



# HEALTH STATUS OF CHILDREN IN HAWAI'I

2011/12 National Survey of Children's Health

HAWAI'I DEPARTMENT OF HEALTH



FAMILY HEALTH SERVICES DIVISION



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Family Health  
Services Division



The 2011/12 National Survey of Children's Health once again provides us with the opportunity to explore different pertinent child health issues both nationally and in Hawai'i. The Hawai'i Department of Health's Family Health Services Division is pleased to present the Health Status of Children in Hawai'i: 2011/12 National Survey of Children's Health. This report is an update and expansion of the previously released Health Status of Children in Hawai'i: 2007 Nation Survey of Children's Health and highlights 38 child health indicators representing the following areas: 1) physical, mental, and dental health, 2) health care access, quality, and insurance coverage, and 3) community, school, and family life/ health. Hawai'i data was examined for each indicator by age, race, gender, federal poverty level categories, insurance type, medical home status, and Adverse Childhood Experiences (ACEs). Disparities among the specific population groups are highlighted for each indicator. The information presented is intended to inform and stimulate action by policy makers, planners, and community members who are invested in the health of children.



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# SUMMARY

The National Survey of Children's Health survey data provides critical information on the health and well-being of children across the country and in the State of Hawai'i. This data includes a wide range of indicators from early child origins as reflected in birth outcome data such as low birthweight and prematurity to late adolescence with indicators such as child obesity. Additionally, the survey data provides information in multiple dimensions including individual and paternal health status indicators, health care associated indicators, and community, school and family indicators. Specific child data spanning from infancy to late adolescence is not available at the population level in any other current data source. This report was designed to provide data on multiple indicators and allow comparison among individual population groups within the constraints of this national survey. This data report is meant to provide some overall information on this population with the goal to increase awareness of differences among population groups. Some of the differences are quite pronounced and may suggest specific population groups that may benefit from targeted interventions. However, it is important to realize that all of the indicators included in this report are complex and will require a better understanding of the reasons for the differences before effective interventions to improve the health of children in the state can be developed. This may require evaluation of additional data available or the creation of new data sources through the work of partners.

Some of the common themes found throughout the report are that Hawai'i is generally, better overall or similar when compared to the rest of the nation, but there are present significant disparities within various population subgroups in the State. Generally the strongest relationship with population subgroups was based on socioeconomic status. For example, the highest risk was found among those with families living below the federal poverty level compared to those with higher incomes, and children with public insurance generally worse indicators than those with private insurance. There were some differences by race group which were not as consistent, but generally found those that were Native Hawaiian/Pacific Islander were at the greatest risks with those that were multi-racial (which would include part-Hawaiians) were generally of intermediate risk. Having a medical home generally reflected a lower risk when compared to not having a medical home, and those children who are not in situations where they experience adverse childhood events generally do much better.

One approach to move forward on many of these disparities would be to use these findings to increase awareness, improve data surveillance among children of all ages, and develop a comprehensive approach such as using the framework of the social determinants of health to look across the life course at multiple individual and system levels to enact change where needed to improve the health of children in Hawai'i.

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# OVERVIEW OF SURVEY: NSCH

The National Survey of Children's Health (NSCH) is a telephone survey first conducted in 2003 and again in 2007 by the Center for Disease Control and Prevention's (CDC) National Center for Health Statistics. In 2011/12, the survey was administered for the third time to continue monitoring the health of children in the United States. This report examines the 2011/12 data at the national and state (Hawai'i) level.

The 2011/12 NSCH was primarily funded by the Maternal and Child Health Bureau (MCHB) of the Health Resources and Services Administration (HRSA) and the United States Department of Health and Human Services (DHHS). Additional funding for specific questions was provided by DHHS, Office of the Assistant Secretary for Planning and Evaluation. The survey is designed to:

1. Estimate national and state-level prevalence for a variety of physical, emotional, and behavioral child health indicators in combination with information on the child's family context and neighborhood environment,
2. Provide information for policy makers, advocates, and researchers,
3. Generate baselines for federal and state Title V Maternal and Child Health performances measures, MCHB companion objectives for Health People 2020, and data for each state's 5-year Title V needs assessment, and
4. Complement the National Survey of Children with Special Health Care Needs.<sup>1</sup>

The 2011/12 NSCH was administered using the CDC's State and Local Area Integrated Telephone Survey (SLAITS) program, a telephone survey mechanisms based on a large Random Digit Dial (RDD) sample design. From February 2011 to June 2012, households with children in the 0-17 year old age range were selected using a random-digit-dialed sample. For the 2011/12 NSCH, an additional independent random-digit-dial sample of cell phone numbers was also selected. In total, 95,677 detailed child-level interviews representing an estimated 73,716,714 children nationwide were conducted. Around 1,811 to 2,200 interviews were completed in all 50 states and the District of Columbia. The respondents were parents or guardians with knowledge of the health and health care of the sampled child in the household. For the completed NSCH interviews, 68.8% of the respondents were mothers, 24.2% were fathers, and 7.2% were other relatives or guardians. The NSCH interview completion rate was 54.1% for the land line sample and 41.2% for the cell-phone sample.<sup>2</sup>

The survey provides a broad range of information about child's health and wellbeing. The standardized data collection methodology allows comparisons to be made across states as well as to the nation. The ten major topics covered by the 2011/12 NSCH include the following: 1) demographics, 2) child's health and functional status, 3) health insurance coverage, 4) health access and utilization, 5) medical home, 6) early childhood (0-5 years) issues, 7) issues specific to middle childhood and adolescence (6-17 years), 8) family functioning, 9) parental health, and 10) neighborhood and community characteristics.

# OVERVIEW OF SURVEY: NSCH

Over 80 indicators of child health status were addressed by the 2011/12 NSCH. In order to standardize the analysis of the NSCH data, the Data Resource Center (DRC) developed recommended codes for the data analysis of each indicator. This report used the DRC's 2011/12 National Survey of Children's Health SAS Code for Data Users as a guide for analysis of the indicators presented.<sup>3</sup>

Each record in the 2011/12 NSCH was assigned a single sample weight to account for each state's unique population of non-institutionalized children between the ages of 0-17. Sampling weights were adjusted to account for non response, household without land lines, and demographics such as age, gender, and race. The survey weights allow estimates representative of all non-institutionalized children aged 0 to 17 years in the United States and in each state to be made.

One major change in the 2011/12 NSCH compared to previous years is the inclusion of cell phones in the 2011/12 sample. Special attention may be warranted. In addition, the 2011/12 NSCH added several new health indicators and revised a few pre-existing ones.

More information regarding the NSCH can be found at the DRC website [www.nschdata.org](http://www.nschdata.org). The DRC is an interactive resource that allows users to compare state, regional, and nationwide results- plus additional resources and personalized assistance for interpreting and reporting findings. The public use file and methodology for NSCH can be found on the SLAITS website at [www.cdc.gov/nchs/slaits/nsch.htm](http://www.cdc.gov/nchs/slaits/nsch.htm).



# Population Characteristics

## Estimates for Hawai'i, NSCH 2011/12 Data

	Estimated Population (N)	Prevalence Estimate (%)	95% Confidence Interval	Respondents (n)	Missing Responses (n)
<b>Age</b>					
0-5 Years	100,800	33.2	30.3-36.1	565	None
6-11 Years	100,944	33.2	30.5-36.1	672	
12-17 Years	102,341	33.7	30.9-36.6	644	
0-8 Years	152,676	50.2	47.2- 53.2	904	
9-17 Years	151,409	49.8	46.8- 52.8	977	
<b>Race</b>					
White Only	70,007	23.8	21.3-26.4	410	50
Black Only	5,938	2.0	1.3-3.2	28	
Asian Only	56,756	19.3	17.1-21.6	467	
NH/PI Only	62,878	21.3	18.8-24.1	350	
Multiracial	99,180	33.7	30.8-36.6	576	
<b>Gender</b>					
Male	154,407	50.9	47.8-53.9	969	4
Female	149,122	49.1	46.1-52.2	908	
<b>% Federal Poverty Level</b>					
<100%	56,725	18.7	16.2-21.4	285	None
100%-199%	72,284	23.8	21.2-26.6	383	
200%-399%	102,517	33.7	31.0-36.6	642	
400%+	72,559	23.9	21.6-26.3	571	
<b>Insurance Type</b>					
Public	93,647	31.3	28.5-34.4	501	24
Private	201,472	67.4	64.4-70.3	1336	
Uninsured	3,699	1.2	0.7-2.1	20	
<b>ACEs</b>					
No ACEs	160,469	53.6	50.3- 56.7	1061	24
One ACE	78,645	26.3	23.6- 29.1	467	
Two or more ACEs	60,260	20.1	17.8- 22.7	329	
<b>Medical Home</b>					
Qualified	166,451	57.4	54.3- 60.5	1056	79
Not Qualified	123,307	42.6	39.5- 45.7	746	
<b>Total *</b>	304,085	100.0	N/A	1881	

Note: NH/PI = Native Hawaiian/ Pacific Islander

\* Total is based on responses for age and is similar but not identical to totals for other variables that have missing values.



## Estimates for Hawai'i Continued

	Estimated Population (N)	Prevalence Estimate (%)	95% Confidence Interval	Respondents (n)	Missing Responses (n)
Selected Additional Characteristics					
Primary Language					
English	279,744	92.1	90.1-93.6	1755	2
Non-English	24,127	7.9	6.4-9.9	124	
Hispanic or Latino Origin					
Yes	44,734	15.2	13.2-17.4	317	51
No	259,350	84.8	82.6-86.8	1513	
Highest Parental Education					
<High School	13,433	4.7	3.3-6.7	44	113
High School/GED	64,760	22.7	20.0-25.6	314	
More than High School	207,688	72.7	69.5-75.6	1410	
Welfare Cash Assistance					
Assistance	21,827	11.8	9.5-14.7	118	836
No assistance	162,466	88.2	85.3-90.5	927	
WIC Assistance					
WIC assistance	35,691	19.3	16.2-22.7	176	835
No WIC assistance	149,763	80.7	77.2-83.7	870	
Premature Birth					
Yes	31,189	10.4	8.7- 12.4	196	23
No	269,699	89.6	87.6-91.3	1662	

# Population Characteristics

In this section, population characteristics estimated from the 2011/12 NSCH data are presented for Hawai'i. Information regarding 1,881 Hawai'i children were included in the 2011/12 data, representing an estimated children 304,085 children.

## Age

The age of the child were grouped in two ways: three and two levels. The three-level categories were: 1) 0-5 years old, 2) 6-11 years old, and 3) 12-17 years old. Most children from surveyed households in Hawai'i fell within the 6-11 year old age group. Weighted estimates for the population showed that the dispersion was relatively even between age groups. An estimated 33.2% of children were in the 0-5 year old age group, 33.2% were in the 6-11 year old group, and 33.6% were in the 12-17 year old group.

The age of the child were also grouped into two levels: 1) 0-8 years old, and 2) 9-17 years old to reflect the interest of community stakeholders towards a broad definition of early childhood to include up to 8 years of age. In Hawai'i, slightly more surveyed children fell into the 0-8 year old age group. Weighted estimates for the population showed that the distribution was relatively equal between the two age groups.

## Race

Specific racial categories for Hawai'i were collected by the NSCH. These racial groups included: 1) White only, 2) Black only, 3) Asian only, 4) Native Hawaiian/ Pacific Islander only, and 5) multiracial. Over 300 children were sampled in each racial group except for the Black only category in which only 28 children were sampled. The estimates for Black children were not reported due to the small number of respondents. Multiracial children (33.7%) made up the greatest percentage of Hawai'i youth, followed by White only (23.8%), NH/PI only (21.3%), and Asian only (19.3%).

## Gender

An approximately equal number of male and female children were sampled. Estimates showed that 50.9% of children in Hawai'i were male and 49.1% of children were female.

## Percent of Federal Poverty Level

Percent of Federal Poverty Level (%FPL) were categorized into four groups: 1) less than 100% FPL, 2) 100%-199% FPL, 3) 200%-399% FPL, 4) 400% FPL or more. The poverty status of a household was determined by household income and the number of people living in the household. The U.S. Department of Health and Human Services (HHS) publishes poverty guidelines every year for the determination of household poverty status. Three separate guidelines are developed for Hawai'i, Alaska and the remaining 48 states (including District of Columbia). In cases where respondents did not report a specific dollar amount for household income, a value was imputed based on a routine developed for groupings of FPL by the DRC. In Hawai'i, an estimated 56,725 or 18.7% of children were living in households below the federal poverty level in 2011. Most children in Hawai'i were within the 200%-399% FPL (33.7%) followed by those living in the 100%-199% FPL (23.8%).

## Insurance Type

Children in Hawai'i were grouped into three categories of insurance type: 1) public insurance such as Medicaid or SCHIP, 2) private health insurance, and 3) uninsured. Most children in Hawai'i were privately insured (67.4%), followed by children who were publicly insured (31.3%). Only 1.2% of youth, or 3,600 children, in Hawai'i were uninsured. The estimates for uninsured children were not reported due to the small number of respondents.

## Adverse Childhood Experiences

Adverse Childhood Experiences (ACEs) capture psychosocial risk factors that affect children. A list of nine ACEs was developed and tested by national experts for inclusion in this survey. For more information regarding what psychosocial risk factors were included in this survey, please refer to the ACE indicator found on page 59 of this report. The ACEs were categorized into the following three groups: 1) No ACEs, 2) One ACE, 3) Two or more ACEs for this report. In the State of Hawai'i, the majority of children (53.6%) have experienced no ACEs. Approximately 26.3% of children experienced one ACE and 20.1% of children experienced two or more ACEs.

## Medical Home

Estimates showed that 57.4% of children in Hawai'i received care that met the criteria for a medical home. 42.6% of children in Hawai'i did not receive care that met the criteria for a medical home. For more information regarding the components of a medical home, please refer to page 51 of this report.

## Additional Characteristics

In this report, we primarily focused on the seven aforementioned population characteristics. However, other additional characteristics have been included in this table to provide a more comprehensive overview of the youth population in Hawai'i. The majority of youth (92.1%) in Hawai'i were reported to speak English as their primary language. An estimated 15.2% of children were of Hispanic or Latino Origin. Most youth (72.7%) had at least one parent who completed more than a high school level of education. Only 4.7% of children were reported to have a parent who completed Less than a high school education. Approximately 11.8% of children lived in a household where someone received cash assistance from a state welfare program at some point in the previous 12 months. Lastly, 19.2% of children lived in a household that received benefits from the Special Supplemental Nutrition Program for Women, Infants and Children (WIC). Approximately 10.4% of all children were reported to have been a premature birth (<37 weeks of gestational age).

## Organization

This report is organized along three major categories commonly used in reports of the 2011/12 NSCH data (Health Status, Health Care, and Community School and Family). Results for each indicator are presented in a two-page format. The first page displays the estimate for all children in the State of Hawai'i with comparison to the rest of the nation. National estimates throughout this report do not include Hawai'i data. Hawai'i is compared separately and independently in the analyses. Also on the first page is the general description on the importance of the indicator and specific information on indicator definitions used in the survey. The second page of results for each indicator represents an examination of Hawai'i data by potential disparities groups based on variation within the population and additional characteristics of interest. Indicators where potential disparities groups were not possible such as (e.g., adverse childhood events by adverse childhood events) or if the age range in which the question did not apply to various standard age categories (e.g., 12-17 year olds) or the overlap didn't allow a reasonable comparison to other standard age categories (e.g., 10-17 year old question would consist of a comparison of 10-11 years to the standard 12-17 years). Bar graphs are used to visually depict the differences for three groups. A brief description of the differences in the graphs and when applicable, those not shown in graphs is also provided.

## 95% Confidence Intervals

The error bars shown in each bar graph illustrates the 95% confidence intervals (95% CI) and is intended to indicate the variability in the estimate of interest. The 95% CI gives an estimate range of values which is likely to include the true value within the population of interest 95% of the time. Confidence intervals can provide quick visual comparisons between different subsets of a variable (e.g., to compare estimates for different insurance types). A 95% confidence interval reflects a significance level of 0.05. Therefore, if the 95% confidence intervals for estimates do not overlap, there is a statistically significant difference between the estimates of interest ( $p < 0.05$ ). In general, if the 95% confidence intervals overlap, then there is no significant difference between the estimates being compared. There may be some exceptions in situations involving minimal overlap of the confidence intervals.

## Pairwise Comparisons and Statistical Testing

Each indicator in this report was examined by population characteristics of interest (e.g., age group) that contain different groups (e.g., age groups: 0-5 years, 6-11 years, and 12-17 years). Pair-wise comparisons were used to compare every pair combination (e.g., 0-5 years to 6-11 years, 0-5 years to 12-17 years, and 6-11 years to 12-17 years) for each indicator using a two sample t-test with a  $p < 0.05$  threshold for statistical significance. In this report, the significant differences are described in the text.

## Unreliable Estimates and Relative Standard Error (RSE)

The NSCH allows the reporting of estimates based on any cell size, but requires the relative standard error (RSE) be calculated when the cell count is <50. The RSE is a measure of variability of an estimate and is calculated as the standard error divided by the estimate for the measure in the particular population group. An estimate is unstable and does not meet standards for reliability and precision when the RSE is greater than 30%.

In this report, any estimate in a population subgroup that did not meet the appropriate RSE threshold was suppressed. Additionally, the pound “#” notation is used when the cell size was <50 for the subgroups. Therefore, caution is needed with interpretation when there are a small number of respondents for the indicator as indicated by the “#” notation due to the small size for the subgroup even if the RSE is within acceptable standards.

## Supplementary Tables

There are specific supplementary tables containing information on each indicator by the population characteristics of interest are included at the end of this report. Each table contains the prevalence estimate as well as the 95% CI values for each examined health indicator by the various population characteristics and for the overall estimate for the State. The population characteristics featured include: race, federal poverty level, insurance type, age (standard, plus the expanded early childhood 0-8 years), gender, Adverse Childhood Experiences (ACEs), and medical home status.

# HEALTH STATUS

## Overall Health Status Ages 0-17 Years

### **Background:**

Beginning from childhood, health continues to develop over a lifetime and is affected by exposures to various risk and protective factors. In order to optimize health across the lifespan, it is important to understand the physical, social, and economic environment that shapes health and disease patterns.<sup>4</sup> Furthermore, differences in these factors are also responsible for health disparities present across populations and communities.<sup>5</sup>

Overall health status is a multifaceted topic that involves the physical, intellectual, and emotional development of children. Measuring overall health status helps to capture the child's overall health status and ability to function.

### **Measurement:**

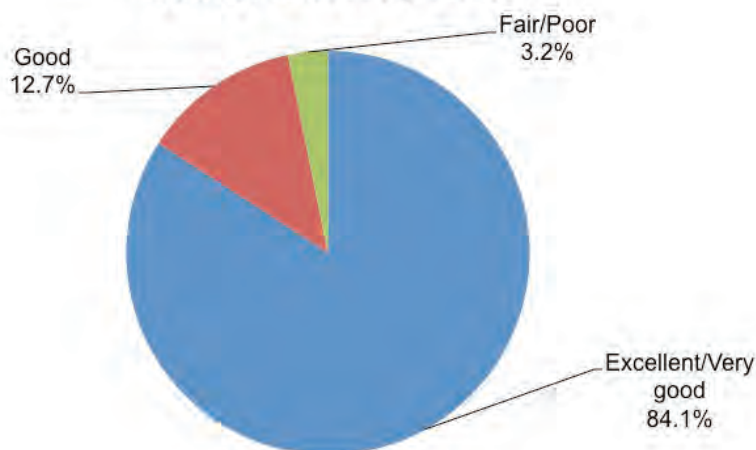
Parents of 0-17 year olds were asked to describe their child's general health (excellent, very good, good, fair, poor). These five categories were combined into three (excellent/very good, good, and fair/poor).

### **National Comparisons:**

In Hawai'i, 86.0% of children were reported in excellent/very good health. This is higher but not significantly different from the national estimate of 84.1%.

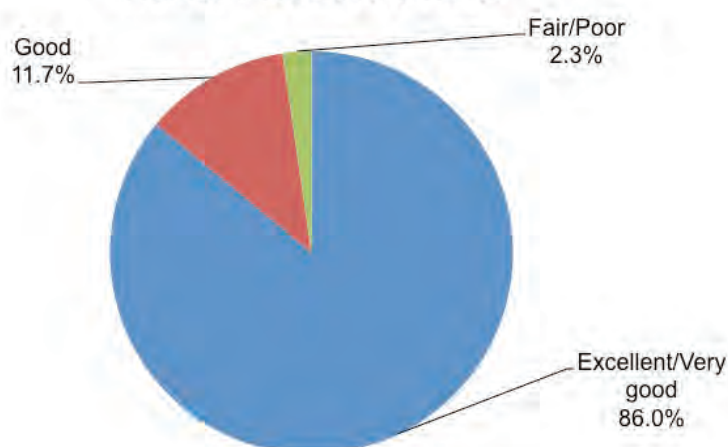
In Hawai'i, 11.7% of children were rated as in good health, followed by 2.3% who were rated as in fair or poor health. National data showed that 12.7% of children were in good health while 3.2% of children were in fair or poor health.

### Overall Health Status, Nation NSCH 2011/12



Data Source: National Survey of Children's Health, 2011/12

### Overall Health Status, Hawai'i NSCH 2011/12



Data Source: National Survey of Children's Health, 2011/12

Overall Health Status of Children:  
86.0% (Hawai'i)  
vs  
84.1% (Nation)



## Overall Health Status Disparities

Data for Hawai'i demonstrated disparities in children with overall excellent/very good health related to race, federal poverty level, insurance type, age, ACEs, and medical home.

### **Race:**

White children (90.3%) were more likely to be in excellent/very good health compared to other racial groups. Differences in health between White children compared to Asian (82.5%) and Hawaiian/Pacific Islander (81.3%) were statistically significant. The differences in health between multiracial (88.5%) children compared to Asians were also significant.

### **Federal Poverty Level:**

Excellent/very good health increased with federal poverty level (FPL). A significantly higher proportion of children living above 400% FPL (91.1%) were in excellent/very good health compared to those at the 200-399% (90.2%), 100-199% (80.0%), and <100% (79.7%) poverty levels.

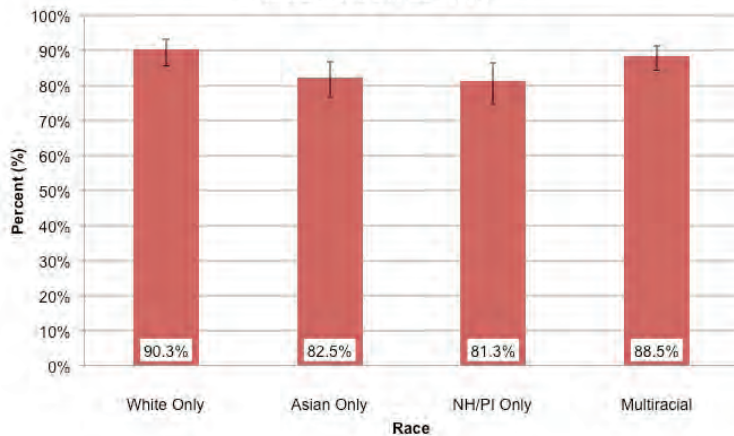
### **Insurance Type:**

More privately insured children were in excellent/very good health (90.2%) compared to other groups. The difference between privately and publicly insured children (77.7%) was statistically significant.

### **Other:**

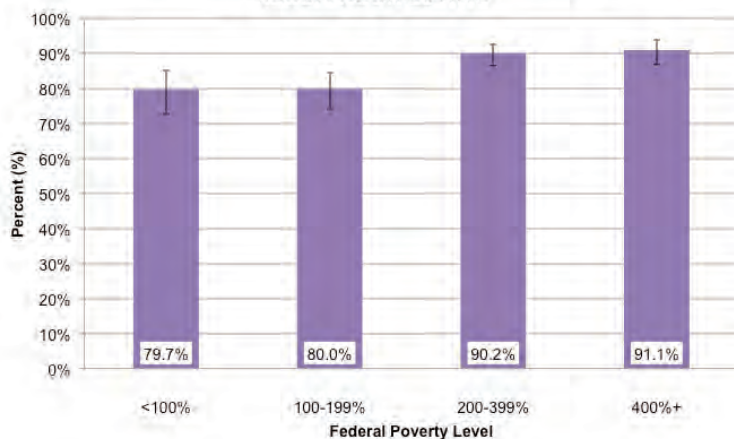
Young children, 0-5 years, had a statistically higher rate of excellent/very good health status (91.1%) than those in the 6-11 (86.8%) and 12-17 (80.2%) age groups. Children who reported no ACEs (90.9%) had significantly higher rates than those who report 1 ACE (83.2%) or 2 or more ACEs (76.1%). Children with a medical home (92.2%) had significantly higher rates than those without a medical home (78.7%).

**Excellent/Very Good Overall Health by Race, Hawai'i NSCH 2011/12**



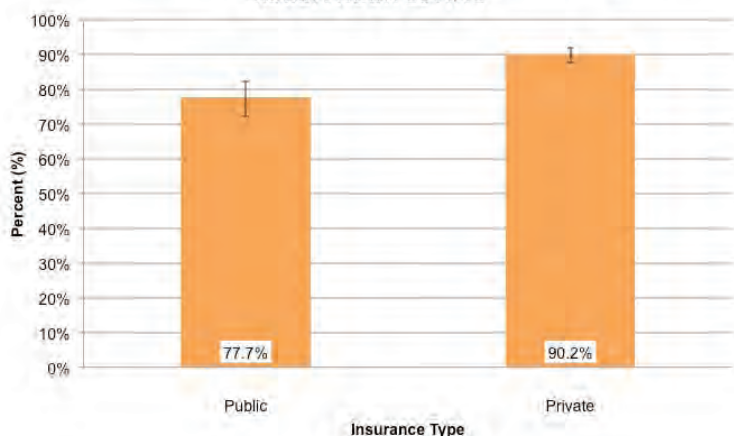
Data Source: National Survey of Children's Health, 2011/12

**Excellent/Very Good Overall Health by Poverty Level, Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

**Excellent/Very Good Overall Health by Insurance Type, Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12



# HEALTH STATUS

## Overall Oral Health Status Ages 1-17 Years

### **Background:**

Oral health is an integral part of general health and can directly influence a child's quality of life. The negative impact of poor oral health includes chewing difficulties, changes in behavior (low self-esteem) and decrease in school performance.<sup>6</sup>

### **Measurement:**

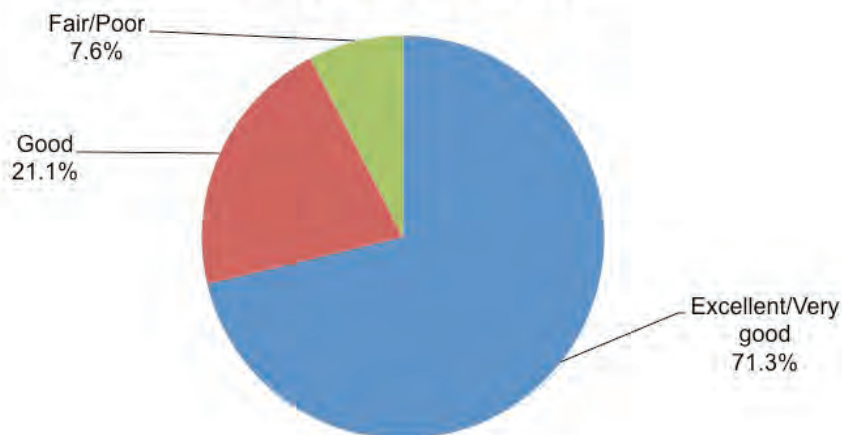
Parents of 1-17 year olds were asked to describe their child's overall oral health status (excellent, very good, good, fair, poor). These five categories were combined into three (excellent/very good, good, and fair/poor).

### **National Comparisons:**

In Hawai'i, 73.1% of children were reported to have excellent/very good overall oral health. This is higher than, but not significantly different from, the national estimate of 71.3%

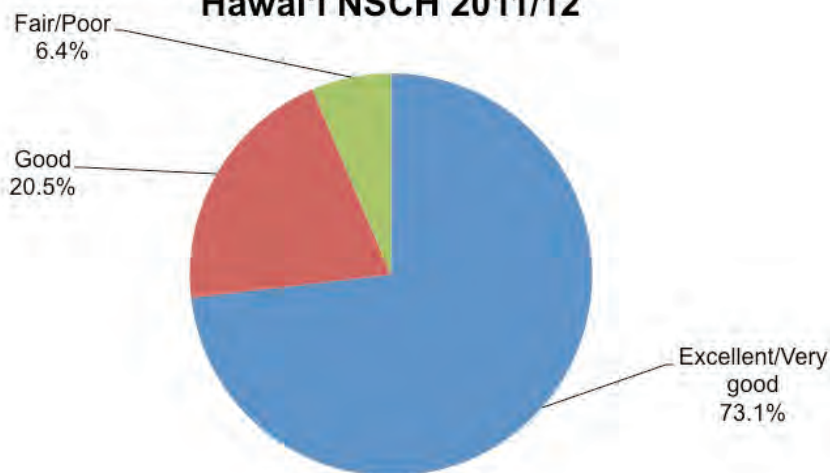
In Hawai'i, 20.5% of children were rated as having good overall oral health and 6.4% were reported to have fair or poor overall oral health. These values are both lower, but not significantly different, from the national values of 21.1% and 7.6% respectively.

**Overall Oral Health Status,  
Nation NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

**Overall Oral Health Status,  
Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

Overall Oral Health Status of  
Children:  
73.1% (Hawai'i)  
vs  
71.3% (Nation)

## Overall Oral Health Status Disparities

Data for Hawai'i showed disparities in excellent/very good reported oral health status for different race, federal poverty levels, age, insurance type, age, ACEs, and medical home.

### Race:

More White children (82.3%) reported having excellent/very good oral health compared to the other racial groups. The differences between White and Asian (72.8%) and between White and Native Hawaiian/Pacific Islander (65.2%) groups were statistically significant.

### Federal Poverty Level:

Excellent/very good oral health increased with federal poverty level (FPL). Fewer children at <100% FPL (57.3%) had excellent/very good oral health compared to children at 100-199% FPL (68.2%), 200-399% FPL (78.7%), and 400%+ FPL (82.7%). These differences were statistically significant across all comparisons, except for 200-399% versus 400%+ FPL.

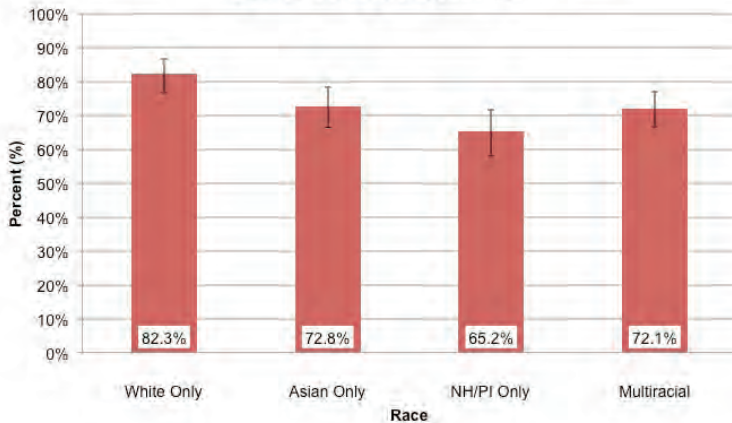
### Insurance Type:

Privately insured children (81.0%) had significantly higher rates of excellent/very good oral health compared to publicly insured children (58.7%) insured children.

### Other:

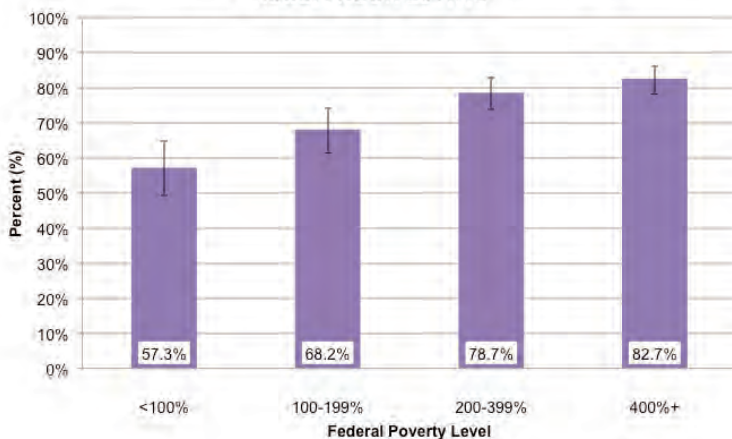
Young children, 0-5 years, had a statistically higher rate of excellent/very good oral health status (78.6%) than those in the 6-11 (71.0%) and 12-17 (70.9%) age groups. Those with no ACEs also have a significantly higher rate (78.2%) compared to children with 1 ACE (69.3%) and 2 or more ACEs (64.6%). Children with a medical home (82.5%) reported having excellent/very good oral health status.

Excellent/Very Good Oral Health by Race, Hawai'i NSCH 2011/12



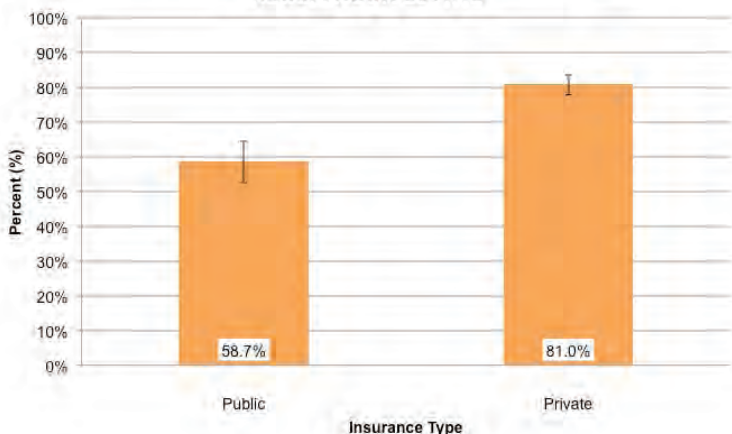
Data Source: National Survey of Children's Health, 2011/12

Excellent/Very Good Oral Health by Poverty Level, Hawai'i NSCH 2011/12



Data Source: National Survey of Children's Health, 2011/12

Excellent/Very Good Oral Health by Insurance Type, Hawai'i NSCH 2011/12



Data Source: National Survey of Children's Health, 2011/12

# HEALTH STATUS

## Oral Health Problems Ages 1-17 Years

### **Background:**

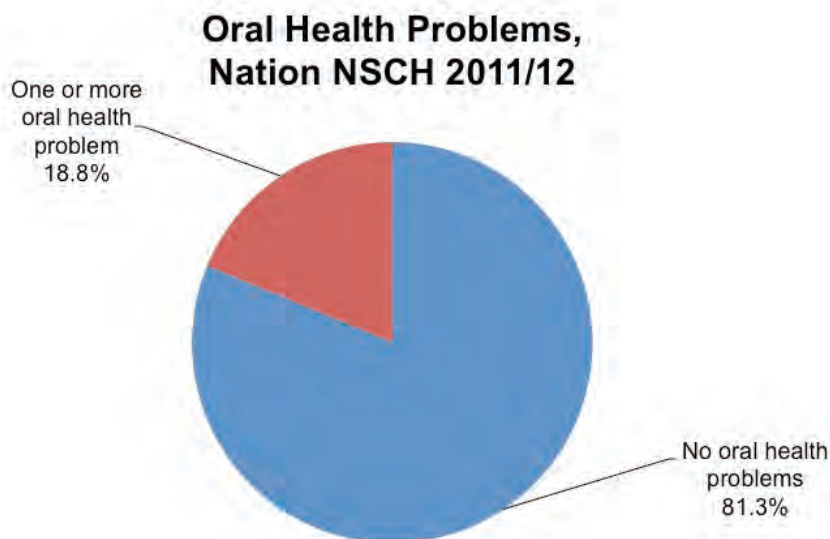
With dental caries being the most prevalent chronic disease among children, the improvement of dental health among youth is a global public health priority.<sup>7</sup> Caries, when left untreated, have been linked with negative effects on general health and well-being. These health consequences include affecting young children's body weight and growth as well as reducing self-expression and communication. Lastly, the cost of treating oral health problems later in life can create a significant financial and social burden on patients.<sup>8</sup>

### **Measurement:**

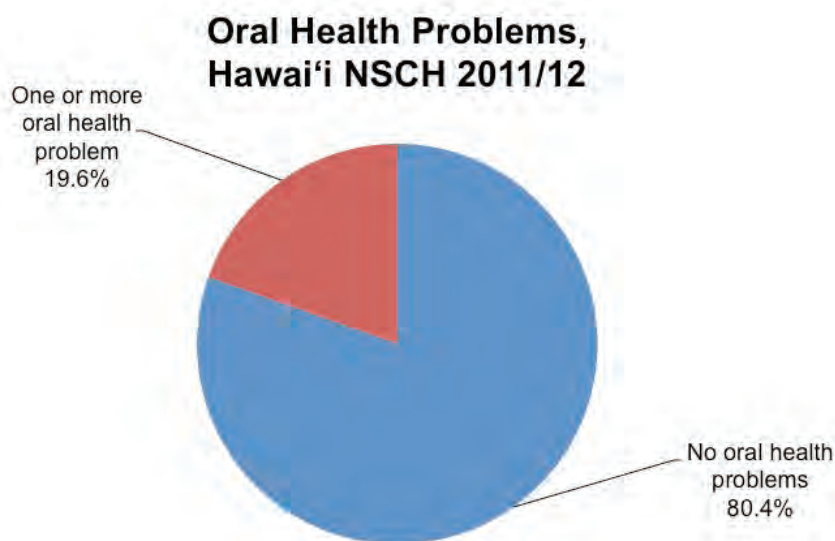
Parents of 1-17 year olds were asked to report whether their child had oral health problems such as toothache, decayed teeth, or unfilled cavities in the past 12 months.

### **National Comparisons:**

In Hawai'i, 80.4% of children were reported to have no oral health problems. This is lower but not significantly different from the national estimate of 81.3%.



Data Source: National Survey of Children's Health, 2011/12



Data Source: National Survey of Children's Health, 2011/12

Children with No Oral Health Problems:  
80.4% (Hawai'i)  
vs  
81.3% (Nation)



## Oral Health Problems Disparities

Data for Hawai'i demonstrated disparities in children with no oral health problems related to federal poverty level, age, medical home, race, insurance type, and ACES.

### **Federal Poverty Level:**

Rates of having no oral health problems increased with increasing FPL status. Children who fell within the 200-399% (85.8%) and 400%+ (87.2%) FPL categories had significantly higher rates of having no oral health problems compared to youth who fell in the <100% (70.7%) and 100-199% (73.4%) FPL categories.

### **Age:**

Fewer children within the 6-11 year old age range (74.2%) had no oral health problems. This rate was significantly smaller than those who are 0-6 years old (87.0%) and 12-17 years old (81.2%). The difference between the oldest and youngest age categories was also statistically significant.

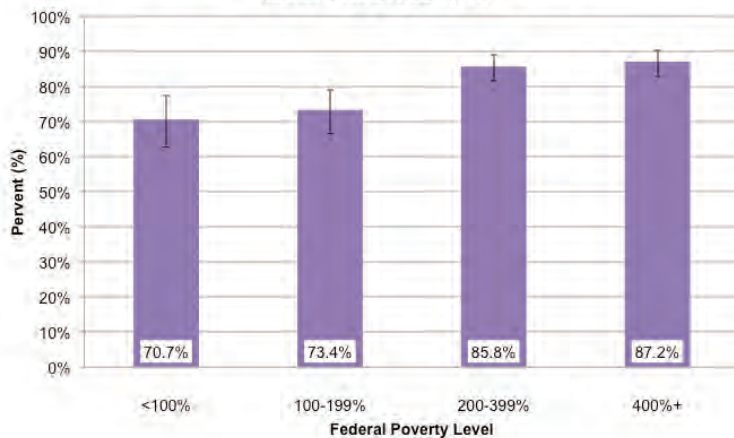
### **Medical Home:**

Youth with a medical home (85.1%) reported having higher rates of no oral health problems compared to those without (75.5%).

### **Other:**

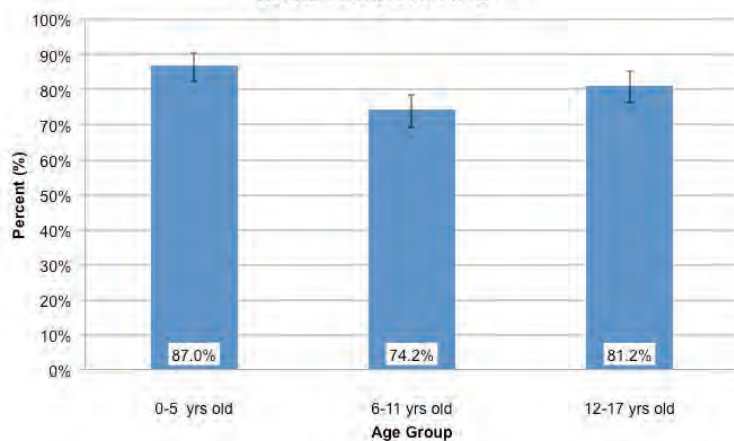
White children reported the greatest rates of having no oral health problems (85.3%). Native Hawaiian/Pacific Islander children (73.8%) had significantly lower rates compared to multiracial children (83.5%). There were no significant differences between the other racial groups. Significantly more privately insured children (83.6%) had no oral health problems compared to publicly insured youth (75.5%). Those with no ACEs (85.3%) had significantly higher rates of having no oral health problems compared to children with one ACE (75.9%) and two or more ACEs (75.1%). There was no significant difference by gender.

**No Oral Health Problems by Poverty Level, Hawai'i NSCH 2011/12**



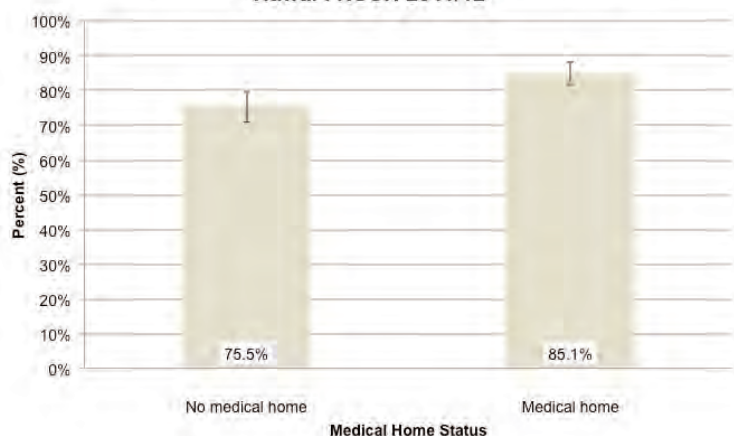
Data Source: National Survey of Children's Health, 2011/12

**No Oral Health Problems by Age, Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

**No Oral Health Problems by Medical Home Status, Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

# HEALTH STATUS

## Breastfeeding Ages 0-5 Years

### **Background:**

Breastfeeding is responsible for a multitude of short- and long-term health benefits including medical and neurodevelopmental advantages. Studies have shown that rates of obesity as well as risk for hospitalization of serious infections and diseases, such as lower respiratory infections, are significantly lower in breastfed infants.<sup>9,10</sup> Together, these benefits optimize infant, child, and adult health as well as child growth and development.

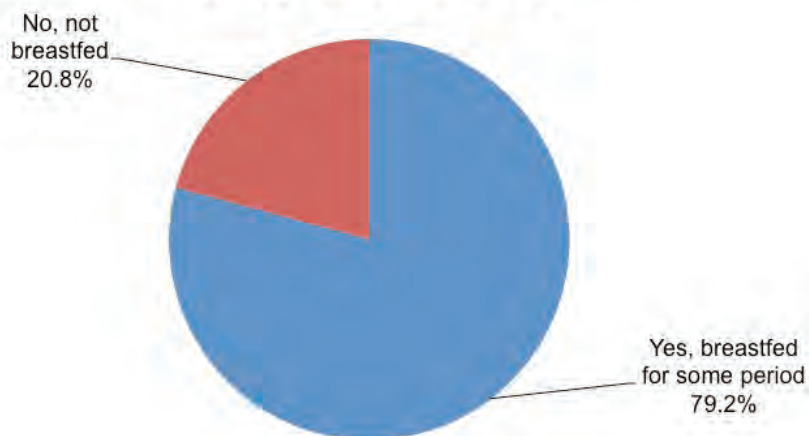
### **Measurement:**

Parents of 0-5 year olds were surveyed as to whether their child was ever breastfed or fed breast milk.

### **National Comparisons:**

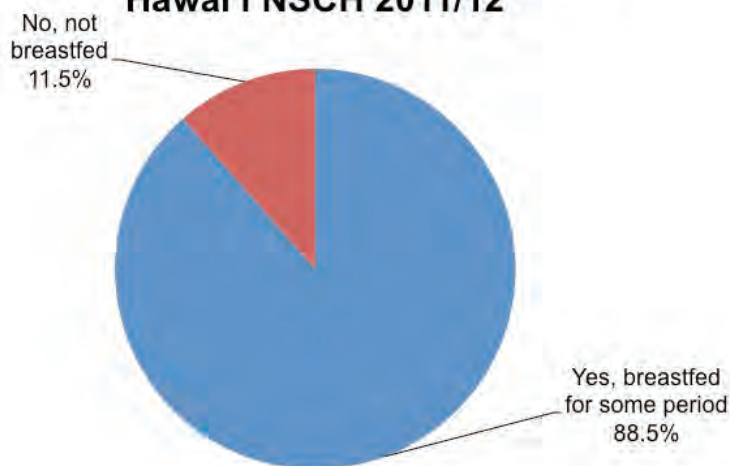
In Hawai'i, 88.5% of children were reported to have been breastfed for some period, which is significantly higher than the national estimate of 79.2%.

**Children Who Were Ever Breastfed,  
Nation NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

**Children Who Were Ever Breastfed,  
Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

**Children Ever Breastfed:**  
**88.5% (Hawai'i)**  
**vs**  
**79.2% (Nation)**

## Breastfeeding Disparities

Data for Hawai'i demonstrated disparities in children who were ever breastfed with respect to race, federal poverty level, and insurance type.

### **Race:**

A significantly smaller proportion of Native Hawaiian/ Pacific Islander children (73.8%) were breastfed compared to White children (91.4%), Asian children (95.2%), and multiracial children (90.5%).

