

STATE OF HAWAI‘I MATERNAL & CHILD HEALTH NEEDS ASSESSMENT SUMMARY

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Department of Health
State of Hawai‘i
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Family Health
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The following is a summary of the 2010 Maternal and Child Health (MCH) Needs Assessment (NA) report completed by the Department of Health Family Health Services Division in compliance with the federal Title V Maternal Child Health Block Grant guidance which requires the completion of a population based needs assessment every five years. This Summary highlights the NA process and outcomes: the identification of seven state MCH priority issues. General descriptive data for the state and MCH population in Hawai'i is also included.

More detailed data and information on the MCH population health status, disparities, and service system capacity can be found in the complete version of the Hawai'i Title V Needs Assessment Report. A copy of the report is available through the federal Title V Information System website at:

<https://perfdata.hrsa.gov/MCHB/TVISReports/NeedsAssessment.aspx>.

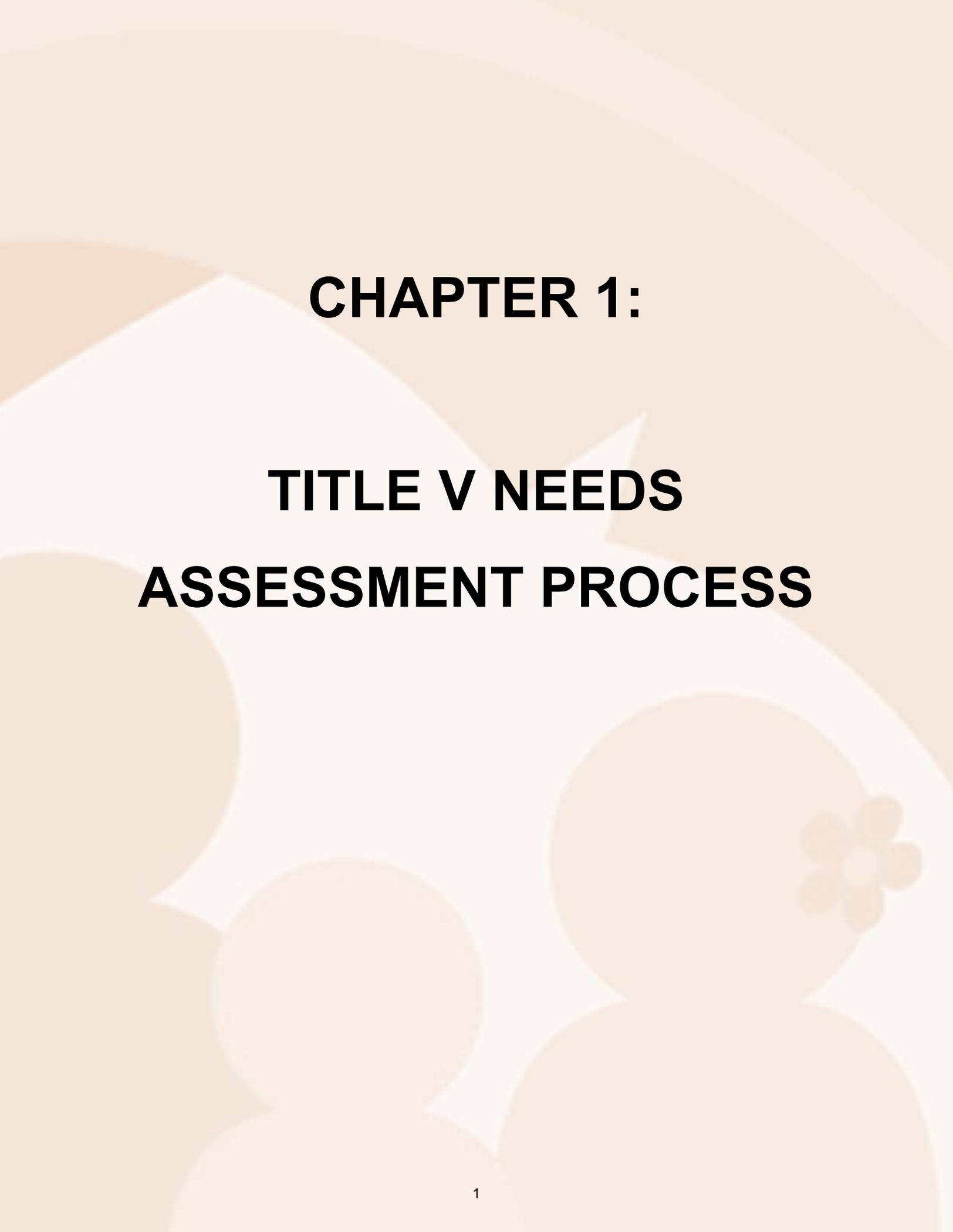
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CHAPTER 1:

TITLE V NEEDS

ASSESSMENT PROCESS

Federal Title V Maternal & Child Health Block Grant

The Department of Health (DOH) Family Health Services Division (FHSD) is the state maternal and child health (MCH) agency serving the needs of women, infants, children, families and children with special health care needs (CSHCN). FHSD receives a federal MCH Block grant which requires the completion of a population based needs assessment every five years. The goal of the needs assessment is to identify and address state priority health issues in partnership with community stakeholders that affect the MCH population. Input from hundreds of stakeholders was compiled through surveys and interviews from Fall 2008 through Spring 2009, coupled with other critical information to identify seven priority issues for this population.

The Title V needs assessment (NA) was conducted in the midst of the state's historically unprecedented economic decline. As a result of the global recession, Hawai'i experienced a very rapid and steep economic and fiscal decline. In one year the overall state government budget went from a \$330M surplus to a projected deficit of \$1.2B for the biennium (out of a \$10B budget).

The state experienced the closure of businesses, high unemployment with a concomitant increase of enrollment into entitlement programs and services. For state government, the economic decline resulted in dramatic budget cuts, the elimination of programs, and a reduction in workforce, more than 300 positions for the state DOH (58 FHSD positions were eliminated). Furthermore, the state also implemented two day per month furloughs for state workers beginning October 2009.

Service programs lost millions of dollars in state funding and witnessed similar reductions in private donations. The system of services residents had come to depend on was in rapid decline at a time when there was increased demand for these programs. Given this context, the Title V NA activities proved to be timely. The need to improve coordination and collaboration among services has become ever more critical to assure existing resources are used more effectively.

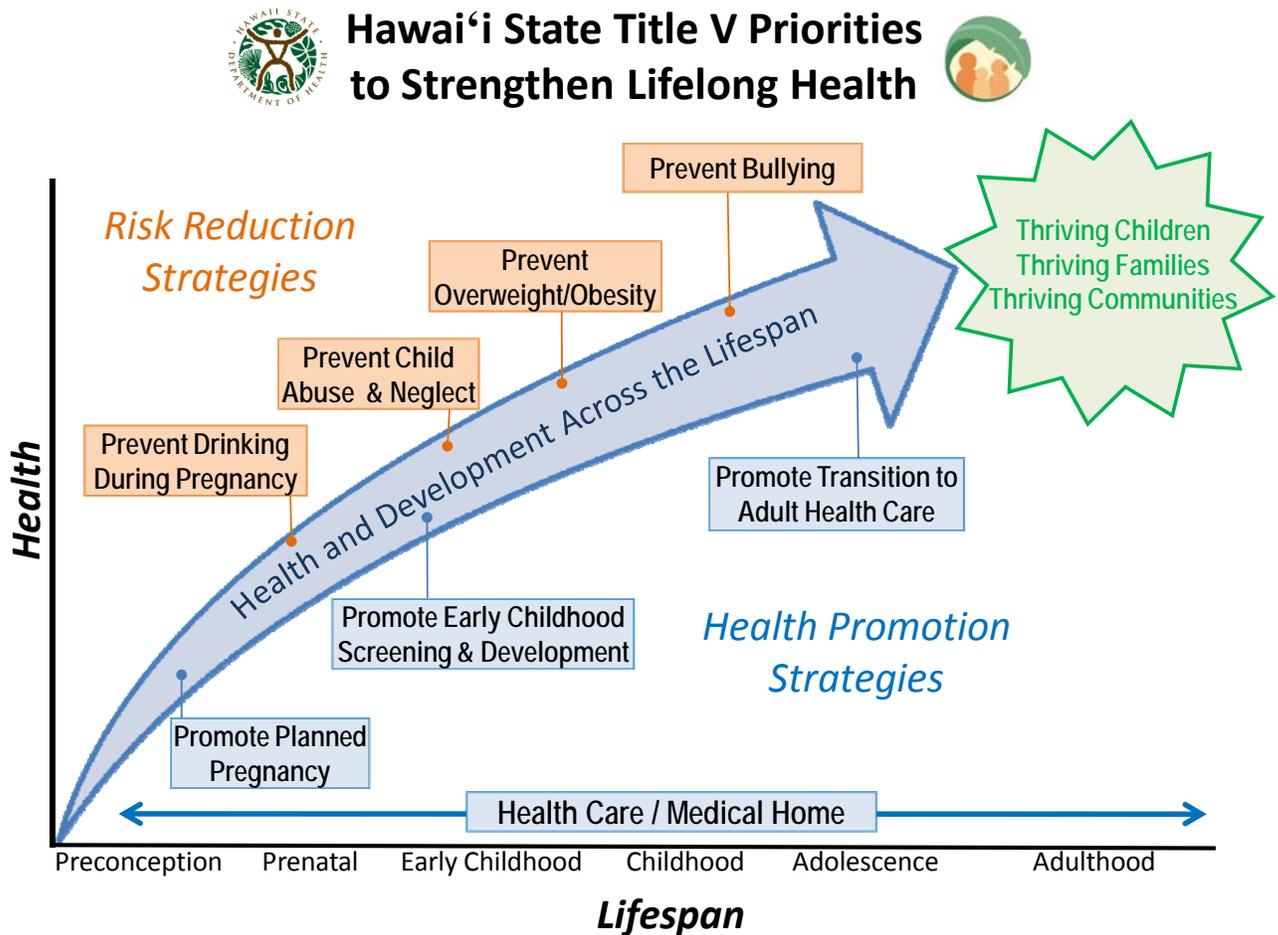
Hawai'i Maternal Child Health Priorities

Seven priority issues were identified through the Title V Maternal and Child Health (MCH) needs assessment (NA) process. These priorities are expected to be the programmatic focus for the Family Health Services Division (FHSD), the state Title V MCH agency, in conjunction with many of our partnering organizations during the next five years (2010-2015). The 7 priorities for the state MCH population are:

1. Reduce the rate of unintended pregnancy
2. Reduce the rate of alcohol use during pregnancy
3. Improve the percentage of children screened early and continuously age 0-5 for developmental delay
4. Improve the percentage of youth with special health care needs age 14-21 years who receive services necessary to make transitions to adult health care
5. Reduce the rate of child abuse and neglect with special attention on ages 0-5 years
6. Reduce the rate of overweight and obesity in young children ages 0-5
7. Prevent bullying behavior among children with special attention on adolescents age 11-18 years.

The priority issues are depicted in Chart 1-1 as key intervention points during the lifespan to assure lifelong health.

Chart 1-1: Hawai'i State Title V Priorities to Strengthen Lifelong Health



NA Process

The NA process involved two phases comprised of two major components:

Phase 1:

Problem definition: identify preliminary list of health issues

Prioritization: identify final list of priorities utilizing specific criteria scoring

Phase 2:

Problem Analysis: identify key goals, targeted behaviors, determinants/influencing factors, existing services

Strategy Design: identify strategies in conjunction with stakeholders

Leadership

The NA process was planned and managed by a Steering Committee comprised of FHSD senior management to provide guidance, assure progress, and coordinate efforts between work groups. Neighbor Island FHSD Coordinators were also included on the Steering Committee to ensure that the issues were of statewide concern. A workgroup was established for each of the three target populations:

- Women and Infants (WI),
- Child and Adolescent (CA), and
- Children with Special Health Care Needs (CSHCN).

Issue Identification

Each population workgroup conducted formal stakeholder surveys of service providers, advocates, and consumers utilizing traditional and electronic survey methods. Data was analyzed and incorporated into the issue prioritization decisions for the population workgroups. Reports on the stakeholder surveys and the major results are found in Appendix A-1 of the complete NA report on the national Title V information website at <https://perfdata.hrsa.gov/MCHB/TVISReports/NeedsAssessment.aspx>. Findings were shared with stakeholders who were surveyed.

Each population workgroup identified an initial list of possible health issues numbering from 15-20 based on a review of previous NA priority issues, input received from staff, stakeholders, literature reviews, and existing data. Then each population workgroup used a prioritization process/criteria to develop a short-list of no more than 5 issues. The results of formal stakeholder surveys were used to reduce the list of issues. The Child and Adolescent and Women and Infants population workgroups used similar criteria as the basis to select their final list of issues:

- Extent of the Problem (measured by data on HI rates)
- Urgency/Severity (measured by comparison of HI rates to national rates, trend data)
- Amendable to Change (existing best practices/programs in place found to be effective)

The Child and Adolescent group added two more capacity criteria given the looming threat of staff layoffs and substantial budget cuts:

- Available community resources/partners, and
- Available FHSD leadership/staffing.

Issues were scored by group members based on the criteria and discussion. Through general consensus, final issues were selected for each population.

The CSHN group used a unique process that grouped related issues identified through stakeholder surveys into broader categories to arrive at a final selection. For example, numerous topics identified by parents and providers concerning development-behavior issues; social-emotional issues; and developmental and autism screening were merged into the larger CSHCN topic of child development. Their decision-making process is captured in a matrix that can also be found in Appendix A-1 of the complete NA report at <https://perfdata.hrsa.gov/MCHB/TVISReports/NeedsAssessment.aspx>.

The three population workgroups identified a total of eleven issues. Presentations were developed by the workgroups for each of the eleven issues selected.

Priority-Setting

The Title V MCH Block Grant guidance requires each state to select 7-10 state priority issues, thus the list of eleven issues was pared down further. Final state priority setting was conducted over two-days in June 2009. In preparation for the June priority setting meetings, the NA Steering Committee identified selection criteria (see page 8). After the presentations were made on the eleven issues, the Steering Committee members scored the issues using the criteria and eight state priority issues were selected: Bullying, Child Abuse & Neglect, Child Obesity, Prenatal Alcohol Use, Unintended Pregnancy, Access to Specialty Care on the Neighbor Islands for CSHN, Identification of Children with Developmental Delays, and Transition to Adult Healthcare for YCHCN. Because some of the issues were very close in scoring, final selections were made to assure an equitable number of issues were chosen for each population workgroup. The three issues dropped from consideration were: Chlamydia, Perinatal Depression, and Intimate Partner Violence. Later in the process, Access to Specialty Care would be dropped due to FHSD staff reductions and budget cuts.

Formation of Issue Workgroups

Workgroups were established for each of the priority issues led by FHSD staff. A general process for the workgroup was developed by the NA Steering Committee with staff (see pages 9-10). The process was largely based on the previous NA with more detailed instructions, staff support, and training.

Issue workgroups were required to develop problem maps, fact sheets, resource lists, and identify a performance measure (to monitor progress in the annual Title V Block Grant report), and conduct an evaluation/summary of the work completed (to assure staff progress, skills development, documentation of lessons learned to improve further NA work in the future).

Problem Analysis

The purpose of conducting the problem analysis was to understand the nature of each health issue based on research, data, expert opinion, experience and practice in the field and stakeholder input. Contributing factors, determinants, that influence or are associated with the health issue were identified and could include: key behaviors, risk/protective factors, demographic characteristics, systems issues, or societal influences. The information is “mapped” into three separate levels: Primary (individual behaviors/characteristics), Secondary (community/institutional settings), and Tertiary (policy, systems, societal influences).

Copies of the issue problem maps are in Chapter 7 of this summary document. The maps are a tool that captures the current understanding/research of the health issue with input from stakeholders. The information is used to inform strategy decisions. Maps may be revised as new research and understanding of the problem evolves.

Resource Assessments

The purpose of the resource assessment is to capture the major resources that can be utilized to identify and help implement strategies to address the health issue. Resources include programs, services, policies, funding, expertise, key stakeholders. Issue workgroups were asked to develop a list of the ten major programs, services, policy initiatives that affect their health issue and provide a short description of each resource. The resource list also included a description of how the resources have been affected by the economic downturn (loss of key programs, loss of staffing/funding, increased caseloads/needs), if at all. The intent was to help the workgroup identify the key partners/resources that would likely be engaged/utilized initially to identify collaborative strategies. The report also included timely updates on the status of resources (i.e. programs and services). Lastly, Issue Workgroups were asked to identify any opportunities for new funding or new collaborations (i.e. federal American Recovery and Reinvestment Act funds).

Workgroups employed various methods to complete this task including conducting “environmental scans”, surveys, key informant interviews, other research to get updated information. In the summer of 2009 the national Child Safety Network (CSN) provided technical assistance to further the needs assessment work on the two injury/violence related issues: child abuse and neglect (CAN) and bullying prevention. To assist with the identification of strategies to strengthen the state’s service system, FHSD conducted a brief survey of family service programs that help prevent child abuse and neglect to identify potential service system needs in light of the poor economy. A similar scan was conducted for bullying prevention programs.

Like the problem maps the resource assessment/lists are a working tool that will be updated periodically as further information/input from stakeholders is compiled.

Strategy Design

Given the current working environment, the Issue Workgroups were asked to identify 1-3 strategies and plan implementation. A critical part of the strategy design is to identify the strategies in collaboration with the key partners identified through the Resource Assessments. The Issue Workgroups were asked to consider evidence-based or recommended practices, determine if any best or promising practices exist in Hawai’i and lastly, to develop a logic model for each strategy. Many of the Issue Workgroups are using the dissemination of the fact sheet to generate discussion on strategies with stakeholders, inviting external community stakeholders to regular workgroups meetings, conducting key informant interviews, and attending meetings of related groups to collect input. A few groups are also considering short surveys to collect feedback. Collaborative planning software used by other DOH programs is also being investigated.

Fact Sheets

Issue Workgroups were asked to develop fact sheets to help network, build awareness of the issues, and mobilize greater involvement and partnerships. A template for the fact sheet was developed to

highlight the key information compiled through the NA process. The fact sheets provide a short description of the health issue, present one or two key data points, summarize the problem (from the problem analysis), highlight a few major resources (from the resource assessment), and present possible strategies for consideration. The fact sheets are attached in Chapter 6 of this summary report. As the Issue Workgroups circulate the fact sheets to engage stakeholders and solicit important feedback, the fact sheet content is revised.

Performance Measure

Issue Workgroups were also asked to identify a performance measure to monitor progress over the next 5 years for the Title V annual Block Grant report/application. The measures for each health issue are listed in Chapter 8 of this summary report.

Refining of Issues

With decreased capacity through state budget cuts, elimination of programs, and imminent staff reductions and early retirements, FHSD decided to eliminate one of the original priorities identified in June 2009: access to specialty care on the neighbor islands. While the CSHN Branch would continue to address this issue through its programmatic work, the FHSD NA Steering Committee decided the scope of the issue was too broad and was largely outside the purview of the Division.

Based on data/information compiled through September 2009, several of the issues were refined to focus on specific target groups, making the NA work more manageable for FHSD's reduced workforce. The greater focus on targeted "gap" groups also helped to further clarify the role of the FHSD in the larger statewide service system.

Based on an initial environmental scan, the Bullying Prevention Group decided to focus efforts on adolescence since many bullying prevention programs focused primarily on elementary school children.

The Transition Workgroup decided to focus its efforts on transition to adult health care for youth with special health care needs versus all aspects of transition to adulthood. The workgroup will partner with other agencies focused on providing transition planning and support services for employment, education, and independent living.

Based on the recent research on the importance of early childhood, the child abuse and neglect group will focus efforts on ages 0-5 years as will the Child Obesity Workgroup.

Stakeholders

Input from stakeholders was collected for all phases of the NA including planning of the process. Various methods were used to assure ongoing input and participation including videoconferencing, telephone conference calls, community meetings, focus groups, coalition meetings, email, surveys and interviews. Stakeholders were used strategically to take advantage of their specific expertise and interest in the NA process. The process has helped to identify new stakeholders and improve working relationships with existing agency partners. Descriptions of the key MCH stakeholders, agencies and programs are provided in the complete NA report.

