit, TAKE CONTROL of Your Life: The choice about if or when you become pregnant is YOURS!, included a patient education flip chart and patient education guide to review the different options for family planning. The toolkit was made available in English, Spanish, and Marshallese. It was distributed to campus health centers/programs at all public two-year and four-year colleges in the state. It was also distributed to the LHUs. The Arkansas Campaign to Prevent Unplanned Pregnancy also developed a YouTube video called *Preventing Unplanned Pregnancy* (https://www.youtube.com/watch?v=FaCyQMrSUg8).

Maternal regionalization site visits: ADH leads the perinatal regionalization efforts in Arkansas. Towards this aim, ADH will coordinate site visits to birthing hospitals as a part of its perinatal regionalization work. ADH will recruit volunteer clinical providers to conduct the site visits and provide an incentive to participating clinical providers using funds from this subaward. Volunteer providers will conduct in-person site visits and complete the "Levels of Care Assessment Tool" (LOCATE) from the Centers for Disease Control and Prevention. ADH will coordinate site visits, collect, and analyze assessment data, and provide results of the LOCATE assessments to UAMS (e.g., confirmed levels of care for each hospital) for inclusion in the state maternal health dashboard.

Arkansas Title V Maternal and Child Health Services Block Grant
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III.E.2.c. State Action Plan Narrative by Domain

Women & Maternal Health 2024 Application Year Plan

Priority Need: Well Woman Care

NPM 1: Percent of women, ages 18 through 44, with a preventive medical visit in the past year.

Annually ensure 100% of the LHUs conduct a minimum of 1 promotion activity for a total of 92 activities; each Local Public Health Region will facilitate a minimum of two (2) community outreach and education activities (one every 6 months) for a total of ten (10) outreach and education activities annually to promote preventive health service activities and accessibility to services at the LHUs.

The ADH's Women's Health Section will continue to work with the ADH's Hometown Health Coalition in each region to partner with local churches, schools, and civic organizations to provide community-based educational programs and activities. Preventative health service promotional activities continue to be facilitated through:

1. Providing approved literature and resources at local health fairs, beauty salons, fast food restaurants and local colleges
2. Providing appropriate literacy-level materials to patients
3. Personal visits to childcare providers as well as health and medical clinics
4. Distribution of periodic electronic and print media articles

Priority Need: Oral Health

NPM 13.1: Percent of women who had a preventive dental visit during pregnancy.

Future Women's Health section partnership with Healthy Birth Day Inc., ADH Women's health, ADH OOH, and Delta Dental to launch a campaign to educate women about the importance of practicing good oral hygiene while pregnant. Count the Kicks could be integrated not just with traditional healthcare settings like OBGYNs or Midwives, but also with Dentist, Hygienist, and Dental Assistants. The connection between poor oral health and poor birth outcomes is undeniable. That is, by creating a systems protocol for Dental Clinics and educating Dentists on the importance of talking about not just oral health but also touching on the importance of tracking fetal movement is just one more touch point expectant women will have in their lives that will ultimately make a difference.

The office of Oral Health will continue its efforts in providing presentations and holding community events at the local health units to educate community members, especially women of reproductive age about the importance of oral health during pregnancy.

Perinatal/Infant Health

National Performance Measures

NPM 3 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)
Indicators and Annual Objectives

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	82	79	82	83	81
Annual Indicator	77.6	81.5	77.6	80.5	76.5
Numerator	382	423	367	453	368
Denominator	492	519	473	563	481
Data Source	Arkansas birth certificates	Arkansas birth certificates	Arkansas birth certificates	Arkansas birth certificates	Arkansas birth certificates
Data Source Year	CY2018	CY2019	CY2020	CY2021	CY2022
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	77.0	77.5	78.0

Evidence-Based or –Informed Strategy Measures

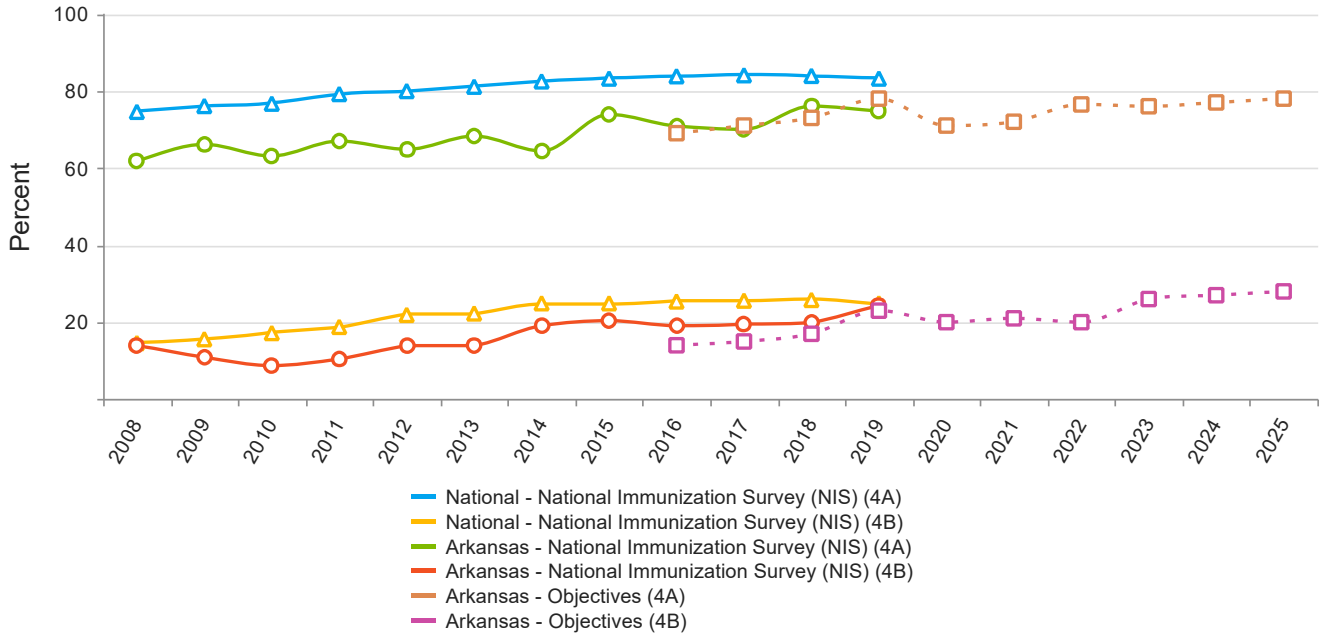
ESM 3.1 - Percent of Arkansas birthing hospitals that complete the CDC Levels of Care Assessment Tool (CDC LOCATe) annually

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			80	85
Annual Indicator		17.5	17.5	17.5
Numerator		7	7	7
Denominator		40	40	40
Data Source		Arkansas LOCATe Survey	Arkansas LOCATe Survey	Arkansas LOCATe Survey
Data Source Year		2020	2020	2020
Provisional or Final ?		Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	17.5	30.0	50.0

NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months Indicators and Annual Objectives



NPM 4A - Percent of infants who are ever breastfed

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	73	78	71	72	76.5
Annual Indicator	73.8	70.9	70.1	76.2	74.9
Numerator	24,924	23,745	24,526	24,737	23,617
Denominator	33,794	33,498	34,998	32,478	31,535
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2015	2016	2017	2018	2019

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	76.0	77.0	78.0

NPM 4B - Percent of infants breastfed exclusively through 6 months

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	17	23	20	21	20
Annual Indicator	20.4	19.2	19.4	19.9	24.4
Numerator	6,660	6,277	6,684	6,239	7,529
Denominator	32,623	32,762	34,403	31,390	30,902
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2015	2016	2017	2018	2019

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	26.0	27.0	28.0

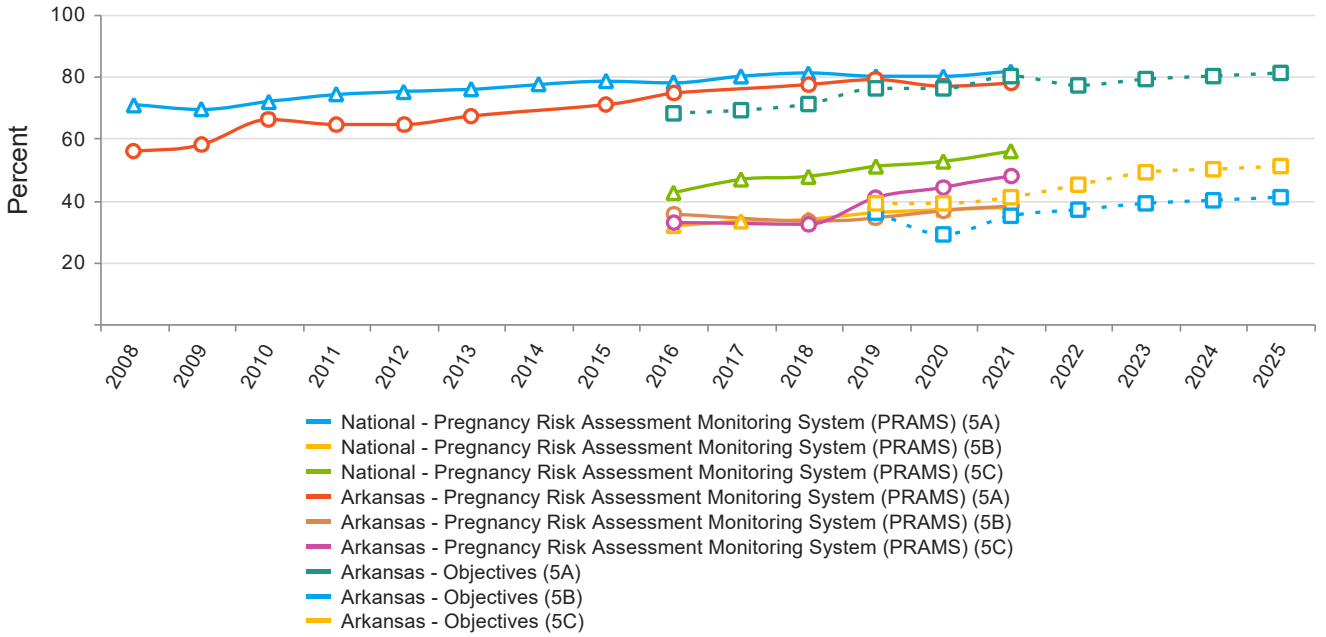
Evidence-Based or –Informed Strategy Measures

ESM 4.1 - Percent of infants enrolled in the WIC program who have ever been breastfed

Measure Status:	Active			
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			57	55
Annual Indicator	55.8	54.2	54.3	59.9
Numerator	8,289	6,948	6,725	7,554
Denominator	14,855	12,813	12,389	12,615
Data Source	ADH WIC Program	ADH WIC Program	ADH WIC Program	ADH WIC Program
Data Source Year	2019	2020	2021	2022
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	60.0	60.5	61.0

NPM 5 - 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 Indicators and Annual Objectives



NPM 5A - Percent of infants placed to sleep on their backs

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	71	76	76	80	77
Annual Indicator	74.4	74.4	79.1	76.9	77.8
Numerator	25,165	25,165	25,862	24,295	24,854
Denominator	33,822	33,822	32,696	31,583	31,928
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2016	2016	2019	2020	2021

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	71	76	76	80	77
Annual Indicator	75				77.8
Numerator	24,865				24,854
Denominator	33,157				31,928
Data Source	PRAMS				PRAMS
Data Source Year	2017				2021
Provisional or Final ?	Final				Final

Annual Objectives			
	2023	2024	2025
Annual Objective	79.0	80.0	81.0

NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective		36	29	35	37
Annual Indicator	35.7	35.7	34.2	36.8	38.0
Numerator	11,688	11,688	10,926	11,239	11,574
Denominator	32,713	32,713	31,928	30,523	30,465
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2016	2016	2019	2020	2021

State Provided Data					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective		36	29	35	37
Annual Indicator	28.2				38
Numerator	9,193				11,574
Denominator	32,587				30,465
Data Source	PRAMS				PRAMS
Data Source Year	2017				2021
Provisional or Final ?	Final				Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	39.0	40.0	41.0

NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective		39	39	41	45
Annual Indicator	32.8	32.8	40.8	44.3	47.8
Numerator	10,723	10,723	12,954	13,606	14,693
Denominator	32,660	32,660	31,776	30,693	30,724
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2016	2016	2019	2020	2021

State Provided Data					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective		39	39	41	45
Annual Indicator	38.8				47.8
Numerator	12,487				14,693
Denominator	32,216				30,724
Data Source	PRAMS				PRAMS
Data Source Year	2017				2021
Provisional or Final ?	Final				Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	49.0	50.0	51.0

Evidence-Based or –Informed Strategy Measures

ESM 5.1 - Percent of women enrolled in the WIC Plus Baby and Me Program who place their infant to sleep on their back

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			92	98
Annual Indicator		91.6	97.5	94.3
Numerator		790	655	467
Denominator		862	672	495
Data Source		ADH WIC Program	ADH WIC Program	ADH WIC Program
Data Source Year		2020	2021	2022
Provisional or Final ?		Provisional	Provisional	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	94.5	95.0	95.5

State Performance Measures

SPM 1 - Percent of newborns with timely follow-up of a failed hearing screening

Measure Status:				Active	
State Provided Data					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective		56	58	61	64
Annual Indicator		54.4	48	49.2	56.5
Numerator		81	59	61	109
Denominator		149	123	124	193
Data Source		IHP ERAVE Hearing and Screening Follow-up Survey	ERAVE EHDI Hearing Screening and Follow-up Survey	ERAVE EHDI Hearing Screening and Follow-up Survey	ERAVE EHDI Hearing Screening and Follow-up Survey
Data Source Year		2019	2020	2021	2022
Provisional or Final ?		Provisional	Provisional	Provisional	Provisional

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	60.0	61.0	62.0

State Action Plan Table

State Action Plan Table (Arkansas) - Perinatal/Infant Health - Entry 1	
Priority Need	
Persistently High Infant Mortality Rate	
NPM	
NPM 3 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)	
Objectives	
1. By December 31, 2025, increase the percent of birthing hospitals with nurseries that are participating in the Perinatal Regionalization Network to 100%.	
Strategies	
1. Encourage hospitals to voluntarily participate in surveys to determine the level of nursery/NICU they provide.	
ESMs	**Status**
ESM 3.1 - Percent of Arkansas birthing hospitals that complete the CDC Levels of Care Assessment Tool (CDC LOCATe) annually	Active
NOMs	
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	
NOM 9.1 - Infant mortality rate per 1,000 live births	
NOM 9.2 - Neonatal mortality rate per 1,000 live births	
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	

State Action Plan Table (Arkansas) - Perinatal/Infant Health - Entry 2

Priority Need

Persistently High Infant Mortality Rate

NPM

NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Objectives

1. By December 31, 2025, increase the percent of infants who are ever breastfed to 78%.
2. By December 31, 2025, increase the percent of infants who are breastfed exclusively through six months of age to 28%.

Strategies

1. Provide technical assistance and recognition to birthing hospitals that achieve Baby-Friendly status.
2. Provide breastfeeding education and support to WIC-enrolled women.
3. Provide breastfeeding education and support to women enrolled in the Arkansas Home Visiting Program.
4. Provide breastfeeding education and support to communities through African-American sororities and fraternities.
5. Provide breastfeeding education and support through the Arkansas Breastfeeding Helpline.

ESMs	Status
ESM 4.1 - Percent of infants enrolled in the WIC program who have ever been breastfed	Active

NOMs

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

State Action Plan Table (Arkansas) - Perinatal/Infant Health - Entry 3

Priority Need

Persistently High Infant Mortality Rate

NPM

NPM 5 - 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

Objectives

1. By December 31, 2025, increase the percent of infants placed to sleep on their back to 81%.
2. By December 31, 2025, increase the percent of infants placed to sleep on a separate approved sleep surface to 41%.
3. By December 31, 2025, increase the percent of infants placed to sleep without soft objects or loose bedding to 51%.

Strategies

1. Provide training for hospital staff on safe sleep and how to encourage safe sleep by their patients.
2. Provide safe sleep education and support to WIC-enrolled mothers.

ESMs	Status
ESM 5.1 - Percent of women enrolled in the WIC Plus Baby and Me Program who place their infant to sleep on their back	Active

NOMs

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

State Action Plan Table (Arkansas) - Perinatal/Infant Health - Entry 4

Priority Need

Access to Care

SPM

SPM 1 - Percent of newborns with timely follow-up of a failed hearing screening

Objectives

1. By December 31, 2025, increase the percent of children who receive a confirmed diagnosis of hearing loss in the recommended timeframe to 62%.

Strategies

1. Increase outreach to provide additional resources to underserved populations statewide by engaging pediatric providers in priority areas to reduce barriers for families obtaining follow-up evaluation after not passing the initial screen.

Arkansas Title V Maternal and Child Health Services Block Grant
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III.E.2.c. State Action Plan Narrative by Domain

Perinatal and Infant Health 2022 Annual Report

Priority Need: Persistently High Infant Mortality Rate

NPM 3: Percent of very low birthweight infants born in a hospital with a Level III+ Neonatal Intensive Care Unit

ADH's strategies to improve the percentage of very low birth weight infants born in a hospital include 1) encourage hospitals to voluntarily participate in surveys to determine the level of nursery/neonatal intensive care unit they provide, and 2) encourage hospitals to voluntarily develop agreements for transfer of high- risk patients to hospitals with the proper level of care to give birth.

Risk-appropriate care is a strategy developed to improve health outcomes for pregnant women and infants. A level of care assessment was conducted by introduction of the CDC Levels of Care Assessment Tool (LOCATe). LOCATe helps assess birthing facilities based on the level of risk-appropriate care and offers a standard process for assessment that aligns with the most recent guidelines and policy statements issued by the American Academy of Pediatrics (AAP), the American College of Obstetricians and Gynecologists (ACOG), and the Society of Maternal-Fetal Medicine (SMFM). In 2021, the results revealed a discrepancy in 50% of maternal and 43% of neonatal self-reported level of care and their LOCATe assessed level of care.

Strategy 3.1: Encourage hospitals to voluntarily participate in surveys to determine the level of nursery NICU they provide.

The Arkansas Maternal and Perinatal Outcomes Quality Review Committee (MPOQRC). Arkansas Act 1032, signed into legislation in 2019, gave ADH authority to establish the MPOQRC to review data on Arkansas births and to develop strategies to improve birth outcomes. The act requires the committee to submit an annual report to the Arkansas legislature. Key information from the report is also shared with policymakers, health care providers, public health professionals, and the public. The 2022 MPOQRC Annual Report was prepared and released in December 2022.

The MPOQRC has formed a partnership with UAMS for the process of determining the level of nursery/neonatal intensive care of each hospital. UAMS has received a five-year, $5 million grant from the U.S. Department of Health and Human Services (HHS) to improve maternal health care in Arkansas. The funding from Health Resources and Services Administration will help increase access to maternal and obstetrics care in rural communities and assist in tackling inequities in maternal health.

To help address the great need for maternal health improvement in Arkansas, UAMS will use the HHS funding to conduct the PeRinatal IMpRovement of Outcomes and Safety for Everyone (PRIMROSE) project. To successfully complete these activities, the PRIMROSE team will build on UAMS' strength in partnering with state agencies, health care organizations, providers, and community-based groups across Arkansas. The team will also rigorously evaluate the implementation and outcomes of innovations to contribute to the evidence base for reducing maternal mortality.

An interdisciplinary team from UAMS and ADH with expertise in clinical care, evaluation research, informatics and health policy will lead activities in the following areas:

- establishing a state maternal health taskforce and strategic plan;
- strengthening data systems for maternal health surveillance
- contributing to regionalization of perinatal care;
- supporting patient engagement in quality improvement;
- delivering evidence-based group prenatal care to disproportionately impacted patients in maternity care deserts; and
- preparing emergency providers in rural areas to respond to obstetric emergencies through simulation training.

Both ADH and UAMS have entered into an Independent Contractor Agreement to establish activities relating to perinatal regionalization. ADH MCH will convene a statewide maternal health taskforce to disseminate information about maternal health and establish state priorities. After this taskforce is established, ADH will work with key interest groups to secure commitment to the taskforce and encourage their members to participate through support letters. The taskforce will meet quarterly for the first two years of the project and at least bi-annually in subsequent years.

ADH will lead the perinatal regionalization efforts in Arkansas by coordinating site visits to birthing hospitals as part of its perinatal regionalization work. Through this agreement, ADH will coordinate site visits, collect, and analyze assessment data and provide results of LOCATe assessments for inclusion in the state maternal health dashboard.

Currently 7 out of the 40 birthing hospitals in Arkansas have taken the LOCATe survey and represents 17.5 %.

Priority Need: Breastfeeding

NPM 4A: Percent of infants who are ever breastfed and B) Percent of infants who are breastfed exclusively through six months.

Breastfeeding rates in Arkansas consistently lag behind national averages and Healthy People 2020 expectations.

The ADH's strategies to improve breastfeeding rates include 1) increasing the percentage of birthing hospitals that have policies requiring staff to encourage new mothers to breastfeed their infants and 2) increasing the percentage of infants who are ever breastfed and who are breastfed exclusively through six months of age.

Strategy 4.1: Provide technical assistance and recognition to birthing hospitals that achieve Baby-Friendly status.

The Baby Friendly Arkansas Toolkit was developed in partnership with the Arkansas Breastfeeding Coalition, the Arkansas Hospital Association (AHA), AFMC, and UAMS. The toolkit includes educational materials for staff and patients plus sample policies and research studies that support early initiation of breastfeeding.

Strategy 4.2: Provide breastfeeding education and support to WIC-enrolled women.

The ADH continues to facilitate a bimonthly meeting of the Breastfeeding Promotion Taskforce. The Taskforce brings together stakeholders from the Family Health Branch; Arkansas's WIC Program; Office of Health Equity; and Child and Adolescent Health Section as well as representatives from the Arkansas Breastfeeding Coalition, Arkansas Injury Prevention Center, Arkansas Children's Hospital, and the Baptist Health System.

The Breastfeeding Promotion Taskforce is working with the Arkansas Division of Corrections on ways to better serve the pregnant and postpartum/breastfeeding women in Arkansas' prisons. A second project is to update

breastfeeding materials to an easy to read, mostly photographic format and have the information translated into multiple languages.

The Arkansas WIC Program offers breastfeeding information and education to all WIC participants online through the WICSmart website (http://www.wicsmart.com) and the USDA's WIC Breastfeeding Support website (https://wicbreastfeeding.fns.usda.gov). In addition, WIC clients who are breastfeeding or intend to breastfeed have access to WIC breastfeeding peer counselors who provide education and support. Breastfeeding peer counselors who work for Arkansas's WIC program must have breastfed for at least six months and have received WIC services.

The Breastfeeding Peer Counselor Program currently serves 24 Arkansas counties and 31 WIC clinics. This service has increased from last year's totals of 17 Arkansas Counties and 21 WIC clinics. Peer counselors provide support in a variety of ways including through hospital visits, home visits, text, email, phone, and through support group meetings. WIC clients who live in areas not served by a peer counselor can receive support by calling the WIC Breastfeeding Helpline, which is available Monday through Friday from 8:00 a.m. to 4:30 p.m. (Meet Our Breastfeeding Peer Counselors Arkansas Department of Health). On nights and weekends, calls to the WIC Breastfeeding Helpline roll over to Baptist Health's Breastfeeding Helpline.

Strategy 4.3: Provide breastfeeding education and support to women enrolled in the Arkansas Home Visiting Program.

Arkansas's Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program has also focused its efforts to support breastfeeding. The program has a benchmark measure regarding breastfeeding (percent of infants among mothers who enrolled in home visiting prenatally who were breastfed any amount at 6 months of age). Four of the five MIECHV-funded programs ask mothers about this measure. The fifth program works with children ages 3-5. In addition, the Following Baby Back Home, Healthy Families America, and Parents as Teachers home visiting programs use the Family Map Inventories questionnaire (http://www.thefamilymap.org), which asks "How old was your child when you stopped breastfeeding?" Answer options are: Not applicable, 2 months, 2-5 months, and 6 or more months. The Nurse-Family Partnership home visiting program asks mothers about initiation of breastfeeding and follows up at six and 12 months. Arkansas's MIECHV Training Institute developed instructor-led and online courses to educate home visitors about breastfeeding. The instructor-led training is available to all home visitors in the state regardless of funding stream (http://www.arhomevisiting.org/Training_Institute/modules). The online training is accessible to anyone with Internet access (https://ahvnti.thinkific.com/).

Strategy 4.4: Provide breastfeeding education and support to communities through African-American sororities and fraternities.

The ADH recognizes the importance of these programs, particularly for historically marginalized and underserved populations. Currently, these programs are being revamped with hopes to relaunch in the fall 2023.

Strategy 4.5: Provide breastfeeding education and support through the Arkansas Breastfeeding Helpline.

The ADH continues to support the Baptist Health Breastfeeding Helpline with funding from the Preventive Health and Health Services Block Grant and Title V MCH Block Grant. The helpline operates 24 hours a day, seven days a week and is in its eighth year of operation. The helpline is a tool to increase adoption and duration of breastfeeding by providing support from an International Board-Certified Lactation Consultant or Certified Lactation Counselor. The Breastfeeding Helpline receives calls via a toll-free phone number (https://www.baptist-health.com/services/labor-delivery/breastfeeding-support/). Call volume continues to be measured in the following ways: Calls between the

hours of 8:30 a.m. to 5:00 p.m., Calls between the hours of 5:00 p.m. to 8:30 a.m., Calls from WIC participants, and Resident of Pulaski County or outside of Pulaski County. During the 2022 federal fiscal year, the helpline received a total of 4,917 calls.

In 2016, Governor Asa Hutchinson launched Healthy Active Arkansas, a platform for improving the health of the citizens of Arkansas. Breastfeeding is one of the nine priority areas addressed through this initiative. The Arkansas Breastfeeding Helpline is a key component to the breastfeeding priority area. A main goal of the breastfeeding priority area is to assist hospitals statewide in obtaining the Baby Friendly Hospital designation. The Baby Friendly designation is based on the World Health Organization's 10 Steps to Successful Breastfeeding to help hospitals improve maternity care and increase breastfeeding rates (https://www.babyfriendlyusa.org/for-facilities/practice-guidelines/10-steps-and-international-code). The Breastfeeding Helpline is an essential piece of the community resources needed to obtain the Baby Friendly designation.

The ADH Breastfeeding Promotion Task Force, established in 2013, is a collaborative workgroup including the Family Health Branch, WIC breastfeeding and peer counseling programs, Office of Health Equity, Hometown Health Coalition Initiative, Office of Health Communications, and School Health Services. Members also include representatives from partner organizations including Baptist Hospital, AFMC, UAMS, and the Baby Friendly Hospital initiative. Although the Task Force's focus has shifted over time in response to changing priorities, it has always provided a forum for private and public partners to convene, share information, and strategize ways to promote and increase breastfeeding in Arkansas. The current focus is strengthening lactation support to incarcerated mothers. The Task Force has continued to meet virtually during 2021-22.

Priority Need: Safe Sleep

NPM 5A: Percent of infants placed to sleep on their backs, B) Percent of infants placed to sleep on a separate approved sleep surface, and C) Percent of infants placed to sleep without soft objects or loose bedding.

The ADH has many efforts focused on improving infant safe sleep practices in the state, including 1) increasing number of women who report placing their infant to sleep on their back, and 2) increasing the number of hospitals with safe sleep policies.

Strategy 5.1: Provide training for hospital staff on safe sleep and how to encourage safe sleep by their patients.

Only one hospital was safe sleep certified prior to Safe Sleep Collaborative Improvement and Innovation Network (CoIIN) implementation in 2015. To date, all 40 hospitals have received the safe sleep toolkit. Currently, 39 of Arkansas's 40 birthing hospitals are safe sleep certified. Two of the 40 are not currently birthing babies. Most of the hospitals are working on recertification by Cribs for Kids (https://cribsforkids.org). This national organization requires all certified hospitals to educate their health care staff, families, and caregivers about safe sleep practices.

Strategy 5.2: Collaborate with CoIIN partners on safe sleep activities and trainings.

The Safe Sleep CoIIN to reduce infant mortality funded by HRSA has ended. However infant mortality in Arkansas is still a priority as shown by the continuation of CoIIN's projects. In November 2019, the Arkansas Nursery Alliance unveiled its Safe Sleep Pathway screening tool during the 2nd annual Nursery Alliance Leadership Conference. The Nursery Alliance includes five Level I and II hospitals as well as Arkansas Children's Hospital, which is the only Level IV hospital according to the state's perinatal levels of care guidelines. Representatives from all six member hospitals participated in a conference breakout session designed to engage hospital representatives in strategy discussions on how to ensure successful implementation of the Safe Sleep Pathway. The discussions became the basis of the

Safe Sleep Pathway's key driver diagram. The project's goal is to screen 100% of babies born or cared for at Nursery Alliance partner sites for a safe sleep environment using the Nursery Alliance Safe Sleep Pathway prior to discharge. Success will be measured by the number of times activation of the Safe Sleep Pathway resulted in supplying families with a Pack-n-Play or resource referral.

The Safe Sleep CoIIN team includes partners representing the ADH's Family Health Branch, Office of Health Equity, WIC Nutrition Program, Emergency Medical Services for Children (EMS-C), and the Nurse-Family Partnership home visiting program as well as Arkansas's Infant and Child Death Review Program, Arkansas Nursery Alliance, ACH's Injury Prevention Center, Arkansas Hospital Association, AFMC, ADHS's Division of Child Care and Early Childhood Education, ACHI, UAMS, Baptist Health Community Outreach, March of Dimes, and the Zeta Dove Foundation. The Safe Sleep CoIIN funding ended in November 2020. The CoIIN team continues to provide training. The ACH Injury Prevention Program partners with local communities to provide Safety Baby Showers for expectant mothers. Safety Baby Showers participants who attend the showers receive education in safe sleep, shaken baby syndrome/crying babies, home safety and child passenger safety. In 2022 ACH Injury Prevention Program conducted a total of 34 face to face Safety Baby Showers educating 183 participants, a total of 19 train the trainer events training over 103 educators. They provided safety products to satellite sites across the state. Train-the-trainer participants were members of law enforcement, fire departments, public health educators, and medical staff.

Strategy 5.3: Provide safe sleep education and support to WIC-enrolled mothers.

WIC Baby and Me parenting program was implemented in selected WIC clinics across the state. The parenting program focuses on strengthening the parent/child relationship, promoting healthy child development, and connecting parents to community resources in WIC clinics selected by the WIC Baby and Me Advisory Board. Parent support mentors meet with interested families during WIC clinic certification visits. The visits include one prenatal learning session on safe infant sleep practices and six brief post-birth learning sessions that include facilitated mother-child interaction time focused on enhancing secure attachment and reinforcing education provided by the mother's birthing hospital and her pediatrician/primary care physician.

The Safe Sleep CoIIN team worked with the WIC program to develop questions about safe sleep environments that the program added to their SPIRIT charting system. This was completed in 2019 with the questions being printed on a laminated job aid (one side is English, the other is Spanish) for the WIC staff to use during certification appointments. An identical postcard is also given to the client. There are two questions, one for pregnant women and one for new mothers/caregivers:

1. Where do you plan for your baby to sleep? (Pregnant Women)
2. Where does your baby sleep? Alone? On his/her back? In a crib, bassinet, or play yard? (New mothers/caregivers)

The staff member will educate the client on safe sleep using the laminated job aid and safe sleep cards based on the client's response and will refer the client to ACH's Injury Prevention Center if indicated that they do not have a safe place for their infant to sleep. This occurred 14,959 in 2022.
Due to COVID-19, most certifications occurred by telephone, which did not allow staff to show participants the safe sleep materials. All parents of infants were asked where their infants sleep and were asked information about and provided information about safe sleep environment. This process was completed 21,697 times in 2022.

If a safe sleep referral was selected from the WIC list, they are referred to the Arkansas Children's Hospital Injury Prevention Center and a representative from that program screens the family and determines if a Pack N' Play will be issued to the family. Safe sleep referrals were selected 1,243 times in 2022.

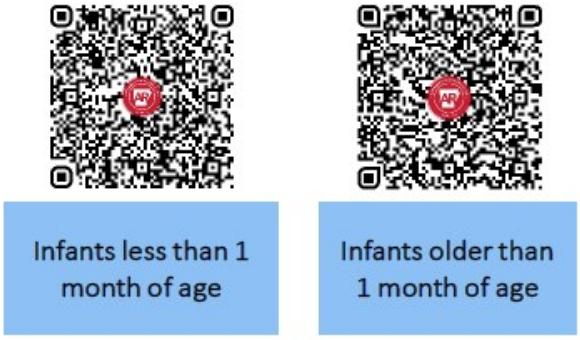
Priority Need: Access to Care

SPM 1: Percent of newborns with timely follow-up of a failed hearing screen.

The Infant Hearing Program (IHP) continued to serve as the lead entity facilitating the state's Early Hearing Detection and Intervention (EHDI) system. The IHP worked to ensure all newborns received: a hearing screening before one month of age, a diagnostic audiological evaluation before three months of age if they did not pass the initial screening and enrollment into early intervention services before six months of age if identified with a hearing condition. Additionally, the program worked to engage and coordinate all stakeholders in the state EHDI system while conducting surveillance of hearing screening, diagnostic evaluation, and the enrollment of Deaf and Hard of Hearing (DHH) children in early intervention services using the Electronic Registration of Arkansas Vital Events (ERAVE). The 2022 ERAVE Hearing Screening and Follow-up Survey indicated that 56% of infants received a confirmed diagnosis of hearing loss by three months of age, an increase in performance from the previous year.

Strategy 1.1: Increase awareness of EHDI recommendations amongst families and pediatric providers statewide.