### **Federal Poverty Level:**

Breastfeeding increased with federal poverty level. Significantly more children in the 400%+ FPL (95.8%) and 200-399% FPL (94.1%) were breastfed compared to <100% (76.3%) and 100-199% (85.6%) categories. There was no significant difference between children in the 400%+ FPL and 200-399% FPL.

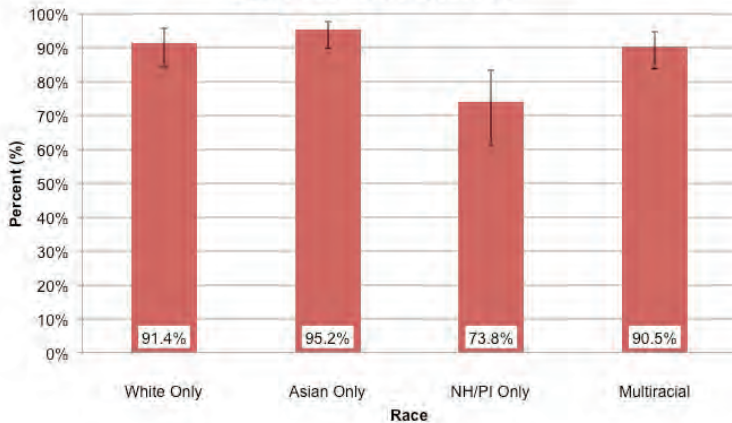
### **Insurance Type:**

Privately insured children (93.4%) had the highest rate of breastfeeding. This was significantly greater than those who are publicly insured (80.5%).

### **Other:**

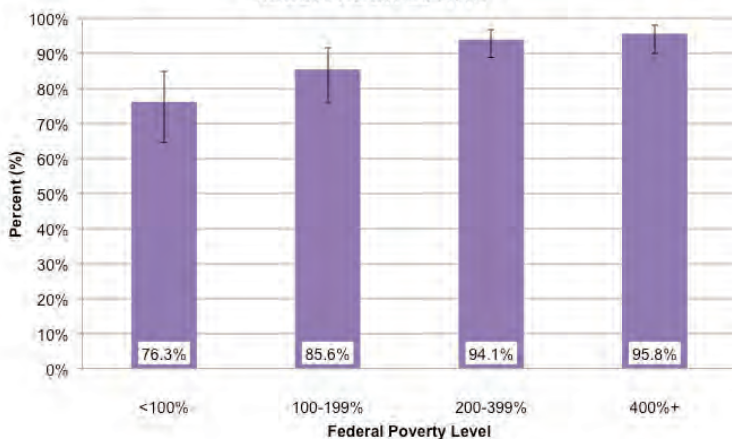
There were no statistically significant differences in ever breastfeeding by the gender, ACEs, and medical home. Differences for age group of the child were not assessed for this indicator.

**Children Ever Breastfed by Race, Hawai'i NSCH 2011/12**



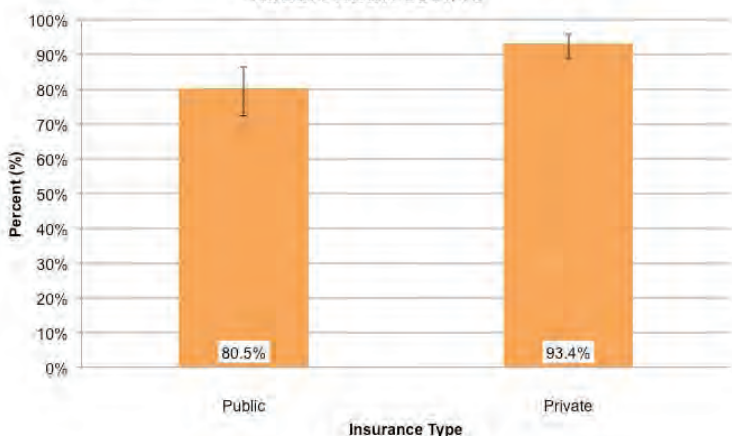
Data Source: National Survey of Children's Health, 2011/12

**Children Ever Breastfed by Poverty Level, Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

**Children Ever Breastfed by Insurance Type, Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12



# HEALTH STATUS

## Exclusive Breastfeeding Ages 6 months-5 years

### **Background:**

Breastfeeding is associated with many health benefits. To realize the full benefits, exclusive breastfeeding is desired. The American Academy of Pediatrics recommends exclusive breastfeeding for 6 months and then partial breastfeeding as long as mutually desired.<sup>10</sup>

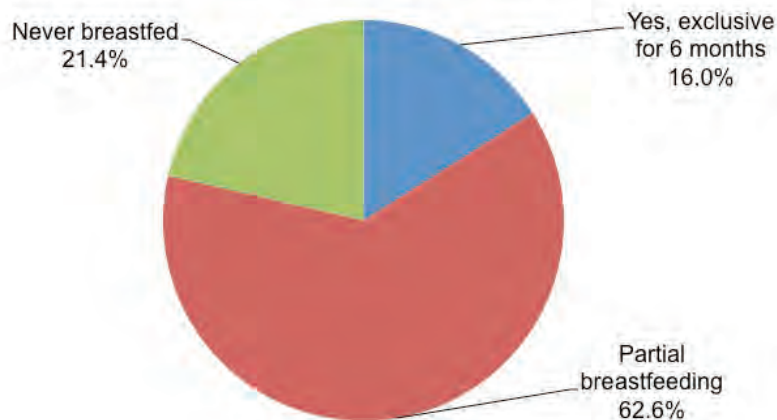
### **Measurement:**

Parents of children 6 months to 5 years of age were surveyed as to whether their child was ever breastfed, age at which breastfeeding stopped, age at which formula was introduced, and age at which anything other than breast milk was introduced. To qualify as having been exclusively breastfed for six months, children met all of the following: be at least six months old, did not stop breastfeeding before six months of age, and not introduced to formula or anything other than breast milk (including juice, cow's milk, sugar water, baby food, or anything else, even water) until at least six months old.

### **National Comparisons:**

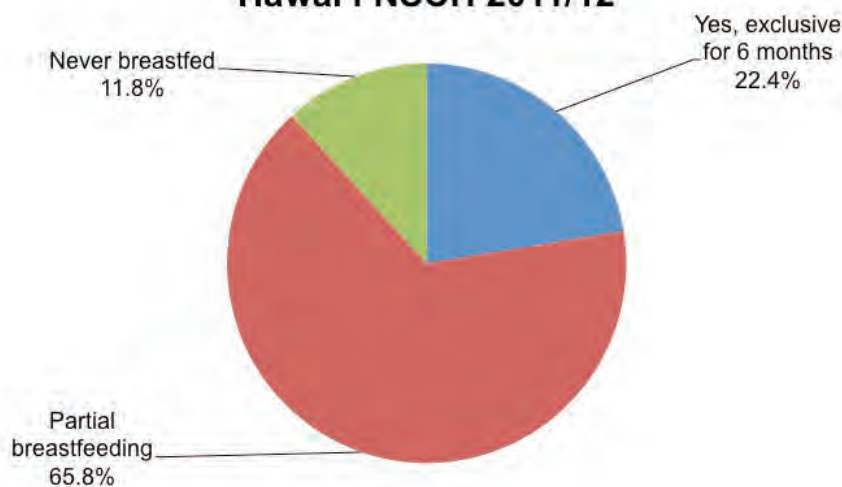
In Hawai'i, 22.4% of children were reported to have exclusively breastfed for 6 months, which is significantly higher than the national estimate of 16.0%. Never breastfeeding was significantly lower with 11.8% of Hawai'i children compared to 21.4% nationally.

**Children Exclusively Breastfed Status,  
Nation NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

**Children Exclusively Breastfed Status,  
Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

Children Exclusively Breastfed at  
least 6 months:  
22.4% (Hawai'i)  
vs  
16.0% (Nation)



## Exclusive Breastfeeding Disparities

Data for Hawai'i demonstrated disparities in children who were ever breastfed related to race, insurance type, and ACEs.

### Race:

Asian children (14.9%) were less likely to exclusively breastfeed 6 months compared to multiracial children (27.1%). There were no other significant differences in exclusively breastfeeding 6 months among other race groups.

### Insurance Type:

The highest rate of exclusively breastfeeding 6 months was in privately insured children (23.8%) although this was significantly different from publicly insured children (18.0%).

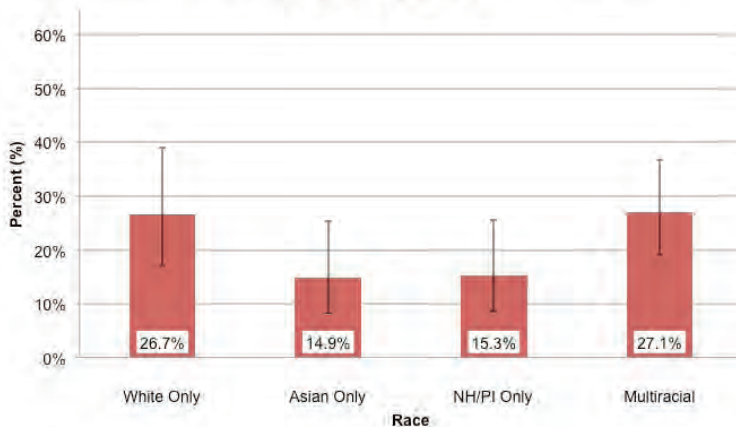
### Federal Poverty Level:

There were no statistically significant differences in exclusive breastfeeding by federal poverty level (FPL) among those at or above 100% of FPL. The estimate for those below 100% FPL was not reliable.

### Other:

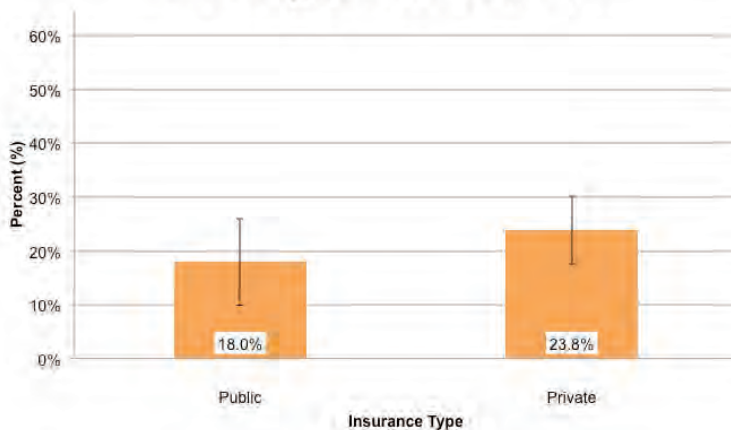
There were no statistically significant differences in exclusive breastfeeding by gender, ACEs, and medical home. Differences for age group of the child were not assessed for this indicator.

Children Breastfed Exclusively for 6 months by Race, Hawai'i NSCH 2011/12



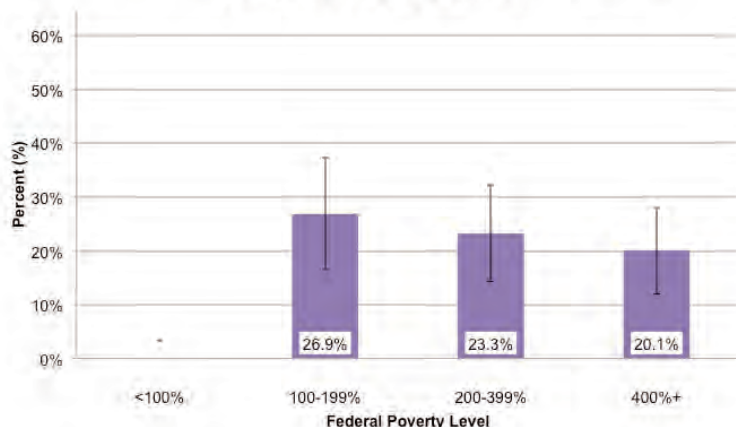
Data Source: National Survey of Children's Health, 2011/12

Children Breastfed Exclusively for 6 months by Insurance Type, Hawai'i NSCH 2011/12



Data Source: National Survey of Children's Health, 2011/12

Children Breastfed Exclusively for 6 months by Poverty Level, Hawai'i NSCH 2011/12



Data Source: National Survey of Children's Health, 2011/12

\* Relative standard error >30%, estimate suppressed

# HEALTH STATUS

## Premature Birth Ages 0-17 Years

### **Background:**

Premature birth is of increasing concern as rates have been increasing for the past two decades. Worldwide, premature birth is the second most common cause of death after pneumonia in children under 5 years old. In addition, premature birth is responsible for cognitive, visual, and learning impairments.<sup>11</sup> Children born prematurely also suffer from a higher risk of non-communicable diseases.<sup>12</sup>

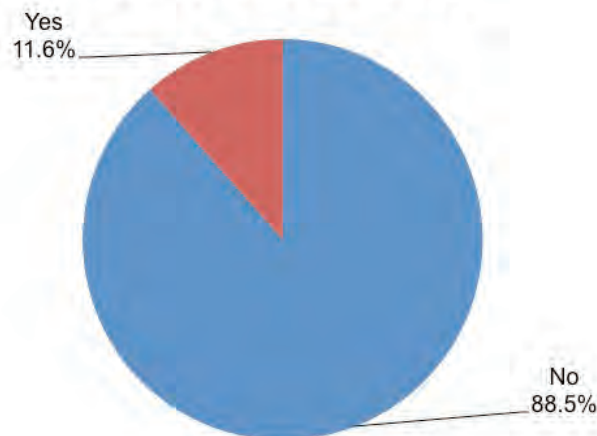
### **Measurement:**

Parents of 0-17 year olds reported whether their child was born premature. A premature birth was defined as a birth 3 or more weeks before the due date.

### **National Comparisons:**

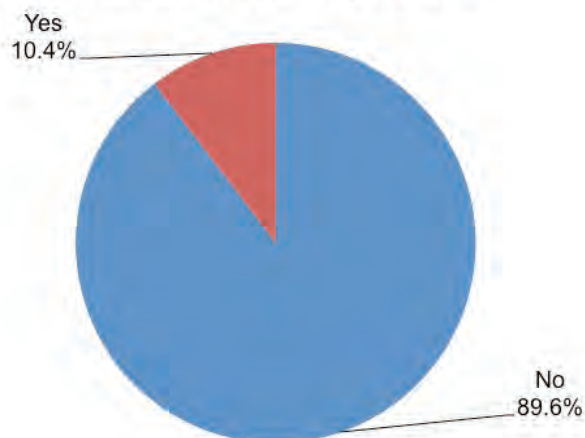
In Hawai'i, 10.4% of children were born premature. This is lower than but not significantly different from the national estimate of 11.6%.

**Premature Birth,  
Nation NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

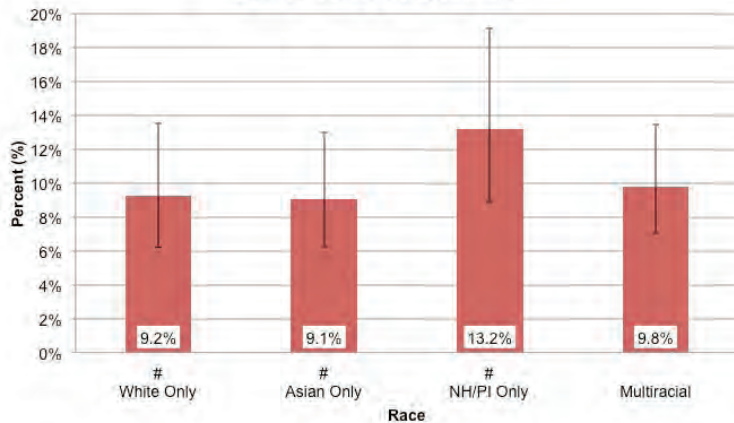
**Premature Birth,  
Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

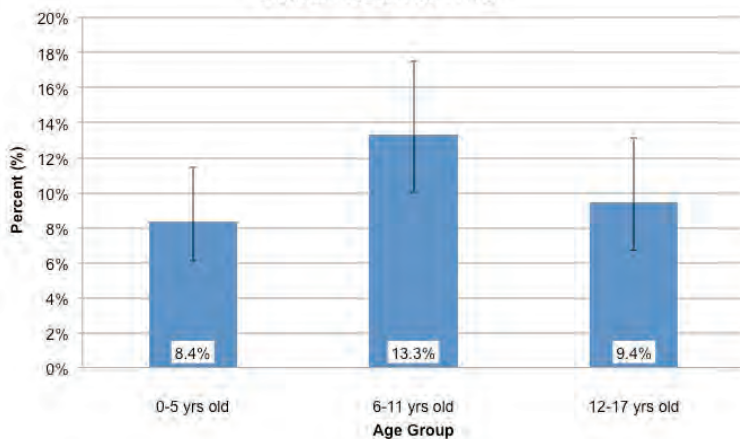
Children Born Prematurely:  
10.4% (Hawai'i)  
vs  
11.6% (Nation)

**Premature Birth by Race,  
Hawai'i NSCH 2011/12**



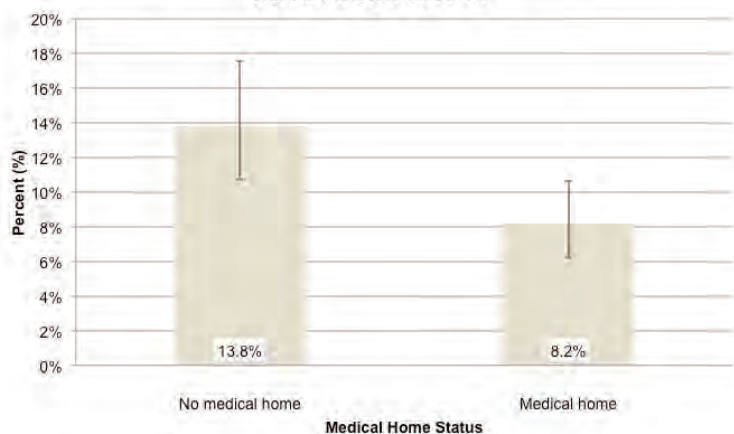
Data Source: National Survey of Children's Health, 2011/12  
# Cell size <50, use caution with interpretation

**Premature Birth by Age,  
Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

**Premature Birth by Medical Home Status,  
Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

## Premature Birth Disparities

Data for Hawai'i demonstrated disparities in children born prematurely related to race, age group, and medical home.

### **Race:**

Native Hawaiian/Pacific Islander children (13.2%) had the highest rate of premature birth. However, this proportion is not significantly different from that of White (9.2%), Asian (9.1%) and multiracial children (9.8%).

### **Age:**

Youth in the 6-11 year old age range (13.3%) had the highest rates of premature birth. This is significantly greater than that of 0-5 year olds (8.4%), but not significantly different from 12-17 year olds (9.4%).

### **Medical Home:**

A significantly greater proportion of children with no medical home (13.8%) were born prematurely compared to those with a medical home (8.2%).

### **Other:**

There were no statistically significant disparities in premature birth related to the child's race, FPL, gender, and ACEs.

# HEALTH STATUS

## Low Birthweight Ages 0-17 Years

### **Background:**

Birthweight serves as an important predictor of long-term health outcomes. Children with low birthweight have an increased risk for health conditions, such as childhood asthma, as well as increased risks of developing behavioral and emotional problems during childhood and adolescence.<sup>13,14</sup> Studies have also suggested reduced school performance in children of low birthweight compared to their normal birthweight peers.<sup>15</sup>

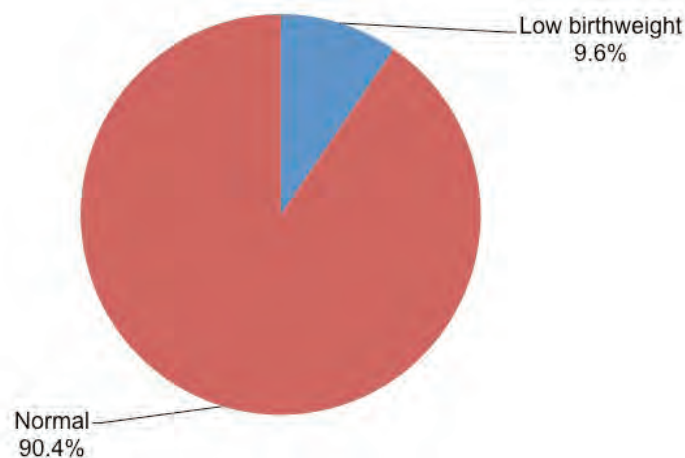
### **Measurement:**

Birthweight status was categorized into the following categories: low birthweight (2,500 grams or less) and normal birthweight (over 2,500 grams).

### **National Comparisons:**

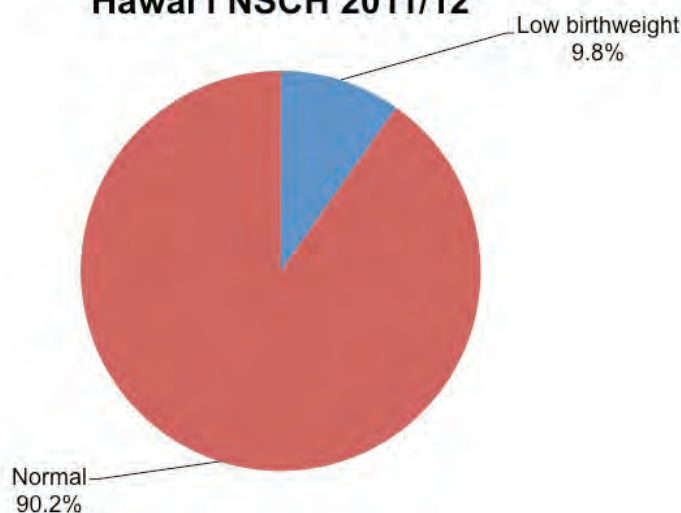
In Hawai'i, 9.8% of children were reported to be low birthweight. This is slightly higher but not significantly different from the national estimate of 9.6%.

**Children's Birthweight,  
National 2011/12**



Data Source: National Survey of Children's Health, 2011/12

**Children's Birthweight,  
Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

Low Birthweight Children:  
9.8% (Hawai'i)  
vs  
9.6% (Nation)



## Low Birthweight Disparities

Data for Hawai'i demonstrated disparities in children born with low birthweight related to race, federal poverty level, and age.

### Race:

Native Hawaiian/Pacific Islander children (13.1%) had significantly higher rates of low birth rate compared to multiracial children (6.9%). No significant differences were observed between the other racial groups.

### Federal Poverty Level:

Children in the <100% FPL category (13.0%) had the highest rates of low birthweight whereas children in the 400%+ FPL category (7.1%) had the lowest rates of low birth rate. The difference between these two groups is statistically significant.

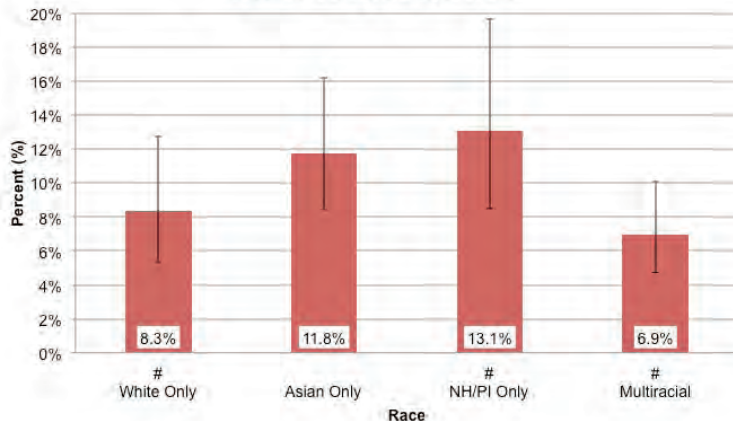
### Age:

Children between the ages of 6-11 years old had the highest rates of low birthweight. This was followed by those in the 12-17 years old age group (8.7%) and then by those in the 0-5 years old age group (7.2%). There was a statistically significant difference between the 6-11 year old group and the 0-5 year old age group.

### Other:

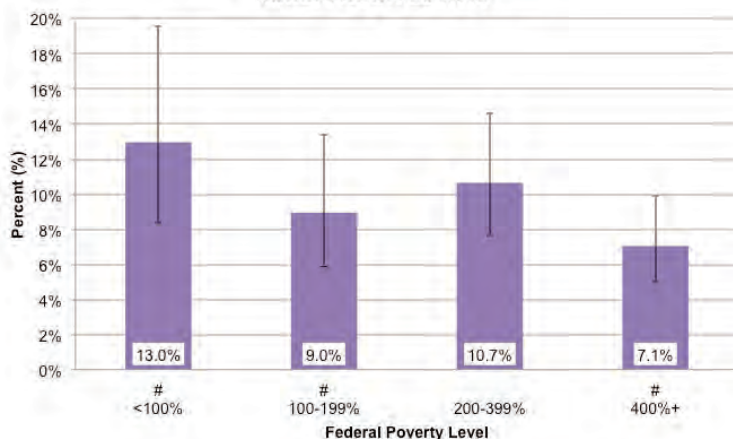
There were no statistically significant disparities in low birthweight related to insurance type, gender, ACEs, and medical home.

**Low Birthweight by Race,  
Hawai'i NSCH 2011/12**



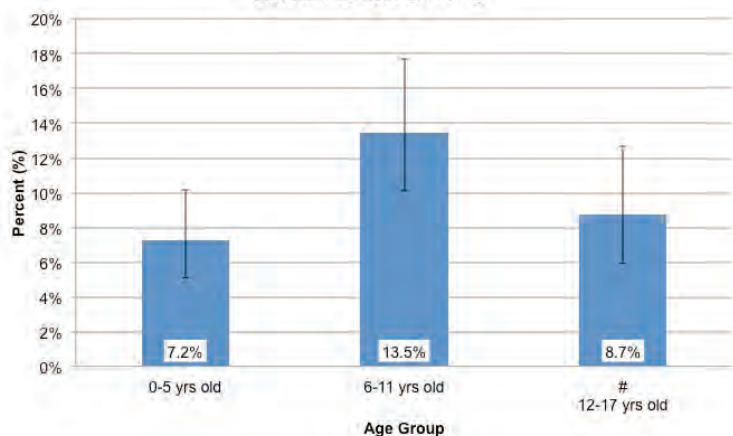
Data Source: National Survey of Children's Health, 2011/12  
# Cell size <50, use caution with interpretation

**Low Birthweight by Poverty Level,  
Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12  
# Cell size <50, use caution with interpretation

**Low Birthweight by Age,  
Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12  
# Cell size <50, use caution with interpretation

# HEALTH STATUS

## Overweight/Obese Children Ages 0-17 Years

### **Background:**

Child obesity is a major public health issue with far-reaching implications. The health consequences of childhood and adolescent obesity include earlier puberty and menarche in girls, type II diabetes, cardiovascular complications, and obesity in adulthood.<sup>16</sup> These health complications have long lasting impact that extends into adulthood, independent of adult weight.<sup>17</sup>

### **Measurement:**

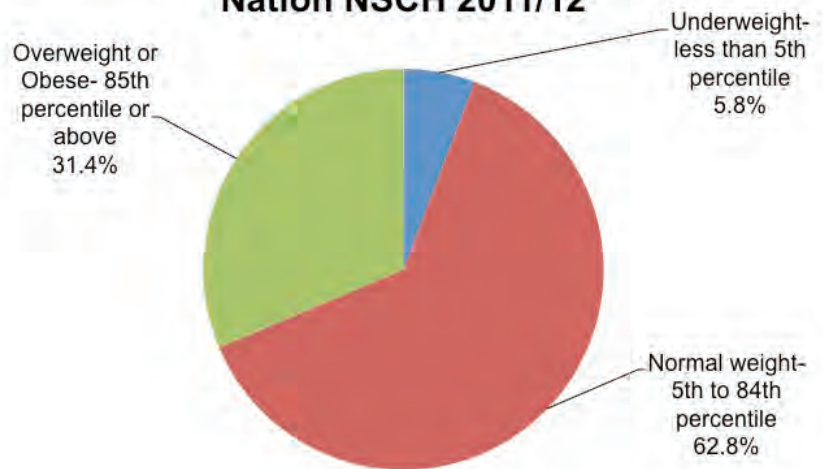
Body Mass Index for age (BMI-for-age) was calculated for children 10-17 years old. The four categories of weight status were the following: underweight (less than 5th percentile), healthy weight (5th to less than 85th percentile), overweight or obese (85th percentile or above).

### **National Comparisons:**

In Hawai'i, 27.4% of children were reported to be overweight or obese, which is less than but not significantly different from the national estimate of 31.4%.

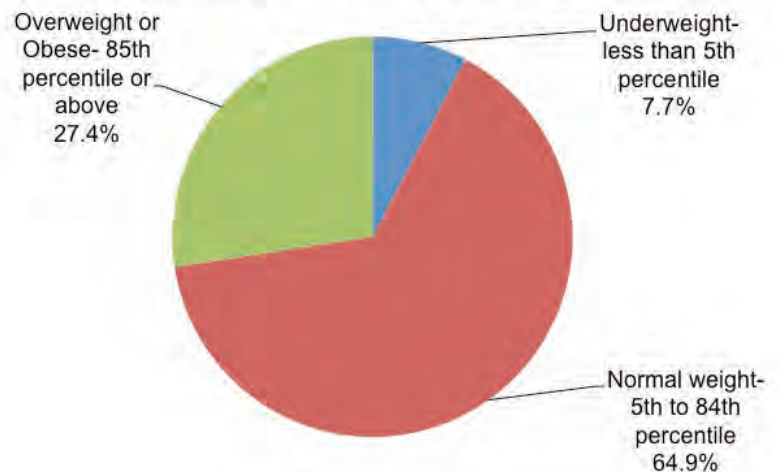
An estimated 64.9% of children in Hawai'i were normal weight while 7.7% were underweight. Nationally, 62.8% of children were normal weight and 5.8% were underweight.

**Body Mass Index for Age,  
Nation NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

**Body Mass Index for Age,  
Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

Overweight/Obese Children:  
27.4% (Hawai'i)  
vs  
31.4% (Nation)

## Overweight/Obese Children Disparities

Data for Hawai'i demonstrated disparities in children who are overweight or obese related to race, federal poverty level, insurance type, and ACEs.

### Race:

Native Hawaiian/Pacific Islander (NH/PI) and multiracial children reported greater rates of being obesity/overweight than other racial groups. The differences between White children (15.5%) and NH/PI (39.8%) as well as multiracial children (31.3%) were significantly different. In addition, Asians (23.1%) also had a significantly lower rate of being obese/overweight compared to NH/PI children.

### Federal Poverty Level:

Rates of being obese/overweight decreased with increasing FPL status. Those in the <100% FPL (40.2%) had significantly higher rates than that of children in the 200-399% (25.7%) and 400%+ (18.9%). The proportion of obese/overweight children was also significantly higher for children in the 100-199% FPL category compared to children in the 400% FPL group.

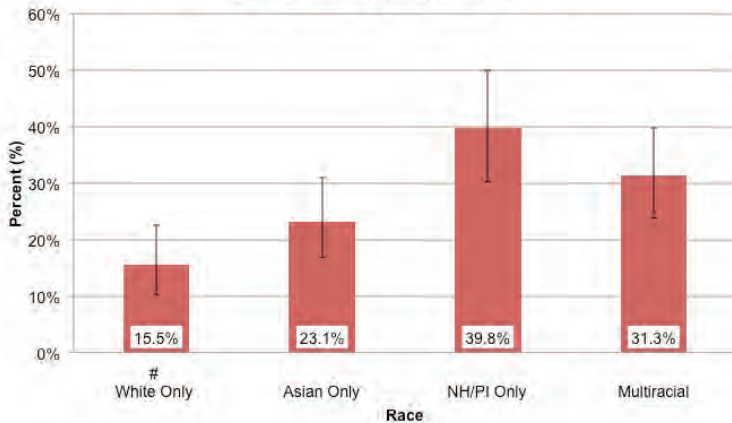
### Insurance Type:

Youth who are publicly insured (36.0%) have a significantly larger percentage of being obese/overweight compared to those who are private insured (23.6%).

### Other:

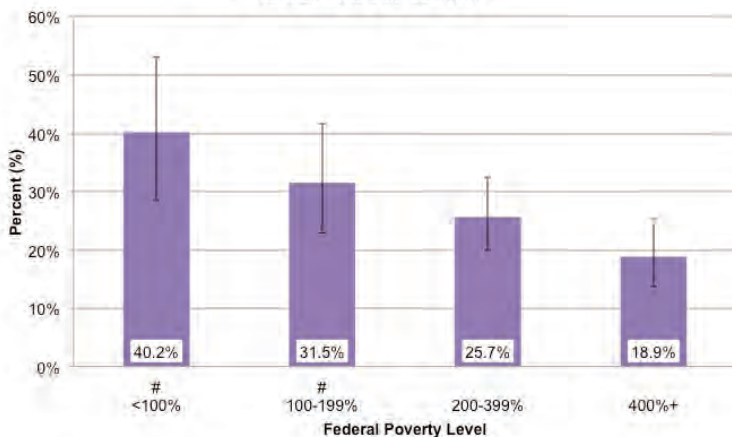
Children who reported no ACEs (22.0%) had significantly lower rates of being obese/overweight than those who report 1 ACE (32.2%). There were no significant differences in being obese/overweight by gender and medical home. Differences for age group of the child were not assessed for this indicator.

**Overweight/Obese Children by Race, Hawai'i NSCH 2011/12**



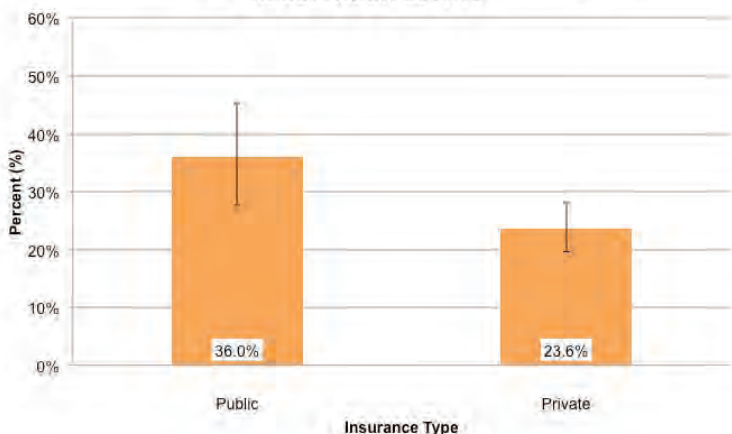
Data Source: National Survey of Children's Health, 2011/12  
# Cell size <50, use caution with interpretation

**Overweight/Obese by Poverty Level, Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12  
# Cell size <50, use caution with interpretation

**Overweight/Obese Children by Insurance Type, Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12



# HEALTH STATUS

## Physical Activity Ages 6-17 Years

### **Background:**

Physical activity and fitness influences health during childhood and adolescence as well as throughout life. Evidence-based data strongly supports the beneficial role physical activity has on adiposity, musculoskeletal health and fitness, and several components of cardiovascular health.<sup>18</sup> Even modest amounts of physical activity can confer substantial health benefits, especially in high-risk youth.

### **Measurement:**

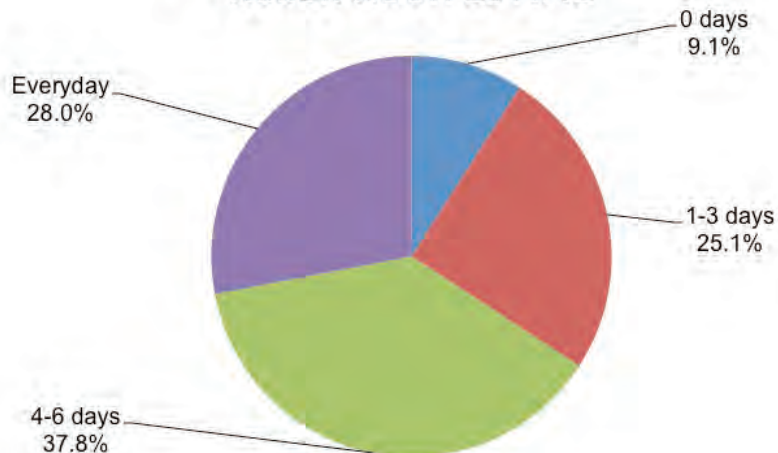
Parents of 6-17 year olds reported the number of days during the past week their child exercised, played a sport, or participated in physical activity for at least 20 minutes that made him/her sweat and breathe hard. Responses were categorized as zero days, one to three days, four to six days, and everyday.

### **National Comparisons:**

In Hawai'i, 28.7% of youth are engaged in physical activity every day. This is slightly greater than but not significantly different from the national estimate of 28.0%.

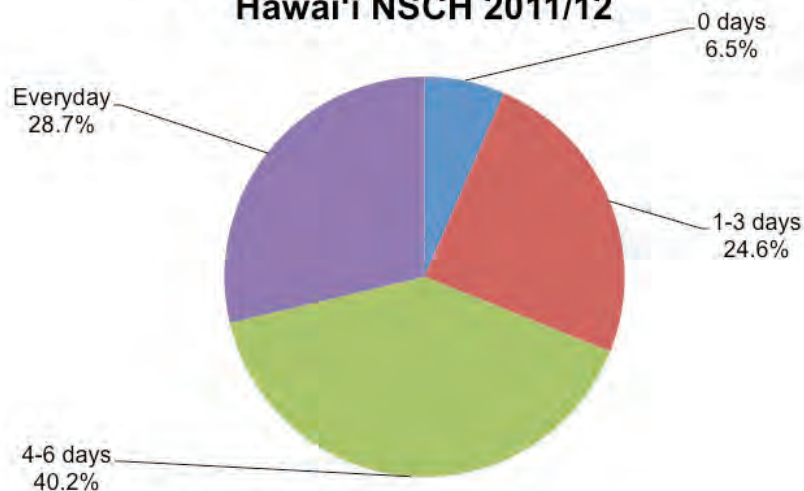
In Hawai'i, 40.2% of children were physically active four to six days, 24.6% active one to three days, and 6.5% active zero days. Nationally, these percentages are 37.8%, 25.1% and 9.1% respectively.

**Physical Exercise per Week,  
Nation NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

**Physical Exercise per Week,  
Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

Children Physically Active Daily:  
28.7% (Hawai'i)  
vs  
28.0% (Nation)

## Physical Activity Disparities

Data for Hawai'i demonstrated disparities in children who are physically active every day related to race, age, and gender.

### Race:

Fewer Asian children (14.7%) were engaged in physical activity every day compared to all other racial groups. This rate was statistically smaller than that of White children (35.9%), Native Hawaiian/Pacific Island children (33.8%) and multiracial children (30.0%).

### Age:

Youth in the 6-11 year old (39.2%) category had higher rates of being physically active everyday compared to their older counterparts in the 12-17 year old category (18.3%).

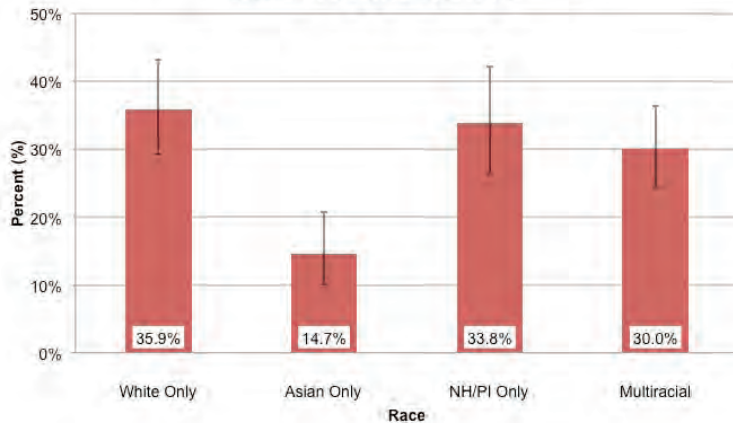
### Gender:

Significantly more males (32.8%) were physically active compared to females (24.6%).

### Other:

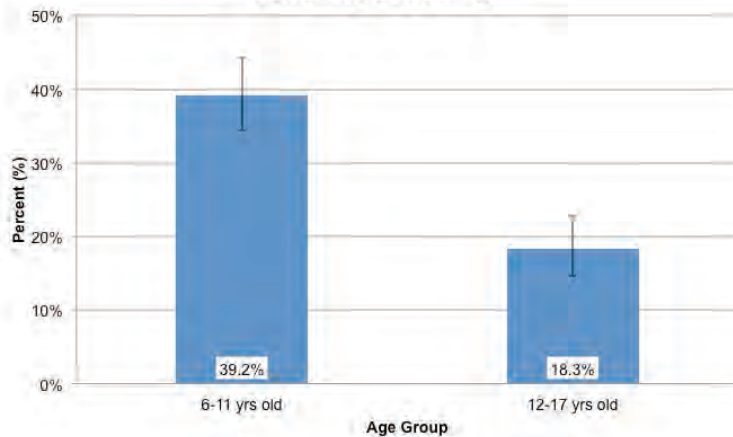
No significant differences were found for children who were physically active every day related to levels of federal poverty level, insurance type, ACEs, and medical home.

**Physical Activity Everyday by Race, Hawai'i NSCH 2011/12**



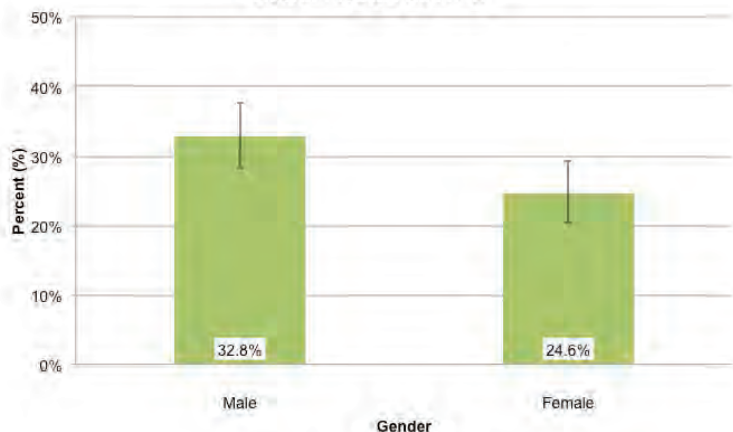
Data Source: National Survey of Children's Health, 2011/12

**Physical Activity Everyday by Age, Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

**Physical Activity Everyday by Gender, Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

# HEALTH STATUS

## Missed School Days Ages 6-17 Years

### **Background:**

Children's regular school attendance plays a critical role in determining whether they successfully complete their education, a major component of healthy childhood development. School absenteeism is associated with many social risk factors and is a major predictor of adult psychosocial problems.<sup>19</sup> At the individual level, a child with excessive absences may be less able to develop peer relationships effectively, thus leading to general feelings of disconnect.<sup>20</sup>

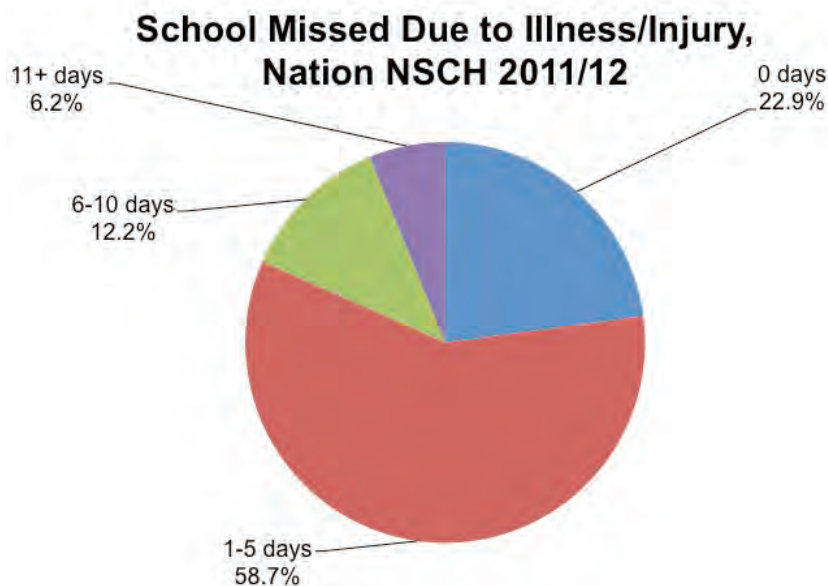
### **Measurement:**

Parents of 6-17 year olds were asked the number of days their child missed school because of illness or injury during the past 12 months. Responses were categorized as zero days, one to five days, six to ten days, and eleven or more days.

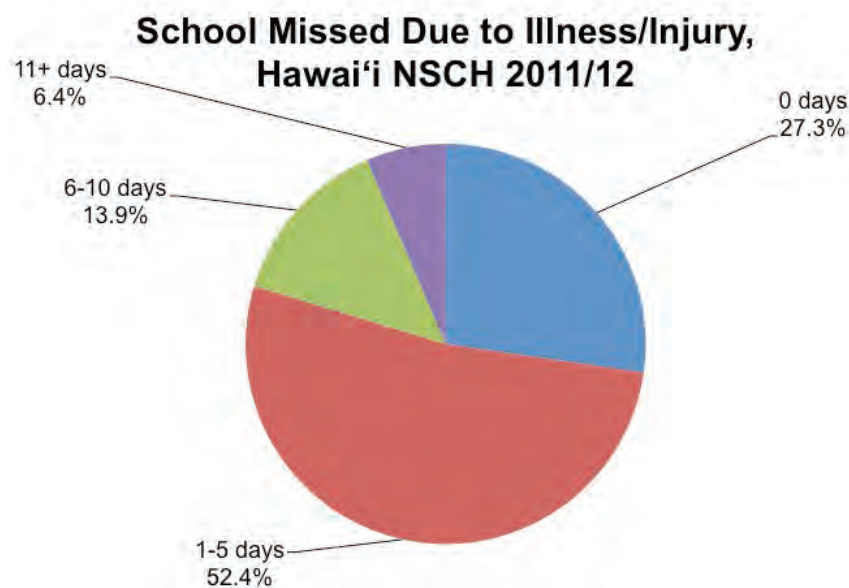
### **National Comparisons:**

In Hawai'i, 27.3% of children were reported to have missed zero days of school. This is higher than but not significantly different from the national estimate of 22.9%.

In Hawai'i, 52.4%, 13.9%, and 6.4% of children missed one to five, six to ten, and eleven or more school days respectively due to illness or injury. Nationally, 58.7%, 12.2% and 6.2% of children missed one to five, six to ten, and eleven or more school days due to illness or injury.