Summary of Prioritization Criteria for Title V Needs Assessment¹

1. Extent of the health issue within the target population

Incidence/prevalence in Hawai'i

2. Urgency/Severity of the health issue within the target population

Death &/or hospitalization over a person's lifetime?

Physical (disability, communicability, other health problems) consequences?

Social-emotional/economic consequences?

Are trends increasing/worsening over time?

Are Hawai'i rates higher than national rates?

3. Amenable to CHANGE in 5 years

Knowledge of intervention strategies & proven effectiveness

Evidence based strategies preferred

If strategy is not proven, then please indicate

4: Feasibility

- **Propriety**: Is the health issue one that falls within the Department of Health's overall mission?
- **Legality**: Does the Department of Health have authority under legislation or policy to implement an intervention/address the health issue?
- **Economics**: Does it make economic sense to address the health issue? Are there economic consequences if the health issue is not addressed?
- **Acceptability**: Is the intervention for the health issue acceptable to the state/legislature/community? Does the state/legislature/community identify the health issues identified as a problem?
- **Resources**: Are resources available or potentially available to address the problem (e.g., staffing, funding, data systems)?

¹ The criteria are adapted from tools developed by:

- the University of California, San Francisco Family Health Outcomes Project,
- the Washington State MCH program in 2000 using G. Pickett & JJ Hanlon in *Public Health Administration and Practice, 9th Edition*, St. Louis,: CV Mosby Company, 1990 and
- Centers for Disease Control, Guide for Establishing Public Health Priorities, modified from the CDC Case Study: Translating Science into Practice.

Health Issue Workgroup Process Steps for Division Needs Assessment

Family Health Services Division

Revised July 15, 2010

1. Complete **Problem Map** for Title V report

- ✓ *Purpose: to understand the nature of the problem using data and research findings*
- ✓ *Identify the risk, contributory, causal factors related to the problem.*
- ✓ *Incorporate data and research to identify evidence for factors. Develop a list of literature, websites, and information sources reviewed for the problem map.*
- ✓ *If map gets too complex, pare down factors to those that are most important, feasible to change*
- ✓ *Keep list of references, working bibliography to support factors in the map*

2. Complete **Fact Sheet** on the health issue (due **April 30**)

- ✓ *Purpose: to help educate and mobilize stakeholder participation*
- ✓ *Reflects current information/research to date on the issue including problem analysis, key resources, and collaborative strategies.*

3. Develop **1-2 page description of Resources** (due **May 15**)

- ✓ *Purpose: Capture the major resources that can be utilized to identify feasible strategies to address the issue*
- ✓ *Resources include programs, services, policies, funding, expertise, key stakeholders that can partner on strategies*
- ✓ *Describe how/whether the state service system capacity has changed due to the economic downturn. Are there more resources available to address this health issue or less?*
- ✓ *Compile a list of the 10 major programs, services, policy initiatives that affect your health issue. Provide a short description of each resource & describe how the resources have been affected by the economic downturn (loss of key programs, loss of staffing/funding, increased caseloads/needs)*
- ✓ *Identify whether there are opportunities for new funding or new collaborations*
- ✓ *May do "environmental scan", surveys, key informant interviews, other research to get updated information*

4. Identify at least 1 statewide **Measure** to monitor progress (due **May 1st**)

- ✓ *To be used to report on progress for the annual Title V block grant report to monitor long-term progress*

Health Issue Workgroup Process Steps for Division Needs Assessment *(continued)*

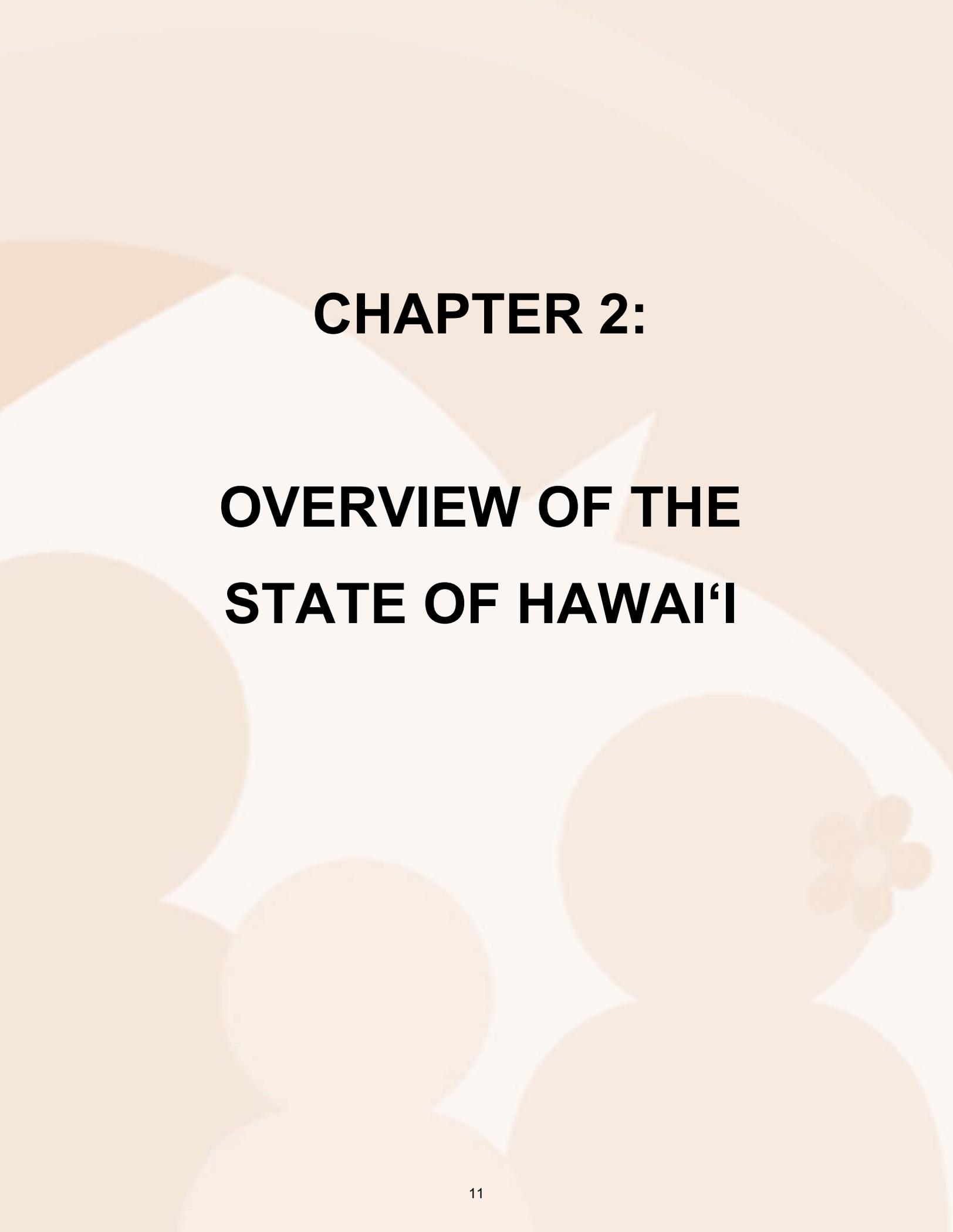
5. Complete 1-2 page summary report that addresses how each of the activities/steps were completed (due **May 24**)

- ✓ *Identify what data was used, key findings from your literature review, environmental scans, surveys, key informant interviews that helped develop the problem map, fact sheet, resource list.*
- ✓ *Identify how stakeholder input was used throughout the process*
- ✓ *Evaluate strengths/weaknesses of the NA process (Were there limitations to the data? Was training/technical assistance (TA) helpful? Was it challenging to engage stakeholders? Was stakeholder input used effectively? Did the process lead to staff development of public health expertise/skills building, improve collaboration, strengthen leadership capacity. Identify areas for improvement that may help to further work on your health issue. Identify any technical assistance/training needs)*

6. Select **1-3 feasible Actions/Strategies** & Develop Logic Model (**ongoing**)

- ✓ *Brainstorm strategies, seek input from stakeholders*
- ✓ *Work with stakeholders to select 1-3 strategies and plan implementation*
- ✓ *Consider evidence-based or recommended practices*
- ✓ *Determine if any best or promising practices exist in Hawai'i*
- ✓ *Briefly describe what information was used to identify the strategies & how stakeholder input/participation was used to select strategies (no more than 1 page)*
- ✓ *Logic model will help show how and what is needed to implement each strategy*

Note: *Although, deadlines have been identified for initial completion of the problem map, fact sheet, resource list, measure and strategies – all NA products are dynamic tools that will continue to be updated, modified and revised as new information, research and decisions are made over the next 5 years.*



CHAPTER 2:

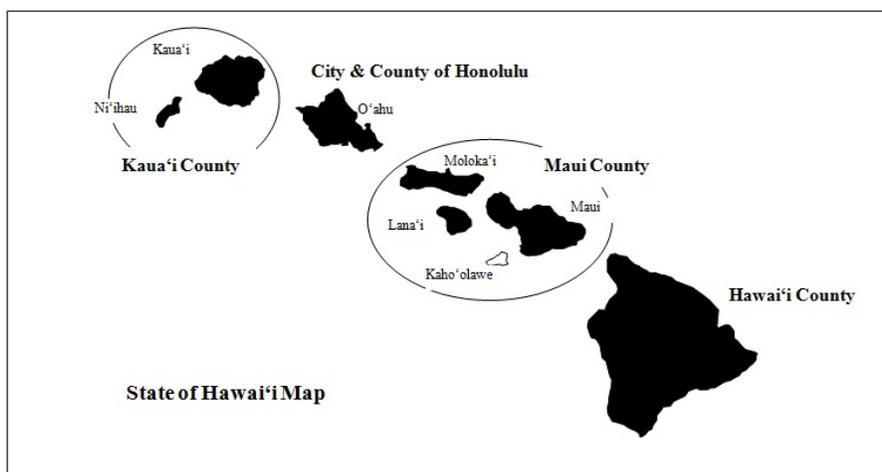
**OVERVIEW OF THE
STATE OF HAWAI‘I**

State Overview

Population and Ethnic Diversity

The State of Hawai'i is composed of seven inhabited islands within four major counties, amounting to 6,423 square miles of land area with an estimated total population of 1.8 million in 2008. Map 2-1 shows a layout of the islands.

Map 2-1 State of Hawai'i



Population Distribution

The City and County of Honolulu encompasses that entire island of Oahu and contains the majority of the population (70.3% of state residents). Honolulu is considered the only urbanized area in the state. The neighbor island counties are Hawai'i, Kauai (includes Niihau island), and Maui (includes Molokai, Lanai and Kahoolawe). Together, the neighboring counties represent only 29.7% of the State's total population. Refer to Table 2-1 for a summary of the population distribution for the state by county.

Overall the state grew by 6.3% between 2000 and 2008.² Hawai'i County experienced the largest growth between 2000 and 2008, an 18% increase, followed by Maui County (12%) and Kauai County (9%). Honolulu County experienced a 3% increase over the same time period.

Table 2-1 Summary of State and County Population Distribution: 2008

Hawai'i		Honolulu		Kauai		Maui		State of Hawai'i
No.	%	No.	%	No.	%	No.	%	
175,784	13.6%	905,034	70.3%	63,689	4.9%	143,691	11.2%	1,288,198

Source: U.S. Bureau of the Census, Federal-State Cooperative Program for Population Estimates, "Time Series of Hawai'i Intercensal Population Estimates by County: April 1, 1990 to April 1, 2000". Hawai'i State Department of Business, Economic Development & Tourism, State of Hawai'i Data Book 2008.

² Hawai'i State Department of Business, Economics Development and Tourism. Subcounty Population Estimates. <http://www.hawaii.gov/dbedt/info/census/population-estimate>. [accessed online July 12, 2010]

The geographic characteristics of the islands and the distances between islands have a major impact on access health care services and are one of the challenging and unique aspects of the State of Hawai'i. As the most populated and urbanized island, Oahu (Honolulu County) is the home to the majority of tertiary health care facilities, most of the specialty and subspecialty care, and the one perinatal Level III facility in the state. For the 29.7% of the population residing on the Neighbor Islands, access to health care on the island of Oahu is a financial hardship. The average round-trip airfare is between \$120 to \$200 with added costs for food, possibly lodging, and local transportation. This hardship is compounded for those neighbor island residents who do not live within a reasonable distance of their local airports. Most of the Neighbor Islands have underdeveloped roadways and limited, if any, public transportation or mass transit systems.

Emergency care for trauma and critical pediatrics must use the state's system for emergency medical air transport that consists of only one private company providing fixed wing air ambulance. Economic constraints have precluded providing consistent rapid transport to tertiary care for neighbor island residents putting them at risk for poor outcomes compared to urban residents.

Age and Gender Distribution

Hawai'i's population, like the nation as a whole is aging. The median age of the population has increased from 36.2 years in 2000 to 38.0 years in 2008, higher than the national average of 36.7. The trend toward an aging population is displayed in Table 2-2 through a comparison of the age distribution between 2000 and 2008. There were increases in the proportion in those 20-34, 55-74, and 75 years and older, while the proportion of children and youth age 0-19 years and younger adults 35-54 years decreased. The largest increase was among the elderly, those 75 years and older, representing a 33% increase since 2000, followed by a 26% increase among those 55-74 years of age.

Table 2-2 Comparison of Age Distribution 2000 & 2008				
Ages	2000	% of Total	2008	% of Total
0-19	327,251	27.0%	318,290	24.7%
20-34	254,568	21.0%	273,815	21.3%
35-54	362,156	29.9%	354,020	25.7%
55-74	192,223	15.9%	241,691	18.8%
75+	75,339	6.2%	100,382	7.8%
Median Age	36.2 years	*****	38.0 years	
Source: U.S. Census Bureau, Population Division, "Table 2: Annual Estimates of the Resident Population by Sex and Age for Hawai'i: April 1, 2000 to July 1, 2008. Hawai'i State Department of Business, Economic Development & Tourism, State of Hawai'i Data Book 2008."				

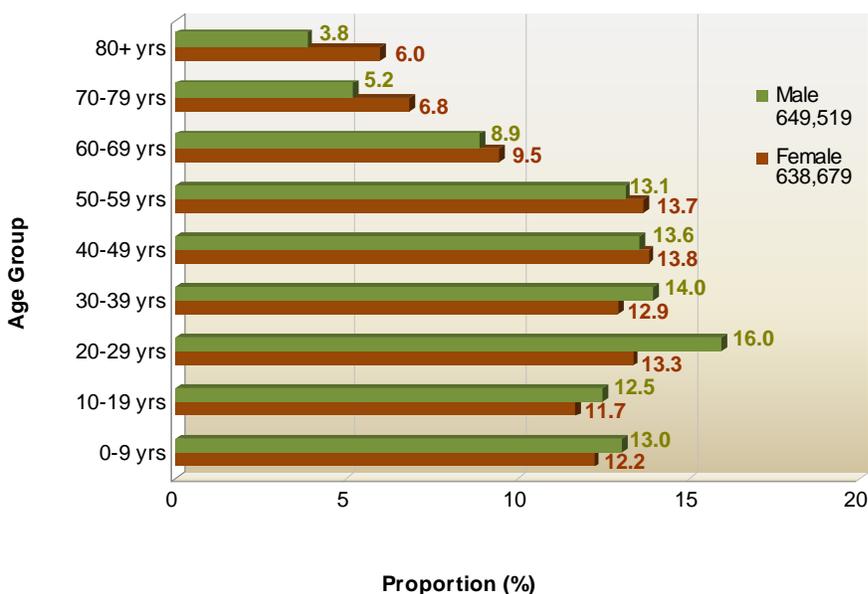
The proportions of females in the population in Hawai'i are generally more evenly distributed than males who have higher proportions at younger ages. It is estimated that 6.0% of the female population is 80 years and older, compared to 3.8% of the male population. At the other extreme, 12.2% of the female

population is under 10 years of age compared to 13.0% of the male population. The transition appears to occur around age 40, when the proportions of females begin to exceed the proportions of males in the age groups shown.

Like the nation, there are slightly more women than men living in Hawai'i. This is due largely to women's longer life expectancy (78.2 years for men compared to 83.3 years for women) in Hawai'i³ The average life expectancy in Hawai'i is greater than the U.S. overall (80.8 years in Hawai'i compared to 77.8 years for the U.S.).

The birth rate in Hawai'i (14.8 per 1,000 population) is similar to that of the nation (14.2 per 1,000).⁴ There has been little variability since 2000 in the birth rate (range 14.0-14.9) in Hawai'i. The fertility rate in Hawai'i (73.9 per 1,000 women aged 15-44 years) is higher than that of the nation (68.5 per 1,000). The death rate in Hawai'i in 2008 (7.3 per 1,000 population) represents a small increase from 2000 (6.7 per 1,000).

Chart 2-1 State of Hawai'i, Population Proportions by Age and Sex: 2008



Source: CC-EST2008-ALLDATA-[ST-FIPS]: Annual County Resident Population Estimates by Age, Sex, Race, and Hispanic Origin: April 1, 2000 to July 1, 2008.

Race/Ethnicity

The state's indigenous population of Native Hawaiians is descendents of the original inhabitants that settled the islands in 300AD. Prior to Western contact, Hawaiians developed a vibrant, sophisticated culture and a stable land tenure system that supported an estimated population of 1,000,000 people. Over 200 years of western colonization have left Hawai'i's indigenous population with some of the poorest statistics for health and mortality.

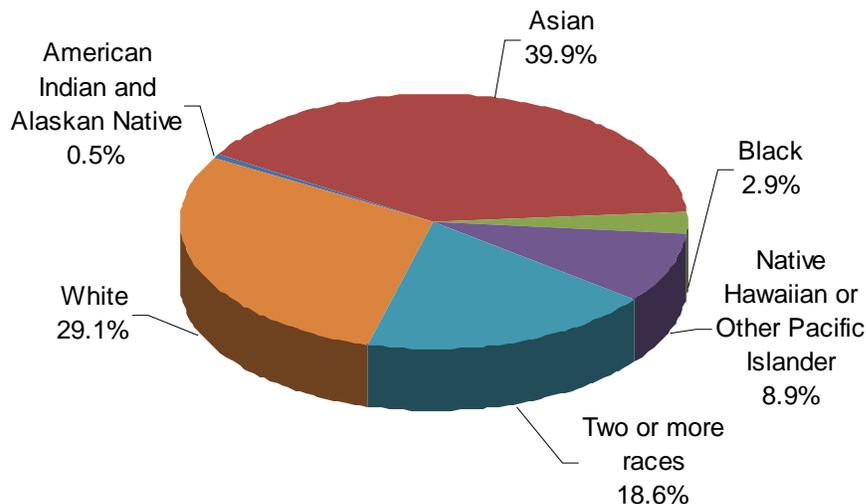
³ Hawai'i State Department of Business, Economic Development & Tourism, State of Hawai'i Data Book 2008.

⁴ Ibid, Table 2-11.

The racial/ethnic composition of Hawai'i is unique in the U.S. with no clear majority population, a large Asian, and a large proportion of those that report more than one racial group. Based on census bureau estimates that includes the ability to select more than one racial group, 18.6% of the population in Hawai'i report two or more races. The Native Hawaiian or other Pacific Islander single race group makes up only 8.9% of the population; whereas, the Asian group (which includes all Asian ethnicities) makes up 39.9% of the state population; and the White group makes up 29.1% of the population.

The racial categories typically utilized at the national level are not useful for the state in tracking disparities. African-Americans and Hispanics are large minority groups within much of the U.S., but are small groups within the state. However, Asian, Native Hawaiian, and Pacific Islander groups comprise most of the state population but are so small at the national level so are combined into one broad category.

Chart 2-2 State of Hawai'i, Population by Race: 2008



Source: CC-EST2007-ALLDATA-[ST-FIPS]: Annual County Resident Population Estimates by Age, Sex, Race, and Hispanic Origin: April 1, 2000 to July 1, 2007. Hawai'i State Department of Health, Family Health Services Division Profiles 2009.

