Program Narrative

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A. Data Currently Available to the State

A number of resources exist within Arkansas to provide data for the needs assessment as outlined in Section 511(b)(1) of the enabling legislation. The Department of Health has birth and death certificate information that can be broken down to the county level to illuminate geographic concentrations of such issues as prematurity, low birth weight, infant mortality, late prenatal care, adolescent pregnancy, etc. Some of this analysis has already been conducted through the Title V five-year needs assessment process. Poverty data with breakdowns to county level (and below) are readily available through the University of Arkansas at Little Rock's Institute for Economic Advancement, which maintains Census data for the state. Crime figures are accessible through the Arkansas Crime Information Center as well as through online FBI resources such as "Crime in the United States," which contains data on all sorts of crimes as reported by both city and county law enforcement agencies. Data on domestic violence may be more difficult to access since crime data do not break out assaults occurring within homes. Nonetheless, groups such as the Arkansas Coalition Against Domestic Violence and the Arkansas State Judiciary should have useful statistics such as numbers of domestic violence-related homicides and numbers of court protective orders issued. Also, the Behavioral Risk Factor Survey (BRFS) conducted through the Department of Health affords county-level data on the frequency of reported intimate partner threats and assaults. High school dropout figures are maintained by the Arkansas Department of Education and should be available for every school district in the state. Estimated rates of substance abuse can be obtained via a number of surveys, such as the BRFS, the Youth Risk Behavior Survey (conducted through the Department of Education), the National Survey on Drug Use and Health, and the Arkansas Prevention Needs Assessment conducted through the Office of Alcohol and Drug Abuse Prevention (ADAP). The number of people treated for substance abuse through licensed programs can be obtained from ADAP, located in the DHS Division of Behavioral Health Services. Hospital discharge data available within the Department of Health may also be helpful in this regard. Unemployment figures by county can be accessed through the State Department of Workforce Services website. Finally, local statistics on child maltreatment can be obtained through a variety of sources, such as the DHS Division of Children and Family Services, the Arkansas Children's Trust Fund, and the Commission on Child Abuse, Rape and Domestic Violence.

With respect to capacity, Arkansas Children's Hospital has recently undertaken a comprehensive survey of all home visitation programs in the state. When complete, data from this survey should encompass numbers of families served by each and allow for judgment regarding gaps in services. Based on survey information, the extent to which such programs are meeting the needs of at-risk families will also be assessable. Capacity for substance abuse treatment and

counseling is best obtained through ADAP within the DHS Division of Behavioral Health Services, which both licenses and funds a number of treatment facilities around the state.

B. Gaps in Available Information

At least some form of data is available in Arkansas for all of the areas listed in the enabling legislation. The following points relate more to limitations in existing data sources rather than major gaps per se.

There are intrinsic difficulties, undoubtedly not unique to Arkansas, in reporting of information related to domestic violence. There is no one state repository of data on the subject. Because reporting is left almost solely to the victim, and victims fear repercussions related to reporting, many instances are believed to go unreported. Victims may fail to report domestic violence even on confidential surveys such as the BRFS. Despite these limitations, however, comparisons among counties using available information should still be useful in identifying geographic regions at higher risk.

Problems of under-reporting also affect child maltreatment statistics. In the case of children, however, other mandatory reporters such as health care workers, teachers, neighbors, or anyone else who suspects abuse or neglect help to improve detection rates. Suspected child abuse reporting is also centralized in Arkansas through the State Police, a system that standardizes the data collection process and facilitates statewide data analysis. While there may be geographic pockets within the state from which there is consistent under-reporting, data from the Division of Children and Family Services represent the most reliable source available particularly for substantiated abuse.

True rates of substance abuse will also be difficult to assess, since many abusers manage to keep their problem hidden until it becomes manifest either as a result of legal intervention, dysfunction (or drug testing) at work, or problems in relationships. Those who reach the point of seeking treatment through substance abuse programs are relatively easy to count, but obviously do not represent the universe of substance abusers. Awareness of and proximity to such a program may strongly influence utilization rates in certain locales. Individuals participating in surveys such as the BRFS may also fail to fully report the extent to which they use certain substances. As before, however, relative comparisons among counties should still prove useful even given these limitations.

In the absence of formal guidance regarding specific data required for the needs assessment, no further comment can be offered at this time with respect to gaps. Based upon the information in the enabling legislation, no other major gaps with respect to maternal-child health, poverty,

crime, unemployment or dropout statistics, or home visiting capacity assessment, are currently anticipated.