Data Source: National Survey of Children's Health, 2011/12



Data Source: National Survey of Children's Health, 2011/12

**Zero Missed School Days:**  
**27.3% (Hawai'i)**  
**vs**  
**22.9% (Nation)**

## Missed School Days Disparities

Data for Hawai'i demonstrated disparities in children who missed zero school days over the past year related to race, insurance type, and ACEs.

### **Race:**

A higher proportion of Asian (37.9%) and Native Hawaiian/Pacific Islander (32.0%) children missed zero days of school compared to White (20.5%) and multiracial (19.8%) children.

### **Insurance Type:**

Privately insured children (26.4%) had lower rates of missing zero days of school compared to publicly insured youth (27.5%).

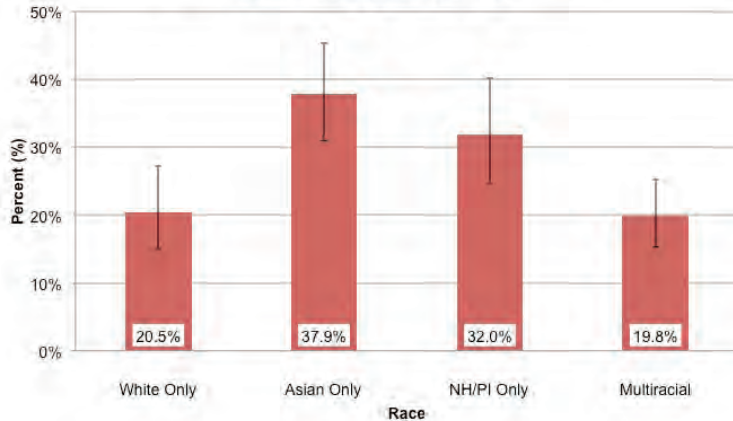
### **ACEs:**

A greater proportion of children who had no ACEs (31.5%) missed zero days of school compared to youth who had two or more ACEs (19.7%).

### **Other:**

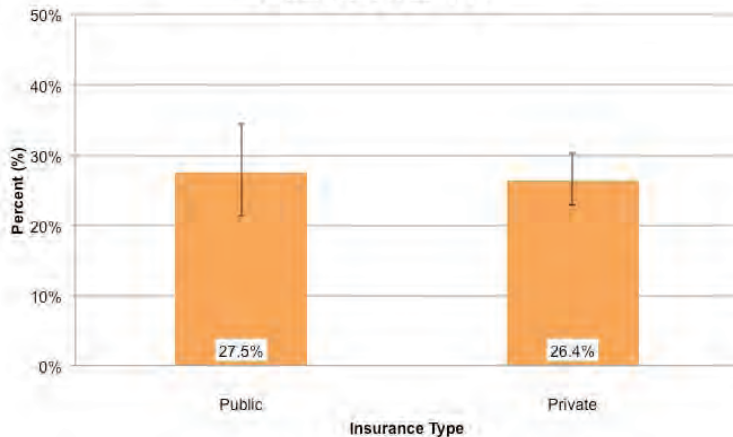
There were no statistically significant differences between federal poverty level, age group, gender, and medical home with missed school days.

**No Missed School Days by Race, Hawai'i NSCH 2011/12**



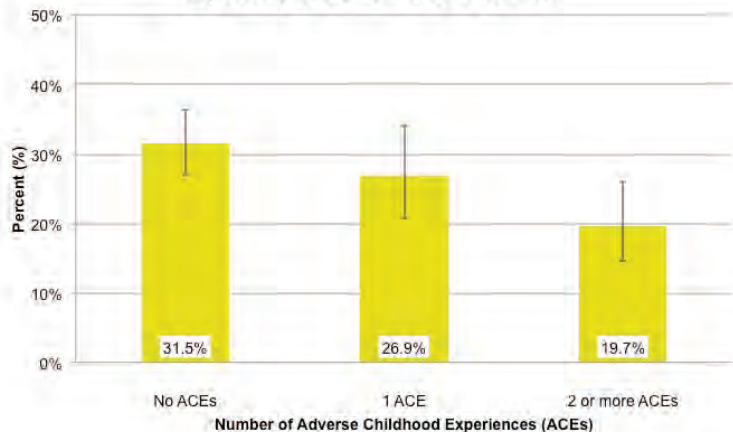
Data Source: National Survey of Children's Health, 2011/12

**No Missed School Days by Insurance Type, Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

**No Missed School Days by Adverse Childhood Experiences, Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12



# HEALTH STATUS

## Risk for Delay Ages 4 Months - 5 Years

### **Background:**

Recognizing and addressing childhood delay in development, behavior, or social skills are crucial for the implementation of timely interventions. The American Academy of Pediatrics recommends that families work closely with their health care providers to identify potential developmental issues in their children. Those who are at risk for delay should be linked with community-based resources like early intervention and school programs so that appropriate care can be coordinated.<sup>21</sup>

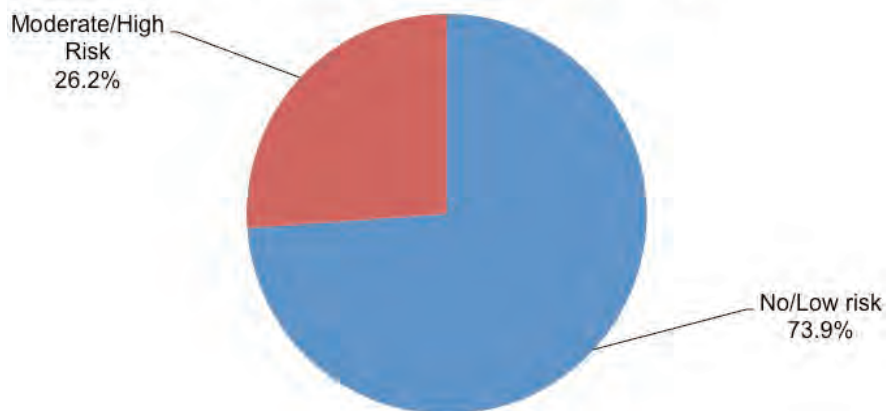
### **Measurement:**

Parents of all children age 4 months through 5 years were asked if they have concerns about their child's learning, development, or behavior. Parents were also asked to rate their levels of concern for their child's speech, comprehension, motor skills, social skills, and learning abilities. The three responses for concern included: a lot, a little, or not at all. Questions and scoring methods were adapted from the Parents' Evaluation for Developmental Status (PEDS). Risk groups were categorized as low/none or moderate/high.

### **National Comparisons:**

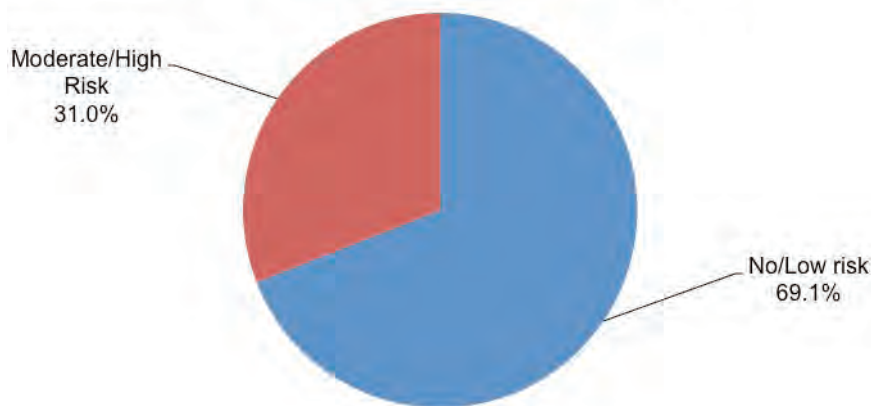
In Hawai'i, 31.0% of children were reported to be at moderate or high risk for developmental, behavioral, or social delay, which is higher but not significantly different from the national estimate of 26.2%.

### **Risk for Developmental, Behavioral, or Social Delay, Nation NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

### **Risk for Developmental, Behavioral, or Social Delay, Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

**High/Moderate Risk of Delay:**  
**31.0% (Hawai'i)**  
**vs**  
**26.2% (Nation)**

## Risk for Delay Disparities

Data for Hawai'i demonstrated disparities in children with moderate to high risk for delay related to federal poverty level, ACEs, medical home, and insurance type.

### **Federal Poverty Level:**

Fewer children living in the 400%+ FPL (19.4%) had moderate/high risk for delay. This was significantly lower than that of children in <100% (42.2%) and in 200-399% FPL (34.1%). Children in the <100% FPL category had the highest rate of being at a moderate/high risk for delay and this was significantly different from children in 100-199% FPL (26.8%).

### **ACEs:**

The proportion of children with moderate/high risk for delay increased with greater numbers of ACEs. Children with no ACEs (24.5%) had significantly lower rates of being at moderate/high risk for delay compared to both children with one ACE (39.5%) and children with two or more ACEs (48.8%).

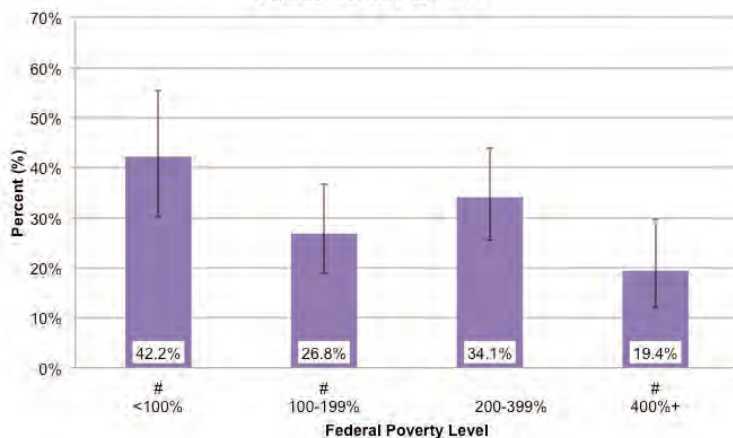
### **Medical Home:**

A significantly greater proportion of children with no medical home (44.1%) were reported to be at moderate/high risk for delay compared to youth with a medical home (22.6%).

### **Other:**

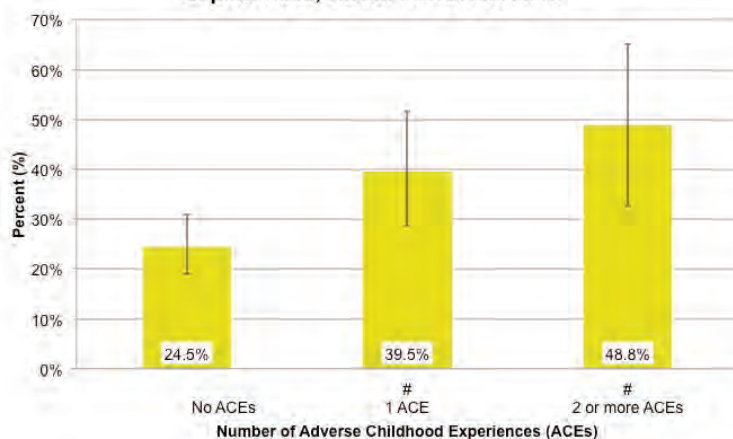
There were no statistically significant disparities in moderate/high risk for delay related to the child's gender. However, those who were publicly insured (41.4%) were significantly more likely than those who are privately insured (24.9%) to be at moderate/high risk for delay. Differences for age group of the child were not assessed for this indicator.

**Moderate/High Risk for Delay by Poverty Level, Hawai'i NSCh 2011/12**



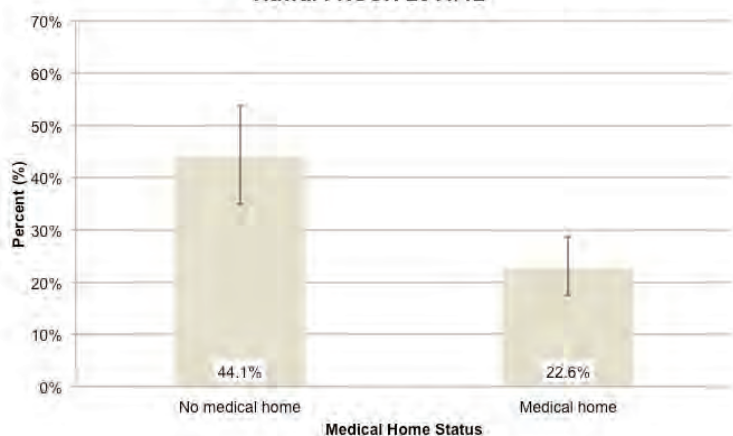
Data Source: National Survey of Children's Health, 2011/12  
# Cell size <50, use caution with interpretation

**Moderate/High Risk for Delay by Adverse Childhood Experiences, Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12  
# Cell size <50, use caution with interpretation

**Moderate/High Risk for Delay by Medical Home Status, Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

# HEALTH STATUS

## Flourishing Ages 6 Months - 5 Years

### **Background:**

Childhood flourishing is a multifaceted concept that includes dimensions of physical health, mental and emotional health, caring, empathy and resilience. A child's ability to thrive within these domains can help him/her develop the skills to cope with challenging experiences as they arise. Furthermore, these character strengths help lay the foundation for future positive youth development.<sup>22</sup>

### **Measurement:**

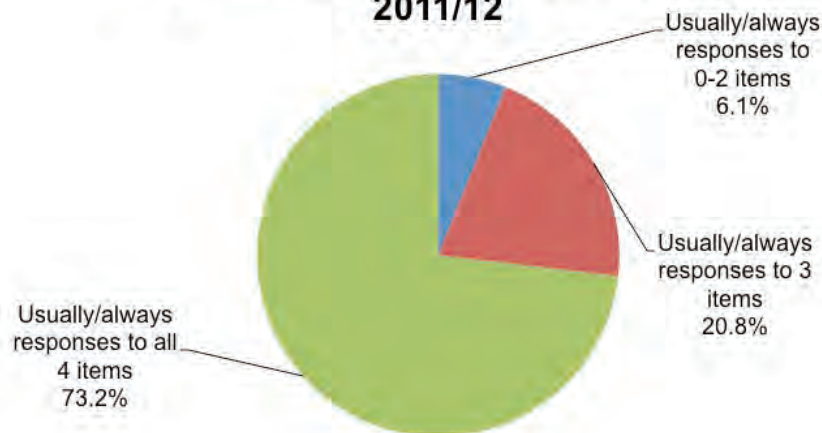
For children age 6 months to 5 years, four questions were asked to capture curiosity and discovery about learning, resilience, attachment with parents, and content with life based on: child being affectionate and tender; bouncing back quickly when things do not go his/her way; showing interest and curiosity in learning new things; and smiles and laughs a lot. These were categorized by number of times a response of usually/always into 0-2, 3, or all 4 items. A child was considered flourishing if all 4 items were met.

### **National Comparisons:**

In Hawai'i, 73.8% of children 5 months to 5 years old were reported to usually/always demonstrating all four of the "flourishing items". This is slightly higher but not significantly different from the national estimate of 73.2%

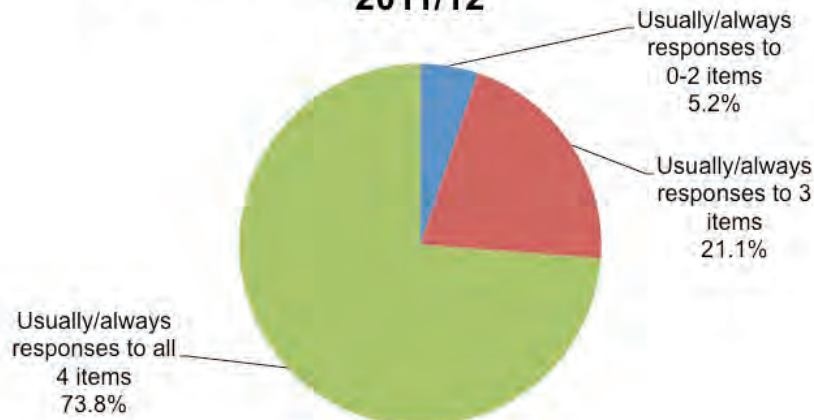
In Hawai'i, 21.1% of children were reported to usually/always demonstrate three of the four "flourishing items" and 5.2% of children demonstrate zero to two of the four items. Nationally, 20.8% and 6.1% of children were reported to usually/always respond to three of the four items and zero to two of the four items respectively.

### **Flourishing- Positive Health Indicators for Children 0-5 Years, Nation NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

### **Flourishing- Positive Health Indicators for Children 0-5 Years, Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

## Displaying All Four Flourishing Items:

73.8% (Hawai'i)

vs

73.2% (Nation)



## Flourishing Disparities

Data for Hawai'i demonstrated disparities in children who demonstrated all four positive health indicators related to race, federal poverty level, and insurance type.

### **Race:**

Significant differences for flourishing were observed across the different racial groups. Multiracial children (82.2%) had significantly higher rates of displaying all four positive health indicators compared to Asian children (64.7%) and Native Hawaiian/Pacific Islander children (66.8%).

### **Federal Poverty Level:**

Children in the 400%+ FPL category had the highest rate of displaying all the flourishing items. On the other hand, children in the 100-199% FPL group had the lowest rate (65.3%). The difference between these two groups is statistically significant.

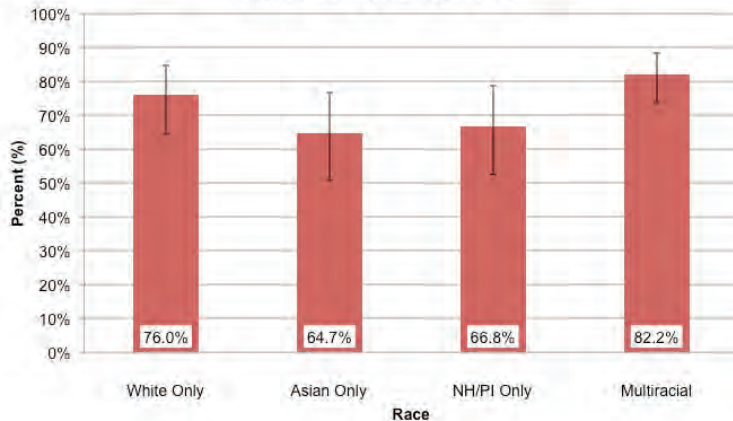
### **Insurance Type:**

The lowest rate of children displaying all four positive health indicators was in publicly insured children (66.5%) which was significantly lower than privately insured children (77.9%).

### **Other:**

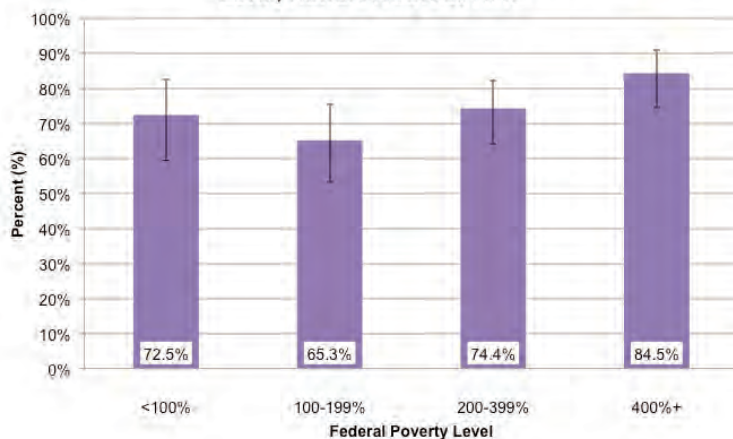
There were no statistically significant disparities in flourishing related to the child's age, gender, ACEs, and medical home. Differences for age group were not assessed for this indicator.

**Flourishing- Positive Health Indicators, Hawai'i NSCH 2011/12**



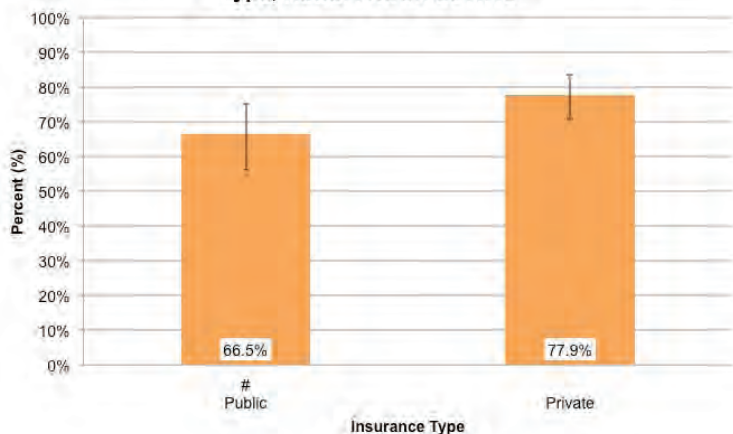
Data Source: National Survey of Children's Health, 2011/12

**Flourishing- Positive Health Indicators by Poverty Level, Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

**Flourishing- Positive Health Indicators by Insurance Type, Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12  
# Cell size <50, use caution with interpretation

# HEALTH STATUS

## Flourishing Ages 6 -17 Years

### **Background:**

Although quantifying negative behaviors and outcomes is important in understanding child health, identifying children's ability to thrive and flourish can also provide insight into childhood wellbeing. The ability to flourish in children contributes to a variety of positive health outcomes as well as a buffer against negative ones, such as psychological disorders.<sup>23</sup>

### **Measurement:**

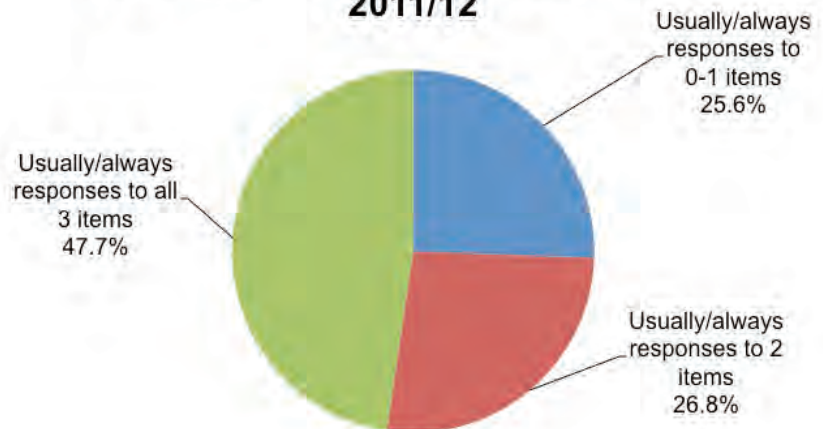
For children age 6-17 years, three questions were asked to capture curiosity and discovery about learning, resilience, and self-regulation based on: shows interest and curiosity in learning new things; staying calm and in control when faced with a challenge; finishes tasks and follows through with plans. These were categorized by number of times a response of usually/always into 0-1, 2, or all 3 items. A child was considered flourishing if all 3 items were met.

### **National Comparisons:**

In Hawai'i, 47.2% of children were reported to usually/always demonstrate all three of the "flourishing items". This is higher but not significantly different from the national average of 47.7%.

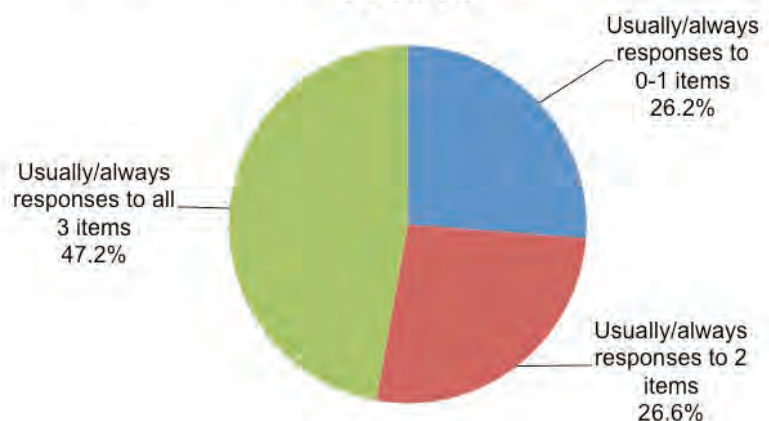
In Hawai'i, 26.6% of children were reported to demonstrate two of the three flourishing items and 26.2% were reported to demonstrate zero to one item. Nationally, 26.8% of children were reported to demonstrate two of the three flourishing items and 25.6% of children were reported to demonstrate zero to one item.

### **Flourishing- Positive Health Indicators for Children 6-17 Years, Nation NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

### **Flourishing- Positive Health Indicators for Children 6-17 Years, Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

## Displaying All Three Flourishing Items:

47.2% (Hawai'i)

vs

47.7% (Nation)

## Flourishing Disparities

Data for Hawai'i demonstrated disparities in children displaying all three positive health indicators related to gender, ACEs, medical home, race, and federal poverty level.

### Gender:

Significantly more females (52.5%) displayed all three flourishing items compared to males (41.9%).

### ACEs:

Children with no ACEs (54.2%) had the highest rates of flourishing, followed by those with two or more ACEs (42.3%), and finally by those with one ACE (38.8%). The proportion of children with no ACEs who were flourishing was significantly greater than that of children with one ACE and two or more ACEs.

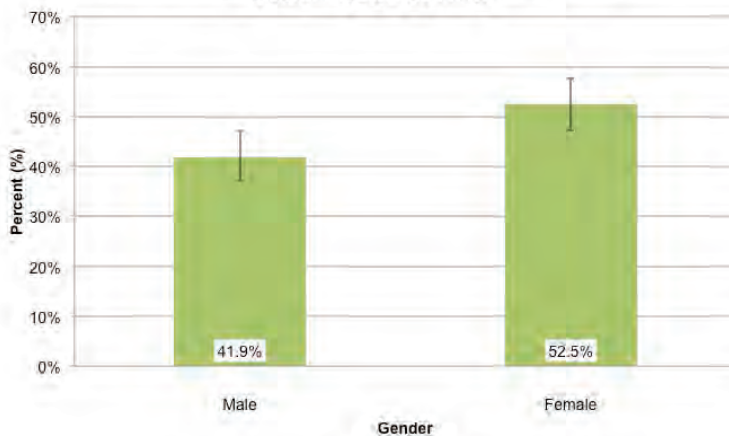
### Medical Home:

A significantly greater proportion of children with a medical home (57.7%) compared to those with no medical home (36.2%) were reported to display all three flourishing items.

### Other:

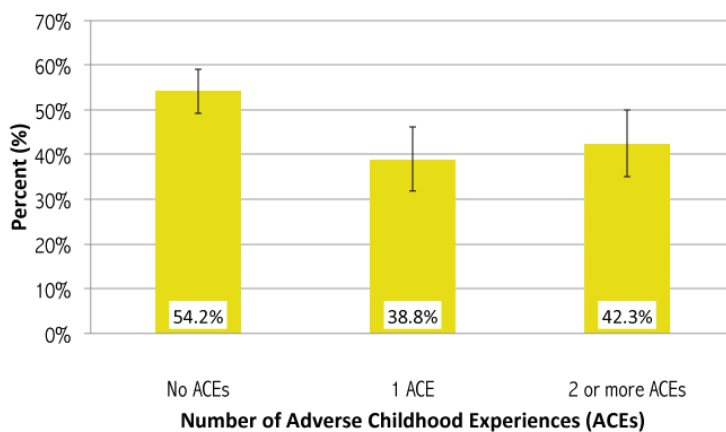
More White children (55.0%) displayed all three flourishing items compared to the other racial groups. This difference was statistically significant between the White children and Native Hawaiian/Pacific Islander children as well as multiracial children. Children in the 100-199% FPL (40.4%) had significantly lower rates of flourishing compared to children in the 200-399% FPL (50.1%) and 400%+ FPL (52.1%) categories. No statistically significant differences were observed in flourishing by the child's insurance. Differences for age group of the child were not assessed for this indicator.

**Flourishing- Positive Health Indicators by Gender, Hawai'i NSCH 2011/12**



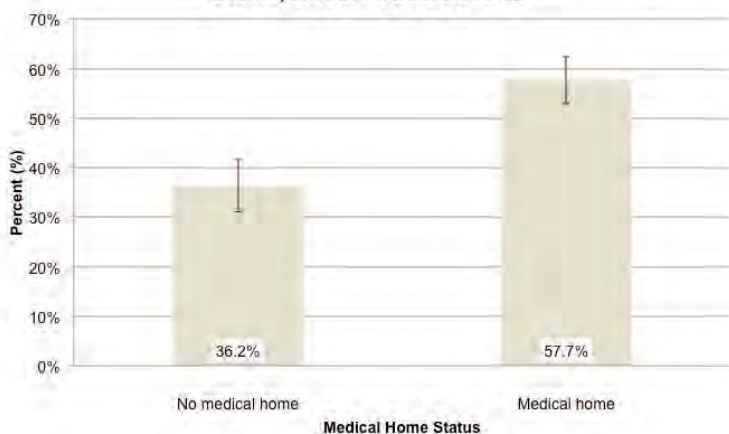
Data Source: National Survey of Children's Health, 2011/12

**Flourishing- Positive Health Indicators by Adverse Childhood Experiences, Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

**Flourishing- Positive Health Indicators by Medical Home Status, Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12



# HEALTH STATUS

## Special Health Care Needs Status Ages 0-17 Years

### **Background:**

Identifying Children with Special Health Care Needs (CSHCN) is essential for effectively providing necessary services to this higher risk youth group. Compared to the general youth population, the CSHCN population is at a greater risk for chronic, physical, developmental, behavioral or emotional conditions.<sup>24</sup>

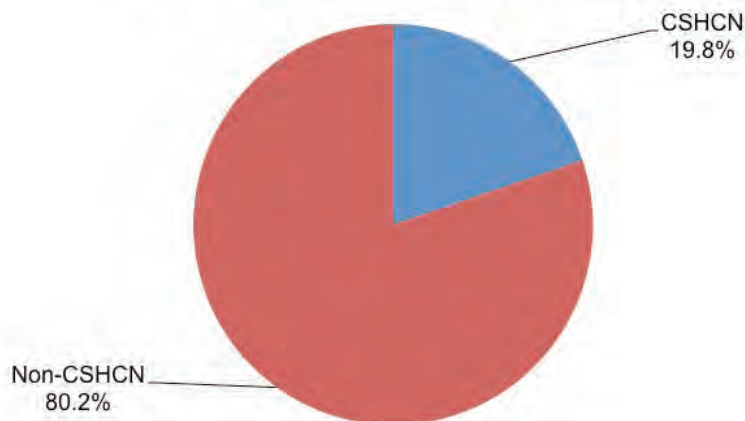
### **Measurement:**

Parents of 0-17 year olds were asked a series of questions from the CSHCN screener designed to reflect the Maternal and Child Health Bureau's consequences-based definition of children with special health care needs. The questions covered five criteria including medication use, special services, functional limitations, special therapies, and mental health services. If one or more of the five criteria were met, then the child was classified as having CSHCN status.

### **National Comparisons:**

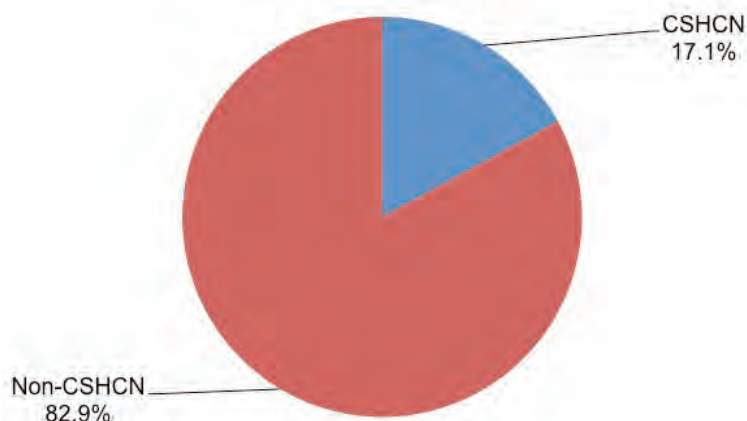
In Hawai'i, 17.1% of children were classified as children with special health care needs, which is significantly lower than the national estimate of 19.8%.

**Children with Special Health Care Needs, Nation NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

**Children with Special Health Care Needs, Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

Special Health Care Needs Status:  
17.1% (Hawai'i)  
vs  
19.8% (Nation)



## Special Health Care Needs Status Disparities

Data for Hawai'i demonstrated disparities in children with special health care needs related to insurance type, ACEs, medical home, and age.

### Insurance Type:

Significantly more publicly insured children (21.8%) were classified as CSHCN compared to privately insured (15.5%) children.

### ACEs:

The proportion of children who were CSHCN increased with greater numbers of ACEs. Children with no ACEs (11.4%) had the lowest rates of CSHCN classification, followed by children with one ACE (17.1%), and then by children with two or more ACEs (30.9%). Differences in rates were statistically significant across all three ACE categorizations.

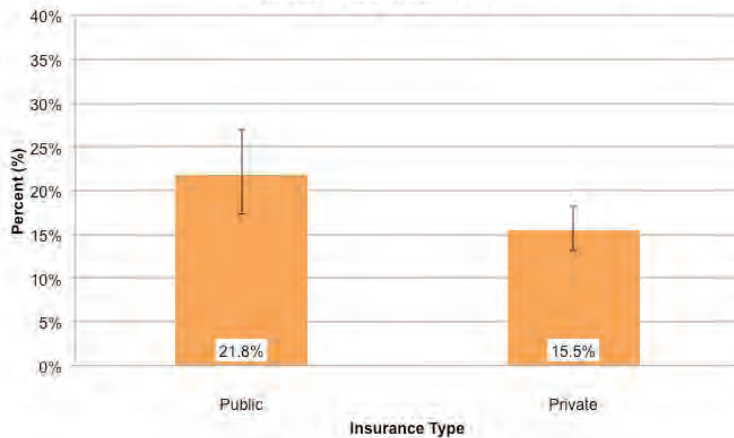
### Medical Home:

Children with no medical home (23.1%) had a significantly greater rate of being screened as CSHCN compared to children with a medical home (13.1%).

### Other:

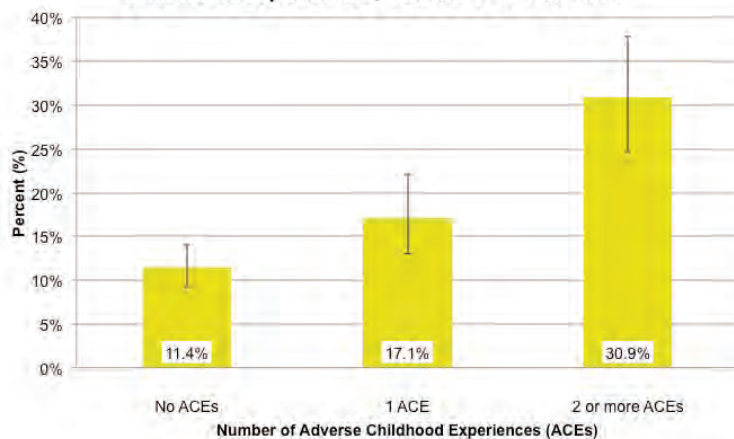
Significantly less children in the 0-5 year age group (8.4%) was classified as CSHCN compared to those in the 6-11 year old (18.6%) and 12-17 year old (24.0%) age groups. No statistically significant differences were observed for CSHCN related to the child's race, federal poverty level, and gender.

**Special Health Care Needs Status by Insurance Type, Hawai'i NSCH 2011/12**



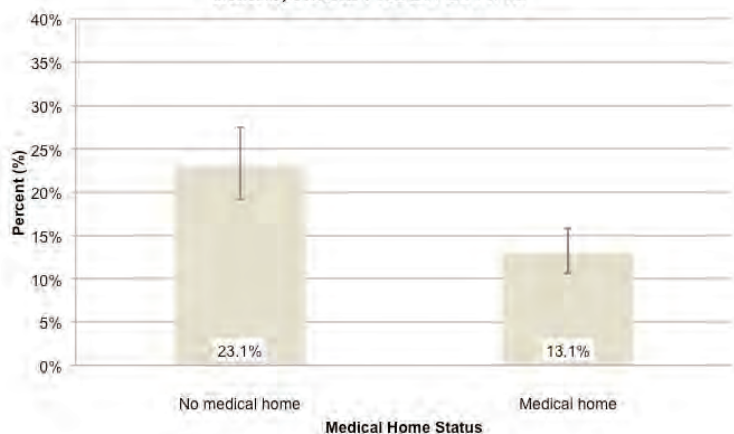
Data Source: National Survey of Children's Health, 2011/12

**Special Health Care Needs Status by Adverse Childhood Experiences, Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

**Special Health Care Needs Status by Medical Home Status, Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

## Chronic Health Conditions Ages 0-17 Years

### **Background:**

Children with chronic health conditions are at higher risk for severe acute illness compared to other youth. This includes cases of hospitalization for complications both related to and unrelated to the child's chronic condition. <sup>25</sup>

### **Measurement:**

Parents of 0-17 year olds were asked if they were ever told by a health care professional that their child has the condition, and whether the child currently has the condition. The 18 acute or chronic health conditions asked include: learning disability, ADD or ADHD, depression, anxiety problems, behavioral or conduct problems, autism or other autism spectrum disorder, developmental delay, intellectual disability, cerebral palsy, speech problems, asthma, diabetes, Tourette Syndrome, epilepsy or seizure disorder, hearing problems, vision problems, bone or joint problems, brain injury or concussion. Based on the number of conditions they had, children were grouped into none, one, and two or more current health conditions.

### **National Comparisons:**

In Hawai'i, 80.2% of children were reported to have no chronic health conditions. This is significantly higher than the national estimate of 76.4%.

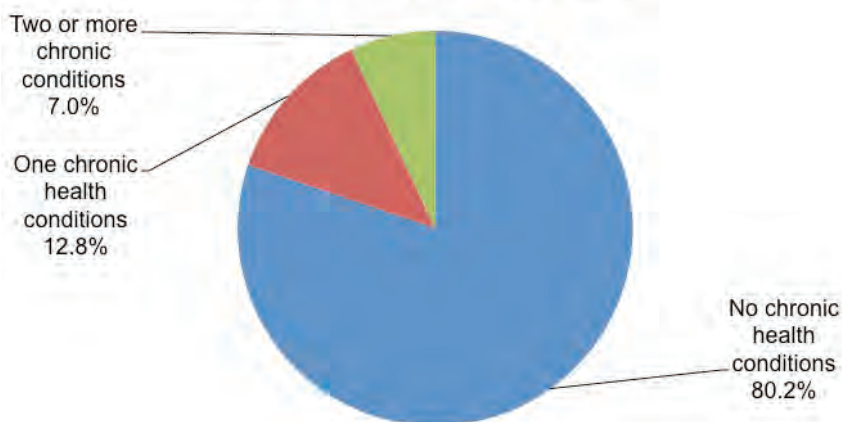
In Hawai'i, 12.8% of children have one chronic health condition and 7.0% have two or more chronic health conditions. Nationally, 14.0% of children have one chronic health condition and 9.6% have two or more chronic health conditions.

**Current Chronic Health Conditions,  
Nation NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

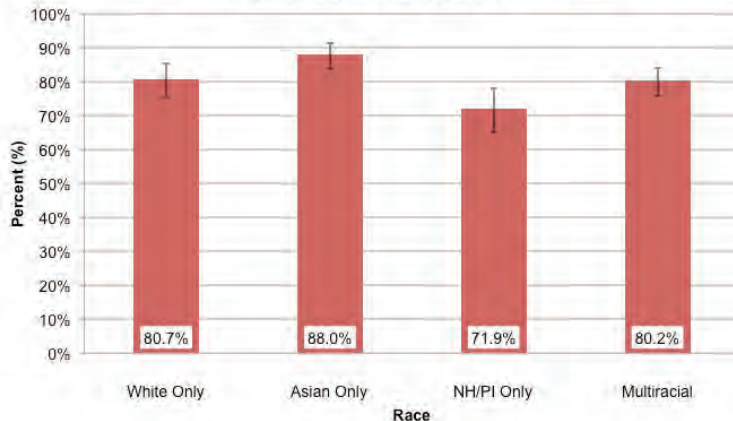
**Current Chronic Health Conditions,  
Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

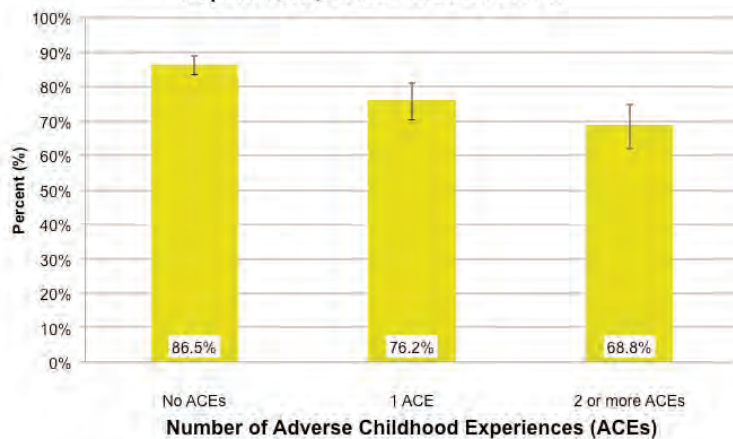
**No Current Chronic Conditions:  
80.2% (Hawai'i)  
vs  
76.4% (Nation)**

**No Chronic Health Conditions by Race,  
Hawai'i NSCH 2011/12**



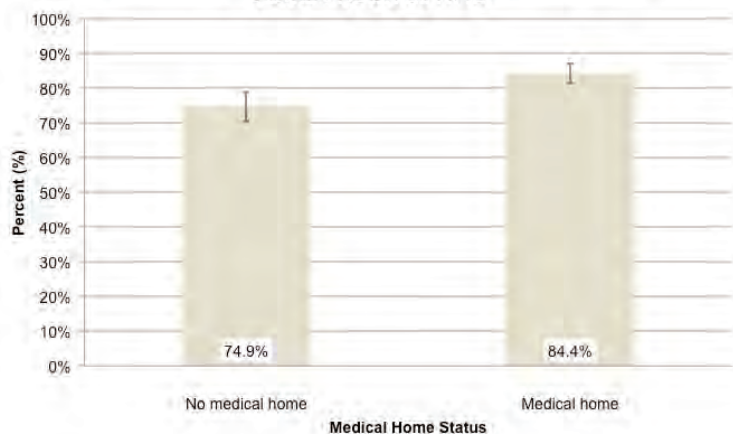
Data Source: National Survey of Children's Health, 2011/12

**No Chronic Health Conditions by Adverse Childhood  
Experiences, Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

**No Chronic Health Conditions by Medical Home Status,  
Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

## Chronic Health Conditions Disparities

Data for Hawai'i demonstrated disparities in children with no chronic health conditions related to race, ACEs, medical home, insurance type, and age group.

### **Race:**

More Asian (88.0%) children had no chronic conditions than other racial groups. This difference was significant when comparing Asian with White (80.7%), Native Hawaiian/Pacific Islander (NH/PI) (71.9%), and multiracial children (80.2%). In addition, NH/PI children had significantly lower rates of having no chronic conditions compared to White and multiracial children.

### **ACEs:**

The proportions of children with no chronic conditions decreased with the number of ACEs. More children with no ACEs (86.5%) had no chronic conditions than children with one ACE (76.2%) and two or more ACEs (68.8%). The estimates between children with no ACEs and one ACE as well as between children with no ACEs and two or more ACEs were statistically significant.

### **Medical Home:**

A significantly greater proportion of children with a medical home (84.4%) report having no chronic conditions compared to those without a medical home (74.9%).

### **Other:**

Privately insured children (82.5%) were more likely to have no chronic conditions compared to publicly insured youth (74.6%). Children 0-5 years (89.0%) were more likely to have no chronic conditions compared to older children. There were no statistically significant disparities between FPL levels and gender for children with no chronic conditions.



# HEALTH CARE

## Health Insurance Status Ages 0-17 Years

### **Background:**

Health insurance coverage for children is an important factor in determining their access to health care. Health insurance allows medical and prescription drug needs to be met in addition to providing access to recommended preventive health services. Because the health insurance status of children is often associated with that of their parents, it is necessary that access to health insurance coverage exists for all members of the family.<sup>26</sup>

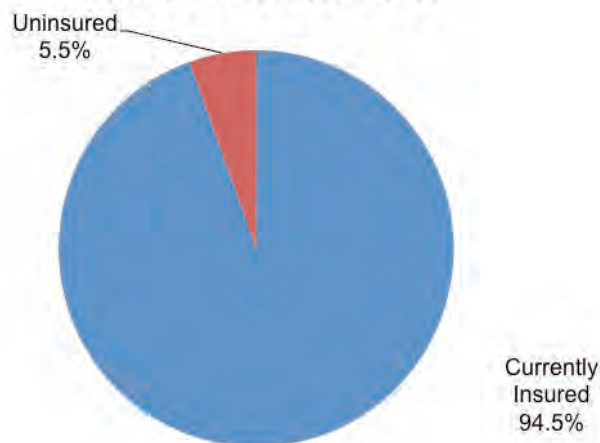
### **Measurement:**

Parents of 0-17 year olds were asked if their children were covered by any type of health insurance. Prepaid plans such as HMOs or government plans for lower income families such as Medicaid were both considered as health care coverage.

### **National Comparisons:**

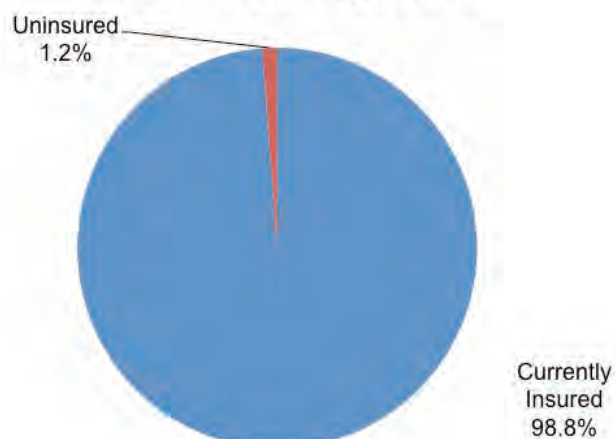
In Hawai'i, 98.8% of children were currently covered by some type of health insurance plan, which is significantly higher than the national estimate of 94.5%.

### Health Insurance Coverage, Nation NSCH 2011/12



Data Source: National Survey of Children's Health, 2011/12

### Health Insurance Coverage, Hawai'i NSCH 2011/12



Data Source: National Survey of Children's Health, 2011/12

Children with Health Insurance:  
98.8% (Hawai'i)  
vs  
94.5% (Nation)



## Health Insurance Status

### Disparities

Data for Hawai'i demonstrated disparities in children with health insurance coverage related to race, federal poverty level, and medical home.