Intermarriage is common in Hawai'i and many individuals claim multiple ethnic identification. The local culture tends to celebrate the presence of multiple ethnicities making assignment to any one category difficult as individuals are reluctant to choose a single category and may change their identification over time and under certain circumstances. In the 2000 Census more than 20% of Hawai'i residents reported being multi-ethnic/racial categories compared to 2.4% for the nation. As the trend toward multiple ethnicities increases, tracking the population by single ethnic categories will become more problematic.

The health among race/ethnic groups in Hawai'i varies considerably for the majority of health indicators. However, the overall pattern of health within the state is that the Japanese and Chinese populations often engage in more protective behaviors and experience lower rates of disease and death

compared to Whites, Filipinos and particularly Native Hawaiians.⁵

In addition to the ethnic diversity in the State, there are many sub-populations that impact the economy and health care systems. The presence of the U.S. Armed Forces has been well established in Hawai'i but decreased in the 1990s. The 2000 U.S. Census Bureau estimates indicate the Armed Forces (both military members and their dependents), comprised 6.8% of the total resident population of the State, a drop from 10.6% in 1990.

Hawai'i is considered a gateway to the U.S. for immigrants from Asia and the Pacific. According to U.S. Census and the Immigration and Naturalization Service, 17.8% of Hawai'i's population is foreign-born, the 6th highest percentage.⁶ Nearly 35,000 immigrants were legally admitted to the state between 2005 and 2009 mainly from the Philippines, Japan, Korea and Vietnam. Smaller groups of Hispanic immigrants have settled in parts of Maui and Hawai'i island, attracted by jobs in tourism and agriculture.⁷ Estimates of illegal immigrant in Hawai'i range from six to nine thousand.⁸

Because of this ethnic diversity, there are a number of people who speak English as a second language. In 2008, approximately 7.8% (13,791) of the state's public elementary school children were enrolled in the Students with Limited English Proficiency Program. According to the Governor's Council on Literacy, over 155,000 adults or an estimated 16% of Hawai'i's adults are functionally illiterate. The 2008 Census reports that 254,172 people in Hawai'i speak a language in the home other than English.

Poverty

A particularly vulnerable population that is at risk for a range of poor health outcomes includes those at or below the poverty level. Since 2000, Hawai'i has seen a decline in the percent of the population at or below the poverty level. In 2007, an estimated 8.5% in Hawai'i lived in poverty, below the national estimate of 12.5%.⁹

⁵ Hawai'i Outcomes Institute, *Toward a Healthy Hawai'i 2010*. Honolulu, 2005. p. 15. Report is available on www.hawaiioutcomes.org. The report presents ethnic comparison data for the major HP 2010 objectives for the state.

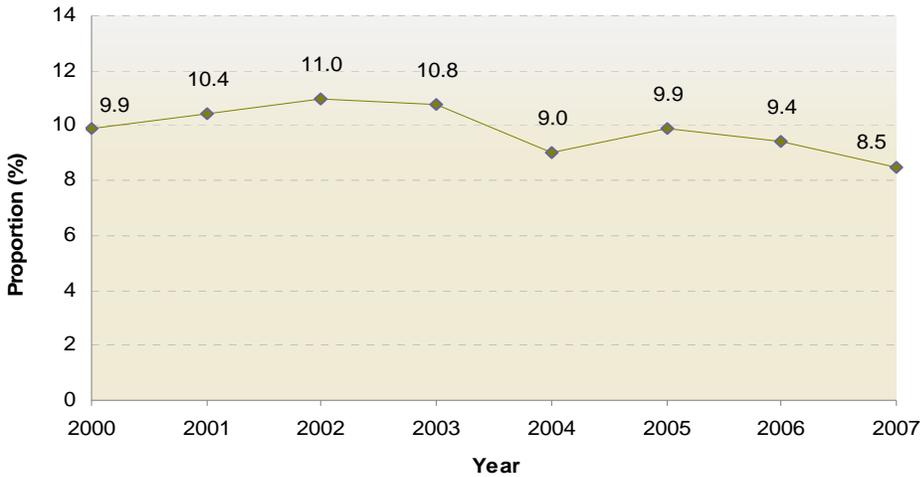
⁶ Source: U.S. Census Bureau, 2008 American Community Survey, "Percent of People Who Are Foreign Born" http://hawaii.gov/dbedt/info/census/ACS2008/acs_2008_rank.

⁷ Hawai'i State Department of Business, Economic Development & Tourism, *State of Hawai'i Data Book 2008*. Table 1.61.

⁸ Yasmin Anwar, "Immigration: Little Room for Leniency," *Honolulu Advertiser*, February 23, 2001, p A14.

⁹ Navas-Walt CD, Proctor BD, and Smith JC. U.S. Census Bureau, *Current Population Reports, P60-235, Income, Poverty, and Health Insurance Coverage in the United States: 2007*, U.S. Government Printing Office, Washington, DC, 2008. US census Bureau.

Chart 2-3 State of Hawai'i, Estimates for All Ages in Poverty: 2000-2007

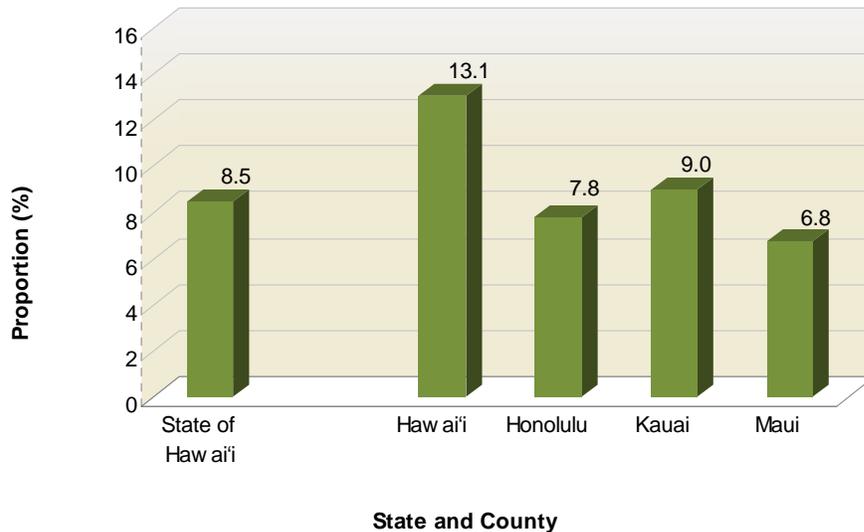


Source: U.S. Census Bureau. Small Area Income and Poverty Estimates (SAIPE) Program.

Note: Beginning with the estimates for 2005, data from the American Community Survey were used in the estimation procedure; all prior years used data from the Annual Social and Economic Supplements of the Current Population Survey. There is uncertainty associated with all estimates in this program. Caution should be used attempting to compare estimates.

In 2007, the highest estimate of individuals living in poverty was in Hawai'i and Kauai Counties with both being above the statewide estimate. Honolulu and Maui Counties had lower estimates of individuals living in poverty.

Chart 2-4 State of Hawai'i, Estimates for All Ages in Poverty by County: 2007



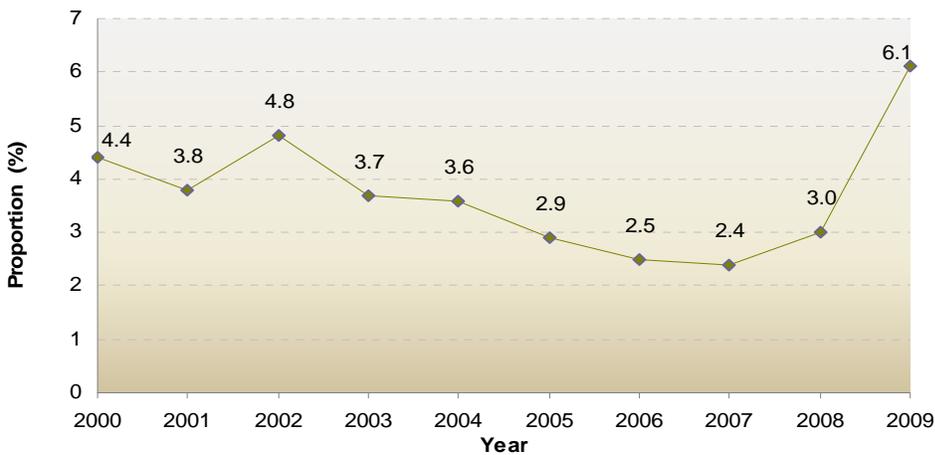
Source: U.S. Census Bureau. Small Area Income and Poverty Estimates (SAIPE) Program.

Note: Beginning with the estimates for 2005, data from the American Community Survey were used in the estimation procedure; all prior years used data from the Annual Social Economic Supplements of the Current Population Survey. There is uncertainty associated with all estimates in this program. Caution should be used in attempting to compare estimates.

Unemployment

Whether people are employed and working more than one job can have an effect on health status. Different types and amount of employment determine insurance coverage, access to care, variations in income, stress and fatigue, occupational risks, and time to devote to family, exercise and preparing healthy foods. From 2002 to 2007, there was a 50% decrease in the unemployment rate for the state of Hawai'i (4.8% to 2.4%, respectively). Since 2007, the unemployment rate has climbed considerably. Data from January 2009 show unemployment at 6.1% in Hawai'i, below the national rate of 7.6%.

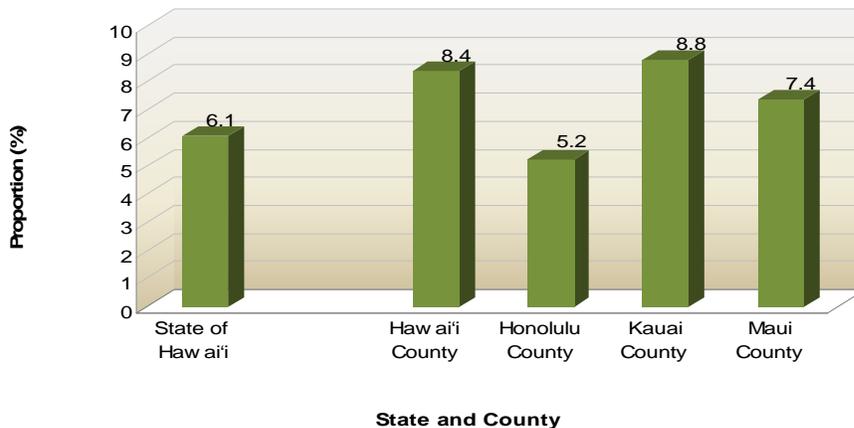
Chart 2-5 State of Hawai'i, Unemployment Rate by Year (January): 2000-2009



Source: U.S. Bureau of Labor Statistics Unemployment Rate (seasonally adjusted), 2000-2009. <http://www.bls.gov/data>. Accessed online March 27, 2009.

Unemployment in the State varies by county. In January 2009, Kauai, Hawai'i, and Maui counties all had unemployment rates higher than the state average rate. Honolulu County's unemployment rate, however, was lower than the state average rate.

Chart 2-6 State of Hawai'i and Counties, Unemployment Rate (January): 2009

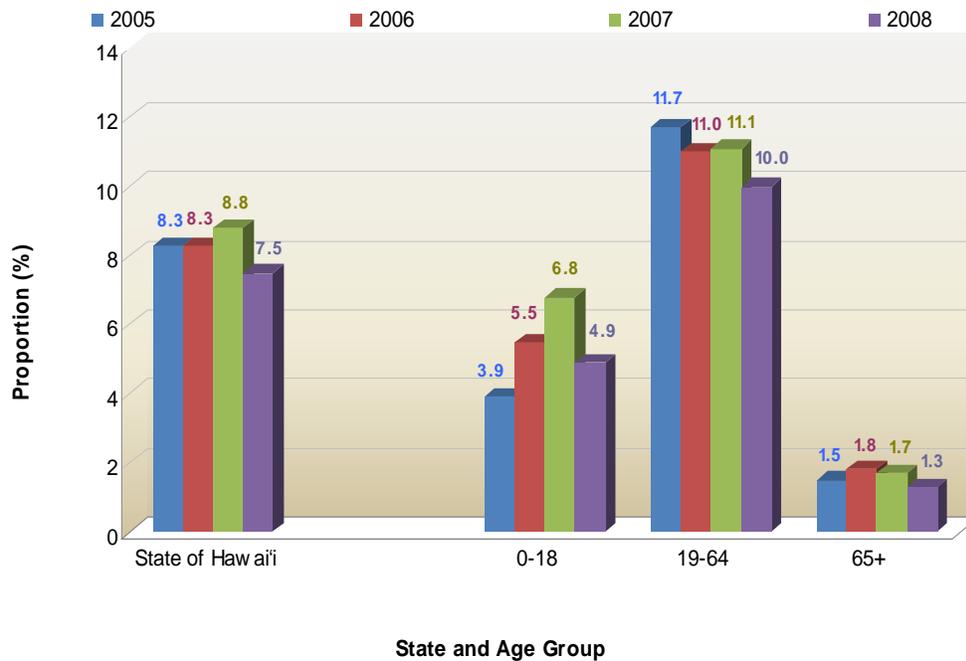


Source: U.S. Bureau of Labor Statistics Unemployment Rate (not seasonally adjusted), January 2009. <http://www.bls.gov/data>. Accessed online Mar 27, 2009.

Uninsured

Nationally, the rate of uninsured individuals has steadily increased from 2000 to 2007 with an estimated 15.3% of all individuals not having health insurance in 2007¹⁰. In Hawai'i, the proportion of the population that is uninsured has generally decreased since 2006, except for those 0-18 years of age which saw an increase in 2006 and 2007 that was followed by a decrease with 4.9% of children uninsured in 2008.

Chart 2-7 State of Hawai'i, Uninsured Population, Overall and by Age: 2005-2008



Source: US Census Bureau, Current Population Survey (CPS), Annual Social and Economic (ASEC) Supplement, Hawai'i Sample 2001-2008. Weighted tabulations. University of Hawai'i at Manoa. Preliminary results. Revised March 2009. Subject to further revisions.

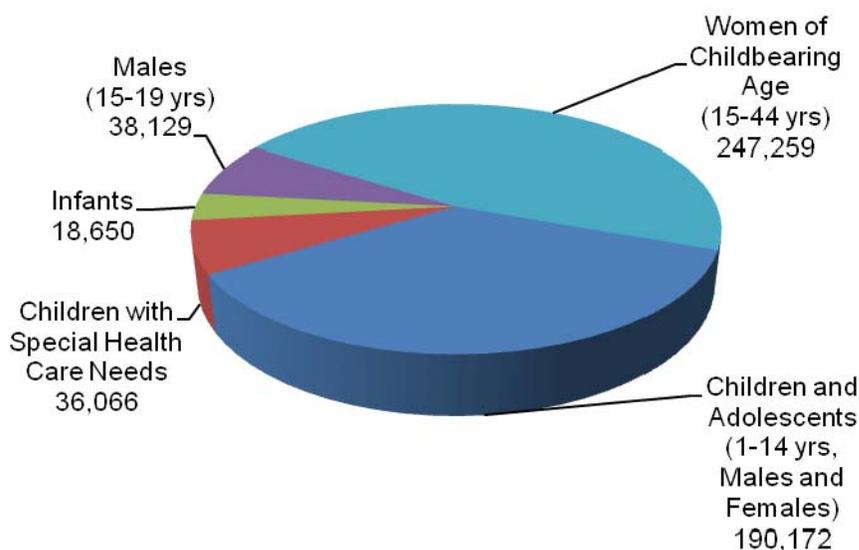
¹⁰ Navas-Walt CD, Proctor BD, and Smith JC. US Census Bureau, Current Population Reports, P60-235, Income, Poverty, and Health Insurance Coverage in the United States: 2007, U.S. Government Printing Office, Washington, DC, 2008. US Census Bureau.

MATERNAL AND CHILD HEALTH POPULATION OVERVIEW

Maternal and Child Health (MCH) Population

This section provides an overview of the MCH population and its subgroups for the State. Following this section, the MCH population will be discussed in more detail, specifically, women and infants, children and adolescents, and children with special health care needs. Based on estimates of the Title V target groups, a summary of the MCH population is provided in Figure 2-8. In 2007, the total estimate for women of childbearing age, infants, children and adolescents was 530,276 or 41% of the entire State population. This includes close to 250,000 women of child bearing age, almost 200,000 children and adolescents 1-14 years of age, and just over 36,000 children have special health care needs.

Chart 2-8 State of Hawai'i, Family Health Services Division Target Population: 2007



Source: U.S. Bureau of the Census. 2000 Census. U.S. Census Bureau, Population Division, "Annual Estimates of the Resident Population by Single Year of Age and Sex for the United States and States: July 1, 2007" (SC-EST2007-AGESEX_RES) (May 1, 2008). U.S. Department of Health and Human Services. Health Resources and Services Administration. The National Survey of Children with Special Health Care Needs. 2005-2006

Geographic Distribution and Racial/Ethnic Composition

The state's unique geography and ethnic/racial composition, relative to the continental U.S., is reflected in the maternal and child health population. The distances between islands, the locations of the tertiary and local primary-care centers, ethnic composition, and cultural and language barriers in the state contribute to both the success and difficulty Hawai'i has encountered in meeting the needs of its residents.

Geographically, the distribution of ages is similar in all counties although Hawai'i and Kauai counties had the highest percentage of children under 18 years. This is significant because both counties are two of the least populated in the state and are both rural areas. With the exception of Oahu, the most

populous island, all of the counties demonstrated substantial increases in their population growth in the last ten years.

It is estimated that nearly two thirds of Hawai'i's children and youth (70%) live in urbanized areas, while the remaining one third (30%) live in rural areas. Persons under 19 years of age are more likely to live in the suburbs, while adults are more likely to live in the central urban areas. The State of Hawai'i has no frontier areas.

The ethnic composition of the counties is also diverse creating challenges in service provision and infrastructure design that are both culturally sensitive and community-based. A representation of the ethnic composition of each county is displayed in Table 2-3. The specific health status of these populations will be discussed in the sections following this overview.

Hawaiians are considered to be one of the most vulnerable populations with respect to health and economic indicators. In 2008, Hawaiians comprised 24% of the State's total population. Hawai'i County has the largest proportion of Hawaiians in state where they are the largest ethnic group representing 30% of the county population.

Ethnic Group	Hawai'i		Honolulu		Kauai		Maui		State of Hawai'i	
	No.	%	No.	%	No.	%	No.	%	No.	%
Caucasian	54,860	31.9	138,078	15.7	16,707	26.7	46,736	32.85	256,381	20.4
Hawaiian [†]	51,971	30.2	201,331	22.9	17,198	27.4	35,337	24.8	305,838	24.4
Chinese	1,688	1.0	44,706	5.1	405	0.6	968	0.7	45,767	3.6
Filipino	10,455	6.1	106,394	12.1	9,156	14.6	22,768	16.0	148,773	11.8
Japanese	20,279	11.8	179,755	20.4	7,258	11.6	12,915	9.1	220,201	17.5
Others	32,757	19.0	210,042	23.9	11,945	19.1	23,902	16.8	278,646	22.2
Total	172,004		880,306		62,669		142,626		1,255,606	

Source: Hawai'i State. Department of Health, Office of Health Status Monitoring, Hawai'i Health Survey 2008
[†] Hawaiian includes all those who report being part-Hawaiian.