C. State Capacity to Locate and Assemble Information

The state Title V unit (housed within the designated lead agency for this project) is well-versed in data acquisition and presentation. The Family Health Branch at the Department of Health has recently completed work on the five-year needs assessment required for MCH Block Grant funding. As part of that work, collaborative relationships have been formed with a large number of groups outside the Department of Health to facilitate transfer and assembly of data as required by MCHB. Some of the data required for the home visiting need assessment is clearly different and will require approaching new partners. However, most of these agencies (as outlined under part A above) have already been contacted and are willing to cooperate as needed to assure provision of the most comprehensive data available. Arkansas Children's Hospital has already graciously facilitated formation of a work group for the needs assessment consisting of many of the key partners needed for the capacity portion in particular. Among other promises of support, members of this group have committed to assist in the process of identifying strengths and gaps related to home visiting activities in the state.

Perhaps the greatest perceived barrier to compilation of data for the needs assessment is time. Until specific guidance is issued, partners within the state cannot reasonably be asked to start supplying information based only on the limited wording in the legislation. Further, if the required data are requested in a format not already produced by a given partner or partners on a routine basis, generation of a special report may not necessarily be feasible in the time allotted to produce the needs assessment.

D. Barriers to and Opportunities for Coordination with Title V, Head Start, Title II of CAPTA

Since the state Title V agency has taken responsibility for carrying out the home visitation needs assessment, data from the five-year MCH Needs Assessment are completely accessible in-house. The Director of the Arkansas Head Start State Collaboration Office has agreed to work with the lead agency to help gather available information from Head Start agencies in Arkansas on community needs assessments conducted as part of that program. Likewise, the Director of the Arkansas Children's Trust Fund, which oversees Title II and administration of Community-Based Child Abuse Prevention grants, has agreed to share any information that group possesses with respect to child abuse prevention needs and capacity in the state. The Trust Fund's director is actually very closely involved in the home visiting capacity survey being conducted through Arkansas Children's Hospital.

A possible barrier to fully incorporating Head Start information into the home visitation needs assessment is the lack of a statewide compilation of the numerous communitywide assessments conducted under that program. The State Collaboration Office does not keep copies on file of all the communitywide assessments conducted by the 21 Head Start agencies in Arkansas. These assessments apparently do not follow a standard format either, although they often include information on at least some of the issues specified in section 511 (b)(1) of the Affordable Care Act. Another barrier to prompt submission of community assessment data by Head Start agencies is that some of them are essentially closed during the summer months. On the other hand, the Director of the HS State Collaboration Office has pledged to assist in any way possible. Potential avenues for information-gathering by the lead agency include a teleconference with Head Start agency directors, a question-and-answer session with agency directors at their July 2010 meeting, and/or submission of a written summary of needs for each community (since detailed analysis of all communitywide assessments may not be possible given time constraints). The exact mode(s) chosen will depend in large degree on the formal requirements for incorporating this information into the needs assessment.

Information available from Title II under CAPTA also carries some limitations. In Arkansas, unlike other some other (larger) states, the responsible entity (Children's Trust Fund) did not conduct its own statewide assessment when applying for Community-Based Child Abuse Prevention funds. Instead, the group relied on other reports, including the Early Childhood Comprehensive Systems plan and a report that was issued in 2007 by the State Legislative Task Force on Abused and Neglected Children. While very useful, these reports do not contain specific county-level information on resources available to combat child abuse. Once again, the Director of the Trust Fund has agreed to assist in any way possible. Exactly how this assistance will take shape depends on specific requirements for incorporating this information into the needs assessment. Needless to say, however, there will be insufficient time for the Title II agency to try and conduct a full-fledged statewide inventory of needs and capacity related to child abuse prevention if that information is specifically called for in the phase 2 guidance.

E. General Description of Approach for Conducting the Needs Assessment

The Department of Health will contact the appropriate sources of data (as listed under part A) as soon as guidance is available. As with the Title V needs assessment, the MCH Epidemiologist will likely be very involved in the procurement, processing and assimilation of required data of elements into the final assessment. The Department of Health's MCH unit will work closely with other internal organizational units to ensure that requests for information from outside groups are reasonable yet meet guidance requirements. Leaders within the MCH unit (Family Health Branch) will help guide outside partners toward delivery of the desired data in a timely way. If for some reason data are not available within the state in the manner requested by the

forthcoming guidance, a detailed explanation for that will be provided along with at least some relevant data that are available.