#### **Race:**

Amongst the five racial groups, Asian children (97.0%) had the lowest rates of being insured. This proportion was significantly lower than that of Native Hawaiian/Pacific Islander children (99.4%), and multiracial children (99.9%). The proportion of White children (98.2%) with insurance was also significantly different from that of multiracial children.

#### **Federal Poverty Level:**

Slightly less children in the <100% FPL group were currently insured compared to the other groups. The proportion of children insured within the 100-199% FPL group (97.9%) was significantly different from that of children within the 200-399% FPL (99.6%) and 400%+ FPL (99.6%) groups.

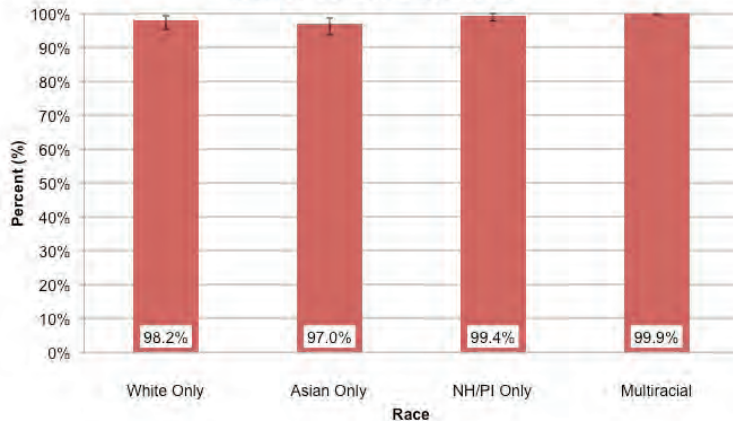
#### **Medical Home:**

Slightly more children with a medical home (99.7%) were currently insured compared to youth without a medical home (97.9%). This difference was statistically significant.

#### **Other:**

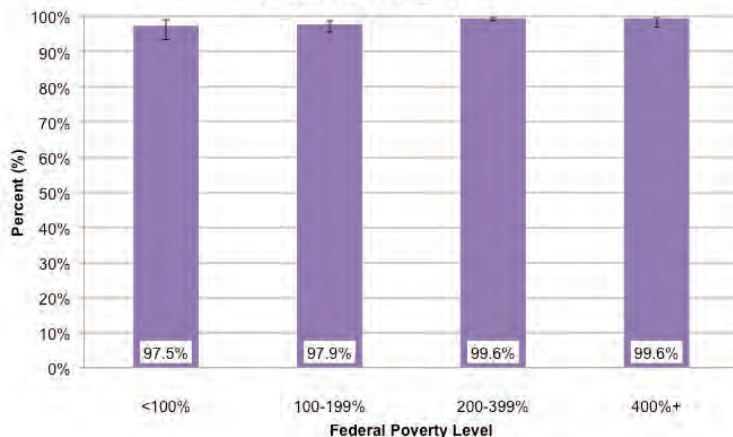
There were no statistically significant disparities between age groups, gender, and ACEs for currently insured children. Differences based on insurance type for the child was not assessed for this indicator.

**Currently Insured by Race,  
Hawai'i NSCH 2011/12**



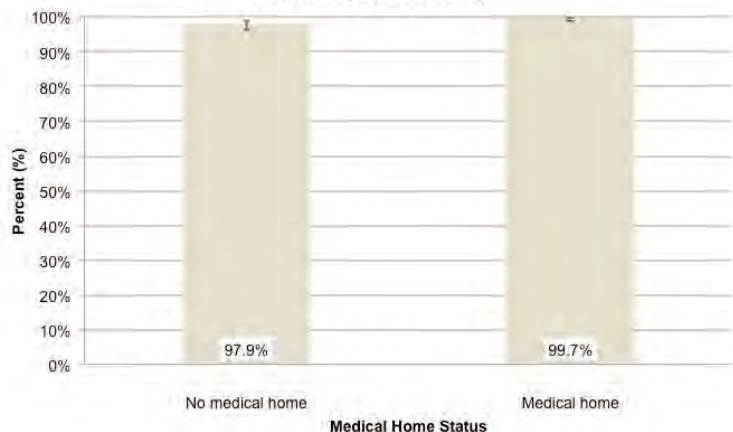
Data Source: National Survey of Children's Health, 2011/12

**Currently Insured by Poverty Level,  
Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

**Currently Insured by Medical Home Status,  
Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

# HEALTH CARE

## Adequacy of Insurance Ages 0-17 Years

### **Background:**

Although a child may be insured, it is important that the health insurance adequately meets his or her needs as well. Families and children with special health care needs depend heavily on access to health services, making adequate insurance critical for ensuring good health.<sup>27</sup>

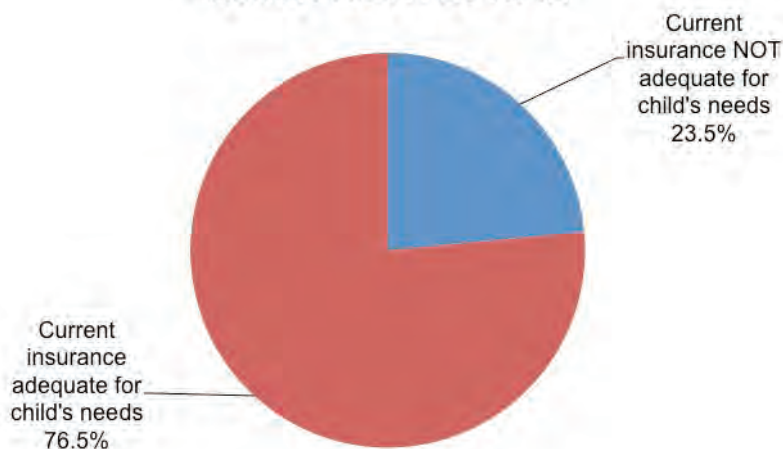
### **Measurement:**

Parents of 0-17 year olds were surveyed as to whether their child's current insurance coverage was adequate to meet his/her needs. The following components had to be met in order for the child's insurance coverage to be deemed adequate: 1) child was current insured, 2) insurance benefits usually/always met the child's needs, 3) benefits usually/always allowed appointments with needed providers, 4) out-of-pocket expenses were either usually/always not required or reasonable.

### **National Comparisons:**

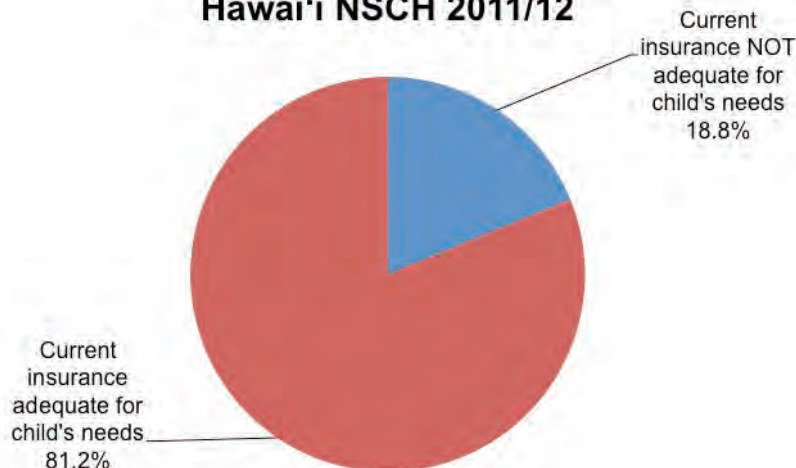
In Hawai'i, 81.2% of children were reported to have insurance that was adequate for their needs. This is significantly higher than the national estimate of 76.5%.

### **Adequacy of Insurance, Nation NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

### **Adequacy of Insurance, Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

Children with Adequate  
Insurance:  
81.2% (Hawai'i)  
vs  
76.5% (Nation)

## Adequacy of Insurance Disparities

Data for Hawai'i demonstrated disparities in children with adequate insurance related to race, federal poverty level, ACEs, and medical home.

### **Race:**

Asian children (72.3%) had significantly lower rates of adequate insurance than Native Hawaiian/Pacific Islander children (77.8%) and multiracial children (84.4%). Lastly, the proportion of White children (86.6%) with adequate insurance is significantly different from multiracial children.

### **Federal Poverty Level:**

Children in the 100-199% FPL group (74.6%) had the lowest rates of adequate insurance. This is significantly different from children in the 200-399% FPL (82.9%) and 400%+ (86.4%) groups.

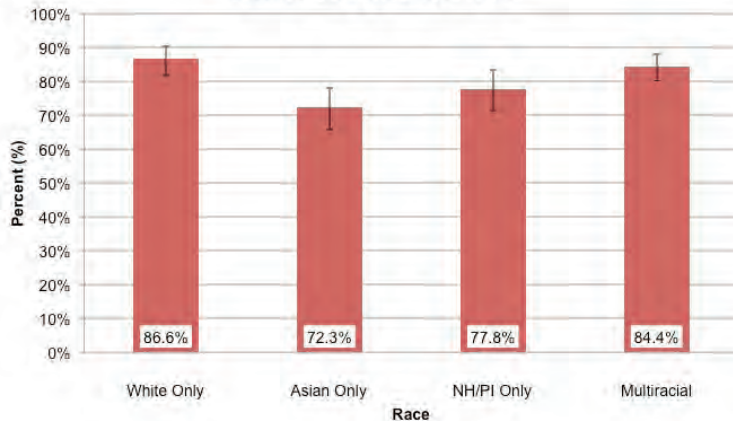
### **ACEs:**

Children with no ACEs (86.1%) were reported to have the highest percentage of adequate insurance coverage. This is significantly different from children with 1 ACE (74.1%) and 2 or more ACEs (78.1%).

### **Other:**

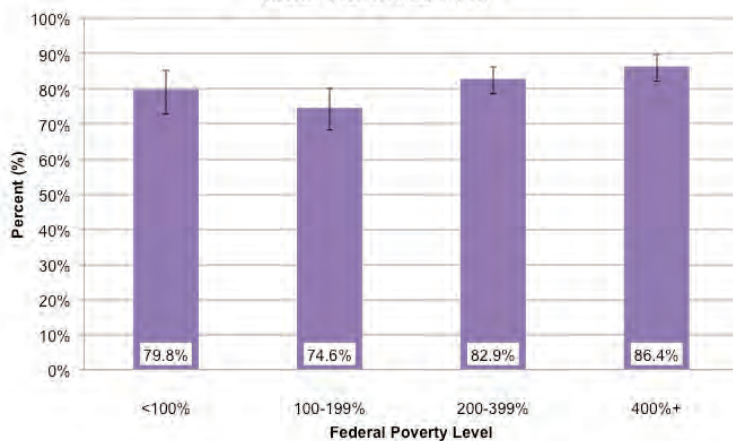
A higher percentage of children with a medical home (88.5%) were covered by adequate insurance compared to those without a medical home (71.5%). No statistically significant difference related to the child's gender and insurance type for the adequate insurance indicator existed.

**Adequate Insurance by Race, Hawai'i NSCH 2011/12**



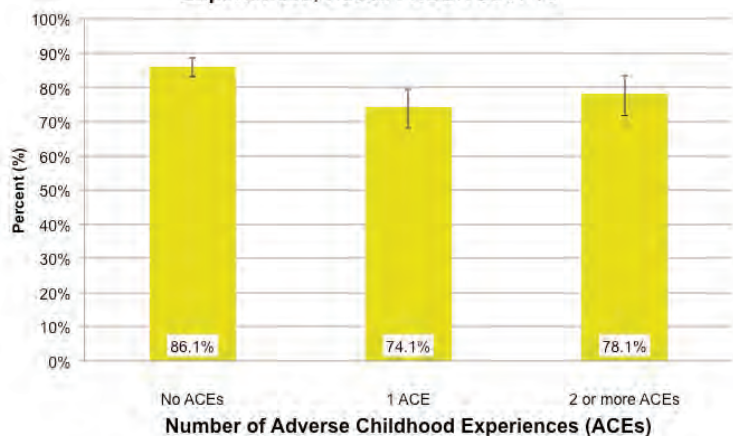
Data Source: National Survey of Children's Health, 2011/12

**Adequate Insurance by Poverty Level, Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

**Adequate Insurance by Adverse Childhood Experiences, Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12



# HEALTH CARE

## Preventive Medical Care Ages 0-17 Years

### **Background:**

Medical preventive care visits offer an opportunity to monitor children's health and administer immunizations as well as to assess a child's behavior and development, provide health guidance, and answer parents' questions. These visits are especially important for youth who exhibit various behavioral and/or medical risk factors. Behaviors that contribute most to the leading causes of mortality and morbidity in adults are often initiated during adolescence making it critical for these problems to be identified early.<sup>28</sup>

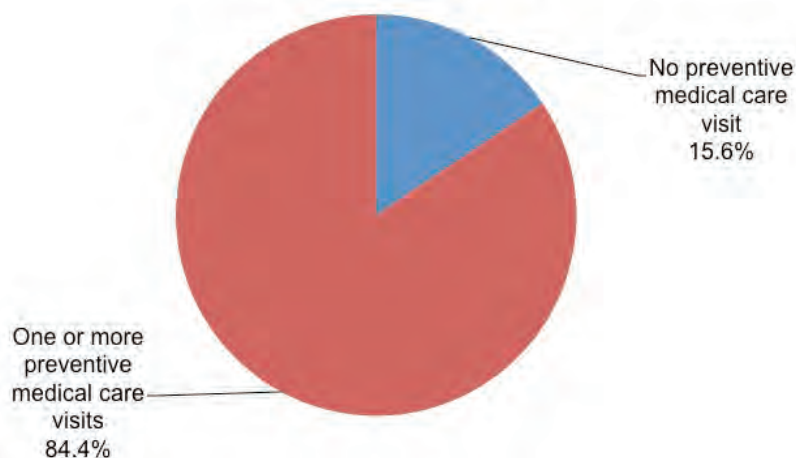
### **Measurement:**

Parents of 0-17 year olds were asked how many times their child saw a doctor, nurse, or other health care provider for preventive medical care such as a physical exam or well-child checkup during the past 12 months. Responses were grouped into no preventive medical visits or one or more preventive medical visits.

### **National Comparisons:**

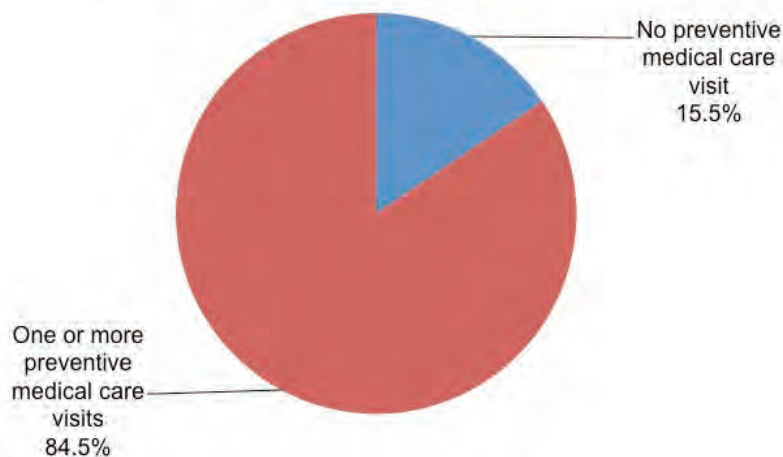
In Hawai'i, parental responses indicated that 84.5% of children received one or more preventive medical care visits during the past 12 months. This is slightly higher but not significantly different from the national estimate of 84.4%

**Preventive Medical Care Visits,  
Nation NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

**Preventive Medical Care Visits,  
Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

**Children with Preventive Medical  
Care:  
84.5% (Hawai'i)  
vs  
84.4% (Nation)**



## Preventive Medical Care Disparities

Data for Hawai'i demonstrated disparities in children for preventive medical care related to federal poverty level, age, and medical home.

### **Federal Poverty Level:**

More children in the 400%+ FPL group (90.2%) had preventive medical care visits compared to the other FPL categories. This proportion was significantly different from that of children in the <100% FPL (76.0%) and 100-199% FPL (82.2%) categories. The proportion of children in the <100% who received preventive medical care was also significantly less than that of children in the 200-399% FPL group (86.6%).

### **Age:**

Children in the youngest 0-5 year old (91.1%) category had significantly higher rates of preventive medical care visits compared to children in the 6-11 year old (80.2%) and 12-17 year old (82.2%) age group.

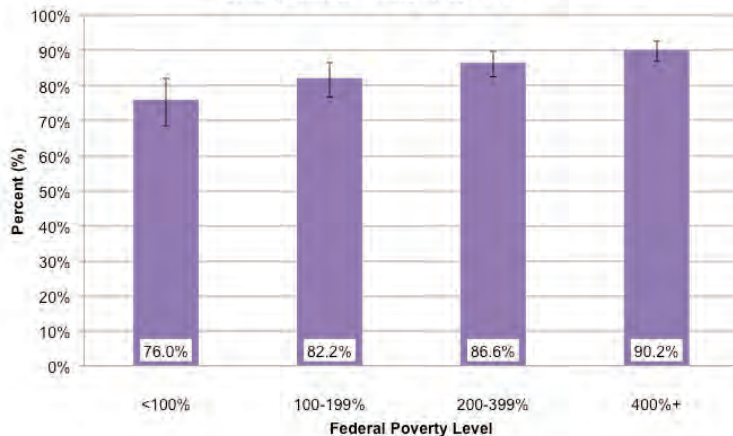
### **Medical Home:**

Significantly more children with a medical home (88.7%) received preventive medical care visits compared to children without a medical home (78.6%).

### **Other:**

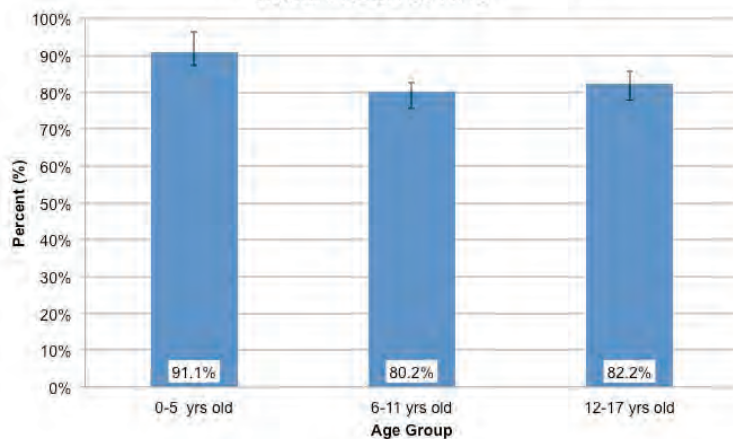
No statistically significant disparities were seen for children who received preventive medical care visits related to race, gender, insurance type, and ACEs.

**Received Medical Preventive Care Visits by Poverty Level, Hawai'i NSCH 2011/12**



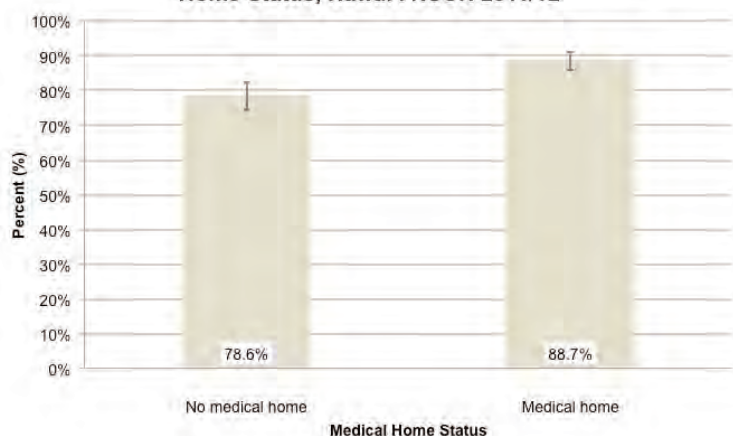
Data Source: National Survey of Children's Health, 2011/12

**Received Medical Preventive Care Visits by Age, Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

**Received Preventive Medical Care Visits by Medical Home Status, Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

# HEALTH CARE

## Preventive Dental Care Ages 1-17 Years

### **Background:**

The currently established national standard is for children to visit a dentist every six months. However, each year in the United States, tens of millions of children go without seeing a dentist. Unrecognized dental diseases can result in exacerbated problems that require more extensive and expensive care. Receiving dental preventive care early in life will help build a foundation for lifelong preventive education and oral health care.<sup>29</sup>

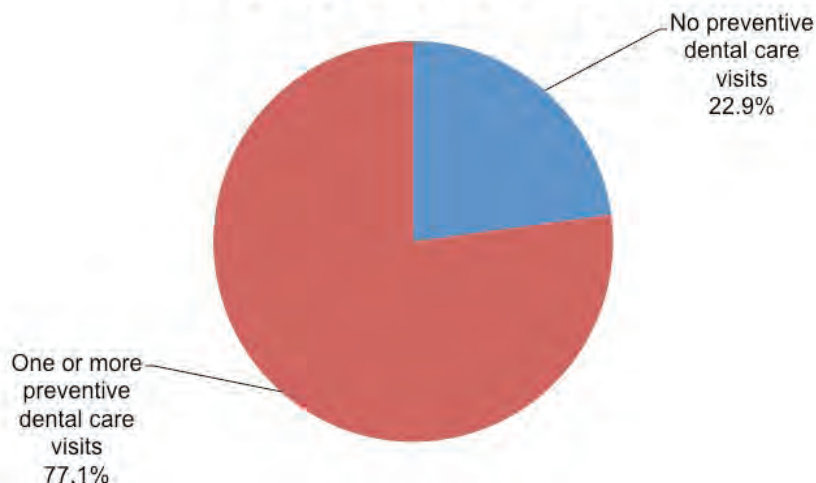
### **Measurement:**

Parents of 1-17 year olds reported whether or not their child had any visits for preventive dental care during the past 12 months. Responses were grouped into no preventive dental visits or one or more preventive dental visits.

### **National Comparisons:**

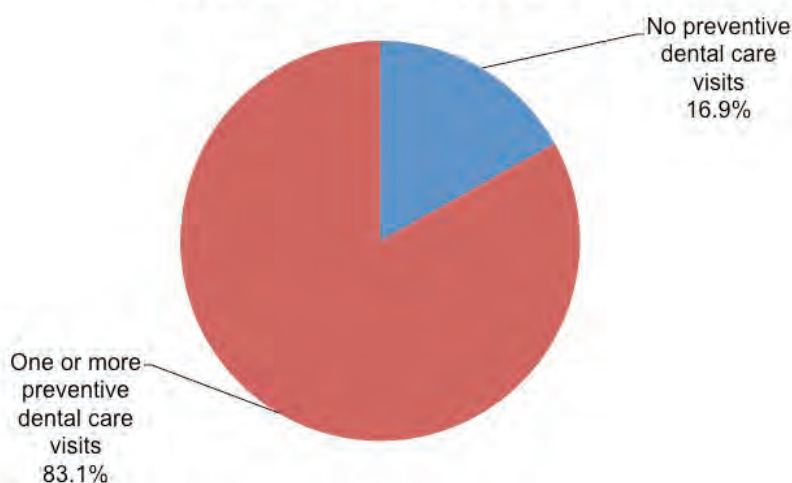
In Hawai'i, 83.1% of children reported having one or more preventive dental care visits. This is significantly higher than the national estimate of 77.1%.

**Preventive Dental Care Visits,  
Nation NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

**Preventive Dental Care Visits,  
Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

Children with Preventive Dental  
Visits:  
83.1% (Hawai'i)  
vs  
77.1% (Nation)

## Preventive Dental Care Disparities

Data for Hawai'i demonstrated disparities in children for preventive dental care visits related to race, federal poverty level, insurance type, and age.

### **Race:**

Asian children (88.4%) had the highest rates of receiving preventive dental care visits, followed by multiracial (84.7%), White (81.4%), and Native Hawaiian/Pacific Islander (NH/PI) children (78.9%). Significantly more Asian children received preventive dental care visits compared to White (81.4%) and NH/PI (78.9%) children.

### **Federal Poverty Level:**

More children at 400%+ FPL (91.6%) compared to <100% (70.0%), 100-199% (79.6%), and 200-399% (86.9%) received preventive dental care. The differences between all FPL groups were statistically significant.

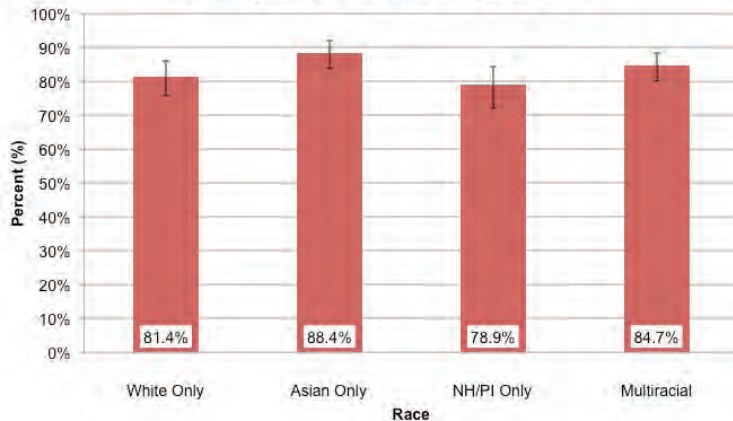
### **Insurance Type:**

Significantly more privately insured (86.9%) children received preventive dental care compared to publicly insured (75.7%) children.

### **Other:**

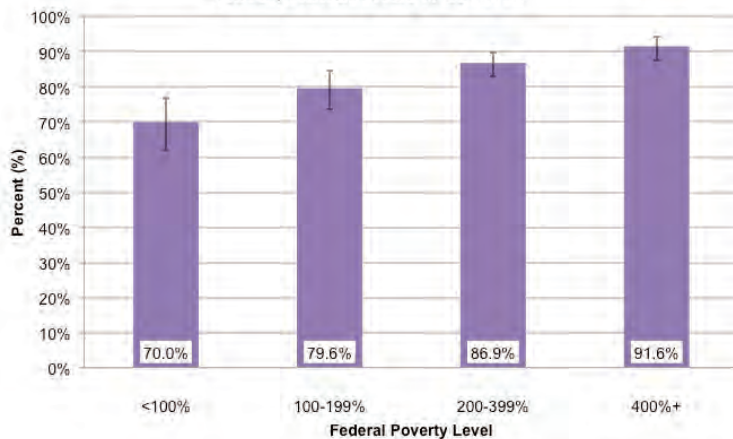
Children in the 6-11 age (92.1%) group had the highest rates of received preventive dental care compared to the 0-5 year old (69.6%) and the 12-17 year old (85.1%) age groups. The differences across all three age groups were statistically significant. There were no statistically significant disparities in preventive dental care related to the child's gender, ACEs, and medical home.

**Received Dental Preventive Care Visits by Race, Hawai'i NSCH 2011/12**



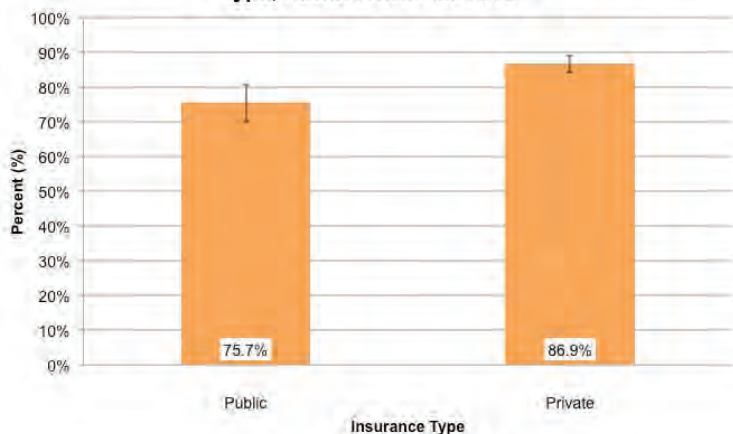
Data Source: National Survey of Children's Health, 2011/12

**Received Dental Preventive Care Visits by Poverty Level, Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

**Received Dental Preventive Care Visits by Insurance Type, Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12



# HEALTH CARE

## Preventive Medical and Dental Care Ages 1-17 Years

### **Background:**

Preventive care is important for ensuring that children have a higher likelihood of achieving desired medical and dental health outcomes. Receiving the recommended number of preventive visits in early childhood may confer many benefits including reduction in the number of emergency department visits and hospitalizations, decrease childhood injuries, and establishing the foundation for good health later on in life.<sup>30</sup>

### **Measurement:**

Parents of 1-17 years who reported their child receiving medical and dental preventive care during the past 12 months were categorized as having received both routine medical and dental care visits.

### **National Comparisons:**

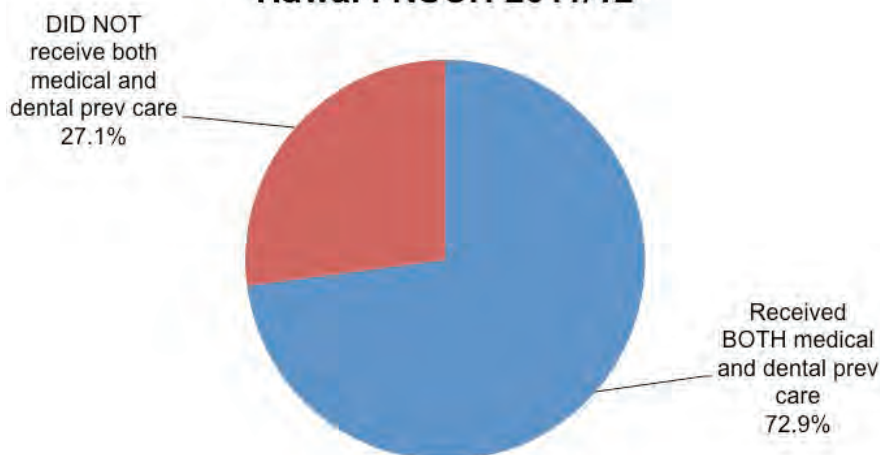
In Hawai'i 72.9% of children were reported to have received both medical and dental preventive care in the past 12 months. This is significantly higher than the national estimate of 68.1%

**Preventive Care Visits,  
Nation NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

**Preventive Care Visits,  
Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

Children with Both Preventive  
Care :  
72.9% (Hawai'i)  
vs  
68.1% (Nation)



## Preventive Medical and Dental Care Disparities

Data for Hawai'i demonstrated disparities in children who received both preventive medical and dental care related to federal poverty level, insurance type, medical home, and ACEs.

### **Federal Poverty Level:**

The percentage of children who received both medical and dental preventive care increased with increasing FPL category. More children in the 400%+ FPL (83.5%) received both preventive care compared to children in the 200-399% (76.9%), 100-199% (70.1%), and <100% (55.4%) FPL groups. The differences across all the FPL categories were statistically significant.

### **Insurance Type:**

Privately insured children (76.0%) had the highest rate of receiving both preventive care which was significantly higher compared to publicly insured (68.3%) children.

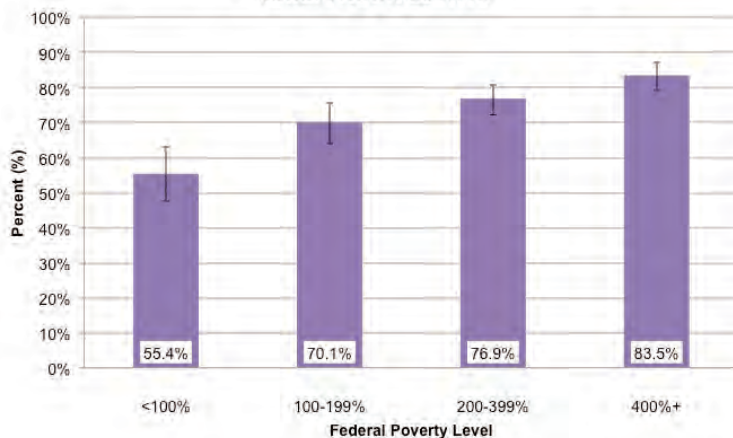
### **Medical Home:**

Youth who had a medical home (77.0%) were significantly more likely than those with no medical home (67.0%) to have received both medical and dental preventive care.

### **Other:**

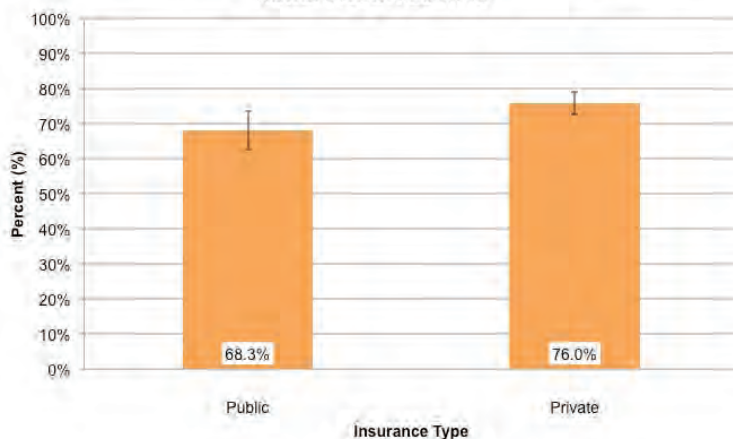
Children with no ACEs (75.4%) had significantly higher rates of receiving both preventive care compared to children with one ACE (68.3%). No differences in this indicator were observed with regard to the child's race, age group, and gender.

**Received Preventive Care Visits by Poverty Level, Hawai'i NSCH 2011/12**



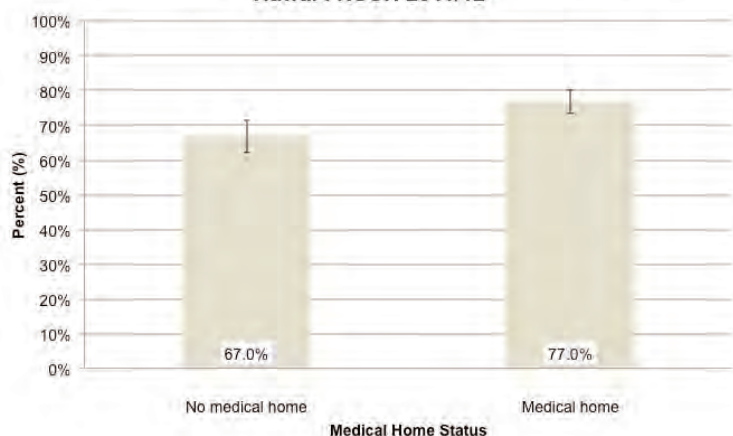
Data Source: National Survey of Children's Health, 2011/12

**Received Preventive Care Visits by Insurance Type, Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

**Received Preventive Care by Medical Home Status, Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

## Vision Screening Ages 0-17 Years

### **Background:**

A child who cannot see well will start their education at a disadvantage. Even a short period of uncorrected poor eyesight can have a significantly adverse effect on the child's ongoing educational performance, which in turn affects their performance, position, employability and economic contribution (or cost) throughout life. It is recommended by the American Academy of Pediatrics that vision screening should be performed at an early age and at regular intervals with age-appropriate, valid methods, ideally within the medical home. The goal remains to identify and treat preventable visual impairment at the earliest feasible age.<sup>31</sup>

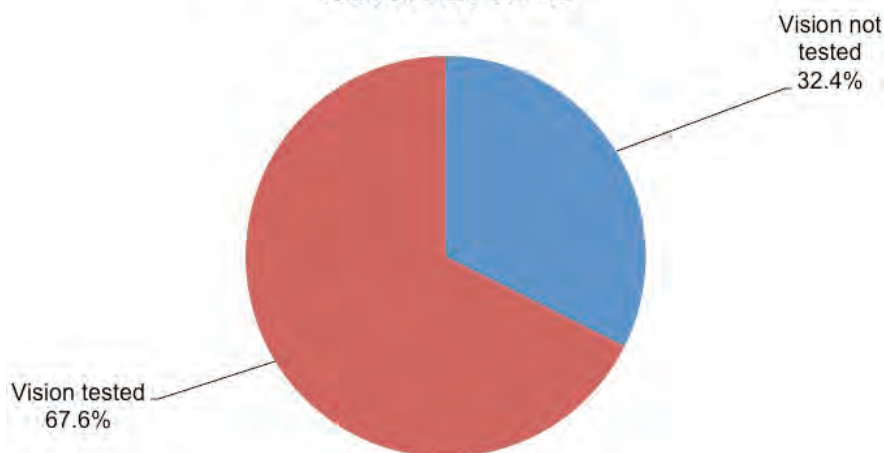
### **Measurement:**

Parents of 0-17 year olds were asked if a child has had their vision tested with pictures, shapes, or letters. For children 2 years of age and older the time frame of question was in the past 2 years; whereas for children under 2 years of age, the time frame was ever received a screen. These were categorized into received a vision screening compared to not having received a screening.

### **National Comparisons:**

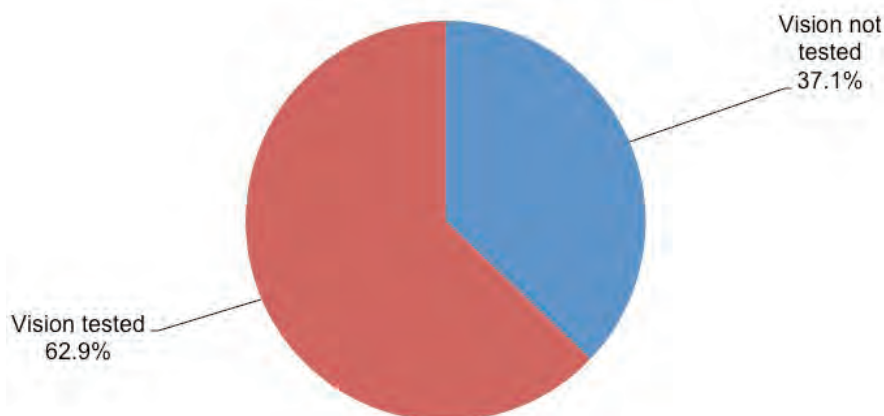
In Hawai'i, 62.9% of children were reported to have received a vision screening. This is lower and significantly different from the national estimate of 67.6%.

**Receipt of Vision Screening,  
Nation 2011/12**



Data Source: National Survey of Children's Health, 2011/12

**Receipt of Vision Screening,  
Hawai'i 2011/12**



Data Source: National Survey of Children's Health, 2011/12

**Vision Screened:  
62.9% (Hawai'i)  
vs  
67.6% (Nation)**

## Vision Screening Disparities

Data for Hawai'i demonstrated disparities in children who received a vision screening related to race, federal poverty level, age group, gender, insurance type, medical home, and ACEs.

### **Federal Poverty Level:**

The proportion of children who received a vision screening increased with FPL. Significantly less children in the <100% (53.3%) and 100-199% (55.5%) FPL groups compared to children in the 200-399% FPL group (66.2%) and the 400%+ group (73.3%) had a vision screening. Additionally, children in the 200-399% FPL group were less likely to have a vision screening than those in the 400%+ group.

### **Age:**

Fewer children within the 0-5 year old age range (37.3%) had received a vision screening compared to older children. This rate was significantly smaller than those who are 6-11 years old (78.1%) and 12-17 years old (73.3%).

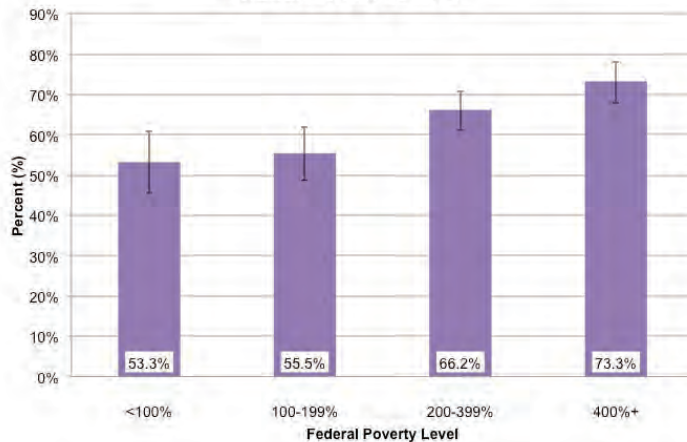
### **Gender:**

Significantly more females (66.7%) received a vision screening compared to males (59.2%).

### **Other:**

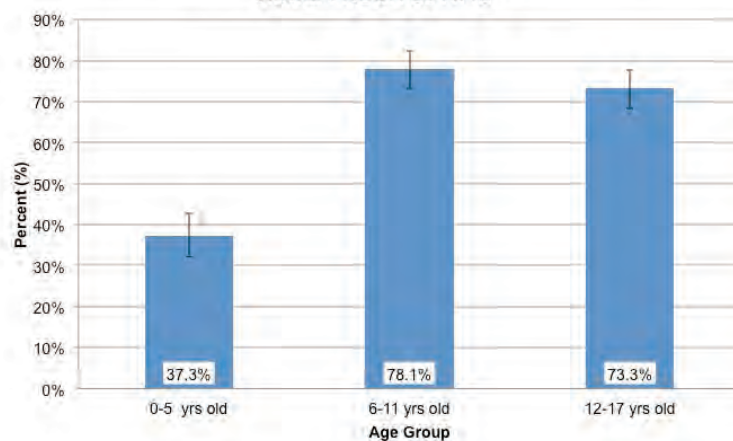
Privately insured children (66.4%) had significantly higher rates of receiving a vision screening compared to publicly insured children (56.5%). In addition, children with a medical home (65.6%) also had significantly higher rates compared to those without (58.9%). In addition, those with 2 or more ACEs (72.4%) were more likely to receive a vision screening compared to children with one ACE (60.3%) and no ACEs (60.8%). No statistically significant differences for this indicator was observed related to race.

Received Vision Screening by Poverty Level, Hawai'i NSCH 2011/12



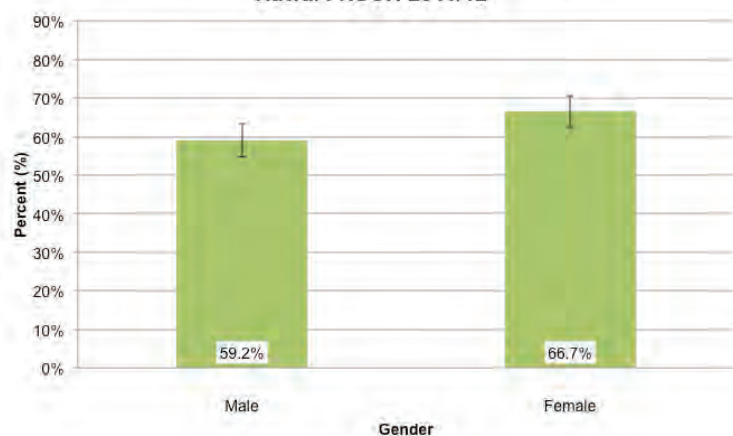
Data Source: National Survey of Children's Health, 2011/12

Received Vision Screening by Age, Hawai'i NSCH 2011/12



Data Source: National Survey of Children's Health, 2011/12

Received Vision Screening by Gender, Hawai'i NSCH 2011/12



Data Source: National Survey of Children's Health, 2011/12



# HEALTH CARE

## Medical Home Ages 0-17 Years

### **Background:**

The medical home has been increasingly accepted as the standard for provision of high-quality comprehensive health care for infants, children, and adolescents. According to the American Academy of Pediatrics, medical homes should encompass a variety of qualities including being accessible, continuous, comprehensive, and culturally effective.<sup>32</sup>

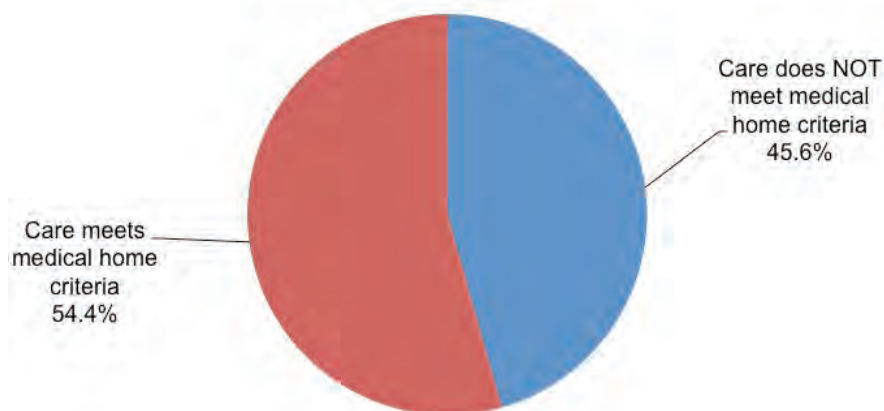
### **Measurement:**

The presence of a medical home for children 0-17 years old was based on five component variables constructed from a total of 19 survey items. The component indicators include: 1) personal doctor or nurse, 2) usual source for sick and well care, 3) family-centered care, 4) no problems getting needed referrals, 5) effective care coordination when needed. Children must meet the first three components in order to qualify as having a medical home. Additionally, for those who needed referrals or care coordination, the last two components must also be met to qualify as having a medical home.