Homeless

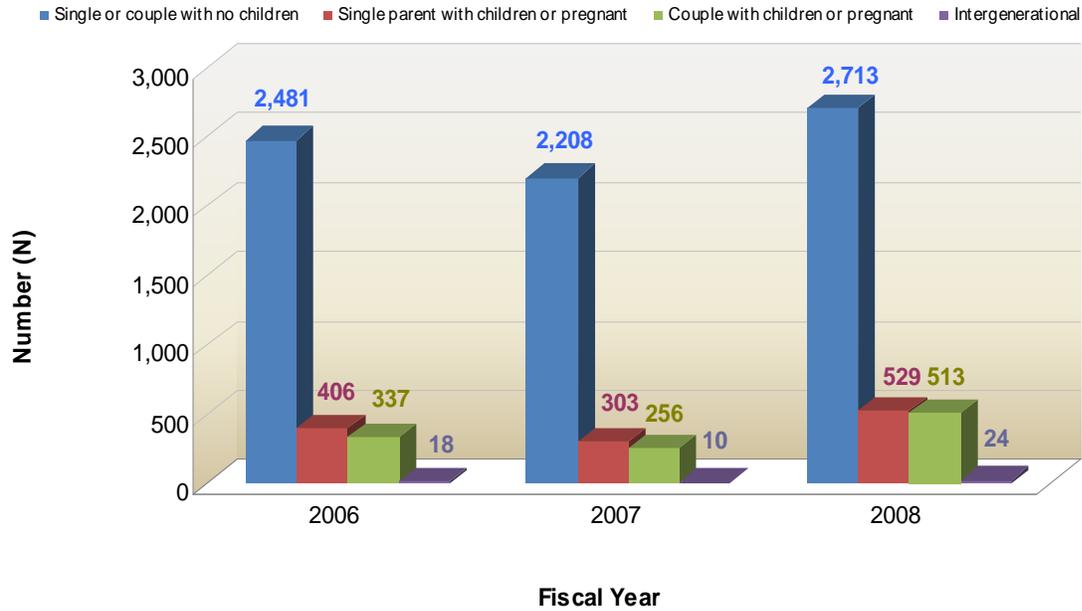
Of the 21 cities with data available nationwide, 193,183 unduplicated persons used transitional housing or emergency shelters in 2007. Of those people 23 percent were members of households with children, 23 percent were individuals, and one percent was made up of unaccompanied youth¹¹.

In Hawai'i, the data on individuals who accessed services from Shelter and/or Outreach Programs that received Hawai'i Public Housing Authority (HPHA) funds show an overall increase in the number receiving services in shelter. In FY 2008, 72% of those receiving shelter services were single individuals, which is a small decrease from previous years.

¹¹ How Many People Experience Homelessness? NCH Fact Sheet #2. National Coalition for the Homeless. June 2008 http://www.nationalhomeless.org/publications/facts/How_Many.html [Accessed 4/13/09]

However, there is a growing concern for the increased number of single (14% in FY 2008 vs. 11% in FY 2007) or couple parents with children (14% in FY 2008 vs. 9% in FY 2007) receiving shelter services. This data only reflects the number of those accessing Shelter and Outreach Programs and thus does not represent all persons experiencing homeless in Hawai'i.

Chart 2-9 State of Hawai'i, Homeless Service Utilization by Families with Children: 2006-2008



Source: University of Hawai'i, Center on the Family. Homeless Service Utilization Report.
 Note: Data reflects Fiscal Year (July1-June 30)

CHAPTER 3:

WOMEN AND INFANTS

Introduction

The health of Hawai'i's mothers and infants is relatively good compared to the nation overall. But, a downturn in the economy and influx of new immigrant groups from Asia and the Pacific may be affecting the health and well-being of the state's women and newborns. Across a spectrum of major health indicators, statewide trends have remained generally stable with no major progress toward greater improvement in population health with a few exceptions such as the continuing decrease in teen births. However, Hawai'i continues to rank in the top half of the states for most health measures including health insurance coverage, and low female mortality rates of for heart disease, and breast and lung cancer.

Despite this general positive overall picture, significant health challenges remain. Like most of the U.S, Hawai'i has witnessed a disturbing upward trend of low birth weight babies and preterm births. There are striking health disparities based on ethnicity, income, and geographic location, especially for Hawaiians that are masked when aggregate data is presented. Furthermore, public health infrastructure has been eroded due to budget cuts. The cost of ignoring these troubling trends could result in increased health costs in the future.

Priority Needs

The State of Hawai'i has recognized the need for improved health services for women to assure healthy outcomes for mothers and infants. As part of the commitment to the health of this population in the state, the Women and Infants (WI) Workgroup was convened as a component of the Title V Needs Assessment. Based on a review of the existing MCH priorities, stakeholder input, and review of research and data; the work group submitted a list of five key health issues for consideration as part of the final state priority needs for the MCH population. Using a set of prioritization criteria, 2 final priorities were identified for the WI population group:

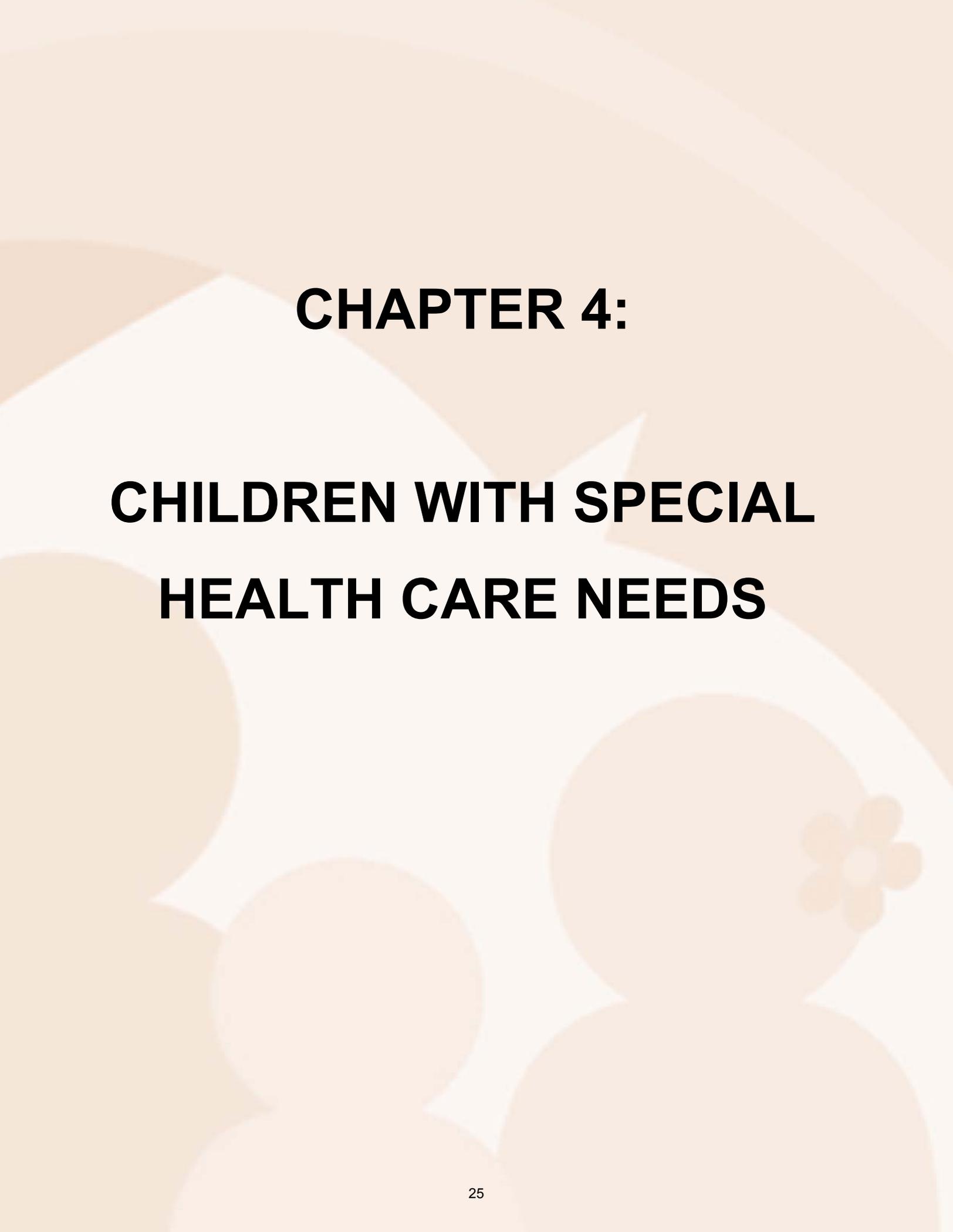
- Reduce the rate of unintended pregnancy (including a focus on teen pregnancy)
- Reduce the rate of alcohol use during pregnancy

Data Sources

The data presented in this report is not a comprehensive review of all data of Hawai'i women and children. Since the last needs assessment report, FHSD continues to focus on efforts to improve the health of mothers and children in Hawai'i. FHSD works collaboratively with other divisions and stakeholders to gather and analyze data to inform program initiatives. For the purpose of this report, data from various sources including the Pregnancy Risk Assessment Monitoring System (PRAMS) survey, the Behavioral Risk Factor Surveillance System (BRFSS) survey, the National Survey of Children's Health, Vital Statistics, Birth Defects data, and the use of various reports produced by the division are highlighted.

Vital statistics provides one of the few types of systematic measures reflecting child well-being that are available fairly consistently across the nation. Of note, Hawai'i is still among the states that have not adopted the 2003 Revision to the birth certificate so some measures are not directly comparable to data from states that have adopted the revision. The data collected from infant birth and death certificates provide some insight into the conditions at birth that may often shape a young person's life.

Please refer to <https://perfddata.hrsa.gov/MCHB/TVISReports/NeedsAssessment.aspx> for the data analysis relative to women and infants.



CHAPTER 4:

**CHILDREN WITH SPECIAL
HEALTH CARE NEEDS**

Introduction

The Hawai'i Title V needs assessment include a focus on the six core outcomes for children with special health care needs (CSHCN):

1. Families of CSHCN partner in decision-making at all levels and are satisfied with the services they receive.
2. CSHCN receive coordinated, ongoing, comprehensive care within a medical home.
3. CSHCN have adequate private and/or public insurance to pay for the services they need.
4. Children are screened early and continuously for special health care needs.
5. Community-based service systems are organized so families can use them easily.
6. Youth with special health care needs receive the services necessary to transition to adult life, including adult health care, work, and independence.

CSHCN are defined as children who have or are at risk for a chronic physical, developmental, behavioral, or emotional conditions and who require health and related services of a type or amount beyond that required by children generally (definition from the federal Maternal and Child Health Bureau). Due to the complexity of their health needs, it is essential to assure access to comprehensive, coordinated, community-based services.

Priority Needs

The State of Hawai'i has recognized the need for improved health services for CSHCN to assure healthy outcomes for the future. As part of the commitment to the health of this population in the state, a CSHCN Workgroup was convened as a component of the Title V Needs Assessment. The Workgroup identified three key health issues based on a review of the existing CSHCN priorities, stakeholder input, and compilation of research and data. Using a set of prioritization criteria, two final priorities were identified for the CSHCN population group:

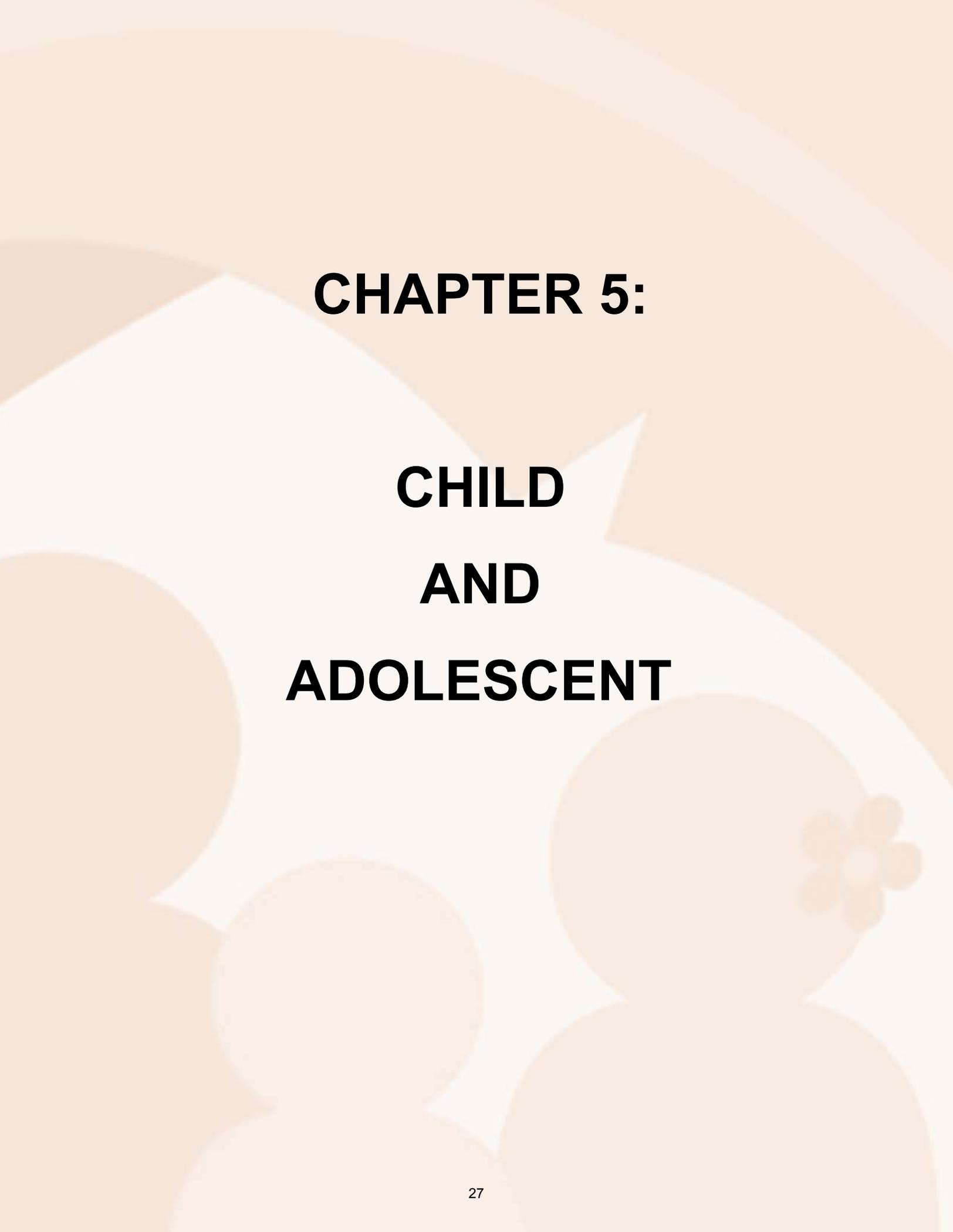
- Promote the identification of children with developmental delay
- Promote the transition of adolescents with special health care needs to adult health care

Data Sources

The data presented in this report is not a comprehensive compilation of all CSHCN data, but is a summary of key health data to assess the overall population health and identify health issues. Data sources for this report include:

- Hawai'i data from the National Survey of CSHCN, 2005-2006.
- Hawai'i CSHCN data from the National Survey of Children's Health, 2007.
- Hawai'i Title V/CSHCN Needs Assessment Survey – 2009. This was a DOH Children with Special Health Needs Branch (CSHNB) survey of family and community/providers to identify areas of biggest challenges/problems for CSHCN in Hawai'i.
- Data and information from state and community agencies and programs.
- Data and information from DOH/CSHNB programs.

Please refer to <https://perfddata.hrsa.gov/MCHB/TVISReports/NeedsAssessment.aspx> for the data analysis relative to CSHCN.



CHAPTER 5:

CHILD

AND

ADOLESCENT

Introduction

The health of Hawai'i's children remained relatively stable over the past decade despite a decade of economic hardship for the state. Across a broad spectrum of major social and health indicators, statewide trends have varied with improvements in some areas. Examples of progress include declines in teen pregnancy and smoking rates, increasing child immunization rates and insurance coverage. When compared with the United States as a whole Hawai'i's children are as healthy as or better than the nation. While Hawai'i's children are not the healthiest in the nation, they are definitely healthier than average in many respects.

The national Kids Count annual assessment of child health, ranked Hawai'i 13th in 2008 which is an improvement over a 24th ranking in 2005.¹² In the 2008 report, Hawai'i ranks in the top 9 states for five of the 10 key indicators. Trend data in the report showed improvement in Hawai'i for 6 areas (infant mortality rate, teen death rate, teen birth rate, teens not attending school and not working, percent of children living in families where no parent has full time employment, percent of children living in poverty), and worsening in the other four (low birth weight, child death rate, high school dropouts, and single parents) compared to 2000 data.

Significant health challenges remain to prevent any further erosion of children's health in the state. A recent downturn in the state economy may make it more difficult for families in Hawai'i particularly among those with disparities in health such as among Native Hawaiians and other Pacific Islander subgroups. There are alarming trends appearing regarding childhood overweight and adolescent Chlamydia in Hawai'i. Furthermore, there are still thousands of children in the state that continue to need assistance with basic health needs because they remained uninsured.

Priority Needs

The State of Hawai'i has recognized the need for improved health services for children to assure healthy outcomes for the future. As part of the commitment to the health of this population in the state, a Child and Adolescent (CA) Workgroup was convened as a component of the Title V Needs Assessment. The Workgroup identified five key health issues based on a review of the existing MCH priorities, stakeholder input, and compilation of research and data. Using a set of prioritization criteria, four final priorities were identified for the CA population group:

- Reduce the rate of child abuse and neglect with special attention on ages 0-5 years
- Reduce the rate of overweight and obesity in young children ages 0-5
- Prevent bullying behavior among children with special attention on adolescents age 11-18

Data Sources

The data presented in this report is not a comprehensive compilation of all child health data, but merely a summary of the key health data reviewed to assess the overall population health to help identify the priority health issues. Socio-economic and household data can be found in Chapter 2. Most of the

¹² 2008 Kids Count Data Book. Annie E. Casey Foundation. Baltimore, MD: 200. Available online at <http://www.aecf.org>.

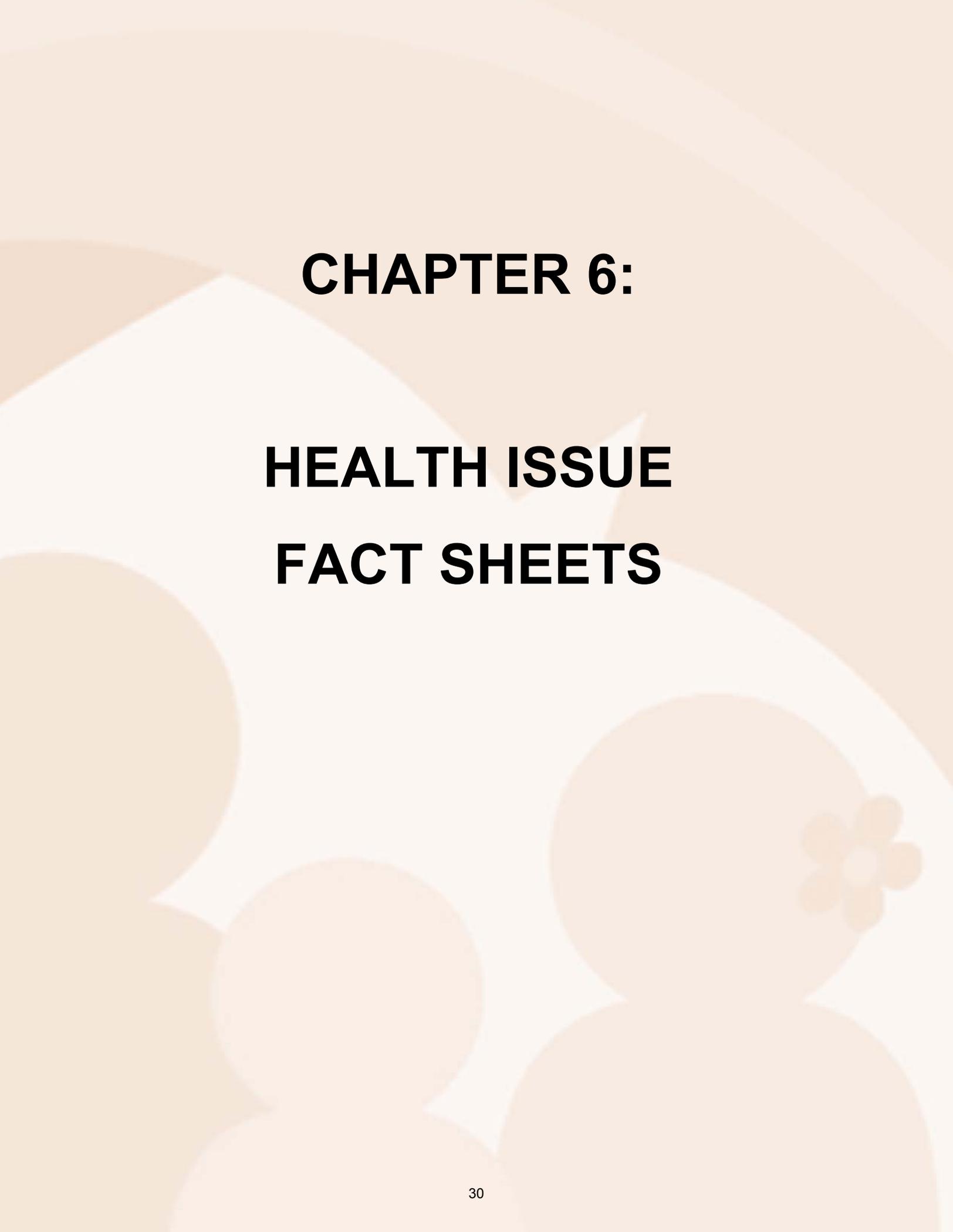
data focuses on the three health priority areas for the population. As the needs assessment work continues over the next 5 years additional data review and analysis will be conducted to develop a greater understanding of the population's health and develop strategies to improve child health in the state.