The IHP focused on completing workplan activities despite challenges imposed by the COVID-19 pandemic by identifying innovative activities to increase awareness of EHDI recommended practices and increase access to services. These efforts enabled the program to address goals and objectives through increased partnerships with stakeholders, virtual activities, and the completion of workplan activities. The program revised follow-up protocols to include contacting primary care physicians immediately when a child does not pass the newborn hearing screening. Adding this initial contact with primary care physicians allows IHP staff to confirm the child's doctor is aware of the test results in efforts to decrease the amount of time between initial screening and outpatient screenings due to the lack of a referral. By notifying the primary care physician of the initial screening results prior to the infant reaching 1 month of age, many families can be referred to the birthing facility for rescreen, and thus eliminating the need for diagnostic evaluation in some instances. Additionally, the program reviewed, and revised system generated follow-up letters to promote increases in timeliness of follow-up screening and diagnostic evaluation. New follow-up letters are available in English and Spanish to accommodate populations statewide. Revisions included clarification of required next steps after an infant does not pass the newborn hearing screen and the timeline indicating when follow-up care should occur. The new follow-up letters include QR codes enabling increased access to IHP educational materials. These QR codes allow parents to download a copy of educational materials for review later when internet services may not be available due to the rural conditions of various areas of the state.



The IHP continued pursuing new opportunities for quality improvement in increasing the number of infants receiving timely diagnostic evaluation through improved educational materials indicating why and when evaluation should occur, increased communication with primary care physicians and audiologists statewide and an expanded partnership between the IHP and the family-based organization Arkansas Hands & Voices (AR H&V). As a result of these collaborations, the program created and distributed toolkits to physicians and interviewed a parent of a DHH

child to develop videos for a media campaign. The videos ran as paid ads on TikTok, Facebook and Instagram during the project period. These paid ads targeted expectant and new parents in counties with the highest loss to follow-up (Benton, Craighead, Greene, Pulaski, and Sebastian) in hopes to improve performance.

The IHP worked to engage stakeholders in the state EHDI system during the current project period by providing training and presentations to health professionals and service providers. During the semiannual Universal Newborn Hearing Screening advisory board meetings, stakeholders representing the entire EHDI system received information regarding EHDI challenges and data. Stakeholders provided feedback indicating opportunities to increase the EHDI system's reach by sharing information with state associations including the Arkansas Chapters of the American Academy of Pediatrics, Academy of Family Physicians and Society of Otolaryngology-Head and Neck Surgery. The IHP experienced challenges in actively engaging and delivering presentations to pediatric specialists participating in these associations during the project period due to COVID-19 restrictions, but the program will continue efforts to engage these providers. Additionally, the IHP continued efforts to facilitate improved coordination of care and services for children at risk for being identified as DHH and their families by maintaining partnerships, assessing diversity and inclusion within the EHDI system and monitoring program performance. Active intra-agency partnerships with the Women, Infant and Children (WIC) program, Home Visiting program and the Center for Local Public Health continued in efforts to increase awareness of 1-3-6 amongst families receiving services statewide in the local health units or through the Nurse Family Partnership program.

Strategy 1.2: Increase family support through the partnership with AR H&V to increase the implementation of the Guide By Your Side (GBYS) Program offering family-to-family support services (FSS).

The IHP's partnership with AR H&V continued providing opportunities for families to connect and enroll in FSS during the reporting period. The IHP revised protocols to reduce the number of records labeled "parent unresponsive" by adding a new referral to AR H&V. AR H&V's Parent Guides received referrals from the IHP indicating families who have missed two or more appointments for follow-up care. Parent Guides contact the families to provide support and share real life experience to encourage parents to obtain recommended follow-up care. IHP staff received feedback from families referred to AR H&V stating they chose to complete follow-up care after speaking with a Parent Guide. Additionally, the program continued completing a referral for each child identified with a hearing condition. AR H&V connected with families through the GBYS and Advocacy, Support and Training (ASTra) programs. Unfortunately, AR H&V continued experiencing barriers to enrolling families in FSS as a result of the COVID-19 pandemic, due to their inability to interact with families during in-person events. However, AR H&V worked to strengthen their partnership with Arkansas Children's Hospital and hosted the following virtual events for families with DHH children in efforts to increase enrollment in FSS:

- Tuesdays Together –an opportunity for families and professionals to connect. Sessions included Springing into Success, Tips for Maintaining Hearing Equipment, Activities Families can do to Facilitate Language Development at Home, and Assistive Technology: What Do You Need to Know.
- Lunch & Learn Virtual Events –a way for parents to join short discussions on topics of interest. These sessions were held during the typical workday and included topics such as: Beginning your Individualized Education Plan and 504 Process and Learn about ICAN (Increasing Capabilities Access Network). During these events, ASTra advocates shared information regarding transition and the ICAN program coordinator shared information about the statewide technology program available to Arkansans.
- Champ Chats –sessions for DHH children to connect with other DHH children, parents are requested to attend with their child. Magic in the Air, a magic show for children birth to 6th grade was held during the current reporting period.
- AR H&V Academy –a series of Zoom calls to introduce basic education concepts and activities. This was a new event for children birth to 3 years of age and their parents.

AR H&V experienced a reduction in attendees at virtual events during the current project period. AR H&V attributes the reduced attendance to Zoom fatigue and the number of obligations parents were faced with during the pandemic. As a result, several virtual events were cancelled during the second quarter of this reporting period. AR H&V was able to host their first in-person event since the start of the pandemic during this project period. The organization hosted pumpkin patch events in four locations across the state with a total of 100 participants attending the events.

See Section V. Supporting Documents: MIECHV Coverage Map

Arkansas Title V Maternal and Child Health Services Block Grant
2022 Report and 2024 Application

III.E.2.c. State Action Plan Narrative by Domain

Perinatal & Infant Health 2024 Application Year Plan

Priority Need: Persistently High Infant Mortality Rate

NPM 3: Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU).

Strategy 3.1: Encourage hospitals to voluntarily participate in surveys to determine the level of nursery NICU they provide.

Arkansas continued progress by forming a partnership with UAMS for the process of determining the level of nursery/neonatal intensive care of each hospital. UAMS has received a five-year, $5 million grant from the U.S. Department of Health and Human Services (HHS) to improve maternal health care in Arkansas. The funding from Health Resources and Services Administration will help increase access to maternal and obstetrics care in rural communities and assist in tackling inequities in maternal health.

- The MPOQRC will continue to encourage all birthing hospitals to participate in the CDC LOCATe Survey.
- MPOQRC staff will be in contact with UAMS to partner as often as possible.

Priority Need: Breastfeeding

NPM 4: A) Percent of infants who are ever breastfed.
B) Percent of infants breastfed exclusively through 6 months.

Arkansas's desired outcome in this priority need area is to increase the percent of infants who are ever breastfed and percent of infants who are exclusively breastfed for six months. Breastfeeding rates in Arkansas consistently lag behind national averages and Healthy People 2020 expectations.

- Increasing the percentage of birthing hospitals that have policies requiring staff to encourage new mothers to breastfeed their infants
- Increasing the percentage of infants who are ever breastfed and who are breastfed exclusively through six months of age
- Provide education about breastfeeding to WIC enrolled women
- Provide breastfeeding education and support through the Arkansas Breastfeeding Helpline.

Priority Need: Safe Sleep

NPM 5: 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.

Arkansas's desired outcome in this priority need area is to decrease the rate of infant mortality:

- Provide training to hospital staff on safe sleep and how to encourage safe sleep by their patients.
- Collaborate with partners on safe sleep activities and trainings.
- Provide safe sleep education and support to WIC-enrolled mothers.

Priority Need: Access to Care

SPM 1: Percent of newborns with timely follow-up of a failed hearing screening.

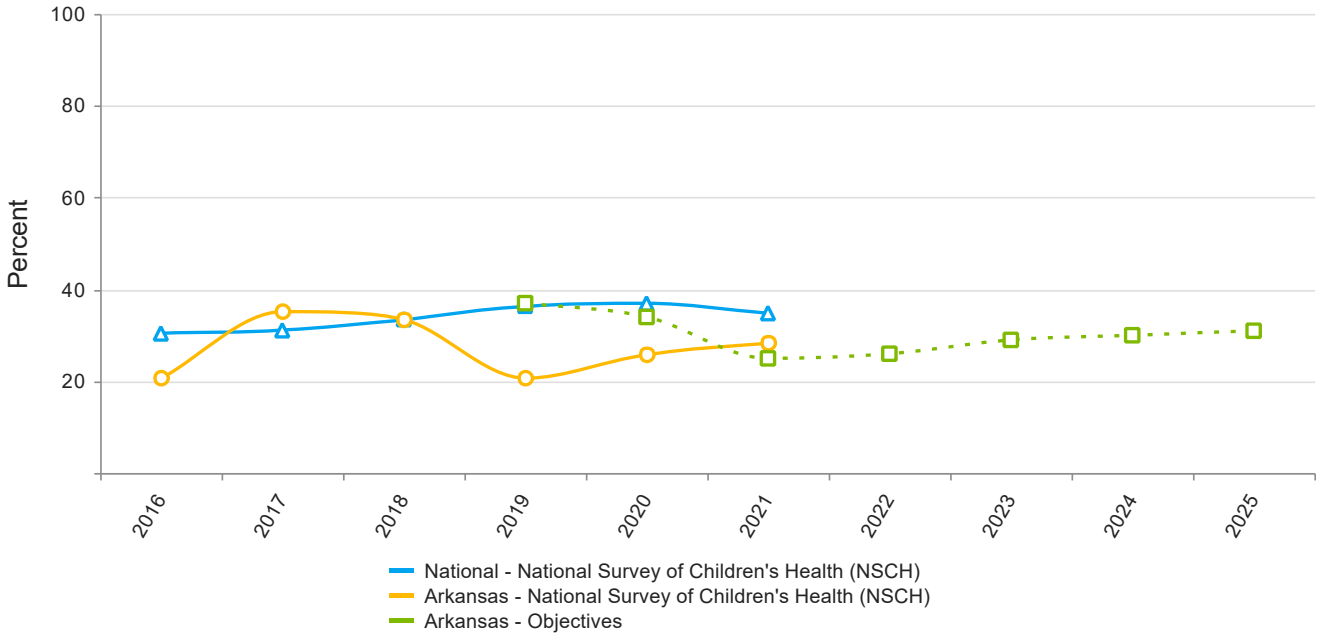
Arkansas's desired outcome in this priority need is to increase the percent of children who receive a confirmed diagnoses of hearing loss in the recommended timeframe to 62.5% by December 31, 2025.The Child Health Section will work with stakeholders to implement the following strategies:

- The Child Health Section improve collaboration between the IHP and pediatric specialist (i.e. primary care physicians/audiologists) to increase timely EHDI reporting and complete data.
- MIECHV will continue encouraging parents to have their newborns screened for hearing loss.

Child Health

National Performance Measures

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year
Indicators and Annual Objectives



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective		37	34	25	26
Annual Indicator	35.2	33.5	20.6	25.9	28.4
Numerator	27,381	30,159	18,621	21,969	23,260
Denominator	77,859	90,076	90,181	84,909	81,900
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	29.0	30.0	31.0

Evidence-Based or –Informed Strategy Measures

ESM 6.1 - Percent of WIC-enrolled children ages 2-59 months at Learn the Signs Act Early (LTSAE) sites who received developmental monitoring

Measure Status:				Active	
State Provided Data					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective		50	55	60	65
Annual Indicator		53.9	0	1.9	0
Numerator		912		79	
Denominator		1,692		4,071	
Data Source		ADH WIC Program	ADH WIC Program	ADH WIC Program	ADH WIC Program
Data Source Year		2019	2020	2021	2022
Provisional or Final ?		Final	Final	Final	Final

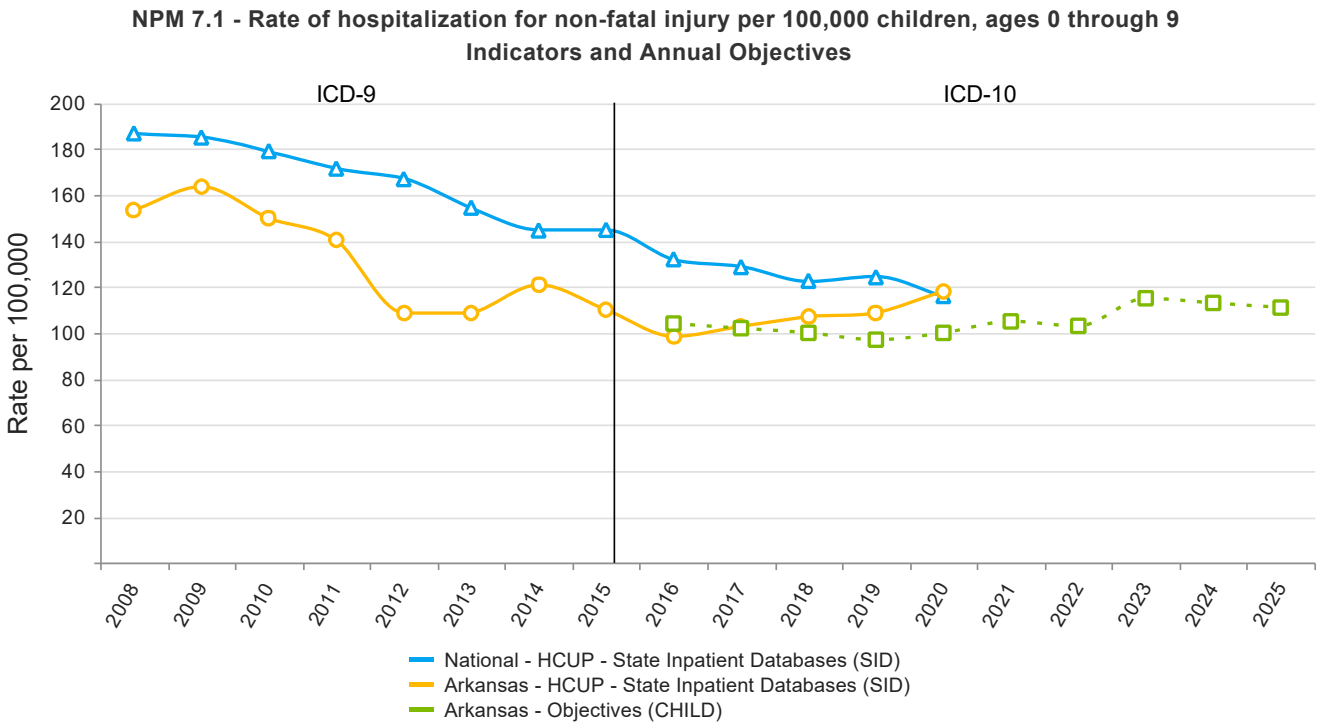
Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	70.0	75.0	80.0

ESM 6.2 - Percent of children, ages 2-59 months, in home visiting programs who were referred for therapy due to the results of a developmental screening using a validated parent-completed tool

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			50	68
Annual Indicator		48.7	66.5	65.4
Numerator		116	135	85
Denominator		238	203	130
Data Source		MIECHV Annual Performance Report	MIECHV electronic records	MIECHV records (Annual Performance Report
Data Source Year		FY2020	FY2021	FY2022
Provisional or Final ?		Final	Final	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	68.0	68.0	68.0



Note: ICD-10-CM beginning in 2016; previously ICD-9-CM with 2015 representing January - September

Federally Available Data					
Data Source: HCUP - State Inpatient Databases (SID)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	100	97	100	105	103
Annual Indicator	98.2	102.7	107.1	108.9	117.8
Numerator	380	397	411	415	447
Denominator	386,820	386,578	383,627	381,211	379,504
Data Source	SID-CHILD	SID-CHILD	SID-CHILD	SID-CHILD	SID-CHILD
Data Source Year	2016	2017	2018	2019	2020

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	115.0	113.0	111.0

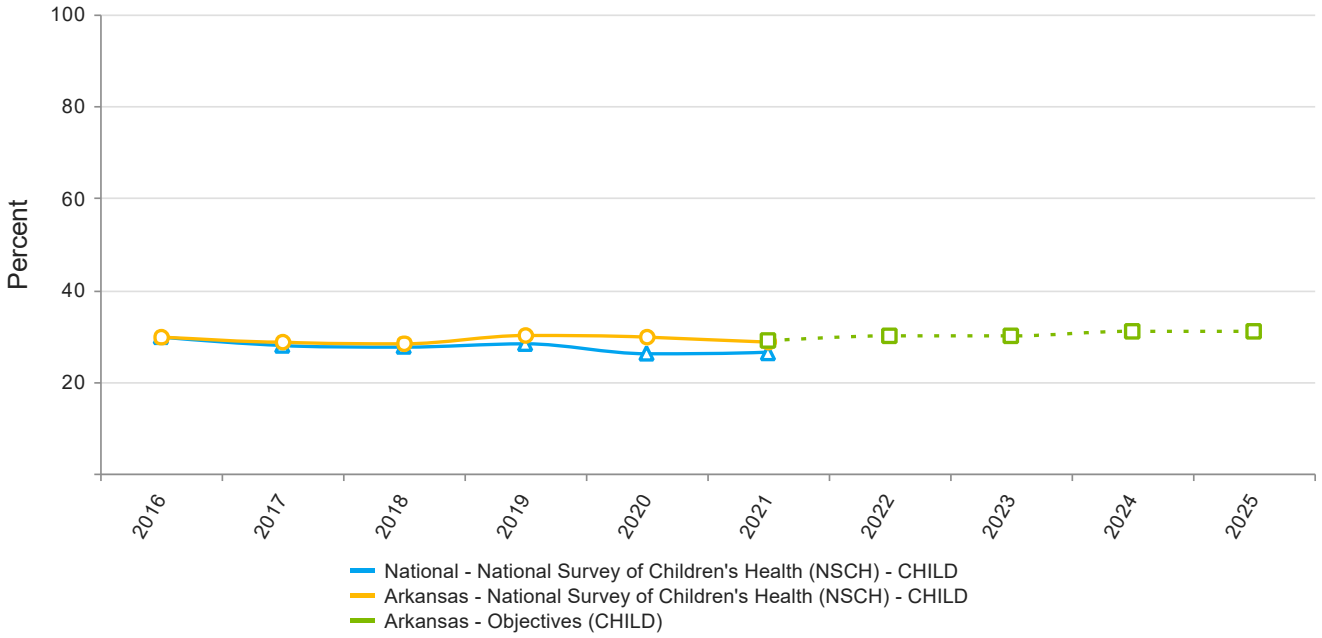
Evidence-Based or –Informed Strategy Measures

ESM 7.1.1 - Percent of families served in home visiting programs who have reports of child maltreatment

Measure Status:				Active	
State Provided Data					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	5.5	6.5	6	7.5	5.5
Annual Indicator	7	6.5	8.1	5.9	5.2
Numerator	172	140	155	114	104
Denominator	2,444	2,168	1,912	1,921	1,983
Data Source	Division of Child and Family Services (DCFS)	Division of Child and Family Services (DCFS)	MIECHV Annual Performance Report	MIECHV APR Child Maltreatment Measure	MIECHV APR Child Maltreatment Measure
Data Source Year	2018	2019	FY2020	FY2021	FY2022
Provisional or Final ?	Provisional	Provisional	Final	Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	5.5	5.0	5.0

NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day
Indicators and Annual Objectives



Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - CHILD				
	2019	**2020**	**2021**	**2022**
Annual Objective			29	30
Annual Indicator	28.4	30.1	29.7	28.8
Numerator	60,424	75,652	74,583	67,786
Denominator	212,390	251,646	250,770	235,539
Data Source	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD
Data Source Year	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	30.0	31.0	31.0

Evidence-Based or –Informed Strategy Measures

ESM 8.1.1 - Percent of children attending public schools, grades K through 5, who are in the normal or healthy weight zone for Body Mass Index.

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			56	57
Annual Indicator	57.1	43.6	48	58.2
Numerator				62,441
Denominator				107,263
Data Source	ACHI BMI assessment reports	ACHI BMI assessment reports	ACHI BMI assessment reports	ACHI BMI assessment reports
Data Source Year	2018-2019	2019-2020	2020-2021	2021-2022
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	58.0	59.0	60.0

ESM 8.1.2 - 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 services provided by School Health Services

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			10	83
Annual Indicator			81.2	95.6
Numerator			56	1,641
Denominator			69	1,716
Data Source			Coordinated School Health Survey	Coordinated School Health Survey
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	95.0	95.0	95.0

State Action Plan Table

State Action Plan Table (Arkansas) - Child Health - Entry 1	
Priority Need	
Developmental, Behavioral and Mental Health of Children	
NPM	
NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year	
Objectives	
1. By December 31, 2025, increase the number of children who receive a developmental screening by 10%.	
Strategies	
1. Increase awareness of the importance of developmental screening by implementing an education campaign promoting the use of the Learn the Signs Act Early application.	
2. Increase the number of children receiving developmental monitoring and/or screening by reviewing strategies to relaunch the LTSAE campaign in WIC clinics and improving data entry accuracy and timelines amongst MIECHV LIAs.	
ESMs	**Status**
ESM 6.1 - Percent of WIC-enrolled children ages 2-59 months at Learn the Signs Act Early (LTSAE) sites who received developmental monitoring	Active
ESM 6.2 - Percent of children, ages 2-59 months, in home visiting programs who were referred for therapy due to the results of a developmental screening using a validated parent-completed tool	Active
NOMs	
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)	
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	

State Action Plan Table (Arkansas) - Child Health - Entry 2

Priority Need

Child Safety Due to Intentional Injury

NPM

NPM 7.1 - Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

Objectives

1. By December 31, 2025, reduce hospitalizations of children due to maltreatment by 10%.

Strategies

1. Identify and teach parenting skills to Home Visiting Program participants to help parents avoid maltreatment that may lead to hospitalization for a non-fatal injury.

ESMs	Status
ESM 7.1.1 - Percent of families served in home visiting programs who have reports of child maltreatment	Active

NOMs

NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

State Action Plan Table (Arkansas) - Child Health - Entry 3

Priority Need

Obesity

NPM

NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Objectives

1. By December 31, 2025, increase the percent of children attending public schools, grades K through 5, who are classified of having a healthy weight to 57%.

Strategies

1. Deliver trainings on opportunities to increase physical activity and physical activity standards for school personnel.
2. Promote opportunities for JUA as an avenue for increasing physical activity in communities statewide.
3. Collaborate with Student Wellness Advocacy Groups statewide to create a public service announcement promoting 60 minutes of physical activity per day.

ESMs	Status
ESM 8.1.1 - Percent of children attending public schools, grades K through 5, who are in the normal or healthy weight zone for Body Mass Index.	Active
ESM 8.1.2 - 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 services provided by School Health Services	Active

NOMs

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

Arkansas Title V Maternal and Child Health Services Block Grant
2022 Report and 2024 Application

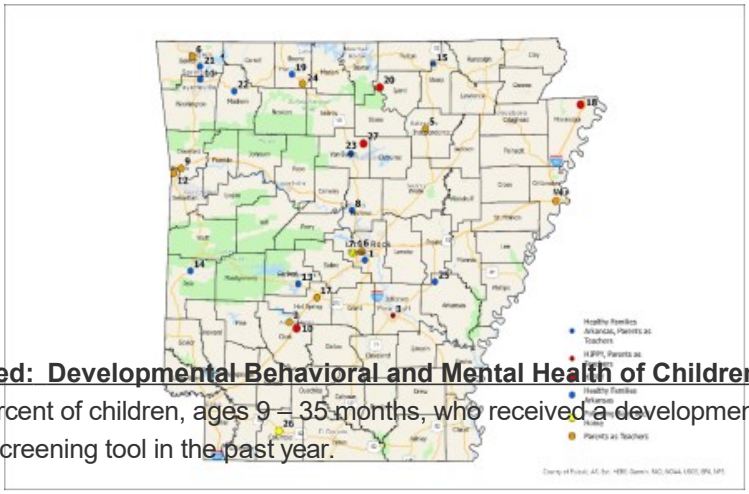
III.E.2.c. State Action Plan Narrative by Domain

Child Health 2022 Annual Report

Title V activities targeting children under age 11 continued to address priority needs: developmental screening, injury hospitalization, and overweight/obesity. These needs were addressed by Title V staff (i.e., Child Health, School Health Services, MIECHV) working with stakeholders to reach children and their parents by increasing awareness of best practices and providing access to resources to support improvement in performance measures. During 2022, Title V staff worked with state physician associations to support the Learn the Signs Act Early (LTSAE) activities promoting developmental milestone education; WIC and MIECHV to deliver parenting education to families in rural areas of the state and local education agencies (LEA) to increase awareness of physical activity best practices amongst individuals with access to children.

The Arkansas Chapter of the American Academy of Pediatrics facilitates the state team's LTSAE efforts through the Arkansas Act Early Ambassador. LTSAE is a nationwide initiative to engage parents and other care providers in ongoing developmental monitoring and early action to reduce developmental delays. LTSAE aims to improve the early identification of children with developmental delays and disabilities. Developmental Milestone Checklists, based on the child's age, are provided to caregivers to complete. Referrals for developmental screening are completed based off the results of the developmental milestone checklist.

The Arkansas MIECHV program supports the delivery of early childhood home visiting services to families who live in at-risk communities in selected counties throughout the state through four evidence-based home visiting models (Healthy Families America, Parents as Teachers, Nurse Family Partnership, and Home Instruction for Parents of Preschool Youngsters) and Arkansas's promising approach (Following Baby Back Home). Arkansas currently has 30 MIECHV-funded Local Implementing Agencies (LIAs) providing home visiting services in 57 counties.



Priority Need: Developmental Behavioral and Mental Health of Children

NPM 6: Percent of children, ages 9 – 35 months, who received a developmental screening using a parent-completed screening tool in the past year.

The 2020-2021 National Survey of Children's Health indicated that 34.8% of parents of children, ages 9-35 months, nationwide completed a developmental screening tool in the last year. The state improved performance for this measure by reporting that 28.4% of parents of children, ages 9-35 months, completed a developmental screening tool in the last year; up from 25.9% in 2021 and exceeding the annual objective of 26%. Child Health, WIC and MIECHV staff continued efforts to raise awareness of the importance of developmental screening throughout the year by implementing the following strategies:

Strategy 6.1: Percent of WIC enrolled children ages 2 through 59 months at Learn the Signs Act Early sites who received developmental monitoring.

LTSAE is closely aligned with WIC's mission to assist in the healthy development of young children and to provide referrals for other needed services. WIC initiated a pilot developmental monitoring project at three sites (Faulkner, Bradley, and Pulaski-North Little Rock local health units) using the CDC's Learn the Signs Act Early checklist in 2019, with plans to expand the program statewide. Due to continued COVID-19 pandemic barriers, the LTSAE expansion was not rolled out and prevented children and their families from being served in 2022. WIC continued operating under a disaster waiver throughout most of the year. As a result, the in-person requirement for WIC services was waived. WIC staff were able to discuss developmental monitoring with participants and refer families to the CDC developmental milestones website when warranted, but there was not a system in place to monitor such referrals. Additionally, 2,355 families with children between ages 2-59 months were documented as completing a WIC program that included the CDC developmental monitoring tool; 1,311 of these families were indicated as already screened by PCP or early interventionist or already receiving therapy. Thirty-Four people completed the "Milestones Matter: Understanding Your Child's Development" module currently available on AR WIC Online.

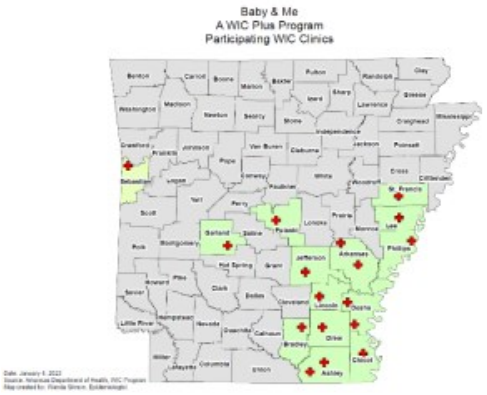
Strategy 6.2: Percent of children, ages 2 through 59 months, in home-visiting programs who were referred for therapy due to the results of a developmental screening using a validated parent-completed tool.

In 2022, the MIECHV program reported 1,907 clients (i.e., parents/caregivers) with 2,005 children between the ages of 0-59 months. Per program guidance, children in home visiting programs should receive a developmental screening if they are between the ages of 9 months and 30 months. This strategy supports early identification to promote optimal development for children. Program reports indicate approximately 85-90% of the participants between the ages of 0-59 months received a developmental screening. Some participants are inadvertently missed when there is a new enrollment and the screening has not occurred at the time of reporting, if the family relocates, or if there is transition within MIECHV staff. All Arkansas home visiting models use the Ages and Stages Questionnaire-Third Edition (ASQ-3) to track developmental milestones. The tool is not difficult to use, but it requires training that can present challenges for the programs.

Additionally, all MIECHV models use the Family Map to promote family engagement while assisting families in navigating their child's early years. This tool is built to meet all requirements from each model to collect information from clients, the tool is not distributed to clients for completion. Seventy Home Visitors were trained to use this tool, and the Family Map was used with 1,604 families. Using these tools, the program identified 65.4% of the children in home visiting programs, between the ages of 2-59 months, were referred for therapy after receiving a developmental screening. While the 2022 performance is a slight decrease from the previous year, the program continues to perform higher than the national average. Additionally, children who screen positive but have not had a completed referral will stay flagged in the database as needing a referral for as long as they remain enrolled in the program. This allows the child to still have an opportunity to obtain a referral during the following year. MIECHV does not have any specific partnerships in place at this time to prioritize developmental screenings and referrals, but current activities support improvement in outcome measures such as school readiness and overall health status for children.

Child Health staff continued providing support to new parents through education on early support and developmental milestones via the agency website and a developmental milestone letter. Parents who request a birth certificate for a child under three years of age receive a developmental milestone letter from the Child and Adolescent Health Medical Director with information about the CDC Milestone Tracker app, locating a primary care physician, toxic stress, breastfeeding, and safe sleep. In 2022, 11,762 developmental milestone letters were distributed with birth certificates requested for children ages 0-3. Additionally, the agency continued to promote the use of the CDC's Milestone Tracker app and additional parent support educational material on the Child Health website. During 2022, the Parent Support webpage received 450 views from 361 first time visitors.

Other Activities:



The WIC Baby & Me program helped ensure families received the latest information on parenting practices that help children grow up healthy and bright. This program is for WIC participants who are either pregnant or have an infant less than 1 month old. Parent Support Mentors meet with participants for seven, 20–30-minute monthly sessions. Sessions cover topics such as developmental milestones, crying, routines, stress, home safety and safe sleep. The WIC Baby & Me program was delivered in 17 counties and served 750 participants. The WIC Baby & Me program does not have any specific partnerships in place at this time to prioritize and/or implement strategies to address disparities as this time. Additionally, the program experienced challenges in effective scheduling to offer in-person services as a result in turnover amongst Parent Support Mentors. However, the program reported increased interest in participating in the program, program completions, and consideration for expanding the program as successes for the year.

Priority Need: Injury Hospitalization

NPM 7: Rate of Hospitalization for non-fatal injury per 100,000 children ages 0-9.

According to the State Inpatient Database, 117.8 per 100,000 children ages 0-9 were hospitalized for non-fatal injuries in 2020. The state did not improve performance for this measure, and performance identified an increase in the rate of hospitalization when compared to the previous period. The Child Health Section has limited staff to conduct activities supporting reductions in hospitalization. However, available staff promote injury prevention by participating in infant child death reviews to provide prevention recommendations and by distributing shaken baby syndrome brochures to educate parents on the dangers of abusive head trauma. Brochures are distributed annually to each birthing hospital for inclusion in the discharge packet each family receives prior to discharge. These brochures are also available on the agency's website and distributed by early childhood centers, through a partnership with the Division of Human Service's Program and Professional Development Administrator's Child Care Aware Resource and Referral Agencies as a result of Arkansas Code § 20-9-1401. Lastly, local health unit's Parent Support Mentors use the brochures during education with new parents on the dangers of abusive head trauma. In 2022, 1,150 brochures were distributed by Child Health in efforts to reduce infant injury.

Strategy 7.1.1: Percent of families served in home-visiting program who have reports of child maltreatment.

Each MIECHV model promotes positive parenting skills, assists parents in becoming self-sufficient and addresses maternal and child health issues that may create significant cost savings for the state. These activities promote reductions in intentional injury seen in children ages 0-9. The MIECHV national average for reports of child maltreatment was 6.0-7.4% over the last four years, but Arkansas continues to report performance exceeding the national average in this area. During 2022, 5.2% of families in home visiting programs reported child maltreatment. This performance indicates a reduction in the number of families reporting child maltreatment when compared to the previous year, 5.9%. The 2022 reporting year is the second year this measure included all models for MIECHV in Arkansas data, and this is the first year there is no missing data. Having complete data depends on timely and accurate data entry after collecting information from a home visit, which can be a challenge; but the program is seeing improvement in collecting complete data.

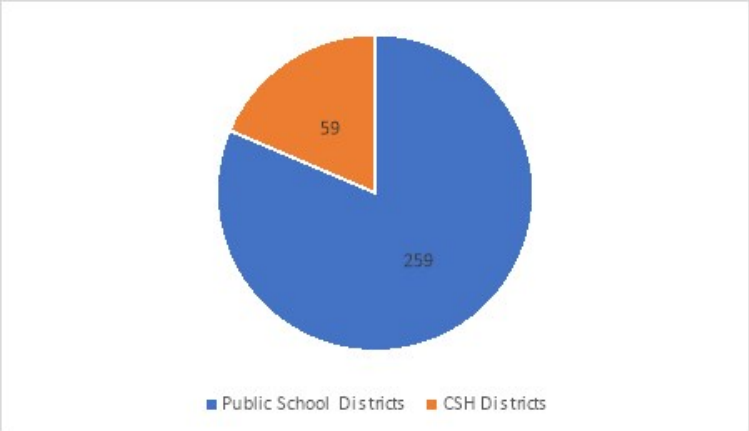
Priority Need: Overweight/Obesity

NPM 8: Percent of children ages 6-11, who are physically active at least 60 minutes per day.

The 2020-2021 National Survey of Children's Health indicated that 26.3% of children nationwide were physically active at least 60 minutes every day. Arkansas exceeded nationwide performance by demonstrating 28.8% of children engaged in physical activity each day, and thus almost meeting the 2022 annual objective of 30%. The School Health Services (SHS) programs at ADH and the Division of Elementary and Secondary Education (DESE) continued efforts to create healthier environments for children to support increases in physical activity through the delivery of the Act 1220 and Coordinated School Health (CSH) programs.