### **National Comparisons:**

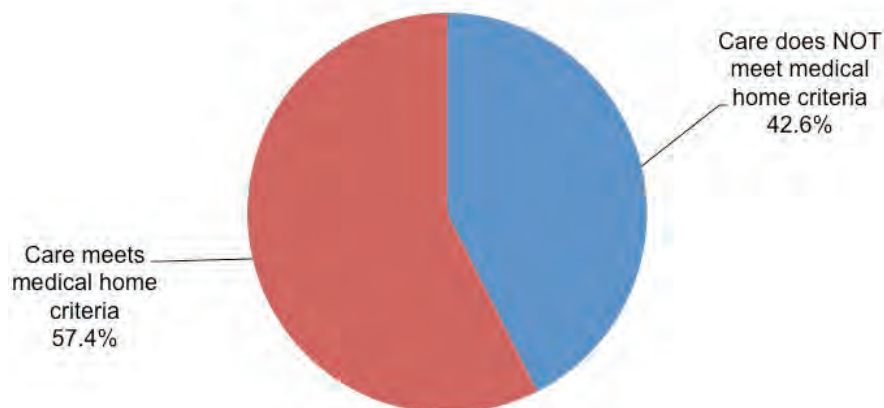
In Hawai'i, parental responses indicated that 57.4% of children received care that meets the medical home criteria. This is higher than but not significantly different from the national estimate of 54.4%

**Children with a Medical Home,  
Nation NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

**Children with a Medical Home,  
Hawai'i NSCH 2011/12**

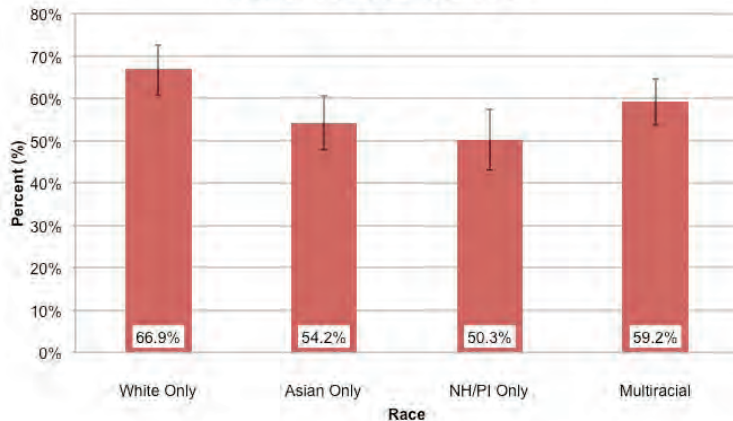


Data Source: National Survey of Children's Health, 2011/12

**Children with a Medical Home:  
57.4% (Hawai'i)  
vs  
54.4% (Nation)**

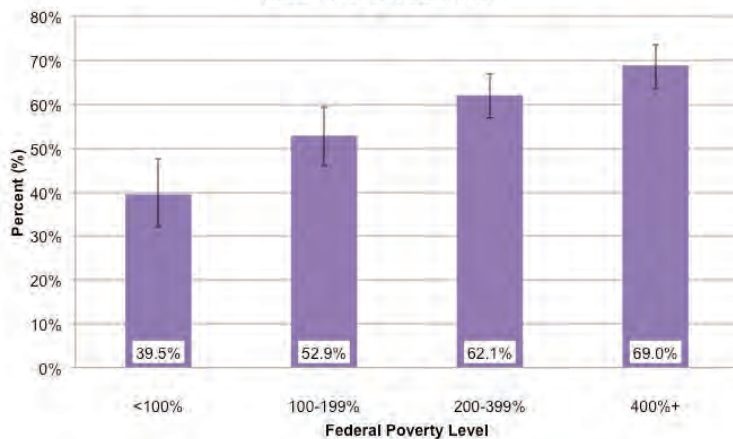


**Children with Medical Home by Race,  
Hawai'i NSCH 2011/12**



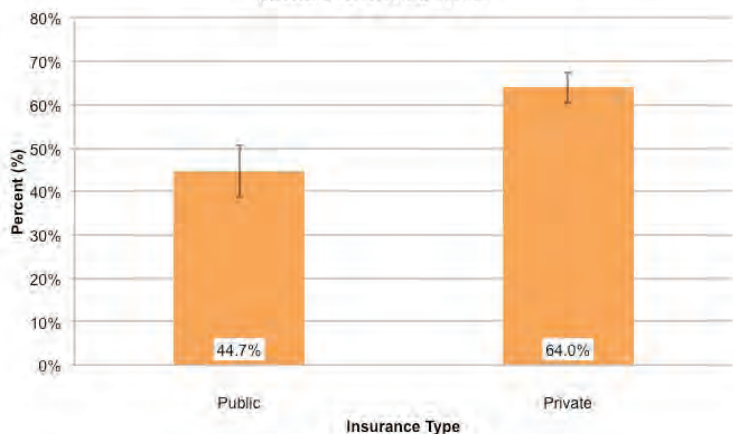
Data Source: National Survey of Children's Health, 2011/12

**Children with Medical Home by Poverty Level,  
Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

**Children with Medical Home by Insurance Type,  
Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

## Medical Home Disparities

Data for Hawai'i demonstrated disparities in children with a medical home related to race, federal poverty level, insurance type, age, and ACEs.

### **Race:**

Native Hawaiian/Pacific Islander (50.3%) and Asian children (54.2%) had the lowest rates of having a medical home out of all the racial categories. This proportion was significantly less than that of White (66.9%) children.

### **Federal Poverty Level:**

The proportion of children who had a medical home increased with increasing FPL category. More children at 400% FPL (69.0%) had a medical home than those at <100% (39.5%), 100-199% (52.9%), and 200-399% (62.1%).

### **Insurance Type:**

Significantly more privately insured children (64.0%) had a medical home compared to publicly insured (44.7%) children.

### **Other:**

Children in the 0-5 year old age group (64.5%) had a statistically higher rate of having a medical home compared to children in the 6-11 year old (55.6%) and 12-17 year old (52.1%) age groups. In addition, those with no ACEs (64.1%) also had statistically higher rates of having a medical home compared to children with one ACE (53.2%) and 2 or more ACEs (45.8%). No statistically significant differences were observed for this indicator related to the gender of the child. Differences for medical home status of the child was not assessed for this indicator.

## Home Visitation Ages 0-3 Years

### **Background:**

Home visits are part of an early-intervention strategy intended to address health and developmental outcome disparities. Families that have insufficient knowledge about parenting skills or lack a support system can benefit from the social support and health education provided by home visits. Successful programs have the potential to improve parenting skills, reduce the frequency of unintentional injury, increase rates of breastfeeding, and improve child behavioral issues such as sleep problems.<sup>33</sup> For at-risk families, comprehensive home visitation programs can also confer positive long-lasting changes on children's future criminal behavior and delinquency.<sup>34</sup>

### **Measurement:**

Participation in a home visitation program was based on family participation as measured by receiving a home visit for either the parent or a child between pregnancy and the time the child was 3 years old. Responses were categorized as having received at least one home visit compared to not receiving a home visit.

### **National Comparisons:**

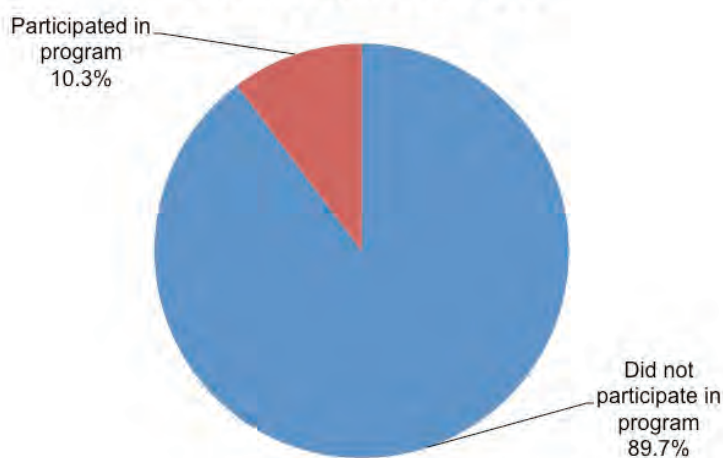
In Hawai'i, responses indicated that 89.7% of families with children did not receive at least one home visit. This is higher but not significantly different from the national estimate of 86.3%.

**Home Vistation Program,  
Nation NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

**Home Visitation Program,  
Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

**Young Children with No Home  
Visitation:  
89.7% (Hawai'i)  
vs  
86.3% (Nation)**

## Home Visitation Disparities

Data for Hawai'i demonstrated no significant disparities in children with family participation in a home visitation program.

### ***Federal Poverty Level:***

The proportion of children who had a medical home was similar across all FPL category.

### ***Gender:***

There were no significant differences among children who had a home visit by gender.

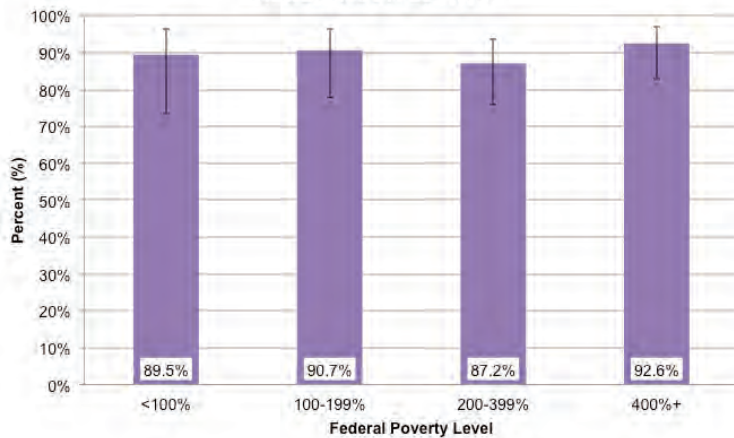
### ***Medical Home:***

There were no significant differences among children who had a home visit by presence of a medical home.

### ***Other:***

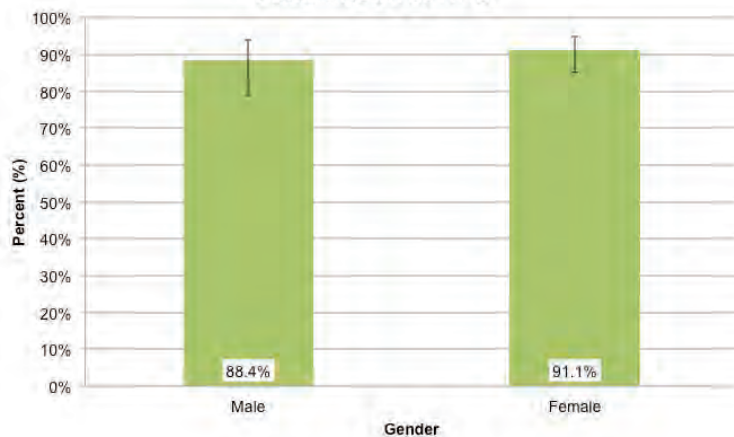
No statistically significant differences were observed for this indicator related to the race, gender, insurance type of the child. Differences for age of the child was not assessed for this indicator.

**No Home Visitation by Poverty Level,  
Hawai'i NSCH 2011/12**



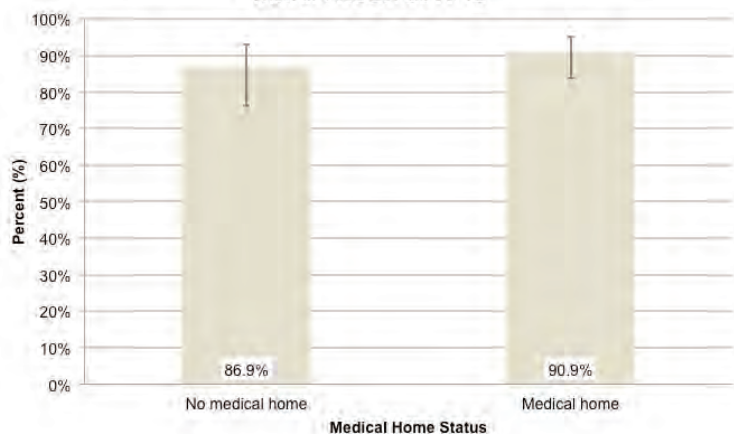
Data Source: National Survey of Children's Health, 2011/12

**No Home Visitation by Gender,  
Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

**No Home Visitation by Medical Home Status,  
Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12



## Inadequate Sleep Ages 6-17 Years

### **Background:**

Studies have shown that insufficient sleep quality and quantity are associated with inattention and other cognitive and behavioral deficits that impair daytime functioning which can affect a child's academic performance at school.<sup>35</sup> According to the National Sleep Foundation, children aged 6-10 years should receive 10-11 hours of sleep whereas those aged 11-17 years should receive 8.5-9.25 hours of sleep per night.<sup>36</sup> The health effects inadequate sleep quality and quantity have on children make sleep an important component of wellness in children.

### **Measurement:**

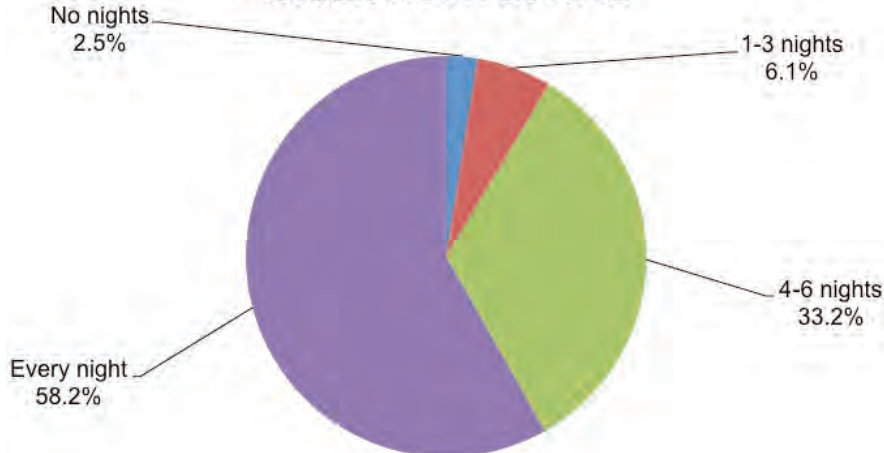
Parents of 6-17 year olds reported the number of nights during the previous week on which children had adequate sleep for their age: none; 1-3 nights; 4-6 nights; and every night. Inadequate sleep was considered for those with 6 or fewer nights of adequate sleep during the prior week.

### **National Comparisons:**

In Hawai'i, 59.4% of children were reported to have adequate sleep every night in the past week. There were 2.0% reported to have zero nights; 7.1% had 1-3 nights; and 31.6% had 4-6 nights of adequate sleep.

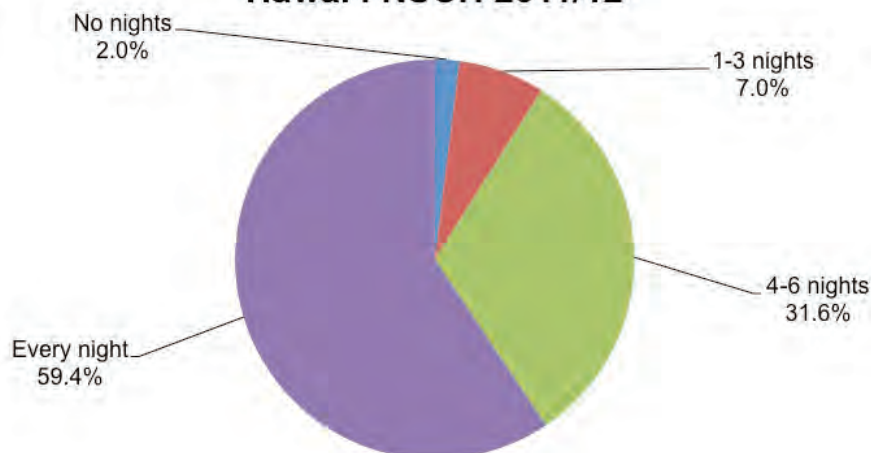
Nationally, 58.2% of children have adequate sleep every night in the past week. There were 2.5% reported to have zero nights; 6.1% had 1-3 nights; and 33.2% had 4-6 nights of adequate sleep.

### **Adequate Sleep per Week, Nation NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

### **Adequate Sleep per Week, Hawai'i NSCH 2011/12**

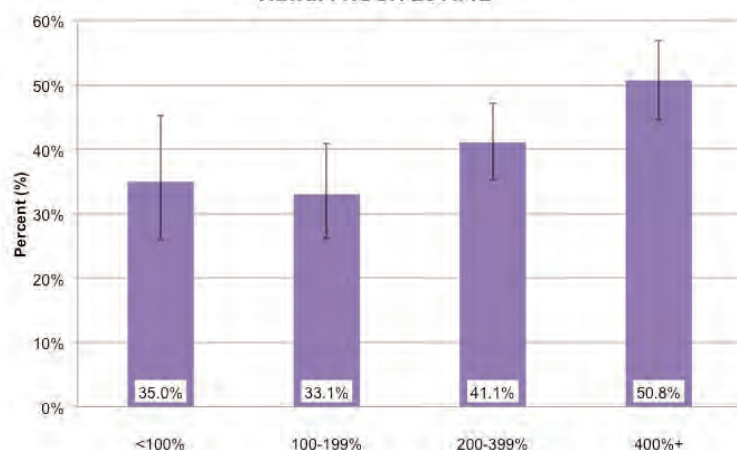


Data Source: National Survey of Children's Health, 2011/12

**Children with Inadequate Sleep:**  
**40.6% (Hawai'i)**  
**vs**  
**41.8% (Nation)**

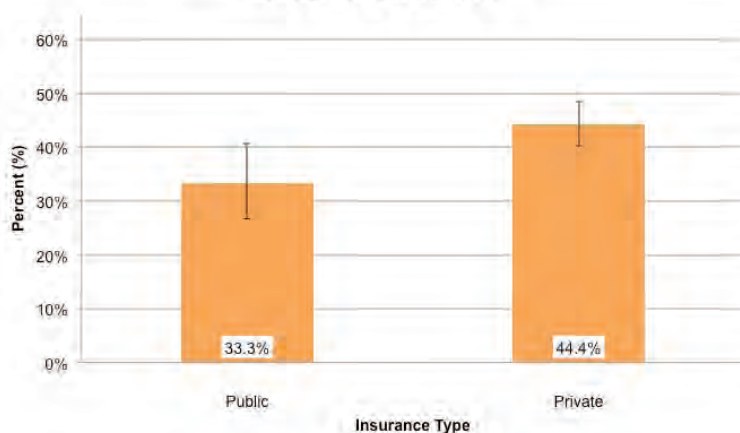


**Inadequate Sleep by Poverty Level,  
Hawai'i NSCH 2011/12**



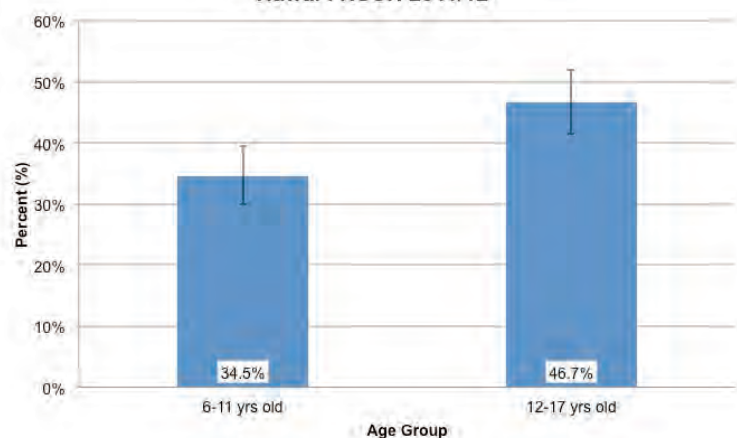
Data Source: National Survey of Children's Health, 2011/12

**Inadequate Sleep by Insurance Type,  
Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

**Inadequate Sleep by Age,  
Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

## Inadequate Sleep Disparities

Data for Hawai'i demonstrated disparities in children with inadequate sleep related to federal poverty level, insurance type, and age group.

### **Federal Poverty Level:**

The proportion of children with inadequate sleep increased with FPL. More children at 400% FPL (50.8%) reported not getting enough sleep every day compared to children in the less than 100% (35.0%), 100-199% (33.1%), and 200-399% (41.1%) FPL groups. The differences across other FPL categories were not statistically significant.

### **Insurance Type:**

Significantly more privately insured children (44.4%) reported inadequate sleep compared to publicly insured (33.3%) children.

### **Age:**

Significantly more children 12-17 years of age (46.7%) reported inadequate sleep compared to children 6-11 years of age (34.5%).

### **Other:**

There were no significant differences in inadequate sleep related to race, gender, medical home, and ACEs.

## Organized Activities Ages 6-17 Years

### **Background:**

Constructive participation in extracurricular activities both at school and in the community allows for positive youth development. Ranging from being in a sports team to performing an instrument, organized activities can provide opportunities to acquire social and intellectual skills that can be used in the classroom, to establish supportive social network, and to experience overcoming various challenges.<sup>37</sup> Together, these skills help prepare youth to successfully transition into adulthood.

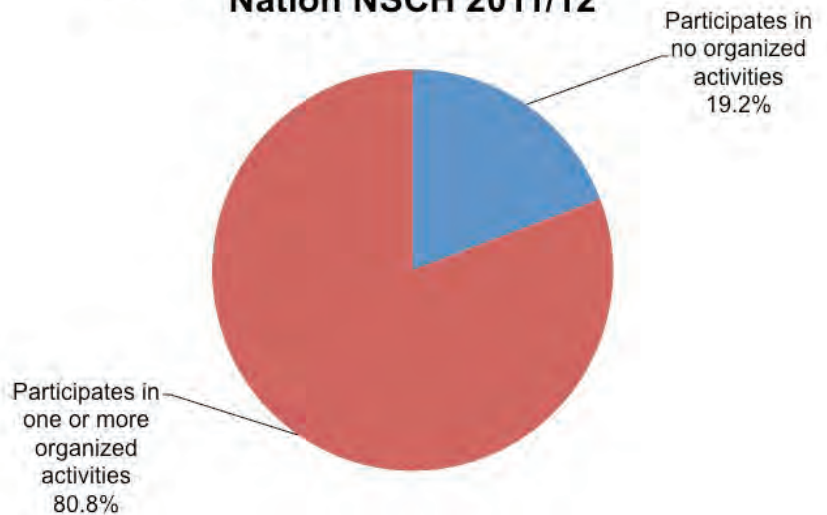
### **Measurement:**

Parents of 6-17 year olds reported whether their child participated in one or more organized activities outside of school. These activities included sports teams or lessons, clubs, organizations, music, dance, language or other arts.

### **National Comparisons:**

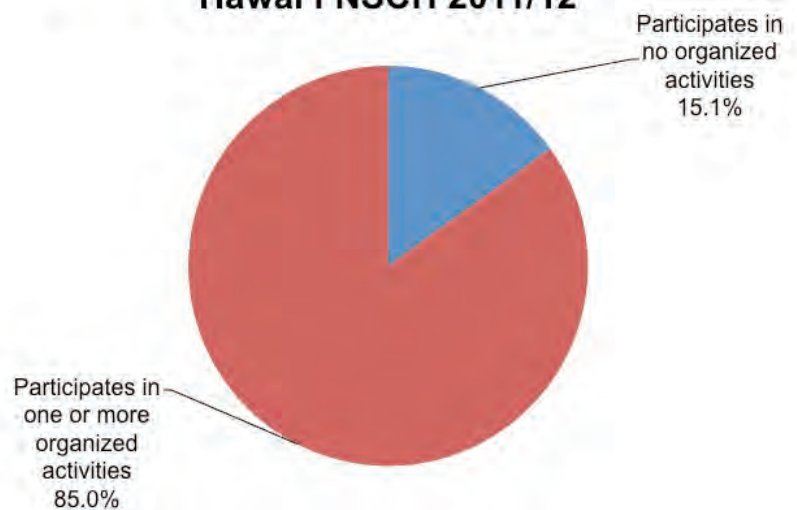
In Hawai'i, 85.0% of children were participating in one or more organized activities, which is significantly higher than the national estimate of 80.8%.

### **Organized Activities Outside School, Nation NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

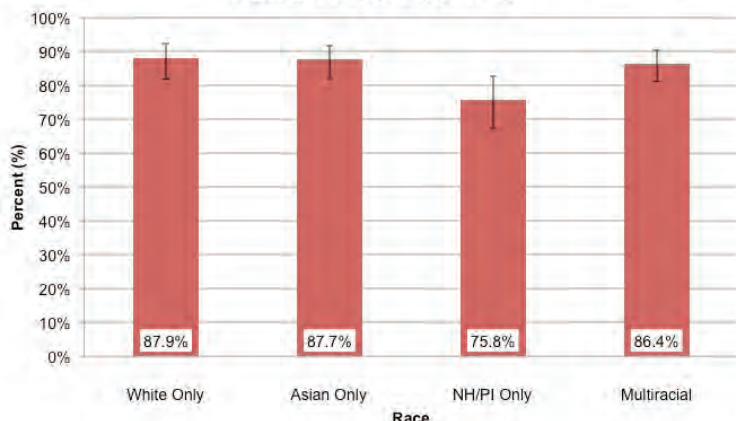
### **Organized Activities Outside School, Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

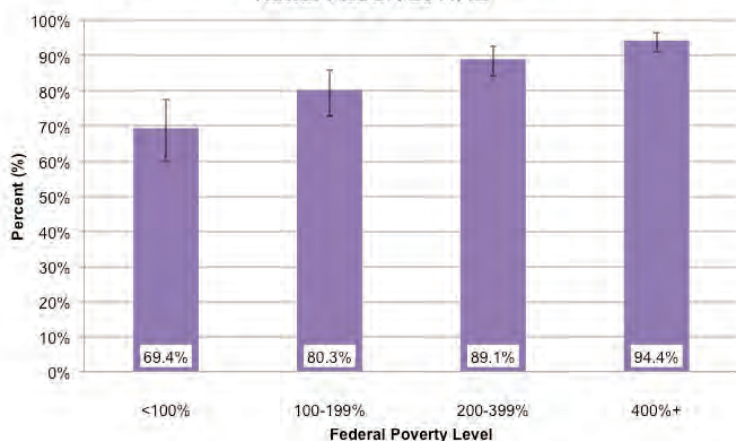
Children in Organized Activities:  
85.0% (Hawai'i)  
vs  
80.8% (Nation)

**Organized Activities Participation by Race,  
Hawai'i NSCH 2011/12**



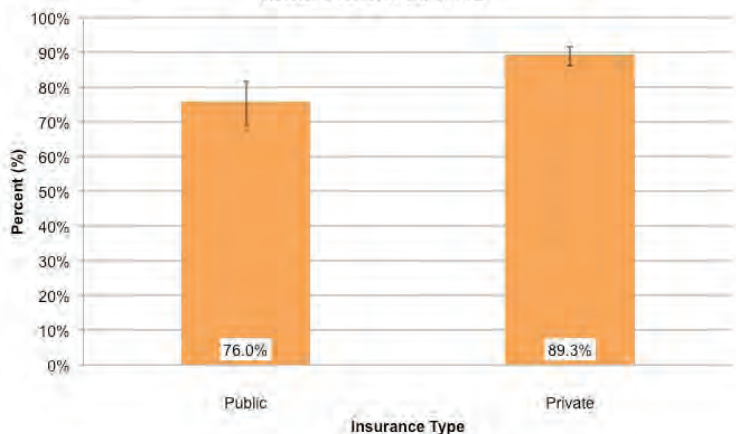
Data Source: National Survey of Children's Health, 2011/12

**Organized Activity Participation by Poverty Level,  
Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

**Organized Activity Participation by Insurance Type,  
Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

## Organized Activities Disparities

Data for Hawai'i demonstrated disparities in children who participate in organized activities related to race, federal poverty level, insurance type, and medical home.

### **Race:**

Significantly less Native Hawaiian/Pacific Islander children (75.8%) reported participation in organized activities compared to White (87.9%), Asian (87.7%), and multiracial (86.4%) children.

### **Federal Poverty Level:**

The proportion of children participating in organized activities increased with increasing FPL status. More children at 400% FPL (94.4%) participated in organized activities compared to children in the 100% (69.4%), 100-199% (80.3%), and 200-399% (89.1%) FPL groups. The differences across all FPL categories were statistically significant.

### **Insurance Type:**

Significantly more privately insured children (89.3%) participated in organized activities compared to publicly insured children (76.0%).

### **Other:**

There were significantly more children with a medical home (88.3%) who participated in organized activities than children without a medical home (81.0%). There were no differences in participation of organized activities related to the child's age group, gender, and ACEs.



## Adverse Childhood Experiences Ages 0-17 Years

### **Background:**

Adverse Childhood Experiences (ACEs) are stressful or traumatic events that occur to people before the age of 19. Studies have shown that ACEs have an impact on children's health and emotional well-being.<sup>38</sup> Adverse health outcomes associated with ACEs that have been observed in adulthood include substance abuse, cardiovascular disease, diabetes, cancer and premature mortality.<sup>39</sup>

### **Measurement:**

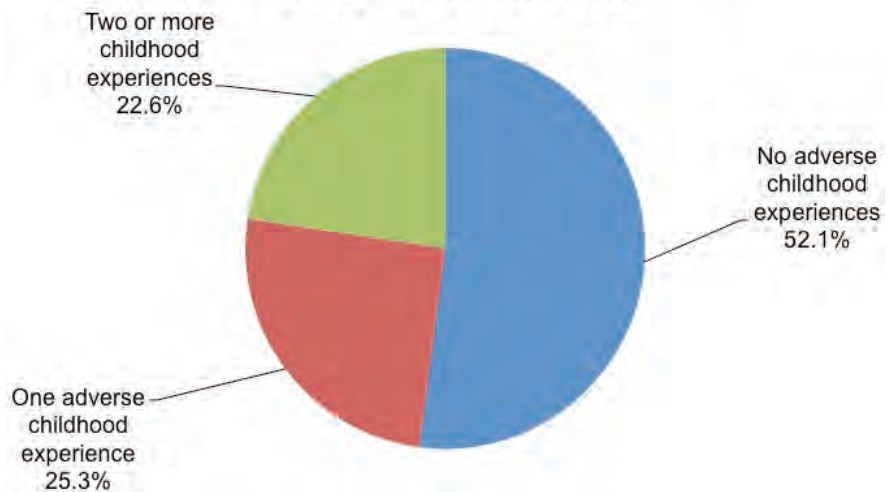
Parents of 0-17 year olds were asked if their child experienced a list of 9 ACEs. These items were: 1) Socioeconomic hardship, 2) Divorce/separation of parents, 3) Death of parent, 4) Parent served time in jail, 5) Witness to domestic violence, 6) Victim of neighborhood violence, 7) Lived with someone who was mentally ill or suicidal, 8) Lived with someone with alcohol/drug problem, 9) Treated or judged unfairly due to race/ethnicity. Children experienced the ACE if parent reported 'somewhat often' or 'very often' to the first item on socioeconomic hardship or 'yes' to the other items. The number of items were categorized as none, one, and two or more.

### **National Comparisons:**

In Hawai'i, 53.6% of children were reported to have experienced none of the nine surveyed ACEs. This is higher but not significantly different from the national estimate of 52.1%

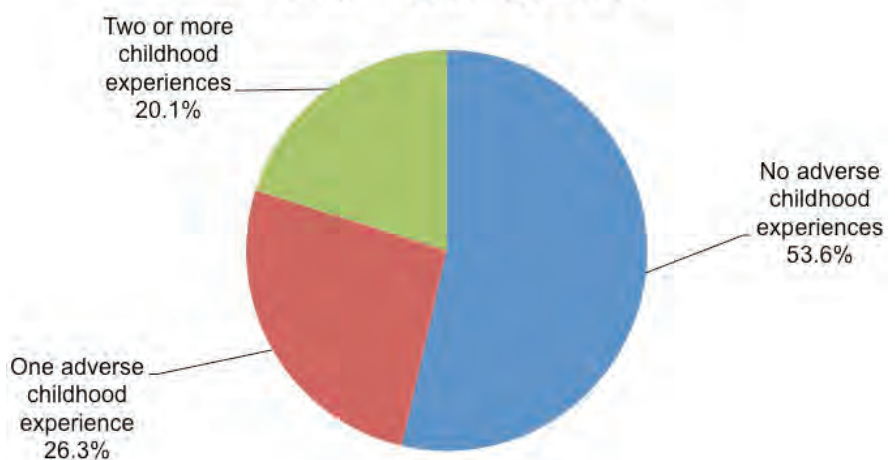
In Hawai'i, 26.3% of children experienced one ACE while 20.1% of children experienced two or more ACEs. Nationally, 25.3% of children had one ACE while 22.6% had two or more. These differences were not significant.

### **Adverse Childhood Experiences, Nation NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

### **Adverse Childhood Experiences, Hawai'i NSCH 2011/12**

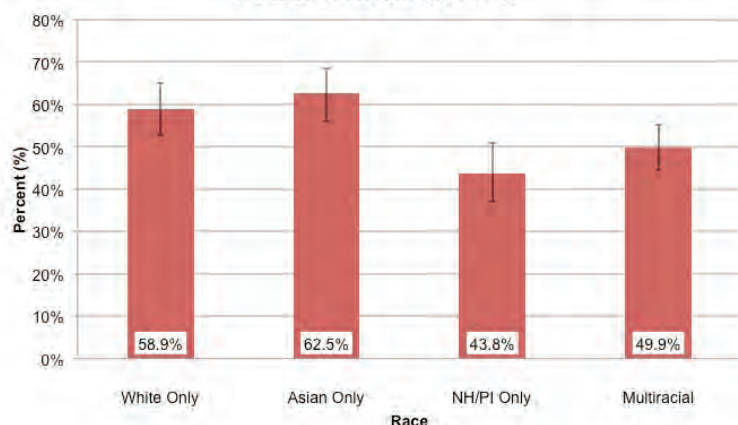


Data Source: National Survey of Children's Health, 2011/12

**No Adverse  
Childhood Experiences:  
53.6% (Hawai'i)  
vs  
52.1% (Nation)**

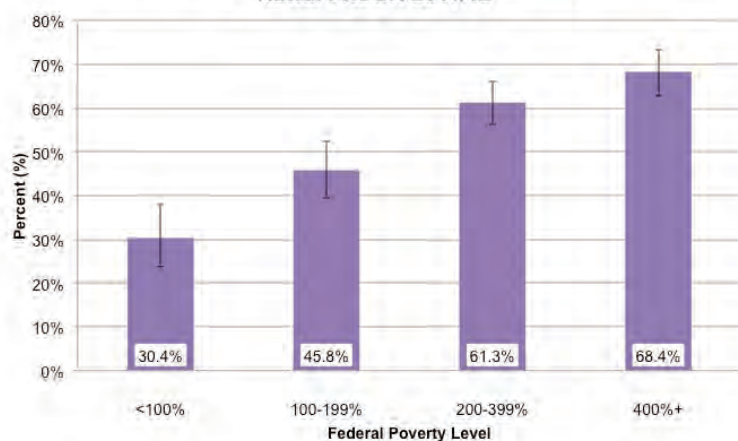


**No Adverse Childhood Experiences by Race, Hawai'i NSCH 2011/12**



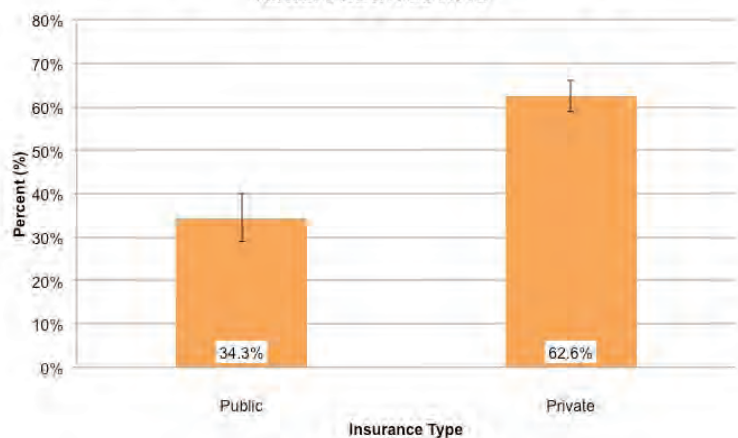
Data Source: National Survey of Children's Health, 2011/12

**No Adverse Childhood Experiences by Poverty Level, Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

**No Adverse Childhood Experiences by Insurance Type, Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

## Adverse Childhood Experiences Disparities

Data for Hawai'i demonstrated disparities in children for no ACEs related to race, federal poverty level, insurance type, medical home status, and age group.

### **Race:**

Native Hawaiian/Pacific Islander children (43.8%) had the lowest rates of having no ACEs. This proportion was significantly lower than that of White (58.9%) and Asian children (62.5%). In addition, multiracial children (49.9%) had significantly lower rates of having no ACEs compared to White and Asian children.

### **Federal Poverty Level:**

The proportion of children who have experienced no ACEs increased with increasing FPL. Youth in 400%+ FPL (68.4%) had the greatest rate of experiencing no ACEs. In comparison, only 30.4% of children in the <100% FPL category were reported to have ACEs. Differences in rates are statistically significant across all four FPL categories.

### **Insurance Type:**

Privately insured children (62.6%) have the highest rates of having no ACEs and this is statistically greater than that of publicly insured children (34.4%).

### **Other:**

With increasing age, there appeared to be a significantly smaller proportion of children who had no ACEs. A significantly greater proportion of children with a medical home (59.9%) had no ACEs compared to that of children with no medical home (45.6%). No statistically significant disparities in ACEs were observed related to the child's gender.

# COMMUNITY, SCHOOL AND FAMILY

## Volunteering Ages 12-17 Years

### **Background:**

Besides conferring many benefits to the recipients of volunteer services, volunteering and community service also positively impacts those who are providing the services. Research has established a strong relationship between volunteering and health. Those who volunteer have lower mortality rates, greater functional ability, and better mental health.<sup>40</sup> These benefits are even more profound in older individuals. Youth introduced to volunteer activities during childhood may be more likely to volunteer in the future and benefit from the positive health outcomes volunteering provides later in life.

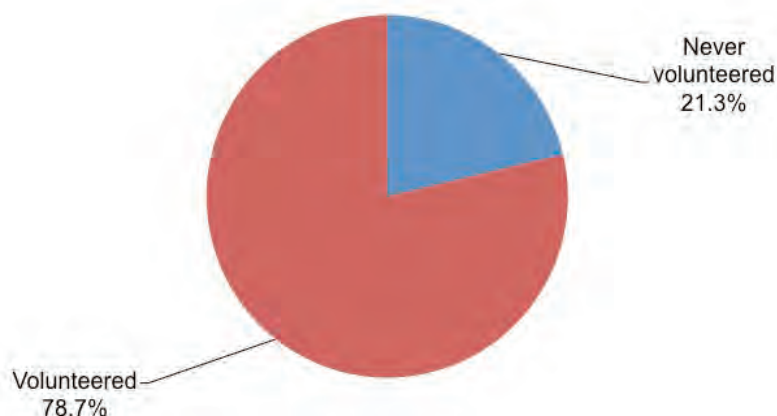
### **Measurement:**

Parents of 12-17 year olds were asked whether their child had been involved in any type of community service or volunteer work at school, church, or in the community during the past 12 months.

### **National Comparisons:**

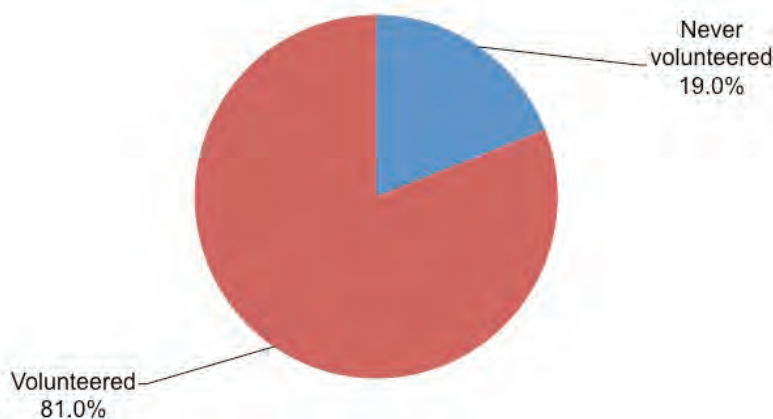
In Hawai'i, 81.0% of 12-17 year old children were reported to have volunteered in the past year. This is higher than but not significantly different from the national estimate of 78.7%.

**Participation in Volunteer Work or  
Community Service, Nation NSCH  
2011/12**



Data Source: National Survey of Children's Health, 2011/12

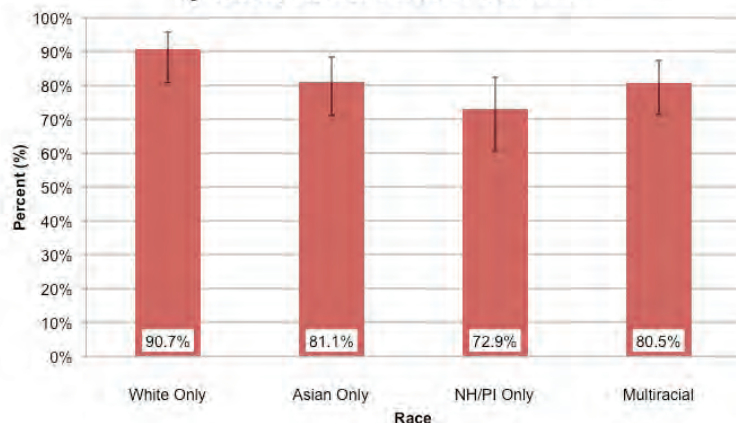
**Participation in Volunteer Work or  
Community Service, Hawai'i NSCH  
2011/12**



Data Source: National Survey of Children's Health, 2011/12

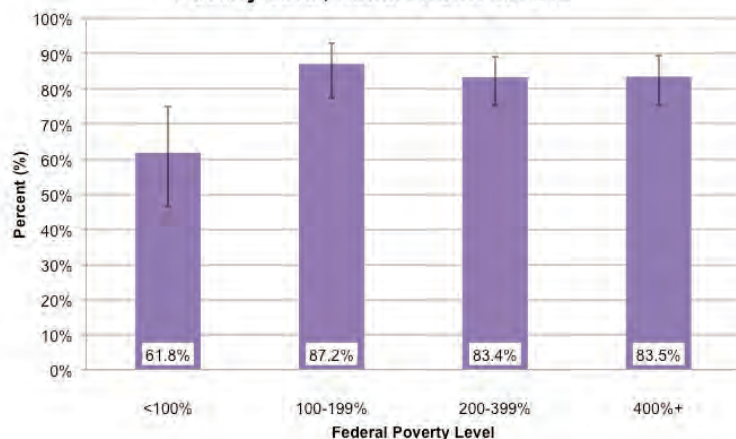
**Children who Ever Volunteered:**  
**81.0% (Hawai'i)**  
**vs**  
**78.7% (Nation)**

**Child Ever Volunteered Over Past 12 Months by Race, Hawai'i NSCH 2011/12**



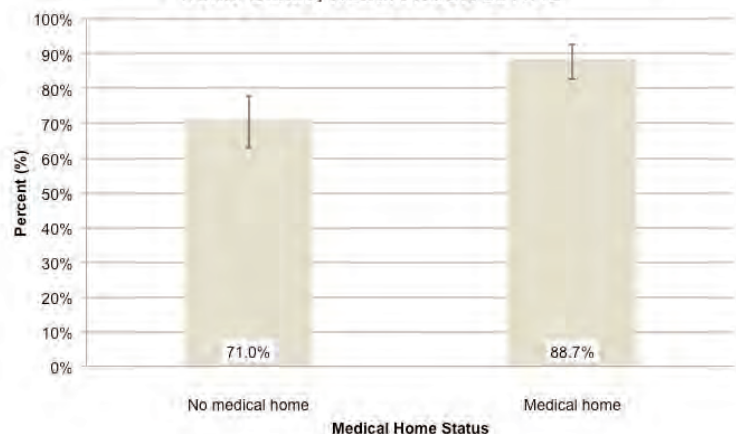
Data Source: National Survey of Children's Health, 2011/12

**Child Ever Volunteered Over the Past 12 Months by Poverty Level, Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

**Child Ever Volunteered Over Past 12 Months by Medical Home Status, Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

## Volunteering Disparities

Data for Hawai'i demonstrated disparities in children who ever volunteered over the past year related to race, federal poverty level, and medical home.

### **Race:**

More White children volunteered during the past 12 months compared to Asian (81.1%), Native Hawaiian/Pacific Islander (72.9%), and multiracial (80.5%) children. However, a statistically significant difference only existed between White and Native Hawaiian/Pacific Islander children.

### **Federal Poverty Level:**

The lowest proportion of children at <100% FPL ever volunteered during the past year compared to youth at 100-199% (87.2%), 200-399% (83.4%), and 400%+ (83.5%) FPL groups. The rate of children at <100% FPL was statistically different from children of the other FPL categories.

### **Medical Home:**

Youth with a medical home (88.7%) were significantly more likely than children without a medical home (71.0%) to have ever volunteered during the past 12 months.

### **Other:**

No significant differences were found for children who have ever volunteered related to gender and ACEs. Differences for age group was not assessed for this indicator.



## Working for Pay Ages 12-17 Years

### **Background:**

There are different motivations why children work and these reasons range from wanting to earn pocket money to hoping to gain valuable real-work experience. Working for pay outside of home can confer many benefits, including the acquisition of social and communication skills as well as financial management abilities.<sup>41</sup> Studies have shown that having paid work experiences are associated with having better career planning.<sup>42</sup>

A major concern for paid work experiences is that they may take away time from school. Certain critics point out that teens who work long hours may have lower grades than those who work fewer hours or not at all.<sup>43</sup>

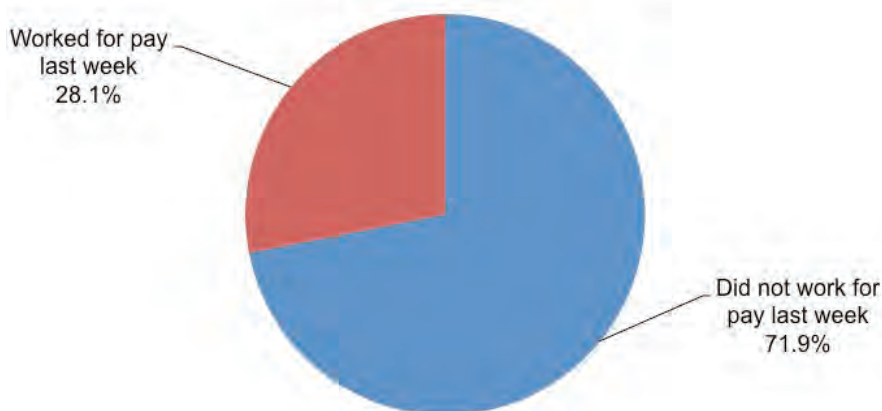
### **Measurement:**

Parents of 12-17 year olds were asked the number of hours their child worked for pay during the past week. "Working for pay" was defined as earning money from work done outside of home, including regular jobs as well as baby-sitting, grass cutting, and other occasional work.

### **National Comparisons:**

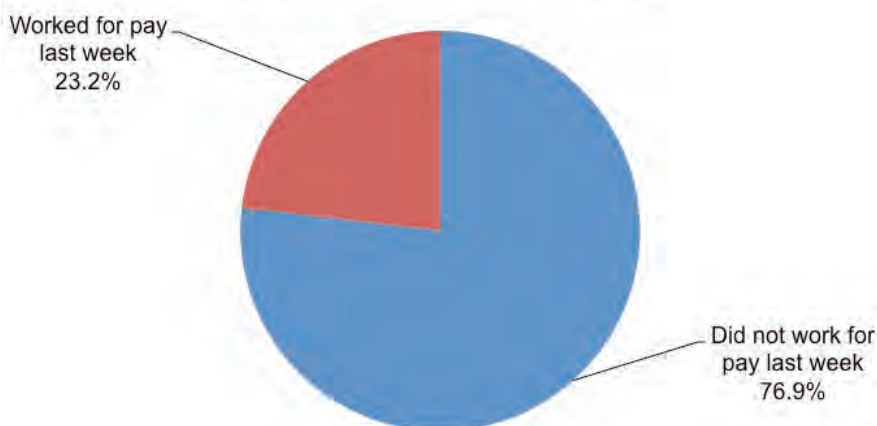
In Hawai'i, 23.2% of youth were reported to have worked for pay during the last week. This is significantly lower than the national estimate of 28.1%.