For adolescents, Hawai'i participates in the national for High School grades 9-12 and Middle School grades. 6-8. Participants must secure parental consent. The survey does not include dropouts or students with poor attendance. Because this is a national surveillance instrument comparable data is available for the U.S. and Hawai'i for High School only. Both surveys are conducted every two years.

For younger children of elementary school age (5-11 years), data was generated from the National Survey on Children's Health. An FHSD data publication was developed that included analysis of 22 child health indicators and highlight disparities among groups.

Analysis of childhood obesity among children entering kindergarten in 2002 by the Hawai'i Department of Health was included as a more current final report was not yet available.

Please refer to <https://perfddata.hrsa.gov/MCHB/TVISReports/NeedsAssessment.aspx> for the data analysis relative to children and adolescents.

The background features several overlapping circles in shades of light beige and cream. A small, stylized flower icon with five petals is positioned on the right side, partially overlapping one of the circles. The overall aesthetic is clean and modern.

CHAPTER 6:

HEALTH ISSUE

FACT SHEETS

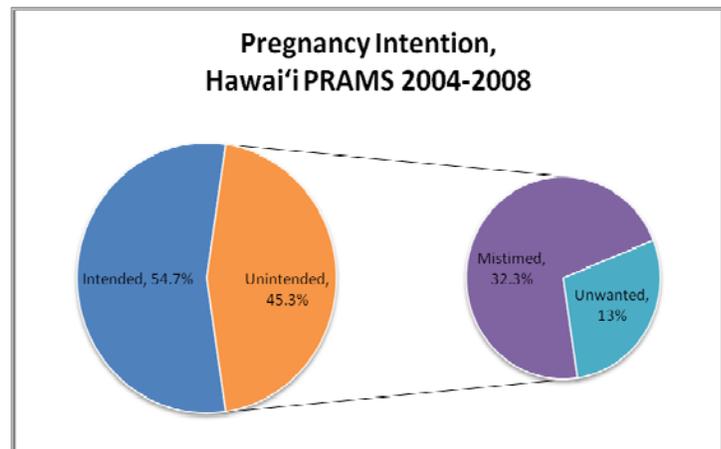
Promote Planned Pregnancy in Hawai'i

Issue:

When pregnancies are intended and planned, there is greater opportunity and motivation for women and their partners to adopt or maintain positive health behaviors.¹ Unintended pregnancy is associated with adverse health outcomes for both mother and infant. Pregnancies that are unintended are more likely to result in adverse health behaviors and outcomes before, during and after pregnancy. Unintended pregnancy is associated with late or inadequate prenatal care, low birth weight, neonatal death, domestic violence, child abuse, and exposure of the fetus to harmful substances like tobacco, alcohol, and other drugs. It is also associated with economic hardship, marital dissolution, and failure to achieve education goals.

Data:

Using data from the Hawai'i Pregnancy Risk Assessment Monitoring System (PRAMS) for the five most recent years available (2004-2008), it was determined that 45.3% of pregnancies in Hawai'i are unintended. Among the unintended pregnancies, the majority were classified as mistimed (32.3%), with the remainder being unwanted (13%). Unwanted pregnancies typically have higher rates of poor outcomes than do mistimed and intended pregnancies.²



Target Group:

There are 23,016 pregnancies annually and 247,259 women of reproductive age (15-44 years of age) in Hawai'i (2006 Data from FHSD Profiles, 2009).

What is the problem?

Unintended pregnancy is a result of complicated and often interactive factors not just limited to an individual. Some factors that can be related to unintended pregnancy are:

- 1) Lack of knowledge about the ways to prevent pregnancy
 - Effective contraceptives come in many forms.
- 2) Lack of access to highly effective contraceptive methods
 - Are providers trained and comfortable with various methods? Are costs prohibitive?
- 3) Lack of comprehensive sexual health education in schools
 - Comprehensive sexual health education is not routinely provided in Hawai'i all schools.
- 4) Lack of funding
 - In FY 2010, funding cuts in Hawai'i have resulted in significant decreases in the number of Department of Health clinical services providers, health educators, and other programs and services designed to reduce unintended pregnancies.
- 5) Partner influence
 - Males also impact family planning decisions, but are less likely than women to be the target of family planning services and programs.

¹ Alexander, G.R. & Krenbrot, C.C. The role of prenatal care in preventing low birth weight. *The Future of Children*. 1995;5(1):103-120.

² Hawai'i PRAMS is a population-based surveillance system funded by the Centers for Disease Control and Prevention (CDC), Division of Reproductive Health. Estimates of pregnancy intendedness in this report may differ from those in other reports as PRAMS samples only women with pregnancies resulting in a live birth, and therefore does not include pregnancies resulting in abortion, miscarriage, or fetal death.

Strategies to Consider

There is an increasing focus in the field of public health on making sure that health-improvement strategies are evidence-based. A review of the current literature suggests that the most effective prevention strategies include:

- increasing the knowledge and availability of Emergency Contraception (EC) for all populations
- increasing comprehensive sex education for adolescent populations
- increasing condom availability for all populations (*references available upon request*)

Resources Available

The Department of Health (DOH) **Family Planning Program (FPP)** in the Maternal and Child Health Branch (MCHB) assures access to affordable birth control and reproductive health services to all individuals of reproductive age with a priority on low income and hard-to-reach individuals (uninsured or underinsured persons, immigrants, males, persons with limited English proficiency, homeless persons, substance abusers, persons with disabilities, and adolescents). Services are offered free or at low cost and include education, counseling, cervical and breast exams, provision of appropriate contraceptive methods, testing for pregnancy and sexually transmitted infections. FPP contracts with 20 providers, offering services in 39 clinics and community sites statewide. In FY 2009, a total of 22,137 clients received Title X FP clinical services. For health education and outreach services, 70,753 direct contacts (through individual or group sessions) and 446,714 indirect contacts (health fairs, exhibits, media information) were made for FY 2009.

The FPP, in collaboration with the Hawai'i DOH **Sexually Transmitted Disease (STD) Branch**, has increased condom availability for the public by purchasing and distributing condoms to contracted Title X agencies across the state. Other condom distribution/availability projects include the condom coupon program being implemented by a Title X agency on the Big Island. With this program, the health educator conducts a FP lesson/presentation, and then distributes condom coupons to participants. This condom coupon allows the participant to go to various outlets in the community that the health educator has established partnerships with, such as a convenience store, to then pick up a pre-packaged bag of condoms and health education materials. This program has been effective in getting condoms to teens that otherwise choose not to or would be able to purchase the condoms or go to a clinic to pick them up.

Population-based services are provided through **Title X statewide FP community health educators**. Activities include presentations, distribution of educational materials, and health fairs. Presentation activities also include comprehensive sex education curricula implementation in schools and other community organizations. Hawai'i's health educators use evidence-based curricula such as Making Proud Choices. All Title X agencies throughout the state have been educated on EC and are able to inform patients about it and offer it to them. This service is based on a sliding fee scale, and those that are not able to pay for it or have no insurance get it for free. Title X community health educators also educate their contacts about EC, and the FPP has purchased various EC educational materials to distribute to the community.

The **Male Achievement Network (MAN) Project** through the Waikiki Health Center which provides outreach and educational counseling services to males most likely to engage in risky sexual behaviors including incarcerated, homeless, and runaway youth. In FY 2009 there were 3,040 direct male contacts; of these, 70 received FP clinical services.

Contact Information:

Unintended pregnancy is a Title V priority issue for the Hawai'i Department of Health, Family Health Services Division. We encourage your questions and efforts to join us in addressing this important issue.

Oahu: Emily Roberson, emily.roberson@doh.hawaii.gov

Maui: Jeny Bissell, jeny.bissell@doh.hawaii.gov

Kauai: Cash Lopez, cash.lopez@doh.hawaii.gov

Hawai'i: Maylyn Tallett, maylyn.tallett@doh.hawaii.gov





Preventing Drinking During Pregnancy

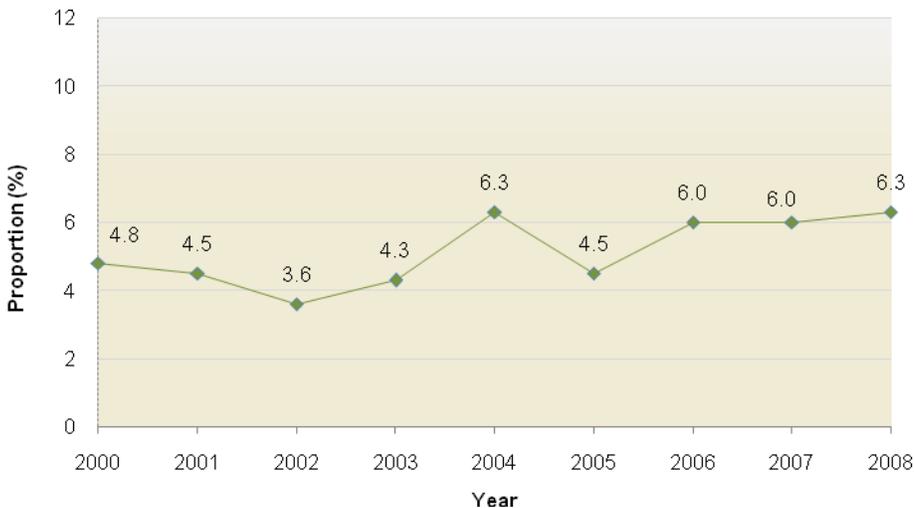
Issue:

No amount of alcohol consumption is considered safe during pregnancy. Drinking alcohol during pregnancy can cause miscarriage, stillbirth, birth defects and a range of lifelong disorders to the child, known as fetal alcohol spectrum disorders (FASD). Alcohol-related birth defects may include growth deficiencies, facial abnormalities, central nervous system impairment, behavior disorders, and impaired intellectual development including mental retardation. Alcohol-related birth defects are completely preventable when women abstain from drinking during pregnancy.

Women should stop drinking alcohol if they are pregnant, are planning to become pregnant, or are sexually active and do not use effective birth control. Over half of the pregnancies are unplanned, a woman may unintentionally expose her unborn child to alcohol by drinking early in a pregnancy. It is important to educate all women of childbearing age of the dangers of alcohol.

Data:

Proportion of Women Who Reported Alcohol Use During Pregnancy, 2000-2008, State of Hawai'i



In Hawai'i, approximately 6.3% of women (1,167) reported using alcohol during their pregnancy in 2008. This is almost a two-fold increase from 2002, when only 3.6% of women reported using alcohol during their pregnancy.

Other data from PRAMS show that from 2005-2008, the rate of alcohol use prior to pregnancy increased from 42.1% in 2004 to 49.2% in 2008;¹ while binge drinking prior to pregnancy remained relatively constant (19.1-19.5%), after an initial increase in 2004 when it was 16.1%.

Data Source: State of Hawai'i, Department of Health, Family Health Services Division, Maternal and Child Health Branch, Hawai'i Pregnancy Risk Assessment Monitoring System (PRAMS).

Target Group:

There are 23,016 pregnancies annually and 247,259 women of reproductive age (15-44 years of age) in Hawai'i (2006 Data from FHSD Profiles, 2009).

What is the Problem?

- People are not well informed of alcohol effects on a developing fetus and the importance to abstain from alcohol when pregnant or when they are planning to become pregnant.
- When a woman has an unplanned pregnancy, the risk of consuming alcohol during the early stages of pregnancy is high. Nearly half of all births in the United States are unplanned. Therefore, women of child-bearing age should consult their physician and abstain from drinking alcohol if they are contemplating pregnancy, are sexually active and not using contraceptives or are pregnant.
- Routine screening and counseling of women for alcohol use may not occur during regular health care visits or during pregnancy.

¹ Kazi M, Shor R, Hayes D, Fuddy L. "Preconception Alcohol Use Fact Sheet." Honolulu, HI: Hawai'i Department of Health, Family Health Services Division; August 2010.

- Alcohol use during pregnancy is attributed to the Fetal Alcohol Spectrum Disorder (FASD) which is a range of adverse birth outcomes of poor neurological, physical and behavioral development including stillbirth, low birth weight, and preterm delivery.

Strategies to Help Prevent Alcohol Use during Pregnancy

- Promote Awareness at the community level on the adverse effects of alcohol use during pregnancy.
- Work with the medical profession to ensure that the subject of alcohol effects during pregnancy is included in instructional curriculum and allied health care schools' training.
- Ensure that local medical professionals and allied healthcare staff implement practices recommended by the U.S. Surgeon General on screening, motivational interviewing and intervention skills for all women of reproductive age.
- Increase collaboration and improve communication among agencies and programs to provide a cohesive delivery of prevention, intervention, and referral services among the different disciplines from mental health, substance abuse, and women's and children's health.

Resources Available:

- **“Drinking and Reproductive Health: A Fetal Alcohol Spectrum Disorders Prevention Tool Kit,”** developed by the American College of Obstetrics and Gynecology (ACOG) in collaboration with the Centers for Disease Control (CDC). The tool-kit provides information and guidelines to help health care providers conduct screening and intervention for all women of reproductive age. Available online at <http://www.acog.org/departments/healthIssues/FASDToolkit.pdf>
- **Centers for Disease Control and Prevention (CDC) – Alcohol Use in Pregnancy; Why Alcohol is Dangerous; Surgeon General’s Advisory on Alcohol Use in Pregnancy**, available at <http://www.cdc.gov/ncbddd/fasd/alcohol-use.html> provides user friendly information on the dangers of alcohol use during pregnancy.
- **SAMHSA, Fetal Alcohol Spectrum Disorders (FASD) Center for Excellence:** Available at <http://fasdcenter.samhsa.gov>. The FASD Center for Excellence provides educational materials to prevent FASD.
- **Healthy Mothers Healthy Babies (HMHB) Coalition of Hawai’i** – Promotes the national HMHB initiatives to improve health outcomes for babies and mothers. HMHB is taking the lead to promote Text4baby, that uses mobile technology to text health education and information throughout a pregnancy and timed to the expected due date. <http://hmhb-hawaii.org/?p=149>
- **March of Dimes, Hawai’i Chapter** - Addresses prenatal issues and focuses on preventing preterm births that contribute to low-birth weight and other compromising neonatal health issues including alcohol use during pregnancy. www.marchofdimes.com.
- **Fetal Alcohol Spectrum Disorder Task Force (FASD)** – FASD State Coordinator naomi.imai@doh.hawaii.gov Promoting abstinence from any alcohol during pregnancy is an objective of the Hawai’i FASD Task Force, which also seeks to train and educate local communities and professionals on screening of pregnant women as well as promoting more awareness and screening to identify children with FASD.

Contact Information: Prevention of alcohol use during pregnancy is a Title V priority issue for the Department of Health, Family Health Services Division. We encourage your questions and efforts to join us in addressing this important issue.

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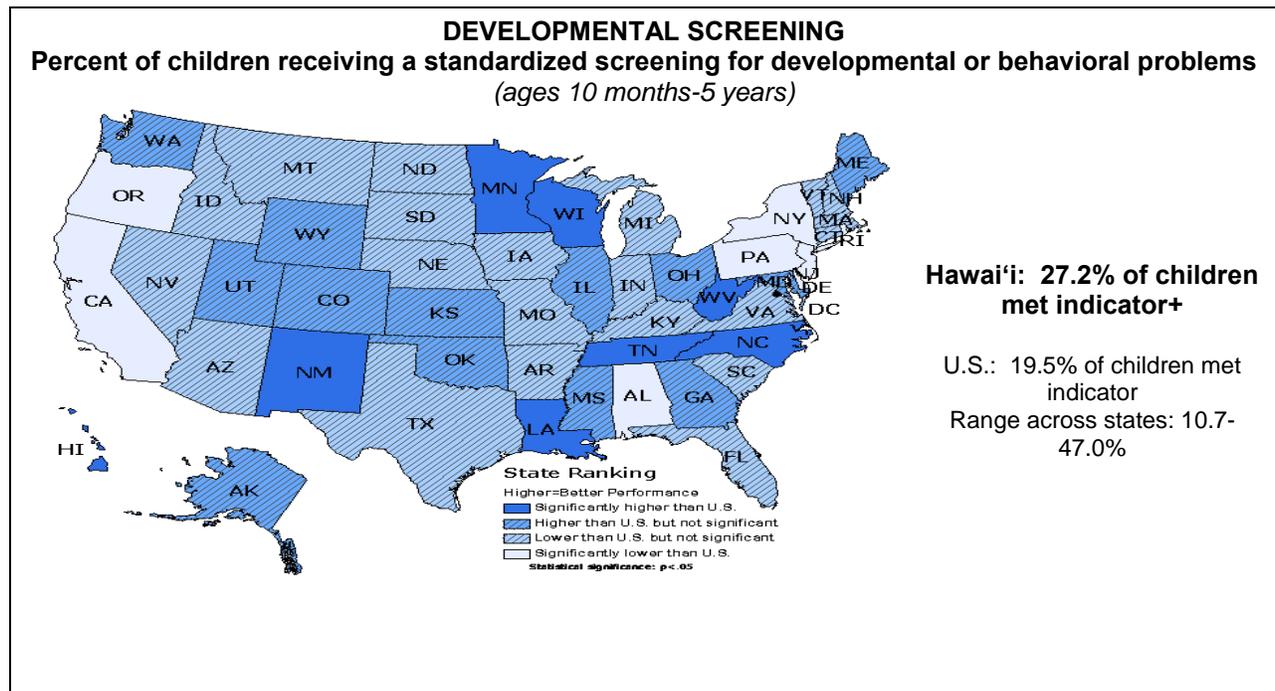
Promote Early Childhood Screening and Development

Issue:

Developmental delay must be identified early to assure that young children receive care and resources to promote optimal development. The sooner concerns are identified and needed services are provided, the better chances that the child's development will be optimized.

Data*:

- In Hawai'i, 27.6% of all children are at moderate or high risk of developmental, behavioral, or social delays. This is similar to the national rate of 26.4%.
- All children 0-5 should be screened for developmental delay (whether by pediatricians, public health nurses, Healthy Start, early childhood practitioners, etc.). In Hawai'i, only 27.2% of children 0-5 are receiving a standardized screening for developmental or behavioral problems.
- Hawai'i vs. National rates: Hawai'i has a higher rate of standardized developmental/behavioral screening (27.2% vs. 19.5%) but this may decrease in the coming years due to decreased funding to Healthy Start and the discontinuation of Department of Health Preschool Developmental Screening Program.



* Data source: 2007 National Survey of Children's Health. From: Child and Adolescent Health Measurement Initiative, Data Resource Center on Child and Adolescent Health website. Retrieved 5/21/2009 from <http://www.nschdata.org>.
 + Statistical difference at the 95% confidence interval between Hawai'i and U.S. rates.

Target Group:

There are an estimated 101,540 children 0-5 years of age in Hawai'i (2006 Intercensal Estimate).

What is the Problem?

- Developmental screening tests are an important part of preventive health care. They can help ensure that more serious concerns are mitigated when conditions are detected and treated early. The American Academy of Pediatrics (AAP) endorses the ASQ or the PEDS; however, not all physicians are using a standardized screening tool. Primary Care Providers (PCPs) vary in their hearing and vision screening practices and whether they follow EPSDT or American Academy of Pediatrics guidelines. PCPs include pediatricians, pediatric specialists, family physicians, community health centers, general practice, internal medicine, etc.