As stated under part C above, a work group has been formed to assist in the needs assessment, particularly the home visiting capacity appraisal. The group consists of representatives from Arkansas Children's Hospital, the Department of Health, the Arkansas Children's Trust Fund (Title II/Community-Based Child Abuse Prevention program), the Head Start State Collaboration Office, the University of Arkansas for Medical Sciences (Dept. of Pediatrics), the DHS Division of Child Care and Early Childhood Education, the Home Instruction Program for Preschool Youngsters (state and national), the Parents as Teachers program, Arkansas Advocates for Children and Families, and the Arkansas Department of Education. These groups have all agreed to work together through the duration of the needs assessment process, as all have a keen interest in seeing that home visiting resources are directed appropriately.

The fact that the work group consists of a large group of key stakeholders who are highly knowledgeable about the Arkansas landscape helps to ensure identification and assimilation of other state- and community-level needs assessments into the home visitation assessment process. The members of the work group are aware of many other contacts within the state who possess useful information and can help direct Department of Health staff toward those resources.

Letters of support from the four principal agencies are attached. All of these groups have an expressed interest in home visitation and in seeing the needs assessment satisfactorily completed. All will be involved in preparation and review of the needs assessment document, and no obstacles to any of them providing formal assent are anticipated at this time.

F. Anticipated Technical Assistance Needs

As previously noted, the Title V unit has significant experience in performance of needs assessments. Preliminary assurances of cooperation by many of the groups possessing relevant data have already been obtained, and Department of Health capacity to carry out the needs assessment is believed to be sufficient. Nonetheless, depending on the specific requirements, some additional assistance might be needed. Such assistance might entail such areas as suggested sources for needed data, appropriate substitutes for data that are not available, or acceptable methods of data analysis. Regardless, whether and in what form help is needed will not be known until the needs assessment guidance has been fully absorbed.

G. Statement of Intent to Apply for Grant Funds, and Assurances

Arkansas intends to apply for grant funds to enable early childhood home visiting services as described in section 511(c) of the enabling ACA legislation.

The Arkansas Department of Health (ADH) has been designated by Governor Mike Beebe as the lead agency for administration of funds under this federal program (see Attachment). The Department of Health has substantial organizational capacity to carry out the program. ADH has one or more local health units located in every county in the state. A strong structure for support of local staff exists through the Center for Local Public Health, which also encompasses five regional management offices. The department has past experience with provision of the Nurse Family Partnership model, albeit somewhat short-lived. Since around 2001, the department's In-Home Services Branch, also within the Center for Local Public Health, has conducted the Maternal-Infant Program of home visiting. Physicians and local health unit staff refer mothers and infants to this program, which provides a maximum of 15 visits over the course of pregnancy and the first year of the infant's life. In FY2009 over 22,000 nurse visits were provided under this program, mostly to pregnant/parenting adolescents and their offspring. The Maternal-Infant Program is funded strictly by Medicaid reimbursement as allowed, although a sizeable proportion of clients are "no-source." In addition to strong clinical and preventive health infrastructure, the Department of Health also possesses strong analytical capability through its Health Statistics and Epidemiology Branches. This capacity will be particularly relevant to helping monitor communities after home visiting is implemented to assess for improvements in benchmark measures. Further, the Department of Health maintains robust relationships with the University of Arkansas for Medical Sciences (UAMS) and the Arkansas Center for Health Improvement that have proven quite rewarding in evaluation of other public health programs.

Data from the full needs assessment are expected to drive decisions regarding populations to be served under this grant opportunity. To the extent possible, targeted communities will include those at highest risk as defined by the enabling legislation [section 511 (b)(1)(A)]. However, other populations (apart from geographically-determined areas) will also be given priority for receipt of home visiting services, including all those defined in section 511 (d)(4) of the Act. The latter include families in poverty, pregnant adolescents, families with a history of child abuse or neglect, families with a history of substance abuse, families with tobacco users, families with children with low academic achievement, families with children with developmental delays, and military families. Additional high risk populations may also be identified as a result of the needs assessment, such as neonatal intensive care unit "graduates" and their families, or families known to have low health literacy. The actual process to be used in selecting populations to be served is expected to be a collaborative one, with input from a large number of interested agencies in the state. The process for achieving this collaboration is already well under way with formation of the needs assessment work group, but will entail even broader involvement than the groups that are currently participating.

A review of evidence-based home visiting models is currently underway within the Health Department. Outside partners are also sharing information on known models meeting the criteria

for "evidence-based," (although additional guidance on this topic is also anticipated from federal partners). Once acceptable models have been studied and are well-understood, data from the needs assessment and perhaps other knowledge of local capacity, cultural characteristics, and community acceptance should logically lead to selection of the best "fit" for the selected population. Again, a collaborative approach with buy-in from all key stakeholders will be the optimal approach in this regard. In particular, local needs and preferences must be given the highest degree of consideration before a specific model is implemented.