**Work for Pay Outside of Home,  
Nation NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

**Work for Pay Outside of Home,  
Hawai'i NSCH 2011/12**

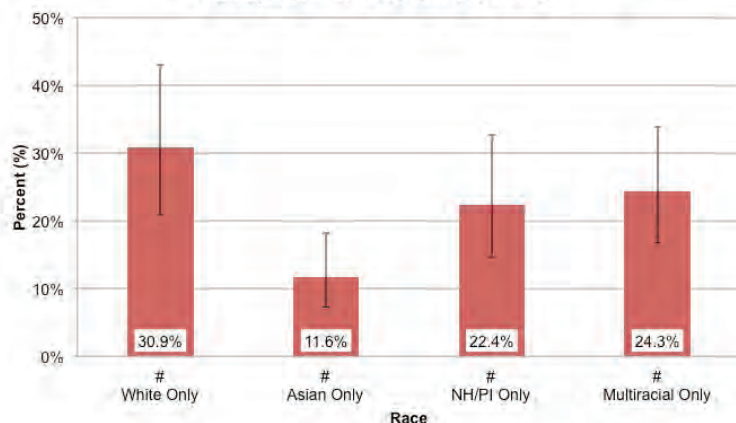


Data Source: National Survey of Children's Health, 2011/12

**Children Who Worked Over the  
Past Week:  
23.2% (Hawai'i)  
vs  
28.1% (Nation)**

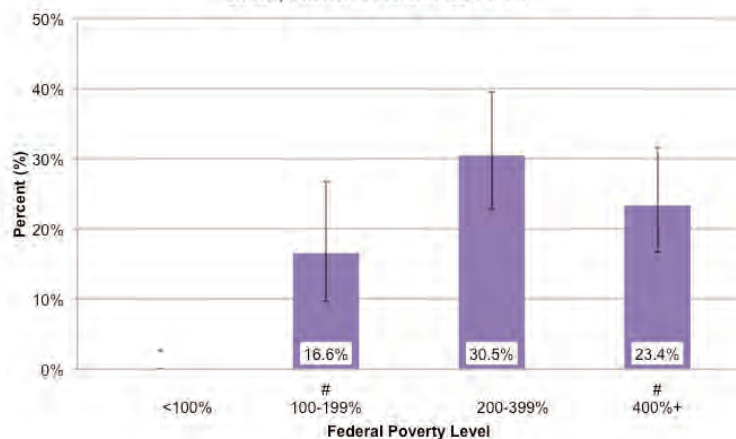


**Child Worked for Pay Over the Past Week by Race, Hawai'i NSCH 2011/12**



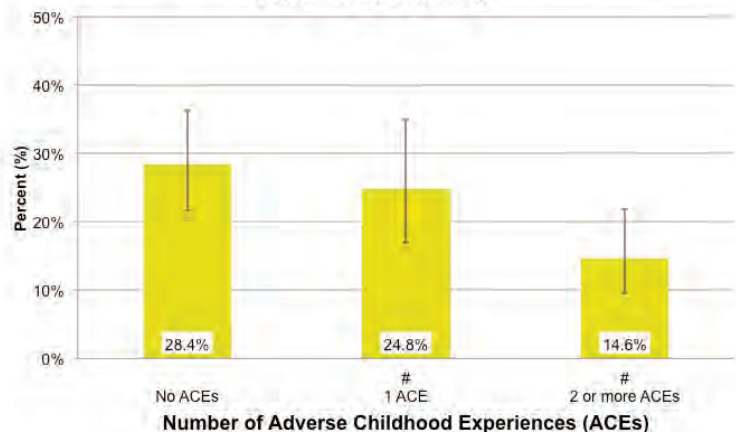
Data Source: National Survey of Children's Health, 2011/12  
# Cell size <50, use caution with interpretation

**Child Worked for Pay Over the Past Week by Poverty Level, Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12  
# Cell size <50, use caution with interpretation  
\* Relative standard error >30%, estimate suppressed

**Child Ever Worked by Adverse Childhood Experiences, Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12  
# Cell size <50, use caution with interpretation

## Working for Pay Disparities

Data for Hawai'i demonstrated disparities in children who worked for pay over the past week related to race, federal poverty level, ACEs, and insurance type.

### **Race:**

Asian children (11.6%) had significantly lower rates than White (30.9%), Native Hawaiian/Pacific Islander (22.4%), and multiracial (24.3%) children.

### **Federal Poverty Level:**

The greatest proportion of children in the 200-399% FPL (30.5%) category worked over the past week. This rate was significantly greater than that of children in the 100-199% FPL (16.6%) category. Children in the 400%+ FPL category (23.4%) had the second highest proportion of children who ever worked over the past week, although this value was not statistically different from other groups. The estimate was unreliable for children living in households below FPL.

### **ACEs:**

More children with no ACEs (28.4%) worked compared to children with one ACE (24.8%) and two or more ACEs (14.6%). The difference between children with no ACEs and two or more ACEs was statistically significant.

### **Other:**

There were statistically significant differences in the proportion of children who worked over the past week across insurance categories. More privately insured children (26.5%) worked compared to publicly insured (16.7%) children. There were no statistically significant disparities in working status related to the child's gender and medical home.

## Maternal Health Status Ages 0-17 Years

### **Background:**

The overall health status of mothers is related to their child's physical and mental health. Poor maternal health is associated with an increased risk of behavioral and emotional problems in children.<sup>44</sup> In addition, mothers in good physical health and free from disease are able to interact and care for their children with greater ease.

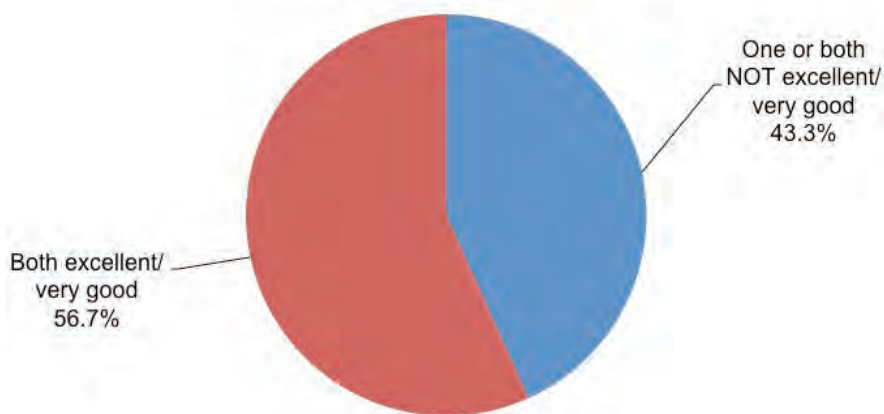
### **Measurement:**

Maternal physical and mental health status were separately rated (excellent, very good, good, fair, poor). These five categories were combined into three (excellent/very good, good, and fair/poor). When the respondent was the child's biological, step, foster or adoptive mother, a self-report rating was used. For a non-mother respondent, he/she was asked to rate the child's mother. Maternal overall health status was then categorized by whether both her physical and mental statuses were rated as excellent/very good or not.

### **National Comparisons:**

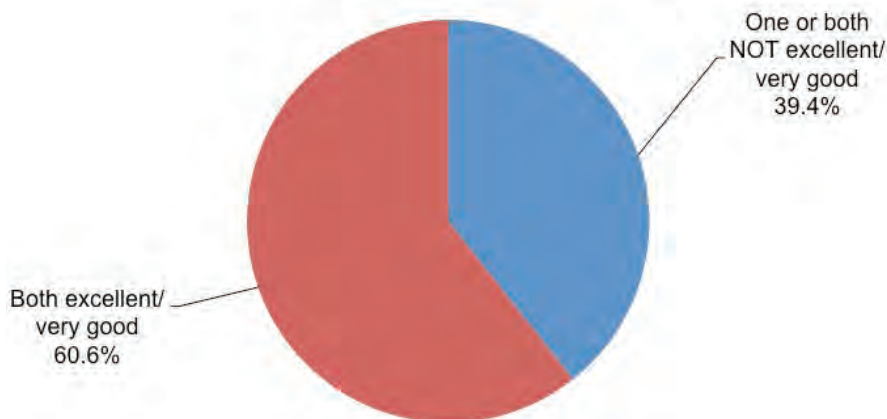
In Hawai'i, 60.6% of children were reported to have mothers who had excellent/very good mental and physical health. This is significantly higher than the national estimate of 56.7%.

**Maternal Health Status,  
Nation NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

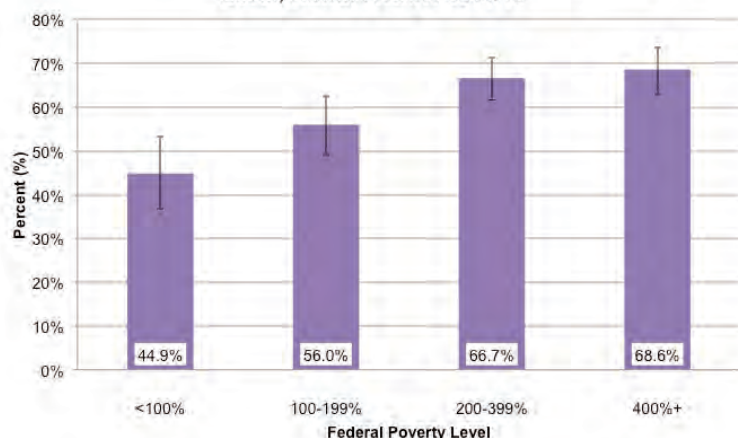
**Maternal Health Status,  
Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

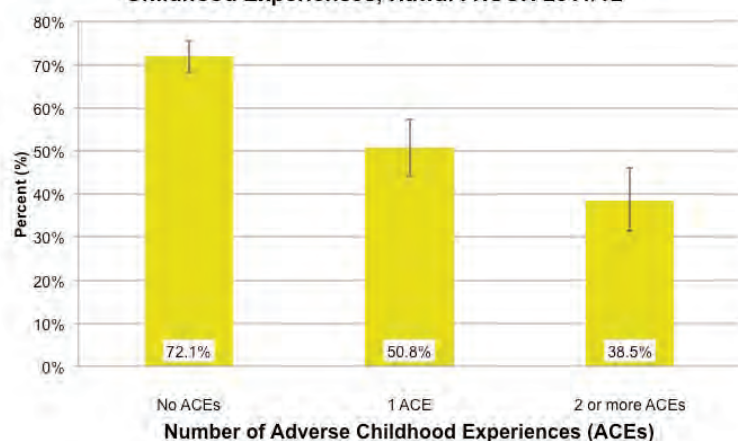
**Excellent/Very Good Maternal  
Health:  
60.6% (Hawai'i)  
vs  
56.7% (Nation)**

**Excellent/Very Good Overall Maternal Health by Poverty Level, Hawai'i NSCH 2011/12**



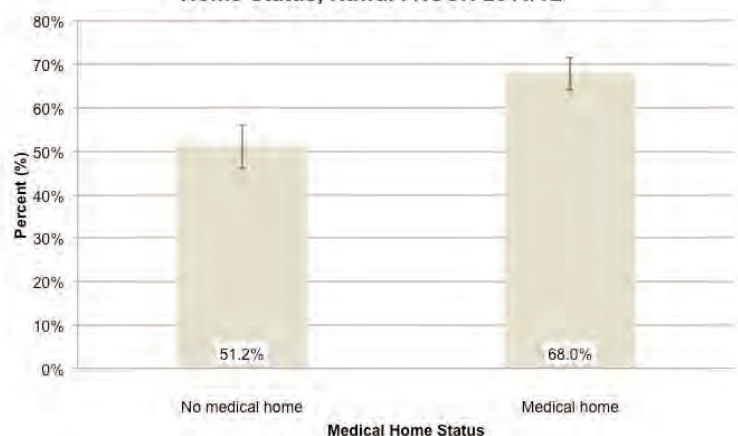
Data Source: National Survey of Children's Health, 2011/12

**Excellent/Very Good Overall Maternal Health by Adverse Childhood Experiences, Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

**Excellent/Very Good Overall Maternal Health by Medical Home Status, Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

## Maternal Health Status Disparities

Data for Hawai'i demonstrated disparities in children with excellent/very good maternal health related to federal poverty level, ACEs, medical home, race, insurance type, and age group.

### **Federal Poverty Level:**

Maternal health status increased with federal poverty level. Less children at <100% FPL (44.9%) compared to 100-199% (56.0%), 200-399% (66.7%), 400%+ (68.6%) FPL groups had mothers in excellent/very good health. Differences between all FPL groups were statistically significant with the exception of the difference between the 200-399% and 400%+ FPL groups.

### **ACEs:**

Maternal health status decreased with increasing number of ACEs. More children with no ACEs (72.1%) compared to children with 1 ACE (50.8%) and 2 or more ACEs (38.5%) had mothers in excellent/very good health. Differences between all ACEs categories were statistically significant.

### **Medical Home:**

Children with a medical home (68.0%) had significantly higher rates of mothers with excellent/very good health compared to children without a medical home (51.2%).

### **Other:**

Significantly more White children (66.3%) had mothers in excellent/very good health than Native Hawaiian/Pacific Islander children (54.9%). In addition, privately insured children (67.4%) had higher rates than publicly insured youth (44.7%). Children 6-11 years (64.1%) were more likely to have mothers in excellent/very good health compared to children 12-17 years (55.5%). There were no significant disparities by child's gender.



## Paternal Health Status Ages 0-17 Years

### **Background:**

In addition to maternal health, paternal overall health status is also important for a child's physical and mental health. Depending on their own health and health behavior, fathers play a role in shaping their child's future health outcomes. Depression in fathers in the postnatal period is associated with psychiatric disorders in their children.<sup>45</sup>

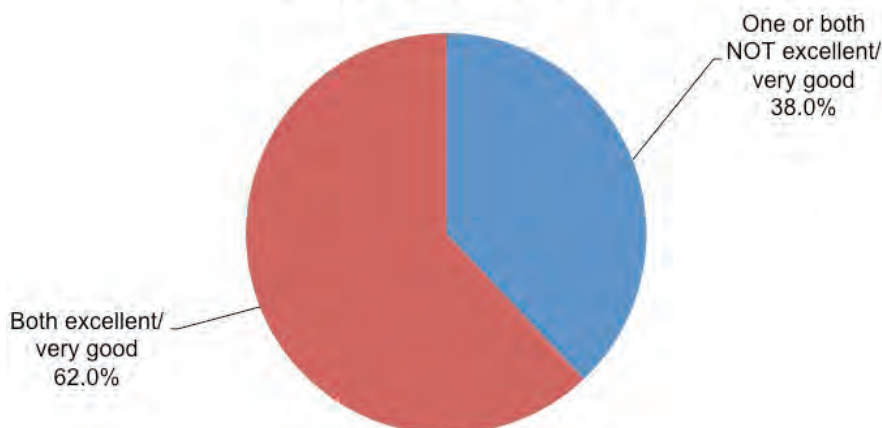
### **Measurement:**

Paternal physical and mental health status were separately rated (excellent, very good, good, fair, poor). These five categories were combined into three (excellent/very good, good, and fair/poor). When the respondent was the child's biological, step, foster or adoptive father, a self-report rating was used. For a non-father respondent, he/she was asked to rate the child's father. Paternal overall health status was then categorized by whether both his physical and mental statuses were rated as excellent/very good or not.

### **National Comparisons:**

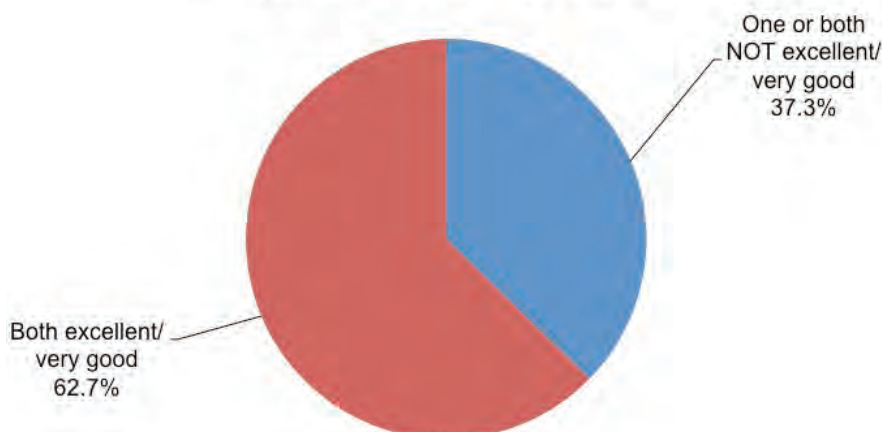
In Hawai'i, 62.7% of children were reported to have fathers who had excellent/very good mental and physical health. This is slightly higher but not significantly different from the national estimate of 62.0%.

**Paternal Health Status,  
Nation NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

**Paternal Health Status,  
Hawai'i NSCH 2011/12**

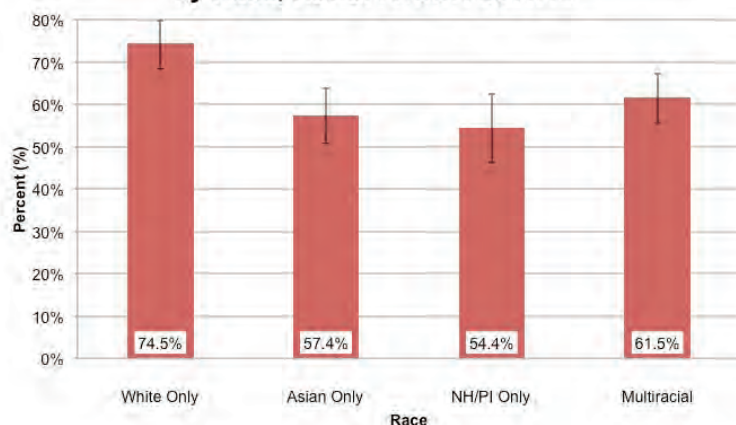


Data Source: National Survey of Children's Health, 2011/12

**Excellent/Very Good Paternal  
Health:  
62.7% (Hawai'i)  
vs  
62.0% (Nation)**

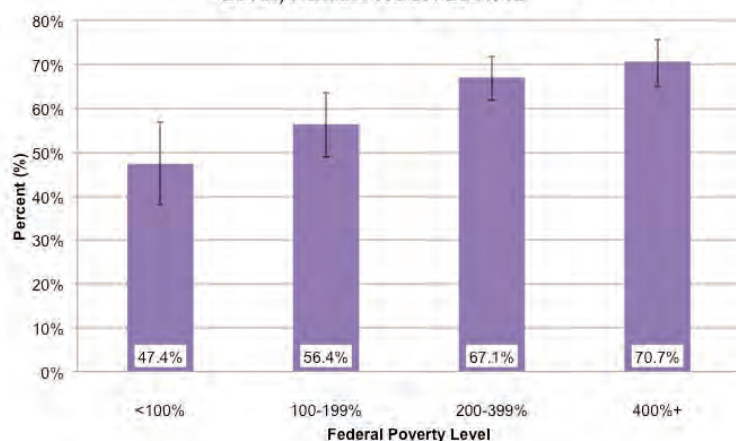


**Excellent/Very Good Overall Paternal Health by Race, Hawai'i NSCH 2011/12**



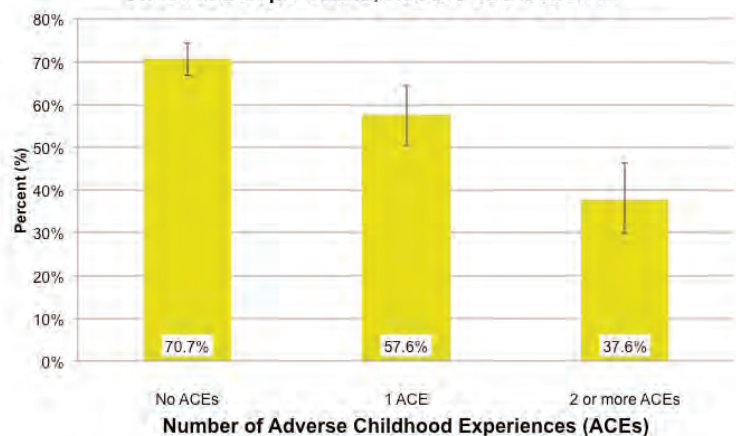
Data Source: National Survey of Children's Health, 2011/12

**Excellent/Very Good Overall Paternal Health by Poverty Level, Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

**Excellent/Very Good Overall Paternal Health by Adverse Childhood Experiences, Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

## Paternal Health Status Disparities

Data for Hawai'i demonstrated disparities in children with excellent/very good paternal health related to race, federal poverty level, ACEs, insurance type, and medical home.

### **Race:**

Significantly more White children (74.5%) had fathers in excellent/very good health compared to that of Asian (57.4%), Native Hawaiian/Pacific Islander (NH/PI, 54.4%), and multiracial (61.5%) children.

### **Federal Poverty Level:**

Less children at 100% FPL (47.4%) compared to 100-199% (56.4%), 200-399% (67.1%), and 400%+ (70.7%) FPL groups had fathers in excellent/very good health. Differences between all FPL groups were statistically significant with the exception of the difference between <100% and 100-199% FPL groups.

### **ACEs:**

Paternal health status decreased with increasing number of ACEs. Significantly more children with no ACEs (70.7%) had excellent/very good paternal health compared to those with 1 ACE (57.6%) and 2 or more ACEs (37.6%),

### **Other:**

Privately insured children (66.7%) had higher rates of having fathers in excellent/very good health compared to publicly insured children (51.8%). Also, significantly more children with a medical home (68.9%) compared to children without a medical home (54.1%). Children 12-17 years (55.3%) were less likely to have fathers in excellent/very good health compared to younger children. There were no significant disparities by child's gender.

## Household Tobacco Use Ages 0-17 Years

### **Background:**

Over the past two decades, second-hand smoke, or environmental tobacco smoke (ETS) exposure in the United States homes has decreased. However, this reduction has been less in children and adolescents than in adults.<sup>46</sup>

Youths exposed to secondhand smoking have an increased risk for cardiovascular and respiratory diseases including early onset asthma.<sup>41</sup> Furthermore, certain studies have suggested that there is a strong link between parental smoking and the initiation of smoking by adolescents.<sup>47</sup>

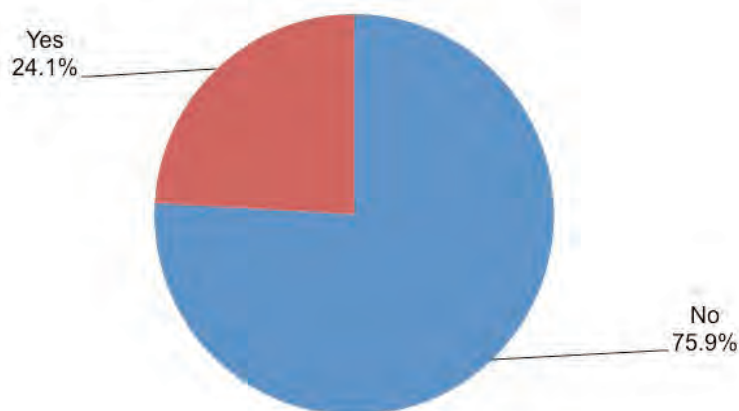
### **Measurement:**

Parents of 0-17 year olds were asked whether anyone in the child's household use cigarettes, cigars, or pipe tobacco. Responses were categorized as either yes or no.

### **National Comparisons:**

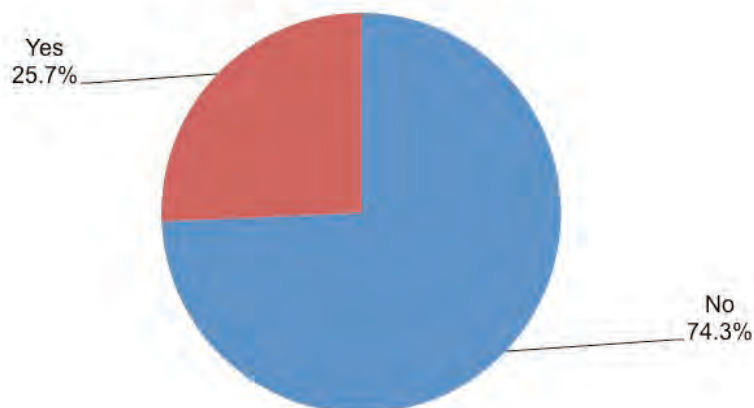
In Hawai'i, 25.7% of children lived in a household where someone used tobacco. This value is higher than but not significantly different from the national estimate of 24.1%.

**Household Tobacco Use,  
Nation NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

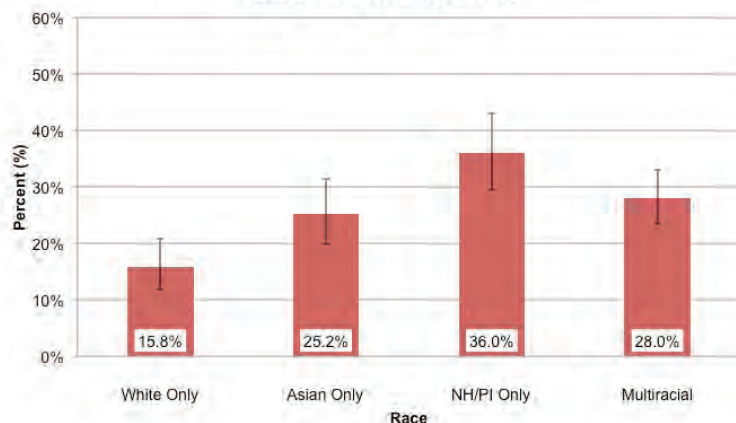
**Household Tobacco Use,  
Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

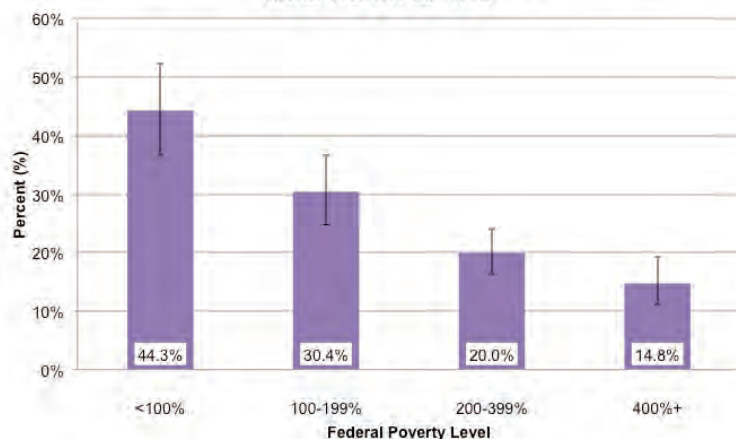
**Household Tobacco Use:**  
**25.7% (Hawai'i)**  
**vs**  
**24.1% (Nation)**

**Tobacco Use in Household by Race, Hawai'i NSCH 2011/12**



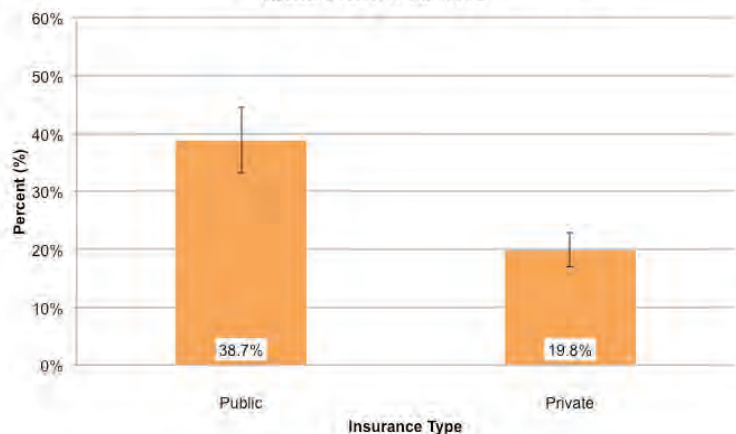
Data Source: National Survey of Children's Health, 2011/12

**Tobacco Use in Household by Poverty Level, Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

**Tobacco Use in Household by Insurance Type, Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

## Household Tobacco Disparities

Data for Hawai'i demonstrated disparities in children who live in a household where tobacco is used related to race, federal poverty level, insurance type, ACEs, and medical home.

### **Race:**

Significantly more Native Hawaiian/Pacific Islander children (36.0%) compared to White (15.8%), and Asian (25.2%) children lived in a tobacco-using household. Also, White children had lower rates of living with someone who smoked than Asian and multiracial (28.0%) children.

### **Federal Poverty Level:**

More children in <100% FPL (44.3%) compared to 100-199% (30.4%), 200-399% (20.0%), and 400%+ (14.8%) FPL categories lived in a household with a smoker. The differences across all FPL categories were statistically significant.

### **Insurance Type:**

Significantly more publicly insured children (38.7%) lived with someone who smoked compared to privately insured (19.8%) children.

### **Other:**

Significantly less children with no ACEs (19.7%) lived in a tobacco-using household compared to children with one ACE (31.4%) and two or more ACEs (34.4%). Also, children with no medical home (29.8%) had significantly higher rates of living with someone who smoked than children with a medical home (23.2%). No significant differences were found for this indicator related to age group or gender.



## Shared Meals Ages 0-17 Years

### **Background:**

Despite lasting only twenty minutes in length on average, shared mealtimes have been shown to be an important aspect of child wellbeing. Studies have shown that the family interactions observed during mealtimes is associated with language development and academic achievement.<sup>48</sup> Furthermore, family mealtimes may act as a protective factor against childhood and adolescence nutritional problems such as overweight, unhealthy eating, and disordered eating since parents may use this time to instill healthy eating habits into their child's daily eating routine.<sup>49</sup>

### **Measurement:**

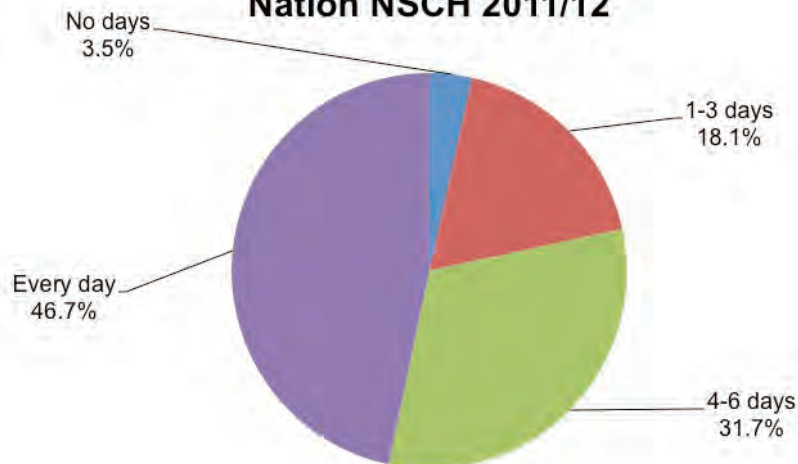
Parents of 0-17 years olds reported the number of days during the past week all the family members who live in the household ate a meal together. Responses were categorized into none, one to three days, four to six days, or every day.

### **National Comparisons:**

In Hawai'i, 52.1% of children shared household meals daily, which was significantly higher than the national estimate of 46.7%

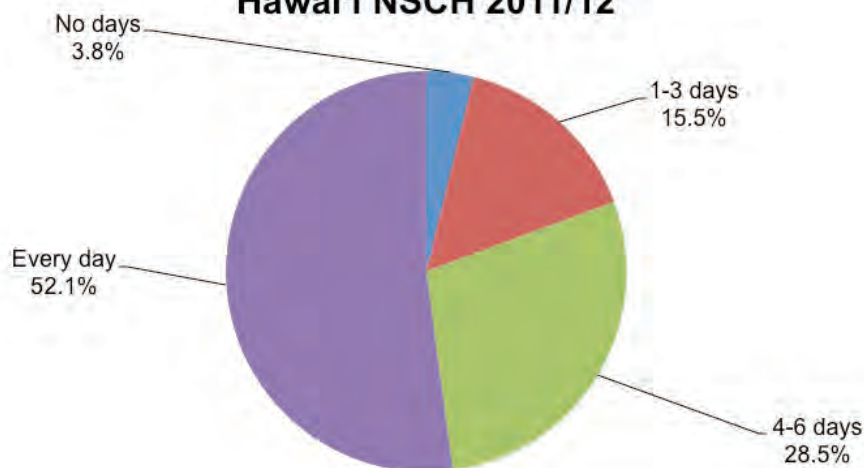
In Hawai'i, 28.5% of children shared meals four to six days a week, 15.5% shared meals one to three times a week and 3.8% never shared meals together. Nationally, these numbers are 31.7%, 18.1% and 3.5% respectively.

**Shared Meals per Week,  
Nation NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

**Shared Meals per Week,  
Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

**Shared Meals Every Day:**  
**52.1% (Hawai'i)**  
**vs**  
**46.7% (Nation)**



## Shared Meals Disparities

Data for Hawai'i demonstrated disparities in children who shared meals together every day related to age, gender, and ACEs.

### Age:

The proportion of children who shared household meals daily decreased with increasing age. Significantly more children in the 0-5 year old age group (65.1%) shared household meals daily compared to children in the 6-11 year old (49.9%) and 12-17% (41.6%) age groups.

### Gender:

Significantly more males (55.2%) shared household meals daily compared to females (48.9%).

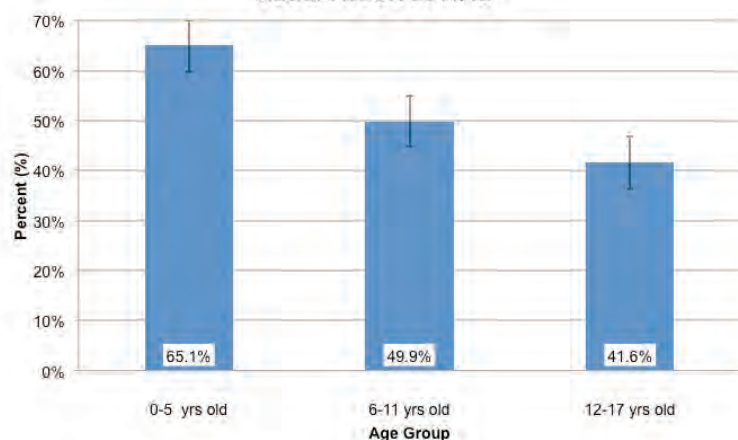
### ACEs:

Fewer children shared household meals daily with increasing ACEs. Significantly more children with no ACEs (56.4%) shared household meals every day compared to children with 1 ACE (49.2%) and two or more ACEs (44.9%).

### Other:

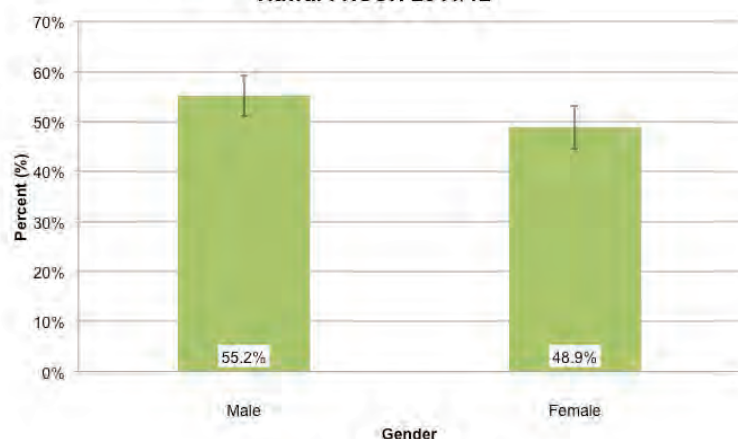
No statistically significant differences in this indicator related to the child's race, FPL status, insurance type, and medical home were observed.

Shared Meals Everyday by Age,  
Hawai'i NSCH 2011/12



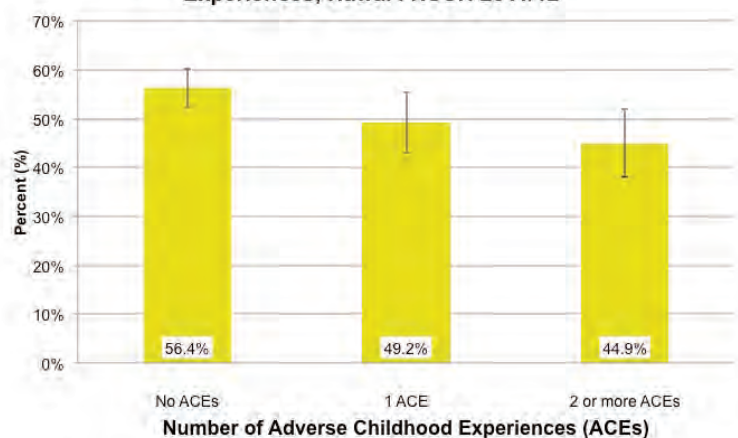
Data Source: National Survey of Children's Health, 2011/12

Shared Meals Everyday by Gender,  
Hawai'i NSCH 2011/12



Data Source: National Survey of Children's Health, 2011/12

Shared Meals Everyday by Adverse Childhood  
Experiences, Hawai'i NSCH 2011/12



Data Source: National Survey of Children's Health, 2011/12

## Screen Time Ages 1-5 Years

### **Background:**

Despite the potential positive influence on social behavior television shows may confer, negative health effects can result as well. Young children are susceptible to the messages conveyed through television and this in turn can influence their perceptions and behavior.<sup>50</sup> The American Academy of Pediatrics recommends children younger than two years old to be refrained from television viewing and be encouraged to participate in more interactive activities instead.<sup>51</sup>

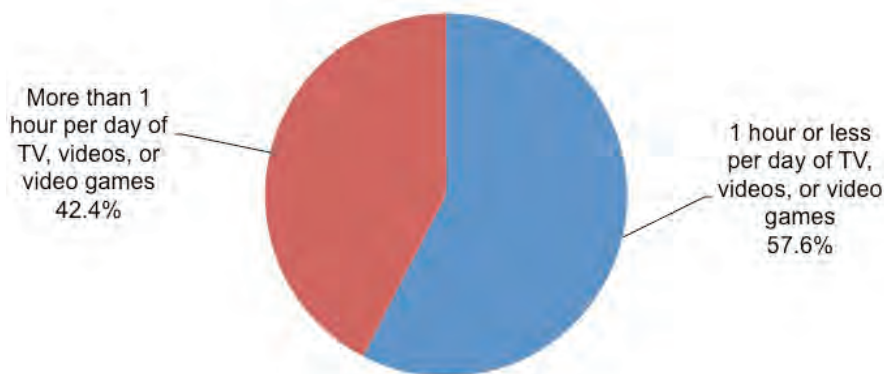
### **Measurement:**

Parents of children aged 1-5 reported the amount of time their child spent watching TV, watching videos, or playing video games on a typical weekday. Responses were then categorized into either 1) 1 hour or less or 2) more than 1 hour.

### **National Comparisons:**

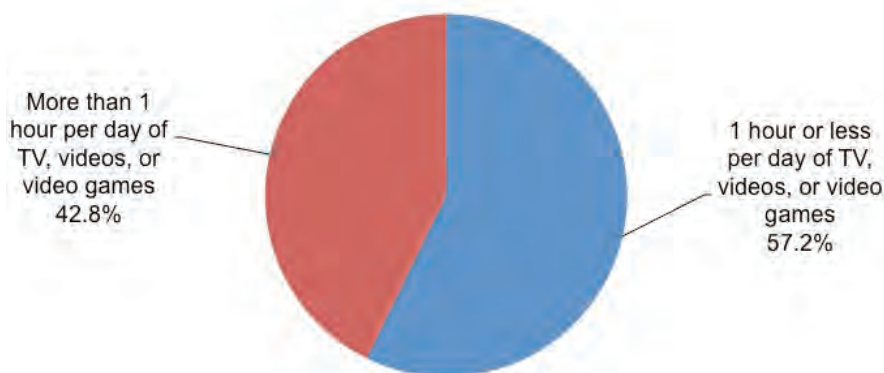
In Hawai'i, 42.8% of children spent more than one hour per weekday watching television/video or playing video games. This is slightly higher but not significantly different from the national estimate of 42.4%

**Average Weekly Screen Time for  
Children 1-5 Years Old, Nation NSCH  
2011/12**



Data Source: National Survey of Children's Health, 2011/12

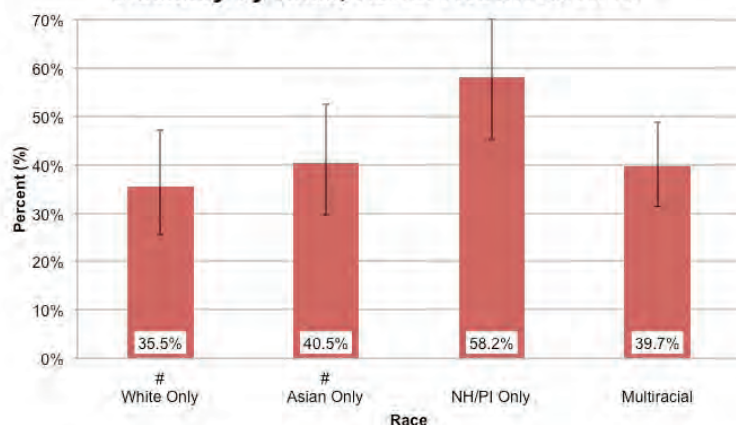
**Average Weekly Screen Time for  
Children 1-5 Years Old, Hawai'i NSCH  
2011/12**



Data Source: National Survey of Children's Health, 2011/12

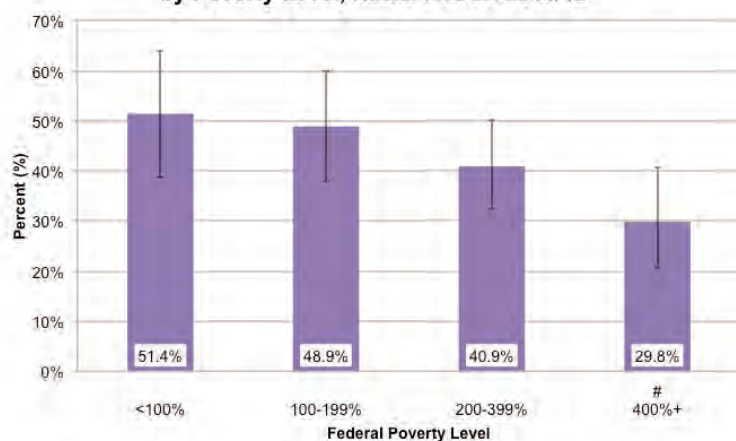
Over one Hour of Screen Time:  
42.8% (Hawai'i)  
vs  
42.4% (Nation)

**More than One Hour Average Screen Time per Weekday by Race, Hawai'i NSCH 2011/12**



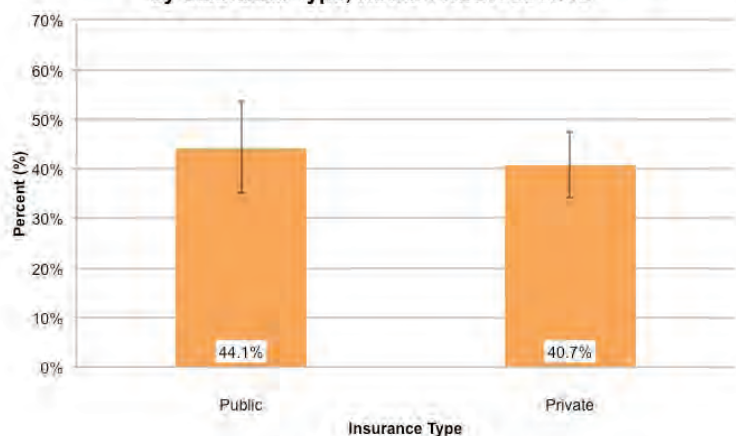
Data Source: National Survey of Children's Health, 2011/12  
# Cell size <50, use caution with interpretation

**More than One Hour Average Screen Time per Weekday by Poverty Level, Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12  
# Cell size <50, use caution with interpretation

**More Than One Hour Average Screen Time per Weekday by Insurance Type, Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

## Screen Time Disparities

Data for Hawai'i demonstrated disparities in children who had more than one hour of screen time per week day related to race, federal poverty level, and insurance type.

### **Race:**

A smaller proportion of White children (35.5%) compared to Asian (40.5%), Native Hawaiian/Pacific Islander (58.2%) and multiracial (39.7%) children watched more than one hour of television/video per weekday. The differences in rates between Native Hawaiian/Pacific Islander children compared to White, Asian, and multiracial children were statistically significant.

### **Federal Poverty Level:**

Less children in the 400%+ FPL group (29.8%) watched more than one hour of television/video per weekday compared to youth in <100% (51.4%), 100-199% (48.9%), and 200%-399% (40.9%) FPL categories. The difference in rates between 400%+ FPL category compared to that of <100% FPL and 200-399% FPL categories were statistically significant.

### **Insurance Type:**

More publicly insured children (44.1%) watched more than one hour of television/video per weekday compared to privately insured (40.7%) children. However, these differences were not statistically significant.

### **Other:**

No statistically significant differences in children who watched more than one hour of television/video per weekday related to gender, ACEs, and medical home. Differences in age group for this indicator were not assessed.



## Screen Time Ages 6-17 Years

### **Background:**

Exposure to screen time and media content for purely entertainment purposes only can negatively influence the behavior and health of children. In particular, violent content is associated with poorer cognitive development and lower academic achievement. What children watch combined with the amount of time spent being exposed can negatively influence children's health in areas such as substance use and abuse patterns, self-image, and nutrition.<sup>50</sup>

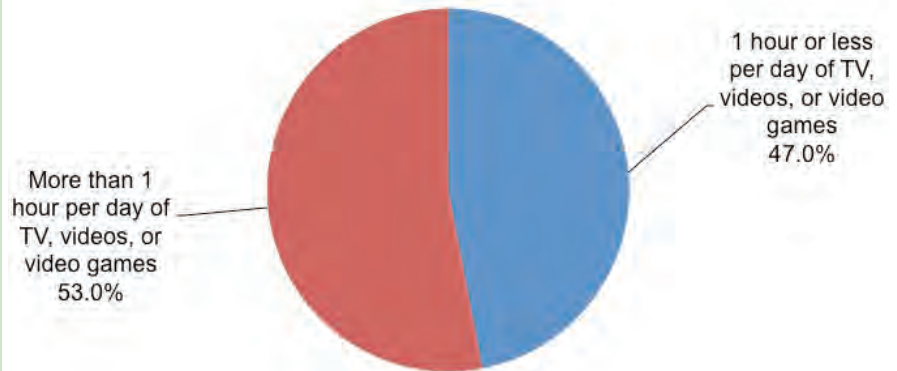
### **Measurement:**

Parents of children aged 6-17 reported the amount of time their child spent watching TV, watching videos, watching DVDs, or playing video games on a typical weekday. Responses were then categorized into either 1) 1 hour or less or 2) more than 1 hour.