The Act 1220 program is facilitated in accordance with Arkansas Code § 20-7-135, which enables the State School Health and Wellness Coordinators and Community Health Promotion Specialist to work with 1,102 schools in the 262 districts statewide to promote physical activity and nutrition while ensuring state and federal school health mandates are met. The SHS program worked to promote reductions in obesity rates by providing education and resources highlighting best practices in food services, nutrition, physical and health education. Lastly, SHS staff worked with school and district wellness committees to complete the annual School Health Index assessment using the Centers for Disease Control and Prevention's (CDC) School Health Index to complete modules 1-4, 10, and 1. The results of the School Health Index are used to create an improvement plan, which is required for accreditation.

The CSH program delivers professional development and resources based on the components of the national Whole School, Whole Community, Whole Child Model (WSCC). Arkansas has emerged as a leader in CSH with LEAs across the state strengthening districts and building-level wellness teams. Any school or district in the state may participate in the CSH program by accessing resources or attending quarterly meetings. However, a school/district must attend at least three quarterly meetings each year to be recognized as a CSH school. Typically, participating CSH schools have highly effective wellness committees with a dedicated chairperson that consistently attends quarterly state-level CSH meetings. In 2022, at least 276 school health coordinators from 59 districts participated in the state CSH program, representing 23% of the state's total school districts.



SHS staff continued supporting schools in implementing health and wellness activities to create a safe environment to promote learning using the following strategies:

Strategy 8.1: Percent of children attending public schools, grades K-5, who are in the normal or healthy weight zone for Body Mass Index (BMI).

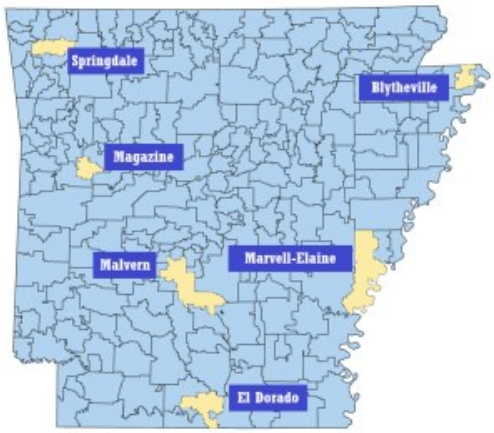
Pursuant to Arkansas Code § 6-20-702, all children in grades K-5 must receive at least 40 minutes of instructional time each day for recess. During recess, students are supervised and must have access to opportunities for vigorous activity and free play whether recess occurs inside or outside. As a result of this standard, Arkansas children can have greater access to physical activity each day, promote opportunities for achieving a BMI in a normal or healthy weight zone and reduce the number of children identified as obese. Through the partnership between ADH SHS and the Arkansas Center for Health Improvement (ACHI), a statewide BMI report is created annually. The report

identifies the student's BMI and includes information to discuss the results with the child's primary care physician. The 2022 BMI report states that 58.2% of students, grades K-5, were in the normal or healthy weight zone for Body Mass Index. The state saw an increase in performance for this measure and the annual objective of 57% was met.

The State School Health and Wellness Coordinators worked to provide technical assistance for school staff and resources to promote physical activity as well as striving to increase partnerships between communities and their schools. However, CSH participants' surveys indicated there are barriers to increasing physical activity for students such as superintendents and principals, lack of facilities for hosting indoor recess during adverse weather, and inadequate infrastructure in communities to promote activity. In previous years, the program encountered success in promoting physical activity using the Joint Use Agreement (JUA) funding opportunity. This process, supported by the Arkansas Tobacco Excise Tax, provided funding to assist schools in implementing community partnerships to maximize resources to increase opportunities for physical activity. For example, funding could be obtained to complete structural changes to school facilities/spaces to allow community members to have a safe environment to engage in physical activity outside of school operating hours. Due to continued COVID-19 pandemic barriers, the DESE was unable to fund any JUA projects in 2022.

Lastly, the CSH program continued promoting the use of playground stencil sets housed at the 15 educational cooperatives (co-ops) in the state. Schools within the co-ops' service area were allowed to check out the stencil sets to enhance play areas, walkways, or gyms to enhance the space and help increase opportunities to engage in physical activity The stencils were used in at least four districts serving more than five schools. Due to staff transitions, the number of students reached was not documented during the current project period. The playground stencils continue to serve as an opportunity to increase children's access to safely participate in physical activity.

Strategy 8.2: Increase the percentage of school personnel who participated in CSH training with increased knowledge of evidenced-based physical activity practices and curriculum and physical activity services provided by SHS.



School staff attending CSH professional development trainings reported improved skills to implement strategies as a result of attending the training. SHS staff worked to promote access to quality physical activity by providing technical assistance to assist school staff. The CSH program provided quarterly training opportunities for all school personnel highlighting the components of the WSC model using funding from a CDC grant. Additionally, the CSH program designated six priority districts to receive targeted technical assistance and funding to improve nutrition, physical activity, and the management of chronic conditions to improve the health of the students and staff. During the reporting period, 1,716 school personnel participated in CSH training and SHS conducting 10 trainings regarding physical activity. Ninety-six percent of the school personnel who participated in CSH training had post-test results that demonstrated an increase in knowledge of evidenced-based physical activity practices and curriculum and SHS physical activity services.

The Child Health Section faced challenges in delivering more services/activities to address priority needs as a result of the lack of additional staff. As a result, direct partnerships with pediatricians have not been established at this time, but the staff regularly communicated with the Arkansas Academy of Pediatricians and Arkansas Academy of Family Physicians to share resources. Additionally, Child Health staff continued identifying opportunities to support efforts to address priority needs by partnering with other collaborators through participation in workgroups such as

Excel by 8, Arkansas Natural Wonders and the Statewide School Health Coalition. Staff collaborate with these organizations to educate partners on available resources and to support their action plan strategies to promote child health.

Arkansas Title V Maternal and Child Health Services Block Grant
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III.E.2.c. State Action Plan Narrative by Domain

Child Health 2024 Application Year Plan

Priority Need: Developmental Screening

NPM 6: Percent of children, ages 9 – 35 months, who received a developmental screening using a parent-completed screening tool in the past year.

Arkansas continued progress toward increasing the number of children who receive a developmental screening by 10% by December 31, 2025, by displaying performance that exceeds the annual objective of 26%. The state improved performance for this measure by reporting 28.4% of parents of children, ages 9-35 months, completed a developmental screening tool in the last year. The following strategies will be implemented to support continued performance:

- The Child Health Section will investigate additional opportunities to identify and develop innovative partnerships with pediatricians and other collaborators to prioritize and implement activities to support increased awareness of the importance of developmental screening.
- The WIC program plans to review strategies to relaunch the LTSAE campaign now that program operations have reverted to in-person services. Additional plans will be made to strengthen and promote the campaign once rolled out.
- MIECHV will support LIAs with current continuous quality improvement projects to improve data entry timeliness and accuracy, including developmental screening/referral.

Priority Need: Injury Hospitalization

NPM 7.1: Rate of Hospitalization for non-fatal injury per 100,000 children ages 0-9.

Arkansas's desired outcome in this priority need area is to decrease the rate of hospitalization for non-fatal injury among children ages 0-9 by December 31, 2025. Data from the 2020 State Inpatient Database indicates a rate of 117.8. The state did not improve performance for this performance measure. The Child Health Section will work with stakeholders to implement the following strategies:

- The Child Health Section will investigate additional opportunities to identify and develop innovative partnerships with pediatricians and other collaborators to prioritize and implement activities to support injury prevention amongst children 0-9.
- MIECHV will continue using curriculum to educate on parenting skills that support the ongoing reduction in the number of families reporting child maltreatment in families participating in home visiting programs.

Priority Need: Overweight/Obesity

NPM 8.1: Percent of children ages 6-11, who are physically active at least 60 minutes per day.

The 2022 performance achieved the previously established desired result in this priority need to increase the percent of students, grades K-5, attending all public schools who are classified as having a healthy weight to 57% by December 31, 2025. The SHS program will work collaboratively with stakeholders to complete the following

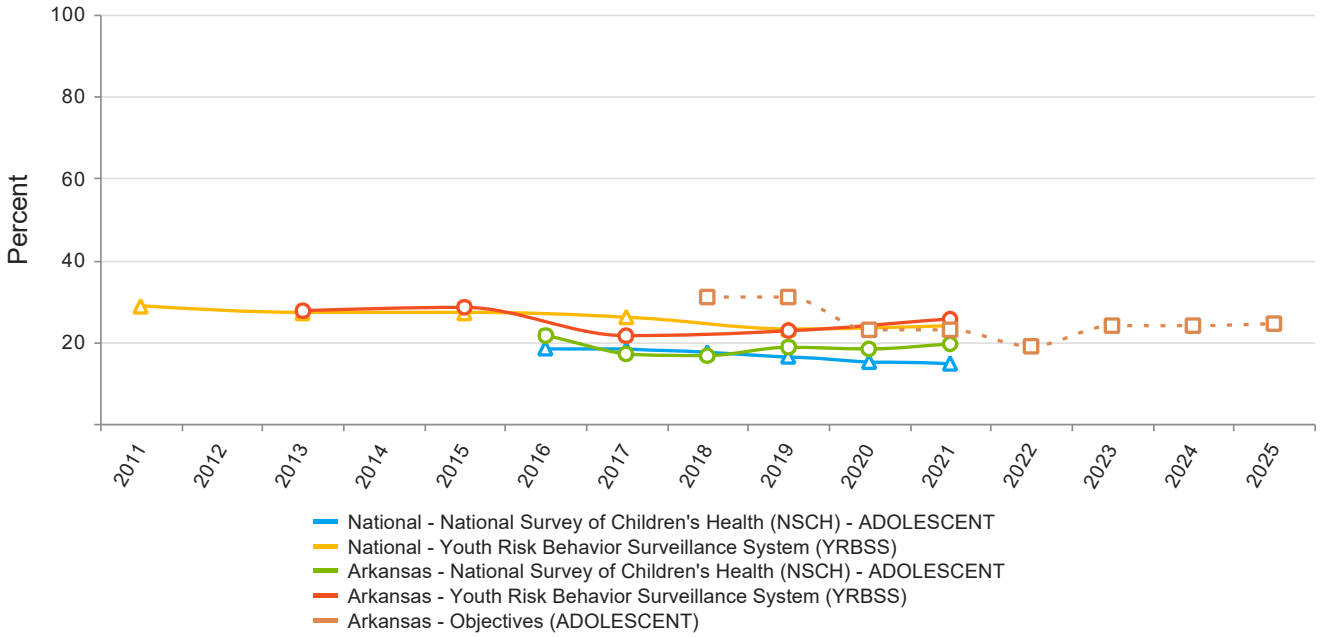
activities in the upcoming year to support further progress:

- Deliver training on opportunities to increase physical activity and physical activity standards for school personnel.
- Promote opportunities for JUA as an avenue for increasing physical activity in communities statewide.
- Collaborate with Student Wellness Advocacy Groups statewide to create a public service announcement promoting 60 minutes of physical activity per day.

Adolescent Health

National Performance Measures

NPM 8.2 - Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day
Indicators and Annual Objectives



Federally Available Data					
Data Source: Youth Risk Behavior Surveillance System (YRBSS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	31	31	23	23	19
Annual Indicator	21.4	21.4	22.7	22.7	25.6
Numerator	28,605	28,605	31,059	31,059	34,669
Denominator	133,427	133,427	136,720	136,720	135,219
Data Source	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT
Data Source Year	2017	2017	2019	2019	2021

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - ADOLESCENT					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	31	31	23	23	19
Annual Indicator	17.2	16.6	18.9	18.3	19.5
Numerator	42,088	42,430	42,470	40,768	46,376
Denominator	244,963	254,983	224,740	222,508	237,248
Data Source	NSCH-ADOLESCENT	NSCH-ADOLESCENT	NSCH-ADOLESCENT	NSCH-ADOLESCENT	NSCH-ADOLESCENT
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

State Provided Data					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	31	31	23	23	19
Annual Indicator		22.7			
Numerator					
Denominator					
Data Source		YRBSS-ADOLESCENT			
Data Source Year		2019			
Provisional or Final ?		Final			

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	24.0	24.0	24.5

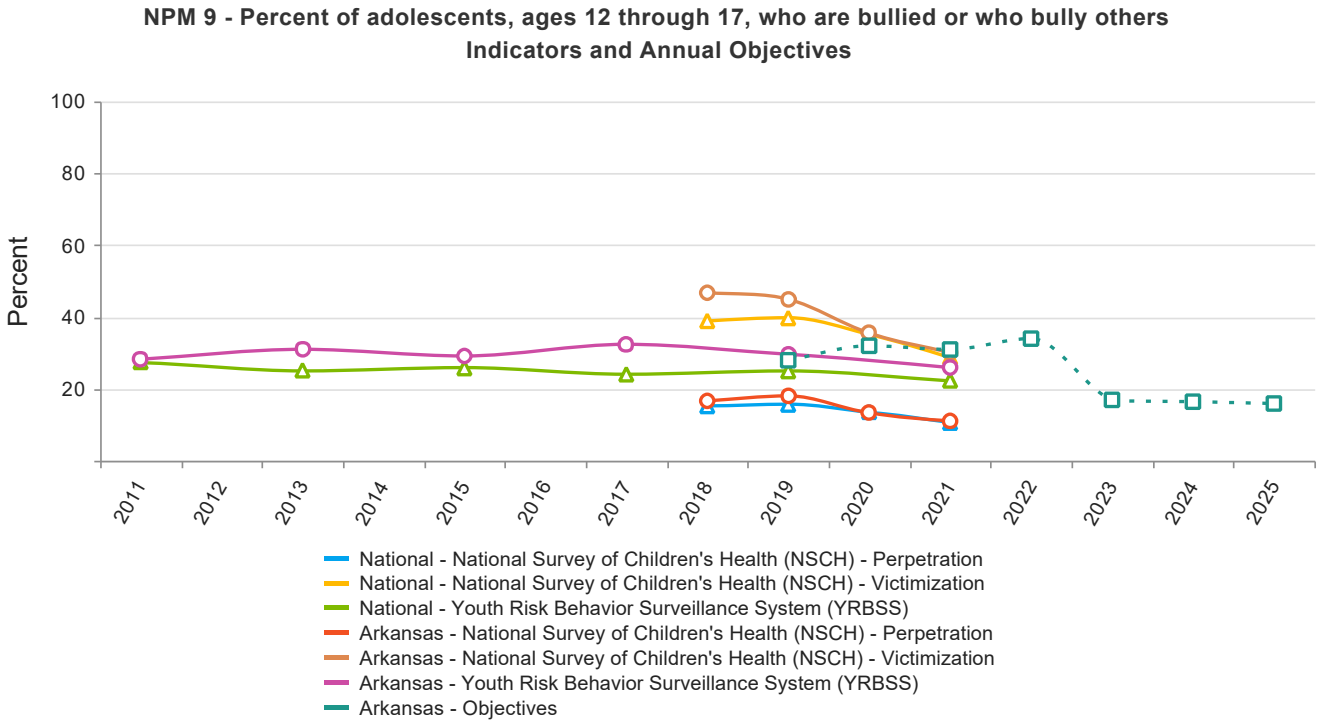
Evidence-Based or –Informed Strategy Measures

ESM 8.2.1 - Percent of school personnel who participated in Coordinated School Health trainings with increased knowledge of evidenced-based physical activity practices and curriculum and physical activity services provided by School Health Services

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			10	83
Annual Indicator			81.2	95.6
Numerator			56	1,641
Denominator			69	1,716
Data Source			Coordinated School Health survey	Coordinated School Health survey
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	95.0	95.0	95.0



Federally Available Data					
Data Source: Youth Risk Behavior Surveillance System (YRBSS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective		28	32	31	34
Annual Indicator	32.2	32.2	29.6	29.6	26.1
Numerator	45,167	45,167	41,441	41,441	36,168
Denominator	140,057	140,057	139,808	139,808	138,575
Data Source	YRBSS	YRBSS	YRBSS	YRBSS	YRBSS
Data Source Year	2017	2017	2019	2019	2021

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - Perpetration					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective		28	32	31	34
Annual Indicator		16.7	18.1	13.4	11.0
Numerator		40,558	40,825	29,771	25,996
Denominator		242,552	225,039	221,941	236,952
Data Source		NSCHP	NSCHP	NSCHP	NSCHP
Data Source Year		2018	2018_2019	2019_2020	2020_2021

Previous NPM-9 NSCH data for survey years 2016 and 2017 that was pre-populated under the 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable to 2018 survey data given major wording and response option changes.

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - Victimization					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective		28	32	31	34
Annual Indicator		46.6	45.0	35.6	30.0
Numerator		112,988	101,363	78,903	70,703
Denominator		242,552	225,039	221,941	235,696
Data Source		NSCHV	NSCHV	NSCHV	NSCHV
Data Source Year		2018	2018_2019	2019_2020	2020_2021

Previous NPM-9 NSCH data for survey years 2016 and 2017 that was pre-populated under the 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable to 2018 survey data given major wording and response option changes.

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective		28	32	31	34
Annual Indicator					17.4
Numerator					
Denominator					
Data Source					YRBSS
Data Source Year					2021
Provisional or Final ?					Final

Annual Objectives			
	2023	2024	2025
Annual Objective	17.0	16.5	16.0

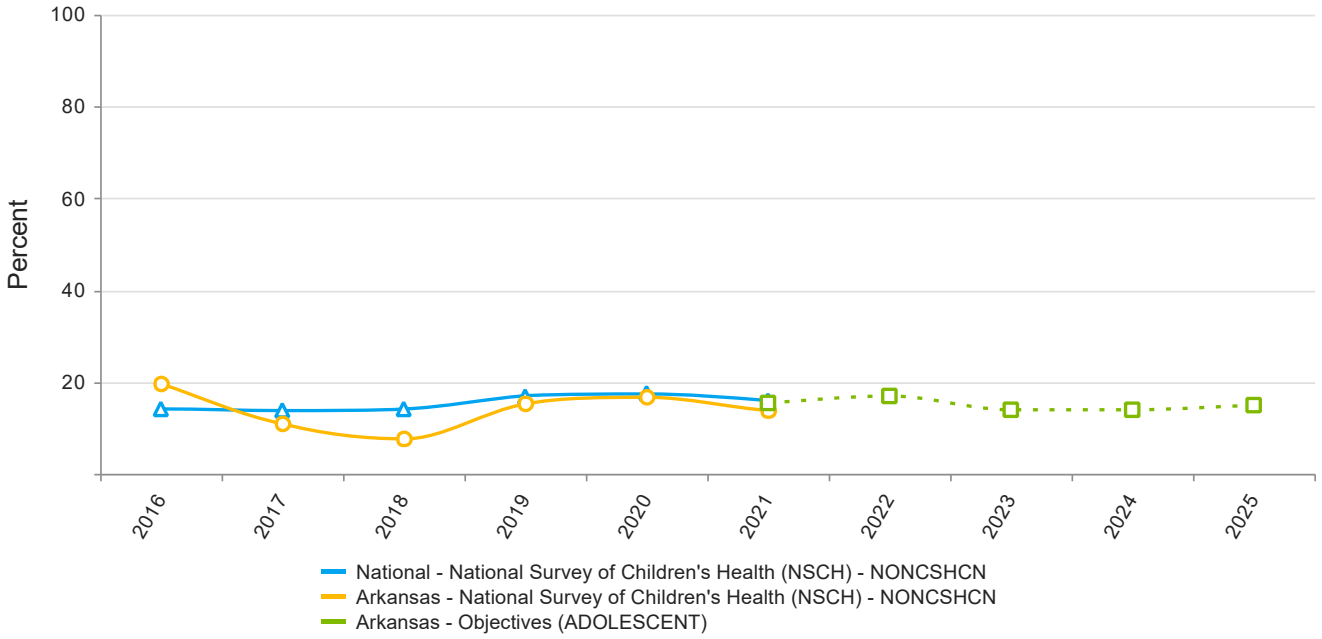
Evidence-Based or –Informed Strategy Measures

ESM 9.1 - Number of school personnel, partners, and community members participating in Youth Mental Health First Aid (MHFA) and other mental health related trainings

Measure Status:			Active	
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			475	550
Annual Indicator		468	806	500
Numerator				
Denominator				
Data Source		School Health Services/Arkansas AWARE	AWARE Year 3 Report	AWARE Annual Report
Data Source Year		2020	2021	2022
Provisional or Final ?		Final	Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	525.0	550.0	575.0

NPM 12 - 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
Indicators and Annual Objectives



NPM 12 - Adolescent Health - NONCSHCN

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - NONCSHCN				
	2019	**2020**	**2021**	**2022**
Annual Objective			15.5	17
Annual Indicator	7.5	15.4	16.7	13.7
Numerator	13,961	24,857	27,261	23,659
Denominator	186,375	161,219	162,826	173,028
Data Source	NSCH-NONCSHCN	NSCH-NONCSHCN	NSCH-NONCSHCN	NSCH-NONCSHCN
Data Source Year	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	14.0	14.0	15.0

Evidence-Based or –Informed Strategy Measures

ESM 12.1 - 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

Measure Status:	Active

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	36	15	26	34	60
Annual Indicator	13.4	25.2	33.9	59.3	67.9
Numerator	22	63	42	54	38
Denominator	164	250	124	91	56
Data Source	Title V CSHCN Transition Providers Survey	Title V CSHCN Transition Providers Survey	Therap reports of Title V CSHCN PCPs	Therap reports of Title V CSHCN PCPs	Therap reports of Title V CSHCN PCPs
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	68.0	68.5	69.0

ESM 12.2 - Percent of key stakeholders and referral sources who participated in the Title V CSHCN Health Care Transition training with increased knowledge of Health Care Transition and Health Care Transition services provided by Title V CSHCN

Measure Status:				Active	
State Provided Data					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective			18	25	29
Annual Indicator		17.1	23.2	28.6	43.8
Numerator					
Denominator					
Data Source		Title V CSHCN Health Care Transition training	Title V CSHCN Health Care Transition training	Title V CSHCN Health Care Transition training	Title V CSHCN Health Care Transition training
Data Source Year		2019	2020	2021	2022
Provisional or Final ?		Final	Final	Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	44.0	44.5	45.0

ESM 12.4 - Number of School District Special Education Teachers, General Education Classroom Teachers, and District Professionals attending professional development training that complete a Title V Health Care Transition Readiness Assessment Survey

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			19	46
Annual Indicator			45	76
Numerator				
Denominator				
Data Source			Title V HCT Readiness Assessment Survey	Title V HCT Readiness Assessment Survey
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	77.0	78.0	79.0

ESM 12.5 - 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

Measure Status:	Active

State Provided Data			
	2020	2021	2022
Annual Objective			3
Annual Indicator			0
Numerator			
Denominator			
Data Source			Title V HCT Readiness Assessment Survey
Data Source Year			2022
Provisional or Final ?			Final

Annual Objectives			
	2023	2024	2025
Annual Objective	4.0	5.0	6.0

ESM 12.6 - Number of CSHCN (ages 12-17) with an annual update to the transition plan developed with the youth and family.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives			
	2023	2024	2025
Annual Objective	15.0	17.0	19.0

State Performance Measures

SPM 2 - Percent of youth, grades 9 through 12, who report using nicotine products

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			25	27.5
Annual Indicator	26.3	29.2	29.2	20
Numerator				
Denominator				
Data Source	CDC YRBSS	CDC YRBSS	CDC YRBSS	CDC YRBSS
Data Source Year	2017	2019	2019	2021
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	20.0	19.0	19.0

State Action Plan Table

State Action Plan Table (Arkansas) - Adolescent Health - Entry 1	
Priority Need	
Obesity	
NPM	
NPM 8.2 - Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day	
Objectives	
1. By December 31, 2025, increase the percent of adolescents, ages 12 through 17, who are physically active at least 60 minutes per day to 24.5%.	
Strategies	
1. Increase community collaborations statewide by providing professional development opportunities to schools statewide.	
ESMs	**Status**
ESM 8.2.1 - Percent of school personnel who participated in Coordinated School Health trainings with increased knowledge of evidenced-based physical activity practices and curriculum and physical activity services provided by School Health Services	Active
NOMs	
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	

State Action Plan Table (Arkansas) - Adolescent Health - Entry 2

Priority Need

Child Safety Due to Intentional Injury

NPM

NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Objectives

1. By December 31, 2025, decrease percent of adolescents, ages 12 through 17, who are bullied to 16%.

2. By December 31, 2025, decrease suicide rates among adolescents, ages 12 through 17, by 5%.

Strategies

1. Provide bullying/suicide prevention presentations statewide delivered by the Arkansas Department of Health's School Health Services program.

2. School Health Services staff and partners will provide Youth Mental Health First training to schools and communities across the state. * (this is a new strategy and directly relates to ESM-4/18/2023)

ESMs	Status
ESM 9.1 - Number of school personnel, partners, and community members participating in Youth Mental Health First Aid (MHFA) and other mental health related trainings	Active

NOMs

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

State Action Plan Table (Arkansas) - Adolescent Health - Entry 3

Priority Need

Transition to Adulthood

NPM

NPM 12 - 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

Objectives

1. By December 31, 2025, increase the percent of public school personnel who participated in the Title V Health Care Transition training with increased knowledge of Health Care Transition for adolescents to 79%.

Strategies

1. Conduct Health Care Transition trainings for public school personnel with DHS support.
2. Use pre-/post test results to improve training and evaluate change in knowledge for those trained.

ESMs	Status
ESM 12.1 - 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	Active
ESM 12.2 - Percent of key stakeholders and referral sources who participated in the Title V CSHCN Health Care Transition training with increased knowledge of Health Care Transition and Health Care Transition services provided by Title V CSHCN	Active
ESM 12.3 - Percent of transition age CSHCN (ages 12 through 17) served by Title V CSHCN who received transition services and supports in the past 12 months from Title V CSHCN	Inactive
ESM 12.4 - Number of School District Special Education Teachers, General Education Classroom Teachers, and District Professionals attending professional development training that complete a Title V Health Care Transition Readiness Assessment Survey	Active
ESM 12.5 - 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	Active
ESM 12.6 - Number of CSHCN (ages 12-17) with an annual update to the transition plan developed with the youth and family.	Active

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

State Action Plan Table (Arkansas) - Adolescent Health - Entry 4

Priority Need

Access to Care

SPM

SPM 2 - Percent of youth, grades 9 through 12, who report using nicotine products

Objectives

1. By December 31, 2025, decrease the percent of youth who use nicotine products to 19%.

Strategies

1. Implement Student Wellness Advocacy Groups (SWAG) to engage youth in student-led activities that improve health norms in their community, family, and student populations.

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III.E.2.c. State Action Plan Narrative by Domain

Adolescent Health 2022 Annual Report

Arkansas' youth population ages 12-17 are in rural, low-to middle income homes. They predominantly attend public schools. Title V activities targeting adolescents aged 12 through 17 continued to address priority needs: overweight/obesity, child safety, access to care, and transition to adulthood. These needs were addressed by Title V staff (i.e., Child Health, School Health Services, MIECHV) working with stakeholders to reach adolescents and their parents by increasing awareness of best practices and providing access to resources to support improvement in performance measures. During 2022, staff worked with state public schools, communities, and stakeholders to address the barriers experienced in previous years and identified additional barriers related to unusually high staff turnover in School Health Services districts. Additional barriers were identified in the survey used to assess School-Based Health Center Coordinators Health Care Transition Readiness Assessment survey.

The staff in School Health Services receives no Title V funding directly but does complement the Title V work. School Health Services immediate staff and the support staff in other areas within the Arkansas Department of Health, and the sister office at the Arkansas Department of Education, Division of Elementary and Secondary Education provide the local and state level work within the state to improve child and adolescent health. There are three programs within the Arkansas Department of Health's School Health Services Office that work in collaboration and coordination with other stakeholders to accomplish Title V goals.

The Coordinated School Health Program is a partnership with the Arkansas Department of Education (ADE), Division of Elementary and Secondary Education (DESE) which receives Center for Disease Control and Prevention funding to improve the health and academic outcomes of students. The Coordinated School Health program assembled the State Core Team and the State CSH Coalition as resources for schools implementing the components of the Whole School, Whole Community, Whole Child model. The Act 1220 and School-Based Health Center programs participate in the Core Team and State CSH Coalition.

Additional partners of the CSH Program at the ADH are the ADE, DESE's School-Based Mental Health Program and the Arkansas AWARE Project.The School Based Health Center Program is a partnership with the ADE, DESE which receives funding from the state legislator through budget appropriations. The School Based Health Center Advisor works closely with the School Based Health Alliance of Arkansas to ensure school-based health centers have the support needed to be successful.

The Act 1220 Program (State School Health and Wellness) Program is a partnership with the ADE, DESE. The ADH uses Master (Tobacco) Settlement Agreement funds to support the implementation of state and federal school health mandates. Additionally, the Act 1220 program allocates funding for Community Health Promotion Specialist (CHPS) to aid in the implementation of work done by the School Health Services Office.

As the reports below will indicate, the state has made some progress towards objectives and National/State Outcome Measures. Upon review of changing partnerships some changes will be made moving forward to better align the NPMs, ESMs, SPMs, and SOMs. Specifically, the American Medical Association adopted a policy de-emphasizing BMI as a health metric as more research indicates that BMI is not an appropriate indication of overall health; this is related to NOM 20. Upon reviewing the remaining NPMs, ESMs, SPMs, and SOMs there seems to be alignment.

Priority Need: Child Safety Due to Intentional Injury

NPM 9: Percent of adolescents, ages 12 through 17, who are bullied or who bully others.

The Student Wellness Advocacy Groups were provided various healthy relationship health education content which was viewed by 8% of participants and subsequently led to 8% of health advocacy projects relating to healthy communication, boundaries, bullying prevention, and how equity and equality differ. While 8% was below our goal, it is important to note that only 28% of reports were completed/received.

In addition to the work the Student Wellness Advocacy Groups did, the Arkansas Department of Health partnered with multiple entities to ensure thorough educational trainings are provided throughout the state with both schools and the communities. One collaboration involved the Arkansas Department of Health Hometown Health Initiative; in which, the Community Health Promotion Specialists (CHPS) educated the community and school on various health topics such as nutrition, physical activity, and mental health. Some residual effects of the COVID-19 safety precautions have led to many school campuses limiting opportunities to provide educational presentations to school staff and students. The Community Health Promotion Specialist conducted resiliency presentations which include bullying and suicide prevention information; however, the data was unavailable at the time of reporting.

In addition to this, the Arkansas Department of Health partners with stakeholders to provide:

Youth Suicide Prevention 101 – training for youth ages 10 – 18 years old, including schools, after school programs, faith-based youth groups, and general population of youth. This training covers myths and facts regarding suicide, teaches youth how to identify someone that is thinking about suicide, discussion on identifying “trusted adults”, the importance of not keeping a secret if they know of someone thinking about suicide, and resources to use for themselves or someone they know that is thinking about suicide.

- Question, Persuade, Refer (QPR) –prevention training for Youth 15+, educators, faith-based, veteran groups, parents, community groups, etc. Key components covered in training are how to appropriately question, persuade, and refer someone who may be suicidal; additionally, how to get help for yourself, how to identify the warning signs of suicide, reviewing myths and facts regarding suicide and how to get help for someone in crisis. QPR training for suicide prevention is listed in the National Registry of Evidence-based Practices and Policies.
- SafeTALK-- training that prepares anyone over the age of 15, regardless of prior experience or training, to become a suicide-alert helper. This program is excellent for anyone who wishes to have basic knowledge of suicide prevention, and it can be a good first class to take in preparation for future, more intense training. Recommend for those in law enforcement, and all first responders.
- Applied Suicide Intervention Skills Training (ASIST)—Is for everyone 16 or older—regardless of prior experience—who wants to be able to provide suicide first aid. The ASIST model teaches effective intervention skills while helping to build suicide prevention networks in the community. This is an intensive 2-day workshop that provides detailed instruction on suicide interventions with someone who is immediately in crisis. Recommended for anyone who might encounter youth who could be in crisis. This could include police, first responders, teachers, administrators, or any trusted adult.

Strategy 9.1: Number of school personnel, partners, and community members participating in Youth Mental Health First Aid (YMHFA) trainings.

AWARE: Advancing Wellness and Resiliency in Education, a project funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). This grant supports school districts in efforts to provide mental health care awareness and trauma-informed practices. Arkansas AWARE has three (3) main goals:

1. To increase coordinated referrals, mental help services and programs, and follow-up for children, and
2. Increase outreach and engagement among youth, families, schools, and communities to increase awareness and implementation of mental health identification services, and programs; and
3. Develop the infrastructure that will sustain mental health among youth and maintain mental and behavioral health services when federal funding ends.

Arkansas Department of Health partners with AWARE to assist in increasing outreach and engagement. Program activities continue to focus on developing comprehensive school mental health best practice programs in pilot schools (Texarkana and Marvell-

Elaine school districts and the Ozark Unlimited Resource Educational Service Cooperative), developing a statewide infrastructure of support and training for school personnel in the Mental Health First Aid (MHFA), Trauma-Informed Schools, and Adverse Childhood Experiences programs and initiatives, and promoting a safe, supportive, and positive school environment for students, staff, educators, and the community.

The AWARE staff trained 500 individuals In Youth Mental Health First Aid (directly related to the evidence-based strategy measure). The AWARE Behavior Specialists engaged youth in groups where topics such as setting goals, demonstrating respect, anti-bullying, friendship, combatting stress, and others related to the Why Try curriculum were the focus. This is an addition to the continuance of the AWARE podcasts that are offered to students, staff, and families.

Mental Health First Aid assists in taking the fear and hesitation out of starting conversations about mental health and substance use problems by improving understanding and providing an action plan that teaches people to identify and address a potential mental illness or substance use disorder safely and responsibly. MHFA indirectly helps school personnel and the community face a student or child who is considering death by suicide.

In addition to the work done by AWARE of the 28% of the Student Wellness Advocacy Groups reporting, 32% of SWAG participants viewed mental health content provided. This led to 20% of health advocacy projects relating to specifically to mental health and an additional 1.6% participating or hosting activities and conversations related to mental health. Mental health content titles were:

- Emotional Intelligence
- Image vs Reality
- Mindfulness
- Motivational Interviewing to Help Others
- Youth Brain Development

Content providers were School Health Services partners from Arkansas with background in education, mental health/licensed social work, and working with adolescents.