- Primary care providers need to have adequate insurance payment for their screening services, and may face difficulties obtaining adequate payment.
- Budget cuts led to the elimination of the Preschool Developmental Screening Program (PDSP) which promoted the early identification and intervention for developmental learning, behavioral and social emotional problems for children ages 3 to kindergarten entry. In FY 2008, PDSP screened 916 children and based on screening results, 613 children were referred for additional services.
- While screening is important, appropriate services for those identified children at risk for developmental delay is equally critical. There needs to be formal protocol for the referral system once children are identified at risk.

Strategies to Consider:

- **Public Awareness:** Develop and disseminate products that promote optimal child development that include screening and services for developmental delay. Families have an important role in ensuring that their children receive screening and follow-up. Education for families and the community may include the importance of screening, follow up, and resources for children and families.
- **Policy Setting:** Advocate for funding for state-wide developmental screening and follow up services to identify children with developmental delay and to do more investigation on mandated coverage for early intervention services.
- **Community-Based Project Focus:** Promote public-private partnerships for the screening system including developing guidelines/screening protocols; collecting/analyzing data; and identifying training and resource needs. An example of this is the Aloha United Way (AUW) Waianae/Nanakuli Developmental Screening Pilot Program through the Learning Disabilities Association of Hawai'i's 'Ekolu 'Ehā 'Ike Pono ("To keenly see our Three and Four Year Olds").

Resources Available

- **American Academy of Pediatrics-Hawai'i Chapter** works to enable pediatric providers to perform developmental surveillance at every well-child visit and do developmental screening using a standardized screening tool at 9, 18, and 24 month visits or when a concern is expressed. Recommended standardized screening tools included Parents' Evaluation of Developmental Status (PEDS) and Ages and Stages Questionnaire (ASQ).
- **Hawai'i Department of Education Operation Search** is a multi-media campaign by the Hawai'i State Department of Education to find children who may need special education services but who are not receiving them. Any child who resides in Hawai'i who is between the ages of 3 and 20 and has met the eligibility criteria may receive special education services. Call Operation Search: 1-800-297-2070 statewide.
- **Hawai'i Keiki Information Service System (H-KISS)** is a free information and referral service administered by the Early Intervention Section, which provides families with referrals to appropriate programs for services based on the individual needs of the child. (On Oahu: 594-0066; Neighbor Islands: 1-800-235-5477)
- **Early Intervention Section (EIS)**—is responsible to ensure that any child from birth to three years of age at risk for a developmental delay receives a timely, multidisciplinary, comprehensive developmental evaluation and services as identified on the child's Individual Family Support Plan (IFSP).
- **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)** is administered by the Department of Human Services Med-QUEST Division which provides health services for individuals under age 21 through Hawai'i QUEST, QUEST-Net and Medicaid Fee-For-Services programs. EPSDT provides coverage surveillance for hearing, vision, and development/behavior at all visits.

Contact Information: Child Development is a Title V priority issue for the Department of Health, Family Health Services Division. We encourage your questions, comments, and efforts to join us in addressing this important issue.

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Prevent Child Abuse and Neglect

Issue:

Child abuse and neglect (CAN) happens to children of every age, race, and family income level. Child abuse can be physical, sexual, emotional, or verbal. Neglect specifically involves the failure to provide for a child's basic physical or emotional needs. Besides the immediate injuries a child may receive from abuse/neglect, Recent research shows the consequences of CAN disrupts healthy child development and are associated with a broad range of health problems into adolescence and adulthood including impaired brain development; compromised immune, cardiovascular and metabolic systems; alcoholism and drug abuse; intimate partner violence; depression; suicide; heart disease; smoking; obesity; and sexually transmitted diseases.¹

Data:

Children under the age of five are the most vulnerable for child abuse and neglect (CAN). For children 0-5 in Hawai'i in 2008, the rate of CAN was 8.0 (per 1,000 children 0-5 years of age) which is a 36% relative decrease since 2005 when the rate was 12.5. There were no comparable national estimates for this particular age group. In 2007 for all children, the national rate of confirmed CAN reports was 10.1 (per 1,000 children, aged 0-17 years) compared to 7.1 in the State of Hawai'i. There was some variation by county with Hawai'i County having the highest rate. Although the CAN rates reflect a slight decline since 2005 many experts believe that increased family stress due to the poor economy may reverse this trend.²

Hawai'i rate of Child Abuse and Neglect, Ages 0-5 year (rate per 1,000 children)	
Year	Statewide rate per 1,000
2008	8.0
2007	9.3
2006	8.8
2005	12.5

Data Source: Hawai'i State Department of Human Services, Management Services Office, accessed through the University of Hawai'i Center on the Family Data Center available at http://uhfamily.hawaii.edu/Cof_Data/cfi/family_indicators.asp

Unduplicated Confirmed Reports of Child Abuse & Neglect, Ages 0-17 years (rate per 1,000 children)						
Year	National	State of Hawai'i	Honolulu	Hawai'i	Kauai	Maui
2007	10.1	7.1	6.5	10.9	5.7	6.8
2006	11.8	8.3	7.7	13.3	7.8	6.2
2005	12.1	8.9	8.1	15.0	6.2	8.2

Data Source: Hawai'i State Department of Human Services, Management Services Office Accessed through the University of Hawai'i Center on the Family Data Center available at http://uhfamily.hawaii.edu/Cof_Data/cfi/family_indicators.asp

Target Group:

There are an estimated 101,540 children 0-5 years of age in Hawai'i (2006 Intercensal Estimate).

What is the Problem?

- For many years, Hawaii's families have benefited from a broad statewide network of family support and strengthening programs that can help prevent incidents of CAN. The recent downturn in the economy has resulted in major cutbacks and changes to programs and services at a time when families are in greater need of support.
- Over the past decade greater focus has been placed on preventing CAN before the initial abuse occurs; moving from a focus on the individual victim and problems in the child welfare system to a much broader array of prevention/health promotion solutions and services that help create social/environmental supports that keep families strong and children safe. Driven by the growing body of research on the importance of early childhood development, resources must shift away from traditional approaches toward a comprehensive national policy to ensure that all children have the ability to live in safe, stable, and nurturing environments.³

¹ Centers for Disease Control and Prevention, "Understanding Child Maltreatment."

² It should be noted that the definition of a "confirmed" CAN case has changed over time. Also new policies have resulted in reported cases receiving early intervention services to divert families from entering into the child protection system. These two factors may lead to an under reporting of the "true" CAN rate.

³ Centers for Disease Control and Prevention, Child Maltreatment as a Public Health Priority, September 10, 2009.

Strategies to Consider:

Policy change and paradigm shifts: Support an active and deliberate policy/paradigm shift away from CAN prevention to child wellness promotion, disseminate the research/science to support this policy change, develop a systematic structure for consistent training for all family service providers regarding family strengthening and promotion of evidence based factors and practices that strengthen families and protect children from child abuse and neglect, and develop new measures of effectiveness for health promotion services.

Public Awareness: Develop and disseminate information for the general public to understand the importance of healthy child wellness and development, the link to healthy outcomes later through life, the cost-effectiveness of this prevention approach, and viable evidence based programmatic and policy options available.

Building Collaborations and Professional Capacity: Improve communication and collaboration across multiple service sectors to develop a unified scientific understanding of the early childhood origins of health, learning and behavior and build more effective mechanisms and systems to share timely information that help promote areas for partnership.

Resources Available for Strengthening the State's Prevention Service System:

- The **Department of Health (DOH)** helps to assure a continuum of prevention services available to the children and families of the State of Hawai'i. Through collaboration with both public and private agencies the DOH ensures that services provided are accessible, culturally appropriate and responsive to the community.
- The **Child Safety Collaborative (CSC)** is a public-private partnership to promote a safe and nurturing environment for children and youth. The CSC conducts public awareness, education, advocacy, and provides leadership for system change; assuring a comprehensive/effective service system; policy development; and provides a forum for communication and collaborative action.
- **Prevent Child Abuse Hawai'i (PCAH)** is a private non-profit organization dedicated to the prevention of child abuse and to ensure that all children in the state are able to grow up in a safe and nurturing environment. Programs are designed to promote positive parenting and healthy families through education, public awareness and advocacy. PCAH maintains an informational website of statewide events at www.preventchildabusehawaii.org.
- **Hawai'i Children's Trust Fund (HCTF)** was established by statute to support family strengthening programs aimed at preventing CAN and promoting healthy child development. HCTF is a public/private partnership between the DOH and the Hawai'i Community Foundation to assure a network of primary prevention services that support and strengthen families to prevent CAN through community-based grants and public awareness.
- **East Hawai'i County Coalition to Prevent Child Abuse and Neglect** empowers the community to keep children safe. The Coalition goals are to raise community awareness, support existing prevention programs, strengthen families, conduct educational activities, develops prevention plans. Coalition partners consist of 17 private & public agencies that meet every month to coordinate and plan events and education trainings for providers.
- Maui County **Ho'oikaika Partnership** was established in August 2008 with a mission to create a seamless safety net of CAN prevention of services that is coordinated, effective, culturally responsive, and collaborative for children and their caregivers.
- **Kauai County Children's Justice Center (CJC)** is a program of the Hawai'i State Judiciary and part of a national network of Children's Advocacy Centers. CJC brings together multidisciplinary professionals, representing key state/county agencies and community organizations to coordinate activities and investigations of CAN, including forensic interviews and examinations for children who have been sexually assaulted. The CJC is also instrumental in policy development and implementation.
- **Blueprint for Change** through its system of Neighborhood Places and partners in the community, is working for positive change to reduce environmental and social risk factors and increasing protective factors by providing access to resources; building the capacity of at risk families to provide for the safety of their children; and serves as a neutral hub in their communities for service coordination and community building.

Contact Information: Child Abuse and Neglect is a Title V priority issue for the Department of Health, Family Health Services Division. We encourage your in efforts to address this important issue.

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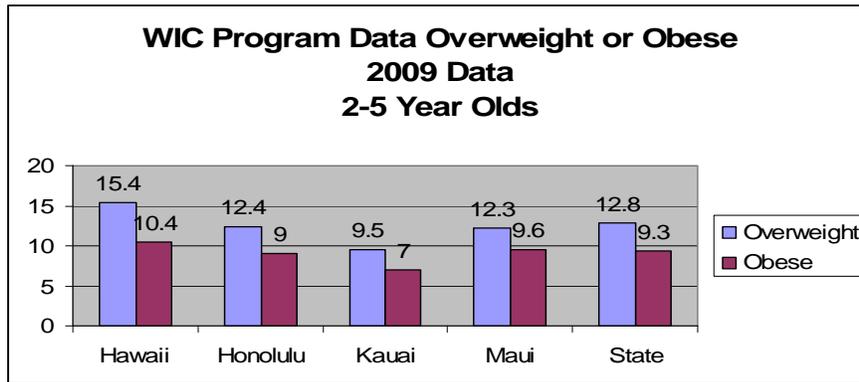
Updated 10/15/2010

Prevent Overweight and Obesity in Children

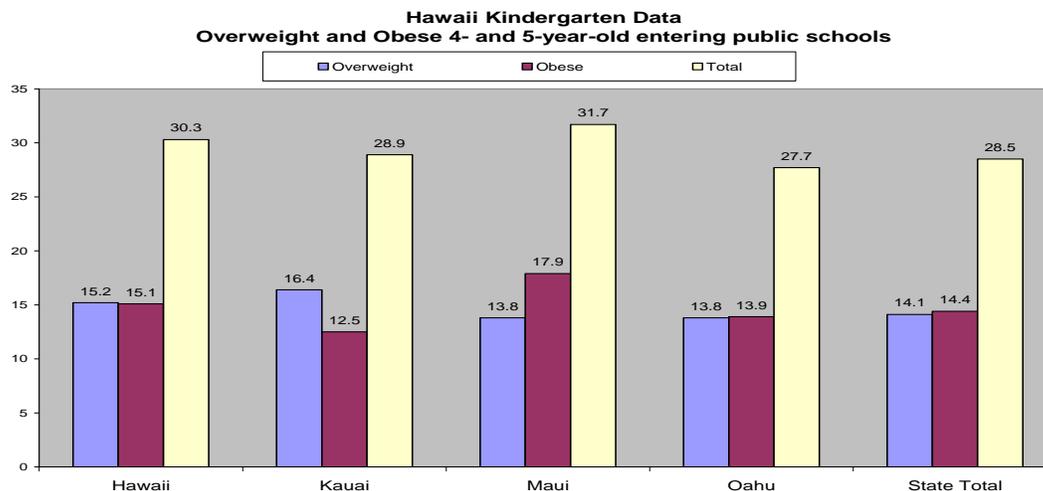
Issue:

Childhood overweight and obesity is a serious public health problem requiring urgent attention, with prevalence in Hawai'i and the United States growing considerably each year. Young children ages 0-5 are dependent on responsible adults to provide healthy and nutritious meals and to instill regular physical activity and healthy eating behaviors. More emphasis on starting early to develop healthful food and physical activity habits in children will lead to better health outcomes.

Data:



Source: Centers for Disease Control and Prevention (CDC) Pediatric Nutrition Surveillance System, 2009



Source: Pobutsky AM, Hirokawa R, Zou L, Huang T, Rosen L, Wood B. Overweight and at risk for overweight among Hawai'i public school students entering kindergarten, 2002-2003. *HI Med J* 2006;65:283-7

Target Group:

There are an estimated 101,540 children 0-5 years of age in Hawai'i (2006 Intercensal Estimate).

What is the Problem?

- A body mass index (BMI) of 85th-94th percentile is considered overweight, a BMI of 95th percentile and above, obese. The complex causes of overweight and obesity include genetic, biological, behavioral and cultural factors and can be related to poor eating habits, overeating, lack of exercise, family history of obesity, medical illnesses (endocrine, neurological problems), medications (steroids, some psychiatric medications), stressful life events or changes (separations, divorce, moves, deaths, abuse), family and peer problems, low self-esteem, depression or other emotional problems.
- Overweight and obesity increases the risk of heart disease, high blood pressure, diabetes, breathing and sleeping problems, depression, discrimination, bullying, poor school grades, low-self-esteem and obesity in adulthood. In addition, there are considerable economic costs with the national health care expenditures for overweight and obese adults alone estimated at over \$129 billion.

Strategies to Help Prevent Childhood Obesity:

- Early childhood programs can serve nutritious foods and beverages and allow at least 45 minutes of physical activity daily within the curriculum. Such programs can promote and reinforce healthy eating and physical activity family practices at home.
- Health care providers can routinely track BMI and counsel parents of children 2-5 years of age on the following evidence-based prevention strategies: a) limiting consumption of sugar-sweetened beverages, b) encouraging recommended quantities of fruits and vegetables, c) limiting TV and other screen time to no more than 2 hours per day, and removing TV and computers from bedrooms, d) eating breakfast daily, e) limiting eating out, particularly fast food restaurants, f) encouraging family meals in which parents and children eat together and g) limiting portion sizes. Health care providers can learn more about obesity prevention and resources, and use motivational interviewing.
- Parents and caregivers can be role models and practice healthy eating and physical activity. A great start towards obesity prevention and wellness early in a child's life is to breastfeed babies for at least the first six months of life.

What's Happening Around the State:

- **Women, Infants and Children (WIC):** This federally funded program provides nourishing supplemental foods, nutrition education, breastfeeding promotion and health and social service referrals. WIC participants are either pregnant, breastfeeding, or postpartum women, and infants and children under age five who meet income guidelines and have a medical or nutritional risk. WIC food packages encourage lower fat choices, higher fiber and whole grains, fruits and vegetables; mothers and infants get more foods if breastfeeding. Families receive a Sesame Workshop's "Healthy Habits for Life" kit to promote healthy weight for children. WIC uses motivational interviewing and stages of change to customize discussion with caregivers. <http://hawaii.gov/health/family-child-health/wic/index.html>
- **Maui:** The islands of Kauai and Maui are one of 40 recipients of the Communities Putting Prevention to Work (CPPW) grant funded by the CDC. The grant's overall goal is to reduce obesity through improved healthy activities and nutrition of all residents, including the hardest to reach and most at risk for diseases preventable by healthier lifestyles. Maui is focusing on improving healthy activities and nutrition primarily by promoting gardening, active volunteering, bike paths and walkable communities. This will include increased community and school gardens and improved networks between farmers, restaurants, grocers and schools. Policy changes to increase the use of local produce in stores and restaurants will be targeted.
- **Kauai:** Kauai will use the CPPW grant to fund a breastfeeding peer counselor, promote healthy eating and active living (e.g., the Mayor's Walk, Walking Workbus, Walkable Communities) and work with community agencies (e.g., community gardens, nutrition and cooking education classes).
- **West Hawai'i:** Big Island Breastfeeding Promotion Project improves infant nutrition among low-income families through an innovative collaboration that partners WIC Breastfeeding Peer Counselors and existing Early Head Start home visiting programs to provide targeted 1 to 1 infant feeding education and support prenatally through Baby's first birthday. In addition, all West Hawai'i women birthing at Kona Community Hospital are offered breastfeeding education, tools and support as an alternative to promotional gifts of infant formula. Project funding is shared among Family Support Hawai'i, WIC, and the West Hawai'i Local Area Consortia (Big Island Perinatal Health Disparities Project). The Family Support Services of West Hawai'i's Early Head Start program partners with WIC on a Breastfeeding Project that includes peer counselors and staff support to promote exclusivity (breastmilk only) and duration (extended period) of breastfeeding.
- **East Hawai'i:** The East Hawai'i Local Area Consortia (Big Island Perinatal Health Disparities Project) identified breastfeeding as a priority. The Public Awareness committee developed a brochure with information that "normalizes" breastfeeding. This brochure was distributed at a local supermarket during a Hawai'i Alliance Community Health event. The Consortia also sponsored two members to participate in a certification training class on Oahu to be certified lactation consultants.
- **Healthy Hawai'i Initiative (HHI):** HHI's Hawai'i Initiative for Childhood Obesity Research and Education (HICORE), University of Hawai'i, John A. Burns School of Medicine (www.hicore.org) to prevent childhood obesity. HICORE trains pediatricians and their office staff on evidence-based recommendations that help children and families maintain a healthy weight and provides ways to approach the subject during regularly scheduled well child visits. Those who pledge to integrate the approaches into their practice will be provided with handouts and posters that outline the recommendations in a way that is culturally tailored, and easy to read and understand. Patient education materials including translated versions are available online at www.healthyhawaii.com, under the Training section.

Contact Information: Childhood Obesity is a Title V priority issue for the Department of Health, Family Health Services Division. We encourage your questions, comments, and efforts to join us in addressing this important issue.