### **National Comparisons:**

In Hawai'i, 47.5% of youth aged 6-17 spent more than one hour per weekday watching television/video or playing video games. This was significantly less than the national estimate of 53.0%.

**Average Weekly Screen Time for  
Children 6-17 Years Old, Nation NSCH  
2011/12**



Data Source: National Survey of Children's Health, 2011/12

**Average Weekly Screen Time for  
Children 6-17 Years Old, Hawai'i NSCH  
2011/12**



Data Source: National Survey of Children's Health, 2011/12

Over One Hour of Screen Time:  
47.5% (Hawai'i)  
vs  
53.0% (Nation)



## Screen Time Disparities

Data for Hawai'i demonstrated disparities in children who had more than one hour of weekly screen time per day related to race, federal poverty level, medical home, and insurance type.

### **Race:**

Less White children (36.4%) reported spending more than one hour per weekday watching television/video or playing video games compared to Asian (51.9%), Native Hawaiian/Pacific Islander (54.5%) and multiracial (47.8%) children. The differences between White children compared to Asian, Native Hawaiian/Pacific Islander, and multiracial children were statistically significant.

### **Federal Poverty Level:**

The difference in rates between <100% FPL (56.3%) compared to 200-399% FPL (43.3%) and 400%+ FPL (39.7%) categories were statistically significant. Also, the difference in rates between 100-199% FPL (55.7%) compared to 200-399% FPL and 400%+ FPL categories were statistically significant.

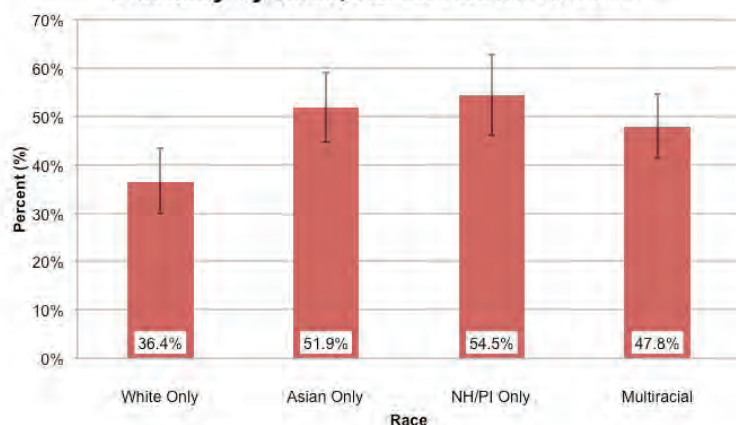
### **Medical Home:**

Children without a medical home (53.0%) had significantly higher rates compared to those with a medical home (43.1%).

### **Other:**

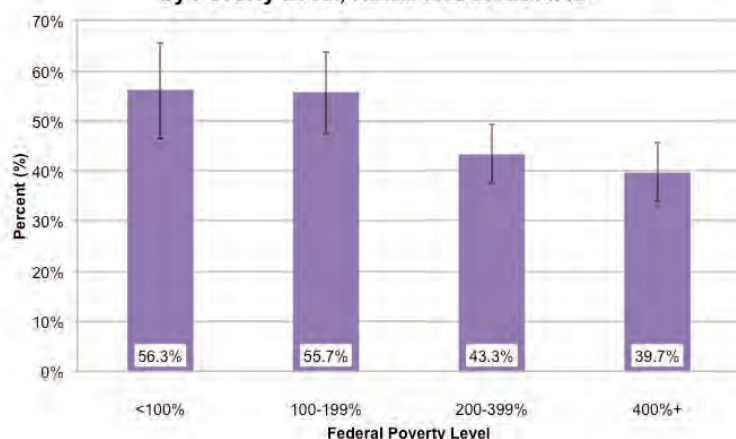
Significantly more publicly insured children (53.8%) watched more than one hour of television/video or playing video games per weekday compared to private insured children (44.8%). No statistically significant disparities related to child's gender and ACEs were found. Differences for age group of the child was not assessed for this indicator.

**More than One Hour Average Screen Time per Weekday by Race, Hawai'i NSCH 2011/12**



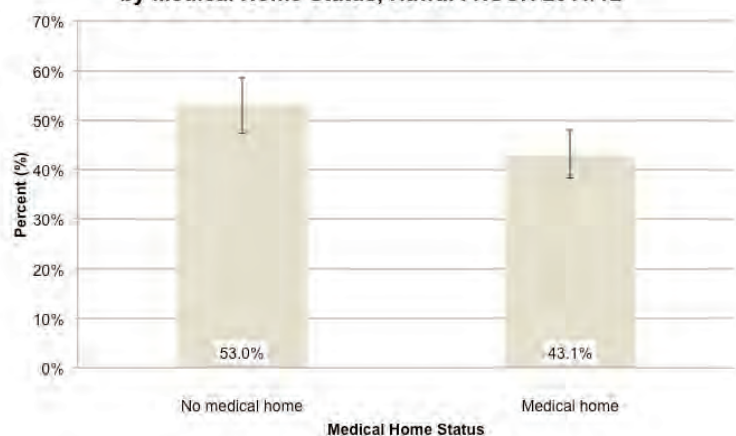
Data Source: National Survey of Children's Health, 2011/12

**More than One Hour Average Screen Time per Weekday by Poverty Level, Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

**More than One Hour Average Screen Time per Weekday by Medical Home Status, Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

## Electronic Device Use Ages 1-5 Years

### **Background:**

With an increasing amount of time being spent on electronic device use, there has been rising concern as to whether children are less engaged in other activities that have more developmental value. In particular, recent studies have suggested that extended electronic device use may be linked to an increased risk of obesity, seizures, and hand injuries.<sup>52</sup>

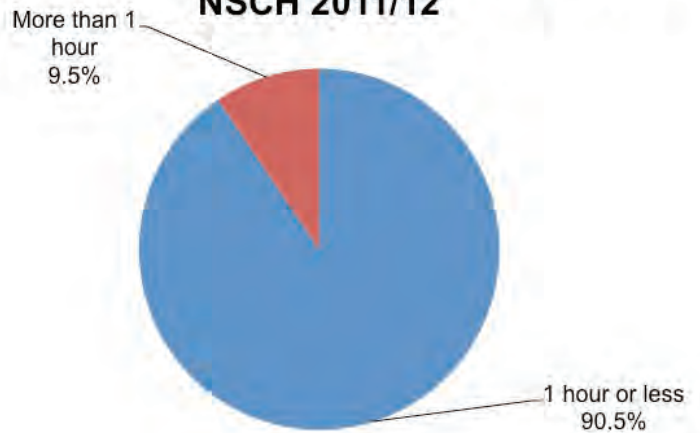
### **Measurement:**

Parents of 1-5 years olds were asked the number of hours their child usually spends with computers, cell phones, handheld video games, or other electronic devices on an average weekday. Responses were then categorized into either 1) 1 hour or less or 2) more than 1 hour.

### **National Comparisons:**

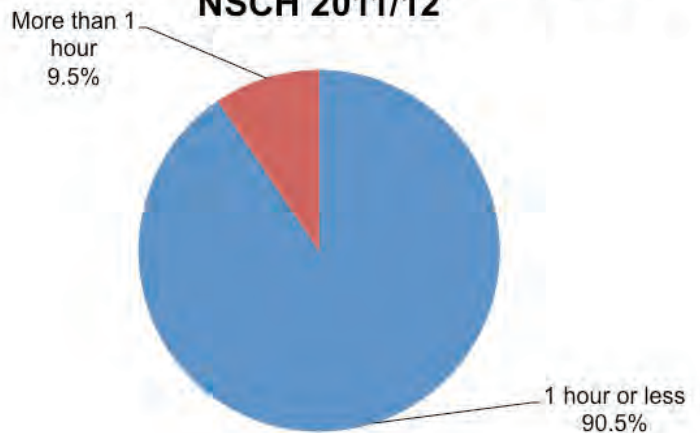
In Hawai'i, 14.8% of children aged 1-5 years were reported to spend more than one hour per weekday on electronic devices like computers and cellphones. This is significantly higher than the national estimate of 9.5%.

**Average Weekday Electronic Device  
Usage for Children 1-5 years old, Nation  
NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

**Average Weekday Electronic Device  
Usage for Children 1-5 years old, Nation  
NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

Over One Hour of Electronic  
Device Use:  
14.8% (Hawai'i)  
vs  
9.5% (Nation)

## Electronic Device Use Disparities

Data for Hawai'i demonstrated disparities in children who spent one hour or more on electronic devices per weekday related to insurance type, and race.

### Insurance Type:

More publicly insured (15.6%) children spent more than one hour per weekday on electronic devices compared to privately insured (13.5%) children. However, these differences were not statistically significant.

### Race:

Native Hawaiian/Pacific Islander (23.1%) children spent more than one hour per weekday on electronic devices which was significantly higher than multiracial children (9.9%). The estimates were unreliable for White and Asian children.

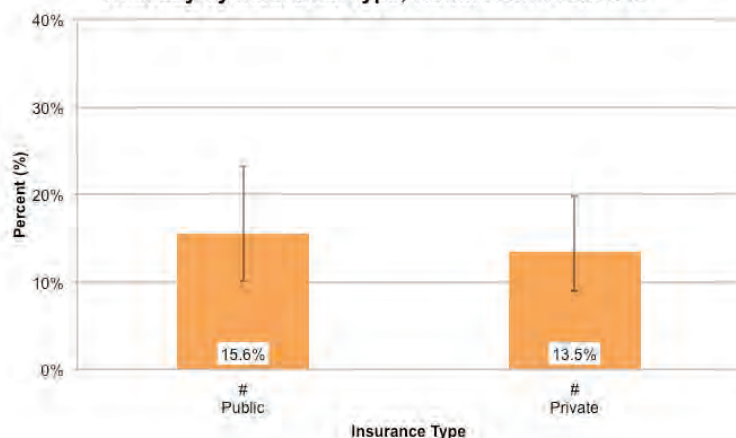
### Gender:

Differences in proportion of children who spent more than one hour per weekday on electronic devices were seen between genders but were not significantly different. More males (18.2%) than females (11.5%) spent more than one hour per week on electronic devices.

### Other:

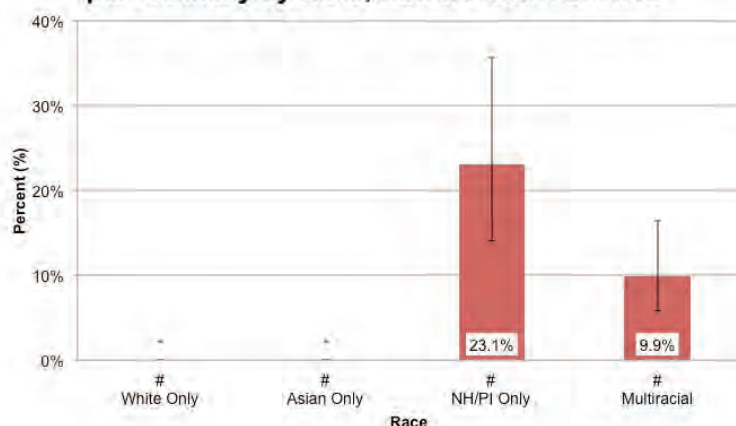
No statistically significant disparities in more than one hour of electronic device use per weekday were observed related to child's gender, federal poverty level, and ACEs. Differences for age group of the child was not assessed for this indicator.

**More than One Hour Average Electronic Use per Weekday by Insurance Type, Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

**More than One Hour Average Electronic Use per Weekday by Race, Hawai'i NSCH 2011/12**

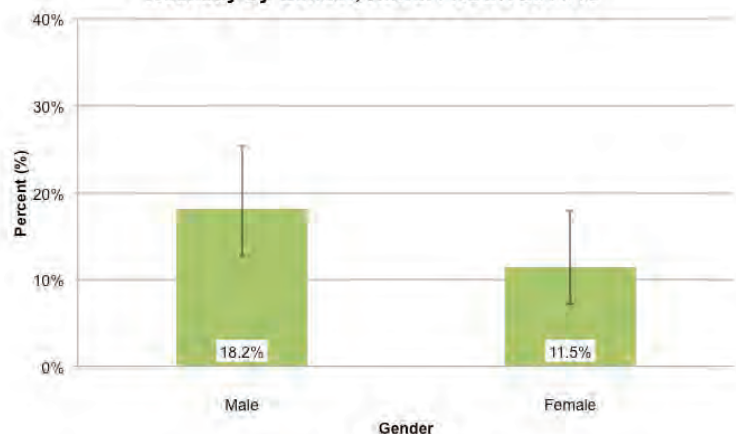


Data Source: National Survey of Children's Health, 2011/12

# Cell size <50, use caution with interpretation

\* Relative standard error >30%, estimate suppressed

**More than One Hour Average Electronic Use per Weekday by Gender, Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12



## Electronic Device Use Ages 6-17 Years

### **Background:**

Outside of educational purposes, most youth use electronic devices to communicate with friends, listen to music, and to find information related to their interests and hobbies. Research has suggested that electronic device use can enhance a child's ability to read and visualize images.<sup>52</sup> When exposed to violent content, however, electronic device use may increase aggressiveness and desensitize a child to suffering.

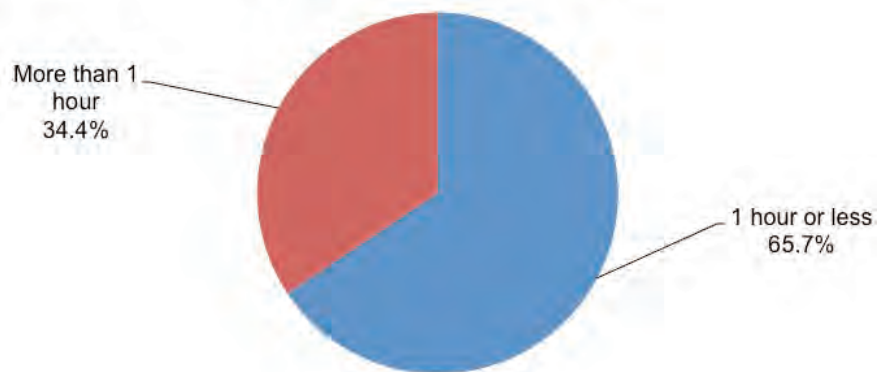
### **Measurement:**

Parents of 6-17 years olds were asked the number of hours outside of schoolwork their child usually spends with computers, cell phones, handheld video games, or other electronic devices on an average weekday. Responses were then categorized into either 1) 1 hour or less or 2) more than 1 hour.

### **National Comparisons:**

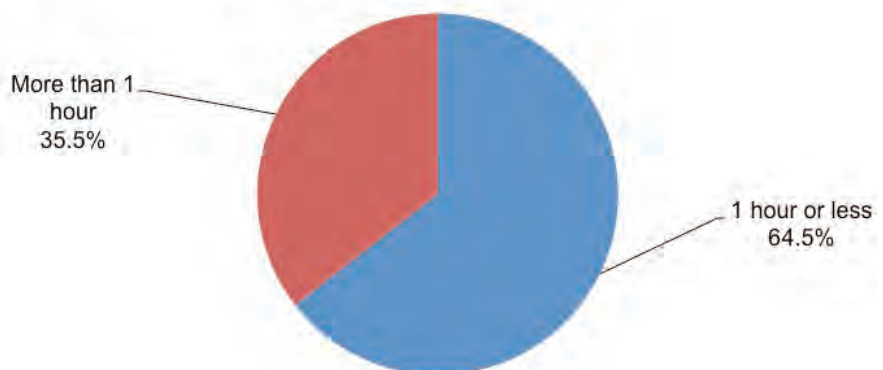
In Hawai'i, 35.5% children 6-17 were reported to have spent more than one hour outside of schoolwork using electronic devices. This is slightly greater than but not significantly different from the national estimate of 34.4%.

**Average Weekday Electronic Device Usage for Children 6-17 years old, Nation NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

**Average Weekday Electronic Device Usage for Children 6-17 years old, Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

Over One Hour of Electronic  
Device Use:  
35.5% (Hawai'i)  
vs  
34.4% (Nation)



## Electronic Device Use Disparities

Data for Hawai'i demonstrated disparities in children who spent more than one hour or more on electronic devices per weekday related to race, age, and ACEs.

### Race:

Asian children (44.2%) had the highest rates of spending more than one hour per weekday using electronic devices. This proportion was significantly different than that of White (28.8%) and multiracial (33.9%) children. In addition, White children had significantly lower rates compared to Native Hawaiian/Pacific Islander children (39.8%).

### Age:

Significantly more children in the older 12-17 year old age group (52.1%) spent more than one hour per weekday using electronic devices compared to their younger 6-11 year old (18.9%) counterparts.

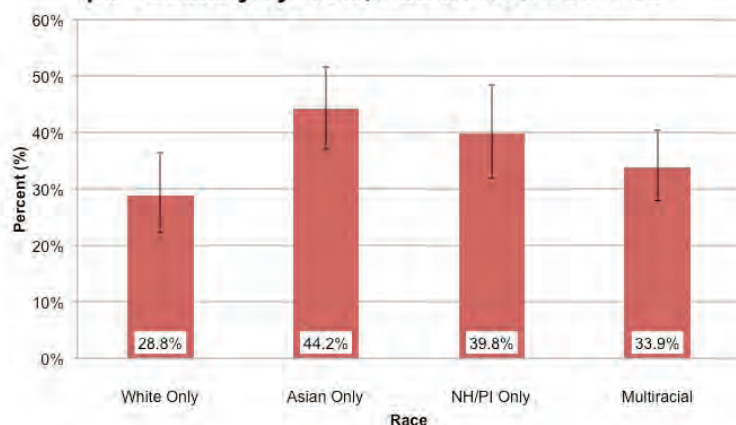
### ACEs:

Proportion of children spending more than one hour per weekday using electronic devices increased with increasing ACEs. Significantly less children with no ACEs (28.0%) spent more than one hour per weekday using electronic devices compared to children with one ACE (39.7%) and two or more ACEs (46.6%).

### Other:

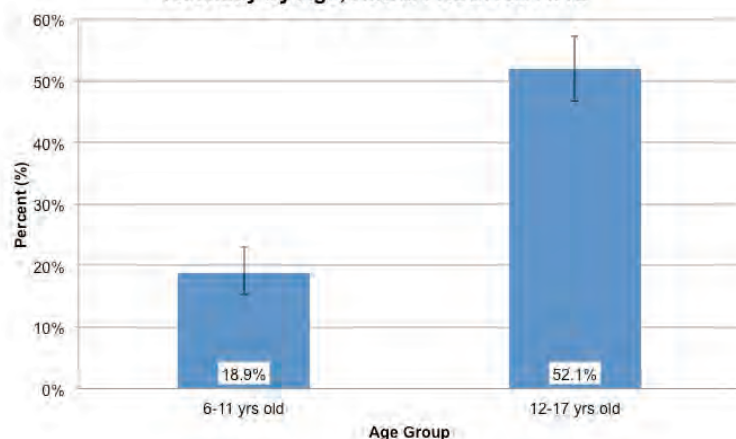
No statistically significant disparities in the proportion of children who spent more than one hour per weekday using electronic devices were observed related to the child's insurance type, gender, and medical home status.

**More than One Hour Average Electronic Use per Weekday by Race, Hawai'i NSCH 2011/12**



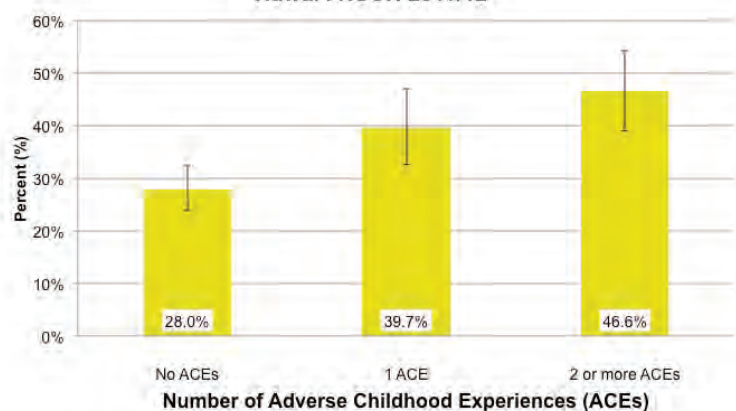
Data Source: National Survey of Children's Health, 2011/12

**More than One Hour Average Electronic Use per Weekday by Age, Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

**More than One Hour Average Electronic Use per Weekday by Adverse Childhood Experiences, Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

# COMMUNITY, SCHOOL AND FAMILY

## Safe Communities Ages 0-17 Years

### **Background:**

Safe communities play a key role in ensuring the health of children. Evidence suggests that residing in unsafe neighborhoods may negatively impact a child's mental health and put youth at greater risk for depression.<sup>53</sup> Furthermore, youth residing in less safe communities may be discouraged to be engaged in physical activity, resulting in long-term health risks such as a obesity and its associated chronic health consequences.<sup>54</sup>

### **Measurement:**

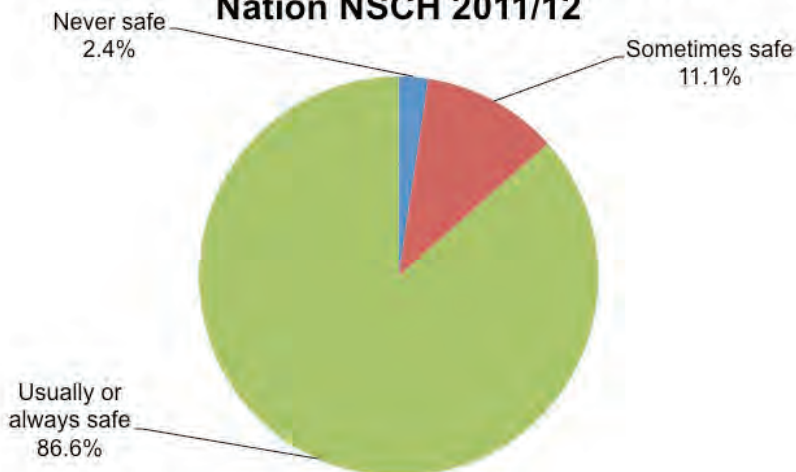
Parents of 0-17 year olds reported whether their neighborhood or community is never safe, sometimes safe, or usually/always safe for children.

### **National Comparisons:**

In Hawai'i, 87.0% of children were reported as usually/always safe in their community/neighborhood. This is higher but not significantly different from the national estimate of 86.6%.

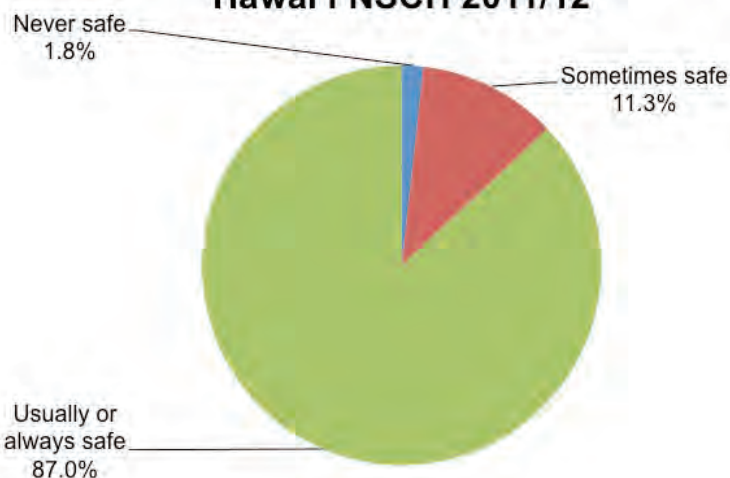
In Hawai'i, 11.3% of children were in sometimes safe communities whereas 1.8% were in unsafe communities. Nationally, 11.1% of children felt sometimes safe while 2.4% felt never safe.

**Safety in Community/Neighborhood,  
Nation NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

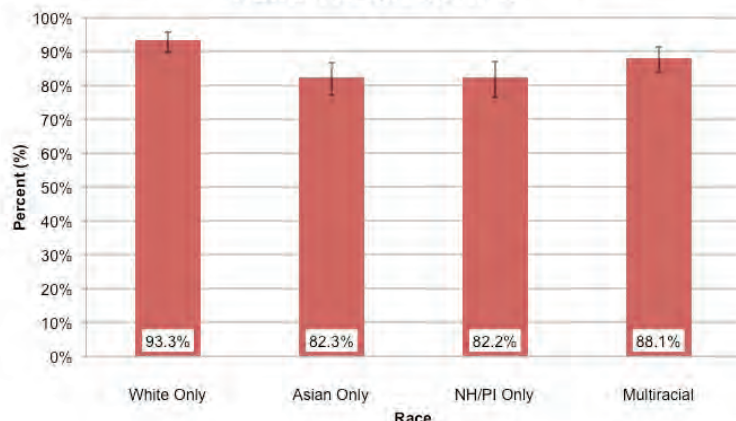
**Safety in Community/Neighborhood,  
Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

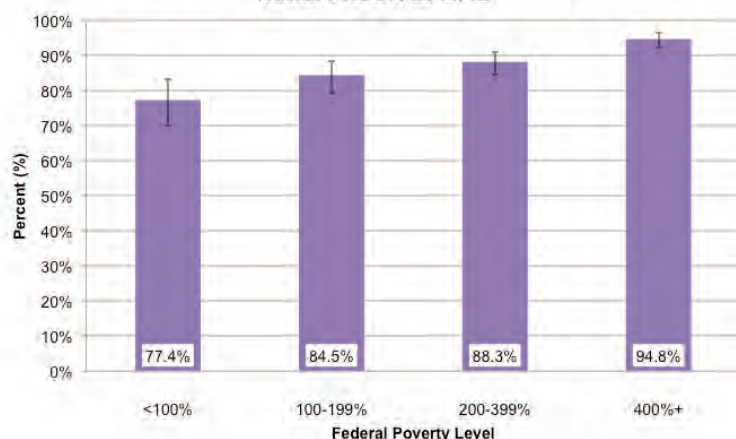
**Children Usually/Always Safe in  
Community:  
87.0% (Hawai'i)  
vs  
86.6% (Nation)**

**Usually/Always Safe in Community by Race, Hawai'i NSCH 2011/12**



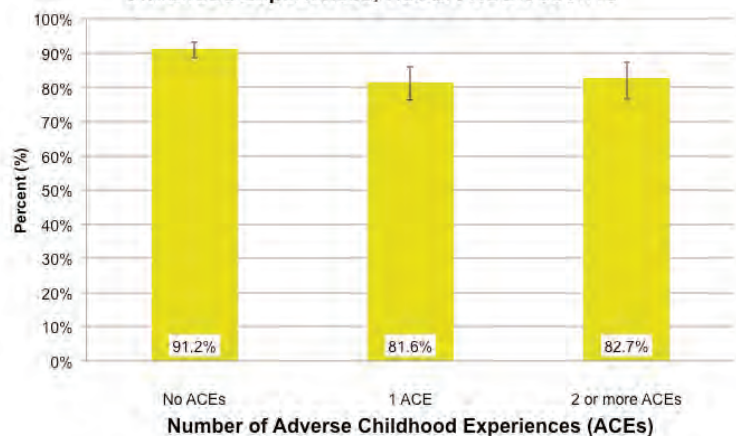
Data Source: National Survey of Children's Health, 2011/12

**Usually/Always Safe in Community by Poverty Level, Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

**Usually/Always Safe in Community by Adverse Childhood Experiences, Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

## Safe Communities Disparities

Data for Hawai'i demonstrated disparities in children who are usually/always safe in their community related to race, federal poverty level, ACEs, insurance type, and medical home.

### **Race:**

Significantly more White children (93.3%) were in usually/always safe communities compared to Asian (82.3%), Native Hawaiian/Pacific Islander (82.2%) and multiracial (88.1%) children. Also, Asian children had lower rates of living in usually/always safe communities compared to multiracial children.

### **Federal Poverty Level:**

The percentage of children in usually/always safe communities increased with increasing FPL. Significantly more children in 400%+ FPL (94.8%) lived in safe communities compared to children in <100% (77.4%), 100-199% (84.5%), and 200-399% (88.3%) FPL. Differences in proportion were statistically significant across all FPL groups.

### **ACEs:**

Significantly more children with no ACEs (91.2%) were usually/always safe in their community compared to children with one (81.6%) and two or more ACEs (82.7%).

### **Other:**

Publicly insured children (83.2%) had significantly lower rates of being in a usually/always safe community than that of private insured children (88.9%). Significantly less children with no medical home (80.8%) also lived in a usually/always safe community compared to children who have a medical home (91.6%). There were no significant disparities related to child's age and gender for this indicator.



# COMMUNITY, SCHOOL AND FAMILY

## Safe Schools Ages 6-17 Years

### **Background:**

Because children spend a large part of their days at school, safety at school is of utmost importance. School-specific violence, which ranges from incidents of bullying and threats to fatalities, can negatively affect the mental health and behavior of youth. Witnesses and victims exposed to violence can suffer from post traumatic stress, anxiety, depression, and aggressive behavior.<sup>55</sup>

### **Measurement:**

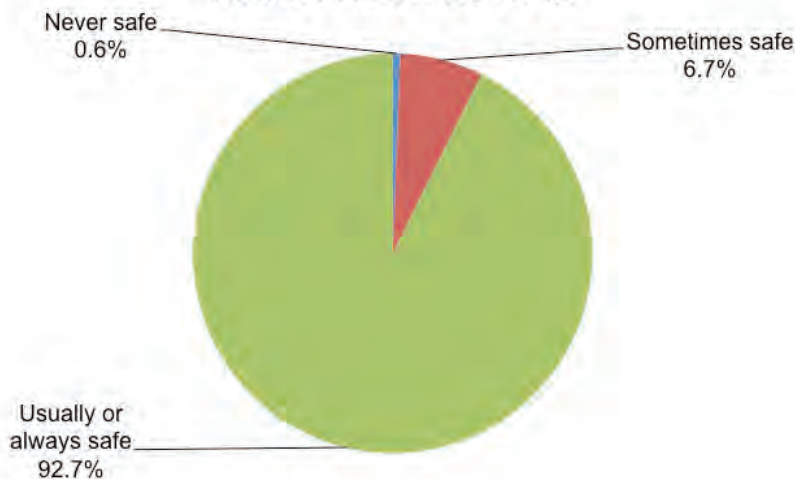
Parents of 6-17 year olds who were enrolled in a school other than home-school in the past 12 months were asked whether their child's school is never safe, sometimes safe, usually, or always safe. These were categorized into never, sometimes, and usually/always safe.

### **National Comparisons:**

In Hawai'i, 89.7% of children were reported to usually/always safe. This is lower than but not significantly different from the national estimate of 92.7%.

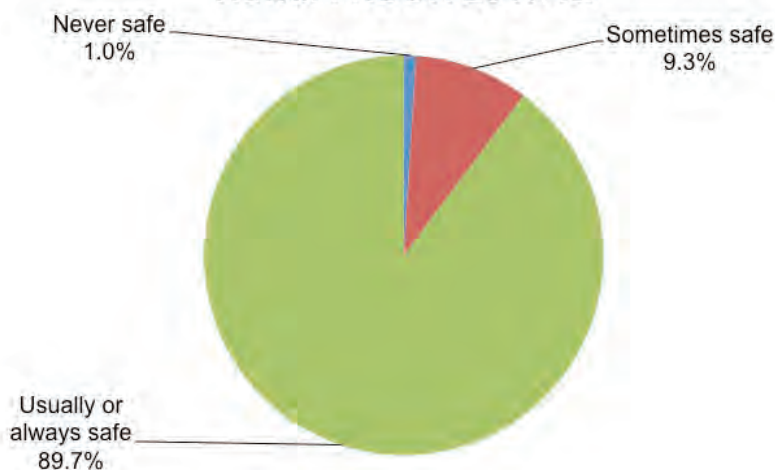
In Hawai'i, 9.3% of children were in sometimes safe communities whereas 1.0% of children were in unsafe communities. Nationally, 6.7% of children felt sometimes safe while 0.6% felt never safe.

**Safety at School,  
Nation NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

**Safety at School,  
Hawai'i NSCH 2011/12**

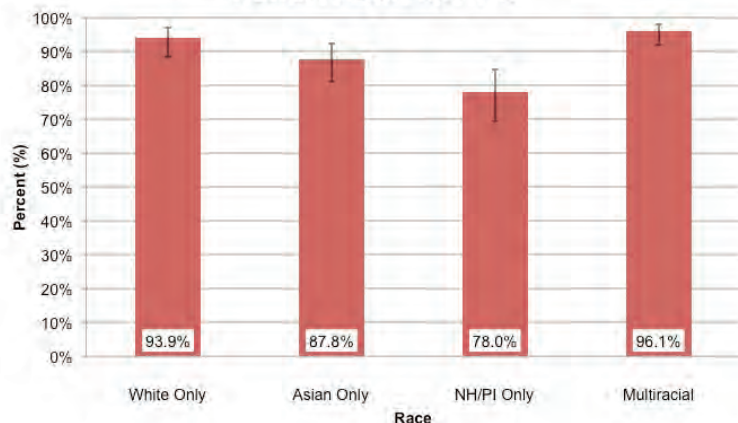


Data Source: National Survey of Children's Health, 2011/12

**Children Usually/Always Safe at  
School:  
89.7% (Hawai'i)  
vs  
92.7% (Nation)**

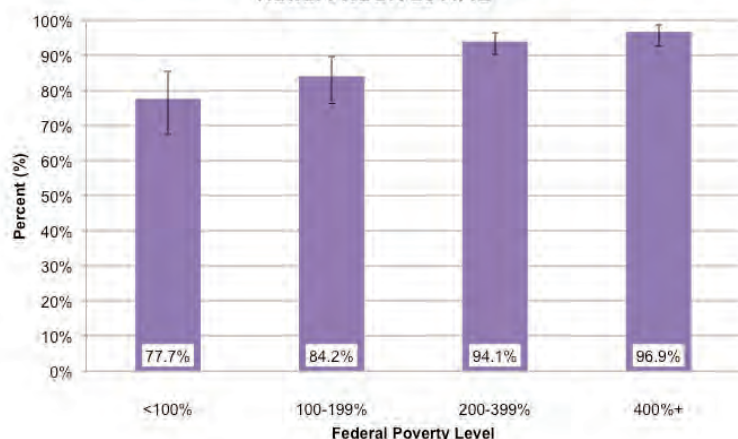


**Usually/Always Safe at School by Race,  
Hawai'i NSCH 2011/12**



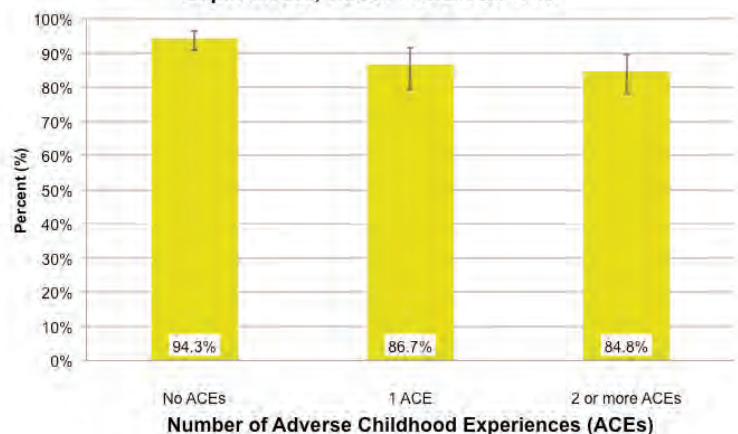
Data Source: National Survey of Children's Health, 2011/12

**Usually/Always Safe at School by Poverty Level,  
Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

**Usually/Always Safe at School by Adverse Childhood  
Experiences, Hawai'i NSCH 2011/12**



Data Source: National Survey of Children's Health, 2011/12

## Safe Schools Disparities

Data for Hawai'i demonstrated disparities in children who are usually/always safe at school related to race, federal poverty level, ACEs, insurance type, and medical home.

### **Race:**

Native Hawaiian/Pacific Islander (78.0%) children had the lowest rates of being safe at school. Asian (87.8%), White (93.9%), and multiracial (96.1%) children (100.0%) had significantly higher rates. Differences between all racial groups were statistically significant, with the exception of no difference in White and Asian children.

### **Federal Poverty Level:**

The proportion of children in a usually/always safe school increased with increasing FPL. Significantly more children in the 400%+ (96.9%) group reported feeling usually/always safe at school compared to children in the <100% (77.7%) and 100-199% (84.2%) FPL groups. Also, children in the 200-399% FPL group (94.1%) had higher rates of being usually/always safe at school compared to those in the <100% and 100-199% FPL groups.

### **ACEs:**

Significantly more children with no ACEs (94.3%) were usually/always safe at school compared to children with one ACE (86.7%) and two or more ACEs (84.8%).

### **Other:**

Privately insured children (92.1%) had significantly higher rates of being in usually/always safe schools compared to publicly insured children (84.4%). In addition, children with a medical home (95.0%) also had significantly higher rates compared to those without (83.9%) of being usually/always safe at schools. No statistically significant differences for this indicator were observed related to age group and gender.

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## Child Health Indicator by Population Characteristics Based on NSCH 2011/12 Data

### Excellent/Very Good Overall Health Status 0-17 Years Old

	Weighted Prevalence (%)	95% Confidence Interval
<b>Race</b>		
White Only	90.3	85.7-93.5
Asian Only	82.5	76.8-87.0
NH/PI Only	81.3	74.8-86.4
Multiracial	88.5	84.4-91.5
<b>Federal Poverty Level</b>		
<100% FPL	79.7	72.7-85.3
100%-199% FPL	80.0	74.1-84.8
200%-399% FPL	90.2	86.6-92.8
400%+ FPL	91.1	87.0-94.0
<b>Insurance Type</b>		
Public	77.7	72.3-82.3
Private	90.2	87.8-92.2
<b>Age</b>		
0-5 years	91.1	87.2-93.9
6-11 years	86.8	83.0-89.8
12-17 years	80.2	75.4-84.4
0-8 years	91.1	88.2-93.3
9-17 years	80.9	77.1-84.2
<b>Gender</b>		
Male	86.2	82.9-89.0
Female	85.7	82.2-88.7
<b>ACEs</b>		
No ACEs	90.9	88.2-93.0
1 ACE	83.2	77.8-87.4
2 or more ACEs	76.1	69.3-81.8
<b>Medical Home</b>		
No medical home	78.7	74.4-82.6
Medical home	92.2	89.7-94.1
<b>Overall</b>	86.0	83.8-88.2

### Excellent/Very Good Oral Health Status 1-17 Years Old

	Weighted Prevalence (%)	95% Confidence Interval
<b>Race</b>		
White Only	82.3	76.7-86.8
Asian Only	72.8	66.5-78.3
NH/PI Only	65.2	58.0-71.8
Multiracial	72.1	66.6-77.0
<b>Federal Poverty Level</b>		
<100% FPL	57.3	49.2-65.0
100-199% FPL	68.2	61.5-74.2
200-399% FPL	78.7	73.9-82.9
400%+ FPL	82.7	78.3-86.3
<b>Insurance Type</b>		
Public	58.7	52.5-64.6
Private	81.0	77.9-83.7
<b>Age</b>		
1-5 years	78.6	72.9-83.3
6-11 years	71.0	66.1-75.4
12-17 years	70.9	65.8-75.6
1-8 years	75.9	71.5-79.7
9-17 years	70.8	66.6-74.5
<b>Gender</b>		
Male	71.3	67.0-75.2
Female	75.0	70.8-78.7
<b>ACEs</b>		
No ACEs	78.2	74.4-81.6
1 ACE	69.3	63.1-75.0
2 or more ACEs	64.6	57.5-71.1
<b>Medical Home</b>		
No medical home	62.6	57.6-67.3
Medical home	82.5	79.2-85.4
<b>Overall</b>	73.1	70.3-76.0

#: Cell size <50, use caution with interpretation

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N/A: Values not reported due to insufficient data or indicator not applicable to specific group

# Child Health Indicator by Population Characteristics Based on NSCH 2011/12 Data

## No Oral Health Problems 1-17 Years Old

	Weighted Prevalence (%)	95% Confidence Interval
<b>Race</b>		
White Only	85.3	79.9-89.4
Asian Only	76.8	70.2-82.3
NH/PI Only	73.8	66.8-79.8
Multiracial	83.5	78.7-87.3
<b>Federal Poverty Level</b>		
<100% FPL	70.7	62.8-77.5
100-199% FPL	73.4	66.6-79.3
200-399% FPL	85.8	81.8-89.1
400%+ FPL	87.2	82.9-90.5
<b>Insurance Type</b>		
Public	75.5	69.8-80.5
Private	83.6	80.5-86.3
<b>Age</b>		
1-5 years	87.0	82.4-90.6
6-11 years	74.2	69.3-78.6
12-17 years	81.2	76.3-85.2
1-8 years	82.4	78.6-85.7
9-17 years	78.6	74.6-82.1
<b>Gender</b>		
Male	82.0	78.2-85.3
Female	78.8	74.7-82.4
<b>ACEs</b>		
No ACEs	85.3	81.9-88.2
1 ACE	75.9	69.8-81.0
2 or more ACEs	75.1	68.2-80.9
<b>Medical Home</b>		
No medical home	75.5	70.9-79.6
Medical home	85.1	81.7-88.1
<b>Overall</b>	80.4	77.8-83.0

## Ever Breastfed 0-5 Years Old

	Weighted Prevalence (%)	95% Confidence Interval
<b>Race</b>		
White Only	91.4	84.3-95.5
Asian Only	95.2	89.8-97.8
NH/PI Only	73.8	61.3-83.4
Multiracial	90.5	83.7-94.6
<b>Federal Poverty Level</b>		
<100% FPL	76.3	64.7-85.0
100-199% FPL	85.6	76.1-91.7
200-399% FPL	94.1	89.0-96.9
400%+ FPL	95.8	90.0-98.3
<b>Insurance Type</b>		
Public	80.5	72.4-86.6
Private	93.4	89.1-96.0
<b>Age</b>		
0-5 years	88.5	84.8-91.5
6-11 years	N/A	N/A
12-17 years	N/A	N/A
0-8 years	N/A	N/A
9-17 years	N/A	N/A
<b>Gender</b>		
Male	86.6	80.4-91.1
Female	90.5	85.9-93.7
<b>ACEs</b>		
No ACEs	88.6	83.6-92.2
1 ACE	90.2	82.2-94.8
2 or more ACEs	85.2	71.1-93.1
<b>Medical Home</b>		
No medical home	84.3	76.8-89.6
Medical home	91.2	86.5-94.4
<b>Overall</b>	88.5	84.8-91.5

#: Cell size <50, use caution with interpretation

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N/A: Values not reported due to insufficient data or indicator not applicable to specific group

## Child Health Indicator by Population Characteristics Based on NSCH 2011/12 Data

### Exclusively Breastfed for 6 months 6 months-5 Years

	Weighted Prevalence (%)	95% Confidence Interval
<b>Race</b>		
White Only	26.7	17.1-39.0
Asian Only	14.9	8.2-25.4
NH/PI Only	15.3	8.6-25.6
Multiracial	27.1	19.2-36.7
<b>Federal Poverty Level</b>		
<100% FPL	*	*
100-199% FPL	26.9	16.5-37.3
200-399% FPL	23.3	14.3-32.2
400%+ FPL	20.1	12.0-28.2
<b>Insurance Type</b>		
Public	18.0	9.9-26.0
Private	23.8	17.6-30.1
<b>Age</b>		
6 months-5 years	22.4	17.5-27.3
6-11 years	N/A	N/A
12-17 years	N/A	N/A
0-8 years	N/A	N/A
9-17 years	N/A	N/A
<b>Gender</b>		
Male	22.7	16.0-29.4
Female	22.0	14.8-29.2
<b>ACEs</b>		
No ACEs	22.5	17.0-29.1
1 ACE	*	*
2 or more ACEs	*	*
<b>Medical Home</b>		
No medical home	26.1	18.3-35.8
Medical home	20.9	15.5-27.5
<b>Overall</b>	22.4	17.5-27.3

### Premature Birth 0-17 Years Old

	Weighted Prevalence (%)	95% Confidence Interval
<b>Race</b>		
White Only <sup>#</sup>	9.2	6.2-13.5
Asian Only <sup>#</sup>	9.1	6.3-13.0
NH/PI Only <sup>#</sup>	13.2	8.9-19.1
Multiracial	9.8	7.1-13.5
<b>Federal Poverty Level</b>		
<100% FPL	11.3	7.2-17.2
100-199% FPL	11.9	8.1-17.2
200-399% FPL	9.5	7.0-12.7
400%+ FPL	9.4	6.8-12.9
<b>Insurance Type</b>		
Public	12.9	9.3-17.7
Private	9.6	7.8-11.8
<b>Age</b>		
0-5 years	8.4	6.1-11.4
6-11 years	13.3	10.0-17.5
12-17 years	9.4	6.7-13.1
0-8 years	9.1	7.0-11.7
9-17 years	11.7	9.1-14.9
<b>Gender</b>		
Male	10.9	8.4-14.0
Female	9.8	7.6-12.6
<b>ACEs</b>		
No ACEs	9.1	7.0-11.8
1 ACE	11.6	8.3-16.1
2 or more ACEs <sup>#</sup>	11.8	7.9-17.3
<b>Medical Home</b>		
No medical home	13.8	10.7-17.6
Medical home	8.2	6.2-10.7
<b>Overall</b>	10.4	8.5-12.2

<sup>#</sup>: Cell size <50, use caution with interpretation

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N/A: Values not reported due to insufficient data or indicator not applicable to specific group