Priority Need: Obesity

NPM 8.1: Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day.

NPM 8.2: Percent of adolescents, ages 12 through 17, who are physically active at least 60 minutes per day (Adolescent Health Domain).

These strategies were done in partnership with the Child Health Domain due to the direct overlap of the work the Adolescent Health Domain does in School Health Services. Please see the Child Health Doman report for these NPMs and Strategies.

Priority Need: Access to Care

NPM 12: 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.

Strategy: 12.5: Number of School-Based Health Center Coordinators that completed the Title V Health Care Transition Readiness Assessment Survey with questions regarding the school district's health center.

As described in the CSHCN 12.4 an assessment and training were provided to special education professionals. Of these professionals 71% of those responded "Yes" to: "If you have a school-based health center, are you aware of any educational resources or materials that are available?". Upon review of the location of the respondents, it can be determined the question caused confusion as some responded "Yes" but did not have a school-based health center

in their district. Of the 71% that responded “Yes”, 10% do not come from a school district with a school-based health center. In addition, 13% of the respondents that stated “No” do have school-based health centers but are not mandated to have working knowledge of the full scope of services provided in the school-based health center. Additionally, the small sample size and lack of specifically targeting the school-based health center coordinators and staff do not allow for a clear picture of the application of the Health Care Transition Readiness Assessment use in school-based health centers. The same sample size is largely due to the COVID-19 pandemic greatly impacting the ability of staff availability to participate in non-required trainings, the school staff that regularly interacts with both special education and the school-based health centers shifting to positions known as “point of contact/POC” for COVID-19, and ADH School-Based Health Center Advisor position being vacant.

This information does indicate a more targeted approach to assessing school-based health center’s use of the Health Care Transition Readiness Assessment will need to take place moving forward. Additionally, more communication facilitated by the SBHC Advisor at the Arkansas Department of Health can greatly improve the accuracy of information gathered for this strategy.

SPM 2: Percent of youth, grades 9 through 12, who report using nicotine products.

Strategy: Youth led health advocacy groups developing PSAs for their campus, district, and/or community regarding tobacco/nicotine cessation/prevention.

For 2022, there were a total of ten (10) Student Wellness Advocacy Groups in Arkansas. Multiple webinars are provided via locked Google Docs for all schools to access. All SWAGs must attend seven (7) webinars and, in partnership with Project Prevent Youth Coalition (PPYC), attend three (3) webinars hosted by PPYC. This past year 28% of reports were received. Of these reports 36% of SWAGs developed Public Service Announcements (PSA) or other advocacy regarding tobacco/nicotine prevention for their campus, district and/or their community.

The SWAGs and their participants in activities totaled 848 of the total activity participants of 2,956. Nicotine usage has decreased and there has been an increased interested in quitting tobacco/nicotine products with 58.6% of youth attempting to quit in 2021 according to the YRBS (see graph below from the YRBSS).

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Adolescent Health 2024 Application Year Plan

Priority Need: Child Safety Due to Intentional Injury

NPM 9: Percent of adolescents, ages 12 through 17, who are bullied or who bully others.

Arkansas's desired outcome in this priority need area is to decrease the rate of students who are bullied by December 31, 2025. Data from the 2021 Youth Risk Behavior Surveillance System indicates 17.3% of students were bullied on school property. The state did improve performance for this performance measure. The Child Health Section will work with stakeholders to implement the following strategies:

- The School Health Services Section will investigate additional opportunities to identify and develop innovative partnerships and opportunities to provide bullying/suicide prevention presentations and trainings statewide such as Youth Mental Health First Aid and other trainings that support mental health.

The SHS section will continue to work with the AWARE Program and the Hometown Health Improvement CHPS to continue training teachers, administrators, and community members in Youth Mental Health First Aid and other mental health related content, as well as working with the Student Wellness Advocacy Groups to develop PSAs on mental health.

Priority Need: Obesity

NPM 8.2: Percent of children ages 12 through 17, who are physically active at least 60 minutes per day.

The 2022 performance achieved the previously established desired result in this priority need to increase the percent of school personnel who participated in Coordinated School Health trainings with increased knowledge of evidence-based physical activity practices and curriculum and physical activity services by December 31, 2025, with 96% of participants indicating increased knowledge. The SHS program will continue to work collaboratively with stakeholders to complete the following activities in the upcoming year to support further progress:

- Deliver training on opportunities to increase physical activity and physical activity standards for school personnel.
- Promote opportunities for JUA as an avenue for increasing physical activity in communities statewide.
- Collaborate with Student Wellness Advocacy Groups statewide to create a public service announcement promoting 60 minutes of physical activity per day.
- Promote the use of physical activity stencils in age-appropriate venues and areas.

Priority Need: Transition to Adulthood

NPM 12: 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 data available for children without special health care needs, from the National Survey of Children's Health, indicates a decline in those that received services.

Title V in Arkansas will better partner with School-Based Health Center Coordinators to include children without special health care needs into the structure and planned health care transition process that studies with CYSHCN have proven to result in improvements in health, the youth's experience related to the health care received, and the use and health outcomes for youth. School-Based Health Clinic coordinators have been informed on health care transition readiness and, in collaboration with the ADH School Health Services Title V CSHCN program, presentations to SBHC coordinators will be conducted in partnership with the Arkansas School-Based Health Center Advisor in the upcoming year. Additionally, the Student Wellness Advocacy Groups will receive content on healthcare transition into adulthood and develop a PSA addressing the concerns of youth.

Priority Need: Access to Care

SPM 2: Percent of youth, grades 9 through 12, who report using nicotine products.

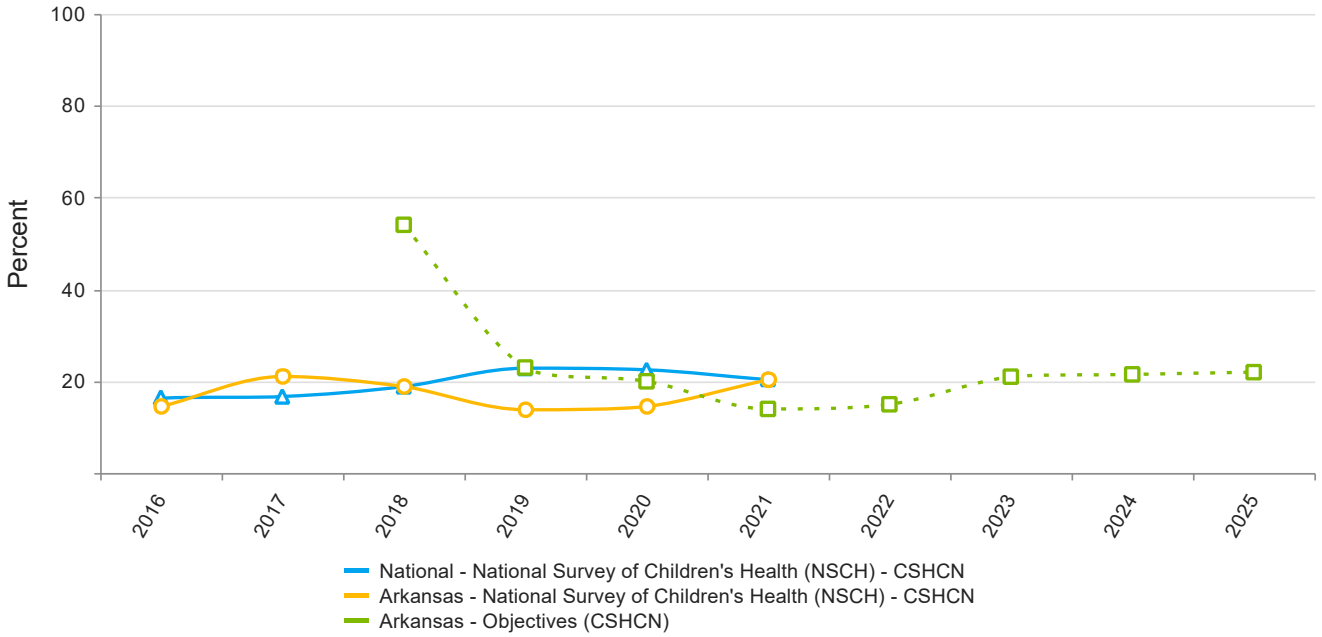
The Youth Risk Behavior Surveillance System indicates this initial measure has been reached. To continue to make progress, Student Wellness Advocacy Groups, student-led groups who are given the mission to address wellness within their school district, will create and host an educational activity and advocacy project before the school year end. Multiple webinars are provided, and the Project Prevent Youth Coalition hosts multiple statewide meetings and contests made available to SWAGs. All SWAGs must attend at least three webinars in partnership with Project Prevent Youth Coalition. In the upcoming year, a minimum of 10 SWAGs is the goal.

CHPS will conduct presentations on the harmful effects of tobacco uses and continue to assist schools with Red Ribbon Week and other tobacco prevention efforts-including policy change focused on cessation when students are found in violation of the tobacco/nicotine policies of their schools.

Children with Special Health Care Needs

National Performance Measures

NPM 12 - 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
Indicators and Annual Objectives



NPM 12 - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	54	23	20	14	15
Annual Indicator	21.2	18.8	13.8	14.6	20.5
Numerator	14,541	13,077	8,912	8,960	13,899
Denominator	68,707	69,399	64,434	61,573	67,703
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	21.0	21.5	22.0

Evidence-Based or –Informed Strategy Measures

ESM 12.1 - 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

Measure Status:	Active

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	36	15	26	34	60
Annual Indicator	13.4	25.2	33.9	59.3	67.9
Numerator	22	63	42	54	38
Denominator	164	250	124	91	56
Data Source	Title V CSHCN Transition Providers Survey	Title V CSHCN Transition Providers Survey	Therap reports of Title V CSHCN PCPs	Therap reports of Title V CSHCN PCPs	Therap reports of Title V CSHCN PCPs
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	68.0	68.5	69.0

ESM 12.2 - Percent of key stakeholders and referral sources who participated in the Title V CSHCN Health Care Transition training with increased knowledge of Health Care Transition and Health Care Transition services provided by Title V CSHCN

Measure Status:				Active	
State Provided Data					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective			18	25	29
Annual Indicator		17.1	23.2	28.6	43.8
Numerator					
Denominator					
Data Source		Title V CSHCN Health Care Transition training	Title V CSHCN Health Care Transition training	Title V CSHCN Health Care Transition training	Title V CSHCN Health Care Transition training
Data Source Year		2019	2020	2021	2022
Provisional or Final ?		Final	Final	Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	44.0	44.5	45.0

ESM 12.4 - Number of School District Special Education Teachers, General Education Classroom Teachers, and District Professionals attending professional development training that complete a Title V Health Care Transition Readiness Assessment Survey

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			19	46
Annual Indicator			45	76
Numerator				
Denominator				
Data Source			Title V HCT Readiness Assessment Survey	Title V HCT Readiness Assessment Survey
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	77.0	78.0	79.0

ESM 12.5 - 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

Measure Status:	Active

State Provided Data			
	2020	2021	2022
Annual Objective			3
Annual Indicator			0
Numerator			
Denominator			
Data Source			Title V HCT Readiness Assessment Survey
Data Source Year			2022
Provisional or Final ?			Final

Annual Objectives			
	2023	2024	2025
Annual Objective	4.0	5.0	6.0

ESM 12.6 - Number of CSHCN (ages 12-17) with an annual update to the transition plan developed with the youth and family.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives			
	2023	2024	2025
Annual Objective	15.0	17.0	19.0

State Performance Measures

SPM 3 - 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

Measure Status:	Active

State Provided Data			
	2020	2021	2022
Annual Objective			15
Annual Indicator			82.1
Numerator			64
Denominator			78
Data Source			Title V CSHCN Survey of Families
Data Source Year			2022
Provisional or Final ?			Final

Annual Objectives			
	2023	2024	2025
Annual Objective	15.0	16.0	17.0

State Action Plan Table

State Action Plan Table (Arkansas) - Children with Special Health Care Needs - Entry 1

Priority Need

Transition to Adulthood

NPM

NPM 12 - 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

Objectives

1. By December 31, 2025, increase the percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care to 18%.

Strategies

1. Encourage practices to use a planned and structured approach for Health Care Transition using the Six Core Elements of Health Care Transition 3.0.

2. Partner with key stakeholders and referral sources to encourage use of and understanding of a planned and structured approach to Health Care Transition.

3. Partner with school systems to prepare youth with and without special health care needs, age 12 through 17, for Health Care Transition.

4. Prepare youth, age 12 through 17, and their families for Health Care Transition.

ESMs	Status
ESM 12.1 - 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	Active
ESM 12.2 - Percent of key stakeholders and referral sources who participated in the Title V CSHCN Health Care Transition training with increased knowledge of Health Care Transition and Health Care Transition services provided by Title V CSHCN	Active
ESM 12.3 - Percent of transition age CSHCN (ages 12 through 17) served by Title V CSHCN who received transition services and supports in the past 12 months from Title V CSHCN	Inactive
ESM 12.4 - Number of School District Special Education Teachers, General Education Classroom Teachers, and District Professionals attending professional development training that complete a Title V Health Care Transition Readiness Assessment Survey	Active
ESM 12.5 - 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	Active
ESM 12.6 - Number of CSHCN (ages 12-17) with an annual update to the transition plan developed with the youth and family.	Active

NOMs
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

State Action Plan Table (Arkansas) - Children with Special Health Care Needs - Entry 2

Priority Need

Access to Care

SPM

SPM 3 - 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

Objectives

1. By December 31, 2025, increase the percent of Title V CSHCN families who report that their child received the health care services they needed to 17%.

Strategies

1. Work with the family to use their informal and formal resources and supports to identify needs and to achieve family identified goals for their child.

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III.E.2.c. State Action Plan Narrative by Domain

CSHCN Health 2022 Annual Report

Infrastructure building activities continued in 2022 that aligned the Title V Children with Special Health Care Needs (CSHCN) Program's policies and goals with those of Health Resources and Services Administration (HRSA) and the Association of Maternal and Child Health Programs. When the CSHCN program policy was promulgated in 2020, Arkansas prioritized enabling services over direct service provision. Program categories of assistance and funding amounts remained the same in 2022. Outreach efforts to inform parents, health care providers, and other agencies continued. These outreach efforts highlighted the benefits of the program to CSHCN and their families in accessing needed resources and in planning and preparing for transition from pediatric to adult health care systems. Strategic planning in 2022 was based on analysis of stakeholder input and needs assessment results. The program developed and rewrote procedures for staff as part of this ongoing program improvement through infrastructure building. The Title V CSHCN program is in the Arkansas Department of Human Services (ADHS) in the Division of Developmental Disabilities (DDS). Lead Agency internal reorganization during the summer of 2022 moved the program from "Children's Services" into DDS Community Services Federal Grants Programs for unified leadership of related programs: Title V CSHCN, First Connections (Part C Early Intervention), and Therapeutic Services (Occupational, Physical, Speech, and Applied Behavioral Analysis Therapy). This internal shift fostered enhanced collaboration with these programs that also serve families of children with special needs.

Additional Lead Agency infrastructure changes included the formation of an online referral portal and a DDS central Intake and Referral Unit to serve as a single point of entry for all DD services. The DDS Central Intake and Referral Unit includes referral to the Title V CSHCN Program as appropriate for children with complex needs. To ensure appropriate referrals, Title V CSHCN Program administration collaborated with DDS Intake and Referral Unit and other DDS programs to ensure that children with needs above those of their typically developing peers are referred to the program. Title V CSHCN Program staff also support families of children referred in completing the application process to access care.

The Title V CSHCN Program adjusts to modifications in Arkansas's health care delivery system. March 2022 marked the third year of operation of Arkansas's Medicaid-funded Provider-Led Arkansas Shared Savings Entity (PASSE). PASSEs changed how services for high-need beneficiaries with behavioral health (BH) disorders or intellectual developmental disabilities (IDD) are provided and funded. PASSE providers receive global payments per enrolled beneficiary to cover the total medical cost of benefits, including medical and specialty support for IDD patients, rather than a fee-for-service system. Arkansas's four PASSEs currently serve approximately 55,000 (ADHS website) members. Children enrolled in a PASSE receive care coordination through the PASSE as well as an array of supportive services covered by the Medicaid State Plan, the Community and Employment Supports (CES) Waiver, therapy services and medically necessary services through the Early Periodic Screening Diagnosis and Treatment (EPSDT) Program. Children enrolled in a PASSE were no longer eligible for the Title V CSHCN program. Analysis of program data indicated a need for Title V CSHCN case management services to be expanded to support families of CSHCN who are not Medicaid-eligible as well as Medicaid-eligible children not served in a PASSE. The PASSE system provided an opportunity for the Title V CSHCN Program to expand case management services to families of CSHCN who have no access to care coordination services through other channels. The system supports these families in accessing care and transitioning adolescents to adult health care services.

Arkansas submitted a proposal to the National MCH Workforce Development Center to host Summer Interns in

2022. Arkansas's Title V CSHCN Program benefitted from collaboration with two MCH Interns from the University of Iowa and the University of South Florida. During their eight-week internship, the Interns supported the program's work around key program goals of access to care and transition to adult health care and assisted with Health Care Transition surveys of medical practices to collect, enter, and analyze program data. Additionally, the Interns conducted outreach to medical professionals, sharing program information to the Arkansas Academy of Pediatrics. The Interns' outreach to education professionals on ways school nurses, special education coordinators, mental health professionals, and coordinators of migrant and homeless youth services can collaborate with the CSHCN program to support youth and children through access to care and planning for transition. The Interns' summer outreach projects with medical and education professionals have rippled on beyond their time in Arkansas, the Title V CSHCN program continues to grow these connections.

Arkansas's CSHCN Program has strong partnerships with families, stakeholders, and colleagues who work together to achieve program goals and objectives. To meet federal guidance and requirements and to reach program goals, the Title V CSHCN program's focus has been on increasing the number of families of program-eligible children receiving care coordination, increasing referrals for children under the age of five, and increasing the number of children with developmental disabilities the program serves. Outreach efforts to primary referral sources for these populations ensures that families of all children with needs beyond those of their same-aged peers have access to support and services. Collaboration with the State's Part C and Part B-619 programs for children birth to five with disability and/or developmental delay has supported the program in increasing referrals of preschool aged children and children with disabilities. Other key activities include building on the Interns' outreach work to school nurses, special education coordinators, coordinators of migrant and homeless youth services, and school-based mental health service coordinators. To increase referrals of children with disabilities and/or developmental delays over the age of 5, Title V CSHCN staff shares program information with regional CoBALT teams (Community-based Autism Liaison and Treatment), UAMS diagnostic clinics, Early Intervention Day Treatment (EIDT) day habilitation programs for children birth to age six, and the James L. Dennis and Schmeiding Developmental Centers. Program information is promoted on the ADHS website with the CSHCN section being continually updated.

To ensure that the Title V CSHCN Program continues to support eligible families, nurses and area managers conduct outreach to medical professionals and primary care providers to explain benefits of the Title V CSHCN Program's case management and transition planning and support. In addition to increasing referrals, ongoing outreach fostered collaborative relationships with clinicians across the state. This outreach further enables families of CSHCN to access needed resources.

Priority Need: Transition to Adulthood for Children with Special Health Care Needs

NPM 12: Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the necessary transition to adult health care.

NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system. Data from the National Survey of Children's Health (NSCH) 2020-2021 indicates 14.8% of CSHCN in Arkansas receive care in a well-functioning system, compared to HRSA Region VI at 12.4%, and to the nation at 13.7%.

NPM 12 was chosen by both the AR Title V Children with Special Health Care Needs and Adolescent Health population domains.

The 2020-2021 National Survey of Children's Health indicates that, nationally, 20.5% of adolescents with and without special health care needs receive services necessary to transition to adult health care. Arkansas's 2022 annual objective of 15.0% was met, with the State's data demonstrating 20.5% of adolescents with and without special health care needs received transition supports and services. To increase the percentage of adolescents with and without special health care needs who are supported in their transition to adult care systems, Arkansas's Title V CSHCN Program continued implementation of the following strategies:

Strategy 12.1 (CSHCN): Percent of PCP practices of transition-aged children (12 through 17) receiving Title V CSHCN services that participate in the Six Core Elements of Health Care Transition self-assessment.

The Title V CSHCN Program provided outreach and training to health care professionals on the importance of transition and elements of transition for CSHCN using the Six Core Elements of Health Care Transition Self-Assessment Tools for Practitioners for Children With and Without Special Health Care Needs, released July 2020 (https://www.gottransition.org). Got Transition is a collaboration between the National Alliance to Advance Adolescent Health and the Adolescent and Young Adult Health National Resource Center.

Title V efforts in this reporting period focused specifically on primary care physicians (PCP) of children ages 12 through 17 receiving services from the Title V CSHCN Program. The Current Assessment of the Six Core Elements of Health Care Transition Activities was distributed to 56 primary care practitioners in the state identified as the medical home for CSHCN aged 12-17 enrolled in the Title V CSHCN program. Thirty-eight of the 56 primary care practitioners completed the Current Assessment of the Six Core Elements of Health Care Transition Activities for transitioning to an adult health care provider (76.3% pediatricians) and eighteen of the 56 primary care practitioners completed the assessment for transitioning to an adult approach to health care without changing providers (23.7% family practice). In the past, the Program mailed paper Got Transition self-assessments tools to medical practices but, beginning in 2022, the self-assessment was set up as two separate online surveys for ease of data collection and analysis. Information about the importance of the survey and the appropriate survey link was sent to the Primary Care Practitioners at Pediatricians' Offices and to Family Practices serving adolescents enrolled in the CSHCN Program. The MCH Interns followed up with these medical professionals to ensure survey participation to collect adequate data. To further encourage busy medical practices to participate in the survey, an internship primary preceptor (from CSHCN Program staff) worked with the MCH Interns to develop an infographic to be sent out to any practices that had completed the self-assessment for 2021 but had not yet completed the assessment for 2022. The infographic shared their prior year data with them (in a bar graph comparing their self-assessment ratings to State averages in implementing each of the six core elements of transition) and linked to the online assessment. The outreach effort included information about a free online continuing education credit for PCP's and Advance Practice Nurses titled "Transitioning to Adult Care for Youth with Chronic Health Conditions and Disabilities" sponsored by the University of British Columbia.

As a result of persistent and personal outreach by the MCH Interns, the program achieved a 67.9% response rate, which is a significant increase from the 59.3% response rate in 2021 and which met the 2022 annual objective of 60.0% of primary care practitioners serving CSHCN Program-eligible adolescents participating in the survey. Of the 38 primary care practitioners who completed the Health Care Transition self-assessment survey in 2022, 73.7% completed the transition practices self-assessment checklist by email, 15.8% by fax, and 10.5% by phone.

An analysis of the data collected from primary care practitioners in their Health Care Transition self-assessment indicated an overall increased rate of implementation for most of the core elements of transition in both Pediatric and Family Practices from 2021 to 2022. State data indicates that ongoing support is needed by Pediatricians in the beginning earlier to support youth in transition to an adult clinician (Transition and Care Policy/Guide). Family Practices could benefit from assistance in implementing the core element of Transition Readiness by encouraging youth to begin to have time alone during office visits without parents/caregivers present and assessment of youths' transition readiness skills. The Title V CSHCN will continue interaction with clinicians in implementation of Health Care Transition process.

To close the feedback loop and to support practitioners who participated in 2022 or in both 2022 and 2021 in assessing "where they stand" in relation to State averages in implementing each of the six core elements of Health Care

transition, the MCH Interns emailed each practitioner their survey results in the form of an infographic that informed them of how the data is used as part of the MCHBG Annual Performance Report.
To begin collecting State data on practices that are not the medical home of a CSHCN Program-eligible adolescent, the MCH Interns expanded outreach to include a presentation to the Arkansas Chapter of the American Academy of Pediatrics PCPs in June 2022. The Pediatricians and Family Practice PCPs were supported by the educational content to transition CSHCN in their practices from Pediatric to the Adult Health Care System. In addition to explaining the Six Core Elements of Health Care Transition, practitioners in attendance were provided links to the online Health Care Transition self-assessments.

Strategy 12.2 (CSHCN): Percent of key stakeholders and referral sources who participated in the Title V CSHCN Health Care Transition training with increased knowledge of Health Care Transition and Health Care Transition services provided by Title V CSHCN.

Title V CSHCN Health Care Transition presentations in 2022 primarily used virtual platforms including Zoom and Microsoft Teams due to the ongoing public health emergency, although some hybrid events with a mix of in person and virtual were facilitated. A barrier to collecting data to assess "increased knowledge" in virtual events is identifying the total number of attendees when participants participate in a shared location/shared computer or device. To overcome this difficulty, the pre and post tests were scaled back to a smaller number of key questions and were provided as brief polls for online participants to complete before information was shared and again afterwards. The comparison of pre-test poll data to post-test poll data shows that the 2022 Annual Objective of 29.0% was met, with program data demonstrating that participants increased their knowledge of Health Care Transition and Title V CSHCN services by an average of 43.8%.

After a webinar was presented July 2022 by MCH Interns for Educational Professionals, such as Special Education Coordinators, school nurses, and McKinney-Vento Coordinators, these professionals averaged a 50% increase in knowledge of the Title V CSHCN Program. Since children and youth served by the CSHCN Program also attend schools, these families are jointly served by Educational Professionals and Title V CSHCN, so a portion of the outreach presentation included ideas about how Education Professionals could work with Title V CSHCN to improve both health and educational outcomes for the State's children. As a result of this outreach, Title V Care Coordinators have been asked to share information at school transition fairs and school staff development days to share CSHCN program information and resources to Education Professionals and to parents. This additional outreach included:

- Participated in Transition Fairs at Harber High School and Pulaski County Special School District (both in person) and Guy Fenter Educational Co-operative as a virtual event by providing program brochures including the CHC Assistance Program Guidelines and answers to questions about available resources for local educational agencies.
- Attended a Health Fair in Sharp County coordinated by the Sharp County Cooperative Extension Office as many communities in the wind down of the pandemic began to host Health Fairs.
- Provided transition tip sheets from the state's Parent Advisory Council (PAC) to parents, students, and school personnel.
- Emailed CHC Assistance Program Guidelines for Parents, in English and in Spanish, and CHC Assistance Program Guidelines for Professionals.

Other outreach to Education Professionals includes the collaborative partnership with the State's Office of Special Education Programs-funded (OSEP) Parent Training and Information Center (PTIC), The Center for Exceptional Families (TCFEF). TCFEF's mission is to "improve educational opportunities for students with disabilities, including students transitioning to adult life beyond high school." With similarly aligned missions, TCFEF and the CSHCN make a logical partnership. To support CSHCN in reaching their goal of helping families access services and plan

for and prepare for transition, TCFEF invited the CSHCN program to share program information in a Facebook Live Webinar with families across the state. Additional collaboration between the two programs included Title V nurse care coordinators referring 19 families to TCFEF for education support with their child's Individualized Family Service Plan (IFSP) or Individualized Education Plan (IEP). The Title V CSHCN Program anticipates additional collaboration as a result of TCFEF administration designating one staff member to serve as a 0-5 Liaison to Part C, Part B-619, and Title V CSHCN. The four programs began having quarterly planning meetings (fall 2022) to identify ways to work together in ways that effectively support children and families. Additionally, having a "go to" person at TCFEF will streamline collaboration and support the CSHCN Program in reaching its goal to increase referrals for children under the age of five.

Strategy 12.3: Percent of transition age CSHCN (ages 12 through 17) served by the Title V who received transition services and supports in the past 12 months. "**Inactive"**

To assess transition services and support provided to transition aged CSHCN (12 through 17) served by the Title V Program in the past 12 months, the CSHCN Program obtained an unduplicated report of youth served by the program. The Program updated the internal audit tool in August 2022. Area managers audited each community-based office under their direct supervision using the Transition Quality Improvement Audit Worksheet to determine whether CSHCN Program-eligible youth between the ages of 12 through 17 received at least one Title V health care transition service. In the audit, area managers reviewed records for progress notes or other documentation in electronic records documented that transition services were provided. "Health care transition services" documentation included:

- Transition goals and objectives were added to the child's Title V Service Plan.
- The family received the Title V Health Care Transition Protocol.
- Families of 12- and 13-year-olds received the Health Care Transition letter with the anticipatory guidance enclosed.
- Program staff conducted a six-month follow-up, as outlined in the Title V Health Care Transition Protocol, with the family and youth, if their condition allowed.
- Health Care Transition Readiness Checklists were completed by youth aged 14-17.
- CSHCN aged 12-17 were provided age and diagnosis appropriate health care transition resources.
    - Resources from Got Transition's A Family Toolkit: Pediatric-to-Adult Health Care Transition used by Title V Staff include:
        - Health Care Transition Timeline for Youth and Young Adults.
        - Health Care Transition Timeline for Parents/Caregivers.
        - Charting the Lifecourse Tool for Exploring Decision Making Supports.

These detailed audits provide quality assessment of internal processes to ensure that Program staff are providing children aged 12-17 with one or more transition services annually. The 2022 annual objective of 93.0% of CSHCN (12-17) received at least one transition service in the past 12 months was not met. Program data demonstrated that 89.8% received at least one identified health care transition service or support. ESM 12.3 was made inactive and was replaced when the block grant was submitted in August 2022 as it did not align with a specific evidenced-based strategy measure and was considered an outcome measure. However, the program intends to continue improving internal processes to ensure that the program does support all youth ages 12-17 in planning and preparing for transition. To meet this goal, regional Program staff completed ongoing personnel development training in June 2022 to emphasize the importance of a planned and structured approach to health care transition. Additionally, the Program updated the Title V Service Plan to expand the goals and objectives in the health care transition section, the program provided training ensured program staff had the knowledge, skills, and abilities to support youth and families in creating individualized service plans. The 90-minute training was recorded with program staff being provided with the link to the recording and a copy of the training slides.

The Title V CSHCN Program's efforts to increase the percentage of CSHCN who receive transition support also included strategies to support program staff, families, and stakeholders. Strategies to support program staff included:

1. Training by Area Regional Manager on Health Care Transition audit results for each community-based office and training for the regional program staff.
2. Utilizing transition flowsheet outlining for each group what the youth and parent/caregiver should receive.
3. Maintaining separate internal written procedures for staff for health care transition from the protocol.

Strategies to support families included:

1. Ensuring the Title V CSHCN website included the most recent Health Care Transition Protocol
2. Having conversations with families on preparing for their child's transition to adult health care while the child is in early adolescence.
3. Informing parents how important they are to their child's successful health care transition and in securing long-term benefits for their child.

Strategies to support stakeholders included:

1. Training primary care and specialty care providers (including AR Chapter of the American Academy of Pediatrics PCPs) on the process of health care transition.
2. Training key stakeholders and referrals sources to support youth with special health care needs as they prepare for the transition to adult systems of care.

To further help families prepare for transition, the Title V CSHCN Program focused on informing and preparing families using parent letters for parents of youth aged 12 and for parents of youth aged 13. These letters introduce families to the concept of health care transition. Each letter lists topics parents may want to discuss with their 12- or 13-year-old. Parents received copies of two guidance documents: *Positive Parenting Tips for Healthy Child Development Young Teens* (CDC, 2017) *and Bright Futures, Early Adolescence, 11-14 Years, Patient and Parent Handout* (2019). Bright Futures is a national health promotion and prevention initiative led by the American Academy of Pediatrics and supported in part by the HRSA Maternal and Child Health Bureau.

Strategy 12.4: Number of School District Special Education Teachers, General Education Classroom Teachers, ad District Professionals attending professional development training that complete a Title V Health Care Transition Readiness Assessment Survey.

Planning continued in 2022 to partner with school systems to prepare youth with and without special health care needs ages 12-17 for health care transition. The Title V CSHCN Program collaborated with Arkansas Transition Services, a consultant group that works with school districts in association with the Arkansas Department of Education's Division of Elementary and Secondary Education Special Education Office. Arkansas Transition Services' mission, "to effectively assist students with disabilities, educators, parents, agency personnel, and community members in preparing students to transition from school to adult life and reach positive post-school outcomes," makes them a logical partner in the Title V CSHCN Program's outreach to education professionals.

In 2022, 76 special education professionals completed a survey in a required professional development training session during which Arkansas Transition Services offered the survey on behalf of the Title V CSHCN Program. The 2022 Annual Objective of 46 Education Professionals completing the Health Care Transition Readiness Assessment Survey was met, as 76 Special Education professionals attending professional development training completed a Title V Health Care Transition Readiness Assessment Survey.

The participation of these Special Education Professionals provided useful data for the Title V CSHCN Program.

The results of the 76 completed Health Care Transition Readiness Assessment Surveys indicate that some Arkansas school districts are promoting Health Care Transition Readiness Assessments with their special education students. Survey results indicate that only 10.5% report doing so on a consistent basis with 13.2% reporting doing so on an inconsistent basis. Special education professionals in attendance indicated that Health Care Transition Readiness Assessments for CSHCN in public schools are most often completed by parents or by IEP Team members, and the remainder by students (with or without support).
This information indicates there are many opportunities for supporting these key stakeholders in implementing organized transition activities consistently with all children receiving special education services in the public school system. The Title V CSHCN program anticipates further collaboration with Arkansas Transition Services to support education professionals in using a planned, structured approach to health care transition for this population.

ESM 12.5: 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.

See State Action Plan Narrative by Domain- 2022 Adolescent Health Annual Report.

Priority Need: Access to Care

SPM 3: 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 needed.

NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system.

Data from the NSCH 2020-2021 demonstrates that 14.8% of CSHCN in Arkansas receive care in a well-functioning system, compared to 12.4% in HRSA Region VI, and 13.7% nationally.