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Updated 10/05/2010



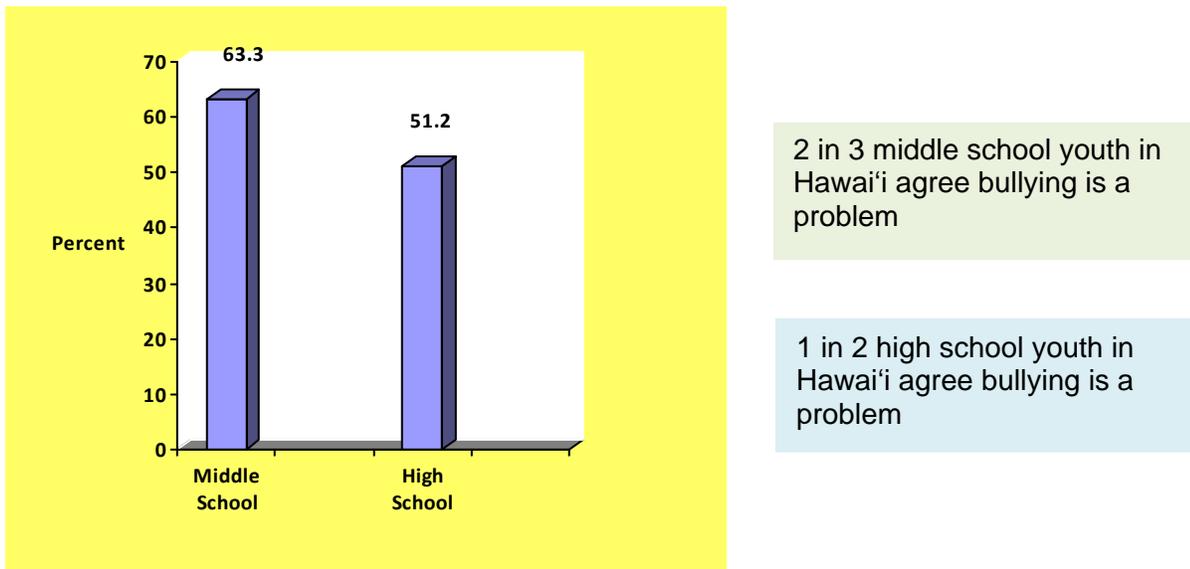
Prevent Bullying Among Adolescents

Issue:

- Bullying among adolescents encompasses a variety of negative physical (hitting, kicking, spitting, pushing, taking personal belongings), verbal (taunting, malicious teasing, name calling, making threats) and psychological acts (spreading rumors, manipulating social relationships, or engaging in social exclusion, extortion, or intimidation) carried out repeatedly over time. It involves a real or perceived imbalance of power, with the more powerful child or group attacking those who are less powerful.
- Bullying among school-aged youth is increasingly recognized as a problem that affects the well-being and social functioning of the broader community.
- The consequences of bullying are serious and the costs to communities are high. The Children Safety Network estimates the financial cost of youth violence in the United States at over \$150 billion per year and this includes medical costs, loss of productivity, and mental health costs.¹

Data:

Hawai'i Students Reporting Bullying & Harassment as a Problem in School, 2009



Source: University of Hawai'i, Curriculum Research and Development Group (DCRG). Hawai'i Youth Behavior Risk Survey (YRBS). Note: YRBS is administered in odd-numbered years in the public middle schools (n=1,231,n=1,611) and high (n=1,191,n=1,511) schools.

Target Group:

There are an estimated 114,644 children 11-17 years of age in Hawai'i (2006 Intercensal Estimate).

¹ Children's Safety Network, Economics & Data Analysis Resource Center, State costs of violence perpetrated by youth. [cited 2006 Jul 31]. Available from URL: www.edarc.org/pubs/tables/youth-viol.htm.

What is the Problem?

- Bullying behavior has been linked to other forms of antisocial behavior, such as vandalism, shoplifting, skipping and dropping out of school, fighting, and the use of drugs and alcohol.
- Bullying is a pervasive problem that has emerged as a public health issue as a response to prevent youth violence. Youth need to feel safe and need an environment where an individual, family, school, neighborhood, community and society support their safety.

Strategies to Consider:

- Identify resources and current status of programs/services statewide.
- Identify and convene county stakeholders to identify and work on collaborative strategies.
- Provide community education and awareness to promote training and education on bullying prevention strategies.
- Implement and support education for parents, teachers, and others who are in contact with adolescents to help them recognize and intervene in episodes of bullying.
- Foster coalitions and networks by convening multidisciplinary community-based teams to improve coordination of the assessment of bullying prevention services.
- Mobilize neighborhoods and communities to become active bystanders and to intervene quickly when risk factors are identified.

Resources Available:

- **Hawai'i Anti-Bullying Coalition** supports the Olweus Bullying Prevention Program in five East Hawai'i schools.
- There has been progress on the community level in bullying prevention programs such as:
 - **Asian Pacific Islander Youth Violence Prevention Center's (APIYVPC)** Safe Schools and Communities
 - the **Office of Attorney General's** Prevention Branch
- The **Department of Education's** (DOE) Comprehensive Student Support Services Positive Behavior Support is a sustainable program for schools and their communities to participate. The DOE has also established an online bullying prevention curriculum for teachers on their web site.

Contact Information: Bullying Prevention is a Title V priority issue for the Department of Health, Family Health Services Division. We encourage your questions, comments and efforts to join us in addressing this important issue.

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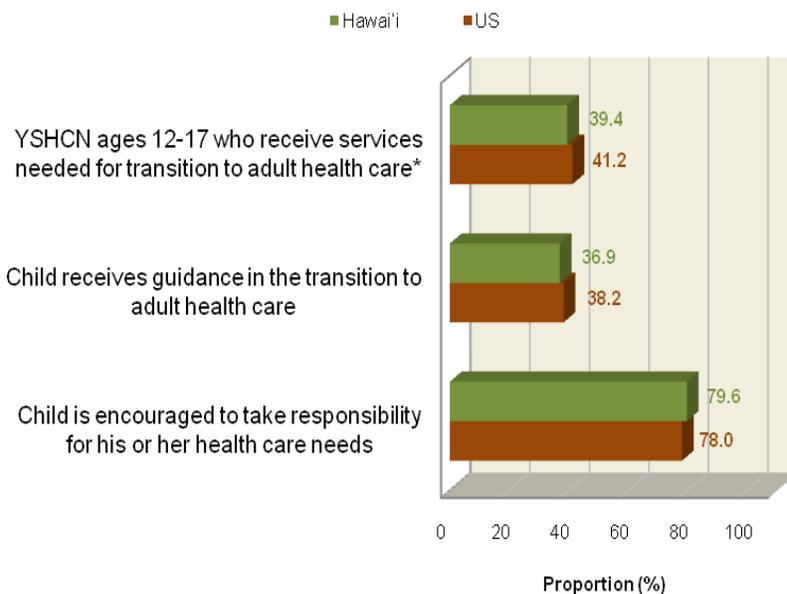
Promote Transition to Adult Health Care among Adolescents with Special Health Care Needs

Issue:

The transition from pediatric to adult health care is a significant issue facing all adolescents, but it is of critical concern to the 17% of adolescents with special health care needs.¹ To make this transition smooth, these young people need assistance over a period of time to assume their new role as informed health care consumers. They also need developmentally appropriate support to understand and manage their condition and to negotiate the changes when they move from pediatric to adult health care systems.

Data:

Health Care Transition Services Data for Youth Ages 12-17 Years with Special Health Care Needs in Hawai'i & the US: 2006



Both national & Hawai'i data reveal major gaps in transition services for Youth with Special Health Care Needs (YSHCN). According to the National Survey of Children with Special Health Care Needs, less than half of parents who have an adolescent with a special health care need report that their child's doctor/health care provider talked about meeting health care needs in adulthood. In fact, as many as three out of five parents with adolescents who have special needs reported not receiving the services necessary to make appropriate transitions to adult health care.

Most parents reported they encourage their adolescent with special needs to take responsibility for their health care.

*Outcome derived from other survey questions.

Source: U.S. Department of Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics. Summary Tables from the National Survey of Children with Special Health Care Needs, 2005-2006.

Target Group:

There are an estimated 15,900 children 14-21 years of age with Special Health Care Needs.¹

What Is The Problem?

A generation ago, most youth with special health care needs (YSHCN) with severe disabilities died before reaching maturity; now more than 90% survive to adulthood.² Most YSHCN are able to find their way to adult systems of care. However, many with severe medical conditions and disabilities (that limit their ability to function) experience difficulty transitioning from child to adult health care for various reasons including:

¹ Child and Adolescent Health Management Initiative. 2005/2006 National Survey of Children with Special Health Care Needs. Accessed from www.cshcndata.org/dataquery/dataqueryprint.aspx on June 1, 2008.

² A Consensus Statement on Health Care Transitions for Young Adults with Special Health Care Needs, *Pediatrics*, Vol. 110 No. 6 Dec, 2002 accessed from <http://aappolicy.aappublications.org/cgi/content/full/pediatrics;110/6/S1/1304>

- There are few adult health care providers who are familiar w/congenital or child onset conditions
- There are limited information, tools, resources, and services for YSHCN, their families, health care providers, and community providers to assist with successful transition to adult health care.

What Is The Transition Planning Process?

Ideally, transition planning is a coordinated effort of the YSHCN with support from the family, community agencies and medical professionals. If possible it should include development of the YSHCN to understand his/her strengths/challenges, to develop independent learning attitudes and informed decision-making skills.

Specific steps for ensuring an effective transition include: 1) having a primary care provider with responsibility for transition planning, 2) providing developmentally appropriate health care transition services, 3) maintaining an up-to-date portable medical summary, 4) creating a written health care transition plan by age 14, and 5) ensuring continuous health insurance coverage.

Strategies to Consider:

- Develop, update, disseminate informational resources and tools on transition planning
- Identify resources and current status of programs/services for transition planning
- Increase collaboration and service integration to improve transition services for YSHCN and their families.

Resources Available:

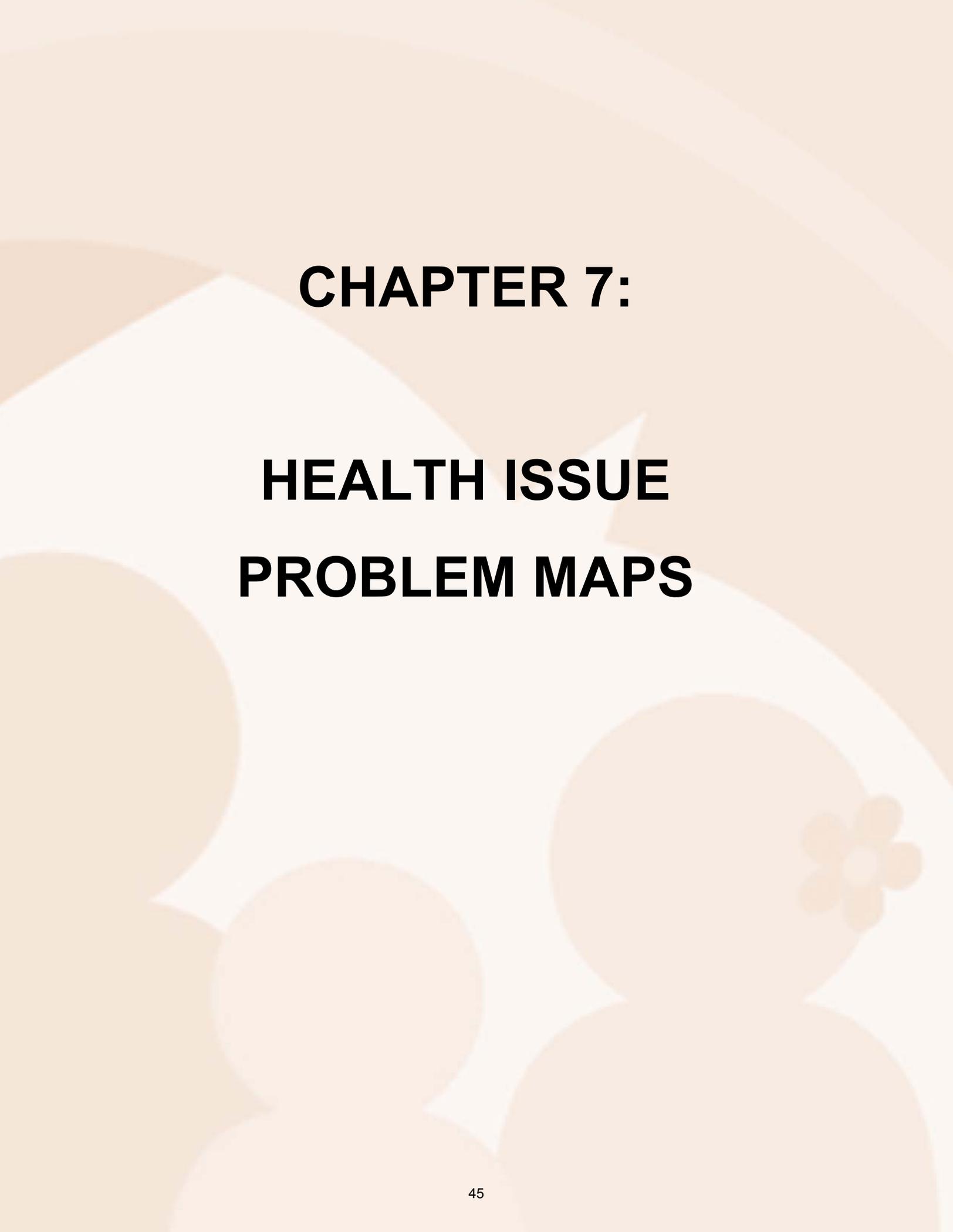
- The **Hilopa'a Family to Family Health Information Center (F2FHIC)**, funded by the MCH Bureau, was established by Family Voices of Hawai'i in partnership with the Hawai'i Pediatric Association Research and Education Foundation. F2FHIC provides information and referral, consultation, and training to families of CSHCN and their professional partners statewide. The following useful information can be found at their website: <http://hilopaa.org/default.aspx>.
 - The **Transition Planning Workbook** is a helpful tool to address transition to adult medical care as well as other areas of adult life. It includes tasks, activities, decisions, timeline and resources, and is a planning guide for families, as well as a facilitation guide for providers/programs to talk with families.
 - **Personal Health Record** a four-page form to record critical health information that can be used for transition planning.
 - **Rainbow Book—A Medical Home Guide to Resources for CSHCN and Their Families** includes programs/services for transition to adult life, including education, higher education and disability access, employment, and vocational rehabilitation.
- **“Where Am I Going? How Will I Get There?”** is a handbook for transition planning in aspects of life other than transition to adult medical care. This handbook was developed by the Statewide Independent Living Council of Hawai'i (ILCH). It is intended to serve as a resource for students and families participating in the development of the transition portion of the student's Individualized Educational Program. The handbook is available on the ILCH website www.hisilc.org/Youth/default.asp.
- **The Children with Special Health Needs Program (CSHNP)** assists eligible families with coordinating and obtaining services. CSHNP develops Family and Individual Plans (FIP) with CSHN families to identify family needs, services being provided, and to promote family involvement. It also assist with information and referral, nutrition consultation, access to medical specialty services, limited financial assistance, and transition planning to adulthood.

Contact Information: Transitioning from pediatric to adult health care is a Title V priority issue for the Department of Health, Family Health Services Division. We encourage your questions, comments, and efforts to join us in addressing this important issue.

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Updated 10/05/2010



CHAPTER 7:

**HEALTH ISSUE
PROBLEM MAPS**

Unintended Pregnancy Problem Map
Key Factors, Behavioral and Social Determinants

	FEMALE FACTORS	FAMILY FACTORS	SERVICE PROVIDER FACTORS
Tertiary Societal, Policy and Systems influences	<ul style="list-style-type: none"> • Mass media portrayals of sex without consequences • Promotion of sex-enhancing drugs (Viagra, etc) • Promotion and normalization of early sex initiation in mass media • Promotion and normalization of promiscuous sexual behaviors in mass media 		
Secondary Community, institutional settings, other social settings	<ul style="list-style-type: none"> • Availability of family planning services • Lack of insurance coverage for contraceptives and/or family planning services • Cost and availability of contraceptives • Lack of community knowledge of consequences of unintended pregnancy • Availability and use of alcohol and drugs • Cultural or religious beliefs regarding contraception use • Community acceptance of adolescent sex • Lack of sex education in schools • Poor quality of existing sex education programs • Dysfunction or abuse within family unit 	<ul style="list-style-type: none"> • Availability of family planning services • Lack of community knowledge of consequences of unintended pregnancy • Cultural or religious beliefs regarding contraception use • Lack of insurance coverage for contraceptives and/or family planning services • Community acceptance of adolescent sex • Lack of sex education in schools • Poor quality of existing sex education programs • Dysfunction or abuse within family unit 	<ul style="list-style-type: none"> • Community acceptance of adolescent sex • Lack of sex education in schools • Poor quality of existing sex education programs • Lack of insurance coverage for contraceptives and/or family planning services • Cost and availability of contraceptives • Lack of comprehensive family planning training for MDs • Lack of community knowledge of consequences of unintended pregnancy
Primary Individual behaviors, characteristics, relationships to others	<ul style="list-style-type: none"> • Lack of contraception use • Lack of contraception effectiveness • High sex frequency • Partner behavior • Substance use/abuse • Lack of health literacy and knowledge • Low income • Low education • Age • Intimate partner violence • Lack of control over personal decisions • Lack of perceived self-efficacy • Unmarried marital status • Mental illness • Coerced or forced sex • Early sexual debut • Lack of positive role models • Older partner • Unsupervised activities • Peer pressure • Low self esteem 	<ul style="list-style-type: none"> • Intimate partner violence • Lack of insurance • Partner behavior • Substance use/abuse • Low income • Early sexual debut • Lack of positive role models • Unsupervised activities 	<ul style="list-style-type: none"> • Lack of insurance • Lack of patient counseling and education

Prevention of Alcohol Use During Pregnancy
 Problem Map: Key Factors, Behavioral and Social Determinants

	MATERNAL FACTORS	SERVICE PROVIDER FACTORS
Tertiary Societal, Policy and Systems influences	<ul style="list-style-type: none"> • The American Congress of Obstetricians and Gynecologists' (ACOG), Center for Disease Control Prevention's (CDC), and the U.S. Surgeon General's professional guidelines recommend that all women within child bearing age are asked not to drink any alcohol during pregnancy and provide information and intervention about the adverse effects of alcohol on the fetus* • Establishments that serve and sell liquor are not required to post warning signs • The lack of programmatic funding • Need training for physicians and other health care professionals about the harmful effects of alcohol, screening, brief intervention and referral sources for all women within the childbearing age • Inconsistent message to women and the general public about the adverse effects of alcohol during pregnancy • Lack of systems collaboration and communication among existing care providers within the mental health, substance abuse, and social/health care professionals to provide a seamless, multidisciplinary delivery of care to women • Lack of education and awareness campaigning to the women, the general public, physicians and other health care professionals • No universal screening and brief intervention for alcohol use during pregnancy 	
Secondary Community, institutional, other social settings	<ul style="list-style-type: none"> • Availability of alcoholic beverages • Lack of public knowledge of alcohol use during pregnancy and the detrimental effects to a developing fetus • Social acceptance and availability of alcohol. • Community resources dwindling due to economic recession 	<ul style="list-style-type: none"> • Training for physicians and other health care professionals to screen and provide intervention/information to all women of child bearing age as recommended the U.S. Surgeon General • No universal alcohol screening and brief intervention for alcohol use during pregnancy tool • Limited collaboration/communication among current mental health, substance abuse, and women's health providers to address specialize prevention, intervention and treatment for pregnant women and their developing child
Primary Individual behaviors, characteristics, relationships to others	<ul style="list-style-type: none"> • All women of childbearing age regardless of age, race, education, and social-economic factors • All pregnant women • Late confirmation of pregnancy and prenatal care • Smokers • Social drinkers • Partner drinking behavior • Family history of alcohol use • Women with substance abuse or mental health problems • Women who have already had a child with a FASD • Women who have multiple sex partners • Recent victims of abuse and violence 	<ul style="list-style-type: none"> • Lack of knowledge of alcohol screening and brief intervention tool • Lack of consistency in routine screening and providing information on the dangers of alcohol use during pregnancy to all women within childbearing age • Limited knowledge of alcohol screening tools and referral resources • Time limits for medical appointment visits

* US DHH, Reducing Alcohol Exposed Pregnancies – A Report of the National Task Force on Fetal Alcohol Syndrome and Fetal Alcohol Effect, March 2009.

Early Identification/Screening for Developmental Delay in Young Children

Problem Map: Key Factors, Behavioral and Social Determinants

Developmental delays in young children should be identified early through regular screenings to assure that children receive appropriate care to promote optimal health.