# Child Health Indicator by Population Characteristics Based on NSCH 2011/12 Data

## Low Birthweight 0-17 Years Old

	Weighted Prevalence (%)	95% Confidence Interval
<b>Race</b>		
White Only <sup>#</sup>	8.3	5.4-12.7
Asian Only	11.8	8.4-16.2
NH/PI Only <sup>#</sup>	13.1	8.5-19.7
Multiracial <sup>#</sup>	6.9	4.7-10.1
<b>Federal Poverty Level</b>		
<100% FPL <sup>#</sup>	13.0	8.4-19.6
100-199% FPL <sup>#</sup>	9.0	5.9-13.4
200-399% FPL	10.7	7.7-14.6
400%+ FPL <sup>#</sup>	7.1	5.0-9.9
<b>Insurance Type</b>		
Public <sup>#</sup>	10.9	7.6-15.6
Private	9.5	7.6-11.8
<b>Age</b>		
0-5 years	7.2	5.1-10.2
6-11 years	13.5	10.1-17.7
12-17 years <sup>#</sup>	8.7	5.9-12.7
0-8 years	8.5	6.5-11.1
9-17 years	11.2	8.5-14.6
<b>Gender</b>		
Male	8.1	6.1-10.6
Female	11.6	8.9-15.0
<b>ACEs</b>		
No ACEs	8.4	6.4-10.9
1 ACE	11.7	8.2-16.5
2 or more ACEs <sup>#</sup>	10.6	6.6-16.7
<b>Medical Home</b>		
No medical home	12.2	9.3-16.0
Medical home	8.4	6.4-11.0
<b>Overall</b>	9.8	7.9-11.7

## Overweight/Obese Children 10-17 Years Old

	Weighted Prevalence (%)	95% Confidence Interval
<b>Race</b>		
White Only <sup>#</sup>	15.5	10.3-22.6
Asian Only	23.1	16.8-30.9
NH/PI Only	39.8	30.2-50.1
Multiracial	31.3	23.9-39.8
<b>Federal Poverty Level</b>		
<100% FPL <sup>#</sup>	40.2	28.6-53.0
100-199% FPL <sup>#</sup>	31.5	22.9-41.6
200-399% FPL	25.7	19.9-32.5
400%+ FPL	18.9	13.8-25.3
<b>Insurance Type</b>		
Public	36.0	27.6-45.3
Private	23.6	19.6-28.1
<b>Age</b>		
0-5 years	N/A	N/A
6-11 years	N/A	N/A
12-17 years	26.0	21.7-30.8
0-8 years	N/A	N/A
9-17 years	27.4	23.6-31.6
<b>Gender</b>		
Male	31.3	25.9-37.4
Female	23.7	18.7-29.6
<b>ACEs</b>		
No ACEs	22.0	17.2-27.6
1 ACE	32.2	24.5-40.9
2 or more ACEs	30.8	23.4-39.2
<b>Medical Home</b>		
No medical home	31.0	25.0-37.8
Medical home	24.2	19.4-29.8
<b>Overall</b>	27.4	23.6-30.8

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## Child Health Indicator by Population Characteristics Based on NSCH 2011/12 Data

### Physically Active Every Day 6-17 Years Old

	Weighted Prevalence (%)	95% Confidence Interval
<b>Race</b>		
White Only	35.9	29.3-43.2
Asian Only	14.7	10.1-20.8
NH/PI Only	33.8	26.4-42.2
Multiracial	30.0	24.4-36.4
<b>Federal Poverty Level</b>		
<100% FPL	31.8	23.6-41.3
100-199% FPL	30.8	23.9-38.8
200-399% FPL	26.0	21.1-31.7
400%+ FPL	28.5	23.1-34.6
<b>Insurance Type</b>		
Public	33.3	26.8-40.6
Private	27.5	23.9-31.4
<b>Age</b>		
0-5 years	N/A	N/A
6-11 years	39.2	34.4-44.2
12-17 years	18.3	14.6-22.8
0-8 years	N/A	N/A
9-17 years	23.5	20.0-27.3
<b>Gender</b>		
Male	32.8	28.2-37.7
Female	24.6	20.3-29.4
<b>ACEs</b>		
No ACEs	28.6	24.3-33.4
1 ACE	28.1	21.9-35.1
2 or more ACEs	31.3	24.8-38.8
<b>Medical Home</b>		
No medical home	26.5	21.8-31.8
Medical home	30.7	26.4-35.4
<b>Overall</b>	28.7	25.5-32.0

### No Missed School Days Due to Illness or Injury 6-17 Years Old

	Weighted Prevalence (%)	95% Confidence Interval
<b>Race</b>		
White Only	20.5	15.0-27.2
Asian Only	37.9	31.0-45.3
NH/PI Only	32.0	24.7-40.2
Multiracial	19.8	15.3-25.3
<b>Federal Poverty Level</b>		
<100% FPL	33.4	24.8-43.2
100-199% FPL	26.3	19.7-34.3
200-399% FPL	25.5	20.7-30.9
400%+ FPL	26.4	21.4-32.2
<b>Insurance Type</b>		
Public	27.5	21.4-34.5
Private	26.4	22.9-30.3
<b>Age</b>		
0-5 years	N/A	N/A
6-11 years	25.6	21.4-30.3
12-17 years	28.9	24.5-33.9
0-8 years	N/A	N/A
9-17 years	28.6	25.0-32.5
<b>Gender</b>		
Male	26.6	22.4-31.3
Female	27.6	23.2-32.5
<b>ACEs</b>		
No ACEs	31.5	27.0-36.3
1 ACE	26.9	20.7-34.1
2 or more ACEs	19.7	14.6-26.1
<b>Medical Home</b>		
No medical home	29.5	24.5-35.1
Medical home	25.1	21.3-29.4
<b>Overall</b>	27.3	24.0-30.5

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## Child Health Indicator by Population Characteristics Based on NSCH 2011/12 Data

### Moderate/High Risk for Delay 4 Months - 5 Years Old

	Weighted Prevalence (%)	95% Confidence Interval
<b>Race</b>		
White Only <sup>#</sup>	29.6	19.7-42.0
Asian Only <sup>#</sup>	45.1	33.0-57.8
NH/PI Only <sup>#</sup>	30.5	20.1-43.3
Multiracial <sup>#</sup>	25.0	18.0-33.7
<b>Federal Poverty Level</b>		
<100% FPL <sup>#</sup>	42.2	30.1-55.4
100-199% FPL <sup>#</sup>	26.8	18.8-36.7
200-399% FPL	34.1	25.5-43.9
400%+ FPL <sup>#</sup>	19.4	12.0-29.8
<b>Insurance Type</b>		
Public	41.4	32.2-51.3
Private	24.9	19.4-31.4
<b>Age</b>		
4 months-5 years	31.0	26.0-36.3
6-11 years	N/A	N/A
12-17 years	N/A	N/A
0-8 years	N/A	N/A
9-17 years	N/A	N/A
<b>Gender</b>		
Male	32.0	25.3-39.6
Female	29.8	23.0-37.8
<b>ACEs</b>		
No ACEs	24.5	19.0-30.9
1 ACE <sup>#</sup>	39.5	28.7-51.5
2 or more ACEs <sup>#</sup>	48.8	32.7-65.1
<b>Medical Home</b>		
No medical home	44.1	34.9-53.7
Medical home	22.6	17.5-28.7
<b>Overall</b>	31.0	

### Flourishing-Displaying All 4 Positive Health Indicators, 6 months - 5 Years Old

	Weighted Prevalence (%)	95% Confidence Interval
<b>Race</b>		
White Only	76.0	64.4-84.8
Asian Only	64.7	50.8-76.6
NH/PI Only	66.8	52.5-78.6
Multiracial	82.2	73.7-88.4
<b>Federal Poverty Level</b>		
<100% FPL	72.5	59.5-82.6
100-199% FPL	65.3	53.3-75.6
200-399% FPL	74.4	64.2-82.5
400%+ FPL	84.5	74.6-91.0
<b>Insurance Type</b>		
Public <sup>#</sup>	66.5	56.3-75.3
Private	77.9	71.0-83.6
<b>Age</b>		
6 months-5 years	73.8	68.3-78.6
6-11 years	N/A	N/A
12-17 years	N/A	N/A
0-8 years	N/A	N/A
9-17 years	N/A	N/A
<b>Gender</b>		
Male	75.0	67.5-81.2
Female	72.5	64.1-79.6
<b>ACEs</b>		
No ACEs	76.1	69.3-81.9
1 ACE <sup>#</sup>	72.3	59.8-82.1
2 or more ACEs <sup>#</sup>	63.2	46.2-77.5
<b>Medical Home</b>		
No medical home	68.0	58.4-76.3
Medical home	76.8	69.6-82.7
<b>Overall</b>	73.8	68.6-79.0

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## Child Health Indicator by Population Characteristics Based on NSCH 2011/12 Data

### Flourishing-Displaying All 3 Positive Health Indicators, 6-17 Years Old

	Weighted Prevalence (%)	95% Confidence Interval
<b>Race</b>		
White Only	55.0	47.7-62.2
Asian Only	46.5	39.4-53.7
NH/PI Only	42.2	34.2-50.6
Multiracial	45.2	38.7-51.9
<b>Federal Poverty Level</b>		
<100% FPL	43.3	33.9-53.3
100-199% FPL	40.4	32.7-48.5
200-399% FPL	50.1	44.1-56.1
400%+ FPL	52.1	45.9-58.2
<b>Insurance Type</b>		
Public	43.6	36.4-51.1
Private	48.7	44.5-52.9
<b>Age</b>		
0-5 years	N/A	N/A
6-11 years	49.8	44.7-54.8
12-17 years	44.6	39.5-49.8
0-8 years	N/A	N/A
9-17 years	45.3	41.2-49.6
<b>Gender</b>		
Male	41.9	37.1-47.0
Female	52.5	47.3-57.7
<b>ACEs</b>		
No ACEs	54.2	49.2-59.1
1 ACE	38.8	31.9-46.1
2 or more ACEs	42.3	35.0-50.0
<b>Medical Home</b>		
No medical home	36.2	31.1-41.7
Medical home	57.7	52.9-62.4
<b>Overall</b>	47.2	43.5-50.8

### Children with Special Health Care Needs Status, 0-17 Years Old

	Weighted Prevalence (%)	95% Confidence Interval
<b>Race</b>		
White Only	16.2	12.2-21.1
Asian Only	13.1	9.5-17.7
NH/PI Only	19.7	14.7-26.0
Multiracial	17.6	13.9-22.1
<b>Federal Poverty Level</b>		
<100% FPL	16.2	11.3-22.7
100-199% FPL	18.0	13.4-23.6
200-399% FPL	14.8	11.6-18.8
400%+ FPL	20.0	16.0-24.7
<b>Insurance Type</b>		
Public	21.8	17.3-27.0
Private	15.5	13.1-18.2
<b>Age</b>		
0-5 years	8.4	6.0-11.8
6-11 years	18.6	15.2-22.6
12-17 years	24.0	19.7-29.0
0-8 years	11.2	8.9-14.0
9-17 years	23.0	19.6-26.8
<b>Gender</b>		
Male	18.3	15.3-21.7
Female	15.9	12.9-19.4
<b>ACEs</b>		
No ACEs	11.4	9.2-14.0
1 ACE	17.1	13.0-22.1
2 or more ACEs	30.9	24.7-37.8
<b>Medical Home</b>		
No medical home	23.1	19.2-27.5
Medical home	13.1	10.7-15.9
<b>Overall</b>	17.1	14.8-19.3

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## Child Health Indicator by Population Characteristics Based on NSCH 2011/12 Data

### Chronic Health Conditions 0-17 Years Old

	Weighted Prevalence (%)	95% Confidence Interval
<b>Race</b>		
White Only	80.7	75.2-85.3
Asian Only	88.0	83.5-91.4
NH/PI Only	71.9	65.0-77.9
Multiracial	80.2	75.6-84.1
<b>Federal Poverty Level</b>		
<100% FPL	75.4	68.1-81.5
100-199% FPL	80.5	74.8-85.3
200-399% FPL	82.3	78.1-85.8
400%+ FPL	80.6	75.8-84.7
<b>Insurance Type</b>		
Public	74.6	69.2-79.3
Private	82.5	79.5-85.1
<b>Age</b>		
0-5 years	89.0	85.2-92.0
6-11 years	77.7	73.2-81.6
12-17 years	74.0	69.0-78.4
0-8 years	85.6	82.3-88.4
9-17 years	74.7	70.8-78.3
<b>Gender</b>		
Male	78.0	74.3-81.3
Female	82.4	78.7-85.5
<b>ACEs</b>		
No ACEs	86.5	83.5-89.0
1 ACE	76.2	70.4-81.1
2 or more ACEs	68.8	62.1-74.8
<b>Medical Home</b>		
No medical home	74.9	70.3-78.9
Medical home	84.4	81.4-87.1
<b>Overall</b>	80.2	77.7-82.6

### Health Insurance Status 0-17 Years Old

	Weighted Prevalence (%)	95% Confidence Interval
<b>Race</b>		
White Only	98.2	95.3-99.3
Asian Only	97.0	93.6-98.6
NH/PI Only	99.4	97.8-99.9
Multiracial	99.9	99.4-100.0
<b>Federal Poverty Level</b>		
<100% FPL	97.5	93.5-99.0
100-199% FPL	97.9	95.7-99.0
200-399% FPL	99.6	98.9-99.8
400%+ FPL	99.6	97.1-99.9
<b>Insurance Type</b>		
Public	100.0	N/A
Private	100.0	N/A
<b>Age</b>		
0-5 years	99.3	98.2-99.7
6-11 years	99.1	97.1-99.7
12-17 years	98.0	96.0-99.0
0-8 years	98.9	97.7-99.5
9-17 years	98.6	97.2-99.3
<b>Gender</b>		
Male	98.5	97.2-99.2
Female	99.1	97.8-99.6
<b>ACEs</b>		
No ACEs	99.1	98.0-99.6
1 ACE	98.6	96.8-99.4
2 or more ACEs	98.6	95.8-99.5
<b>Medical Home</b>		
No medical home	97.9	96.2-98.9
Medical home	99.7	98.9-99.9
<b>Overall</b>	98.8	98.2-99.4

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\*: Estimate does not meet standards for reliability and precision, relative standard error >30%

N/A: Values not reported due to insufficient data or indicator not applicable to specific group



## Child Health Indicator by Population Characteristics Based on NSCH 2011/12 Data

### Adequate Insurance 0-17 Years Old

	Weighted Prevalence (%)	95% Confidence Interval
<b>Race</b>		
White Only	86.6	81.7-90.3
Asian Only	72.3	65.7-78.0
NH/PI Only	77.8	71.2-83.2
Multiracial	84.4	80.1-87.9
<b>Federal Poverty Level</b>		
<100% FPL	79.8	72.9-85.3
100-199% FPL	74.6	68.3-80.0
200-399% FPL	82.9	78.7-86.4
400%+ FPL	86.4	82.2-89.7
<b>Insurance Type</b>		
Public	81.4	76.3-85.6
Private	81.1	78.1-83.8
<b>Age</b>		
0-5 years	85.2	81.1-88.6
6-11 years	80.5	75.9-84.3
12-17 years	77.9	73.2-82.1
0-8 years	83.8	80.4-86.7
9-17 years	78.6	74.7-82.0
<b>Gender</b>		
Male	80.1	76.3-83.4
Female	82.3	78.9-85.3
<b>ACEs</b>		
No ACEs	86.1	83.2-88.5
1 ACE	74.1	68.0-79.5
2 or more ACEs	78.1	71.8-83.3
<b>Medical Home</b>		
No medical home	71.5	66.8-75.8
Medical home	88.5	85.7-90.8
<b>Overall</b>	81.2	78.8-83.6

### Received Preventive Medical Care 0-17 Years Old

	Weighted Prevalence (%)	95% Confidence Interval
<b>Race</b>		
White Only	86.3	81.5-90.1
Asian Only	81.8	76.4-86.1
NH/PI Only	83.5	77.1-88.4
Multiracial	85.5	81.2-88.9
<b>Federal Poverty Level</b>		
<100% FPL	76.0	68.5-82.2
100-199% FPL	82.2	76.7-86.6
200-399% FPL	86.6	82.5-89.8
400%+ FPL	90.2	87.0-92.7
<b>Insurance Type</b>		
Public	85.0	80.3-88.7
Private	85.2	82.4-87.7
<b>Age</b>		
0-5 years	91.1	87.3-93.8
6-11 years	80.2	75.6-84.1
12-17 years	82.2	77.9-85.9
0-8 years	86.7	83.4-89.5
9-17 years	82.2	78.7-85.2
<b>Gender</b>		
Male	82.8	79.2-85.9
Female	86.1	82.9-88.8
<b>ACEs</b>		
No ACEs	86.6	83.6-89.0
1 ACE	81.9	76.4-86.4
2 or more ACEs	83.2	77.2-87.8
<b>Medical Home</b>		
No medical home	78.6	74.3-82.4
Medical home	88.7	85.9-91.0
<b>Overall</b>	84.5	82.2-86.7

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N/A: Values not reported due to insufficient data or indicator not applicable to specific group

## Child Health Indicator by Population Characteristics Based on NSCH 2011/12 Data

### Received Preventive Dental Care 1-17 Years Old

	Weighted Prevalence (%)	95% Confidence Interval
<b>Race</b>		
White Only	81.4	75.7-86.0
Asian Only	88.4	83.7-91.9
NH/PI Only	78.9	72.1-84.5
Multiracial	84.7	80.1-88.4
<b>Federal Poverty Level</b>		
<100% FPL	70.0	62.0-76.8
100-199% FPL	79.6	73.7-84.5
200-399% FPL	86.9	83.0-90.0
400%+ FPL	91.6	87.5-94.4
<b>Insurance Type</b>		
Public	75.7	70.0-80.7
Private	86.9	84.2-89.3
<b>Age</b>		
1-5 years	69.6	63.7-74.8
6-11 years	92.1	88.9-94.4
12-17 years	85.1	80.6-88.7
1-8 years	77.8	73.7-81.4
9-17 years	87.8	84.5-90.5
<b>Gender</b>		
Male	80.9	77.0-84.2
Female	85.3	81.7-88.3
<b>ACEs</b>		
No ACEs	84.9	81.4-87.8
1 ACE	80.0	73.9-85.0
2 or more ACEs	83.3	77.9-87.6
<b>Medical Home</b>		
No medical home	82.2	77.8-85.8
Medical home	83.5	80.1-86.4
<b>Overall</b>	83.1	80.7-85.5

### Received Both Medical and Dental Preventive Care, 0-17 Years Old

	Weighted Prevalence (%)	95% Confidence Interval
<b>Race</b>		
White Only	71.4	65.4-76.8
Asian Only	74.0	68.2-79.0
NH/PI Only	69.4	62.2-75.8
Multiracial	76.5	71.6-80.7
<b>Federal Poverty Level</b>		
<100% FPL	55.4	47.5-63.1
100-199% FPL	70.1	64.0-75.6
200-399% FPL	76.9	72.2-81.0
400%+ FPL	83.5	79.1-87.2
<b>Insurance Type</b>		
Public	68.3	62.6-73.6
Private	76.0	72.7-79.0
<b>Age</b>		
0-5 years	69.5	64.3-74.3
6-11 years	74.7	69.9-79.0
12-17 years	74.5	69.5-78.9
0-8 years	70.3	66.2-74.2
9-17 years	75.5	71.6-79.1
<b>Gender</b>		
Male	70.2	66.1-74.0
Female	75.6	71.7-79.2
<b>ACEs</b>		
No ACEs	75.4	71.7-78.7
1 ACE	68.3	62.0-74.0
2 or more ACEs	73.6	67.2-79.2
<b>Medical Home</b>		
No medical home	67.0	62.2-71.5
Medical home	77.0	73.4-80.3
<b>Overall</b>	72.9	70.2-75.7

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## Child Health Indicator by Population Characteristics Based on NSCH 2011/12 Data

### Vision Screening 0-17 Years Old

	Weighted Prevalence (%)	95% Confidence Interval
<b>Race</b>		
White Only	64.4	58.1-70.2
Asian Only	61.6	55.1-67.7
NH/PI Only	61.7	54.5-68.5
Multiracial	64.5	59.0-69.6
<b>Federal Poverty Level</b>		
<100% FPL	53.3	45.4-61.0
100-199% FPL	55.5	48.7-62.0
200-399% FPL	66.2	61.2-70.9
400%+ FPL	73.3	67.8-78.2
<b>Insurance Type</b>		
Public	56.5	50.6-62.3
Private	66.4	62.7-69.8
<b>Age</b>		
0-5 years	37.3	32.2-42.8
6-11 years	78.1	73.3-82.3
12-17 years	73.3	68.2-77.8
0-8 years	51.5	47.1-55.9
9-17 years	74.3	70.3-78.0
<b>Gender</b>		
Male	59.2	54.8-63.4
Female	66.7	62.4-70.8
<b>ACEs</b>		
No ACEs	60.8	56.7-64.8
1 ACE	60.3	53.8-66.4
2 or more ACEs	72.4	65.6-78.3
<b>Medical Home</b>		
No medical home	58.9	54.0-63.7
Medical home	65.6	61.6-69.5
<b>Overall</b>	62.9	59.9-65.9

### Child with Medical Home 0-17 Years Old

	Weighted Prevalence (%)	95% Confidence Interval
<b>Race</b>		
White Only	66.9	60.8-72.5
Asian Only	54.2	47.8-60.5
NH/PI Only	50.3	43.0-57.5
Multiracial	59.2	53.6-64.6
<b>Federal Poverty Level</b>		
<100% FPL	39.5	32.1-47.5
100-199% FPL	52.9	46.1-59.6
200-399% FPL	62.1	56.9-67.0
400%+ FPL	69.0	63.7-73.8
<b>Insurance Type</b>		
Public	44.7	38.8-50.7
Private	64.0	60.5-67.4
<b>Age</b>		
0-5 years	64.5	59.0-69.7
6-11 years	55.6	50.4-60.7
12-17 years	52.1	46.7-57.5
0-8 years	61.1	56.7-65.3
9-17 years	53.7	49.3-58.0
<b>Gender</b>		
Male	56.4	52.0-60.7
Female	58.4	54.0-62.8
<b>ACEs</b>		
No ACEs	64.1	60.0-68.0
1 ACE	53.2	46.8-59.6
2 or more ACEs	45.8	38.8-53.0
<b>Medical Home</b>		
No medical home	N/A	N/A
Medical home	N/A	N/A
<b>Overall</b>	57.4	54.4-60.5

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## Child Health Indicator by Population Characteristics Based on NSCH 2011/12 Data

### No Home Visiting Program 0-3 Years Old

### Inadequate Sleep 6-17 Years

	Weighted Prevalence (%)	95% Confidence Interval		Weighted Prevalence (%)	95% Confidence Interval
<b>Race</b>			<b>Race</b>		
White Only	84.1	70.8-92.1	White Only	40.1	33.2-47.4
Asian Only	94.0	80.7-98.3	Asian Only	44.4	37.4-51.7
NH/PI Only	88.3	66.2-96.7	NH/PI Only	36.9	29.1-45.4
Multiracial	92.8	84.2-96.9	Multiracial	42.2	35.8-49.0
<b>Federal Poverty Level</b>			<b>Federal Poverty Level</b>		
<100% FPL	89.5	73.3-96.4	<100% FPL	35.0	26.0-45.2
100-199% FPL	90.7	77.9-96.4	100-199% FPL	33.1	26.1-40.9
200-399% FPL	87.2	76.0-93.6	200-399% FPL	41.1	35.3-47.2
400%+ FPL	92.6	83.0-97.0	400%+ FPL	50.8	44.5-57.0
<b>Insurance Type</b>			<b>Insurance Type</b>		
Public	86.8	75.4-93.4	Public	33.3	26.7-40.6
Private	91.3	85.0-95.1	Private	44.4	40.2-48.6
<b>Age</b>			<b>Age</b>		
0-5 years	89.7	84.4-93.4	0-5 years	N/A	N/A
6-11 years	N/A	N/A	6-11 years	34.5	29.9-39.5
12-17 years	N/A	N/A	12-17 years	46.7	41.5-52.0
0-8 years	N/A	N/A	0-8 years	N/A	N/A
9-17 years	N/A	N/A	9-17 years	43.4	39.2-47.6
<b>Gender</b>			<b>Gender</b>		
Male	88.4	78.9-94.0	Male	39.6	34.7-44.6
Female	91.1	85.2-94.8	Female	41.7	36.6-46.9
<b>ACEs</b>			<b>ACEs</b>		
No ACEs	88.0	81.2-92.6	No ACEs	41.7	36.9-46.7
1 ACE	93.2	78.2-98.2	1 ACE	38.1	31.1-45.5
2 or more ACEs <sup>#</sup>	92.0	69.1-98.3	2 or more ACEs	41.3	34.0-48.9
<b>Medical Home</b>			<b>Medical Home</b>		
No medical home	86.9	76.2-93.2	No medical home	42.1	36.6-47.8
Medical home	90.9	83.8-95.1	Medical home	39.9	35.2-44.9
<b>Overall</b>	89.7	84.4-93.4	<b>Overall</b>	40.6	37.1-44.2

<sup>#</sup>: Cell size <50, use caution with interpretation

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## Child Health Indicator by Population Characteristics Based on NSCH 2011/12 Data

### Organized Activities Participation 6-17 Years Old

### No Adverse Childhood Experiences (ACEs) 0-17 Years

	Weighted Prevalence (%)	95% Confidence Interval		Weighted Prevalence (%)	95% Confidence Interval
<b>Race</b>			<b>Race</b>		
White Only	87.9	81.8-92.2	White Only	58.9	52.7-64.9
Asian Only	87.7	81.9-91.8	Asian Only	62.5	56.0-68.6
NH/PI Only	75.8	67.3-82.7	NH/PI Only	43.8	37.0-50.8
Multiracial	86.4	81.1-90.3	Multiracial	49.9	44.5-55.3
<b>Federal Poverty Level</b>			<b>Federal Poverty Level</b>		
<100% FPL	69.4	59.8-77.6	<100% FPL	30.4	23.8-37.9
100-199% FPL	80.3	72.8-86.1	100-199% FPL	45.8	39.4-52.4
200-399% FPL	89.1	84.2-92.6	200-399% FPL	61.3	56.3-66.2
400%+ FPL	94.4	91.1-96.5	400%+ FPL	68.4	62.9-73.4
<b>Insurance Type</b>			<b>Insurance Type</b>		
Public	76.0	69.2-81.7	Public	34.3	29.0-40.0
Private	89.3	86.1-91.9	Private	62.6	59.0-66.1
<b>Age</b>			<b>Age</b>		
0-5 years	N/A	N/A	0-5 years	66.3	60.8-71.3
6-11 years	84.2	79.9-87.8	6-11 years	56.7	51.6-61.6
12-17 years	85.7	81.4-89.1	12-17 years	38.0	33.3-43.0
0-8 years	N/A	N/A	0-8 years	65.2	60.9-69.2
9-17 years	85.8	82.3-88.7	9-17 years	41.9	37.9-46.1
<b>Gender</b>			<b>Gender</b>		
Male	82.4	77.8-86.2	Male	51.8	47.6-56.1
Female	87.5	83.5-90.7	Female	55.3	50.8-59.6
<b>ACEs</b>			<b>ACEs</b>		
No ACEs	87.7	83.6-90.8	No ACEs	N/A	N/A
1 ACE	84.2	77.8-89.0	1 ACE	N/A	N/A
2 or more ACEs	80.7	73.7-86.1	2 or more ACEs	N/A	N/A
<b>Medical Home</b>			<b>Medical Home</b>		
No medical home	81.0	75.8-85.2	No medical home	45.6	40.8-50.5
Medical home	88.3	84.6-91.3	Medical home	59.9	55.8-63.9
<b>Overall</b>	85.0	82.2-87.7	<b>Overall</b>	53.6	50.6-56.7

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## Child Health Indicator by Population Characteristics Based on NSCH 2011/12 Data

### Volunteered in Past Year 12-17 Years Old

	Weighted Prevalence (%)	95% Confidence Interval
<b>Race</b>		
White Only	90.7	80.8-95.7
Asian Only	81.1	71.1-88.3
NH/PI Only	72.9	60.6-82.5
Multiracial	80.5	71.4-87.3
<b>Federal Poverty Level</b>		
<100% FPL	61.8	46.7-75.0
100-199% FPL	87.2	77.4-93.1
200-399% FPL	83.4	75.2-89.2
400%+ FPL	83.5	75.2-89.5
<b>Insurance Type</b>		
Public	71.8	60.6-80.8
Private	85.4	80.5-89.2
<b>Age</b>		
0-5 years	N/A	N/A
6-11 years	N/A	N/A
12-17 years	81.0	76.3-85.0
0-8 years	N/A	N/A
9-17 years	N/A	N/A
<b>Gender</b>		
Male	77.4	70.4-83.2
Female	84.7	77.9-89.6
<b>ACEs</b>		
No ACEs	85.3	79.2-89.9
1 ACE	76.9	66.2-85.0
2 or more ACEs	80.0	70.7-86.9
<b>Medical Home</b>		
No medical home	71.0	63.0-77.9
Medical home	88.7	82.7-92.8
<b>Overall</b>	81.0	76.3-85.0

### Worked in Past Week 12-17 Years Old

	Weighted Prevalence (%)	95% Confidence Interval
<b>Race</b>		
White Only <sup>#</sup>	30.9	20.9-43.0
Asian Only <sup>#</sup>	11.6	7.3-18.2
NH/PI Only <sup>#</sup>	22.4	14.6-32.7
Multiracial <sup>#</sup>	24.3	16.7-33.9
<b>Federal Poverty Level</b>		
<100% FPL	*	*
100-199% FPL <sup>#</sup>	16.6	9.7-26.8
200-399% FPL	30.5	22.8-39.6
400%+ FPL <sup>#</sup>	23.4	16.7-31.7
<b>Insurance Type</b>		
Public <sup>#</sup>	16.7	10.4-25.9
Private	26.5	21.3-32.4
<b>Age</b>		
0-5 years	N/A	N/A
6-11 years	N/A	N/A
12-17 years	23.2	19.0-27.9
0-8 years	N/A	N/A
9-17 years	N/A	N/A
<b>Gender</b>		
Male	21.5	16.3-27.7
Female	24.9	18.6-32.4
<b>ACEs</b>		
No ACEs	28.4	21.7-36.2
1 ACE <sup>#</sup>	24.8	16.9-35.0
2 or more ACEs <sup>#</sup>	14.6	9.5-21.8
<b>Medical Home</b>		
No medical home <sup>#</sup>	18.9	13.5-25.8
Medical home	26.6	20.4-33.8
<b>Overall</b>	23.2	19.0-27.9

<sup>#</sup>: Cell size <50, use caution with interpretation

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## Child Health Indicator by Population Characteristics Based on NSCH 2011/12 Data

### Excellent/Very Good Maternal Health Status 0-17 Years Old

	Weighted Prevalence (%)	95% Confidence Interval
<b>Race</b>		
White Only	66.3	59.9-72.1
Asian Only	62.5	56.2-68.4
NH/PI Only	54.9	47.3-62.2
Multiracial	59.4	53.8-64.7
<b>Federal Poverty Level</b>		
<100% FPL	44.9	36.7-53.3
100-199% FPL	56.0	49.2-62.6
200-399% FPL	66.7	61.7-71.3
400%+ FPL	68.6	63.0-73.7
<b>Insurance Type</b>		
Public	44.7	38.5-51.1
Private	67.4	63.9-70.7
<b>Age</b>		
0-5 years	62.3	56.7-67.6
6-11 years	64.1	58.9-69.0
12-17 years	55.5	50.0-60.9
0-8 years	63.7	59.3-67.8
9-17 years	57.4	53.0-61.8
<b>Gender</b>		
Male	61.5	57.1-65.7
Female	59.7	55.2-64.0
<b>ACEs</b>		
No ACEs	72.1	68.3-75.5
1 ACE	50.8	44.2-57.4
2 or more ACEs	38.5	31.4-46.2
<b>Medical Home</b>		
No medical home	51.2	46.0-56.2
Medical home	68.0	64.0-71.7
<b>Overall</b>	60.6	57.5-63.7

### Excellent/Very Good Paternal Health Status 0-17 Years Old

	Weighted Prevalence (%)	95% Confidence Interval
<b>Race</b>		
White Only	74.5	68.3-79.8
Asian Only	57.4	50.7-63.7
NH/PI Only	54.4	46.2-62.4
Multiracial	61.5	55.5-67.1
<b>Federal Poverty Level</b>		
<100% FPL	47.4	38.0-57.0
100-199% FPL	56.4	49.0-63.6
200-399% FPL	67.1	61.9-72.0
400%+ FPL	70.7	65.1-75.8
<b>Insurance Type</b>		
Public	51.8	44.7-58.9
Private	66.7	63.0-70.3
<b>Age</b>		
0-5 years	66.0	60.2-71.4
6-11 years	66.4	60.9-71.4
12-17 years	55.3	49.5-61.0
0-8 years	66.4	61.9-70.7
9-17 years	58.5	53.8-63.1
<b>Gender</b>		
Male	63.8	59.3-68.1
Female	61.4	56.5-66.0
<b>ACEs</b>		
No ACEs	70.7	66.8-74.3
1 ACE	57.6	50.5-64.4
2 or more ACEs	37.6	29.7-46.2
<b>Medical Home</b>		
No medical home	54.1	48.7-59.5
Medical home	68.9	64.8-72.8
<b>Overall</b>	62.7	59.5-65.9

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N/A: Values not reported due to insufficient data or indicator not applicable to specific group

## Child Health Indicator by Population Characteristics Based on NSCH 2011/12 Data

### Household Tobacco Use 0-17 Years Old

	Weighted Prevalence (%)	95% Confidence Interval
<b>Race</b>		
White Only	15.8	11.7-20.9
Asian Only	25.2	19.9-31.5
NH/PI Only	36.0	29.4-43.1
Multiracial	28.0	23.4-33.0
<b>Federal Poverty Level</b>		
<100% FPL	44.3	36.6-52.3
100-199% FPL	30.4	24.8-36.8
200-399% FPL	20.0	16.4-24.2
400%+ FPL	14.8	11.1-19.3
<b>Insurance Type</b>		
Public	38.7	33.2-44.6
Private	19.8	17.0-22.9
<b>Age</b>		
0-5 years	29.0	24.2-34.3
6-11 years	24.8	20.6-29.6
12-17 years	23.5	19.3-28.2
0-8 years	27.8	24.0-31.9
9-17 years	23.7	20.2-27.6
<b>Gender</b>		
Male	26.7	23.0-30.9
Female	24.6	21.1-28.5
<b>ACEs</b>		
No ACEs	19.7	16.5-23.2
1 ACE	31.4	25.9-37.6
2 or more ACEs	34.4	28.2-41.3
<b>Medical Home</b>		
No medical home	29.8	25.5-34.5
Medical home	23.2	19.9-26.9
<b>Overall</b>	25.7	23.0-28.4

### Shared Meals Everyday 0-17 Years Old

	Weighted Prevalence (%)	95% Confidence Interval
<b>Race</b>		
White Only	52.3	46.1-58.5
Asian Only	55.0	48.9-61.0
NH/PI Only	53.6	46.5-60.5
Multiracial	49.1	43.6-54.5
<b>Federal Poverty Level</b>		
<100% FPL	56.0	48.2-63.6
100-199% FPL	53.5	46.9-59.9
200-399% FPL	51.4	46.3-56.4
400%+ FPL	48.8	43.3-54.3
<b>Insurance Type</b>		
Public	54.8	48.9-60.6
Private	51.0	47.4-54.6
<b>Age</b>		
0-5 years	65.1	59.7-70.1
6-11 years	49.9	44.9-54.9
12-17 years	41.6	36.5-46.9
0-8 years	61.5	57.2-65.6
9-17 years	42.7	38.5-47.0
<b>Gender</b>		
Male	55.2	51.0-59.4
Female	48.9	44.5-53.2
<b>ACEs</b>		
No ACEs	56.4	52.4-60.3
1 ACE	49.2	43.0-55.5
2 or more ACEs	44.9	38.1-51.9
<b>Medical Home</b>		
No medical home	51.2	46.3-56.0
Medical home	52.8	48.8-56.8
<b>Overall</b>	52.1	49.1-55.2

#: Cell size <50, use caution with interpretation

\*: Estimate does not meet standards for reliability and precision, relative standard error >30%

N/A: Values not reported due to insufficient data or indicator not applicable to specific group



## Child Health Indicator by Population Characteristics Based on NSCH 2011/12 Data

### More than 1 Hour Average Screen Time per Weekday, 1-5 Years Old

	Weighted Prevalence (%)	95% Confidence Interval
<b>Race</b>		
White Only <sup>#</sup>	35.5	25.4-47.1
Asian Only <sup>#</sup>	40.5	29.6-52.4
NH/PI Only	58.2	45.2-70.2
Multiracial	39.7	31.4-48.7
<b>Federal Poverty Level</b>		
<100% FPL	51.4	38.8-63.9
100-199% FPL	48.9	38.0-59.9
200-399% FPL	40.9	32.3-50.2
400%+ FPL <sup>#</sup>	29.8	20.8-40.8
<b>Insurance Type</b>		
Public	44.1	35.1-53.6
Private	40.7	34.2-47.5
<b>Age</b>		
1-5 years	42.8	37.5-48.2
6-11 years	N/A	N/A
12-17 years	N/A	N/A
0-8 years	N/A	N/A
9-17 years	N/A	N/A
<b>Gender</b>		
Male	44.9	37.4-52.5
Female	40.6	33.3-48.3
<b>ACEs</b>		
No ACEs	41.2	34.8-47.9
1 ACE	46.7	35.4-58.3
2 or more ACEs <sup>#</sup>	46.9	31.1-63.4
<b>Medical Home</b>		
No medical home	46.3	37.3-55.5
Medical home	42.1	35.5-49.1
<b>Overall</b>	42.8	37.5-48.2

### More than 1 Hour Average Screen Time per Weekday, 6-17 Years Old

	Weighted Prevalence (%)	95% Confidence Interval
<b>Race</b>		
White Only	36.4	29.9-43.5
Asian Only	51.9	44.7-59.1
NH/PI Only	54.5	46.0-62.7
Multiracial	47.8	41.2-54.5
<b>Federal Poverty Level</b>		
<100% FPL	56.3	46.5-65.6
100-199% FPL	55.7	47.5-63.7
200-399% FPL	43.3	37.6-49.3
400%+ FPL	39.7	33.9-45.8
<b>Insurance Type</b>		
Public	53.8	46.3-61.1
Private	44.8	40.7-49.0
<b>Age</b>		
0-5 years	N/A	N/A
6-11 years	47.2	42.2-52.2
12-17 years	47.9	42.7-53.1
0-8 years	N/A	N/A
9-17 years	48.1	43.9-52.4
<b>Gender</b>		
Male	47.9	42.8-52.9
Female	47.2	42.0-52.5
<b>ACEs</b>		
No ACEs	45.0	40.1-50.0
1 ACE	47.2	39.9-54.6
2 or more ACEs	54.1	46.4-61.6
<b>Medical Home</b>		
No medical home	53.0	47.3-58.7
Medical home	43.1	38.3-47.9
<b>Overall</b>	47.5	43.9-51.2

<sup>#</sup>: Cell size <50, use caution with interpretation

\*: Estimate does not meet standards for reliability and precision, relative standard error >30%

N/A: Values not reported due to insufficient data or indicator not applicable to specific group

## Child Health Indicator by Population Characteristics Based on NSCH 2011/12 Data

### More than 1 Hour Average Electronic Device Use per Weekday, 1-5 Years Old

	Weighted Prevalence (%)	95% Confidence Interval
<b>Race</b>		
White Only <sup>#</sup>	*	*
Asian Only <sup>#</sup>	*	*
NH/PI Only <sup>#</sup>	23.1	14.1-35.6
Multiracial <sup>#</sup>	9.9	5.8-16.5
<b>Federal Poverty Level</b>		
<100% FPL <sup>#</sup>	15.4	8.8-25.5
100-199% FPL <sup>#</sup>	16.9	9.9-27.3
200-399% FPL <sup>#</sup>	14.9	8.8-23.9
400%+ FPL <sup>#,*</sup>	11.7	5.3-23.9
<b>Insurance Type</b>		
Public <sup>#</sup>	15.6	10.1-23.2
Private <sup>#</sup>	13.5	8.9-19.8
<b>Age</b>		
1-5 years	14.8	11.1-19.4
6-11 years	N/A	N/A
12-17 years	N/A	N/A
0-8 years	N/A	N/A
9-17 years	N/A	N/A
<b>Gender</b>		
Male	18.2	12.7-25.3
Female	11.5	7.1-17.9
<b>ACEs</b>		
No ACEs	16.1	11.3-22.5
1 ACE <sup>#</sup>	9.5	5.4-16.3
2 or more ACEs <sup>#</sup>	*	*
<b>Medical Home</b>		
No medical home <sup>#</sup>	14.1	8.8-21.8
Medical home <sup>#</sup>	14.7	10.0-21.1
<b>Overall</b>	14.8	11.1-19.4

### More than 1 Hour Average Electronic Device Use per Weekday, 6-17 Years Old

	Weighted Prevalence (%)	95% Confidence Interval
<b>Race</b>		
White Only	28.8	22.2-36.3
Asian Only	44.2	37.0-51.6
NH/PI Only	39.8	31.8-48.3
Multiracial	33.9	27.9-40.4
<b>Federal Poverty Level</b>		
<100% FPL	37.5	28.7-47.3
100-199% FPL	41.2	33.3-49.6
200-399% FPL	33.4	28.0-39.2
400%+ FPL	32.0	26.3-38.3
<b>Insurance Type</b>		
Public	39.4	32.4-46.9
Private	33.5	29.6-37.6
<b>Age</b>		
0-5 years	N/A	N/A
6-11 years	18.9	15.2-23.1
12-17 years	52.1	46.8-57.3
0-8 years	N/A	N/A
9-17 years	42.2	38.1-46.5
<b>Gender</b>		
Male	35.9	31.1-40.9
Female	35.1	30.2-40.3
<b>ACEs</b>		
No ACEs	28.0	23.9-32.4
1 ACE	39.7	32.7-47.2
2 or more ACEs	46.6	39.0-54.4
<b>Medical Home</b>		
No medical home	38.9	33.5-44.5
Medical home	31.9	27.4-36.7
<b>Overall</b>	33.5	32.1-39.1

<sup>#</sup>: Cell size <50, use caution with interpretation

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N/A: Values not reported due to insufficient data or indicator not applicable to specific group

## Child Health Indicator by Population Characteristics Based on NSCH 2011/12 Data

### Usually/Always Safe in Community 0-17 Years Old

	Weighted Prevalence (%)	95% Confidence Interval
<b>Race</b>		
White Only	93.3	89.6-95.7
Asian Only	82.3	77.0-86.5
NH/PI Only	82.2	76.2-87.0
Multiracial	88.1	83.9-91.3
<b>Federal Poverty Level</b>		
<100% FPL	77.4	70.1-83.4
100-199% FPL	84.5	79.4-88.6
200-399% FPL	88.3	84.5-91.3
400%+ FPL	94.8	92.3-96.5
<b>Insurance Type</b>		
Public	83.2	78.4-87.2
Private	88.9	86.4-91.0
<b>Age</b>		
0-5 years	88.5	85.1-91.1
6-11 years	84.9	80.4-88.5
12-17 years	87.5	83.4-90.7
0-8 years	86.7	83.6-89.3
9-17 years	87.2	83.9-89.9
<b>Gender</b>		
Male	86.1	82.8-88.9
Female	87.8	84.7-90.3
<b>ACEs</b>		
No ACEs	91.2	88.7-93.2
1 ACE	81.6	76.3-86.0
2 or more ACEs	82.7	76.5-87.5
<b>Medical Home</b>		
No medical home	80.8	76.5-84.5
Medical home	91.6	89.1-93.5
<b>Overall</b>	87.0	84.9-89.0

### Usually/Always Safe at School 6-17 Years Old

	Weighted Prevalence (%)	95% Confidence Interval
<b>Race</b>		
White Only	93.9	88.2-97.0
Asian Only	87.8	80.9-92.4
NH/PI Only	78.0	69.4-84.7
Multiracial	96.1	92.0-98.1
<b>Federal Poverty Level</b>		
<100% FPL	77.7	67.4-85.5
100-199% FPL	84.2	76.4-89.8
200-399% FPL	94.1	90.3-96.5
400%+ FPL	96.9	92.8-98.7
<b>Insurance Type</b>		
Public	84.4	77.3-89.7
Private	92.1	89.0-94.4
<b>Age</b>		
0-5 years	N/A	N/A
6-11 years	91.9	87.7-94.8
12-17 years	87.5	83.1-90.9
0-8 years	N/A	N/A
9-17 years	89.4	86.0-92.1
<b>Gender</b>		
Male	90.2	85.9-93.3
Female	89.2	84.8-92.5
<b>ACEs</b>		
No ACEs	94.3	90.9-96.5
1 ACE	86.7	79.5-91.7
2 or more ACEs	84.8	78.0-89.8
<b>Medical Home</b>		
No medical home	83.9	78.6-88.1
Medical home	95.0	91.5-97.1
<b>Overall</b>	89.7	87.1-92.3

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## Additional Resources:

<http://health.hawaii.gov/>

<http://www.nschdata.org>

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# FEEDBACK SURVEY

Family Health Services Division  
Attn: Health Status of Children in Hawai'i Data Book Feedback Survey  
1250 Punchbowl St, Room 216  
Honolulu, HI 96813  
FAX: (808) 586-9303

The Family Health Services Division is committed to making the *Health Status of Children in Hawai'i Data Book* as useful and user-friendly as possible. Please complete this questionnaire and mail or fax it to us. The form could also be completed online at <http://health.hawaii.gov/health/doc/eval.pdf>. Mahalo for your assistance.

## Organizational Identity (circle one)

1. Your organization or role is best described as a:

(a) Community non-profit organization

(c) Student/Educational institution

(e) Political representative

(g) Other: \_\_\_\_\_

(b) Government office

(d) For-profit clinical provider

(f) Private citizen

## Feedback on the Data Book (select all that apply)

2. The Data Book helps you accomplish:

(a) Planning

(c) Grant writing

(e) Recruitment or retention of providers

(b) Needs assessment

(d) Facility or services planning

(f) Other: \_\_\_\_\_

3. Please describe how you use the information shared in this book (knowing specific examples would be helpful).

4. Which health indicators/information did you use most often in your work?

5. Which health indicators/information were less important in your work?

6. What other data/information would you like included in future Data Books?







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This report is available online at:  
<http://health.hawaii.gov/about/publications/health-status-of-children-in-hawaii-report>

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