The Title V CSHCN Program relies on a statewide network of partners to serve families of CSHCN and to ensure access to needed and continuous systems of care. Networking with existing partners and forging new working relationships with related agencies, programs, and groups serving families of CSHCN is an essential part of improving families' access to care. In this reporting period, partnerships were strengthened with the State's OSEP-funded Parent Training and Information Center, The Center for Exceptional Families (TCFEF) to share information with families of CSHCN through TCFEF's family education program. The Title V CSHCN Program formed stronger working relationships with other programs and agencies serving youth with special needs such as the Arkansas Department of Health's (ADH) Infant Hearing Program's Early Hearing Detection and Intervention Program (EHDI); Maternal, Infant, and Early Childhood Home Visiting's (MIECHV) Nurse-Family Partnership (NFP) and Following Baby Back Home (FBBH) programs; the State's Part C early intervention program First Connections; Arkansas's Part B-619 Early Childhood Special Education (ECSE) program; Early Head Start/Head Start, and Family 2 Family (F2F) Health Information Center within the Arkansas Disability Coalition. Improved collaboration with these programs increased CSHCN referrals, which will improve these families' access to care.

The Title V CSHCN program's active involvement in two collaborative partnership initiatives with the Part C Program and MIECHV Home Visiting Network, supports families' access to care. The focus of these multi-agency initiatives is working together in new ways to support families in accessing desired resources to advocate for their child and family, smooth transitions into preschool and kindergarten for CSHCN 0-5, and improved health and early learning outcomes for children. Participating in these two early childhood initiatives has resulted in increased referrals of children under the age of five as well as better cross agency collaboration to support families of children enrolled in two or more initiative programs. The new ways of working together with the State's Part C early intervention program

allows (with parent consent) a regional CSHCN Program care coordinator to be part of a child's Individualized Family Service Plan (IFSP) Team. When a child is turning three and preparing to exit early intervention, a Title V nurse care coordinator is an asset to families identifying and planning "what's next" and what resources, programs, and supports are available for their child's preschool years and to provide care coordination when the family's service coordination through early intervention ends on the child's 3rd birthday. Collaboration with the State's Part B-619 Early Childhood Special Education Program makes it possible for the Title V nurse care coordinator to be a part of the child's Individualized Education Plan (IEP) Team to support transition to kindergarten and beyond. This partnership with early education programs creates a more well-functioning system to support families in accessing care.

Collaboration through the initiatives has also forged effective working relationships with two of the state's MIECHV Home Visiting programs, Nurse-Family Partnership (NFP) and Following Baby Back Home (FBBH). Through streamlining collaboration across programs for children who are jointly enrolled in the CSHCN Program and a MIECHV Home Visiting Program, the Title V CSHCN program's nurse care coordinators receive results of developmental screenings and/or evaluations completed by the Home Visiting Program and can continue supporting the child and family after the child ages out of the Home Visiting program at age three or four. Developing effective partnerships with these early learning and Home Visiting programs has helped the CSHCN program increase referrals of children under the age of five while creating a more well-functioning system to support families in accessing care.

To build on these exiting early childhood partnerships in 2022, key Title V staff began meeting with Arkansas Children's Hospital Natural Wonders' Partnership Council and workgroups. Arkansas' Kids Count data (https://datacenter.aecf.org/data#AR/2/0/char/0) provides statistics on children, youth, and families in Arkansas from the Annie E. Casey Foundation and Arkansas Advocates for Children & Families. Kids Count data measures overall well-being of children and families in 100 different indicators of health, safety, and educational well-being can be aggregated by school district or county, by age, by demographic group, and by specific indicators or measures, and the data shows huge disparities for children in rural areas and certain demographic groups. Natural Wonders brings programs and agencies together to understand these challenges of Arkansas's young children in underserved areas. The First 2,100 Days Workgroup focuses on the first five years of a child's life as the foundation for health, development, growth, happiness, and learning achievement. Title V CSHCN has participated in the work of this group to revise State goals (through 2024) to improve results for children and families.

Utilizing the ideas and energy of the two MCH Interns, the Title V program revised and updated the 2018 parent survey into an online parent survey in which parents who participated could identify program strengths as well as areas that could be improved. Since the Interns' time with the State was very limited, survey information and a link was sent out to each parent of a child who at that time was currently receiving Title V CSHCN Program services who had an email address on file (n=384). The MCH Interns emailed the parent of each child a flyer stating the importance of parent feedback to identify Program strengths and areas that could use improvement around care coordination and health care transition services and supports. The flyer included a link to the online survey and invited parents to provide feedback to the program to improve the quality of services to families. Parents were given Title V staff contact information (email or phone) if they had any questions about the survey or voluntary survey participation.

384 emails with survey links were sent to parents of CSHCN, and 78 parents completed the online, anonymous survey (20.3% response rate). 2022 Family Survey data helps the Title V CSHCN Program identify programmatic areas of strengths and need. For example, 79.5% of families responding to the survey indicated that the Program's care coordination (like case management) is helpful to the child/family (62 of 78) and 70% of parents of children 12—17 who completed the survey received information to help prepare for the child's transition from child to adult health care systems and services. The program can use this information as baseline data and work to increase the percentage o

families who report that care coordination was helpful to their family and helped plan for transition.

Family Survey data also provides a way to identify from family report whether the State system is well functioning or not. 2022 online Family Survey data demonstrates that 71% (55 of 78) of families indicate that they always or usually receive as much help as they need in arranging or coordinating their child's health care and that 82.1% (64 of 78) hav not experienced a time that their child needed health care, but it was not received. 94.9% (74 of 78) of parents responding indicated that their child's health insurance covered the cost of services the child needed always or usuall

Another way the CSHCN Program ensures that parents of CSHCN the program serves can access care and navigate a complex health system is through parent education, information, and training. The long-standing work of key stakeholders that make up the Parent Advisory Council (PAC) supports the CSHCN Program in this work. Arkansas's PAC is one of the oldest in the nation and has been in operation since 1990. The PAC is a diverse group of parents and guardians of CSHCN that provides support, information, and education to families, government agencies, and health care professionals on CSHCN issues. Parent representatives on the PAC support outreach efforts by facilitating at least one regional parent support group meeting or workshop annually. PAC parent representatives share information with families in their regions using email distribution lists, social media, and parent support group activities.

In April 2022, the Arkansas PAC held the 9th Annual Famous Family Bistro Conference through the virtual platform Whova. The Family Bistro is an annual event featuring out-of-state and local experts, program representatives, vendors, and other sources of information on topics of parent-identified interest, including the following:

1. Respite Care: The Need, the Benefits, and Best Practices, ARCH National Respite Network and Resource Center
2. Struggles to Successes, Autism Mentor and Advocate
3. About the Governor's Council on Developmental Disabilities
4. Empowering Families
5. Tools for a Self-Determined Life
6. Learning LEND and Arkansas Resources
7. Respite in Underserved Populations
8. Arkansas Governor's Commission on People with Disabilities
9. The Impact of COVID on Children and Families
10. Feeding Struggles and Food Selectivity in Children with ASD
11. Providing the Ingredients to Successful Access to Care
12. School-based Mental Health Resources for Students and Families.

The Whova platform reported 79 attendees, 438 messages, 39 community posts, and 81 photos shared during the conference. Ten exhibitors provided information and resources through Whova. Collaborating partners included the Division of Workforce Services, ARCH National Respite and Resource Center, Arkansas School for the Deaf, AR Governor's Commission on People with Disabilities, Disability Rights of Arkansas, Governor's Council on Developmental Disabilities, F2F Health Information Center, University of Arkansas for Medical Sciences, First Connections' program under Part C, and the state's Early Childhood Special Education program under Part B-619. The Title V CSHCN Program develops and maintains collaborative partnerships with other agencies, programs, and entities that support the state's CSHCN population.

While the use of telemedicine during COVID decreased travel expenses for many families, it did not eliminate travel. One element of a well-functioning system that supports families in accessing care includes Title V CSHCN support

to assist families in covering the expense for travel to appointments or other needed care services in which Title V care coordinators referred 140 families to non-Medicaid transportation brokers for transportation in 2022. For families in Southeast and Southwest Arkansas lacking technology and resources to utilize telehealth services, Family 2 Family and a technology grant from the Black Hall of Fame supported families in accessing care via telehealth by providing tablets. Family 2 Family supported tablet recipients in how to prepare for a telehealth visit by learning to use the equipment, preparing questions for health care providers in advance, and basics of recordkeeping.

Care Coordination supports families in accessing the resources and care they need. Title V CSHCN Program's care coordinators made 14 referrals for other DDS special needs services. Care coordinators helped families access DDS Special Needs Program services by providing direction on how to access, complete, and submit the DDS Special Needs Program's application packets which helped families of CSHCN access needed respite services funded through the DDS Special Needs Program. Nineteen CYSHCN under age 21 were awarded DDS Special Needs services in 2022 for a total of $9,046.00. The average amount awarded per child was $476.11. Title V CSHCN Program's care coordinators made 42 referrals to the DDS Intake and Referral Unit for the Community and Employment Supports (CES) Waiver. The CES Waiver helps recipients live in their communities with support for activities of daily living. Title V CSHCN care coordinators' knowledge of state and local resources enabled them to make referrals to appropriate agencies and programs that supported families of CSHCN through case management.

To improve access to care, the Title V CSHCN Program provides gap-filling services to families of program-eligible children with identified needs when no other funding source exists, in addition to care coordination and case management support. In 2022, the program paid for direct medical services not covered by insurance or other funding sources for eligible CSHCN whose family gross monthly income was under 350% of the federal poverty level. Services fall into seven assistance categories: Medically Necessary Item or Equipment, Deductibles/Coinsurance/Co-pays, Parent Education, Medical Camps, Adaptive Equipment, Respite Services, and Vehicle Modification. An eligible child may receive assistance in more than one category.

Many CSHCN services are covered by public or private insurance or other state funding, and case management provided by the Title V CSHCN Program supports these families in accessing needed medical services and resources for planning for transition to adult care. Program expenditures totaling $48,842.47 in 2022 provided gap-filling services for 24 unduplicated children when no other pay source existed.

The Family 2 Family Health Information Center is an important partner in the work of the Title V CSHCN Program. The F2F Program, funded by HRSA through a Title V subgrant, is part of the Arkansas Disability Coalition. F2F provided family support by completing applications for benefits, providing information on COVID testing centers, transportation, vaccination education, family engagement, finding adult dental and primary care providers, and early screenings for children. F2F reported that parents were provided with information at drive through events, health fairs, and community-based events such as music festivals and food banks. During 2022, F2F regional coordinators provided direct services to 2,413 families and 2,676 professionals. Regional F2F coordinators distributed 22 Health Care Plan books to families. The books help parents understand and navigate the health care system and access available resources. The Title V CSHCN Program will continue to rely on PAC and F2F input on health care access needs.

The Arkansas Disability Coalition, as a Family Voices Affiliate Organization for Arkansas, provided two training courses in 2022 to families on record keeping, advocacy, and leadership building. Arkansas Disability Coalition supported the Title V CSHCN Program's goals by offering the "Leadership Gym" leadership training for families. Although leadership skills were taught through collaborative efforts with other organizations, the Leadership Gym will

provide an essential foundation for parent advocacy skills building and parent leadership and mentoring. When families develop self-advocacy skills, they are better able to access needed services.

In 2022, Title V CSHCN Program staff made 97 referrals to the Arkansas Autism Partnership Waiver to support parents of young children with an autism diagnosis in accessing autism-specific supports and services. The Title V CSHCN Program will continue to support families in accessing educational services by making referrals to early intervention or early childhood special education to support the learning and development of children aged 0 to 5 with a disability and/or developmental delay.

Strategy 3.1: Increase the percent of CSHCN who receive case management to support them in accessing needed services.

Program data on care coordination activities provided to families and CSHCN the Program serves is measured by reviewing case management billing compared to the total number of program-eligible children served. By collecting data and comparing to previous years, the program can monitor progress toward reaching the goal outlined in Strategy 3.1 to increase the number of CSHCN receiving case management services (NOM 17.2; SPM 3). Increasing case management services ensures that families of CSHCN are supported in navigating the state and local care systems to access care and plan for their child's transition to adult health care systems.

Care coordination improves child and family outcomes. For example, care coordinators provided 172 families (2022) with information about Arkansas Health Insurance Premium Payment Program (ARHIPP) when many families were struggling financially due to COVID. ARHIPP is a resource for families with private health insurance and Medicaid in which eligible families receive Medicaid reimbursement for out-of-pocket expenses such as health insurance premiums. In 2022, Title V nurses referred 187 families of CSHCN to the state's TEFRA program to increase access to care. TEFRA can help families of eligible children under age 19 receive care at home rather than in an institution while paying for all or part of the cost of services depending on family income.

Increasing the number of CSHCN that the program serves is a key strategy to ensuring access to care. Through collaboration with the statewide TEFRA Unit, the Title V CSHCN Program was asked to present program information to TEFRA workers in March 2022. Comparison of pre- and post-test scores of attendees demonstrated a 31% increase in knowledge. As a result, the number of referrals to the Title V program from TEFRA has increased as TEFRA workers communicate with parents of CSHCN and learn of needs that could be met with Title V care coordination and/or the assistance program.

Outreach to related agencies and potential referral sources is a critical component of increasing the percentage of CSHCN referred to the program and who receive case management services. A brochure and infographic explaining the program were updated in 2021 by the DHS Office of Communications. These documents are shared with referral sources, families, and health care professionals to educate them about the program and available services. The brochure and infographic are on the Title V CSHCN Program website in English, Spanish, and Marshallese (added in 2022) at https://humanservices.arkansas.gov/about-dhs/ddds/childrens-services-information/title-v. The CSHCN Program conducts outreach by sharing a brief program overview presentation at state conferences, interagency collaborative meetings, or as part of related agencies' staff development.

Increasing Program referrals relies on partnerships with other programs and agencies who serve the CSHCN population, and the program networks to form new partnerships. When changes in Arkansas's Medicaid program opened access to Medicaid for the Marshallese population in 2018, the program collaborated with the ADH and the Arkansas Minority Health Commission to develop a letter to Marshallese parents informing them of the Title V

CSHCN Program and how to apply for services. A Title V CSHCN brochure and infographic in Marshallese were added to the Title V CSHCN program website in 2022. Title V staff have participated in the Marshallese Interpreting for Community Inclusion (MICI) training specific for Disability Service Providers. The training is a project of the University of Arkansas's Partners for Inclusive Communities to better understand this community's values and culture relating to disability and government-funded services. Further planning and collaboration with MICI on strategies to increase awareness of the Title V Program in the Marshallese community is needed.

The Title V CSHCN Program has a long-standing positive working relationship with University of Arkansas for Medical Sciences (UAMS), Arkansas Children's Hospital (ACH), and the Dennis Developmental Center. One of the most significant contributions resulting from this partnership is the CoBALT (Community-based Autism Liaison and Treatment) project, a joint venture between the UAMS Department of Pediatrics and the Title V CSHCN Program. CoBALT teams are trained to screen, evaluate, and in some cases diagnose autism and to route these children and their families to available developmental, health, and medical services in rural areas of Arkansas where specialized services may be difficult to access. The Title V CSHCN program participates in annual training of CoBALT teams. 2022 training of a new CoBALT team in NW Arkansas resulted in an 11% increase in CSHCN Program knowledge (in a comparison of pre- and post-test scores). CoBALT teams are one of many sources of referrals to the Program. From January through June of 2022, 276 families were seen by regional CoBALT teams for autism-specific testing and diagnosis so that these families and children accessed care without a prolonged wait and travel to the state capitol for these services.

An important way that the Title V CSHCN Program conducts outreach to medical professionals is through monthly participation in the Leadership Education in Neurodevelopmental and Related Disabilities (LEND) Program trainings. The LEND program educates future health care professionals about family-centered care through long-term, graduate level interdisciplinary training on the complex needs of children with neurodevelopmental and related disabilities and their families. The goal of LEND training for future health care professionals is to enhance their understanding of families' complex needs as well as their clinical expertise and leadership skills. Title V staff, including the Parent Consultant, participated in the following LEND Trainings in 2022:

1. Leadership in Family and Professional Consultation
2. Arkansas Medicaid Programs
3. Introduction to Policy US Government
4. Special Education IDEA, 504, and Legal Aspects Overview
5. Transition to Adulthood
6. Autism Signs, Screening, and Assessments
7. Social Determinants of Health

LEND participants include advocates and graduate students from three universities: UAMS, the University of Arkansas at Little Rock, and the University of Central Arkansas. The LEND program has used collaborative partnerships to enhance outreach efforts by participating in other agencies' professional development activities to share information about the importance of Title V CSHCN Program's care coordination to support families in accessing needed care and preparing for transition.

The Title V CSHCN Program contracts with the Arkansas Disability Coalition to fund Project DOCC (Delivery of Chronic Care). Project DOCC is a requirement for pediatric residents during their training and includes a Grand Rounds panel presentation, a home visit, and a parent interview discussing the child's chronic illness history. Project DOCC trained 35 medical residents in 2022 through 105 encounters. Due to restrictions on in-person meetings, visits via Zoom and telephone were used to carry out Project DOCC activities. Parent comments about this collaboration included:

- “It is so refreshing that the pediatric residents want to hear our story. It makes me feel like the information we are sharing will impact their work in serving the needs of our children.”
- “The doctor was very engaged and asked many questions about social and medical issues.”
- “I had a great visit with the doctor. She had lots of questions and was very interactive. She stated that she has been looking forward to this part of her training.”
- “The doctor really wanted to know what resources families need. He knew a little about TEFRA but was unaware of insurance challenges/limitations families face.”
- “The doctor asked a lot of questions. She was interested in insurance, social activities, and transition.”
- “The residents and trainees were very interested in resources ranging from supportive services like respite to transition services.”
- “I did the Parent Interview with two doctors. They had great questions and different questions about how diversified Medicaid is and seemingly divided on treatment options and coverage. They are interested in how they can help families now and in the future.”

Pediatric residents’ comments about this collaboration included:

- “It can be hard to share so many details, but it was amazing to learn from the parent and it is a privilege to learn what a family goes through.”
- “Thank you for your family story! I loved learning about resources, in particular, respite.”
- “I loved hearing about your family! I learned so much and enjoyed the experience. The information is very valuable.”
- “We appreciate the parents for all that they do. It seems like they are good advocates for their kids. I am excited to work with families like this.”

The CSHCN Program’s contract with UAMS provides opportunities for the Title V CSHCN nurses to provide ongoing support to the communities in which they work by participating in diagnostic clinics in four regions of the state. Regional diagnostic clinics provide access to care for many CSHCN who otherwise would not have local access to pediatric specialists. Under the contract, the Title V CSHCN Program provides a nurse at each outreach clinic to ensure that each child is screened for Title V CSHCN services, including case management, at each quarterly clinic visit. Through participation in these regional diagnostic clinics, Title V nurses referred children to other appropriate services as well, which also supported families’ access to care. During the reporting period, some regional diagnostic clinics held in-person visits at facilities where social distancing was possible, but many operated through a blend of telemedicine and in-person visits. To support families in this virtual format, the Title V CSHCN Program mailed Title V application packets, a program overview brochure, and contact information for the CSHCN Program’s nurse affiliated with the clinic the family was scheduled to attend. Also, the Program’s nurse care coordinators contacted each family prior to the regional diagnostic clinic to help them prepare for their telemedicine appointment and to screen for Title V CSHCN services and to assess any gaps in services or care. The Program’s nurse care coordinators also contacted families after the visit if a child received a diagnosis to offer information, support, and access to care coordination. These efforts increased the number of CSHCN the Program serves.

In 2020, UAMS began hosting a statewide tele-education series, Connecting Across Professions (CAP), to provide live and recorded training and information to pediatric professionals about programs supporting children with developmental disabilities. The CAP tele-education series Learn on Demand ended in February 2022. By July 2022, all CAP lectures were uploaded to the Learn on Demand website and are available for professionals from a variety of fields to access “on demand.” Program information recorded in the Learn on Demand series supports referral sources across the state and across fields in making referrals to the Title V CSHCN program.

Building relationships with hospitals and clinicians ensures that these important referral sources know about the support available to CSHCN and their families. Outreach to medical professionals is not limited to sharing program information in professional development or conference settings. The Program's regional nurse care coordinators build working relationships with primary care physicians and area hospitals and clinics to support CSHCN and their families in accessing care. Physicians become aware of families' needs for services not covered under the Arkansas Medicaid state plan, such as respite, education, care coordination, or medically necessary services covered through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. These working relationships provide primary care physicians a go-to person in their community to whom they can reach out to for information or when they need assistance obtaining Medicaid services such as personal care and durable medical equipment for CSHCN clients. Title V CSHCN nurse care coordinators ensure that families have support to access needed care by assisting families in completing required documentation. Partnerships between the Title V CSHCN Program and medical professionals create a more well-functioning system that helps families access care.

Serving as a stakeholder representing the Title V CSHCN Program in the State's Infant Hearing Program's (IHP) advisory council meetings formed an effective working relationship with the IHP's Early Hearing Detection and Intervention (EHDI) program. Title V CSHCN staff collaborate with the EHDI program to identify ways to work together to better support children who are deaf or hard of hearing and their families and operate under a Memorandum of Agreement (MOA) between EDHI and the Title V CSHCN Program (revised September 2020). This collaborative work supports the Program's goal of increasing referrals of young children and children with disabilities and developmental delays and supports Arkansas' families in access to care. Collaboration in 2022 with IHP/EHDI included:

- Title V CSHCN Program staff participating in the IHP Learning Community and IHP Advisory Council. These monthly meetings provide an opportunity to identify existing family support services and to explore expansion of these services to promote access to care. The meetings provide an opportunity to share Program information and network with related programs that may serve as referral sources, such as Arkansas Hands and Voices and Children and Youth with Sensory Impairments (CAYSI) that serve as new sources of referrals.

- The updated MOA facilitated Interagency collaboration so that the Arkansas Department of Health (ADH) was able to send parent contact information from birthing hospitals for 97 infants who failed their newborn hearing screening to the Title V CSHCN Program in 2022. Title V staff training on details of the MOA and written protocols can support the work of the EHDI program by reaching out to these families to reduce the number lost-to-follow-up after birthing hospital discharge. The IHP also referred 48 infants with confirmed diagnosis of hearing loss to the CSHCN program in 2022. This collaboration supports families in accessing care and supports the CSHCN Program in increasing referrals of children under age three and children with developmental disabilities.

- Collaboration with the IHP included training Title V CSHCN Program staff on how to document support and services provided to these families in the ADH's Electronic Registration of Arkansas Vital Events (ERAVE) database.

The Program reviews data from the Social Security Administration (2022) which shows that 21,336 children under the age of 18 in Arkansas were SSI recipients. According to 2022 data from an Arkansas Integrated Eligibility System (ARIES) Medicaid report, 6,888 children under the age of 19 were recipients of Tax Equity and Fiscal Responsibility Ac (TEFRA) benefits. The number eligible for TEFRA benefits increased from 6,724 in the calendar year 2021 to 6,888 in 2022. Combining the data for SSI and TEFRA recipients, approximately 28,224 children in Arkansas were categorized as being in a Medicaid disability category. A Therap report indicates that the total number of Title XIX (SSI and TEFRA)

recipients served by the Title V CSHCN in 2022 was 400 which represents 1.4% of children with disabilities in the state. Having this baseline data supports the Program in measuring its effectiveness at reaching program goals of serving more children and families.

An analysis of Program data (2022) sorted by child's age indicates that the program predominantly serves CSHCN who are 5-12 years old (50.6% of current clients), followed by children 3-5 years old (26.9%), followed by CSHCN 12-18 years old (13.7%), with only 8.8% of children currently receiving case management services under age 3. The percentage of children served under age 3 has increased slightly from 8.1% in 2021, indicating that strategies to work more closely with the State's Part C Early Intervention program and MIECHV home visiting programs to increase referrals appear to be effective.

After Lead Agency infrastructure changes that put the Title V CSHCN Program and the state's Part C early intervention program (First Connections) under the same leadership and direction, collaboration between the two programs has been streamlined. As a result, some Title V CSHCN staff members have taken an active role in learning more about the early intervention program and networking with representatives of related agencies by attending quarterly meetings of the Arkansas Interagency Coordinating Council (AICC). The AICC is the advisory council to the state's Part C Program. First Connections now requires regional service coordinators to refer all children with an active IFSP to the CSHCN regional care coordinator serving the area. This strategy is expected to increase referrals of young children under age 3.

The partnership with First Connections resulted in an opportunity for the Title V CSHCN Program to be included on the roster of lecturers for the pediatric residents on rotation at the James L. Dennis Developmental Center at Arkansas' Children's Hospital. The training enables future pediatric professionals to be aware of the Title V CSHCN Program, supports and services the program offers, who and how to refer a child, and why planning for transition is important. Comparison of pre- and post-test scores of pediatric residents trained by Title V staff in 2022 demonstrated a 36.5% increase in knowledge. The monthly lecture also provides program handouts and the opportunity for pediatric residents to ask questions about the program and services provided so that these professionals can make referrals to the program to increase families' access to care. James L. Dennis Developmental center provided autism-specific evaluation and diagnosis to 185 children between January and June of 2022 and referred man of these families to the Title V CSHCN program for support because of this collaboration.

Additional collaboration with First Connections to increase referrals of children 0-5 included partnering with the early intervention program and the State's MIECHV Home Visiting Network of Programs, Part B-619, Family 2 Family, and Early Head Start/Head Start for the 0-5 Community Partnership Initiative. The Initiative's goals are to improve outcomes for young children by supporting parents in knowing their rights, knowing how to advocate for their child and family, and knowing how to promote their child's health and early learning. Monthly Initiative meetings in 2022 built effective work relationships between program administrators of the multiple participating programs and among in-the-field workers to support working together in new ways to ensure that families can access care in the 2 rural counties of the pilot (Crittenden and Van Buren counties). In monthly meetings, in-the-field staff from all programs report high-level collaborations such as joint home visits (or virtual meetings with families to streamline processes and support families in developing individualized plans and accessing services, and planning transition to preschool services when early intervention ends at age 3 or to kindergarten at age 5). Also reported are mid-level collaboration such as (with parent consent) record sharing and staff from programs in which a child is jointly enrolled reviewing records or evaluation results together for the purpose of planning and/or making referrals that support the family in accessing care. A result of this collaboration has been the inclusion of CSHCN nurse care coordinators (with parent consent) being included on families' Individualized Family Service Plan (IFSP birth to 3) and Individualized Education Plan (IEP 3-graduation) teams.

A related and similar 0-3 Initiative between one MIECHV-funded Home Visiting Program, Following Baby Back Home (FBBH), First Connections, and the Title V CSHCN Program has scaled up from an 8-county pilot to Statewide. The 0-3 Community Partnership Initiative also has monthly team meetings. Teams are the in-the-field staff from all three partner programs in the various geographic regions of the State. All Title V CSHCN Program nurse care coordinators attend the monthly team meetings to share updates on implementation of strategies that support families in accessing care, knowing how to promote their child's health and early learning, and supporting smooth transitions to programs and services for preschool aged children 3-5. FBBH and First Connections staff make referrals to Title V CSHCN to support parents of 3-year-olds in transitioning to preschool or other appropriate services for children when Home Visiting and early intervention ends. The collaboration across programs ensures that young children access needed services to support health and early learning.

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III.E.2.c. State Action Plan Narrative by Domain

CSHCN Health 2024 Application Year Plan

Title V Children with Special Health Care Needs Program staff examined the Arkansas MCH Evidence Center's 2021 report as part of the state's 2024 Application Year planning process. The analysis assists agency staff in determining the impact of the program's efforts on children and families. The 2024 Application Year reflects needs identified in the Annual Needs Assessment update for CSHCN and their families with no new identified priorities.

Priority Need- Transition to Adulthood

As previously indicated, Arkansas established desired result in this priority need area is to increase the percentage of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transition to adult health care to 22% by December 31, 2025. The 2020-2021 National Survey of Children's Health indicates that 20.5% of CSHCN in Arkansas received health care transition (HCT) support, an increase from 14.6% in 2019-2020.

Health Care Transition evidence demonstrates that use of a structured and planned process improves the health of CYSHCN as well as their experience and the health care received. Evidence-based strategies will support the program's work in increasing the percentage of adolescents with and without special health care needs, ages 12 through 17, who receive services necessary to make transitions to adult health care (NPM 12). Program strategies for CSHCN in this priority area involve preparing youth ages 12-17 and their families for health care transition through the following:

- Providing outreach and training to key stakeholders and referral sources so that they understand health care transition supports provided by Title V CSHCN
- Ensuring the program's Care Coordinators use the Six Core Elements of Health Care Transition as a foundation for care coordination to prepare youth and their families for health care transition.
- Developing transition plans with family and youth that are updated annually with goals for their age according to the Title V Health Care Transition Protocol
- Conducting Quality Improvement (CQI) annual audits aligned with the Title V HCT Protocol to determine services and supports the Title V CSHCN Program provided to youth and their families like a copy of the Title V Health Care Protocol, timelines for youth and families, life course decision making supports, and health care transition care plans.
- Collaborating with pediatric health care practices to support their practices in implementing a planned and structured approach for health care transition using the Six Core Elements of Health Care Transition, especially the elements of transition readiness (Family Practice) and transition and care policy/guide (Pediatricians)
- Planning with Arkansas Medicaid methods of ensuring CSHCN ages 12-17 receive structured and planned health care transition supports and services.
- Partnering with school-based health professionals to prepare youth with and without special health care needs for health care transition.

Priority Need: Access to Care

In this priority area, Arkansas's desired outcome is to increase the percentage of families of CSHCN who report that their child received the health care services they needed to 17% by December 31, 2025. Data from the 2020-2021 National Survey of Children's Health for National Outcome Measure 17.2 demonstrates that 14.8% of children with special health care needs (CSHCN) ages 0 through 17 receive care in a well-functioning system, a decrease from 16.1% in 2019-2020. Arkansas CSHCN Program will implement practices and evidence-based strategies to support CSHCN and their families in accessing needed support and services through the following:

- Increasing the number of active care coordination plans through collaboration with referral sources to increase referrals to the Title V CSHCN program for children with special health care needs so that the program's care coordination may assist families in accessing care.
- Ensuring Title V CSHCN Care Coordinators conduct the Title V Needs Assessment to assist the family in

identifying needed supports and services as a part of care coordination.

- Making referrals to services and supports to enhance families' abilities to reach identified goals for their child.
- Partnering with parent organizations to provide parents with family support and information from the Parent Training Information Center (Center for Exceptional Families), Family 2 Family, and the Parent Advisory Council.

Cross-Cutting/Systems Building

State Performance Measures

SPM 4 - Percent of Family Health Branch, Arkansas Home Visiting Program, and Title V CSHCN staff who complete an equity training

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			50	90
Annual Indicator			89.2	57.8
Numerator			33	100
Denominator			37	173
Data Source			Program reports	Program reports
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	91.0	92.0	93.0

State Action Plan Table

State Action Plan Table (Arkansas) - Cross-Cutting/Systems Building - Entry 1
Priority Need
Access to Care
SPM
SPM 4 - Percent of Family Health Branch, Arkansas Home Visiting Program, and Title V CSHCN staff who complete an equity training
Objectives
1. By December 31, 2025, increase the percent of Family Health Branch, Arkansas Home Visiting Program, and Title V CSHCN staff who have completed an equity training to 93%.
Strategies
1. Educate maternal and child health staff on the existence, influences, and consequences of biases in healthcare.
2. Share training evaluation results with ADH leadership for potentially expanding the training to other parts of the agency and the state.
3. Incorporate results of the staff training evaluation into current program activities.

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III.E.2.c. State Action Plan Narrative by Domain

Cross-Cutting/Systems Building Annual Report

CSHCN:

Priority Need: Access to Care

SPM 4: Percent of Family Health Branch, Arkansas Home Visiting Program, and Title V CSHCN staff who complete an equity training.

Objective: By December 31, 2025, increase the percent of Family Health Branch, Arkansas Home Visiting Program, and Title V CSHCN staff who have completed an equity training to 93%.

Strategy 1: Educate maternal and child health staff on the existence, influences, and consequences of biases in healthcare.

Title V CSHCN Community-based Nurses, Area Managers, Parent Consultant, and Nurse Manager had increased opportunities for equity training in 2022. Thirteen out of 14 Title V CSHCN Staff completed at least one equity training which is 92.9% of Title V CSHCN program staff. The one out of 14 staff not meeting this requirement is a CSHCN nurse who resigned in the first quarter of 2022. Title V CSHCN staff completed a variety of equity trainings including the following topics/courses:

- A Massachusetts Roadmap for Family Engagement through a Racial Equity Lens - 2022
- Let me Tell You About my Amazing Child! Using CYSHCN Data at the Association of Maternal Child Health Programs (AMCHP) Conference 2022 - Equity and Access Track for Children and Youth with Special Health Needs
- Integrating the Charting the Lifecourse into MCH Health Workers Support of Children and Families to Support a Well-Functioning Healthcare System at the AMCHP Conference 2022 - Equity and Access Track
- Global Ideas for Local Challenges: A Learning Network to Advance Health Equity at the AMCHP Conference 2022
- CYSHCN Program Strategies for Addressing Family Financial Hardship at the AMCHP Conference 2022
- Access and Equity in Asthma Care - Peds Place
- Creating Partnerships to Ensure Access and Equity for Students with Disabilities International Health Care Transition Conference
- Diverse Family Leadership- Hands and Voices
- Diversity Training- Partners for Inclusive Communities
- Embedding Equity-focused Family & Parent Leadership- Pritzker Children's Initiative, National Center for Family & Parent Leaderships, Early Childhood Investment Corporation (ECIC)
- Embedding Equity-focused Family and Parent Leadership – National Center for Family and Parent Leadership
- From Awareness to Answers-National Institute for Children's Health Quality (NICHQ)
- Hasten Internal Program Changes to Support Equity Centered Title V Services- Session 1 of 3 of Technical Assistance Partnership Meeting
- Georgia Framework to Address Health Equity- Special Projects and Areas of Focus, Ways to Operationalize MCH Objectives and Strategies- Session 3 of 3 of Technical Assistance Partnership Meeting
- Health Disparities Structures Social Determinants
- Health Equity Landscape-National Institute for Children's Health Quality (NICHQ)

- Health Equity- Start Where You Are- National Institute for Children's Health Quality (NICHQ)
- Health Systems Moving the Needle of Health Equity- National Institute for Children's Health Quality (NICHQ)
- Marshallese History and Culture - Marshallese Education Initiative- University of AR at Fayetteville
- Marshallese History and Culture: A Virtual Training Webinar for Disability Service Providers
- Marshallese History and Culture: A Virtual Training Webinar for Disability Service Providers Assistive Technology 101 UAMS
- Marshallese Training- Partner's for Inclusive Communities
- Meeting the Care Needs of CYSHCN and Their Families: Implementation of Equitable Care Coordination
- Meeting the Care Needs of CYSHCN and Their Families: Implementation of Equitable Care Coordination Part 2
- Pursing Equity at the Intersection of Disability
- Pursuing Equity at the Intersection of Language, Culture and Disability – Foundational Session
- Pursuing Equity at the Intersection of Language, Culture and Disability- Data Literacy- National Center for Systemic Improvement
- Pursuing Equity at the Intersection of Language, Culture and Disability Thought Leader Conversation (TLC) Series- Session 1: Foundational Session
- Racial Equity- AR Kids Count Coalition
- Respite in Underserved Populations- Family Bistro
- Social Determinants of Health- LEND
- Stressors of Inequity in Maternal Mental Health- GOT Webinar
- Title V CHC Program: Equitable Access Part 1
- Title V CHC Program: Equitable Access Part 2
- What is Privilege? And What is Allyship- UTUBE Videos for Technical Assistance Partnership Meeting (Approaches to Addressing Systems Challenges in MCH)

Strategy 2: Share training evaluation results with ADH leadership for potentially expanding the training to other parts of the agency and the state.