	FAMILY FACTORS	CHILD FACTORS	HEALTH CARE PROVIDER FACTORS
Tertiary Societal, Policy and Systems influences	<ul style="list-style-type: none"> ● Poor State economy and budget cuts led to elimination of programs for children and families ● AAP policy needs to be re-enforced to ensure that pediatricians are using a standardized screening tool ● Early childhood practitioners need resources for screening to refer families if there is a concern for developmental delay ● Health care reform needs to advocate for the importance of screening and appropriate follow-up services. ● Policies supporting screening and follow-up services must be supported by resources to service children and families 		
Secondary Community, institutional, other social settings	<ul style="list-style-type: none"> ● Lack of education to inform parents on developmental milestones and the need for periodic developmental screening ● Lack of resources for parents if they have questions about their child's development. ● Lack of resources to support parents to advocate for and express concerns about their child's development with their primary care providers or early childhood practitioners 	<ul style="list-style-type: none"> ● Lack of quality early childhood programs for children to be observed by practitioners able to recognize possible delay ● Lack of a quality program in the child's community that provides routine screening ● Children develop at different ages and stages; they need a skillful caregiver to recognize what is developmentally appropriate behavior 	<ul style="list-style-type: none"> ● Lack of community resources for providers to refer parents for concerns about children's developmental delay ● Lack of assurance measures for completion of screening for EPSDT compliance ● Lack of community safety net services to refer families to
Primary Individual behaviors, characteristics, relationships to others	<p><i>Families have an important role in ensuring that their children receive screening and follow-up. Parents may not have an awareness of the need for developmental screening. Parents may not be aware of resources for developmental screening.</i></p> <p>Other factors affecting parents are:</p> <ul style="list-style-type: none"> ● Household income & Employment ● Education ● Family Structure ● Race/ethnicity/Cultural beliefs ● Health Literacy & Language ● Transportation 	<p><i>Children are dependent on their parents and caregivers to provide them with access to screening, services, and care if they are at risk for developmental delay.</i></p> <p>Some factors include</p> <ul style="list-style-type: none"> ● Age, Sex, Race/Ethnicity ● Health insurance ● Environmental Issues ● Type of delay (biological, developmental) ● Access to primary care or a medical home 	<p><i>Health care providers can recognize, screen, and assess whether children are at risk for developmental delay.</i></p> <p>Some factors include:</p> <ul style="list-style-type: none"> ● Lack of a standardized developmental screening tool ● Lack of time for providers to spend assessing a child's development ● Barriers to screening by primary care providers: office staffing, time, training, cost of tools, and payment issues

Updated November 2010

Child Abuse and Neglect Prevention (Ages 0-5 years) Problem Map

Key Factors, Behavioral and Social Determinants

Children Abuse & Neglect (CAN) Prevention with focus on activities that are targeted to the community at large and impacts families before an incident occurs.

	FAMILY FACTORS	CHILD FACTORS	INSTITUTIONAL CAREGIVERS & PROVIDERS FACTORS
Tertiary Societal, Policy and Systems influences	<ul style="list-style-type: none"> • Economy, increased rates of unemployment, lack of funding, dependence on outside caregivers because both parents work • Family friendly policies – e.g. health insurance, work/employer policies • Reporting laws • Social stigma • Domestic Violence policy (i.e. Temporary Restraining Orders and Child Protective Services referrals) • Lack of coordinated services 	<ul style="list-style-type: none"> • Lack of political will • Lack of positive family role models and media images • Lack of quality, affordable care for young children • Cultural norms – belief that you do not ask/seek assistance • Exposure to violence in the home, community, media • We often take a problem identification and not a problem solving approach • Geographic isolation and challenges of an island State 	
Secondary Community, institutional settings, other social settings	<ul style="list-style-type: none"> • Cultural values • Religious aspects • Unemployment • Lack of services for substance abuse • Lack of education services • Availability of parenting support • Lack of availability/access to community based services: transportation, substance abuse treatment, housing, food services • Lack of mental health services 	<ul style="list-style-type: none"> • Pediatrician, school, neighbors, community – not reporting CAN, “looking the other way” • Lack of awareness, sense of responsibility, accountability • Lack of knowledge and awareness of CAN signs and symptoms • Exposure to violence 	<ul style="list-style-type: none"> • Lack of training (reporting, signs/symptoms) • Lack of initiative to learn about services • Lack of resources • Lack of awareness of scope of resources • Lack of access to services
Primary Individual behaviors, characteristics, relationships to others	<ul style="list-style-type: none"> • Social isolation • Lack of knowledge of child development and parenting • Stress from depression (post-partum), socio economic disadvantage, unemployment • Substance abuse. • Domestic violence • Mental Illness • Caregiver history of abuse • Age – young/teen parent • Family & cultural values/practices • Ambivalent feelings about being a parent • Lack of financial resources 	<ul style="list-style-type: none"> • Age • Temperament • Special needs • Gender • Exposure to violence 	<ul style="list-style-type: none"> • Lack of knowledge of child development and parenting • Lack of understanding their role for identifying and preventing CAN • Lack of knowledge of resources • Lack of financial support • Lack of access for parental screening and tools (e.g. Maternal depression) • During times of stress, lack of recognition and understanding of signs and symptoms of protective and risk factors

Overweight and Obesity in Children ages 0 to 5 years
 Problem Map: Key Factors, Behavioral and Social Determinants

	DIETARY FACTORS	PHYSICAL ACTIVITY FACTORS	SOCIAL, ENVIRONMENTAL & HEALTH FACTORS
Tertiary Societal, Policy and Systems influences	<ul style="list-style-type: none"> • Poor State Economy (increase in poverty and unemployment) and budget cuts led to elimination of programs • Need more funding for prevention of childhood obesity programs • Health insurance does not reimburse for obesity prevention or treatment • Food industry continues to market unhealthy foods to children and does not promote prevention of obesity • Department of Education Wellness Policy not implemented consistently. No Early Childhood Wellness Policy • Lack of collaboration on obesity prevention (public health agencies, schools and community organizations) • Need workplace wellness policies to target parents to make healthier choices for themselves and their children 		
Secondary Community, institutional, other social settings	<ul style="list-style-type: none"> • Nutritious food is costly • Lack of access to healthy food • Abundance of fast food restaurants • Fast food can be inexpensive and convenient • Food Insecurity** 	<ul style="list-style-type: none"> • Early childhood programs need to promote physical activity for young children • Need more community programs promoting young children's physical activity 	<ul style="list-style-type: none"> • Parental under education (< than high school education)* • Lack of interaction during shared family mealtimes * • Lack of affordable housing* • Limited public transportation • Unsafe parks and neighborhoods* • Proximity of fast food restaurants
Primary Individual behaviors, characteristics, relationships to others	<p><u>Child Factors</u></p> <ul style="list-style-type: none"> • Drinking sweetened beverages • Eating Fast food/Junk food • Skipping breakfast • Eating out of boredom or stress • (Over) Eating in front of the TV • Food Insecurity** <p><u>Parental Factors</u></p> <ul style="list-style-type: none"> • Parents have poor food choices • Parents lack nutrition knowledge* • Mothers not breast feeding • No shared family mealtimes 	<ul style="list-style-type: none"> • Little physical activity by choice or due to disability • Excess (greater than 2 hours a day) of screen time i.e. TV, computer, video games • Lack of physical activity (recommended 60 minutes a day) • Parents lack knowledge about child's need for physical activity • Parents don't have time for physical activity with children 	<ul style="list-style-type: none"> • Health Care providers not aware of or do not follow best practices for prevention and treatment of obesity • Cultural perception of healthy weight and physical activity for infants & children • Lack of accepted wellness guidelines for early childhood programs. • Excess calories and portion sizes • Lack of dietary recommendations for fruits and vegetables and whole grains

* Direct and indirect causes of stress and health disparities

** Food Insecurity for a family means limited or uncertain availability of nutritionally adequate and safe foods, or uncertain ability to acquire appropriate foods in socially acceptable ways. Food insecurity forces people to buy and consume less-expensive foods, which are often less nutrient dense but more calorically dense and higher in fat than more expensive foods. In contrast, food secure families have access to sufficient food for a healthy lifestyle at all times.

Bullying Problem Map

Key Factors, Behavioral and Social Determinants

Bullying

One's need for power and (negative) dominance; finds satisfaction in causing injury and suffering to others; are often rewarded in some way for their behavior with material or psychological rewards. Four components of bullying: duration, frequency, intensity, and power imbalance.

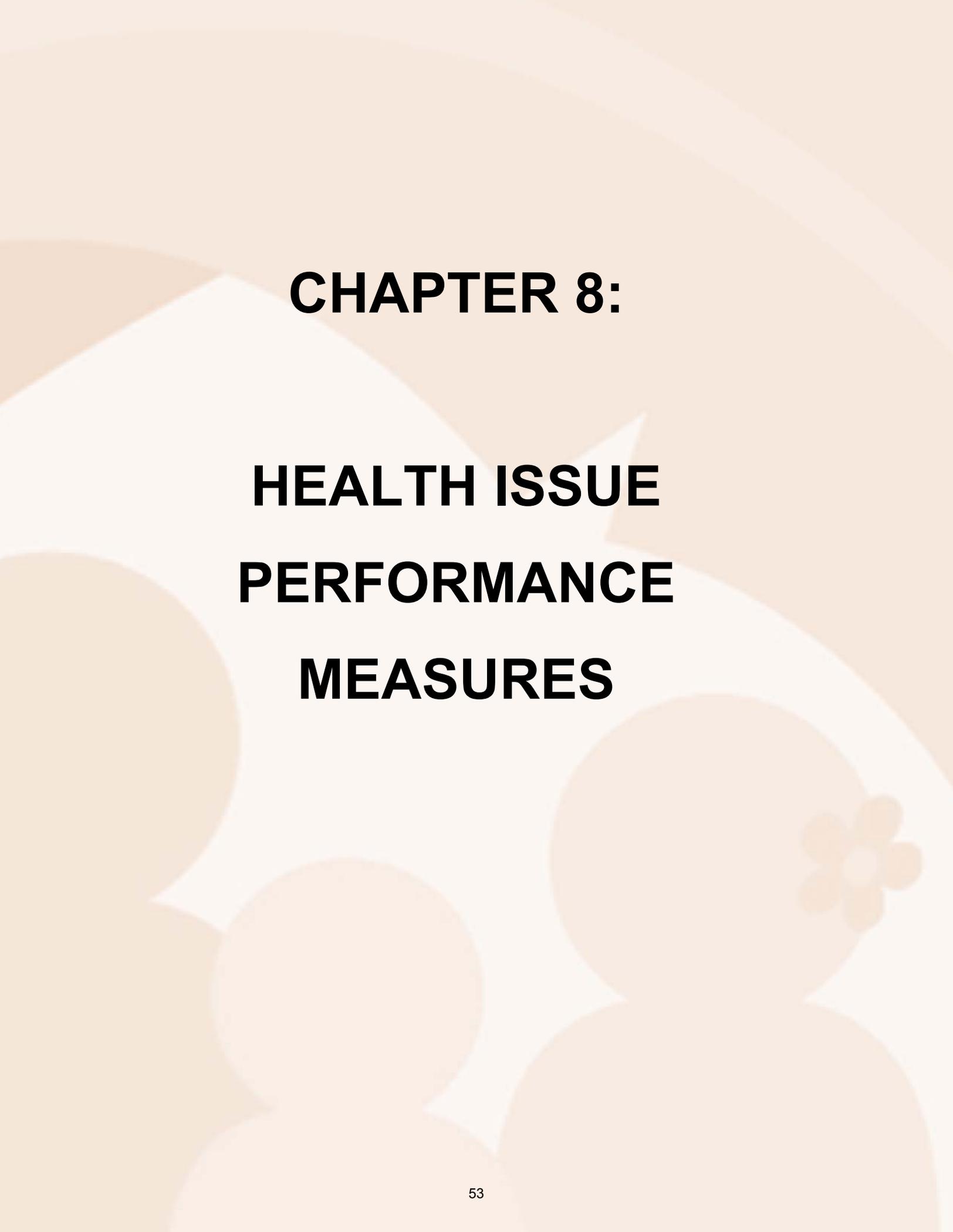
	BULLY	BULLIED	BYSTANDER
	<p>A bully has needs for power and (negative) dominance; finds satisfaction in causing injury and suffering to other students; are often rewarded in some way for their behavior with material or psychological rewards</p>	<p>A person is bullied when he or she is exposed, repeatedly and over time, to negative actions on the part of one or more other persons, and he or she has difficulty defending himself or herself</p>	<p>The bystander is a peer, sibling or adult who doesn't act to defuse the situation</p>
Tertiary Societal, Policy and Systems	<ul style="list-style-type: none"> • Social Norms • Colonial history • Technology • Economy 		<ul style="list-style-type: none"> • International Relations • Popular, Historical, Traditional Culture • Majority/minority issues • Racism
Secondary Community, institutional, other social settings	<ul style="list-style-type: none"> • Policies and procedures • Policy environment does not deter harm • Institutional norms, rules, structure • Unable to get help from adults in setting 	<ul style="list-style-type: none"> • Lack of or no security in setting • Inadequate supervision • Inappropriate adult intervention • Institutional prejudice • Community or widespread fear 	<ul style="list-style-type: none"> • Policies to include technology • Safe reporting system • Social norms/tolerance • Culture that surrounds problem behavior • Awareness of problems
Primary Individual behaviors, characteristics, relationships to others	<ul style="list-style-type: none"> • Family attitudes that reinforce power differentials • Family history of violence • Family dysfunction • Poor adult models • Ability to control and influence peers • Activities that promote aggressive behavior as positive • Lack positive connection with neighborhood environment • Exposure to drugs, gangs, criminal activities • Parental availability and supervision • Intolerance of differences, i.e. religious practices, morals, values, beliefs • Poor social behaviors • Individual character traits, i.e. lack of empathy, lack of respect 	<ul style="list-style-type: none"> • Physically weaker • Few friends (socially isolated) • Non-conformist • Lack social skills • Distrust of others • Unable to communicate needs • Shy, sensitive, insecure, low self-esteem, easily intimidated • Feelings of depression, anxiety, helplessness, and hopelessness • Physical disability • Non-traditional lifestyle • Non-membership in dominant group(s) • No confidence in authority figures to provide long-term solutions • Perceived threat to bully 	<ul style="list-style-type: none"> • Social influence • Mislabeling/misperception of aggression • Diffusion of responsibility • Social norms • Fear of retaliation • Lack of empathy for the bullied • Individual versus group responsibility and values (audience inhibition) • Complicit (state of being an accomplice)

Transition Planning for Youth with Special Health Needs (YSHN) From Pediatric to Adult Healthcare
 Problem Map: Key Factors, Behavioral and Social Determinants that Contribute or are Associated with the Issue

Transition planning is the purposeful & deliberate movement from a pediatric to adult health care provider as the individual moves from adolescence to adulthood. Careful transition planning assures developmentally appropriate health care services continue uninterrupted. YSHCN can face significant challenges finding an adult healthcare provider that is able to manage severe medical conditions or disabilities that originate in childhood.

	FAMILY FACTORS	CHILD FACTORS	HEALTH SERVICE FACTORS
Tertiary Societal, Policy and Systems influences	<ul style="list-style-type: none"> • Poor State economy leading to increased unemployment & budget cuts to healthcare services • National healthcare reform-impact is unknown at this time • Eligibility & access barriers to enroll into Med-QUEST • Medicaid's delay in payment to providers due to budget shortfall 	<ul style="list-style-type: none"> • Fragmentation of adult health care system* • National consensus statement on health care transitions for young adults with special health care needs by the American Academy of Pediatrics, American Academy of Family Physicians, American College of Physicians-American Society of Internal Medicine* Endorsed by the Society of Adolescent medicine* 	
Secondary Community, institutional settings, other social settings	<ul style="list-style-type: none"> • Inadequate transportation services for YSHCN to access healthcare especially on the neighbor islands/rural areas • Lack of education/materials on transition planning for families in English and other languages • Loss of Insurance coverage as the child becomes an adult* • Loss of health insurance due to unemployment or under employment • Difficulty finding & accessing support services for transition planning* 	<ul style="list-style-type: none"> • Youth "age out" of their case management services at age 19-21* • Difficulty finding & accessing support services for transition planning* 	<ul style="list-style-type: none"> • Less community services (SW, Case Managers, etc) to assist with transition planning for young adults* • Inadequate transportation services to access health care services, especially on the neighbor islands/rural areas • Lack of adult primary and specialty providers, (especially on Neighbor Islands) • Fragmentation of primary and specialty care* • No clear model/recommendations for health care transition for YSHCN* • Lack of trainings (materials/resources)for transition planning for health care providers* • Lack of medical reimbursement for transition planning* • Poor reimbursement for chronic illness care* • Limited adult providers w/knowledge and experience of childhood-onset conditions* • Lack of facilitators to coordinate healthcare transition*
Primary Individual behaviors, characteristics, relationships to others	<ul style="list-style-type: none"> • Income below poverty level* • Lack of family support system • Lack of knowledge/education on transition planning* • New immigrants* • Non-English speaking household* • Inadequate transportation • Live on neighbor islands or in rural areas w/limited access to specialized care • Desire to stay w/pediatric providers* • Lack of motivation to plan for transition* • Cultural barriers* • Lack of knowledge about health insurance coverage • Multiple stresses related to many transitions occurring during this time* • Providers may not acknowledge importance of family's role 	<ul style="list-style-type: none"> • Affects children 14-21 years of age • Males more are less likely to receive planning* • YSHN with severe medical conditions or disabilities* • Uninsured or underinsured* • Limited employment opportunities that offer health insurance • Lack of awareness, motivation to plan for transition* • Lack of self-confidence, self-advocacy skills* • Desire to stay w/pediatric provider* • Lack of knowledge/understanding of their underlying medical condition • No medical home* • May not visit primary care doctor regularly to do transition planning (may see specialists more often) • Maturity level, developmental functioning still emerging • Multiple stresses related to many transitions occurring during this time* 	<ul style="list-style-type: none"> • Difficulty identifying primary care providers willing to take YSHN* • Lack of provider knowledge of transition planning* • Lack of time and reimbursement for planning* • Adult care providers hesitant to take YSHN w/end of life issues in young patients* • Lack of knowledge/connections to community resources* • Resistance from family/youth* • Hesitancy of pediatricians to transition youth to adult health care system

*Based on literature review



CHAPTER 8:

**HEALTH ISSUE
PERFORMANCE
MEASURES**

Priority Issue Performance Measures

The Title V Needs Assessment Steering Committee identified seven state priority issues. These Priorities are the programmatic focus areas for FHSD work in partnership with other agencies/programs through 2015. Three priorities are continuing from the 2005 needs assessment: unintended pregnancy, child overweight (with a focus on early childhood), and alcohol use during pregnancy. Each priority is described in relationship to the National and State performance measures used to track them and are listed in no particular order.

Priority 1: REDUCE THE RATE OF UNINTENDED PREGNANCY

The performance measures related to this priority are:

NPM 8 the rate of birth (per 1,000) for teenagers ages 15-17 years.

SPM 1 The percent of pregnancies (live births, fetal deaths, abortions) that are unintended.

Priority 2: REDUCE THE RATE OF ALCOHOL USE DURING PREGNANCY

The performance measure related to this priority is:

SPM 2 Percent of women who report use of alcohol during pregnancy.

Priority 3: REDUCE THE RARE OF OVERWEIGHT AND OBESITY IN YOUNG CHILDREN AGE 0-5

The performance measure related to this priority is:

NPM 14 Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.

Priority 4: IMPROVE THE PERCENTAGE OF CHILDREN SCREENED EARLY AND CONTINUOUSLY AGE 0-5 FOR DEVELOPMENTAL DELAY

The performance measure related to this priority is:

SPM 3 The percentage of parents of children 5 months to 5 years who report completing a standardized developmental and behavioral screener (SDBS) during a health care visit in the past 12 months.

Priority 5: IMPROVE THE PERCENTAGE OF YOUTH WITH SPECIAL HEALTH CARE NEEDS AGE 14-21 YEARS WHO RECEIVE SERVICES NECESSARY TO MAKE TRANSITIONS TO ADULT HEALTH CARE

The performance measure related to this priority is:

NPM 6 The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work and independence.

Priority 6: REDUCE THE RATE OF CHILD ABUSE AND NEGLECT WITH SPECIAL ATTENTION ON AGES 0-5 YEARS

The performance measure related to this priority is:

SPM 4 The Rate of confirmed child abuse/neglect reports per 1,000 children aged 0-5 years.

Priority 7: PREVENT BULLYING BEHAVIOR AMONG CHILDREN WITH SPECIAL ATTENTION ON ADOLESCENTS AGE 11-18 YEARS

The performance measure related to this priority is:

SPM 5 Percent of teenagers in grades 6 to 8 attending public school who report ever being bullied.

Note: SPM refers to State Performance Measure and NPM refers to National Performance Measure in the federal Title V Maternal & Child Health Block Grant Report

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