As the designated lead agency, the Arkansas Department of Health assures that:

- -Priority for services will be given to serving low-income families and families in at-risk communities, as consistent with the statewide needs assessment
- -The state program will obtain and submit appropriate evidence from whatever group or organization has developed the selected service model(s) to verify that the program's services are implemented in accordance with the model's specifications
- -The state program will establish procedures to verify that participation of each enrolled family is voluntary and that services are provided to an eligible family in accordance with the individual assessment for that family
- -The state program will submit annual reports to the Secretary regarding the program and activities carried out by the program
- -The state program will participate in and cooperate with data and information collection necessary for the evaluation required under section 511(g)(2) and other research and evaluation activities carried out under section 511(h)(3)
- -The state is not one of the 17 ACF-funded projects in the Evidence-Based Home Visiting cluster

Furthermore, the Department of Health assures that the populations to be served and the service delivery model(s) chosen will be consistent with the statewide needs assessment. In addition, the service delivery model(s) chosen will be consistent with section 511(d)(3)(A) of the Act and with forthcoming guidance from HHS.

Quantifiable benchmarks must be established as required by the Act [section 511(d)(1)(A)] to demonstrate that the program improves specific areas for participating families, i.e. maternal and child health; child injuries, child abuse/neglect, and emergency department visits; school readiness and achievement; crime and domestic violence; family economic self-sufficiency; and coordination and referrals for other community resources. Such benchmarks will require an established baseline in order to track progress over the course of the project. To prove that served families are better off in these areas than non-served families, a control group may need to be identified for use as a comparison. To help set up the benchmarks, experts in program

evaluation will need to be consulted. These experts may be internal (Health Statistics, Epidemiology) external (e.g. Arkansas Center for Health Improvement, UAMS College of Public Health or Department of Pediatrics, national model specialists), or a combination of both. A work group dedicated to creation of appropriate benchmarks is likely to be required to ensure that improvements resulting from the program are captured. This group would ideally be formed toward the end of the needs assessment process so that existing data could be examined and a plan for benchmarks formulated during the application process for phase 3.

The Arkansas Department of Health assures that reporting on selected benchmarks will occur as required by law during the 3rd and 5th years of the program.

Existing home visitation programs within the state have not been fully catalogued to date, but will be when the Arkansas Children's Hospital survey process is complete. In a recent preliminary survey of home visiting conducted by the hospital, a total of 17 programs involved in home visiting responded. Other programs are thought to exist although they probably have a relatively small scope of activity. Seven of the 17 respondents reported employing their own "home-grown" or some other model, while the rest utilize one or more national models. A variety of public and private funding sources support these programs, which in turn report spending a range of $242 to $5,000 per year per family served. At present it appears that few, if any, of these programs have been formally evaluated. Again, further information-gathering is underway.

A very brief description of some of the larger home visiting programs in Arkansas follows. The Maternal-Infant Program conducted through In-Home Services within the Department of Health has already been described (second paragraph, this section). The Home Instruction Program for Preschool Youngsters (HIPPY) also deserves special mention. HIPPY, sponsored through Arkansas Children's Hospital, teaches parents how to prepare preschool children for success in school. The program partners with a diverse array of responsible local agencies to provide instruction both in the home and through group parent meetings. About 5,000 families in the state are served through HIPPY, which is funded in large part by Arkansas Better Chance (ABC) legislation originally passed in 1991. Another program with a home visiting component is Head Start. In Arkansas, six of the 21 Head Start agencies currently provide the full complement of home-based services to a total of about 300 children. About 10% of these children are served under Early Head Start (0-3 years of age). The Arkansas Children's Trust Fund (Community-Based Child Abuse Prevention grant agency) also supports home visiting services through a number of community-based agencies around the state. Trust Fund grantees involved in home visitation target various populations, including pregnant and parenting adolescents and parents of infants and preschoolers. These grantees employ a range of models and curricula to meet the needs of their target populations. The Parents as Teachers model is employed through approximately 13 sites in Arkansas at present. Similar to the HIPPY model, trained, certified

professionals (usually with bachelor's degrees) make home visits to help teach parents how to support their children's healthy development. The most commonly used curriculum is Born to Learn, which follows a mother from the prenatal period until the child is three years old. Other specialized curricula are also employed as determined by family need. Parents as Teachers programs are funded through several sources, including ABC, Even Start grants, and the Children's Trust Fund.