The Title V Children with Chronic Health Conditions (CHC) Program: Equitable Access Part I and II were presented and facilitated by a DDS Trainer using the National Center for Family and Parent Leadership's Equitable Intervention Framework of accessibility, safety, and utility. Eighteen out of 19 Title V CSHCN and Arkansas Department of Health staff invited attended Part 1. Fifteen out of 22 invited participated in Part II.

To engage staff in their learning throughout Part I and Part II, those in attendance posted ideas, thoughts, and questions for consideration (anonymously) on IdeaBoardz. Open ended and thought-provoking questions to explore program processes through an equity lens included questions such as, "how might some populations perceive your program's letters, applications, web site, and informational brochures?" Participants could also interact with each other's ideas by voting for the ideas they found most relevant. Participant's answers to this question included:

- I don't think it looks very professional to have to make photocopies of brochures and information (4 votes)
- Letters are unclear about what the program is/does and don't include useful this information for families (4 votes)
- Some parents get confused and think that the CES [Community Employment Supports] waiver paperwork is the CHC [Children with Chronic Health Conditions] paperwork and don't realize it is two different programs (2 votes)
- Not user friendly, letters are not clear because they don't give good examples of how we can help children and families (2 votes)
- Not friendly look/tone (1 vote)

- Application and paperwork is too bulky and complicated, most parents are overwhelmed with all the applications they are receiving and completed application return rate is lower than desired (1 vote)

Strategy 3: Incorporate results of the staff training evaluation into current program activities.

An unexpected result of attending Equity Access training was the identification of a need to realign ethnicity and race questions on the program's application with Federal ethnicity and race categories. The ethnicity of the child will be asked first followed by race to accurately represent ethnicity and race as two distinct categories in future block grant reports.

The Title V CSHCN program applied the information gathered from the IdeaBoardz used in the Equitable Access training to make letters and program information more family-friendly and clear. To address concerns that the application itself could be a barrier to accessing services for some populations, the program formed a work group to streamline the application. The "Choppers" work group began by gathering all the components of the current application packet and comparing each part to State and Federal program requirements to eliminate anything that is non-essential and to assess the information requested of parents/guardians in applying for Title V CSHCN. The intended result is a more streamlined and user friendly, "uncomplicated" application that does not create a barrier to accessing services and support. When an updated program application is approved, the application will be translated into Spanish as State demographics indicate a relatively large Spanish-speaking population in the State.

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III.E.2.c. State Action Plan Narrative by Domain

Cross-Cutting/Systems Building Application Year

N/A

III.F. Public Input

III.F. Public Input

ADH seeks ongoing input on priorities and program activities. This is accomplished through annual domain lead meetings with partners and stakeholders and soliciting public comment for 30 days at the end of each fiscal year.

Beginning July 1, 2023, the Title V MCH Executive Summary for the 2022 Annual Report and the 2024 Application was made available to the public via the ADH MCH website. In addition, an email was sent to various partners and stakeholders statewide (organizations, councils, associations, i.e.). Below is a sample list of partners and stakeholders.

- Arkansas Chapter of the American Academy of Pediatrics
- Arkansas Chapter of the American Academy of Family Physicians
- Arkansas Children's Hospital
- Arkansas Department of Education
- Arkansas Department of Human Services
- Arkansas Foundation for Medical Care
- University of Arkansas for Medical Sciences
- Arkansas School for the Deaf
- Arkansas State University
- Arkansas Hands & Voices
- Baptist Health
- Arkansas Department of Disability Services
- Arkansas Autism Resource & Outreach Center
- Arkansas Down Syndrome Association
- Arkansas Autism Foundation

The email sent to stakeholders contained information about how to access the public comment website and a pdf copy of the Executive Summary.

The website content shared includes a hyperlink to a secure portal for submitting comments to an embedded email address (https://www.healthy.arkansas.gov/programs-services/topics/needs-assessment-applications).

All questions will be forwarded to the State MCH Project Director. Relevant questions and/or comments will be reviewed by the State MCH Project Director and the domain leads. A response will be drafted and included in the grant application under Section: III.F. Public Input.

The End

No comments were received regarding the Title V MCH Block Grant.

III.G. Technical Assistance

III.G. Technical Assistance

Technical assistance is not requested at this time.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - IV. Title V Medicaid IAA-MOU.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - MCH Supporting Documents.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - Organizational Charts.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Arkansas

	FY 24 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 7,136,666	
A. Preventive and Primary Care for Children	$ 3,872,285	(54.2%)
B. Children with Special Health Care Needs	$ 2,236,632	(31.3%)
C. Title V Administrative Costs	$ 414,160	(5.9%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 6,523,077	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 4,722,429	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 603,629	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 12,424,008	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 17,750,066	
A. Your State's FY 1989 Maintenance of Effort Amount $ 5,797,136		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 24,886,732	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 16,363,473	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 41,250,205	

OTHER FEDERAL FUNDS	FY 24 Application Budgeted
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 160,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) American Rescue Plan (ARP)	$ 1,884,779
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Innovation Grants	$ 1,999,754
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 7,498,042
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 4,026,880
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 235,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000
Department of Health and Human Services (DHHS) > Other > Children's Trust Fund	$ 369,796
US Department of Education > Other > School health Services	$ 89,222

	FY 22 Annual Report Budgeted		FY 22 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 6,961,610 (FY 22 Federal Award: $ 7,136,666)		$ 7,136,666	
A. Preventive and Primary Care for Children	$ 3,674,422	(52.8%)	$ 3,827,528	(53.6%)
B. Children with Special Health Care Needs	$ 2,181,769	(31.3%)	$ 2,236,632	(31.3%)
C. Title V Administrative Costs	$ 448,328	(6.4%)	$ 411,673	(5.8%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 6,304,519		$ 6,475,833	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 4,785,791		$ 4,042,597	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 603,629		$ 482,506	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 15,681,851		$ 12,994,345	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 21,071,271		$ 17,519,448	
A. Your State's FY 1989 Maintenance of Effort Amount $ 5,797,136				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 28,032,881		$ 24,656,114	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 13,826,992		$ 12,466,369	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 41,859,873		$ 37,122,483	

OTHER FEDERAL FUNDS	FY 22 Annual Report Budgeted	FY 22 Annual Report Expended
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 227,559	$ 138,475
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 7,496,732	$ 6,995,984
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 258,310	$ 203,358
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 5,385,000	$ 4,767,533
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000	$ 100,000
US Department of Education > Other > School Health Services	$ 70,906	$ 65,915
Department of Health and Human Services (DHHS) > Other > Children's Trust Fund	$ 288,485	$ 195,104

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**
	Field Note: Part of the funds budgeted was spent in another budget period.	
2.	**Field Name:**	**5. OTHER FUNDS**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**
	Field Note: There were two vacant positions.	
3.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**
	Field Note: There were several vacant positions. In addition, part of funds budgeted was spent in another budget period.	

Data Alerts: None

Form 3a
Budget and Expenditure Details by Types of Individuals Served

State: Arkansas

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 24 Application Budgeted	FY 22 Annual Report Expended
1. Pregnant Women	$ 613,589	$ 660,833
2. Infants < 1 year	$ 619,566	$ 612,404
3. Children 1 through 21 Years	$ 3,252,719	$ 3,215,124
4. CSHCN	$ 2,236,632	$ 2,236,632
5. All Others	$ 0	$ 0
Federal Total of Individuals Served	$ 6,722,506	$ 6,724,993

IB. Non-Federal MCH Block Grant	FY 24 Application Budgeted	FY 22 Annual Report Expended
1. Pregnant Women	$ 973,909	$ 546,391
2. Infants < 1 year	$ 5,603,104	$ 3,423,695
3. Children 1 through 21 Years	$ 2,286,381	$ 2,923,046
4. CSHCN	$ 2,379,279	$ 2,306,876
5. All Others	$ 6,507,393	$ 8,319,439
Non-Federal Total of Individuals Served	$ 17,750,066	$ 17,519,447
Federal State MCH Block Grant Partnership Total	$ 24,472,572	$ 24,244,440

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

1.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1 through 21 years**
	Fiscal Year:	**2024**
	Column Name:	**Application Budgeted**
	Field Note: The amount on Line 1A on Form 2 is comprised of Infants<1 year and Children 1 through 21 years.	
2.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1 through 21 years**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**
	Field Note: The amount on Line 1A on Form 2 is comprised of Infants<1 year and Children 1 through 21 years.	

Data Alerts:

- Children 1 through 21 Years, Application Budgeted does not equal Form 2, Line 1A, Preventive and Primary Care for Children Application Budgeted. A field-level note indicating the reason for the discrepancy was provided.
- Children 1 through 21 Years, Annual Report Expended does not equal Form 2, Line 1A, Preventive and Primary Care for Children, Annual Report Expended. A field - level note indicating the reason for the discrepancy was provided.

Form 3b
Budget and Expenditure Details by Types of Services

State: Arkansas

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 24 Application Budgeted	FY 22 Annual Report Expended
1. Direct Services	$ 397,832	$ 329,452
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 397,832	$ 329,452
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 0	$ 0
2. Enabling Services	$ 6,092,011	$ 6,171,128
3. Public Health Services and Systems	$ 646,823	$ 636,086
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 15,935
Physician/Office Services		$ 192,620
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 87,953
Laboratory Services		$ 0
Other		
Other		$ 32,944
Direct Services Line 4 Expended Total		$ 329,452
Federal Total	$ 7,136,666	$ 7,136,666

IIB. Non-Federal MCH Block Grant	FY 24 Application Budgeted	FY 22 Annual Report Expended
1. Direct Services	$ 1,178,440	$ 1,097,374
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 1,178,440	$ 1,097,374
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 0	$ 0
2. Enabling Services	$ 15,967,997	$ 15,939,568
3. Public Health Services and Systems	$ 603,629	$ 482,506
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 266,898
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 647,771
Laboratory Services		$ 0
Other		
other		$ 182,705
Direct Services Line 4 Expended Total		$ 1,097,374
Non-Federal Total	$ 17,750,066	$ 17,519,448

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

None

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: Arkansas

Total Births by Occurrence: 34,567 **Data Source Year: 2022**

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Valid Screen	(B) Aggregate Total Number of Out-of-Range Results	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	33,227 (96.1%)	7,406	97	97 (100.0%)

Program Name(s)				
3-Hydroxy-3-Methyglutaric Aciduria	3-Methylcrotonyl-Coa Carboxylase Deficiency	Argininosuccinic Aciduria	Biotinidase Deficiency	Carnitine Uptake Defect/Carnitine Transport Defect
Citrullinemia, Type I	Classic Galactosemia	Classic Phenylketonuria	Congenital Adrenal Hyperplasia	Critical Congenital Heart Disease
Cystic Fibrosis	Glutaric Acidemia Type I	Glycogen Storage Disease Type II (Pompe)	Hearing Loss	Holocarboxylase Synthase Deficiency
Homocystinuria	Isovaleric Acidemia	Long-Chain L-3 Hydroxyacyl-Coa Dehydrogenase Deficiency	Maple Syrup Urine Disease	Medium-Chain Acyl-Coa Dehydrogenase Deficiency
Methylmalonic Acidemia (Cobalamin Disorders)	Methylmalonic Acidemia (Methylmalonyl-Coa Mutase)	Mucopolysaccharidosis Type I (MPS I)	Primary Congenital Hypothyroidism	Propionic Acidemia
S, ßeta-Thalassemia	S,C Disease	S,S Disease (Sickle Cell Anemia)	Severe Combined Immunodeficiences	Spinal Muscular Atrophy Due To Homozygous Deletion Of Exon 7 In SMN1
ß-Ketothiolase Deficiency	Trifunctional Protein Deficiency	Tyrosinemia, Type I	Very Long-Chain Acyl-Coa Dehydrogenase Deficiency	X-Linked Adrenoleukodystrophy

2. Other Newborn Screening Tests

None

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

The Health Department collects data on infants with positive newborn screening results each year for five years to determine health care maintenance and health status, especially the presence of mental retardation or permanent disability. The Department has established protocols for follow-up of all screened disorders in collaboration with medical specialists under contract at the Arkansas Children's Hospital. For infants with abnormal test results, the physician will be notified of the results and informed of the recommended protocols for follow-up of the specific disorder. The Infant Hearing Program works to support families with children up to 3 years of age who are at risk or identified as Deaf/Hard of Hearing (DHH) receive appropriate and timely services. The Follow-up Coordinator monitors program data to identify children at risk for becoming loss to follow-up and initiates follow-up actions with those families. (continued in Form 4 notes)

Form Notes for Form 4:

Newborn Section:
Critical congenital heart disease (CCHD) screening and hearing screening are performed at the hospital. Glycogen Storage Disease Type II (Pompe) and Mucopolysaccharidosis Type 1 (MPS-1) were added to the test panel on 3/27/23. At this time, the Newborn Screening Program does not screen for GAMT deficiency and MPS II. The new ACT490 / HB1102 states “testing for newly added core medical conditions to the RUSP shall begin within thirty-six (36) months upon introduction to the RUSP. The program is working to update the Arkansas State Board of Health Arkansas Department of Health rules pertaining to testing of newborn infants.

Long-Term Follow-Up Section:
(continued) Additionally, the Follow-up Coordinator completes case management for all DHH children to include: referral to early intervention services and enrollment in family support programs with an opportunity to connect with a DHH adult. The program continues efforts to strengthen capacity to engage families with DHH children throughout the EHDI system to reduce delays in language acquisition for these children.

Field Level Notes for Form 4:

1.	**Field Name:**	**Total Births by Occurrence**
	Fiscal Year:	**2022**
	Column Name:	**Total Births by Occurrence Notes**
	Field Note: CY2022 data are provisional and subject to change.	

Data Alerts: None

Form 5
Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V

State: Arkansas

Annual Report Year 2022

Form 5a – Count of Individuals Served by Title V (Direct & Enabling Services Only)

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	1,265	40.0	0.0	56.0	4.0	0.0
2. Infants < 1 Year of Age	34,006	40.0	0.0	56.0	4.0	0.0
3. Children 1 through 21 Years of Age	139,524	48.0	0.0	45.0	0.0	7.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	917	97.1	0.4	2.0	0.5	0.0
4. Others	98,992	19.0	0.0	71.0	10.0	0.0
Total	273,787					

Form 5b – Total Percentage of Populations Served by Title V (Direct, Enabling, and Public Health Services and Systems)

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	35,965	No	35,358	89.2	31,539	1,265
2. Infants < 1 Year of Age	35,120	No	34,567	98.4	34,014	34,006
3. Children 1 through 21 Years of Age	827,750	Yes	827,750	69.6	576,114	139,524
3a. Children with Special Health Care Needs 0 through 21 years of age^	203,543	Yes	203,543	69.6	141,666	917
4. Others	2,163,421	Yes	2,163,421	4.6	99,517	98,992

^Represents a subset of all infants and children.

Form Notes for Form 5:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2022**
	Field Note: Pregnant women served is the unduplicated count of women receiving maternity services at ADH local health units. Data Source: ADH electronic health records. Insurance Source: National Vital Statistics System, 2021	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2022**
	Field Note: Infants < 1 Year of Age is the unduplicated count of infants receiving an initial hearing screening through the ADH Infant Hearing Program. The IHP monitors every infant hearing test, links to birth certificates, and conducts follow-up on missing hearing tests results. Those who don't pass are alerted regarding follow-up. Title V funds salary for the follow-up nurse coordinator. Data Source: ADH Infant Hearing Program (previously used Newborn Screening Program data). Insurance Source: National Vital Statistics System, 2021	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2022**
	Field Note: Total children 1-21 years of age served is the sum of children served through family planning, immunizations, and WIC. Insurance Source: American Community Survey - Children 1-21, 2021. * WIC = 59,358 * ADH flu vaccinations = 69,313 * Family planning = 10,853	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2022**

	Field Note: Total CSHCN number served is up from 821 in calendar year 2021 to 917 . Total Title V Served (A) includes: CMS Status X (Case Management, up to the age of 21); CMS Status A (Active with private health insurance, not Medicaid eligible, up to the age of 18), CMS Status K (ARKids B, Arkansas's Children's Health Insurance Program or CHIP, coverage up to the age of 18); and CMS Status Pending with Medicaid= No. Title XIX (B) is impacted by CSHCN being enrolled in a Provider-led Arkansas Shared Savings Entity (PASSE). PASSE is an organized care delivery model for the highest need behavioral health and developmental disability populations. CMS Status X decreased at a slower rate than in 2021 due to CSHCN being enrolled in a PASSE for case management. Title XXI (C) covers eligible gap filling services. Private/Other (D) includes CSHCN with gross monthly household incomes that are under 350% of the Federal Poverty Level. None (E) represents CSHCN without Medicaid or private health insurance. The Title V CSHCN Program will extend the reach of the program with continued outreach efforts to physicians, Part C and Part B programs under IDEA, schools, MIECHV Home Visiting programs, parents, and other stakeholders.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2022**
	Field Note: Total Others served is the sum of persons ages 22 and older served in family planning, WIC, and flu vaccinations. Insurance Source: American Community Survey - Others 22+, 2021. * Family planning = 23,891 * WIC = 24,918 * ADH flu vaccinations = 50,183 Data Source: ADH Immunizations Program Insurance Source: American Community Survey - Others 22+, 2021	

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women Total % Served**
	Fiscal Year:	**2022**
	Field Note: Numerator: Number of Arkansas resident live births delivered in an Arkansas Perinatal Regionalization-participation birthing hospital, CY2022 (31,555). Source: Arkansas resident live birth records, CY2022	
2.	**Field Name:**	**Pregnant Women Denominator**
	Fiscal Year:	**2022**
	Field Note: Data Source: Arkansas live birth records – Resident Live Births, 2022	
3.	**Field Name:**	**Infants Less Than One Year Total % Served**
	Fiscal Year:	**2022**

	Field Note: Numerator: Number of Arkansas infants receiving a hearing screening, CY2022 (34,006) Source: Arkansas Infant Hearing Program, CY2022	
4.	**Field Name:**	**Infants Less Than One Year Denominator**
	Fiscal Year:	**2022**
	Field Note: Data Source: Arkansas live birth records – Occurrent Live Births, 2022	
5.	**Field Name:**	**Children 1 through 21 Years of Age Total % Served**
	Fiscal Year:	**2022**
	Field Note: Denominator: US Census Bureau Population Estimates, 2021 Numerator: Persons participating in the following age groups (CY2022). To reduce duplication, the numerator is examined by age group and selected programs with the highest reach. Ages 1-5 = Children ages 1-5 participating in WIC (52,581), flu vaccinations (16,503) Ages 6-17 = 2022-2023 school enrollment (i.e., school-based health centers, 476,579) Ages 18-21 = Persons ages 18-21 years participating in flu vaccinations (13,202), family planning (10,853), and WIC (6,087)	
6.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age Total % Served**
	Fiscal Year:	**2022**
	Field Note: Denominator: National Survey of Children's Health CSHCN Prevalence Estimates 0-17 (2020-2021) multiplied by US Census Bureau Population Estimates 1-21, 2021. The Total % Served assumes that activities addressing the non-CSHCN population will also address CSHCN population are similar rates.	
7.	**Field Name:**	**Others Total % Served**
	Fiscal Year:	**2022**
	Field Note: Denominator: US Census Bureau Population Estimates, 2021. Numerator: Persons ages 22 years and older participating in flu vaccinations (50,183), family planning (23,891), and WIC (24,918).	

Data Alerts:

1.	Infants Less Than One Year, Form 5a Count is greater than or equal to 90% of the Form 5b Count (calculated). Please check that population based services have been included in the 5b Count and not in the 5a Count.
2.	Others, Form 5a Count is greater than or equal to 90% of the Form 5b Count (calculated). Please check that population based services have been included in the 5b Count and not in the 5a Count.

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Arkansas

Annual Report Year 2022

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non-Hispanic White	(C) Non-Hispanic Black or African American	(D) Hispanic	(E) Non-Hispanic American Indian or Native Alaskan	(F) Non-Hispanic Asian	(G) Non-Hispanic Native Hawaiian or Other Pacific Islander	(H) Non-Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	34,567	21,976	5,604	4,080	285	693	491	716	722
Title V Served	33,530	21,317	5,436	3,958	276	672	476	695	700
Eligible for Title XIX	21,460	11,779	4,612	3,182	219	244	409	417	598
2. Total Infants in State	35,358	22,190	6,183	4,208	192	692	461	718	714
Title V Served	34,297	21,524	5,998	4,082	186	671	447	696	693
Eligible for Title XIX	21,966	11,827	5,095	3,278	139	240	384	409	594

Form Notes for Form 6:

None

Field Level Notes for Form 6:

None

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Arkansas

A. State MCH Toll-Free Telephone Lines	2024 Application Year	2022 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 235-0002	(800) 235-0002
2. State MCH Toll-Free "Hotline" Name	Arkansas Resource and Health Information	Arkansas Resource and Health Information
3. Name of Contact Person for State MCH "Hotline"	Kimberly Smith	Kimberly Smith
4. Contact Person's Telephone Number	(501) 661-2480	(501) 661-2480
5. Number of Calls Received on the State MCH "Hotline"		357

B. Other Appropriate Methods	2024 Application Year	2022 Annual Report Year
1. Other Toll-Free "Hotline" Names		
2. Number of Calls on Other Toll-Free "Hotlines"		
3. State Title V Program Website Address	www.healthy.arkansas.gov	www.healthy.arkansas.gov
4. Number of Hits to the State Title V Program Website		0
5. State Title V Social Media Websites		
6. Number of Hits to the State Title V Program Social Media Websites		

Form Notes for Form 7:

None

Form 8
State MCH and CSHCN Directors Contact Information

State: Arkansas

1. Title V Maternal and Child Health (MCH) Director	
Name	Dr. Hattie Scribner
Title	Family Health Branch Chief
Address 1	4815 West Markham St. Slot #16
Address 2	
City/State/Zip	Little Rock / AR / 72205
Telephone	(501) 661-2495
Extension	
Email	Hattie.Scribner@arkansas.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Tracy Turner
Title	Arkansas Part C Coordinator/CHC Program Director
Address 1	P.O. Box 1437 - Slot N504
Address 2	
City/State/Zip	Little Rock / AR / 72201
Telephone	(501) 682-8703
Extension	
Email	Tracy.Turner@dhs.arkansas.gov

3. State Family Leader (Optional)	
Name	Rodney Farley
Title	Parent Consultant of Division of Developmental Disabilities Services
Address 1	P.O. Box 1437 - Slot S380
Address 2	
City/State/Zip	Little Rock / AR / 72201
Telephone	(501) 662-1461
Extension	
Email	Rodney.Farley@dhs.arkansas.gov

4. State Youth Leader (Optional)	
Name	
Title	
Address 1	
Address 2	
City/State/Zip	
Telephone	
Extension	
Email	

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Arkansas

Application Year 2024

No.	Priority Need
1.	Obesity
2.	Access to Care
3.	Oral Health
4.	Developmental, Behavioral and Mental Health of Children
5.	Child Safety Due to Intentional Injury
6.	Transition to Adulthood
7.	Persistently High Infant Mortality Rate
8.	Well Woman Care

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 9 State Priorities – Needs Assessment Year – Application Year 2021

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Obesity	Continued
2.	Access to Care	Continued
3.	Oral Health	Continued
4.	Developmental, Behavioral and Mental Health of Children	Continued
5.	Child Safety Due to Intentional Injury	Continued
6.	Transition to Adulthood	Revised
7.	Persistently High Infant Mortality Rate	Continued
8.	Well Woman Care	Continued

Form 10
National Outcome Measures (NOMs)

State: Arkansas

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

None

NOM 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	71.6 %	0.2 %	25,481	35,602
2020	71.4 %	0.2 %	24,910	34,904
2019	71.9 %	0.2 %	26,006	36,183
2018	70.6 %	0.2 %	25,828	36,581
2017	70.2 %	0.2 %	24,901	35,447
2016	68.4 %	0.3 %	23,106	33,803
2015	67.7 %	0.3 %	22,728	33,584
2014	65.7 %	0.3 %	21,663	32,978

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 1 - Notes:

None

Data Alerts: None

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2020	67.8	4.5	231	34,072
2019	58.6	4.1	207	35,310
2018	69.8	4.5	247	35,370
2017	57.1	4.0	209	36,583
2016	63.4	4.1	236	37,243
2015	58.8	4.6	162	27,556
2014	56.8	3.9	209	36,767
2013	57.6	4.0	209	36,305
2012	49.5	3.7	184	37,172
2011	53.9	3.8	203	37,682
2010	56.6	3.9	213	37,629
2009	57.8	3.9	224	38,785
2008	51.4	3.6	203	39,527

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 2 - Notes:

None

Data Alerts: None

NOM 3 - Maternal mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2021	40.6	4.7	74	182,318
2016_2020	34.1	4.3	63	184,627
2015_2019	30.8	4.1	58	188,262
2014_2018	32.6	4.1	62	190,209

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 3 - Notes:

None

Data Alerts: None

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2021	9.5 %	0.2 %	3,422	35,929
2020	9.6 %	0.2 %	3,388	35,223
2019	9.2 %	0.2 %	3,380	36,544
2018	9.4 %	0.2 %	3,465	36,998
2017	9.3 %	0.2 %	3,477	37,498
2016	8.8 %	0.1 %	3,361	38,247
2015	9.2 %	0.2 %	3,564	38,874
2014	8.9 %	0.2 %	3,432	38,502
2013	8.8 %	0.2 %	3,312	37,826
2012	8.7 %	0.1 %	3,332	38,342
2011	9.1 %	0.2 %	3,516	38,701
2010	8.8 %	0.1 %	3,391	38,527
2009	8.9 %	0.1 %	3,546	39,797

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 4 - Notes:

None

Data Alerts: None

NOM 5 - Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2021	12.0 %	0.2 %	4,328	35,940
2020	11.8 %	0.2 %	4,142	35,225
2019	11.9 %	0.2 %	4,362	36,557
2018	11.6 %	0.2 %	4,299	36,992
2017	11.4 %	0.2 %	4,268	37,504
2016	10.9 %	0.2 %	4,157	38,251
2015	10.8 %	0.2 %	4,207	38,864
2014	10.0 %	0.2 %	3,845	38,480
2013	10.2 %	0.2 %	3,825	37,653
2012	10.4 %	0.2 %	3,990	38,219
2011	10.8 %	0.2 %	4,162	38,574
2010	10.8 %	0.2 %	4,136	38,425
2009	11.1 %	0.2 %	4,394	39,684

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 5 - Notes:

None

Data Alerts: None

NOM 6 - Percent of early term births (37, 38 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2021	30.5 %	0.2 %	10,956	35,940
2020	30.0 %	0.2 %	10,578	35,225
2019	29.4 %	0.2 %	10,740	36,557
2018	28.4 %	0.2 %	10,507	36,992
2017	27.2 %	0.2 %	10,203	37,504
2016	26.4 %	0.2 %	10,103	38,251
2015	27.0 %	0.2 %	10,508	38,864
2014	26.4 %	0.2 %	10,143	38,480
2013	25.0 %	0.2 %	9,416	37,653
2012	26.1 %	0.2 %	9,992	38,219
2011	27.1 %	0.2 %	10,457	38,574
2010	30.9 %	0.2 %	11,870	38,425
2009	33.1 %	0.2 %	13,153	39,684

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 6 - Notes:

None

Data Alerts: None

NOM 7 - Percent of non-medically indicated early elective deliveries

Data Source: CMS Hospital Compare

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2021/Q1-2021/Q4	3.0 %			
2020/Q4-2021/Q3	3.0 %			
2020/Q3-2021/Q1	3.0 %			
2019/Q4-2020/Q3	2.0 %			
2019/Q1-2019/Q4	2.0 %			
2018/Q4-2019/Q3	2.0 %			
2018/Q3-2019/Q2	2.0 %			
2018/Q2-2019/Q1	1.0 %			
2018/Q1-2018/Q4	2.0 %			
2017/Q4-2018/Q3	2.0 %			
2017/Q3-2018/Q2	2.0 %			
2017/Q2-2018/Q1	2.0 %			
2017/Q1-2017/Q4	2.0 %			
2016/Q4-2017/Q3	2.0 %			
2016/Q3-2017/Q2	2.0 %			
2016/Q2-2017/Q1	2.0 %			
2016/Q1-2016/Q4	2.0 %			
2015/Q4-2016/Q3	2.0 %			
2015/Q3-2016/Q2	2.0 %			
2015/Q2-2016/Q1	3.0 %			
2015/Q1-2015/Q4	3.0 %			
2014/Q4-2015/Q3	3.0 %			
2014/Q3-2015/Q2	4.0 %			

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014/Q2-2015/Q1	4.0 %			
2014/Q1-2014/Q4	5.0 %			
2013/Q4-2014/Q3	5.0 %			
2013/Q3-2014/Q2	5.0 %			
2013/Q2-2014/Q1	5.0 %			

Legends:

NOM 7 - Notes:

None

Data Alerts: None

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	7.6	0.5	270	35,393
2019	6.8	0.4	249	36,697
2018	7.0	0.4	261	37,151
2017	7.0	0.4	264	37,654
2016	6.8	0.4	262	38,404
2015	6.9	0.4	269	39,020
2014	6.8	0.4	263	38,637
2013	7.5	0.4	283	37,977
2012	7.5	0.4	290	38,505
2011	7.0	0.4	273	38,842
2010	6.9	0.4	268	38,689
2009	6.5	0.4	261	39,944

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 8 - Notes:

None

Data Alerts: None

NOM 9.1 - Infant mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	7.4	0.5	260	35,251
2019	7.0	0.4	256	36,564
2018	7.5	0.5	278	37,018
2017	8.1	0.5	304	37,520
2016	8.2	0.5	314	38,274
2015	7.5	0.4	293	38,886
2014	7.5	0.4	288	38,511
2013	7.9	0.5	297	37,832
2012	7.1	0.4	271	38,347
2011	7.3	0.4	282	38,715
2010	7.2	0.4	279	38,540
2009	7.6	0.4	301	39,808

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.1 - Notes:

None

Data Alerts: None

NOM 9.2 - Neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	4.7	0.4	164	35,251
2019	4.3	0.3	156	36,564
2018	4.7	0.4	174	37,018
2017	4.6	0.4	174	37,520
2016	4.5	0.3	172	38,274
2015	4.2	0.3	164	38,886
2014	4.5	0.3	173	38,511
2013	4.5	0.4	171	37,832
2012	4.3	0.3	164	38,347
2011	4.6	0.4	178	38,715
2010	4.2	0.3	161	38,540
2009	4.1	0.3	164	39,808

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.2 - Notes:

None

Data Alerts: None

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	2.7	0.3	96	35,251
2019	2.7	0.3	100	36,564
2018	2.8	0.3	104	37,018
2017	3.5	0.3	130	37,520
2016	3.7	0.3	142	38,274
2015	3.3	0.3	129	38,886
2014	3.0	0.3	115	38,511
2013	3.3	0.3	126	37,832
2012	2.8	0.3	107	38,347
2011	2.7	0.3	104	38,715
2010	3.1	0.3	118	38,540
2009	3.4	0.3	137	39,808

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.3 - Notes:

None

Data Alerts: None

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	229.8	25.6	81	35,251
2019	213.3	24.2	78	36,564
2018	210.7	23.9	78	37,018
2017	205.2	23.4	77	37,520
2016	180.3	21.7	69	38,274
2015	198.0	22.6	77	38,886
2014	168.8	21.0	65	38,511
2013	153.3	20.2	58	37,832
2012	174.7	21.4	67	38,347
2011	214.4	23.6	83	38,715
2010	186.8	22.0	72	38,540
2009	170.8	20.7	68	39,808

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.4 - Notes:

None

Data Alerts: None

NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	136.2	19.7	48	35,251
2019	161.4	21.0	59	36,564
2018	145.9	19.9	54	37,018
2017	151.9	20.1	57	37,520
2016	216.9	23.8	83	38,274
2015	200.6	22.7	78	38,886
2014	168.8	21.0	65	38,511
2013	203.5	23.2	77	37,832
2012	179.9	21.7	69	38,347
2011	152.4	19.9	59	38,715
2010	171.3	21.1	66	38,540
2009	203.5	22.6	81	39,808

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.5 - Notes:

None

Data Alerts: None

NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	5.5 %	1.1 %	1,915	34,956
2013	5.8 %	1.2 %	1,994	34,689
2012	5.7 %	1.4 %	1,996	34,867
2011	6.6 %	1.1 %	2,347	35,524
2010	4.3 %	0.7 %	1,527	35,298
2009	6.1 %	1.0 %	2,221	36,261
2008	5.7 %	0.8 %	2,138	37,239
2007	4.1 %	0.6 %	1,560	37,853

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 10 - Notes:

None

Data Alerts: None

NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	3.1	0.3	100	32,390
2019	2.6	0.3	92	35,180
2018	4.0	0.3	140	35,261
2017	4.2	0.3	154	36,625
2016	3.2	0.3	119	37,217
2015	3.1	0.4	77	24,724
2014	2.5	0.3	87	34,575
2013	2.3	0.3	84	36,109
2012	2.5	0.3	94	37,431
2011	2.1	0.2	82	38,142
2010	1.3	0.2	49	37,784
2009	1.2	0.2	48	38,937
2008	0.9	0.2	36	39,718

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 11 - Notes:

None

Data Alerts: None

NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 12 - Notes:

None

Data Alerts: None

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 13 - Notes:

None

Data Alerts: None

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	12.7 %	1.2 %	82,515	650,349
2019_2020	13.5 %	1.3 %	88,400	653,638
2018_2019	13.2 %	1.3 %	87,655	662,654
2017_2018	12.8 %	1.5 %	85,506	668,795
2016_2017	14.2 %	1.6 %	95,500	670,633
2016	15.9 %	2.1 %	106,214	667,843

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 14 - Notes:

None

Data Alerts: None

NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2021	24.1	2.7	82	339,937
2020	22.7	2.6	78	343,469
2019	23.8	2.6	82	344,856
2018	28.0	2.8	97	346,726
2017	23.8	2.6	83	348,612
2016	22.9	2.6	80	349,083
2015	23.4	2.6	82	350,670
2014	21.8	2.5	77	352,568
2013	27.4	2.8	97	354,507
2012	31.7	3.0	113	356,186
2011	22.5	2.5	80	355,634
2010	27.0	2.8	96	356,164
2009	28.2	2.8	100	354,126

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 15 - Notes:

None

Data Alerts: None

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	51.1	3.6	208	406,733
2020	55.8	3.8	222	397,553
2019	44.5	3.4	177	397,717
2018	45.2	3.4	180	398,493
2017	49.1	3.5	195	397,485
2016	44.6	3.4	177	396,631
2015	43.1	3.3	170	394,736
2014	44.7	3.4	176	393,298
2013	38.6	3.1	152	394,044
2012	47.1	3.5	186	394,644
2011	41.9	3.3	166	396,123
2010	40.6	3.2	163	401,364
2009	45.1	3.4	180	399,413

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.1 - Notes:

None

Data Alerts: None

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2019_2021	20.0	1.8	119	595,981
2018_2020	20.6	1.9	122	592,053
2017_2019	19.7	1.8	117	593,285
2016_2018	20.5	1.9	122	595,147
2015_2017	20.5	1.9	122	595,320
2014_2016	20.6	1.9	122	592,811
2013_2015	19.9	1.8	117	589,235
2012_2014	19.6	1.8	115	586,564
2011_2013	19.8	1.8	116	587,217
2010_2012	21.5	1.9	128	595,485
2009_2011	22.0	1.9	133	603,744
2008_2010	28.6	2.2	175	611,405
2007_2009	34.4	2.4	210	610,606

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.2 - Notes:

None

Data Alerts: None

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2019_2021	13.3	1.5	79	595,981
2018_2020	13.9	1.5	82	592,053
2017_2019	15.3	1.6	91	593,285
2016_2018	14.5	1.6	86	595,147
2015_2017	14.3	1.6	85	595,320
2014_2016	11.0	1.4	65	592,811
2013_2015	10.9	1.4	64	589,235
2012_2014	11.1	1.4	65	586,564
2011_2013	11.1	1.4	65	587,217
2010_2012	10.2	1.3	61	595,485
2009_2011	9.9	1.3	60	603,744
2008_2010	9.8	1.3	60	611,405
2007_2009	9.5	1.3	58	610,606

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.3 - Notes:

None

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs (CSHCN), ages 0 through 17

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	23.6 %	1.4 %	164,238	697,084
2019_2020	22.4 %	1.5 %	156,776	698,403
2018_2019	22.3 %	1.5 %	157,034	703,335
2017_2018	22.7 %	1.8 %	159,984	705,537
2016_2017	23.0 %	1.9 %	161,690	703,442
2016	23.1 %	2.0 %	162,132	702,152

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.1 - Notes:

None

Data Alerts: None

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	14.8 %	2.1 %	24,211	164,003
2019_2020	16.1 %	2.6 %	25,132	156,542
2018_2019	16.2 %	2.8 %	25,417	157,034
2017_2018	11.1 %	2.3 %	17,733	159,984
2016_2017	12.8 %	2.2 %	20,741	161,690
2016	15.1 %	2.9 %	24,435	162,132

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	3.0 %	0.6 %	17,082	578,820
2019_2020	2.5 %	0.5 %	14,219	578,126
2018_2019	2.9 %	0.6 %	16,756	581,157
2017_2018	2.3 %	0.6 %	13,717	589,818
2016_2017	1.9 %	0.5 %	11,339	604,105
2016	2.2 %	0.9 %	13,491	607,037

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	13.7 %	1.2 %	79,408	581,058
2019_2020	12.5 %	1.2 %	72,604	579,551
2018_2019	11.2 %	1.1 %	64,972	578,257
2017_2018	10.9 %	1.3 %	63,705	585,535
2016_2017	9.9 %	1.2 %	59,474	598,915
2016	10.1 %	1.4 %	60,470	599,638

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	54.5 %	4.2 %	56,816	104,269
2019_2020	52.7 %	4.8 %	54,538	103,414
2018_2019	51.0 %	4.8 %	50,156	98,358
2017_2018	41.2 %	5.3 %	36,870	89,583
2016_2017	42.1 %	5.5 %	36,105	85,761
2016	50.7 %	6.7 %	41,427	81,753

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	90.2 %	1.1 %	623,705	691,677
2019_2020	89.4 %	1.2 %	621,377	695,003
2018_2019	88.5 %	1.3 %	621,152	701,620
2017_2018	88.7 %	1.6 %	622,749	702,328
2016_2017	88.1 %	1.5 %	617,471	700,945
2016	87.4 %	1.7 %	612,925	701,062

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	13.9 %	0.3 %	1,636	11,735
2018	13.1 %	0.2 %	2,801	21,377
2016	13.3 %	0.2 %	3,140	23,647
2014	14.4 %	0.2 %	4,115	28,543
2012	14.6 %	0.2 %	4,826	33,058
2010	14.8 %	0.2 %	4,628	31,245
2008	13.7 %	0.2 %	3,421	25,003

Legends:

Indicator has a denominator <20 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2021	19.4 %	1.4 %	24,345	125,538
2019	22.1 %	1.0 %	29,736	134,249
2017	21.7 %	2.0 %	28,851	133,010
2015	18.0 %	1.0 %	24,459	135,662
2013	17.8 %	1.1 %	23,091	129,610
2011	15.2 %	1.0 %	19,316	127,361
2009	14.3 %	1.2 %	17,801	124,436
2007	13.7 %	1.2 %	18,431	134,128
2005	15.3 %	1.0 %	19,889	129,762

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2020_2021	19.1 %	2.0 %	60,126	314,235
2019_2020	20.6 %	2.2 %	63,382	307,027
2018_2019	20.2 %	2.0 %	64,387	318,159
2017_2018	16.2 %	2.1 %	53,965	332,721
2016_2017	15.6 %	2.2 %	48,402	309,544
2016	19.1 %	2.9 %	55,065	288,446

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children, ages 0 through 17, without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2021	5.2 %	0.5 %	36,858	703,425
2019	5.2 %	0.5 %	36,112	698,580
2018	3.8 %	0.4 %	26,638	704,361
2017	4.5 %	0.5 %	31,861	708,691
2016	3.7 %	0.4 %	26,144	705,780
2015	4.9 %	0.5 %	34,600	706,790
2014	4.5 %	0.5 %	31,564	706,853
2013	5.8 %	0.6 %	40,814	710,207
2012	5.4 %	0.5 %	38,506	710,185
2011	5.5 %	0.5 %	38,831	711,320
2010	6.3 %	0.5 %	44,797	709,524
2009	6.2 %	0.5 %	43,903	707,769

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 21 - Notes:

None

Data Alerts: None

NOM 22.1 - Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	64.8 %	3.3 %	24,000	36,000
2017	65.0 %	3.5 %	24,000	37,000
2016	69.7 %	4.0 %	27,000	38,000
2015	64.1 %	3.8 %	24,000	38,000
2014	63.6 %	4.2 %	24,000	38,000
2013	68.0 %	4.6 %	26,000	38,000
2012	62.6 %	4.3 %	24,000	39,000
2011	61.4 %	4.7 %	24,000	39,000

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths >20 or that are inestimable might not be reliable

NOM 22.1 - Notes:

None

Data Alerts: None

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS) – Flu

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	58.5 %	1.7 %	386,705	661,165
2020_2021	55.5 %	1.8 %	367,060	661,369
2019_2020	65.9 %	1.5 %	437,827	664,381
2018_2019	63.5 %	1.6 %	422,058	664,553
2017_2018	63.6 %	1.8 %	423,053	664,881
2016_2017	60.7 %	1.9 %	400,524	660,386
2015_2016	66.4 %	2.0 %	442,745	666,584
2014_2015	66.0 %	2.1 %	443,895	672,467
2013_2014	69.0 %	1.9 %	461,376	668,523
2012_2013	62.3 %	2.6 %	416,588	669,268
2011_2012	63.3 %	2.6 %	421,118	665,409
2010_2011	56.1 %	3.8 %	372,342	663,711
2009_2010	61.4 %	4.9 %	400,329	652,001

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or because the relative standard error is >0.3.

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.2 - Notes:

None

Data Alerts: None

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	73.2 %	2.9 %	147,915	201,965
2020	70.9 %	3.2 %	141,951	200,121
2019	67.9 %	3.1 %	134,366	197,978
2018	60.8 %	3.4 %	120,299	197,850
2017	61.1 %	3.2 %	121,539	199,026
2016	54.4 %	3.2 %	107,808	198,268
2015	53.6 %	3.1 %	106,716	199,107

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.3 - Notes:

None

Data Alerts: None

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	94.9 %	1.6 %	191,685	201,965
2020	94.2 %	1.5 %	188,467	200,121
2019	93.4 %	1.7 %	184,931	197,978
2018	90.2 %	2.0 %	178,436	197,850
2017	92.4 %	1.6 %	183,821	199,026
2016	91.0 %	1.7 %	180,395	198,268
2015	91.2 %	1.7 %	181,602	199,107
2014	84.6 %	2.4 %	169,050	199,835
2013	77.7 %	2.7 %	155,135	199,744
2012	64.4 %	3.5 %	127,094	197,473
2011	48.4 %	4.1 %	96,999	200,291
2010	43.0 %	3.4 %	83,247	193,761
2009	34.6 %	3.0 %	66,972	193,741

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.4 - Notes:

None

Data Alerts: None

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	96.1 %	1.2 %	194,154	201,965
2020	93.8 %	1.8 %	187,691	200,121
2019	95.6 %	1.2 %	189,192	197,978
2018	91.7 %	2.0 %	181,398	197,850
2017	91.7 %	1.8 %	182,550	199,026
2016	89.1 %	1.9 %	176,569	198,268
2015	81.5 %	2.4 %	162,213	199,107
2014	64.8 %	3.1 %	129,452	199,835
2013	40.4 %	3.3 %	80,692	199,744
2012	37.5 %	3.6 %	74,103	197,473
2011	27.6 %	3.6 %	55,310	200,291
2010	30.9 %	3.2 %	59,831	193,761
2009	21.9 %	2.5 %	42,351	193,741

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.5 - Notes:

None

Data Alerts: None

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	26.5	0.5	2,609	98,289
2020	27.8	0.5	2,676	96,125
2019	30.0	0.6	2,882	96,172
2018	30.4	0.6	2,928	96,352
2017	32.8	0.6	3,178	96,842
2016	34.6	0.6	3,372	97,359
2015	37.9	0.6	3,677	97,018
2014	39.2	0.6	3,782	96,408
2013	43.2	0.7	4,155	96,206
2012	45.1	0.7	4,349	96,325
2011	49.8	0.7	4,845	97,301
2010	52.7	0.7	5,229	99,232
2009	57.8	0.8	5,753	99,470

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 23 - Notes:

None

Data Alerts: None

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	19.7 %	2.1 %	6,334	32,168
2020	23.2 %	2.2 %	7,371	31,805
2019	19.1 %	2.0 %	6,298	32,993
2018	21.0 %	2.2 %	6,855	32,669
2016	19.2 %	1.9 %	6,611	34,358
2015	22.3 %	1.9 %	7,837	35,145
2013	20.5 %	2.0 %	7,039	34,355
2012	20.3 %	2.3 %	7,091	34,975

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 24 - Notes:

None

Data Alerts: None

NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	4.0 %	0.7 %	27,938	695,112
2019_2020	3.3 %	0.7 %	23,121	695,613
2018_2019	3.0 %	0.6 %	20,800	700,575
2017_2018	3.7 %	0.8 %	26,048	703,431
2016_2017	4.0 %	0.9 %	28,161	701,513
2016	4.3 %	1.2 %	29,901	701,225

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 25 - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)

State: Arkansas

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective			75	76	74
Annual Indicator		74.8	76.2	73.1	75.5
Numerator		383,916	391,445	369,110	386,008
Denominator		513,590	513,789	504,995	511,351
Data Source		BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year		2018	2019	2020	2021

Previous NPM-1 BRFSS data for survey year 2017 that was pre-populated under the 2018 Annual Report Year is no longer displayed since it is not comparable with 2018 survey data.

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	76.0	76.5	77.0

Field Level Notes for Form 10 NPMs:

None

NPM 3 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	82	79	82	83	81
Annual Indicator	77.6	81.5	77.6	80.5	76.5
Numerator	382	423	367	453	368
Denominator	492	519	473	563	481
Data Source	Arkansas birth certificates	Arkansas birth certificates	Arkansas birth certificates	Arkansas birth certificates	Arkansas birth certificates
Data Source Year	CY2018	CY2019	CY2020	CY2021	CY2022
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	77.0	77.5	78.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Data reflect births to Arkansas residents in the state. There are seven Arkansas Level III birthing hospitals.	
2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Data reflect births to Arkansas residents in the state. There are seven Arkansas Level III birthing hospitals.	
3.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Data reflect births to Arkansas residents in the state. There are seven Arkansas Level III birthing hospitals.	
4.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Data reflect births to Arkansas residents in the state. There are seven Arkansas Level III birthing hospitals.	
5.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Data reflect births to Arkansas residents in the state. There are seven Arkansas Level III birthing hospitals.	

NPM 4A - Percent of infants who are ever breastfed

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	73	78	71	72	76.5
Annual Indicator	73.8	70.9	70.1	76.2	74.9
Numerator	24,924	23,745	24,526	24,737	23,617
Denominator	33,794	33,498	34,998	32,478	31,535
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2015	2016	2017	2018	2019

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	76.0	77.0	78.0

Field Level Notes for Form 10 NPMs:

None

NPM 4B - Percent of infants breastfed exclusively through 6 months

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	17	23	20	21	20
Annual Indicator	20.4	19.2	19.4	19.9	24.4
Numerator	6,660	6,277	6,684	6,239	7,529
Denominator	32,623	32,762	34,403	31,390	30,902
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2015	2016	2017	2018	2019

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	26.0	27.0	28.0

Field Level Notes for Form 10 NPMs:

None

NPM 5A - Percent of infants placed to sleep on their backs

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	71	76	76	80	77
Annual Indicator	74.4	74.4	79.1	76.9	77.8
Numerator	25,165	25,165	25,862	24,295	24,854
Denominator	33,822	33,822	32,696	31,583	31,928
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2016	2016	2019	2020	2021

State Provided Data					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	71	76	76	80	77
Annual Indicator	75				77.8
Numerator	24,865				24,854
Denominator	33,157				31,928
Data Source	PRAMS				PRAMS
Data Source Year	2017				2021
Provisional or Final ?	Final				Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	79.0	80.0	81.0

Field Level Notes for Form 10 NPMs:

None

NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective		36	29	35	37
Annual Indicator	35.7	35.7	34.2	36.8	38.0
Numerator	11,688	11,688	10,926	11,239	11,574
Denominator	32,713	32,713	31,928	30,523	30,465
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2016	2016	2019	2020	2021

State Provided Data					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective		36	29	35	37
Annual Indicator	28.2				38
Numerator	9,193				11,574
Denominator	32,587				30,465
Data Source	PRAMS				PRAMS
Data Source Year	2017				2021
Provisional or Final ?	Final				Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	39.0	40.0	41.0

Field Level Notes for Form 10 NPMs:

None

NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective		39	39	41	45
Annual Indicator	32.8	32.8	40.8	44.3	47.8
Numerator	10,723	10,723	12,954	13,606	14,693
Denominator	32,660	32,660	31,776	30,693	30,724
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2016	2016	2019	2020	2021

State Provided Data					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective		39	39	41	45
Annual Indicator	38.8				47.8
Numerator	12,487				14,693
Denominator	32,216				30,724
Data Source	PRAMS				PRAMS
Data Source Year	2017				2021
Provisional or Final ?	Final				Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	49.0	50.0	51.0

Field Level Notes for Form 10 NPMs:

None

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective		37	34	25	26
Annual Indicator	35.2	33.5	20.6	25.9	28.4
Numerator	27,381	30,159	18,621	21,969	23,260
Denominator	77,859	90,076	90,181	84,909	81,900
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	29.0	30.0	31.0

Field Level Notes for Form 10 NPMs:

None

NPM 7.1 - Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

Federally Available Data					
Data Source: HCUP - State Inpatient Databases (SID)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	100	97	100	105	103
Annual Indicator	98.2	102.7	107.1	108.9	117.8
Numerator	380	397	411	415	447
Denominator	386,820	386,578	383,627	381,211	379,504
Data Source	SID-CHILD	SID-CHILD	SID-CHILD	SID-CHILD	SID-CHILD
Data Source Year	2016	2017	2018	2019	2020

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	115.0	113.0	111.0

Field Level Notes for Form 10 NPMs:

None

NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - CHILD				
	2019	**2020**	**2021**	**2022**
Annual Objective			29	30
Annual Indicator	28.4	30.1	29.7	28.8
Numerator	60,424	75,652	74,583	67,786
Denominator	212,390	251,646	250,770	235,539
Data Source	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD
Data Source Year	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	30.0	31.0	31.0

Field Level Notes for Form 10 NPMs:

None

NPM 8.2 - Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day

Federally Available Data					
Data Source: Youth Risk Behavior Surveillance System (YRBSS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	31	31	23	23	19
Annual Indicator	21.4	21.4	22.7	22.7	25.6
Numerator	28,605	28,605	31,059	31,059	34,669
Denominator	133,427	133,427	136,720	136,720	135,219
Data Source	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT
Data Source Year	2017	2017	2019	2019	2021

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - ADOLESCENT					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	31	31	23	23	19
Annual Indicator	17.2	16.6	18.9	18.3	19.5
Numerator	42,088	42,430	42,470	40,768	46,376
Denominator	244,963	254,983	224,740	222,508	237,248
Data Source	NSCH-ADOLESCENT	NSCH-ADOLESCENT	NSCH-ADOLESCENT	NSCH-ADOLESCENT	NSCH-ADOLESCENT
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	31	31	23	23	19
Annual Indicator		22.7			
Numerator					
Denominator					
Data Source		YRBSS-ADOLESCENT			
Data Source Year		2019			
Provisional or Final ?		Final			

Annual Objectives			
	2023	2024	2025
Annual Objective	24.0	24.0	24.5

Field Level Notes for Form 10 NPMs:

1. **Field Name:** **2019**

   Column Name: **State Provided Data**

   Field Note:
   2019 Arkansas Youth Risk Behavior Survey, page 149.
   http://dese.ade.arkansas.gov/public/userfiles/Learning_Services/School_Health_Services/YRBS/2019/2019_YRBS_State_-24-2020.pdf

2. **Field Name:** **2023**

   Column Name: **Annual Objective**

   Field Note:
   2023-2025 Annual Objectives are based on NSCH data.

NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Federally Available Data					
Data Source: Youth Risk Behavior Surveillance System (YRBSS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective		28	32	31	34
Annual Indicator	32.2	32.2	29.6	29.6	26.1
Numerator	45,167	45,167	41,441	41,441	36,168
Denominator	140,057	140,057	139,808	139,808	138,575
Data Source	YRBSS	YRBSS	YRBSS	YRBSS	YRBSS
Data Source Year	2017	2017	2019	2019	2021

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - Perpetration					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective		28	32	31	34
Annual Indicator		16.7	18.1	13.4	11.0
Numerator		40,558	40,825	29,771	25,996
Denominator		242,552	225,039	221,941	236,952
Data Source		NSCHP	NSCHP	NSCHP	NSCHP
Data Source Year		2018	2018_2019	2019_2020	2020_2021

Previous NPM-9 NSCH data for survey years 2016 and 2017 that was pre-populated under the 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable to 2018 survey data given major wording and response option changes.

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - Victimization					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective		28	32	31	34
Annual Indicator		46.6	45.0	35.6	30.0
Numerator		112,988	101,363	78,903	70,703
Denominator		242,552	225,039	221,941	235,696
Data Source		NSCHV	NSCHV	NSCHV	NSCHV
Data Source Year		2018	2018_2019	2019_2020	2020_2021

Previous NPM-9 NSCH data for survey years 2016 and 2017 that was pre-populated under the 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable to 2018 survey data given major wording and response option changes.

State Provided Data					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective		28	32	31	34
Annual Indicator					17.4
Numerator					
Denominator					
Data Source					YRBSS
Data Source Year					2021
Provisional or Final ?					Final

Annual Objectives			
2023	**2024**	**2025**	
Annual Objective	17.0	16.5	16.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Source: 2021 Arkansas YRBS Results - Detail Tables, Arkansas Department of Education, https://dese.ade.arkansas.gov/Files/2021ARH_Detail_Tables_LS.pdf, p. 46. Unweighted numerator: 260 Unweighted denominator: 1498	
2.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**
	Field Note: 2023-2025 Annual Objectives are based on YRBS data.	

NPM 12 - 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 - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	54	23	20	14	15
Annual Indicator	21.2	18.8	13.8	14.6	20.5
Numerator	14,541	13,077	8,912	8,960	13,899
Denominator	68,707	69,399	64,434	61,573	67,703
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	21.0	21.5	22.0

Field Level Notes for Form 10 NPMs:

None

NPM 12 - 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 - Adolescent Health - NONCSHCN

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - NONCSHCN				
	2019	**2020**	**2021**	**2022**
Annual Objective			15.5	17
Annual Indicator	7.5	15.4	16.7	13.7
Numerator	13,961	24,857	27,261	23,659
Denominator	186,375	161,219	162,826	173,028
Data Source	NSCH-NONCSHCN	NSCH-NONCSHCN	NSCH-NONCSHCN	NSCH-NONCSHCN
Data Source Year	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	14.0	14.0	15.0

Field Level Notes for Form 10 NPMs:

None

NPM 13.1 - Percent of women who had a preventive dental visit during pregnancy

Federally Available Data				
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)				
	2019	**2020**	**2021**	**2022**
Annual Objective			40	34
Annual Indicator	36.2	40.0	33.9	41.3
Numerator	12,462	13,291	10,887	13,559
Denominator	34,405	33,232	32,120	32,811
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2016	2019	2020	2021

State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			40	34
Annual Indicator				41.3
Numerator				13,559
Denominator				32,811
Data Source				PRAMS
Data Source Year				2021
Provisional or Final ?				Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	42.0	43.0	44.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
Source: Arkansas Pregnancy Risk Assessment Monitoring System (PRAMS), data analyzed by Arkansas PRAMS Program, 2021

Form 10
State Performance Measures (SPMs)

State: Arkansas

SPM 1 - Percent of newborns with timely follow-up of a failed hearing screening

Measure Status:				Active	
State Provided Data					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective		56	58	61	64
Annual Indicator		54.4	48	49.2	56.5
Numerator		81	59	61	109
Denominator		149	123	124	193
Data Source		IHP ERAVE Hearing and Screening Follow-up Survey	ERAVE EHDI Hearing Screening and Follow-up Survey	ERAVE EHDI Hearing Screening and Follow-up Survey	ERAVE EHDI Hearing Screening and Follow-up Survey
Data Source Year		2019	2020	2021	2022
Provisional or Final ?		Provisional	Provisional	Provisional	Provisional

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	60.0	61.0	62.0

Field Level Notes for Form 10 SPMs:

None

SPM 2 - Percent of youth, grades 9 through 12, who report using nicotine products

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			25	27.5
Annual Indicator	26.3	29.2	29.2	20
Numerator				
Denominator				
Data Source	CDC YRBSS	CDC YRBSS	CDC YRBSS	CDC YRBSS
Data Source Year	2017	2019	2019	2021
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	20.0	19.0	19.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: The latest available data source for this measure is the 2017 YRBSS (CDC Youth Online).	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Source: CDC Youth Online: High School YRBS query system, 2021 data. Nicotine products include cigarette, cigar, smokeless tobacco, or electronic vapor.	

SPM 3 - 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

Measure Status:	Active

State Provided Data			
	2020	2021	2022
Annual Objective			15
Annual Indicator			82.1
Numerator			64
Denominator			78
Data Source			Title V CSHCN Survey of Families
Data Source Year			2022
Provisional or Final ?			Final

Annual Objectives			
	2023	2024	2025
Annual Objective	15.0	16.0	17.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
As described in the 2022 Annual Report, Title V CSHCN had 384 parents/guardians with an email address in 2022. These parents/guardians were sent an email containing a flyer with information containing why parent feedback is so important and a link to an online survey. Seventy-eight parent surveys were completed out of 384 (20.3%).

A question on the 2022 Parent Survey was “During the last 12 months, was there a time when this child needed health care but it was not received?” Sixty-four out of 78 respondents said “No.”

2.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**

Field Note:
The 2022 response rate is believed to be high due to several factors. The Title V CSHCN Program had not sent parents a survey to complete since 2017. The 2022 Parent Survey was the first to be sent out via email to parents/guardians with a link to an online survey. Additionally, the program had the added workforce capacity of two MCH Interns during the summer of 2022. Program data used in the 2022 Annual Report, will not be used to increase the Annual Objective for 2023. The program will not have this increased workforce capacity during the summer of 2023. The 2023 Annual Objective for SPM 3 will remain at 15.0.

SPM 4 - Percent of Family Health Branch, Arkansas Home Visiting Program, and Title V CSHCN staff who complete an equity training

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			50	90
Annual Indicator			89.2	57.8
Numerator			33	100
Denominator			37	173
Data Source			Program reports	Program reports
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	91.0	92.0	93.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
Data for MIECHV are not included in the SPM 4 indicator. In CY2021, 450 home visitors had the opportunity to participate in six health equity trainings. Below are the number of participants for each training:

Improving Family Health: Tobacco Use & Young Children's Health – 91

Parental Depression – 119

Improving Family Health: The ABCs of Breastfeeding – 69

Improving Family Health: Family Planning – 40

Health Literacy Awareness for Home Visitors – 58

COVID-19 and Families with Young Children – 4

Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)

State: Arkansas

ESM 1.1 - Number of women, ages 18 through 44, with a past year preventive medical visit in an Arkansas Department of Health local health unit

Measure Status:	Active

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	53,000	41,000	33,105	28,000	29,000
Annual Indicator	39,593	33,105	27,082	27,055	27,349
Numerator					
Denominator					
Data Source	ADH Electronic Health Records	ADH Electronic Health Records	ADH Electronic Health Records	ADH Electronic Health Records	ADH Electronic Health Records
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	30,000.0	30,000.0	30,000.0

Field Level Notes for Form 10 ESMs:

None

ESM 3.1 - Percent of Arkansas birthing hospitals that complete the CDC Levels of Care Assessment Tool (CDC LOCATe) annually

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			80	85
Annual Indicator		17.5	17.5	17.5
Numerator		7	7	7
Denominator		40	40	40
Data Source		Arkansas LOCATe Survey	Arkansas LOCATe Survey	Arkansas LOCATe Survey
Data Source Year		2020	2020	2020
Provisional or Final ?		Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	17.5	30.0	50.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
The Arkansas's Maternal and Perinatal Outcomes Quality Review Committee (MPOQRC) is currently developing a hybrid process using parts of the CDC's Levels of Care Assessment Tool (LOCATe) Survey and other tools for Arkansas hospitals to assess their maternal and neonatal levels of care. The process will involve completion of a written survey and a site visit conducted once every three years for each Level III and IV hospital. The Site Visit Workgroup within the MPOQRC plans to begin site visits in 2022.

2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
Both ADH and UAMS has entered into an Independent Contractor Agreement to establish activities relating to perinatal regionalization. ADH MCH will convene a statewide maternal health taskforce to disseminate information about maternal health and establish state priorities. After this taskforce is established, ADH will work with key interest groups to secure commitment to the taskforce and encourage their members to participate through support letters. The taskforce will meet quarterly for the first two years of the project and at least bi-annually in subsequent years.

ADH will lead the perinatal regionalization efforts in Arkansas by coordinating site visits to birthing hospitals as part of its perinatal regionalization work. Through this agreement, ADH will coordinate site visits, collect, and analyze assessment data and provide results of LOCATe assessments for inclusion in the state maternal health dashboard.

ESM 4.1 - Percent of infants enrolled in the WIC program who have ever been breastfed

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			57	55
Annual Indicator	55.8	54.2	54.3	59.9
Numerator	8,289	6,948	6,725	7,554
Denominator	14,855	12,813	12,389	12,615
Data Source	ADH WIC Program	ADH WIC Program	ADH WIC Program	ADH WIC Program
Data Source Year	2019	2020	2021	2022
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	60.0	60.5	61.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Data Source: WIC SPIRIT data system. For this measure, infants are considered as "ever breastfed" if the infant was ever put to the breast with the intention of breastfeeding OR fed expressed breast milk.

ESM 5.1 - Percent of women enrolled in the WIC Plus Baby and Me Program who place their infant to sleep on their back

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			92	98
Annual Indicator		91.6	97.5	94.3
Numerator		790	655	467
Denominator		862	672	495
Data Source		ADH WIC Program	ADH WIC Program	ADH WIC Program
Data Source Year		2020	2021	2022
Provisional or Final ?		Provisional	Provisional	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	94.5	95.0	95.5

Field Level Notes for Form 10 ESMs:

None

ESM 6.1 - Percent of WIC-enrolled children ages 2-59 months at Learn the Signs Act Early (LTSAE) sites who received developmental monitoring

Measure Status:				Active	
State Provided Data					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective		50	55	60	65
Annual Indicator		53.9	0	1.9	0
Numerator		912		79	
Denominator		1,692		4,071	
Data Source		ADH WIC Program	ADH WIC Program	ADH WIC Program	ADH WIC Program
Data Source Year		2019	2020	2021	2022
Provisional or Final ?		Final	Final	Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	70.0	75.0	80.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: The WIC program planned to implement the LTSAE program statewide in March 2020. Due to COVID-19 changing the delivery of services, the program was forced to delay the rollout. WIC plans to move forward with implementing the LTSAE program statewide when in-person services resume.	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: WIC operated under a disaster waiver through the entirety of 2021, which waived the in-person requirement for WIC services. Developmental monitoring as an in-person service was not possible, except for a limited number of WIC participants who were seen in-person. WIC plans to move forward with implementing the LTSAE program statewide when in-person services resume. See the Child Health Domain annual report for more details.	
3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Due to COVID, LTSAE was not rolled out. There were no WIC LTSAE sites in 2022.	

ESM 6.2 - Percent of children, ages 2-59 months, in home visiting programs who were referred for therapy due to the results of a developmental screening using a validated parent-completed tool

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			50	68
Annual Indicator		48.7	66.5	65.4
Numerator		116	135	85
Denominator		238	203	130
Data Source		MIECHV Annual Performance Report	MIECHV electronic records	MIECHV records (Annual Performance Report
Data Source Year		FY2020	FY2021	FY2022
Provisional or Final ?		Final	Final	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	68.0	68.0	68.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Home Visiting Program fiscal year = 10/1/2020 - 9/30/2021	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Children who screen positive but have not had a completed referral will stay flagged in the database as needing a referral (if they remain enrolled). They do not drop off the list when the reporting period ends. In other words, 65.4% referred (above) means 34.6% did not get a referral, but some of the 34.6% can get a referral in the following year.	

ESM 7.1.1 - Percent of families served in home visiting programs who have reports of child maltreatment

Measure Status:	Active

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	5.5	6.5	6	7.5	5.5
Annual Indicator	7	6.5	8.1	5.9	5.2
Numerator	172	140	155	114	104
Denominator	2,444	2,168	1,912	1,921	1,983
Data Source	Division of Child and Family Services (DCFS)	Division of Child and Family Services (DCFS)	MIECHV Annual Performance Report	MIECHV APR Child Maltreatment Measure	MIECHV APR Child Maltreatment Measure
Data Source Year	2018	2019	FY2020	FY2021	FY2022
Provisional or Final ?	Provisional	Provisional	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	5.5	5.0	5.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: We were not able to obtain data for this indicator and are currently working to establish a Memorandum of Understanding (MOU) with DCFS to obtain this data.	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Data source: Administrative data from Arkansas Department of Human Services, Division of Children and Family Services	
3.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: MIECHV fiscal year = 10/1/2020 - 9/30/2021. Data are taken from the MIECHV Annual Performance Report (APR).	

ESM 8.1.1 - Percent of children attending public schools, grades K through 5, who are in the normal or healthy weight zone for Body Mass Index.

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			56	57
Annual Indicator	57.1	43.6	48	58.2
Numerator				62,441
Denominator				107,263
Data Source	ACHI BMI assessment reports	ACHI BMI assessment reports	ACHI BMI assessment reports	ACHI BMI assessment reports
Data Source Year	2018-2019	2019-2020	2020-2021	2021-2022
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	58.0	59.0	60.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Among students in grades K, 2, and 4 attending Coordinated School Health Schools, 3674 out of 6192 students (59.3%) had a healthy or underweight BMI classification. Statewide data showed 2.2% of students were underweight. We used 59.3% - 2.2% = 57.1% as our baseline estimate for this measure.
Data sources: http://bmi.achi.net/Pages/SchoolPersonnel/BMIDistrictPicker.aspx?Year=Districts_2018_2019, https://achi.net/wp-content/uploads/2020/04/Year-16-State-BMI-Report.pdf

2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
https://bmi.achi.net/BMIContent/Documents/220222A_Year_18_(2020-21)_Arkansas_BMI_Report_FINAL.pdf

BMI data collection for the 2020–2021 school year was met with challenges, as the COVID-19 pandemic continued to impact the lives of students and school staff throughout the state. Many students attended school virtually due to risk mitigation efforts and quarantining protocols. Completion of BMI measurements and data entry was affected by these activities which led to a decrease in valid BMI measurements to 55% of students compared to 64% in the previous year.

Due to COVID-19 impacts and a relatively lower number of students having valid height and weight measurements, results in this year's report should be interpreted cautiously.

3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
CSH Schools – 50.5% (9,086/17,979) of the children in Coordinated School Health Schools' physical education classes, in grades K-5, were in the normal or health weight zone for BMI.

This measure was changed from all public schools to include Coordinated School Health schools.

4.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**

Field Note:
Rationale for selecting annual performance objectives: There was a steep increase in PA that is likely tied to the covid-19 pandemic. The evidence is unclear if this increase is reactionary to the pandemic or indicative of behavior change. Given previous years data, the likelihood is that it is some of both is high.

ESM 8.1.2 - 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 services provided by School Health Services

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			10	83
Annual Indicator			81.2	95.6
Numerator			56	1,641
Denominator			69	1,716
Data Source			Coordinated School Health Survey	Coordinated School Health Survey
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	95.0	95.0	95.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: CSH survey was conducted among quarterly meeting participants.	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: 10 School Health Services trainings were held regarding physical activity services.	

ESM 8.2.1 - Percent of school personnel who participated in Coordinated School Health trainings with increased knowledge of evidenced-based physical activity practices and curriculum and physical activity services provided by School Health Services

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			10	83
Annual Indicator			81.2	95.6
Numerator			56	1,641
Denominator			69	1,716
Data Source			Coordinated School Health survey	Coordinated School Health survey
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	95.0	95.0	95.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: CSH survey was conducted among quarterly meeting participants.	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: 10 School Health Services trainings were held regarding physical activity services.	

ESM 9.1 - Number of school personnel, partners, and community members participating in Youth Mental Health First Aid (MHFA) and other mental health related trainings

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			475	550
Annual Indicator		468	806	500
Numerator				
Denominator				
Data Source		School Health Services/Arkansas AWARE	AWARE Year 3 Report	AWARE Annual Report
Data Source Year		2020	2021	2022
Provisional or Final ?		Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	525.0	550.0	575.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
This measure was revised to match the outcomes and strategies of the program Arkansas AWARE.

ESM 12.1 - 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

Measure Status:	Active

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	36	15	26	34	60
Annual Indicator	13.4	25.2	33.9	59.3	67.9
Numerator	22	63	42	54	38
Denominator	164	250	124	91	56
Data Source	Title V CSHCN Transition Providers Survey	Title V CSHCN Transition Providers Survey	Therap reports of Title V CSHCN PCPs	Therap reports of Title V CSHCN PCPs	Therap reports of Title V CSHCN PCPs
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	68.0	68.5	69.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
The Title CSHCN Transition Providers Survey was not conducted in 2017. The 2018 survey was conducted and data will be reported in next year's application.

2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
The Current Assessment of Health Care Transition Activities for Transitioning Youth to Adult Health Care Providers or the Current Assessment of Health Care Transition Activities for Integrating Young Adults into Adult Health Care, Six Core Elements of Health Care Transition 2.0 from Got Transition was hand delivered, mailed, or emailed to providers in January of 2018. The practices were given the appropriate survey depending on whether they were transitioning youth (Pediatric) or integrating young adults (Family Practice). A convenience sample of willing providers were used due to the easy access and established working relationship with Title V CSHCN Program. The objective continued from 2016 was to distribute to selected Pediatric and Family Practice Providers. Twenty-three percent of the surveys were hand delivered with the remainder being mailed or emailed.

ESM 12.2 - Percent of key stakeholders and referral sources who participated in the Title V CSHCN Health Care Transition training with increased knowledge of Health Care Transition and Health Care Transition services provided by Title V CSHCN

Measure Status:				Active	
State Provided Data					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective			18	25	29
Annual Indicator		17.1	23.2	28.6	43.8
Numerator					
Denominator					
Data Source		Title V CSHCN Health Care Transition training	Title V CSHCN Health Care Transition training	Title V CSHCN Health Care Transition training	Title V CSHCN Health Care Transition training
Data Source Year		2019	2020	2021	2022
Provisional or Final ?		Final	Final	Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	44.0	44.5	45.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: In CY2019, Title V CSHCN conducted 9 trainings with 50 total participants. There were issues with participants completing the pre-test and post-test as well as matching pre-tests with post-tests for each participant. Overall, there was a 12.5-percentage point increase, or 17.1% increase, in knowledge when comparing combined completed pre-test scores (44 participants' combined score of 3220 = 73.2%) and post-test scores (42 participants' combined score of 3600 = 85.7%).	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
Title V CSHCN switched from in person presentations in 2020, to presentations using virtual platforms such as Zoom and Microsoft Teams. Our focus was on outreach efforts and use of the Title V Overview which included Health Care Transition. Title V initially had a steep learning curve with pre and posttests with the virtual platforms. Once we were able to resume the pre and posttests, the number of questions were shortened for the virtual platform.

One training in calendar year 2020 included pre and posttests to measure a percentage of increase in knowledge for ESM 12.2. This training was the conclusion of a Title V Health Care Transition Quality Improvement Audit performed in 2019. Seventeen Title V Staff completed both a pre and a posttest.

When compared to pre-test scores, the group overall showed a 23.2% increase on the post-test. The average percent increase per person was 25.4%. All participants improved (82.4%; 14 participants), already had a perfect score (11.8%; 2 participants), or had the same score (5.8%, 1 participant) on the post-test.

3.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
The Annual Indicator is calculated by subtracting the overall group's average pretest score from the average posttest score and then dividing by the average pretest score.

2021 Title V CSHCN presentations used virtual platforms Zoom, Microsoft Teams, and Whova. Our focus continued with outreach efforts through use of the Title V Overview which included Health Care Transition.

Matching up each respondent's pretest with their posttest was a challenge since many respondents within an organization have the same IP address. Respondent ID numbers were not helpful in matching up a pretest with a posttest, as a unique respondent ID is assigned to each pretest and to each posttest. In March 2021, the success rate of matching up a respondent's pretest with their posttest was increased by the first question in the pretest and the posttest being "what is your birthday (mm/dd)?" Some trainings used the stakeholder group's virtual platform . If reports included the respondents' names with the results of pre and posttests, documentation, after matching them up, used "respondent 1, respondent 2, etc."

One training included pre and posttests to measure a percentage of increase in knowledge for ESM 12.2. This training had 26 attendees and seven unduplicated pre or posttests which included the "when is your birthday" question. Two respondents completed both the pretest and the posttest. An equal number of respondents completed both a pretest and a posttest. When compared to the pretest scores, the group overall showed a 28.57% increase on the posttest. The average increase per person was 66.67%, with one person having the same score on both the pretest and the posttest. The pretest average (70) was subtracted from the posttest average (90) to obtain the points in increase in knowledge. 90-70=20. The points of increase in knowledge (20) was then divided by the average pretest score (70). 20/70=.2857 or 28.57%.

4.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
The Annual Indicator is calculated by subtracting the overall group's average pretest score from the average posttest score and then dividing by the average pretest score.

Title V CSHCN HCT presentations in 2022 used virtual platforms Zoom,
Microsoft Teams, or hybrid events with a mix of in person and virtual. Our focus continued in 2022 with outreach efforts through use of the Title V Overview which included Health Care Transition.

In March 2021, the success rate of Title V matching up a respondent's pretest with their posttest was increased by the first question in the pretest and the posttest being "what is your birthday (mm/dd)?" Some Title V trainings used the virtual platform of the stakeholder group. If these reports included the respondents' names with the results of pre and posttests, Title V documentation, after matching them up, used "respondent 1, respondent 2, etc."

The first training in 2022 was a hybrid event with some attendees in person and some virtual. The number of attendees of the hybrid event were unknown. Twelve virtual attendees completed a pretest, with an average pretest score of 60. None of the participants completed a posttest.

One training in 2022 included pre and posttests to measure a percentage of increase in knowledge for ESM 12.2. This training had 19 attendees and 11 unduplicated pre or posttests which included the "when is your birthday" question. Two out of the 19 attending did not complete a pretest. Six out of the 19 did not take the posttest. Two out of the 11 taking both a pretest and a posttest did not have a change in knowledge after the HCT training.

When compared to the pretest scores, the group overall showed a 43.8% increase on the posttest. The pretest average (58.18) was subtracted from the posttest average (83.64) to obtain the points in increase in knowledge. 83.64 – 58.18 = 25.46. The points of increase in knowledge (25.46) were then divided by the average pretest score (58.18). 25.46/58.18 =.4376 or 43.8%.

ESM 12.4 - Number of School District Special Education Teachers, General Education Classroom Teachers, and District Professionals attending professional development training that complete a Title V Health Care Transition Readiness Assessment Survey

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			19	46
Annual Indicator			45	76
Numerator				
Denominator				
Data Source			Title V HCT Readiness Assessment Survey	Title V HCT Readiness Assessment Survey
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	77.0	78.0	79.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
The title for this ESM was revised to include general education classroom teachers.

This ESM was previously titled "Number of School District Special Education Teacher/Professionals attending professional development training that complete a Title V Health Care Transition Readiness Assessment Survey".

The new title is "Number of School District Special Education Teachers, General Education Classroom Teachers, and District Professionals attending professional development training that complete a Title V Health Care Transition Readiness Assessment Survey".

Arkansas Transition Services offered the survey at professional development training for School District Special Education Teachers/Professionals in 2022. Arkansas Transition Services provided Title V with the number of School District Special Education Teachers/Professionals that completed a Title V Health Care Transition Readiness Assessment Survey.

ESM 12.5 - 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

Measure Status:	Active

State Provided Data			
	2020	2021	2022
Annual Objective			3
Annual Indicator			0
Numerator			
Denominator			
Data Source			Title V HCT Readiness Assessment Survey
Data Source Year			2022
Provisional or Final ?			Final

Annual Objectives			
	2023	2024	2025
Annual Objective	4.0	5.0	6.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
The School-Based Health Advisor position responsible for this training was vacant for a large portion of the year. A survey question had been used to capture data for this activity. But the question wording was confusing, and we don't have data to report for CY2022. The questionnaire and survey methods are being re-evaluated at this time.

ESM 12.6 - Number of CSHCN (ages 12-17) with an annual update to the transition plan developed with the youth and family.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives			
	2023	2024	2025
Annual Objective	15.0	17.0	19.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
The Title V Service Plan was revised June 21, 2022, to improve transition goals. Health Care Transition Quality Improvement Audits were performed by Area Managers for transition age youth with birth months from August 2021 through July 2022. This audit was related to 2022 data for the last reporting year for the inactive ESM 12.3 Percent of transition age CSHCN (age 12 through 17) served by Title V CSHCN who received transition services and supports in the past 12 months from Title V CSHCN. The audit worksheets asked if the Title V Service Plan with revised date of June 21, 2022, was used by the Title V RN. Fourteen out of 88 transition age youth (15.9%) had a Title V Service Plan with revised date of June 21, 2022. The program expects the Annual Indicator for 2023 to increase when the program reports a full year of data next year.

ESM 13.1.1 - Number of presentation or education events on the importance of oral health during pregnancy

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			5	7
Annual Indicator			7	11
Numerator				
Denominator				
Data Source			Office of Oral Health and Womens Health Section	Office of Oral Health and Womens Health Section
Data Source Year			2021-2022	2022-2023
Provisional or Final ?			Provisional	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	8.0	9.0	10.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
The Office of Oral Health gave 14 presentations at local health units and community events (i.e., Pink Out Day, Pink Pancake Breakfast, Women's Health Education event, etc.). They provided oral health kits, presentations or oral health educational counseling at domestic violence and sexual assault shelters and in-door community events. For the "More than Pink" Run & Walk event, they provided age-appropriate oral health educational information and oral health kits to anyone visiting the exhibit table.

Form 10
State Performance Measure (SPM) Detail Sheets

State: Arkansas

SPM 1 - Percent of newborns with timely follow-up of a failed hearing screening
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Active
Goal:	Increase the percent of infants failing the newborn hearing screen and receiving a confirmatory diagnosis by three months of age (Joint Committee on Infant Hearing recommendation).
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of infants receiving diagnostic testing by three months of age after failing the newborn hearing screen **Denominator:** Number of infants receiving diagnostic testing after failing the newborn hearing screen
Data Sources and Data Issues:	Electronic Registration of Arkansas Vital Records (ERAVE)
Significance:	Early hearing detection and intervention improves quality of life and reduces risk for communication delays in children.

SPM 2 - Percent of youth, grades 9 through 12, who report using nicotine products
Population Domain(s) – Adolescent Health

Measure Status:	Active
Goal:	Decrease nicotine product use among adolescents
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of youth, grades 9 through 12, who reported having smoked cigarettes or cigars or used smokeless tobacco or an electronic vapor product on at least 1 day during the 30 days before the survey **Denominator:** Number of youth, grades 9 through 12
Data Sources and Data Issues:	CDC Youth Risk Behavior Survey (YRBS)
Significance:	Scientific knowledge about the health effects of tobacco use has increased greatly since the first Surgeon General's report on tobacco was released in 1964. Tobacco use has been linked to several diseases including cancer, heart disease and stroke, lung diseases, and other health conditions. Known reproductive effects are ectopic pregnancy, premature birth, low birth weight, stillbirth, reduced fertility in women, and erectile dysfunction; and birth defects such as clept-lip and/or cleft palate.

SPM 3 - 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
Population Domain(s) – Children with Special Health Care Needs

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To ensure that Children with Special Health Care Needs receive primary, preventative, and specialty care to achieve the best health outcomes.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of families of children with special health care needs served by Title V CSHCN Program who report on the Title V CSHCN Survey that their child received the health care services they needed</td></tr>
<tr><td>Denominator:</td><td>Number of families with children with special health care needs served by Title V CSHCN Program who participated on the Title V CSHCN Survey</td></tr>
</table>
</td></tr>
<tr><td>Healthy People 2030 Objective:</td><td>Related to Objective Maternal, Infant, and Child Health (MICH) 31: Increase the proportion of children with special health care needs who receive their care in family-centered, comprehensive, coordinated systems.</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Title V CSHCN Survey of Families</td></tr>
<tr><td>Significance:</td><td>The Omnibus Budget Reconciliation Act of 1989 requires Title V to provide and promote family-centered, community-based, coordinated care and facilitate the development of community-based systems of services for children with special health care needs and their families. To address this requirement a minimum of 30 percent of the Title V Block Grant funding is allocated for this purpose, and HP 2020 Objective MICH-31 establishes the goal to " Increase the proportion of children with special health care needs who receive their care in family-centered, comprehensive, and coordinated systems".</td></tr>
</table>

SPM 4 - Percent of Family Health Branch, Arkansas Home Visiting Program, and Title V CSHCN staff who complete an equity training
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	To increase awareness of conscious and unconscious biases in health care and their impact on people who are disproportionately affected by disparities in health and healthcare
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of Family Health Branch, Arkansas Home Visiting Program, and Title V CSHCN staff who complete an equity training **Denominator:** Number of Family Health Branch, Arkansas Home Visiting Program, and Title V CSHCN staff
Data Sources and Data Issues:	Family Health Branch, Arkansas Home Visiting Program, and Title V CSHCN administrative records
Significance:	Although many underlying causes contribute to health care disparities, the Institute of Medicine's study Unequal Treatment concluded that bias, stereotyping, prejudice, and clinical uncertainty on the part of health care providers may be major contributing factors. New evidence has shed light on the following: the dynamics of conscious and unconscious biases; the effects of bias on patients and providers; and the correlation between bias, differential treatment, and disparities in the health status and outcomes for specific racial, ethnic, and other cultural groups.

Form 10
State Outcome Measure (SOM) Detail Sheets

State: Arkansas

No State Outcome Measures were created by the State.

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Arkansas

ESM 1.1 - Number of women, ages 18 through 44, with a past year preventive medical visit in an Arkansas Department of Health local health unit
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	To increase the number of women who have a preventive medical visit at an ADH LHU
Definition:	**Unit Type:** Count **Unit Number:** 100,000 **Numerator:** Women ages 18-44 receiving a preventive health visit at an ADH LHU **Denominator:**
Data Sources and Data Issues:	ADH's electronic health record. Includes appointment types for women ages 18-44 years: (1) family planning (FP) initial and annual (FPAR) and (2) well woman (WW) with BreastCare, WW with FP, WW without FP and WW follow-up visits.
Significance:	A well woman/preventive visit provides an opportunity for women to receive recommended clinical preventive services, including screening, counseling, and immunizations, which can lead to the appropriate identification, treatment, and prevention of disease to optimize the health of women before, between, and beyond potential pregnancies. The annual well woman visit has been endorsed by the American College of Obstetrics and Gynecologists (ACOG) and was also identified among the women's preventive services required by the Patient Protection and Affordable Care Act to be covered by private insurance plans without cost-sharing.

ESM 3.1 - Percent of Arkansas birthing hospitals that complete the CDC Levels of Care Assessment Tool (CDC LOCATe) annually
NPM 3 – Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Measure Status:	Active
Goal:	To decrease preterm and low birth weight births and to improve birth outcomes
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of Arkansas birthing hospitals that completed the CDC Levels of Care Assessment Tool (CDC LOCATe) **Denominator:** Number of Arkansas birthing hospitals
Data Sources and Data Issues:	Family Health Branch administrative records
Significance:	A significant cause of infant mortality is prematurity. Maternal and newborn intensive care for very premature deliveries and births has reduced mortality for those most at risk. Regionalization of NICUs seeks to increase the likelihood that a mother and infant receive risk-appropriate medical care in order to reduce maternal and infant morbidity and mortality, and to minimize cost.

ESM 4.1 - Percent of infants enrolled in the WIC program who have ever been breastfed
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	Promote breastfeeding to ensure better health for infants and mothers
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of infants certified for the WIC program whose mothers reported initiation of breastfeeding (at the time of WIC certification) **Denominator:** Number of infants certified for the WIC program
Data Sources and Data Issues:	Arkansas WIC Program SPIRIT System. Breastfeeding initiation data are collected on the telephone call to set up the initial WIC certification appointment.
Significance:	Breastfeeding is the best source of nutrition for most infants. It can also reduce the risk for certain health conditions for both infants and mothers. Infants who are breastfed have reduced risks of asthma, obesity, Type 1 diabetes, severe lower respiratory disease, acute otitis media (ear infections), sudden infant death syndrome (SIDS). gastrointestinal infections (diarrhea/vomiting), and necrotizing enterocolitis (NEC) for preterm infants. Mothers who breastfeed also experience several benefits, including lowering a mother's risk of high blood pressure, Type 2 diabetes, ovarian cancer, and breast cancer.

ESM 5.1 - Percent of women enrolled in the WIC Plus Baby and Me Program who place their infant to sleep on their back
NPM 5 – 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

Measure Status:	Active
Goal:	Promote safe and healthy infant sleep behaviors and environments, including improving support systems and the daily living conditions that make safe sleep practices and family functioning challenging
Definition:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>Number of women enrolled in WIC Plus Baby & Me who completed Module 1 who answered "always" to the question on Month 1 Pre-crying Module - When your child sleeps, do you or anyone else place your baby on his/her back to sleep?</td></tr><tr><td>**Denominator:**</td><td>Number of women enrolled in WIC Plus Baby & Me who completed Module 1</td></tr></table>
Data Sources and Data Issues:	Arkansas WIC Plus Baby and Me Program data - Month 1 Pre-Crying Session Form (REDCap)
Significance:	Sleep-related deaths is a major contributor of infant mortality in the United States and in Arkansas. Safe sleep practices can help lower the risk of sleep-related infant deaths, including sudden infant death syndrome (SIDS), accidental suffocation, and deaths from unknown causes. Safe sleep practices recommended by the American Academy of Pediatrics include: placing the baby on his or her back at all sleep times – including naps and at night; using a firm sleep surface, such as a safety-approved mattress and crib; keeping soft objects and loose bedding out of the baby's sleep area; and sharing a room with baby, but not the same bed.

ESM 6.1 - Percent of WIC-enrolled children ages 2-59 months at Learn the Signs Act Early (LTSAE) sites who received developmental monitoring
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active
Goal:	Increase the number of children who receive developmental monitoring.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of WIC-enrolled children ages 2-59 months at LTSAE sites whose parents completed the developmental milestones checklist at certification/re-certification **Denominator:** Number of WIC-enrolled children ages 2-59 months at LTSAE sites who come in to be certified/re-certified
Data Sources and Data Issues:	WIC electronic records
Significance:	Early identification of developmental disorders is critical to the well-being of children and their families. The American Academy of Pediatrics recommends developmental screening for all children ages 9, 18, 24, or 30 months.

ESM 6.2 - Percent of children, ages 2-59 months, in home visiting programs who were referred for therapy due to the results of a developmental screening using a validated parent-completed tool
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active
Goal:	Increase the number of children who receive developmental monitoring.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of children in home visiting programs referred for therapy (i.e., did not pass) **Denominator:** Number of children in home visiting programs receiving developmental screening indicating a positive result
Data Sources and Data Issues:	MIECHV electronic records (e.g., Annual Performance Report)
Significance:	Early identification of developmental disorders is critical to the well-being of children and their families. The American Academy of Pediatrics recommends developmental screening for all children ages 9, 18, 24, or 30 months.

ESM 7.1.1 - Percent of families served in home visiting programs who have reports of child maltreatment
NPM 7.1 – Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

Measure Status:	Active
Goal:	Increase parenting skills to help parents avoid maltreatment.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of families served in home visiting programs who have substantiated reports of maltreatment **Denominator:** Number of families served in home visiting programs
Data Sources and Data Issues:	ADH Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Annual Performance Report (APR) child maltreatment benchmark measure
Significance:	Child maltreatment has lifelong effects (ACEs) on health and well-being. It also increases emergency department visits.

ESM 8.1.1 - Percent of children attending public schools, grades K through 5, who are in the normal or healthy weight zone for Body Mass Index.
NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active
Goal:	Increase the number of children enrolled in public school physical education class, who are in the normal or healthy weight zone for BMI
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of children in public schools, grades K-5, who are in the normal or healthy weight zone for BMI **Denominator:** Number of children in public school in grades K-5.
Data Sources and Data Issues:	ACH BMI Assessment Reports BMI is only measured in grades K, 2 and 4.
Significance:	Increasing the amount of physical activity a child receives each week will aid in efforts to decrease childhood obesity levels.

ESM 8.1.2 - 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 services provided by School Health Services
NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the number of children enrolled in public school physical education class, who are in the normal or healthy weight zone for BMI</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of school personnel who participated in CSH training who reported an increase in knowledge of evidenced-based physical activity practices and curriculum and SHS physical activity services on the CSH evaluation survey</td></tr>
<tr><td>Denominator:</td><td>Number of school personnel who participated in CSH training</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>ADH School Health Services</td></tr>
<tr><td>Significance:</td><td>Increasing the amount of physical activity a child receives each week will aid in efforts to decrease childhood obesity levels.</td></tr>
</table>

ESM 8.2.1 - Percent of school personnel who participated in Coordinated School Health trainings with increased knowledge of evidenced-based physical activity practices and curriculum and physical activity services provided by School Health Services
NPM 8.2 – Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day

Measure Status:	Active
Goal:	Increase the number of children enrolled in public school physical education class, who are in the normal or healthy weight zone for BMI
Definition:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>Number of school personnel who participated in CSH training who reported an increase in knowledge of evidenced-based physical activity practices and curriculum and SHS physical activity services on the CSH evaluation survey</td></tr><tr><td>**Denominator:**</td><td>Number of school personnel who participated in CSH training</td></tr></table>
Data Sources and Data Issues:	ADH School Health Services
Significance:	Increases in physical activity supports reduction in obesity.

ESM 9.1 - Number of school personnel, partners, and community members participating in Youth Mental Health First Aid (MHFA) and other mental health related trainings
NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Measure Status:	Active
Goal:	To increase coordinated referrals, mental health services/programs, and follow-up for children; outreach/engagement among youth, families, schools, and communities to increase awareness, mental health identification, & service/program implementation.
Definition:	**Unit Type:** Count **Unit Number:** 1,000 **Numerator:** Number of school personnel, partners, and community members participating in Youth Mental Health First Aid (MHFA) trainings **Denominator:**
Data Sources and Data Issues:	School Health Services/Arkansas AWARE
Evidence-based/informed strategy:	Arkansas AWARE is a project funded through the Substance Abuse and Mental Health Services Administration RFA-SM-18-006 AWARE (Advancing Wellness And Resiliency in Education) State Education Agency Grant to support districts in efforts to provide mental health care awareness and trauma informed practices. Mental Health First Aid is a skills-based training course that teaches participants about mental health and substance-use issues.
Significance:	To enable school staff and other adults in the community to respond rapidly to youth who may be exhibiting signs of need for clinical intervention.

ESM 12.1 - 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
NPM 12 – 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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To increase the number of Arkansas Medicaid Pediatric & Family Practice providers who develop a Transition Policy within their practice by implementing the Six Core Elements of Health Care Transition. Related to Disability and Health (DH) Objective 5</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>The number 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 3.0 Self-assessment Tools for practitioners</td></tr>
<tr><td>Denominator:</td><td>The number of PCP practices of transition age children (12 through 17) receiving Title V CSHCN services</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data Source: Therap reports of Title V CSHCN PCPs. The program is using the Six Core Elements of Health Care Transition 3.0 Self-assessment Tools for practitioners released July 2020 by Got Transition for children with and without special health care needs.</td></tr>
<tr><td>Significance:</td><td>Will enable CSHCN providers with the ability to be able to assist and teach families the Six Core Elements of Transition to optimize their ability to assume adult roles & activities to ensure that health care services are available in an uninterrupted manner.

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 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.</td></tr>
</table>

ESM 12.2 - Percent of key stakeholders and referral sources who participated in the Title V CSHCN Health Care Transition training with increased knowledge of Health Care Transition and Health Care Transition services provided by Title V CSHCN
NPM 12 – 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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To allow for an easy transition from secondary to higher education/workforce for our CSHCN and make sure that they do not fall through the cracks of our healthcare systems.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of key stakeholders and referral sources who participated in the Title V CSHCN Health Care Transition (HCT) training whose post-test results demonstrate an increase in knowledge of HCT and Title V CSHCN services</td></tr>
<tr><td>Denominator:</td><td>Number of key stakeholders and referral sources (school personnel, providers, youth, families) who participated in the Title V CSHCN Health Care Transition (HCT) training</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Sign in sheets from Title V CSHCN Health Care Transition training and results of pre- and post-tests</td></tr>
<tr><td>Significance:</td><td>Related to Healthy People 2020 Disability and Health (DH) Objective 5: Increase the proportion of youth with special health care needs whose health care provider has discussed transition planning from pediatric 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 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.</td></tr>
</table>

ESM 12.4 - Number of School District Special Education Teachers, General Education Classroom Teachers, and District Professionals attending professional development training that complete a Title V Health Care Transition Readiness Assessment Survey
NPM 12 – 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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To allow for an easy transition from secondary to higher education/workforce and make sure that students do not fall through the cracks of our healthcare systems</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>1,000</td></tr>
<tr><td>Numerator:</td><td>Number of School District Special Education Teachers, General Education Classroom Teachers, and District Professionals that complete a Title V Health Care Transition Readiness Assessment Survey</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Title V Health Care Transition Readiness Assessment Survey of School District Special Education Teachers/Professionals</td></tr>
<tr><td>Significance:</td><td>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.</td></tr>
</table>

ESM 12.5 - 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
NPM 12 – 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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To allow for an easy transition from secondary to higher education/workforce and make sure that children do not fall through the cracks of our healthcare systems</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>1,000</td></tr>
<tr><td>Numerator:</td><td>Number of School-based Health Center Coordinators that complete a Title V Health Care Transition Readiness Assessment Survey</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Title V Health Care Transition Readiness Assessment Survey with questions regarding the school district's health center</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>Arkansas will partner with school systems to encourage their use of and understanding of a planned and structured approach to Health Care Transition for children with and without special health care needs. Got Transition has examples of Health Care Readiness Assessments for children with Individualized Education Plans and assessments for use by School-based Health Centers (Washington DC Health). Arkansas will work with School District Special Education Teachers and School-based Health Center Coordinators to implement an evidence-based approach to Health Care Transition and their policies in keeping with the Six Core Elements of Health Care Transition 3.0.</td></tr>
<tr><td>Significance:</td><td>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.</td></tr>
</table>

ESM 12.6 - Number of CSHCN (ages 12-17) with an annual update to the transition plan developed with the youth and family.
NPM 12 – 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

Measure Status:	Active
Goal:	To ensure that youth and families are prepared for health care transition by participating in the development of the Title V HCT service plan.
Definition:	**Unit Type:** Count **Unit Number:** 1,000 **Numerator:** Number of CSHCN (ages 12-17) with an annual update to the transition plan developed with the youth and family **Denominator:**
Data Sources and Data Issues:	Title V CSHCN Health Care Transition Quality Improvement Audits. Review of Title V Service Plans with transition plan developed with youth and family updated annually.
Evidence-based/informed strategy:	“Moderate/Emerging - Multicomponent intervention (strategies) with activities related to planning for transition, transfer assistance, and care coordination appear to be effective in preparing youth to transition for adult health care services.” https://mchevidence.org/tools/strategies/12-9.php
Significance:	This ESM measures the HCT goals that are developed with the youth and the family and updated annually. This is a multicomponent intervention with activities related to transition planning, transfer assistance, and care coordination.

ESM 13.1.1 - Number of presentation or education events on the importance of oral health during pregnancy
NPM 13.1 – Percent of women who had a preventive dental visit during pregnancy

Measure Status:	Active
Goal:	To educate providers, the community, and pregnant women on the importance of good oral health during pregnancy.
Definition:	**Unit Type:** Count **Unit Number:** 100 **Numerator:** Number of presentation or education events on the importance of oral health during pregnancy **Denominator:**
Data Sources and Data Issues:	ADH Office of Oral Health This is the first year of implementation and data collection.
Significance:	Pregnancy may make women more prone to periodontal (gum) disease and cavities. Oral health may be considered an important part of prenatal care, given that poor oral health during pregnancy can lead to poor health outcomes for the mother and baby. Nearly 60 to 75% of pregnant women have gingivitis, an early stage of periodontal disease that occurs when the gums become red and swollen from inflammation that may be aggravated by changing hormones during pregnancy. Periodontitis has been associated with poor pregnancy outcomes, including preterm birth and low birth weight. Pregnant women may also be at risk for cavities due to changes in behaviors, such as eating habits. Women who have a lot of cavity-causing bacteria during pregnancy and after delivery could transmit these bacteria from their mouth to the mouth of their baby. Early contact with these bacteria and to other sugars, such as from frequent snacking or taking a bottle to bed, can lead to early childhood cavities and the need for extensive dental care at a young age.

Form 11
Other State Data

State: Arkansas

The Form 11 data are available for review via the link below.

Form 11 Data

Form 12
MCH Data Access and Linkages

State: Arkansas

Annual Report Year 2022

	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source

	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
1) Vital Records Birth	Yes	Yes	Annually	0		• COVID-19 Pregnancy Women and Infants Registry • Arkansas Maternal Mortality Review Committee • Pregnancy Risk Assessment Monitoring System • Infant Deaths • Hospital Discharge Data System • Children with Special Health Care Needs program data • Newborn Screening Program • WIC Eligibility Files

	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
2) Vital Records Death	Yes	Yes	Annually	0	Yes	• COVID-19 Pregnancy Women and Infants Registry • Arkansas Maternal Mortality Review Committee
3) Medicaid	Yes	Yes	Annually	0	Yes	• Arkansas Maternal Mortality Review Committee
4) WIC	Yes	No	Annually	0	Yes	
5) Newborn Bloodspot Screening	Yes	Yes	Daily	0	Yes	
6) Newborn Hearing Screening	Yes	Yes	Daily	0	Yes	
7) Hospital Discharge	Yes	Yes	Annually	12	Yes	• Arkansas Maternal Mortality Review Committee
8) PRAMS or PRAMS-like	Yes	No	Annually	24	Yes	

Form Notes for Form 12:

None

Field Level Notes for Form 12:

Data Source Name:	**1) Vital Records Birth**
	Field Note: The Family Health Branch, where the Title V grant is housed, and the Health Statistics Branch, where the SSDI grant is housed, has data sharing agreements in place that allow the MCH Epidemiologist access to individual-level birth datasets to support the grant application, annual report, and specific projects.
Data Source Name:	**2) Vital Records Death**
	Field Note: The Family Health Branch, where the Title V grant is housed, and the Health Statistics Branch, where the SSDI grant is housed, has data sharing agreements in place that allow the MCH Epidemiologist access to individual-level mortality datasets to support the grant application, annual report, and specific projects.
Data Source Name:	**3) Medicaid**
	Field Note: ADH and the Arkansas Department of Human Services has a data sharing agreement in place that allows sharing of Medicaid data for Title V and other ADH programs. Aggregated data and activities such as data linkages for maternal mortality case reviews are available upon request.
Data Source Name:	**4) WIC**
	Field Note: Requests can be made to the WIC program for aggregated data.
Data Source Name:	**5) Newborn Bloodspot Screening**
	Field Note: The Newborn Screening Program is a Family Health Branch program, so access to individual-level data is available.
Data Source Name:	**6) Newborn Hearing Screening**
	Field Note: The Infant Hearing Program is a Family Health Branch program, so access to individual-level data is available.
Data Source Name:	**7) Hospital Discharge**

	Field Note: A data set is made available for agency epidemiologists without personal identifiers and a limited number of fields. Data requests can also be made to the Hospital Discharge Data System program. A data sharing agreement exists between the Family Health Branch - Maternal Mortality Review Committee and the Hospital Discharge Data System to obtain individual-level hospitalization data on maternal death cases for review.
Data Source Name:	**8) PRAMS or PRAMS-like**
	Field Note: Requests for aggregated data can be made to the ADH Health Statistics Branch where the PRAMS program is stationed.